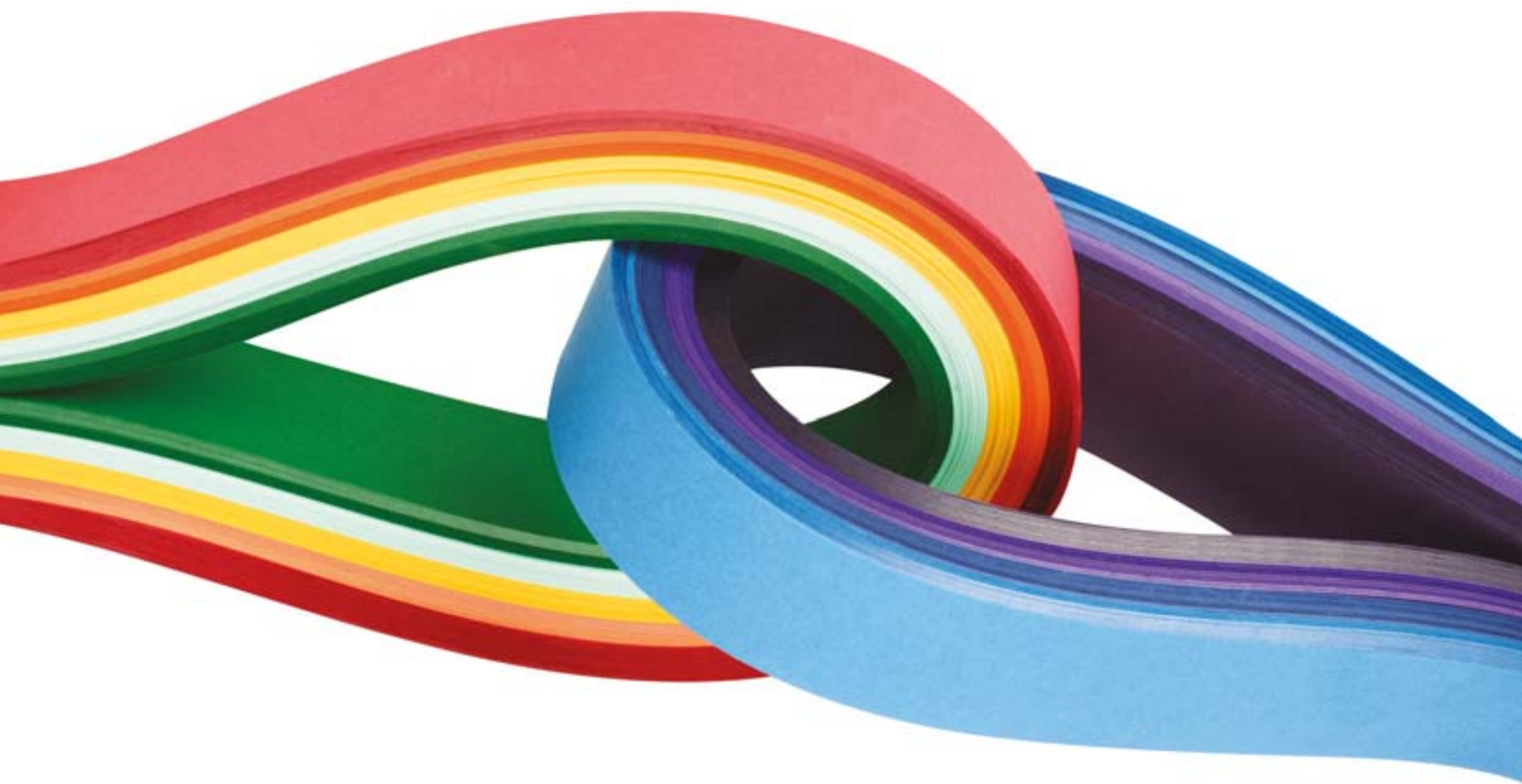


**Deloitte.**

Healthcare for the Homeless  
Homelessness is bad  
for your health



Deloitte Centre  
for Health Solutions

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## **The Deloitte Centre for Health Solutions**

The Deloitte Centre for Health Solutions generates insights and thought leadership based on the key trends, challenges and opportunities within the healthcare and life sciences industry. Working closely with other centres in the Deloitte network, including the US Center in Washington, our team of researchers develop ideas, innovations and insights that encourage collaboration across the health value chain, connecting the public and private sectors, health providers and purchasers, and consumers and suppliers.

# Foreword

Welcome to the Deloitte Centre for Health Solutions report on Healthcare for the Homeless. This report presents the Centre's views on:

- the extent of homelessness and challenges faced by the single homeless
- Government policy and commissioning challenges
- the need for wider adoption of innovative solutions.

There have been numerous local and central government initiatives over the last decade aimed at reducing homelessness and ending rough sleeping. The past three years, however, have seen homelessness begin to increase. The effects of the recession and the recent housing benefit cap have many commentators predicting that the numbers will continue to rise unless urgent action is taken.

Single homeless people have a high prevalence of physical ill health, mental ill health and addiction, and are chaotic users of healthcare, relying to a large extent on accident and emergency departments. While improving their health addresses only one of their many needs, it can be a vital first step in helping to tackle some of the other underlying problems that led to them becoming homeless. In a civilised society, the provision of a good standard of medical care for the homeless is not only morally right, it also makes good economic sense.

Improving the health of the homeless is dependent on effective commissioning of appropriate healthcare services. Until recently GPs could decide whether or not to provide such services, with Primary Care Trusts responsible for commissioning where GPs opted not to. The Health and Social Care Act 2012 requires the new GP-led clinical commissioning groups to address the healthcare needs of the whole population, not just their registered lists, and provides an ideal opportunity to develop services for the homeless in a cost-effective way.

This report is the result of fact-finding, analysis and interviews with policymakers, service providers and experts who support homeless people to lead healthier lives. While this report presents the opinion of the Centre for Health Solutions, we hope that it provides an insightful viewpoint on a largely invisible and neglected part of our population. We thank you for your interest and would welcome your feedback.

**Karen Taylor**

Director, Centre for Health Solutions

# Executive summary

There are currently over 2,000 rough sleepers in England and more than 40,000 people living in hostels and other temporary accommodation. By 2003, initiatives launched during the late 1990s to reduce the number of homeless people had started to have an impact and homelessness numbers started to decline. However since 2009 the levels have begun to rise.

Chronic homelessness is characterised by tri-morbidity: physical ill health, mental ill health and substance abuse. Long-term homeless people often die at a much younger age than the general population and have a much poorer quality of life. Being homeless for even a short period of time increases the risk of long-term health problems.

Despite the complex health needs of the homeless, they are often underserved by both primary and secondary care. The National Health Service is difficult to access for people without a fixed address or an address of any kind. This, along with the generally unpredictable lifestyles of homeless people, tends to result in them neglecting their health and seeking help at a much later stage in an illness than the general population. More often than not, they seek help from accident and emergency departments, attending six times as often as the general population. They stay in hospital three times as long, with the average cost of hospital services for a single homeless person four times higher.

While there are a number of NHS and charitable services across the country dedicated to providing healthcare and other support to the homeless, half of homeless services have experienced funding cuts. In addition, the amount of NHS funding on services is shrinking.

Homelessness is a complex issue, with no single cause or solution, requiring cross-government co-ordination and support. The research evidence suggests unequivocally that 'being homeless is bad for your health'. This report does not set out to provide solutions for tackling homelessness; instead, the focus is on addressing the complex health challenges of the homeless and identifying practical solutions for commissioners and providers to implement.

This report provides policymakers, local decision makers, commissioners and providers of healthcare with an overview of these healthcare challenges. The focus of the report is on the single homeless, those who move between the streets and hostels. It presents a number of innovative models of care which have some measurable evidence of success along with models of care that are operating successfully in other countries. While one size solutions won't fit all, wider adoption and diffusion of these models should help improve health outcomes for the homeless population.

Effective commissioning is essential in building a new healthcare landscape. Commissioning services for the homeless has always been a challenge; however, under the Health and Social Care Act 2012, reducing health inequalities is now a requirement. From April 2013 the new NHS Commissioning Board and local clinical commissioning groups will be responsible for commissioning healthcare services, and local health and wellbeing boards will be responsible for determining their commissioning priorities based on strategic needs assessments. Clinical commissioning groups will have a duty to provide services for all patients in their locality, whether registered or not, including services for the homeless.

The new NHS policy and commissioning landscape provides an opportunity to highlight and prioritise the healthcare needs of all disenfranchised groups, including the homeless. It also has the potential to give added impetus to improving the standard and quality of services provided to them.

More specifically, the Act promotes the principle of primary, community and acute providers working together to provide an integrated health and social care approach. An integrated system would enable healthcare providers to keep better track of homeless patients and encourage them to seek care when it is needed, rather than waiting until a minor ailment has developed into a more serious problem. Failure to integrate services effectively is likely to lead to neglected health problems, higher levels of emergency admissions, prolonged and repeated hospital spells, and poor health outcomes.

# Part 1. The extent and healthcare costs of homelessness

## Who are the homeless?

The Department for Communities and Local Government (DCLG) describes a person as statutorily homeless, and therefore eligible to apply for homeless duty, if: “they do not have accommodation that they have a legal right to occupy, and which is accessible and physically available to them (and their household), and which is reasonable for the whole household to continue to live in. Someone is ‘threatened with homelessness’ if they are likely to become homeless in 28 days.”<sup>1</sup>

Homelessness comes in different forms. Many people consider that rough sleepers – those who live and sleep on the street – represent the homeless population. However, in reality, rough sleepers make up only a small proportion of the total homeless population. Homeless people are also hostel dwellers, those in bed and breakfast or other temporary accommodation, and ‘sofa surfers’ – those staying with relatives or friends. This report focuses on single homeless people who move between the streets and hostels.

It is difficult to know how many people are homeless in England. By the very nature of homelessness, they are rarely on any comprehensive formal register or record which would allow them to be counted. As a result, there are varying estimates and methodologies for assessing the total homeless population, with most using street counts and users of homeless services to reach a total. Figure 1 shows the current estimates of the number of homeless people and while none of the figures are definitive, they all show that in recent years homelessness has been increasing.

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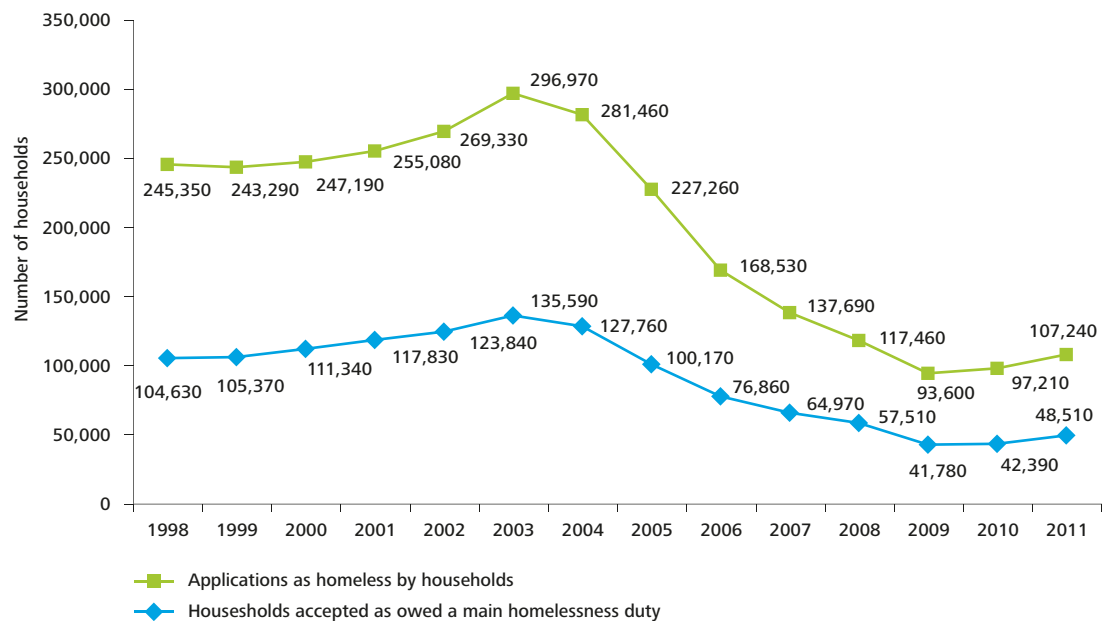
Figure 1. Estimates of the number of homeless people

Estimate	Year	Notes	Source
48,150 42,390	2011 2011	The number of households accepted as owed a homelessness duty	Statutory Homelessness Statistics, DCLG
107,240 97,210	2011 2010	The number of households that applied for homelessness duty	Statutory Homelessness Statistics, DCLG
40,500	2010	Number of homeless people, based on 45,000 available hostel spaces, assuming 90% occupancy rates	Healthcare for Single Homeless People, Department of Health
47,093 45,452	2010 2009	Number of homeless people by definition ‘single homeless people with support needs’, using housing support services (e.g. hostels)	A Review of Single Homelessness in the UK 2000-2010, Crisis
105,500	2010	Number of people cycling in and out of homelessness, based on Supporting People data and homeless population estimates.	Healthcare for Single Homeless People, Department of Health; A Review of Single Homelessness in the UK 2000-2010, Crisis

Figure 2 details the number of households applying for and accepted by local authorities as owed a homelessness duty. This data is useful as it has been consistently collected over a number of years. Although the figures may not fully reflect the total number of homeless people, the period of decline followed by a recent increase is the best available representation of the pattern of homelessness experienced over the last 13 years. Nearly one-quarter of the households accepted as owed a homeless duty were in London.

Since peaking in 2003, numbers fell by 69 per cent between 2003 and 2009. An independent study concluded that this was due in part to initiatives implemented by the Labour Government.<sup>2</sup> This fall, however, has been followed by an increase of 16 per cent over the period 2009-11. In 2011, some 107,240 people approached their local authorities as homeless, a ten per cent increase from 2010.<sup>3</sup>

**Figure 2. Households applying for and accepted by local authorities as owed a homelessness duty**

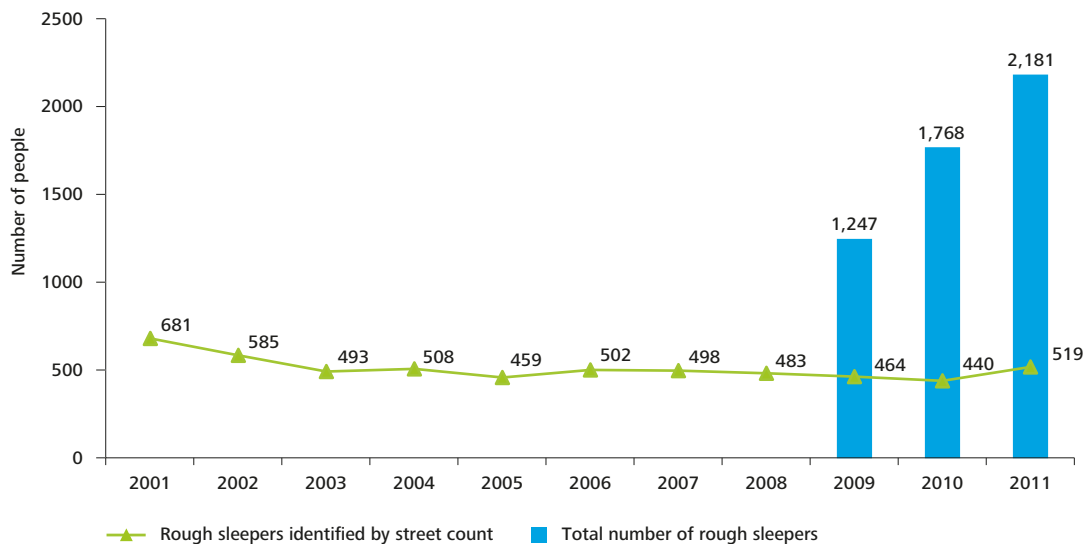


Source: Statutory Homelessness Statistics England, Department of Communities and Local Government, 2011

Total numbers of rough sleepers are even harder to gauge; the methodology for estimating rough sleepers involves conducting a street count on one night each year. Unfortunately, only 70 of 326 local authority areas participate in the street count, with the remaining 256 providing estimates since 2009. Figure 3 shows the *actual* number counted by the 70 local authorities (the line), and for 2009-11, the columns show the total estimated numbers based on street counts plus *estimates* from non-participating local authorities.<sup>4</sup>

The latest estimate from the annual street count suggests that there were 2,181 rough sleepers in 2011, an increase of 75 per cent since 2009.<sup>5</sup> London and the South East consistently account for around 40 per cent of all rough sleepers. However, these figures are much lower than those reported by some local agencies; for example a report from Broadway, a London-based homelessness charity, estimates that there were 4,000 people sleeping rough in London in 2010-11.<sup>6</sup>

Figure 3. Rough Sleepers, street count and total



Source: Rough Sleeping Statistics England, Department of Communities and Local Government, 2011

In 2011, 50 per cent of the homeless population were between the ages of 25 and 44. The second largest group was those aged 16 – 24, with 35 per cent of the homeless population in this category in 2011.<sup>7</sup>

Research suggests that homeless people are predominantly male; the Combined Homeless and Information Network (CHAIN) database reports that 87 per cent of rough sleepers in London are male.<sup>8</sup> Data from the Department of Health (the Department) reports that 78 per cent of patients with no fixed abode (NFA) are male.<sup>9</sup>

### The homeless as users of healthcare

All UK residents are entitled by law to access primary care services which are free at the point of need, as laid out by the NHS Constitution.<sup>10</sup> Under the rules of the NHS you have the right to choose a general practice and be accepted onto the register by that practice unless there are reasonable grounds to refuse you, such as living outside the practice boundary. If you are not able to provide a fixed address, you are less likely to be able to register; indeed studies show that homeless people are considerably less likely to be registered with a local GP.<sup>11</sup> In addition, four out of five general practitioners (GPs) acknowledged that it was difficult for a homeless person to register with a GP.<sup>12</sup> As a result, GPs are not the routine gateway to healthcare for homeless people that they are for the general population.<sup>13</sup>

For the general population, 90 per cent of patient contact with the NHS is within primary care.<sup>14</sup> A number of research studies indicate that the majority of contact for the homeless is with acute hospitals:

- Homeless people attend A&E up to six times as often as the general population, are admitted four times as often and once admitted, tend to stay three times as long in hospital, as they are much sicker and as a result, acute services are four times and unscheduled hospital costs are eight times those of general patients.<sup>15</sup>
- One in ten homeless people who accessed A&E in the past year used it at least once a month.<sup>16</sup>
- Nearly 90 per cent of all NFA admissions are emergency admissions, compared to around 40 per cent of admissions for the general population.<sup>17</sup>

Some homeless people may actually be registered with a GP but since becoming homeless may have moved to a different practice area. Homeless services generally encourage their clients to register with a GP, and while they have had some success, maintaining this contact is quite challenging and generally fails to improve their visibility within the practice as their homeless status is not flagged in the patient records in a consistent way.

In 2010, the Department acknowledged that there may be a disincentive for primary care trusts (PCTs) to provide good primary care for such a complex and mobile population as such services could attract homeless people from other areas.<sup>18</sup> Yet the poor health status of homeless people means they are more likely to be in need of primary care than many in the general population.<sup>19</sup>

Chronic homelessness is characterised by tri-morbidity: physical ill health, mental ill health and substance abuse.<sup>20</sup> In fact, homeless people have twice the level of mental ill health than the general population. Mental ill health is a major contributing factor in making people homeless and can also be a consequence of being homeless. Up to 70 per cent of people who use homeless services suffer from mental ill health and many self-medicate with alcohol and drugs, exacerbating existing health problems.<sup>21</sup>

Illnesses that could easily be treated within a primary care setting, such as impetigo and foot and wound infections, are prevalent within the homeless population. However, the lack of access to healthcare means they do not seek help until they are profoundly ill, and then often from A&E. Sometimes the extent of the illness is so acute that it would have forced any other person to seek medical help days earlier.<sup>22</sup>

One of major challenges in caring for the homeless is after they leave hospital. Once they are no longer ill enough to command a hospital bed they are discharged, but into an environment that rarely facilitates effective recuperation. As a result they often end up back in A&E; research shows that emergency readmission rates within 28 days of discharge from hospital are particularly high among homeless people.<sup>23</sup>

These scenarios all contribute to secondary care costs for the homeless population of at least £85 million annually. This equates to over £2,100 per person, compared with £525 for the general population (see Figures 4 and 5).<sup>24</sup>

**Figure 4. Estimated resource use and cost of the homeless population<sup>25</sup>**

*Inpatient admissions:*  
Taking into account the relative rate of admission and relative cost per episode, inpatient stays are costed at **£76.2 million**. This is a minimum estimate.

*Outpatients:*  
Assuming the same number of outpatient admissions for the homeless per person as for the general population, there are an estimated 45,000 outpatient appointments per year, totalling **£4.4 million**.

*A&E attendances:*  
Assuming that attendance is, on average, five times as frequent for the homeless, this would amount to 53,000 annual attendances, totalling **£5.1 million**.

*Overall:*  
The total cost of hospital usage by the homeless is conservatively estimated to be **£85 million**.

**Figure 5. Comparison of healthcare costs<sup>26</sup>**

Indicator	Homeless population	General population	Ratio
Acute services	£2,115	£525	4:1
Inpatient	£1,877	£391	4.8:1
Inpatient aged 16-64	£1,877	£235	8:1



One hospital, University College London (UCLH), estimated that in 2009 the total cost of homeless admissions was £1,515,954, with each homeless patient admission costing £3,399.<sup>27</sup>

While different sources cite different figures, it is accepted that healthcare costs per homeless person are significantly more than for the general population.

### Healthcare challenges faced by the homeless

Being homeless, even for a short period of time, can have a huge impact on a person's health; the average age of death for a homeless person sleeping rough is 47 years old, compared with 77 for the general population.<sup>28</sup> This is different to life expectancy and does not mean that someone aged 40 can only expect to live for another seven years. However, sources confirm that homelessness is associated with increased mortality.<sup>29,30</sup>

### Access to primary care

There are various specialist primary care services for homeless people. These take the form of dedicated homeless teams at mainstream general practices or general practices that only treat homeless patients. However, these services may come with caveats. For example, patients must be living in temporary accommodation locally or sleep rough locally.

The high incidence of A&E admittances for homeless people suggests that access to primary care is still a problem. The Survey of Needs and Provision (SNAP) 2012 conducted by Homeless Link found that 12 per cent of homeless people reported access problems to physical health services, 37 per cent to mental health services, 32 per cent alcohol services and 26 per cent drug services.<sup>31</sup>

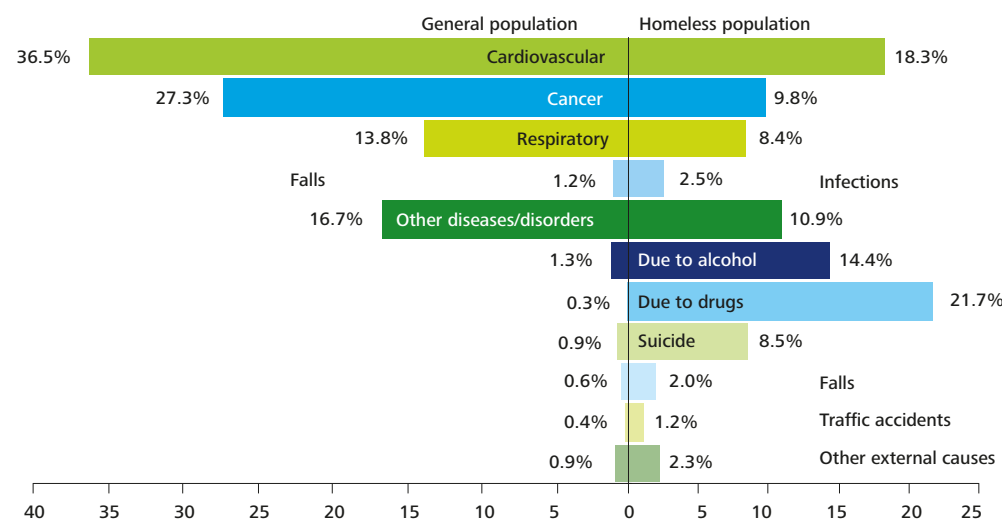
Access on its own is insufficient if the homeless do not know how and when to access primary care, or if they previously had a negative experience. Research also suggests that homeless people require better information about the health services available.<sup>32,33</sup>

### Complex healthcare needs

Problems with drugs and alcohol are often a contributing factor to becoming homeless, but problems may also develop after becoming homeless as a mechanism for coping. In fact, four out of five homeless people start using at least one new drug after becoming homeless.<sup>34</sup>

Homelessness has a high correlation with tuberculosis, trench foot, frost bite, wound infection, asthma, bronchitis and pneumonia, diabetes, hepatitis C, HIV and aids, especially among intravenous drug users.<sup>35</sup> Their cases are often far more complicated than the average patient accessing primary care. This is reflected in the causes of death among homeless people (see Figure 6).<sup>36</sup>

Figure 6. Distribution of causes of death for the general population compared with the homeless population



Source: Homelessness: A silent killer, Crisis, 21 December 2011

### **The need for more integrated services**

Homeless people need co-ordinated help from different parts of the health and social care system, such as hospitals, supported hostel places, drug and alcohol detoxification programmes, psychiatric help, social services and GPs. Integration of any kind can be difficult due to multiple incomplete or missing medical records and the difficulty of contacting and maintaining contact with patients with chaotic lifestyles.<sup>37</sup> This can result in patients not receiving appropriate treatment in different care settings.

Many benefits are claimed for integrated health services: that they are cost-effective, patient-oriented, equitable and locally owned;<sup>38</sup> that they minimise organisational barriers between different services and commissioners.<sup>39</sup> For the homeless, the main benefit of integration is that services are easier to navigate, allowing them to receive all the services they need without separate appointments and different locations.

In 2011, the NHS Future Forum called for the commissioning of integrated care for patients with long-term conditions, complex needs or at the end of life.<sup>40</sup> While there was only limited reference to healthcare for vulnerable groups, including the homeless, the Forum acknowledged that such groups would likely benefit from a similar approach to commissioning.<sup>41</sup>

### **Absence of effective hospital and post-hospital discharge care**

In 2006, the Department published guidelines for the hospital admission and discharge of homeless people. The guidelines recommend identifying homeless people as soon as possible after admittance in order to make plans for them after discharge.<sup>42</sup>

A report, *Improving Hospital Admission and Discharges for People who are Homeless*, identified examples of effective working as well as where improvements were still needed. It found that while some areas have introduced effective measures to address homeless people's accommodation needs during their hospital stay, this is not widespread with only one-third of homeless people interviewed for the study receiving any support around their homelessness. Housing was seen as a key part of a safe discharge from hospital; however there was a lack of accountability for ensuing this happens.<sup>43</sup>

Where the patient did have accommodation to return to, poor communication also led to late notifications of discharge or no communication at all leaving out-reach teams and hostels unable to provide enough support for their often very vulnerable clients. Patients also stressed the lack of support they were given on discharge, such as inappropriate clothing or a lack of transport. The report found that more than 70 per cent of people were being discharged from hospital back onto the streets. Many of the people surveyed felt that their homelessness had led to discriminatory treatment while in hospital. Too many felt they had been discharged too early or self-discharged, often because the primary reason for admission had been dealt with, but other conditions such as mental ill health and methadone treatment were not.<sup>44</sup>

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**Where the patient did have accommodation to return to, poor communication also led to late notifications of discharge or no communication at all leaving out-reach teams and hostels unable to put in enough support for their often very vulnerable clients.**

Data from London Pathway, a new homeless charity, suggests that ten per cent of homeless patients discharged from hospital are too unwell to recover from their illness, let alone other long-term problems, if they simply return to a hostel, or even worse, the streets.<sup>45</sup>

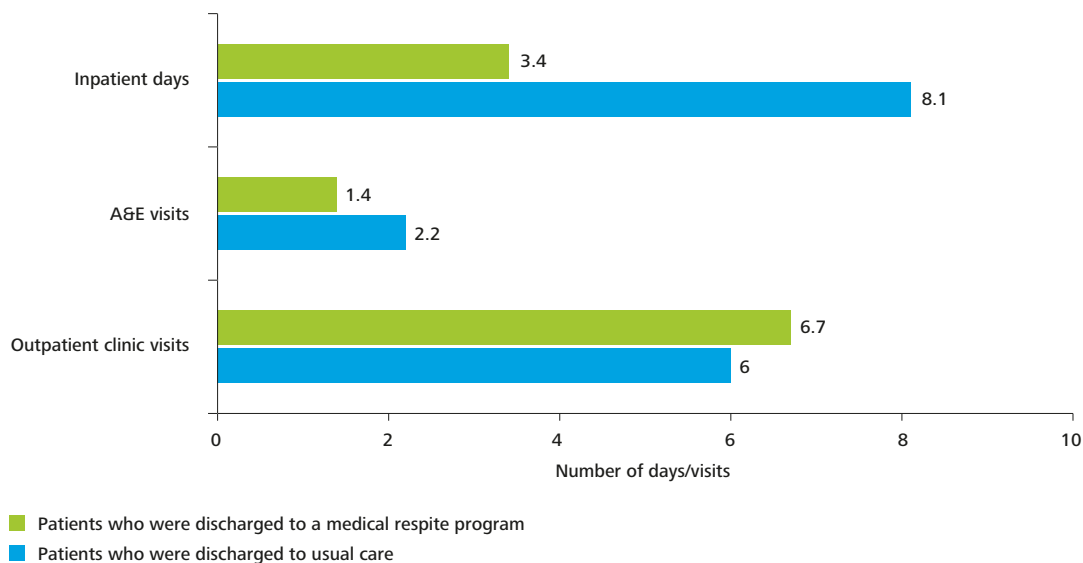
Figure 7 shows the results of a US study on the effects of providing effective post-hospital care for homeless patients. Inpatient days (over the following 12 months) were reduced by 58 per cent and A&E visits nearly halved. Outpatient clinic visits increased slightly, however this was viewed as a result of improved personal responsibility for healthcare and is in part reflected in the reduced inpatient days.<sup>46</sup>

### Lack of long-term respite care

Currently, there is little, if any, provision of respite care for the homeless. Those with disabilities, mental ill health or those in need of palliative care may not be physically capable of caring for themselves. End of life care is a particular issue for homeless people due to their lack of settled home and the poor social network available to support them. Access to specialist palliative care units is especially poor for the homeless.<sup>47</sup>

NHS guidance has helped raise awareness of the end of life needs for the homeless, but the Department acknowledges that more training and resources are required.<sup>48</sup>

**Figure 7. Average number of treatment days/visits by homeless people during the 12-month follow up period after hospital discharge**



Source: The effects of respite care for homeless patients, American Journal of Public Health, 2006

# Part 2. The policy, funding and commissioning landscape

This part of the report examines the policies that influence the priority given to addressing the healthcare needs of the homeless. It also examines the new funding and commissioning landscape introduced by successive governments.

## Homelessness issues are integral to the wider health inequalities agenda

Health inequalities between disadvantaged groups like the homeless and the most affluent members of society are long standing and have proved difficult to rectify. In 1997, the then government put reducing health inequalities at the forefront of its policies in order to create a more just and equitable society, as well as to reduce the costs associated with ill health. However, it took until 2006 for the Department to identify reducing health inequalities as a top six NHS priority, alongside requirements for PCTs to report on action taken.<sup>49</sup>

In April 2008, Joint Strategic Needs Assessments (JSNAs) and Local Area Agreements between the NHS and local government became statutory requirements, aimed at improving the identification of local needs and priorities. The Department also established the Health Inequalities National Support team to provide support in tackling health inequalities. The Department estimated that around 15-20 per cent of inequalities in mortality rates could be directly influenced by health interventions that prevent or reduce the risk of ill health.<sup>50</sup>

In 2010, the previous government published Inclusion Health which showed that health inequalities were still very much evident. It proposed a system of proportionate universalism “but with a scale and intensity that is proportionate to the level of disadvantage”. Guidance for PCTs was produced to show how to commission improved access to high quality primary services for socially excluded people (see Figure 8).<sup>51</sup>

Figure 8. Objectives and building blocks of Inclusion Health

Building blocks	<p><b>Leadership</b> Strong, clear national and local leadership, dynamic movement for change</p>	<p><b>Workforce</b> Strong, stable and capable workforce to drive change and make a difference</p>	<p><b>From needs to outcomes</b> Capability to identify needs, set priorities and measure outcomes</p>	<p><b>Responsive and flexible services</b> Innovative models of joined-up, cost-effective and equitable care</p>	<p><b>Health promotion and prevention</b> Improving health aspirations, prevention and early intervention</p>	<p><b>Assurance and accountability</b> Making best use of available resources and levers</p>
Objectives	<p><b>Focus</b> Increase understanding and visibility of health needs and outcomes, establish accountability</p>	<p><b>Voice</b> Provide a strong voice, ensure strategic planning and commissioning address needs</p>	<p><b>Personalisation</b> Promote flexible and tailored responses to complex needs</p>	<p><b>Quality and innovation</b> Drive improvements in quality and standards of services</p>	<p><b>Recovery</b> Ensure services support clients, improve continuity of care, encourage personal control</p>	<p><b>Professional development</b> Recognise achievements in the field and support their progression</p>

Source: Inclusion Health: improving the way we meet the primary health care needs of the socially excluded, HM Government, 22 March 2010

In 2012, for the first time, the Health and Social Care Act proposed legal duties for NHS commissioners and the Secretary of State around tackling inequalities. These duties mean that the NHS Commissioning Board, clinical commissioning groups (CCGs) and the Secretary of State must have a regard to the need to reduce health inequalities and commission accordingly. The first Public Health Outcomes Framework, published in January 2012, also includes as a key indicator the number of statutory homeless people at national and local level.<sup>52</sup>

### Specific policies aimed at tackling rough sleepers

In 1998, the Labour Government launched its first rough sleeping strategy to reduce numbers on the streets by two-thirds and then to as close to zero as possible. That two-thirds reduction was achieved by 2003 and was sustained for several years. Although evidence showed that services were effective at helping people off the streets, there was a constant flow of new people. New groups, for example from Eastern Europe, were presenting new challenges. In response, in November 2008 the government launched a strategy aimed at ending rough sleeping for good, supported by a £200 million investment.<sup>53</sup> At the same time the Mayor of London pledged to end rough sleeping in the capital by the end of 2012.<sup>54</sup>

In 2011, the Coalition Government published “No second night out”, its commitment to end rough sleeping by the end of 2012. This set out six areas where government departments and partners committed to work together to end rough sleeping, including a commitment to help homeless people access healthcare. Communities across England can obtain up to £250,000 each to adopt the initiative.<sup>55</sup>

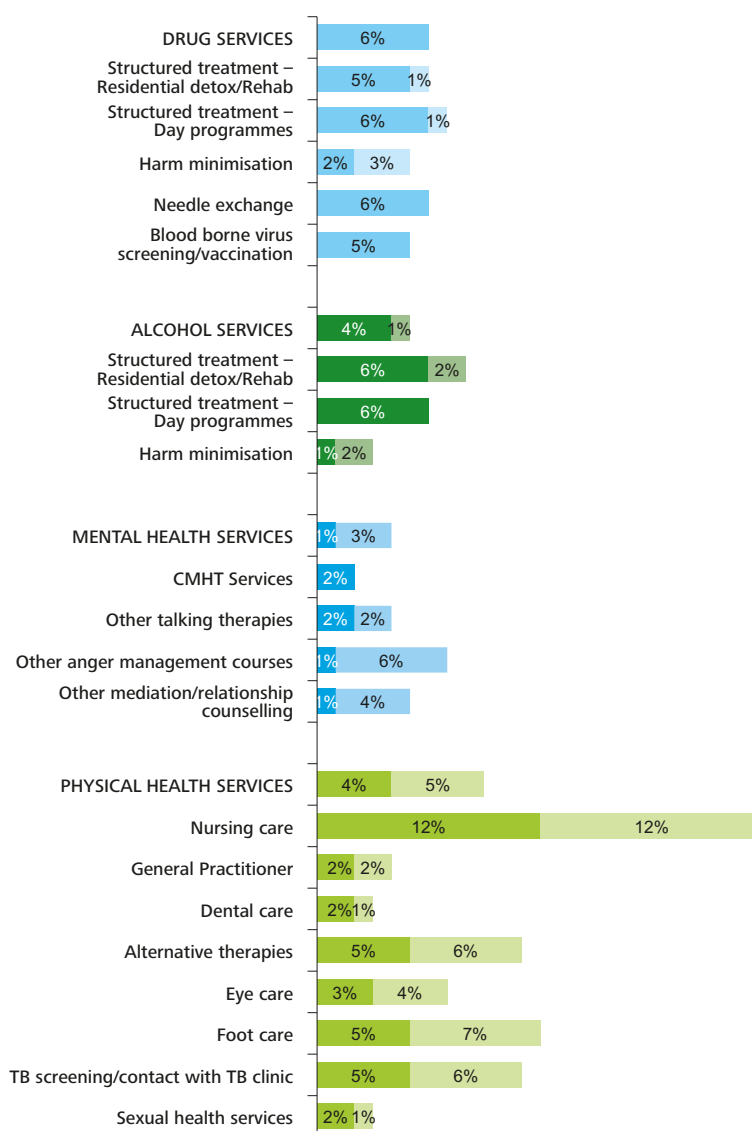
### Funding for homeless services

In 2010, local councils were told that their budgets for homeless services would be cut. The Homeless Grant remained the same but Supporting People, one of the main sources of funding, faces a 12 per cent reduction over four years, starting in 2011-12.<sup>56</sup> As these services have not been ring-fenced, they are still at risk in the future.

In 2012, research from Homeless Link of 500 homelessness service providers indicated that 58 per cent of these providers have had a reduction in income compared to 2011, with 47 per cent of all providers considering that their services had been adversely affected.<sup>57</sup>

Figure 9 shows the decrease in service provision, with the first bar showing the decrease from 2010-11 and the second bar from 2011-12. Nursing, and physical health services in general, have been the worst affected.

Figure 9. Decrease in service availability, 2010-12



Source: Survey of Needs and Provision, Homeless Link, 2012

### Commissioning services for the homeless

Commissioning services for the homeless is extremely localised; each area will have its own specific needs and accurately assessing this need is challenging.<sup>58</sup> Further challenges may arise with the new GP commissioning model, due to inexperience and the previous focus on providing services for a registered list of patients. Currently services are commissioned by PCTs from both NHS and voluntary providers. Most PCTs use Local Enhanced Services agreements, with a small number using National Enhanced Services agreements (see Figure 10). The Health and Social Care Information Centre was unable to provide any information on the amount of money spent by PCTs on services for the homeless.<sup>59</sup>

**Figure 10. Enhanced Services<sup>60</sup>**

**National Enhanced Services:** PCTs can choose to commission these services according to local needs, but in line with nationally set standards and prices.

**Local Enhanced Services:** PCTs have the freedom to design, negotiate and commission any other services they believe are needed in their area. Examples could include services for drug and alcohol abuse or homeless people. In some cases the National Enhanced Service standards are used with adjustments to meet local needs, but otherwise standards and prices are negotiated locally.

In a number of areas, PCTs have developed specialist commissioning teams for vulnerable groups such as homeless people, which have led to the provision of more responsive and targeted services. This commissioning expertise needs to be safeguarded in the new structures. Commissioning standards have been produced by the Faculty for Homeless Health, although it is still too early to evaluate their impact.<sup>61</sup>

New ways of identifying homeless needs are crucial. Suggestions include identifying where homeless people gather – for example, a hostel, A&E department or soup kitchen – and working with the service providers to identify the target population and pooling resources with partner organisations to improve service delivery.<sup>62</sup> Similarly, guidance from Inclusion Health called for the voluntary sector to play a part, providing expertise and support to GPs to develop their commissioning capability for socially excluded groups.<sup>63</sup>

The key is not only commissioning the right services, but also having the connections between the services. The idea of networks of homeless commissioners and providers, similar to the cancer or neonatal networks, has some traction. The idea of a network is to bring together commissioners and providers to plan and deliver high quality services to the population. Cancer networks have proven an effective tool in aiding commissioners;<sup>64</sup> a similar network of commissioned services for the homeless population could likewise be effective.

Recent reforms have established statutory health and wellbeing boards to encourage local authorities to take a more strategic approach to commissioning. Recommendations from Homeless Link suggest that the health and wellbeing boards' role should be strengthened to approve commissioning plans and ensure appropriate services have been provisioned for excluded groups like the homeless. If, in designing the detail of the new commissioning landscape, the NHS Commissioning Board considers that CCGs are not the vehicle to commission healthcare services for these groups, responsibility would then likely fall to the NHS Commissioning Board. While this could be justified due to the size and geographical spread of the homeless population, the ultimate aim of the reforms was to have responsibility and responsiveness at a local level.<sup>65</sup>

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**The key is not only commissioning the right services, but also having the connections between the services.**

# Part 3. New models of care

In this section, we highlight models of care and evidence as to their impact. These solutions should be considered by the new commissioners and care providers.

## Mobile and outreach clinics

Schemes to establish clinics for the homeless, such as drop-in GP and nurse services or visits to homeless shelters, have been largely successful and in some cases have expanded due to the demand from patients attending. However, there may be opposition from residents to placing homeless clinics in their neighbourhood.<sup>66</sup>

Specialist mobile healthcare clinics for the homeless could provide a range of services such as prescriptions, treatment of minor injuries and infections, and rehabilitation from substance abuse and immunisation. This model would allow staff and resources to be shared across multiple local authorities and could deliver care to homeless people in rural areas, where specialist healthcare is not always available.<sup>67</sup>

Mobile health centres already exist for the treatment of the general population and have reported success, however they are not yet widely used to deliver care to the homeless.<sup>68</sup> Evidence suggests that using mobile health clinics may also encourage homeless people to attend existing health services, such as general practices.<sup>69</sup>

The US state of New Hampshire operates a mobile healthcare scheme involving nurse practitioners, nurses and a substance abuse counsellor who travel in specially designed vans bringing healthcare services places where the homeless congregate. Patients can receive a variety of services, including routine health checks, treatment for illnesses and even dental services.<sup>70</sup> Case examples 1 and 2 illustrate the use of mobile health centres for the homeless in the UK.

### Case example 1. St John Ambulance, Brighton Homeless Service<sup>71</sup>

#### Overview

St John Ambulance operates a mobile healthcare clinic in Brighton, Sussex. The clinic is nurse-led and provides basic health assessments, first aid treatment, wound care and health advice. There is also a podiatrist available. When the team cannot help, they are able to provide referrals to appropriate local services.

#### Results

There has not been an evaluation of the service; however comments from homeless users are positive.

"I am writing with the feeling of gratitude due to the service that has been provided to me over three years. I was once homeless and in those days, if there was one day I looked forward to it was a Thursday at the Hove peace statue at 7pm. Your workers would, in all weathers, attend to not just my needs, but lots of others too."

"A friendly ear, a cup of tea or coffee, socks, hats and medical help.... I just want to say thank you for the time and support that St John Ambulance has given to me."

# Stories from the frontline

## A day in the life of the London Pathway team



The team meet in the discharge lounge. The two specialist homelessness nurses have already been at work tracking developments over the weekend including any new homeless patients who have been admitted. One of the nurses has promised a new patient, Sue, a dressing gown, and has to check the London Pathway's small clothing store. Five patients are still in from Friday: Omar is dying of cancer but has nowhere to go and no family; Steve is a drug-using TB patient – he's fit to leave hospital but his hostel won't take him back and he won't take his medication on the streets. John is a chronic alcoholic and heroin addict with infected wounds in his legs and lost his last detox place because he started drinking again. No place wanted him back. Tony has signs of alcohol-induced dementia, serious liver damage and an amputated foot. Mike has HIV and hepatitis C along with mental health issues and diabetes. The team's specialist homelessness GP, Dr H, is scanning hospital records for new admissions and reviewing successes from Friday: a hostel place was found for Joe, an alcoholic with mental health needs and, after a week of trying, a charity took Sayed, a destitute asylum seeker with cancer.



Dr H has a chat with a junior registrar about getting the right drug dose for a new patient, an injecting drug user who has been beaten up. Many medics who are inexperienced in working with homeless people don't always realise that heroin addicts, while feeling pain like anyone else, need a different approach to pain relief to other patients. Nurse F has befriended the new patient and is beginning to get some facts – who he is, where he is from. He doesn't want to return to his old hostel, and wants help. He is likely to be in hospital for several days, long enough for the team to put a plan together for when he leaves.



The team meet again in the discharge lounge. Nurse F is on the phone, making contact with the new patients' social workers, street alcohol teams and relevant council housing departments. One of the new patients has family, and has agreed for them to be contacted. Nurse T has found the dressing gown, and provided Tony with some more books. Keeping patients in hospital is part of the trick to successful treatment. Nurse T has also spent some more time with Mike and found out that he has no official documents or ID of any kind – because he is in hospital and without ID his benefits cannot be claimed. She obtains his personal details to start the process of getting a duplicate birth certificate. However, this is put on hold as she is summoned to A&E to see one of her regulars.



Nurse F is still on the phone. One of the new patients was picked up by ambulance in Westminster, but seems to originate from Lambeth. Neither council wants him back. This is not uncommon; the team often has protracted negotiations around a patient's housing status. Dr H is finishing some discharge letters and beginning new case reports and a note to social services about a patient's care needs. Nurse T is back on the ward, seeing a new patient who has just been admitted, and also a female patient whom ward staff suspect is homeless as she has had no visitors and won't provide a number for anyone to call to talk about discharge.



Nurse T leaves for home; Nurse F updates team notes for the day, recording interactions with each patient, and significant details about their lives that will help build a plan for when they leave hospital. There are no discharges today, but two patients are expected to leave tomorrow, and good placements have been sorted for both of them. Hopefully there will be no last minute hitches to the plans.



## Typical case histories of homeless patients

### **Dave, male, 54**

Dave was admitted to hospital for surgical drainage of his infected leg and hand. He was an alcohol dependent intravenous drug user on methadone, with poor engagement with community services and no local GP. He required treatment over several days, during which he had problems with pain control due to high opiate tolerance. This caused friction with the ward staff. The London Pathway ward team befriended him and liaised with the ward staff, pain team and drug treatment team to ensure adequate pain relief. A hostel key worker was invited into hospital to discuss a possible rehabilitation placement on discharge. Dave was also supported with his benefits claim.

He became abstinent from drugs and alcohol on the ward, but finally decided against a rehab placement. Negotiation with the community drug team and GP ensured that he has methadone and stable opiate analgesia prescribed on discharge for daily collection to minimise risk. He stayed out of hospital for a year after discharge.

### **Michael, male, 59**

Michael has multiple physical and mental health problems together with a history of substance abuse. His chronic obstructive pulmonary disease, hypertension, hypothyroidism and type 2 diabetes are managed at Health E1 by a general clinician, either a GP or advanced nurse practitioner. He is also on a methadone prescription for his illicit drug use which is managed in-house by clinical nurse specialists in Substance Misuse in conjunction with a GP. Despite this, he continues to use heroin and crack but at a much reduced level prior to commencing substitution therapy.

Michael also visits a Community Mental Health Team psychiatrist fortnightly at the clinic, to explore his mental health and possible psychosis. He has been referred to specialist support for his COPD and diabetes. As a result of his multiple conditions, Michael is on approximately 17 medications daily. To improve concordance, Health E1 arranged for these to be administered via a daily dosing system. His ongoing care at Health E1 has successfully minimised his risk of harm and enabled him to gain access to specialists who can treat his many health problems.

### **John, male, 39**

John began using drugs at the age of 27 and has been a heavy drinker since a teenager. He is currently homeless, after being evicted from social housing for non-payment of rent and anti-social behaviour. John accessed healthcare via the Homeless Healthcare team at the Vaughan Centre, Gloucester. Here, it was diagnosed that he had hepatitis C, chronic abscesses, and suspected Korsakoff's psychosis, among other ailments. He was offered access to psychosocial programmes and support via the Substance Misuse Team, as well as ongoing physical health observation by healthcare staff to monitor his hepatitis. He was also prescribed methadone maintenance, alcohol detoxification and diazepam stabilisation programmes.

Unfortunately, as John is currently on remand with no definite release date, it is difficult to plan for his release from prison, and housing referral providers will only consider him upon his release. This means that the most likely outcome will be that he is released as 'No Fixed Abode' and will need a hostel place, probably resulting in alcohol and drug abuse again.

### Case example 2. Find and Treat, London<sup>72</sup>

#### Overview

Find and Treat operates a mobile x-ray unit that carries out quick and painless x-rays for tuberculosis. A patient infected with untreated TB can infect 10–15 individuals in a year, and 38 per cent of all cases occur in London. Find and Treat focuses on hard to reach communities in London.

#### Results

A study assessing the cost-effectiveness of the service found that, on average, the service identified 123 active cases of tuberculosis a year, at a cost of £1.4 million. The incremental cost-effectiveness ratio was found to be £6,400 per QALY gained. The NHS typically judges an intervention as cost effective if it is less than £20,000 per QALY.

One alternative to an actual mobile healthcare clinic would be a mobile team who set up clinics in locations where homeless people stay. The Three Boroughs Primary Healthcare Team in Lambeth, London, provides such a service. They run open-access nurse-led health clinics in homeless hostels and day centres in Lambeth and the surrounding areas, providing minor illness and injury assessment and management, dentistry, wound care, and referral to drug and alcohol services. The team encourages patients to register with a GP within four visits because its main aim is to promote the use of mainstream GP services.<sup>73</sup>

In Brussels, Infirmiers de rue is a team of three nurses who search the streets three days a week looking for homeless people. They offer medical aid to any homeless person they come across, and if the person cannot be treated there and then, they offer referral to another service or accompany the patient to the doctor for treatment. This has resulted in earlier intervention in health matters, which has meant fewer trips to A&E.<sup>74</sup>

#### Specialist facilities

There are various specialist general practice clinics throughout England that either have homeless people as one of their target client groups or deal solely with homeless people.

Ways of tailoring care to homeless people include:

- patients being allowed to register without a fixed address; some practices allow patients to use the clinic as their address. One scheme, in Bristol, has an 'official' park bench address for homeless patients<sup>75</sup>
- drop-in clinics, support groups (for example substance misuse clinics) and flexible appointment booking, such as booking more than two weeks in advance and online booking
- multiple primary health services under one roof, such as dental, sexual health and chiropody services
- daily prescription-pick up services to reduce the chances of drug abuse or theft by the patients or others.

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Schemes to establish clinics for the homeless, such as drop-in GP and nurse services or visits to homeless shelters, have been largely successful and in some cases have expanded due to the demand from patients attending.

Case example 3 shows how these changes have been incorporated into a primary care clinic.

### Case example 3. Luther Street Medical Centre<sup>76</sup>

#### Overview

Luther Street Medical Centre provides a comprehensive primary care service for homeless and vulnerably housed people within Oxford. This includes a GP, practice nurse, mental health practitioner, support worker, dentist and podiatrist. They also offer community alcohol detoxification, addiction services and outpatient psychiatry clinics, among other services. These services are all offered under one roof in a purpose-built medical centre. They offer drop-in and pre-booked appointments.

#### Results

More than 500 patients are fully registered at Luther Street, with a further 17 temporary patients. Twenty-two per cent of the patients (119) are being treated under shared care drug addiction therapy.

The clinic also received excellent QOF (Quality and Outcomes Framework) results, scoring a total of 89.1 per cent.

“The treatment by the doctors and nurses here has saved my life. I would not be here today if it had not been for the intervention of Luther Street.”

Great Chapel Street Surgery in Westminster, London, operates a similar model to Luther Street. They offer clinics run by GPs, practice nurses, substance use/mental health specialists, counsellors, podiatrists, dentists, psychiatrists, a benefits advice worker and an advocacy housing worker. The centre operates as a one-stop shop, allowing anyone who is homeless or vulnerably housed to walk in off the street and be seen that day or make an appointment. In April 2011, they also started doing outreach work to improve access and their visibility to the homeless.<sup>77</sup>

Specialist facilities also exist in other countries; in Australia, the Sydney-based Haymarket Foundation Clinic provides primary healthcare and welfare services for the inner-city homeless. The clinic provides nurse-delivered primary care seven days a week and GP services five days a week. It also has links with a nearby alcohol detoxification centre.<sup>78</sup>

#### Integrated health and social care

Integrated health and social care brings together hospitals, general practitioners, social workers, health visitors, outreach programmes, and most importantly, the patient. These multi-agency community teams work together to care for patients during and after their treatment, including, for example, enrolling the patient in an outreach programme for drug abuse. A key feature of integrated services is that the patient is supported even when they are no longer critically ill or in need of healthcare, in order to break the homeless cycle.

Initiatives such as portable health records (kept by the patient) and greater use of electronic medical records will improve integration by giving providers the potential to improve the co-ordination, safety, efficiency and quality of care provided to homeless people.<sup>79</sup>

In Toronto, Canada, there is the Coordinated Access to Care for the Homeless (CATCH) programme, an integrated healthcare services programme. The programme connects homeless people with the support they need to recover, such as primary care, psychiatry, case management, transitional housing and peer support. It is the first programme of its kind in Canada.<sup>80</sup> Case examples 4 and 5 highlight programmes in London.

#### Case example 4. London Pathway<sup>B1</sup>

##### Overview

London Pathway offers integrated health and social care to homeless people within London. There are currently three core services offered:

- **Acute hospital ward rounds** – A specialist GP and homeless healthcare nurse practitioner who visits every homeless patient admitted to the hospital to co-ordinate care and make plans for discharge.
- **Homeless healthcare nurse practitioners** – A dedicated nurse practitioner working full time in the hospital supporting the ward round. They liaise with both medical staff and other involved agencies. They provide support to homeless patients and help them plan a life after hospital.
- **Care navigators**– Someone with personal experience of homelessness who befriends, supports, challenges and mentors patients in the hospital, and helps with follow-ups post discharge.

##### Results

Results from a 2009 report indicated that:

- average duration of unscheduled admissions for homeless patients was reduced by 3.2 days (12.7 reduced to 9.5 days)
- appropriate durations of stay increased with double the number of patients staying 6-10 days
- proportion of patients discharged with multi-agency care plans increase from 3.5 per cent to 35 per cent
- an average saving of £1,600 per patient
- no change was seen in A&E attendances or hospital admissions.

A 2012 report, Improving Hospital Admission and Discharge for People who are Homeless, identified considerable improvements in joint working and quality of service as evidenced by homeless people interviewed as part of the report.

#### Case example 5. The Broadway Centre<sup>B2</sup>

##### Overview

The Broadway Centre, also in London, opened in 2001 and offers a mix of health and social services, including access to GPs and health specialists, a nurse, a podiatrist and a range of health education activities, alongside support for employment and housing issues.

##### Results

During the first five years of service, they provided primary care to 1,858 people, with 80 per cent of patient respondents stating that using the health services had made some or a lot of difference to their health.

### Medical respite care

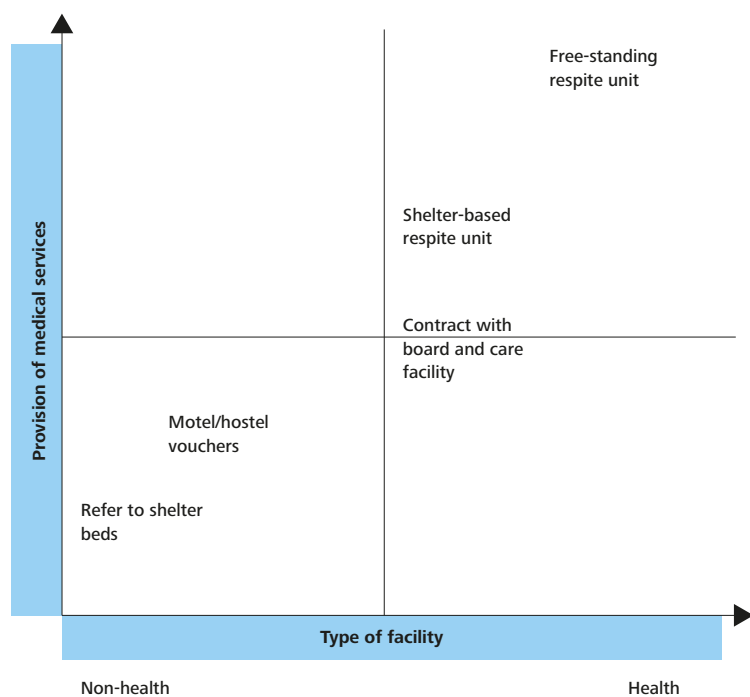
Medical respite care is acute and post-acute medical care for homeless people who are too ill or frail to recover from a physical illness or injury on the streets, but who are not ill enough to be in hospital. Medical respite in short-term residential care allows homeless individuals the opportunity to recuperate in a supported environment.<sup>83</sup>

St. Mungo's is one of the only services providing palliative care for the elderly and dying homeless. Few other services have the facilities to provide short-term respite care. In the US over 50 cities now provide community-based respite facilities.<sup>84</sup>

Figure 11 demonstrates the different models of respite care in the US, with the free-standing respite unit considered the most effective due to greater control over admission and discharge policies. While hostel-based respite centres are less costly, and remove the initial difficulty of needing a building, there is reduced control over policies and protocols which can result in a conflict between providing both shelter and medical care.<sup>85</sup> Research on outcomes found that homeless patients discharged to a respite programme experienced 50 per cent fewer hospital readmissions within 90 days of being discharged than patients discharged into their own care.<sup>86</sup> Case example 6 shows a successful model of respite care.

London Pathway has recently secured funding for 'The Sanctuary', a respite centre model based on the principles of compassion and high quality healthcare.<sup>89</sup> The Sanctuary is expected to have revenue streams from various sources, including the Department, social care and housing budgets for patients. This will most closely model a free-standing unit. The feasibility study for The Sanctuary estimates that 35 per cent of patients admitted to hospital each year would benefit from medical respite, reducing the impact on acute services from readmission by up to 1,364 bed days, based on usage by over 190 patients.<sup>90</sup>

Figure 11. Models of respite care



Source: National Health Care for the Homeless Council

While hostel-based respite centres are less costly, and remove the initial difficulty of needing a building, there is reduced control over policies and protocols which can result in a conflict between providing both shelter and medical care.

**Case example 6. Barbara McInnis House, Boston, Massachusetts<sup>87</sup>**

**Overview**

Barbara McInnis House, part of the Boston Health Care for the Homeless Program, is a 104-bed medical respite facility. It is located on the campus of Boston Medical Center. They offer cost-effective, short-term medical and recuperative services to the homeless. There are patient visits with staff GPs and nurse practitioners, 24-hour nursing care and palliative care. They provide respite for those with complex conditions such as cancer, heart disease and HIV.

**Results**

A study found that those sent to Barbara McInnis House were half as likely to be readmitted to hospital compared with patients who returned to the streets on discharge. It was also found to be more effective than schemes where the patient is discharged to a planned care setting, such as a nursing home.

**Case example 7. Santa Clara County Medical Respite Center, California<sup>88</sup>**

**Overview**

In California, the Santa Clara County Medical Respite Center is attached to a homeless shelter – but separate – and close to nine hospitals in the area. The Center operates a ‘pay per use’ programme; the hospitals pay the shelter to take homeless patients in and provide care, avoiding expensive, unnecessary bed days and ‘bed blocking’. This way the hospitals also avoid readmissions for conditions that didn’t heal due to early discharge, which could often result in a fine.

**Results**

In the first two years, the Center saved 783 bed days for the hospitals, saving approximately \$1 million (£630,000 at current exchange rates).

**Wider adoption of good practice**

While the full details of the commissioning framework are still being finalised, the NHS Outcomes Framework 2012-13 provides a guide as to the domains which the Secretary of State and the Department expect to measure.<sup>91</sup>

Figure 12 shows how the solutions in this part of the report align to the domains in the Framework. Commissioners need to consider how the homeless services in their localities are performing and whether the models of care in this report might provide a more cost-effective alternative.

**Figure 12. Solutions that align to the NHS Outcomes Framework’s domains**

Five domains of the Outcomes Framework	Examples of solutions to deliver improved outcomes for homeless people
Preventing people from dying prematurely	<i>Specialist facilities, Integrated health and social care</i>
Enhancing quality of life for people with long term conditions	<i>Respite care, Integrated health and social care</i>
Helping people to recover from episodes of ill health or following injury	<i>Respite care, Specialist facilities</i>
Ensuring that people have a positive experience of care	<i>Mobile and outreach clinics, Specialist facilities</i>
Treating and caring for people in a safe environment and protecting them from avoidable harm	<i>Mobile and outreach clinics, Specialist facilities, Integrated health and social care</i>

### **Actions for stakeholders**

This report demonstrates the challenges of providing effective healthcare services for a complex and vulnerable population. It also identifies good practice examples that, through wider adoption, would help transform services and patient outcomes. Similar approaches may also be applicable to other vulnerable groups. To get some traction, we have identified the following actions for key stakeholders.

#### ***The NHS Commissioning Board should provide guidance on commissioning healthcare services for the homeless and the circumstances in which local and/or national commissioning would provide the best quality, cost-effective services***

If commissioning is to be local, there needs to be clarity as to how CCGs might commission for unregistered groups, and how the NHS Commissioning Board will hold CCGs to account for their performance in providing services for groups such as the homeless. The NHS Commissioning Board might also consider whether a specialist commissioning approach might be more suitable for relatively small populations such as the homeless.

#### ***Clinical commissioning groups need to identify ways to engage constructively with housing, social care and voluntary sector providers to obtain an integrated input into service design***

Good health should not be seen as an outcome which can be achieved solely through clinically driven solutions. Models of care which take into account, or involve partnership working with, social care, housing and welfare needs are more likely to be sustained and achieve better outcomes. Longer-term contracts are also likely to achieve the most benefits.

#### ***NHS and charitable homeless service providers should consider creating a formal network with CCGs and local health and wellbeing boards to improve commissioning and provision of healthcare services for the homeless***

The networks should identify the most appropriate models to enable health and wellbeing boards and CCGs to share access to relevant information to help them assess and identify unmet needs, not only healthcare needs but also other priorities such as housing, benefits and employment.

#### ***GPs and other primary care providers could improve the services provided for groups like the homeless by adopting a consistent standardised flag system to ensure that the accommodation status of patients is clearly identified***

If homeless people are to have the services they need, they must be more visible in the new commissioning system; this suggests the use of a standard flag in GP systems.

#### ***Hospitals, local authority housing teams and voluntary organisations in every local area need to work together to agree a clear process from admission through to discharge to ensure that homeless people are discharged with somewhere to go and with support in place for their on-going care***

Hospitals should also improve the recording of their patients' housing status and in determining whether fit for discharge should include consideration of whether the patient has somewhere to go and agree plans for their ongoing care.

#### ***All statutory and voluntary healthcare providers need to collect and provide commissioners with robust, reliable and timely data to provide an evidence base on activity, cost and outcomes***

This will improve the dialogue with commissioners and provide confidence in the value for money of their investments. This should also place them on more secure footing in relation to future funding and allow them to provide a more sustainable service.

### Closing thoughts

In this report we have provided a range of solutions to the healthcare challenges faced by the homeless. In particular we offer models of care that focus on making access to primary care easier for the patient, which is in line with the Department's vision for the NHS to be designed around the patient, not the provider.

The overarching principle behind all of the solutions is a new approach to commissioning services. This is not a solution in its own right, but an enabler to match services to the needs of this complex population. Many of the models we have outlined and which have been shown to have a positive impact are currently in use in small pockets of the population, but few have been evaluated as to their cost-effectiveness. There is a need for better data on the extent of the problem and the value for money of the different models of care to help commissioners commission services effectively.

The evidence provided demonstrates the need for action. This report is intended to provide insight and to act as a lever in galvanising action.

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The overarching principle behind all of the solutions is a new approach to commissioning services. This is not a solution in its own right, but an enabler to match services to the needs of this complex population.





# Notes

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