

Homelessness and the response to COVID-19: learning from lockdown

Final report

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Contents

Executive summary	1
1. Introduction	4
2. What is the current policy intention?.....	8
3. What was done before the crisis?.....	16
4. What was done in response to the crisis?	26
5. Is the response an advance on previous practice?.....	43
6. What next?	48
Glossary of terms.....	52
References.....	53
Appendix A: stakeholder interviews topic guide.....	56
Appendix B: Research findings against FHIH standards	58

Executive summary

The COVID-19 pandemic has drawn a radical response from health and care services. Long-accepted ways of doing things have been discarded; new approaches have been designed and adopted with unprecedented speed; what was previously unthinkable is now widely practiced. This was especially true for services supporting people experiencing homelessness.

This study, commissioned by NHS England and Improvement (NHSE/I) and undertaken by the Strategy Unit, aimed to learn from this situation. The essential questions for the work were: what service changes were made under lockdown? How have these changes affected access to care for people experiencing homelessness? What should be learnt from this experience?

This was complex territory to navigate. The work was carried out as service changes were being made, under far from ideal research conditions. The study drew evidence from stakeholder interviews, a survey, a literature and policy review, and workshops with academics, policy makers, people with lived experience and service providers. The main body of the report analyses this evidence in detail; in this summary we concentrate on the resulting recommendations.

RECOMMENDATION 1: NHSE/I should lead a programme of work to create a community of practice on health and homelessness

More needs to be done to make health and homelessness services a priority. National attention is required to do this, and NHSE/I should be playing a significant, strategic national leadership role.

Yet care is also required. Action to improve access to and delivery of care is better concentrated at the local level and no 'single best model' is available. NHSE/I should therefore nurture work begun under the pandemic to convene and network local areas and organisations. What began as informal and improvised arrangements under lockdown should move to become a formal programme of work led by a dedicated team.

The overall aim of this work should be to focus attention and improve practice. NHSE/I should convene people, share intelligence, and maintain a community of practice dedicated to improving care for people experiencing homelessness. The programme should be locally led, but nationally supported and funded. It should shine a light on good practice and improve the evidence base. It should act as a visible source of guidance and expertise for areas only just beginning to realise the presence of a problem. Influencing government and other NHSE/I initiatives should be an explicit aim of this team and programme.

One early task would be to encourage changes noted in this study in relation to: enhancing outreach practices, better joined-up working, and the way in which drug and alcohol services are delivered. These changes were seen as positive innovations under lockdown – albeit with the significant proviso that their implementation is patchy. Work should be done to help spread and scale these changes.

RECOMMENDATION 2: NHSE/I should commission supporting research

Too little is known about health service support for people experiencing homelessness. The data are poor and previous mapping work provides limited information. Further research is needed, into:

- *What is.* Not enough is known, systematically, about current service provision. There is a lack of information on topics such as what is provided, how it is experienced, how it compares to accepted standards, who is involved in providing it (etc)? This would provide an essential starting point for the programme recommended above; and
- *What could be.* This study uncovered two potentially useful innovations, spurred by lockdown, in: how people are supported to access a GP, and ways of delivering mental health services. Yet we found too much uncertainty to recommend their wider adoption. Specific evaluation is needed.

RECOMMENDATION 3: NHSE/I should set clear expectations of local areas

Recommendations 1 and 2 are supportive. NHSE/I should also then set clear expectations of local systems, that improving the health outcomes of people experiencing homelessness should be a priority. In the immediate term, this means embedding the requirement to consider homelessness in the NHS' current and future COVID-19 response phases.

NHSE/I should also consider tasking Integrated Care Systems and Sustainability and Transformation Partnerships (ICS and STPs) with developing inclusion health plans, showing the nature and scale of problems in their area – and what they are doing/propose to do about them. This could be overseen by the reinstatement of the National Inclusion Health Board (or similar), with clinical engagement and multi-departmental involvement. The national homeless voluntary sector organisations could also support this, perhaps coordinated by the #HealthNow alliance.

RECOMMENDATION 4: STPs and ICSs should set a direction for local organisations to address health and homelessness

Leaders in STPs/ICSs have an important role to play. They set the conditions within which local action takes place. They should therefore give prominence and attention to the health and homelessness agenda. In approaching this, they should add value to local efforts. They should set direction and create conditions, avoiding displacing or crowding out local (sub-system) efforts. Local conditions will determine the best path, but the principle of subsidiarity is essential: actions should be taken at the most local level possible.

RECOMMENDATION 5: STPs and ICSs should take intelligence-led approaches

Reflecting the character of the national programme recommended above, local systems should use their response to the health and homelessness agenda to develop increasingly intelligence-led approaches.

Systems are being encouraged by NHSE/I to take a 'population health management' approach: to gather data and insight into specific population groups, then devise and evaluate responses to the needs uncovered. Homelessness is an ideal topic to show the value of a PHM approach. In doing this, systems may also wish to test some of the innovations highlighted in this report. They may wish to focus on those innovations needing further study: ways of supporting people to access a GP and remote ways of delivering mental health services.

Whatever the approaches taken, one foundational element of intelligence that must always be considered is the experience of the people involved. Those most affected are often least heard and – because of the inadequacy of current data – least seen. Leaders can therefore act to correct this. They should consider whether the voice of people experiencing homelessness is heard.

These five recommendations should be shared at the highest level of NHSE/I and MHCLG, as well as voluntary sector organisations and researchers; specific plans should be put in place to enact them where they are agreed.

Restrictions under lockdown necessitated practical change. These changes were made locally and incrementally by frontline teams; they were not determined by policy or strategy. This study is therefore part of policy catching up with, learning from - and amplifying the best of – changes in practice. This study is a contribution to this task, but it by no means completes it.

1. Introduction

“What COVID has done is laid bare these stark inequalities in our society and we really have an opportunity here to address some of these inequalities, and in particular some of the most vulnerable people in our society. We know that health and housing are inextricably linked; poor health can lead to homelessness, homelessness can lead to worse health outcomes and we can’t underestimate the impact of a warm and safe place to stay... People being housed.., allows a period of stability in which to address some of these unmet health needs [and] increase access to healthcare which can lead to better health and housing outcomes.”

Dr Binta Sultan, Consultant Physician, Find and Treat, UCLH (HLP, 2020).

1.1 Background and objectives

The COVID-19 pandemic has drawn a radical response from health and care services. Long-accepted ways of doing things have been discarded; new approaches have been designed and adopted with unprecedented speed; what was previously unthinkable is now widely practiced.

This situation contains risks and opportunities. Done with care, the best of the current crop of innovations could be nurtured and spread. Done without care, the risk of evidence-free advocacy and ‘sliding back’ is great. Understanding these opportunities and risks is therefore a prerequisite to effective action.

The chair of the Royal College of GPs’ health inequalities group described the COVID-19 pandemic as an ‘unprecedented opportunity’ to change how care is delivered, to focus on marginalised and disengaged groups. However, he continued, ‘that window for change is closing rapidly with the rising clamour for return to normality’ (Serle, 2020).

NHSE/I commissioned this study to learn from the response to the COVID-19 pandemic in supporting people who are homeless to access health and care services in England. The work has been led by the [Strategy Unit](#), operating within the context of an analytical collaboration with the Health Foundation, King’s Fund, Nuffield Trust and Imperial College Health Partners. More information can be found [here](#).

In both conducting the research and developing the recommendations for this report, we have worked with the homeless charity [Groundswell](#) who are conducting a parallel project focusing on the impact of COVID-19 on people experiencing homelessness.

The study was conducted immediately following the first national lockdown. At the time of writing, England has entered a third such lockdown. The contents of this report should therefore be timely. Moreover, and as will be seen, many of the findings presented and recommendations made would apply under non-pandemic conditions.

1.2 Structure of this report

The aim of the study was to investigate innovations made in response to COVID-19 and ask whether any of these innovations seemed to improve access to health and care services, such that they might merit replication. To meet this aim, the study sought to answer five questions around which this report is structured.

Chapter 2 considers *what is the current policy intention?* What are the official statements of intent for the 'health and homelessness agenda'?

Chapter 3 then reviews *what was done before the crisis?* What did health and care services for people experiencing homelessness look like and how were they organised prior to the pandemic?

Chapter 4 moves into answering *what is being done now?* Across England, how has the response to the COVID-19 pandemic played out? What innovations in practice have taken place? How have they been done? To what effect?

Chapter 5 evaluates these changes to reflect *to what extent they represent an advance on previous practice?* What should we keep and what should we discard in future models of care for people experiencing homelessness? What don't we know enough about yet to answer this question?

Chapter 6 then makes recommendations based on the findings from this study for NHSE/I and other stakeholder organisations to take forward in order to improve access to health and care services for this group.

1.3 Study methodology

The method used for the study was informed by two fundamental considerations:

- Radical changes in practice provides fertile territory for learning. Making the most of this requires a clear framework for knowing what we want to find out and why. It also requires a process for making sense of findings and how they might be used.
- Undertaking research during a pandemic presents practical and evidential challenges. A rapidly changing situation - and a pre-existing lack of data - tends towards the fragmentation of evidence. The task for the research therefore was to gather these fragments from multiple sources and make a coherent whole.

The following methods were therefore employed to gather and evaluate relevant data:

1. A review of relevant policy, as well as academic and grey literature;
2. Semi-structured interviews with stakeholders;
3. A review of [Groundswell briefings](#) reporting experiences of the homeless during the COVID-19 response;

4. A survey of individuals and organisations involved in health services for people experiencing homelessness;
5. A facilitated workshop with people experiencing homelessness;
6. A facilitated workshop with stakeholders to validate our findings and develop recommendations for what NHSE/I should do next.

1. Policy and literature review

Legislation, policy documents, research and grey literature was reviewed exploring the background to health and care services for people experiencing homelessness in policy and practice. This has largely informed chapter 2 of this report.

2. Semi-structured interviews with sector stakeholders

At the outset of this research we conducted thirteen interviews to inform the study. These were carried out under conditions of anonymity but included representatives from:

- National homelessness charities
- Academic institutions, thinktanks and advisors
- Local government
- Healthwatch
- Public Health England
- NHSE/I
- Local homelessness services

The topic guide for these interviews is included as appendix A and the content from them has informed all chapters of this report. Interviews lasted between 30-60 minutes; they were recorded with consent, summarised by a member of the project team and analysed against the objectives of the project outlined above. Where quotations from these interviews are used in this study, they are assigned only to the unique identifier of the participant.

3. Review of Groundswell briefings

We have worked closely with Groundswell during this project in order to reflect the views of people with lived experience of homelessness in this study. Groundswell have released regular briefings detailing their own research reflecting the impact of COVID-19 on people experiencing homelessness throughout the pandemic. We have drawn upon these in chapter 4.

4. Survey

An online survey was published in July 2020 and shared via our networks. A snowball sample was used to try and reach as many people as possible and given lack of data on the population to be surveyed. The survey focused on the views of people involved in delivering health and care services for people experiencing homelessness, as well as researchers, advocates, and policy makers. The

survey questions concentrated on views of how changes to services during COVID-19 had impacted positively or negatively on peoples' ability to access them. The survey has largely informed chapters 4 and 5 of this report.

5. Workshop with people with lived experience

In partnership with Groundswell, we presented our findings from the above methods to a peer reference group on 25 September 2020. There were nine attendees to this workshop sourced from Groundswell's network. The purpose of this workshop was to test our findings with people with lived experience to gauge any discrepancies in reflections of changes to services between service providers and service users.

6. Stakeholder workshop

On 9 October 2020 we co-delivered a workshop with Groundswell to engage with sector stakeholders in developing the recommendations for this report. The workshop included eighteen people with representatives from:

- Public Health England
- People with lived experience
- Pathway
- NHSE/I
- Crisis
- Homelessness and inclusion health clinician
- Homeless Link
- Department of Health and Social Care (DHSC).

Outputs from this workshop informed chapters 5 and 6 of this report.

The context to the research was highly fluid. Usual limitations from the above research methods apply - but in this case the limitations of method are dwarfed by the limitations of circumstance. The research was conducted during the pandemic: conditions were changing, evidence was scant, and uncertainty was consequently high. What follows should be read in this light.

2. What is the current policy intention?

2.1 Introduction

This chapter outlines the policy intention around health and homelessness in England in recent years. It starts with the response to housing statute from 1996, and subsequent major legislation with the stated intention to reduce levels of homelessness. References to the role of health services in this intention are highlighted. Alongside this, a review of how homelessness outcomes have been considered through health policy is presented.

The chapter finds clear links between health and homelessness in policy dating from the latter part of the last century and early part of this one, particularly in the New Labour government's social exclusion agenda. Despite some short-lived initiatives to improve access to health services for people experiencing homelessness at the start of the last decade, the links between health and homelessness policy become less clear, broadly coinciding with the period of austerity in public spending. Reinstatement of the relationship can be seen in response to the 2017 Homelessness Reduction Act. The chapter concludes that the policy intention in 2020 around health and homelessness is more specific, with a commitment to resource it, than it has been in almost two decades.

2.2 The current state of homelessness in England

The housing and homelessness charity Shelter defines being homeless not simply as having nowhere to stay and living on the streets, but stress that you can be homeless even if you have a roof over your head. This can include staying in a hostel or night shelter, being at risk of violence or abuse at home, or living in poor conditions that affect a person's health.

Recent research by the charity describes six categories of homelessness (Shelter, 2019):

- People who are living in temporary accommodation (TA) arranged by the council
- People who are in self-arranged TA or are homeless at home (HAH)
- People who are rough sleeping
- People who are owed a relief of duty but not accommodated by the council
- People living in a homeless hostel
- People living in TA arranged by social services.

For the purposes of this research 'people experiencing homelessness' corresponds to those falling into these categories. It is recognised that not all the documents used in support of this chapter do the same. Most often a narrower definition including just those who are rough sleeping is employed. Where policy responses are clear that they are targeting a particular group experiencing homelessness, this will be noted.

Table 1 below shows how many people were estimated to fall into these categories in England in 2019.

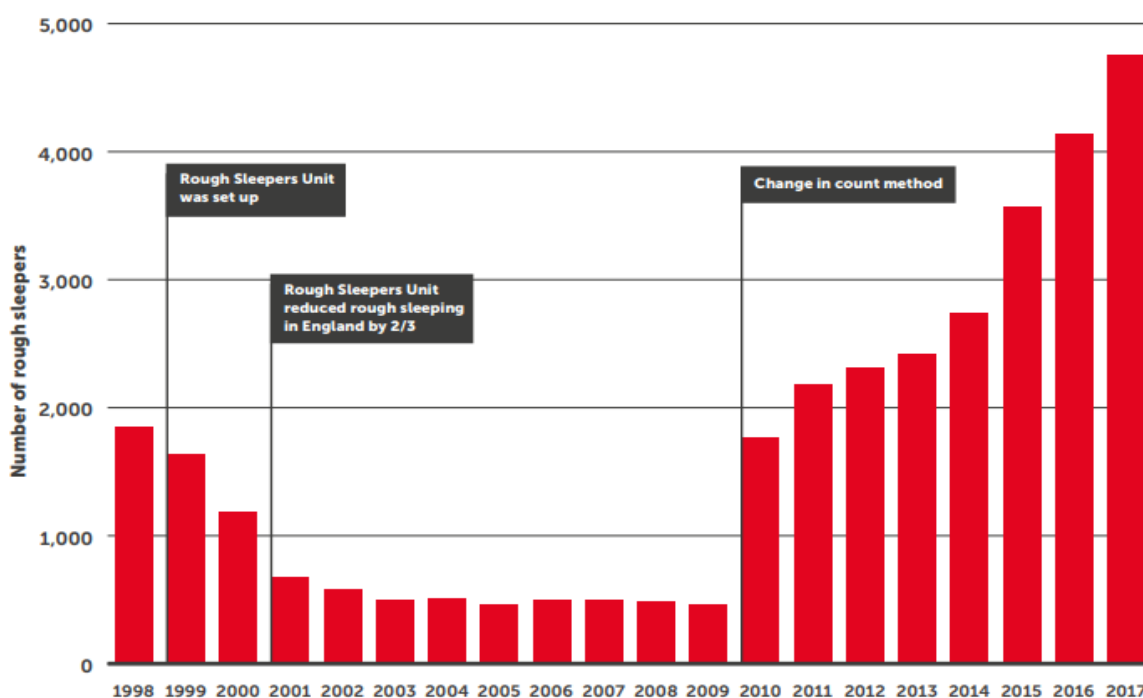
Table 1: people experiencing homelessness in England in 2019. Adapted from Shelter (2019).

Homeless in TA by the council	Homeless in self-arranged TA or HAH	Rough sleeping	Owed relief but not accommodated	Living in a homeless hostel	Living in TA arranged by social services	Total people homeless
236,610	18,317	4,677	2,292	14,684	3,937	280,517

Regionally, London has by far the highest proportion of people experiencing homelessness with 1 in 52 people affected. The Shelter research also presents homelessness as a problem that is getting worse. In all but one of the regions of England, the number of people experiencing homelessness has increased over the past three years, most significantly in the North West (117% increase), the West Midlands (64% increase) and the East Midlands (50% increase).

This finding is supported by data from elsewhere. Figure 1 below shows the trend in the number of people rough sleeping in England since 1998. Reference to the creation of a Rough Sleeping Unit is explained in more detail later in this chapter.

Figure 1: Numbers of Rough sleepers in England, 1998-2017 (Crisis, 2018).



2.3 The relationship between health and homelessness policy in England, 1996-2017

Policy is used here to describe any *national* instruction or initiative from the UK government, or a national public body responsible directly to a government ministerial department, with the stated intention to address issues related to homelessness. This could, for example, be legislation, or a national strategy/significant programme created in response to legislation.

In England, the lead government department responsible for enacting policy around homelessness is the Ministry of Housing, Communities and Local Government (MHCLG), although, as shown below, other government departments have also looked to address issues related to homelessness through their own policy positions.

Table 2 introduces the main pieces of legislation relating to homelessness in England since 1996 and the key provisions within them that opened the door to a multi-agency approach to tackling homelessness, including health.

Table 2: Homelessness legislation enacted by the UK government, 1996-2017.

Legislation	Year	Key provisions supporting a multi-agency response
Part 7 of the Housing Act	1996	<ul style="list-style-type: none"> Statutory underpinning for action to prevent homelessness and provide assistance to people threatened with or actually homeless.
Homelessness Act	2002	<ul style="list-style-type: none"> Required a homelessness strategy for every housing authority district.
Homelessness Reduction Act	2017	<ul style="list-style-type: none"> Duty on certain public authorities to refer service users who they think may be homeless or threatened with homelessness to a housing authority. The service user must give consent and can choose which authority to be referred to. The housing authority should incorporate the duty to refer into their homelessness strategy and establish effective partnerships and working arrangements with agencies to facilitate appropriate referrals.

2.3.1 Homelessness and social exclusion

In 1999, a Rough Sleepers Unit was established and tasked with reducing rough sleeping in England by two-thirds by 2002. The methods it employed in pursuit of this aim – that it achieved a year early - included expanding hospital provision and hiring new specialists in mental health and addiction services.

Although the 2002 Act required a homeless strategy to be formulated by each local housing authority to support people who were, or might become, homeless, which local services should be included in this was open to interpretation. Shelter reported in 2003 that 'health services are less frequently involved in the review and strategy process..., and their input does not produce clear outcomes' (Shelter, 2003).

The role of health services in supporting people experiencing homelessness in policy documents is largely absent in subsequent years until an analysis conducted by the Social Exclusion Task Force (SETF) and Department of Health (DoH) highlighted the poor health outcomes of vulnerable groups, including the homeless (SETF, 2010). 'Inclusion health' became the term used to describe challenges in accessing health services and ways to address this for certain groups not explicitly afforded protection under the 2010 Equality Act. This has most often referenced the following groups:

- Homeless people
- Gypsies and travellers
- Vulnerable migrants
- Sex workers

Following the SETF's work, it released joint plans with the DoH to improve health outcomes for these groups, specifically within primary care (SETF[2], 2010; DoH, 2010).

In the same year, the Marmot Review made recommendations to central and local government on policy objectives to address health inequalities in England (Marmot, 2010). Subsequently, the Health and Social Care Act 2012 introduced the first legal duties in relation to health inequalities and a National Health Inclusion Board (NHIB) was established, meeting for the first time that year, with responsibilities to:

- provide cross-sector and interdisciplinary leadership and ownership of the Inclusion Health agenda nationally;
- champion the needs of vulnerable groups and promote the principles of the Inclusion Health approach;
- provide direction, oversight and decision making for the delivery of the Inclusion Health programme;
- provide evidence-based challenge across health and social care work in partnership with Government to develop and drive innovative solutions.

It should be noted, however, that the NHIB did not meet after December 2013 and oversight of these responsibilities is not evident. Writing in 2018, the Faculty for Homeless and Inclusion Health (FHIH) stated:

“The Health and Social Care Act 2012 introduced, for the first time, statutory duties on NHS commissioning organisations to have regard to the need to reduce health inequalities in access to and outcomes achieved by services, and to integrate services where this will reduce inequalities. The National Inclusion Health Board, together with the Royal College of General Practitioners, produced commissioning guidance, based on this duty. However, organisations struggling with austerity measures may overlook this duty, and it is not clear how they may be held to account.” (FHIH, 2018).

Crisis echoed the particular lack of impact of the NHIB’s intentions in tackling rough sleeping. They have suggested a loss of momentum in tackling the broader issues that drive rough sleeping arguing that ‘the dramatic rise in England of rough sleeping since 2008 [can be attributed to] the absence of political targets, cross-governmental approaches, and sufficient budgets (Crisis, 2018). The King’s Fund have also noted the reversal in progress in tackling rough sleeping since 2010 (Cream et al, 2020).

A lack of accountability for health commissioners and providers in improving health outcomes for people experiencing homelessness is also evident during this period. NHS commissioning guidance on equality and health inequalities legal duties (NHS et al, 2015) referenced the need for commissioners to analyse their performance against the stated outcomes for each group afforded protection under the Equality Act 2010, plus Inclusion Health groups. The latter, however, were not included in the summary report for NHS commissioners and providers to complete demonstrating their implementation of the NHS’s Equality Delivery System. Homeless and Inclusion Health standards for commissioners and service providers have been published by [Pathway](#) in 2011, 2013 and 2018 (the first edition focusing on homeless people) but these have not been endorsed by NHSE.

Although the level of accountability in addressing health inequalities has been questioned, the need to address this issue has continued to form part of national health policy since the publication of the Health and Social Care Act. The table below contains some of the most significant examples.

Table 3: Health policy and health inequalities

Policy	Year	Key provisions
NHSE: The Five Year Forward View	2014	<ul style="list-style-type: none"> The NHS will work with CCGs and others to design new incentives to encourage new GPs and practices to provide care in under-doctored areas to tackle health inequalities.
PHE: Strategic plan for the next 4 years: Better	2016	<ul style="list-style-type: none"> We will work in collaboration with local authorities, NHS commissioners and providers, the voluntary and community sector and academics, to support local approaches to improve health and reduce health inequalities for communities.

Policy	Year	Key provisions
outcomes by 2020		<ul style="list-style-type: none"> We will provide expert advice on the health aspects of town planning, housing and homelessness, raising awareness and developing the skills of the public health workforce for local joint action.
NHSE: Next steps on the Five Year Forward View	2017	<ul style="list-style-type: none"> Locally, we will work with patients and the public to identify innovative, effective and efficient ways of designing, delivering and joining up services. And by prioritising the needs of those who experience the poorest health outcomes, we will be better able to improve access to services, reduce health inequalities in our communities and make better use of resources.

2.4 The relationship between health and homelessness policy in England, 2017-2020

The requirement for multi-agency working, including health, in addressing homelessness did not become explicit in legislation until the 2017 Homelessness Reduction Act. This required local authorities to 'ensure that their homelessness strategy is coordinated with the Health and Wellbeing Strategy, and that their review of homelessness informs and is informed by the Joint Strategic Needs Assessment' (MHCLG, 2018).

A more prominent role for health services within national homelessness initiatives to implement the 2017 Act can be seen in response.

2.4.1 Duty to refer

The 2017 Act required public authorities to refer individuals who may be at risk, or already homeless, to local authorities from October 2018. This included:

- Emergency departments
- Urgent treatment centres
- Hospitals in their function of providing inpatient care

An evaluation of the implementation of the Act published in 2020, however, suggested that relatively few health providers had been effective in their response to this duty. The report cited several queries from participants in the evaluation as to why GPs, mental health and drug and alcohol services had not been included in the duty and argued for it to be extended to include them (ICF, 2020).

2.4.2 Rough Sleeping Initiative

In March 2018 the MHCLG announced its Rough Sleeping Initiative (RSI). This included a package of measures to deliver on the government's promise to halve rough sleeping in England by 2022 and eradicate it by 2027. These included:

- a new Rough Sleeping Team made up of rough sleeping and homelessness experts, drawn from and funded by government departments and agencies with specialist knowledge, across a wide-range of areas from housing, mental health, and addiction;
- a £30 million fund for 2018 to 2019 with further funding agreed for 2019 to 2020 targeted at local authorities with high numbers of people sleeping rough. The Rough Sleeping Team will work with these areas to support them to develop tailored local interventions to reduce the number of people sleeping on the streets;
- £100,000 funding nationally to support frontline Rough Sleeping workers to make sure they have the right skills and knowledge to work with vulnerable rough sleepers.

Delivery of these intentions required inter-departmental cooperation, including from the DHSC, which would make experts in mental health and drug treatment services available to support the new outreach teams.

2.4.3 Rough Sleeping Strategy

In August 2018 the MHCLG released its Rough Sleeping Strategy (RSS), providing more specificity as to how they planned to tackle homelessness, supported by £100 million of funding over the next two years. The vision for this was built around 'prevent, intervene, and recover'. As part of the 'intervention' approach the RSS committed to providing £2 million to enable access to health and support services for people who sleep rough. It also required NHSE to spend up to £30 million on health services for people who sleep rough over the next five years.

2.4.4 The NHS Long Term Plan

The NHS Long Term Plan (LTP), published in 2019, included the intention from the RSS to intervene in homelessness. This was described in terms of both targeting of resources to tackle health inequalities and to provide specialist services for rough sleepers. The relevant commitments were:

- To help tackle health inequalities, NHSE will base its five-year funding allocations to local areas on more accurate assessment of health inequalities and unmet need. As a condition of receiving LTP funding, all major national programmes and every local area across England will be required to set out specific measurable goals and mechanisms by which they will contribute to narrowing health inequalities over the next five and ten years;
- We will invest up to £30 million extra on meeting the needs of rough sleepers, to ensure that the parts of England most affected by rough sleeping will have better access to specialist homelessness NHS mental health support, integrated with existing outreach services.

Since the publication of the LTP, NHSE/I, Public Health England (PHE), partners in the voluntary and community sector (VCS) and local government have worked to develop a 'menu' of evidence-based interventions to draw upon to reduce health inequalities. (NHSE/I, undated). This includes interventions for improving access to health services for inclusion health groups.

3. What was done before the crisis?

3.1 Introduction

Assessing changes in access to care under COVID-19 requires a sense of the starting point. What was the situation pre-pandemic? What health and care services targeted people experiencing homelessness? How have they developed? What are the barriers facing people in accessing these services? How have barriers to access been overcome?

While not attempting comprehensiveness, this chapter addresses these questions. It draws upon sector literature and interviews carried out with stakeholders.

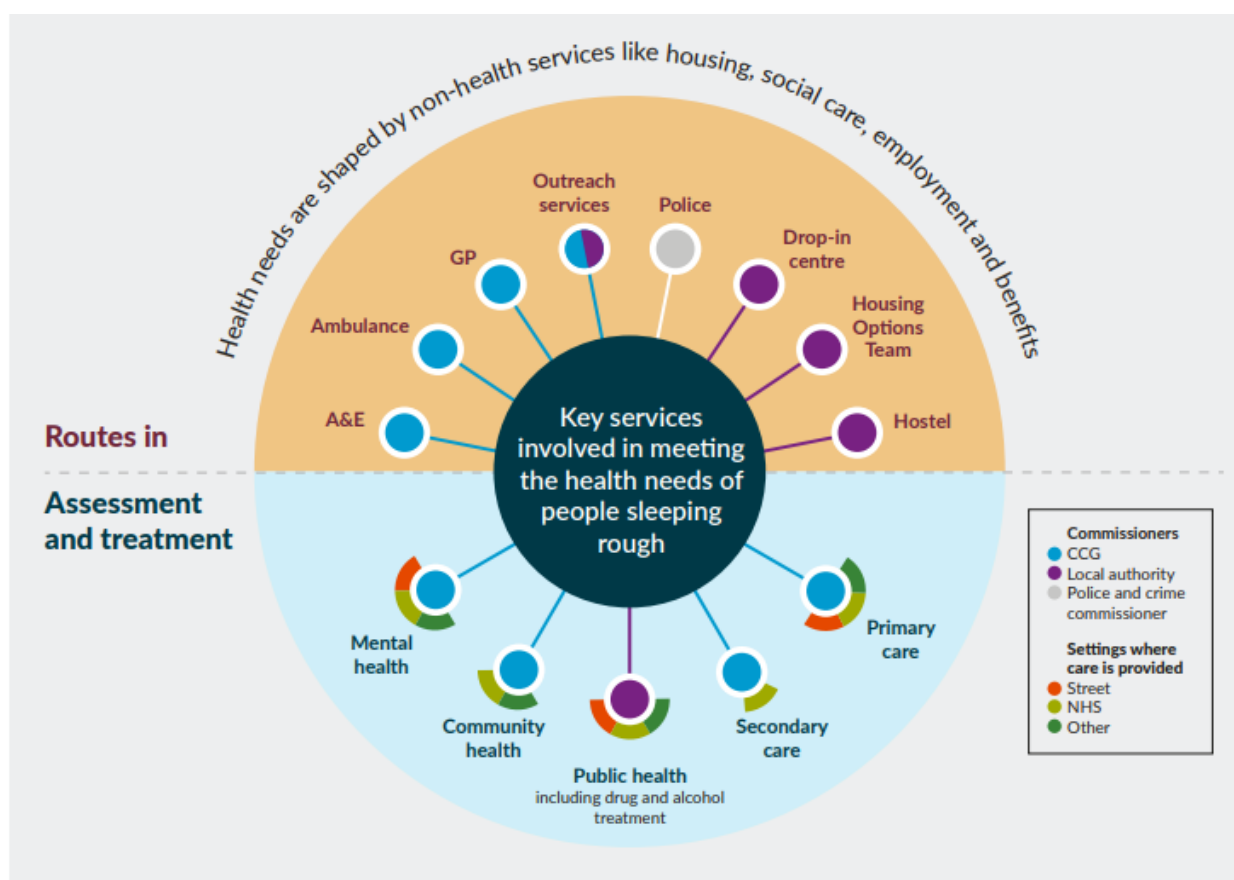
The chapter begins with a description of how primary care, secondary care, mental health and drug and alcohol services for people experiencing homelessness have been organised, noting the diversity in models across them and lack of a national picture outside of primary care. It highlights the standards for commissioners and providers developed by the FHIH for inclusion health that recognise this inconsistency and have tried to address it.

The chapter concludes that there are particular environmental factors that have led to this difficulty in describing health and homelessness services. These include poor data collection, a reliance on influential local individuals or organisations to develop services, a lack of clarity as to who is responsible for taking the lead in this area and a lack of formal routes for sharing learning with health and care commissioners and providers not already engaged in inclusion health.

3.2 What services are there for supporting the health of people experiencing homelessness?

As suggested in the previous chapter, increasingly, policy has recognised the multiple services that can influence the health outcomes of people experiencing homelessness. The King's Fund have summarised the key services in meeting the health needs of people sleeping rough specifically, shown in figure 2.

Figure 2: Key services involved in meeting the health needs of people sleeping rough (taken from Cream et al, 2020).



People experiencing chronic homelessness are more likely to present with tri-morbidity; suffering from mental ill-health, physical ill-health and substance misuse (Bradley, 2018). This complexity means that being able to navigate multiple services is important for this group.

This chapter will focus on the 'assessment and treatment' elements of services presented in figure 2 in describing what health and care services looked like for people experiencing homelessness prior to the pandemic, whilst noting the 'routes in' where they have been described as means to accessing these services. 'Community health' has not formed part of this study and is therefore not described in more detail. For reference, it can include podiatry, midwifery, occupational therapy, and palliative care, amongst other services.

3.2.1 Primary care

Accessing primary care is important in supporting all people to receive health interventions before emergency care is necessary. However, socially excluded groups use significantly more emergency and acute care and are less likely to be registered with a GP than the rest of the population (SETF, 2010). This can sometimes be down to GP practices refusing to register patients because of a lack of ID or proof of address, something reflected in recent peer research (Pleace and Bretherton,

2020). Homelessness charity Groundswell have developed a card for clients detailing their rights to registration demonstrating the prevalence of this issue.

Some areas have contracted specialist GP practices to provide services for people experiencing homelessness. Research by King's College London identified 123 specialist primary care services for this group operating in 2018 (Crane et al., 2018). These were grouped into three categories:

1. Specialist health centres that worked primarily with homeless people, and possibly other groups of people who were marginalised;
2. GP practices that served the general population but also provided 'enhanced' or targeted services to people who are homeless, such as clinics in a hostel;
3. Mobile homeless health teams that ran clinics in several hostels and day centres for people who are homeless.

Table 4 below, shows their distribution across England.

Table 4: Distribution of specialist homeless primary care services in England

Midlands and East	London	North	South East	South West
26	29	32	20	16

Distribution of specialist services is related to the location of significant population centres which explains the lower number in the South West and South East.

Research has found that areas without these services reported increased difficulty in homeless clients accessing primary care. There is though, a lack of information for commissioners about the effectiveness of each service category to guide them in decision-making as to which, if any, they should adopt for their populations (Crane et al., 2018; Cream et al., 2020).

This was reflected through the research interviews for this study:

"What there isn't is good robust studies on, for example, mainstream versus specialist care... For example, in south London the model has been no specialist GP practices at all [but] a specialist nursing team which works alongside mainstream practices. We know that patients tend to like the pure specialist model... Whilst each of [these] models has had service evaluation done there isn't, I don't think, clear evidence of which of those is best."

Stakeholder interviewee 3

The King's Fund study suggested that most commissioners advocated a system where 'people were supported to "move on" from specialist services when they were ready' (Cream et al., 2020). Similar

findings came from the study interviews, where homeless clients were encouraged to access mainstream primary care alongside being able to access some specialist support.

3.2.2 Secondary care

As suggested above, difficulty in accessing primary care services has meant people experiencing homelessness may disproportionately rely on secondary care through emergency attendance. Research with this group also suggests that they are more comfortable attending A&E as there is less stigma attached than attending a GP (Pleace and Bretherton, 2020). Specialist services for clients in secondary care have focused largely on supported discharge to ensure that people are not discharged from hospital to the street and receive appropriate follow-on care. As highlighted in chapter 2, hospitals have a duty to refer patients they think are homeless to the relevant services although the application of this has been inconsistent.

The [Pathway Programme](#) for homeless patients admitted to hospital involves in-hospital GPs and dedicated Pathway nurses working with others to address the housing, financial and social issues of patients. The model has been able to demonstrate a reduction in A&E attendances and time spent in hospital. It has been replicated, with Pathway support, in eleven hospitals across England since its inception in 2009.

As in primary care services, research has shown different models of supported discharge:

"We saw two approaches to specialist hospital discharge across our sites. First, all areas embedded a diverse range of staff – such as primary care and community health workers, social workers or housing professionals – into a hospital discharge team to help plan for a patient's discharge from hospital... Second, there were variations in the availability of this support. For example, one area had a full-time member of staff based in its main acute hospital who spent one day a week in its mental health hospital. In another, there were four team members, not all full time, and they worked with discharge but also supported people experiencing homelessness who were admitted to the hospital." (Cream et al., 2020).

Access to secondary care is also supported in some places, through funding to help people experiencing homelessness to attend hospital appointments where there is a cost involved (Pleace and Bretherton, 2020).

3.2.3 Mental health

An important feature of many of the specialist primary care services described above has been to support patients to access mental health services. Typically, this has been through developing closer relationships between primary care, mental health, and other relevant services. In some cases, such as in [Exeter](#), this has led to the co-location of primary care, mental health, housing, probation, and street homeless outreach services.

Voluntary sector and social enterprises play an important role in improving access to mental health services for people experiencing homelessness. For example, the [Enabling Assessment Service London](#) (EASL) carries out multidisciplinary mental health assessments as well as training and support to others in order to reduce mental health crises. [Homeless Link](#) have also provided guidance for professionals on mental health and homelessness (Homeless Link, 2018).

The funding provision from the NHS LTP noted in the previous chapter is also supporting activity in this area. An interviewee described how this funding, over five years:

"...has enabled some 7 or 8 pilots in different parts of the country' to get under way with approximately £300-500,000 funding for each project, where there was already some activity in the area of mental health and homelessness, to develop the initiatives further and enable local authorities to try things they didn't have enough money to try before."

Stakeholder interviewee 10

There have however, been criticisms of mental health provision for this group, specifically around:

- eligibility criteria being too restrictive;
- people getting discharged with high mental health needs without access to appropriate ongoing support and follow-up;
- a lack of early intervention and rapid access to mental health services, and it is hard to get people assessed on the street (Cream et al., 2020).

People experiencing homelessness also reported difficulty in accessing services at an early stage, leading to a deterioration in their mental health. This can have a knock-on effect which can exacerbate their housing situation or make it more difficult to treat a drug and alcohol dependency (Crisis et al., 2018).

3.2.4 Drug and alcohol services

In 2017, drug poisoning accounted for around one in three deaths among homeless people (ACMD, 2019). The government sponsored Advisory Council on the Misuse of Drugs (ACMD) concluded in 2019 that safe housing was key to tackling homeless drug misuse. It recommended:

- enabling local services to adopt a tailored approach to tackling the specific needs of homeless drug users in their area;
- substance use, mental health and homelessness services adopting evidence-based approaches to tackling drug misuse such as integrated and targeted services, outreach, and peer mentors to engage and retain homeless people in proven treatments;
- raising awareness among service providers of the levels of stigma experienced by homeless individuals who use drugs and ensure they are treated with respect;

- involving people with experience of homelessness and substance use in the design and delivery of the service provision for substance use and homelessness services.

Many of the specialist primary care services noted above already work closely with drug and alcohol services in this way. But this is not consistently the case. In its research of four case study areas, the King's Fund found that none of them aligned thresholds of access across drug and alcohol, mental health, and housing services (Cream et al., 2020). Dual diagnosis, where a patient requires treatment for mental ill-health as well as substance misuse, has been recorded as a common issue as reported by one interviewee:

"In terms of drug and alcohol services and mental health there is always an issue of dual diagnosis... You speak to any front-line worker..., and that will be one of the key issues they will probably report to you... You have the added pressures that people experience when you say that you need to address your drug and alcohol abuse before...[you can get] a mental health diagnosis."

Stakeholder interviewee 4

As shown in figure 3, drug and alcohol services are commissioned via the local authority rather than health. This requires joint commissioning intentions to help avoid this issue. The King's Fund research found that their case study sites had employed dedicated dual diagnosis workers and designated leads to support collaboration between organisations (Cream et al., 2020).

3.2.5 The voluntary and community sector

The voluntary and community sector supporting people experiencing homelessness is large and diverse. There are organisations operating at a national, regional, and very local level providing a range of services such as advocacy, shelters, information and guidance, and research, to name a few. This sector has been vital in supporting health services to reach people experiencing homelessness, most often by embedding health staff in their own outreach teams.

Homelessness charities such as [Groundswell](#) and [St Mungo's](#) have implemented approaches to improving access to health care and advocated for more to be done at the national level. Groundswell's #HealthNow campaign has created Homeless Health Peer Advocacy Services in three cities and is collecting evidence of inequalities experienced by this group in accessing health and care services.

3.2.6 Resources to support local commissioning decisions around improving access to health and care

Although there has been no nationally funded scheme to address the health needs of people experiencing homelessness until recently, there are resources that can support the case for change and recommend commissioning approaches.

The FHH compiled [standards](#) based upon evidence and practice from members across multiple disciplines, current research, and the lived experience of excluded people (FHH, 2018). The standards are designed as a framework for the commissioning and provision of health services for excluded people. They cover a wide range of services including, amongst others:

- Primary care
- Mental health
- Substance misuse
- Secondary care services

The standards make provision for reducing many of the barriers to accessing care highlighted above. These standards are explored more fully in appendix B of this report in assessing service changes during the COVID-19 response.

The National Institute for Health and Care Excellence (NICE) are also developing guidance for integrated health and care for people who are homeless through being roofless, expected to be published in 2022.

3.3 Stakeholder observations on health and homelessness services prior to the COVID-19 response

The above section has drawn largely upon the literature relating to health and homeless services. An observation from this work is that it is not possible to describe in detail models of delivery for these services, with the possible exception of primary care.

This section draws more significantly upon the stakeholder interviews conducted as part of this study to describe some of the consequences of this lack of clarity; why these services might be needed; how they should be organised; and who should organise them, prior to the COVID-19 response?

3.3.1 Homelessness prevention and intervention approaches are housing-led

As set out in chapter 2, there has been an increase in recognition that improving the health outcomes of people experiencing homelessness requires a multi-agency approach. The interviews raised the suggestion that more leadership from health agencies was needed to support this:

"The Rough Sleeping Strategy recognises that ill-health is a challenge for a number of reasons... The strategy wasn't health-led, it's been very much led by the [MHCLG] and the [DHSC] is.., committed to helping. But it's not a health-led strategy.., it's housing-led, so let's put people in accommodation rather than thinking.., a house in itself won't tackle the ill-health that we know a lot of people experience. [National charities] still advocate for their being more of a health-led approach to homelessness."

Stakeholder interviewee 11

This argument is supported by the King's Fund research where none of the case study sites it reported on had the NHS as taking the system leadership role for health for this group. Of the four sites, this role was fulfilled by the local authority housing department in two of them, with public health and adult social care taking the lead in the others.

3.3.2 Variation in delivery

Stakeholders interviewed cited lack of local collaboration as a significant weakness in current services. This lack of cohesion has resulted in variation of provision of services around health and homelessness and one cause of this was seen as confusion over ownership:

"Is [health and homelessness] the health service's responsibility, or [is] this the local authority's responsibility? It would be possibly easier but there is a lot of: 'well, we don't have the funding for that, we don't have the expertise for that, I thought that service was doing it'."

Stakeholder interviewee 2

However, where the right conditions were in place, another interviewee saw opportunities in locally-driven services:

"We have a placed-based programme and partnerships with local areas, the rationale is that we don't have the right conditions in England to end homelessness but locally we can help with that change."

Stakeholder interviewee 5

3.3.3 Reliance on the influential local actor

The presence of specialist services is often determined by local advocates. In the absence of national direction, this provision has developed as a result of grassroots championing. Interviewees acknowledged that success within a system was often down to individuals or organisations such as local politicians or advocacy services.

For example, in Bournemouth, Christchurch and Poole, long-standing advocacy from the local voluntary sector for drug and alcohol interventions for people experiencing homelessness has led to action. The council now has a Homelessness Reduction Board with membership from primary care, Clinical Commissioning Groups (CCGs), Public Health, and the voluntary sector. This can influence local commissioning decisions.

The reverse of this situation also applies. An absence of 'campaigning' by local actors and partnerships often results in an absence of services. Stakeholders cited few other mechanisms for influencing local commissioning priorities.

3.3.4 Challenges with data

The data challenge in homelessness is significant. This research is accompanied by a more detailed look at the data collection and sharing around health and homelessness, but it is important to note here that lack of consistency in how homelessness is recorded and shared has been a real barrier to joining up services. As one interviewee put it:

"Even in specialist primary care we're not collecting the same data. In an ideal world the community teams, the hospital teams, the mental health teams, anybody that is a specialist team, would be singing to the same song-sheet. Even in the way they record homelessness and housing status... We're not even recognising homelessness in the same way in specialist services.., we're a very long way from being able to produce comparative data."

Stakeholder interviewee 3

There currently exist no common standards for how homelessness should be recorded by agencies working in this area.

Developing the evidence base for the benefits of improving access to health and care for people experiencing homelessness is related and crucial to this:

"We don't really know the impact of this variability of services, that work hasn't really been done. It's a big piece of data work that needs doing as is only ever looked at retrospectively at the moment."

Stakeholder interviewee 3

These reflections are also borne out in the literature. The mapping work of primary care services described above argued that little is known about their effectiveness in engaging and treating people who are homeless (Crane, 2018).

3.3.5 Stigma relating to homelessness

Research has shown that staff and the wider public may demonstrate cultural and attitudinal barriers that shape what support this group deserve. This leads some clients to feel unwelcome when trying to access services (Cream et al., 2020). This was repeated in the interviews:

"There is still a lot of prejudice.., old ideas about deserving and undeserving poor. A lot of clinicians still get very little training.., in inclusion healthcare and don't have much of an understanding of the social determinants of health and adverse childhood experiences."

Stakeholder interviewee 1

3.3.6 Mechanisms for mutual learning

As has been shown above, there are examples of health services targeted at people experiencing homelessness, although there are gaps in provision across geographies and a lack of a clear picture of how services outside of primary care are organised nationally. Where examples have been

provided, there was considerable support from interviewees for the diverse ways in which these targeted services operated and the local actors who made health and homelessness a priority. The challenge, as suggested by one interviewee, was how to share this learning and enthusiasm with places in which they do not yet exist:

"People share learning... but it's a bit of an echo chamber to people who are keen on this, the ones who go to conferences, the ones who join up to the Faculty for [Homeless and Inclusion] Health, or Inclusion Network... The people who are good at this get better. The people who know nothing about it don't find out about it."

Stakeholder interviewee 2

4. What was done in response to the crisis?

4.1 Introduction

This chapter describes how health and care services adapted to the initial government response to the pandemic for people experiencing homelessness. This included providing funding to local authorities to supply emergency accommodation and implement approaches to prevent the spread of COVID-19.

The chapter draws on the survey of service providers, as well as literature and discussion forums from sector stakeholders in describing the response of services to COVID-19. It also includes the views of people experiencing homelessness, collected from Groundswell's fortnightly briefings describing service users' experiences of the COVID-19 response, and a peer reference workshop. The chapter finds many examples of services using the crisis to address some of the barriers to access highlighted in the previous two chapters, as well as instances where these barriers have been exacerbated.

Findings are organised into: changes found that affected access to services; and changes that affected how a service was delivered. Findings are purely descriptive; reported rather than analysed. This is the function of chapter 5.

4.2 Initial government response to the outbreak

On 26 March 2020, the Minister for Local Government and Homelessness wrote to all local authorities setting out the national strategy for reducing the impact of COVID-19 on people facing homelessness (MHCLG, 2020). This required six key actions:

1. Convening a local 'coordination cell' involving local government and local NHS partners;
2. Taking action to stop people congregating in groups;
3. Procuring accommodation for people on the streets;
4. Triaging people accommodated into three cohorts:
 - Cohort 1 - Those with symptoms of COVID-19
 - Cohort 2 - Those with pre-existing conditions but without symptoms
 - Cohort 3 - Those without any of the above
5. Providing social care basics to people who need it in self-contained accommodation;
6. Where possible, separating people who have significant drug and alcohol needs from those who do not.

Local authorities were required to provide a multi-agency response, setting up a centralised co-ordination function referred to as 'HOMELESS COVID-COMMAND' (NHSE/I, 2020). People identified within cohort 1 were required to be isolated in appropriate accommodation for 14 days unless requiring hospital care. On recovery, people not considered at risk of severe illness should be discharged to residential hostel accommodation or another local authority supported tenancy. Those considered at risk should be moved to a designated 'COVID-PROTECT' site designated for cohort 2.

This strategy, and the subsequent response from professionals across the homelessness sector, was significantly informed by members of the University College London's (UCL) Institute of Epidemiology and Health Care.

An initial £3.2 million was provided to councils for three months to fund placements in emergency accommodation. By July 2020, around 15,000 people had been accommodated in hotels across the UK (Groundswell, 2020). Most areas underestimated the level of homelessness in their communities:

"All across the country, the numbers of people who have been put into emergency accommodation have vastly exceeded any.., previous counts or estimates [of homelessness]."

Stakeholder interview 1

On 24 June, the Minister for Rough Sleeping and Housing wrote to all local authorities in England announcing a further £105 million 'to help local authorities implement a range of support interventions for people placed into emergency accommodation during the COVID-19 pandemic' (MHCLG [2], 2020).

As of 26 June, 16 deaths had been recorded from COVID-19 in England of people identified as homeless (ONS, 2020).

The rest of this section considers what health and care services did to try and ensure that people experiencing homelessness could access them following the implementation of the above response. Although this largely describes the initial three-month period, where emergency accommodation was funded by the government, the survey was conducted in August 2020 and so also captures learning from beyond this period. From July 2020, the provision of emergency accommodation was variable as it required local authorities to pay for it.* Many of the changes to health services implemented in the initial phase, however, were still in place. The period of study for this chapter will therefore be referred to as the COVID-19 response.

* Although additional funding has been provided as part of the new national restrictions put in force on 5 November 2020, this is beyond the scope of this research.

4.3 Examples of service change during the COVID-19 response

“There was initial resistance [from health service organisations] to joint-working because it wasn’t a burning issue at that moment in time and sometimes you need a burning platform to do what we needed to do.... COVID was the perfect storm for us... We see barriers and siloes breaking as a consequence of this [but] it’s dependent on the individuals and leadership to see the value in this” (HLP, 2020).

As this statement suggests, the COVID-19 outbreak and subsequent government response sharpened the focus on the health needs of people experiencing homelessness. The presence of homelessness became a health protection issue. Areas which had existing services for this group adapted in various ways. Areas with little existing provision or infrastructure had to begin constructing some. Examples of both extremes are provided here, but the very different starting positions determined much of what followed.

It should be noted however, that many of the interviewees engaged in this research urged caution in suggesting that improvements in access to health and care for this group were systematic or widespread. As the above quote (and previous research) suggests, action has relied on individuals and leadership:

“My view is that it [the COVID-19 response] has enhanced and strengthened existing relationships. If your local area’s response was to retreat into its siloes then this has been reinforced as well. If the response is ‘we don’t have a significant problem here, or these are temporary people who don’t have a local connection’ then that doesn’t turn out as well.”

Stakeholder interviewee 1

Yet the unprecedented change of context – and the opportunities following from that - was also recognised:

“During COVID people have engaged with services who no-one expected to engage with services... People who have been experiencing rough sleeping for twenty plus years and they’ve never accepted accommodation; they have now. That’s because you have a system and consistent outreach workers going out to people and building that relationship, they then felt safe.”

Stakeholder interviewee 4

Areas with existing partnerships and services needed to adapt them to the limitations imposed by the government lockdown, specifically around social distancing. For areas where these services did not exist, the need for them became more apparent.

Five main services have been identified here for which examples of adaption and adoption will be provided:

- Primary Care

- Secondary care
- Mental health
- Drug and alcohol services
- Smoking cessation

Sexual health and wound care have also been referenced during data collection with some examples provided.

4.3.1 Survey results: new ways of working during the COVID-19 outbreak

The survey found two main types of change:

- Changes that affected access to services
- Changes to the way services were delivered

By way of summary, approaches within these categories are described in the tables below, grouped according to the service categories above. This is followed by fuller description of the changes, backed by case study examples.

The purpose here is descriptive, not evaluative. What follows does not suggest that changes were good, bad or indifferent – just that they were mentioned in survey responses. A key has been provided to give a sense of the weight of this response.

Table 5: Summary of reported changes to accessing services by type

	Additional capacity to take new registrations/referrals	Threshold reduced/changed	Suspension of part/all of service	New service commissioned to enhance access
Primary care	✓ ✓ ✓			✓
Secondary care			✓	✓
Drug and alcohol		✓ ✓	✓	✓
Smoking cessation		✓		✓
Mental health	✓	✓	✓	✓
Sexual health		✓		
Wound care		✓		

Key: ✓ = little mention; ✓✓ = some mention; ✓✓✓ = significant mention

Table 6: Summary of reported changes in how services were delivered by type

	Online/ remote registration /referral	Service delivered remotely	Provision of phones	Services working together	Service delivered through outreach/ inreach	Provision of transport	Support to navigate service	National guidance
Primary care	✓	✓✓✓	✓	✓✓	✓✓		✓✓✓	✓
Secondary care		✓✓✓	✓	✓		✓✓✓	✓✓	
Drug and alcohol	✓	✓✓✓		✓✓	✓✓✓		✓✓	✓
Smoking cessation	✓	✓✓		✓✓	✓✓✓			
Mental health	✓	✓✓✓		✓	✓		✓✓	
Sexual health		✓			✓			
Wound care				✓	✓			

Key: ✓ = little mention; ✓✓ = some mention; ✓✓✓ = significant mention

To aid data validation, these findings were tested during the workshop with people with lived experience of homelessness. Overall, participants agreed that more services were delivered remotely during the COVID-19 response, and face to face provision was reduced. They also agreed that there had been evidence of health and non-health services working together to support access to services. There was less agreement however, with evidence that services had been delivered directly into emergency accommodation.

The changes summarised above are now described in more detail. These descriptions draw on evidence from the survey, case study examples sourced from the survey and other research, and the views of people with lived experience of homelessness.

4.3.2 Primary care

Results from the survey

Patient registration in general practice has been noted as a significant issue both before and during the COVID-19 response. Lack of ID or address has often been a barrier to registration. Designated practices for homeless patients exist in some areas. These practices have worked to register a significant number of new patients during the response.

On 27 March 2020, NHSE/I responded to the issue of patient registration by writing to GPs and commissioners stating that people with no fixed address are equally entitled to be registered with a GP and this, or lack of photo ID, were not reason enough to refuse registration. This was reiterated in NHSE/I guidance for primary care issued during the COVID-19 response (NHSE/I [2], 2020).

Although it is unknown how many practices adhered to this instruction – indeed stakeholder interviewees suggested this has remained a significant problem throughout the response - examples from the survey suggested that some practices did adapt to register more people experiencing homelessness. This was done in different ways. For example:

- Specialist health teams working directly with local GPs who were willing to accept registrations from those housed in nearby hotels and hostels and supporting this process;
- Provision of remote registration systems;
- Support workers in emergency accommodation encouraging and helping clients to complete online registration forms and navigate the appointments system;
- Provision of phones to clients to register with a GP and to make and attend remote appointments;
- Commissioning of a Homelessness Healthcare Service that nominated a specific GP practice to register patients;
- Attendees to hospital emergency departments registered with a primary care team;
- Requiring housing officers to enquire as to GP registration as part of the housing assessment process;

- Multi-disciplinary working between health, care, and housing services to ensure GP registration.

Making it easier for **patients to attend** primary care appointments has also been considered as part of the COVID-19 response. This has included:

- Primary care clinicians carrying out visits to emergency accommodation rather than patients attending clinics;
- Increased use of telephone or other remote consultations with clients provided with the equipment to do so. This includes triage to determine whether a GP appointment is needed.

Clients have been able to **access prescriptions** more easily in some cases, being able to do this over the phone rather than in person.

View from people experiencing homelessness

GP registration and being able to make appointments remained a significant problem during the COVID-19 response and there were instances reported during the peer workshop of cancelled or delayed assessments or treatments in primary care. Groundswell, in their own peer research during the pandemic, found particular barriers to registering with mainstream general practice 'who are not adapting their access routes to suit new patients.' This was exacerbated by practices moving more of their services (including registration) online making it more difficult to discuss issues over registration in person, as well as requiring people to have access to digital tools to complete a registration (Groundswell [2], 2020).

The switch to remote delivery was found to have some positive feedback, for example, reducing the need to travel made attending the GP cheaper and easier if the client suffered from mobility problems. The provision of phones, however, was seen as vital to this service change, and these were largely reported to have been provided by voluntary sector organisations. Some participants also struggled to talk about their medical issues over the phone and preferred to do so face to face.

Case Study 1: St Werburghs Medical Practice – Chester

(Source: research survey)

A small dedicated General Practice for the homeless in Chester. Practice staff have described their response to the lockdown:

"A really big moment for us was when we shut and locked the front door. We went from having a bustling and busy waiting room with many drop-ins throughout the day to total telephone triage. We were concerned as to how we would be accessible to our patients. We were trained in the use of [accuRx](#) but very few of our patients have smart phones and many have no phones at all.

Communication can be difficult for patients with mental health concerns and the phone can add further complications to it. We have an intercom outside for those that were still dropping in and we were able to ask some questions there and bring them into the lobby to continue. We worked with hostels and through hotel reception to speak to patients who did not have access to a phone.

We made a list of all the patients that we thought needed extra support who were not on the shielding list. Many of our patients have mental health issues, with no family or friends to support them, and also had been registered with us for many years from being street homeless to living in temporary accommodation. They felt that we were family, and so did we. All six of us in the surgery went through the list to decide who was the most appropriate to provide a wellbeing call to and we ensured that we spoke to them at least once a week. For some patients it was three or four times a week.

To maintain access the clinical staff visited the hotels and hostels on a weekly basis to provide support to patients and staff and to ensure that they knew we were still available. We picked up concerns from both patients and staff from these visits.”

Case study 2: Haringey - Greater London

(Source: HLP, 2020)

The London Borough of Haringey funded five of its own hotels – many in London were funded centrally by the Greater London Authority (GLA) - and housed almost 200 people as part of the COVID-19 response. A local GP coordinated the medical response for this group and focused on:

- GP registration with local surgeries (75 per cent of the 200 have been registered).
- set-up of an MDT consisting of a GP, care navigator, dual diagnosis coordinator, members of hotel support teams, mental health nurse. This runs once per week and, amongst other things, works with GPs to facilitate the patient journey in primary care with clients.
- developing links with local acute hospitals.

The aim of the team is to baseline the health needs of those who have been housed through health checks to understand possible ongoing need and attend to any urgent needs through acute engagement where appropriate. There is uncertainty as to what will happen to this service once the emergency accommodation funding ceases.

4.3.3 Secondary care

Results from the survey

Changes here were reported in relation to:

- **Patient transport** to attend outpatient appointments has been a significant area of concern during COVID-19. Provision of transport to support their attendance has been variable. Where it has not been put in place it has created difficulty in attending appointments, particularly outside large cities. Using taxis or other funded private transport to attend appointments has been the most prevalent solution;
- **Support worker attendance** at appointments with clients has also been challenging, with several survey respondents reporting that due to social distancing and remote working, clients have needed to attend outpatient appointments alone. This can lead to missed appointments due to the travel difficulties mentioned, and also anxieties around visiting hospitals during the pandemic. Mitigation has been reported such as meeting people at hospitals to support attendance;
- As in primary care, **remote appointments** have been used for outpatient services although many **outpatient services were withdrawn** during the height of the pandemic. Distributing phones to clients to help attend appointments has been reported in places, as well as the provision of support to set up appointments and follow-up on condition management with people;
- **Hospital discharge** was reported to be difficult, with people discharged to the street or shared accommodation from A&E and told to self-isolate. Supporting discharge has previously been the area of most focus for this group in secondary care, as outlined in chapter 3. This finding suggests that where this was not already in place, it has not been implemented during the response;
- One charity-run hospital in London **commissioned an inpatient service** from April 2020 and facilitated these patients to attend outpatient appointments. As a charitable institution, this hospital has more flexibility as to how it operates.

View from people experiencing homelessness

Participants in the peer workshop had not experienced hospital care during the response so could not comment on the finding of additional transport provision or difficulty in hospital discharge; although there was support for more examples of the Pathway model to support discharge, described in chapter 3. There had been experience, however, of hospital appointments being cancelled during the COVID-19 response.

4.3.4 Mental Health

Results from the survey

As described in chapter 3, access to mental health services for people experiencing homelessness is a key issue across the country. This was also reflected through the survey responses. Of the five main services described here, mental health was the area where most of the survey respondents felt access had become *more* difficult during the COVID-19 response.

Access to mental health is mediated by GP registration, given that primary care is usually the gateway to a mental health referral. Another significant factor is the issue of dual diagnosis, defined above (3.2.4). Some places have pointed to loosening of dual diagnosis barriers during COVID-19 and more people being able to access mental health services as a result.

Other changes to mental health services reported during the COVID-19 response include:

- Mental health practitioners commissioned to provide **flexible outreach** support to individuals in emergency accommodation;
- **Lower thresholds** for offering mental health assessments;
- Use of community volunteers to provide **peer support**;
- **Remote access** to mental health consultations;
- **Online counselling** tools;
- **Hospital discharge arrangements** for clients communicated with local third sector homelessness organisations;
- Mental health services **working with local government housing** teams;
- Remote **multi-disciplinary team meetings** between primary care and community mental health trust to discuss patient actions;
- In some case **referrals into some services were suspended** including psychological therapy and routine psychiatric referrals.

View from people experiencing homelessness

In their peer research, Groundswell spoke to a number of clients who missed the interaction of things like group therapy. The shift to remote delivery and lack of continuity of services was raised as an issue especially where people found it difficult to forge trusting relationships with mental health professionals. Barriers to accessing mental health services mirror the issues with primary care; if a client struggles to register with a GP, they also struggle to access mental health services. Groundswell's research has found that the need for mental health services has risen as the pandemic has gone on.

Case study 3: GP Federation based in the Midlands

(Source: research survey)

During the pandemic a mental health practitioner was appointed to the rough sleeper team already in place. Although employed by the Mental Health Trust this person was co-located with the rough sleeper team and proved to be valuable. The rough sleeper team also has a named social worker assigned to them. Having these named individuals has improved access to mental health and social care for homeless individuals. The social worker has also arranged occupational therapy assessments using the kitchen provided by a local church; this has helped in safely moving people onto their own accommodation through identifying previously unrecognised support needs.

4.3.5 Drug and alcohol services

Results from the survey

Clients with addictions to drugs and/or alcohol required significant flexibility during the COVID-19 response. For example, temporary accommodation needed to allow alcohol on premises and in some cases licenses were required to do so. **Accessing prescriptions for drug addiction treatments** was also challenging with many GP practices closed for visits. Several changes to how these services were delivered have been reported:

- **Alcohol was purchased and delivered** directly to clients in accordance with guidance from their GP so that they did not need to leave the emergency accommodation to source funds or purchase alcohol;
- Drug and alcohol services were delivered **via 'in-reach'** in emergency accommodation in some places;
- **Outreach work was suspended** in some places. More often places reported the **suspension of all face-to-face contacts** for drug and alcohol referrals, moving to telephone access only;
- **Remote prescriptions** were sent directly to clients and for longer periods of time, for example, weekly rather than daily, to reduce the number of assessments required. We found examples of drug prescriptions taken directly to emergency accommodation and distributed by a local practice nurse;
- **Guidance for commissioners and providers** of services for people who use drugs or alcohol was published by the government and has been updated throughout the pandemic (DHSC, PHE, 2020). This allowed for a relaxation of the rules around opiate substitute prescriptions. It states that the joint working between housing, public health and the NHS had led to some people experiencing homelessness using health services for the first time. As people are moved into more stable accommodation commissioners and providers should ensure that continuity of care arrangements are in place and support is continued to be offered, even if it was not accepted in the first instance.

View from people experiencing homelessness

Increasing the length of prescriptions was also reported in the peer workshop as something they had seen during the COVID-19 response, as well as clinical pharmacists acting in an outreach capacity to provide prescriptions. The risks of overdose within this, however, were also recognised.

The switch to remote working, especially in the assessment phase of a substance misuse referral, was stated to have slowed down access to drug and alcohol services. There was, however, some support for remote delivery of this service once the initial assessment and treatment plan had been completed.

Case study 4: Bournemouth, Christchurch and Poole (BCP)

(Source: research survey)

BCP Council's Drug and Alcohol Commissioning Team (DACT) have commissioned two 'Rough Sleeper Drug and Alcohol Workers' to assertively engage with clients in hostels/emergency accommodation, work with them at pre-contemplative stage (where clients do not consider their behaviour to be a problem) and then assess for treatment.

The DACT have also earmarked one rapid medical assessment for prescribing per week for homeless individuals. The RSI workers have become part of the weekly rota of multi-disciplinary workers who walk around town daily, to engage with people who have refused accommodation or walked away from emergency accommodation. They also, whilst in hotels and undertaking assertive outreach, undertake needle exchange and encourage people to go to the hepatitis C clinics set up in the hotels.

The DACT have also been instrumental in fostering a close partnership with Royal Bournemouth Hospital ensuring that clients living in hostels, temporary accommodation, supported accommodation and hotels have access to hepatitis C testing and treatment. Approximately 180 individuals have been tested with approximately 75 people commencing treatment.

Case study 5: Homeless Hotels Drug and Alcohol Support Service (HDAS) – London

(Source: FHIH, 2020)

Following the instruction to accommodate people experiencing homelessness, a Homeless Hotels Drug and Alcohol Support Service (HDAS) was set up through a collaboration between South London and Maudsley; Change, Grow, Live; Turning Point; and Phoenix Futures. This was commissioned by the GLA at a cost of £45,000 per month. HDAS offers a 'single point of contact' which means there are workers available 9–5 to take enquiries and support and guide the homelessness health and care staff working in hotels on any drug and alcohol support needs. A clinician is then available to cover emergencies out of hours. As well as support and guidance the HDAS is able to offer harm reduction materials including naloxone and lockboxes to those in the homeless hotel system.

The lead for HDAS reported in June 2020 that 18 new people had entered into treatment as a result of this service and it had successfully improved communication between groups serving this population. Meetings are held between service leads fortnightly and the boroughs involved have all committed to retaining responsibility for service provision regardless of where the person is re-located in the city.

4.3.6 Smoking cessation

Results from the survey

Having people experiencing homelessness housed in emergency accommodation led some places to proactively offer nicotine replacement therapies (NRT), particularly electronic cigarettes. As well as the health benefits of giving up smoking, this discouraged clients from congregating to smoke and share cigarettes. Where this was offered, there are also examples of it being flexible to accommodate the needs of clients. This includes:

- **Provision of NRT** without enforced attendance at smoking cessation clinics or an appointment with a smoking cessation counsellor;
- **Relaxing rules** around vaping in some hotels;
- In London, HDAS secured **free vaping kits** from local suppliers to pass on to clients;
- **GPs suggesting smoking cessation services** during remote consultations.

4.3.7 Other reported service changes during the COVID-19 response

Contributors to the survey also pointed to changes in sexual health and wound care provision as part of the COVID-19-response. These include:

- **Sexual health tests** could be requested over the phone which reduced the stigma of waiting in a clinic according to one respondent. Consultation is only required if the client returns a positive test;
- Direct support from the sexual health service via a health link worker around **hepatitis C screening and treatment**;
- **Wound Care**: patients are contacted on discharge from hospital and are able to access same-day dressing and wound care through a GP practice. One respondent noted that this was being offered as an outreach service in east London.

Summary remarks from people experiencing homelessness

Many of the changes to services noted by providers were also recognised by service users. In terms of overall access however, there was a consensus view that in places where access to services had been poor prior to the COVID-19 response, this situation remained.

4.4 Enablers to new ways of working

Although there are many processes, tools and guidance that have supported the changes described above, this section focuses on two that we have found to have had a significant impact on enabling these changes to take place:

- Data collection to understand the health needs of people experiencing homelessness; and
- Collaborative effort to share learning from the pandemic as it happened.

4.4.1 Collecting health data for people experiencing homelessness during the COVID-19 response

Covid-19 Homeless Rapid Integrated Screening Protocol (CHRISP)

The CHRISP tool is a clinician administered survey developed by the [Healthy London Partnership](#) (HLP) in response to COVID-19. It is administered by clinicians over the phone with identified rough sleepers. Its primary aims are to:

- inform housing needs according to a health assessment
- identify individual needs around:
 - physical health
 - mental health
 - drug and alcohol problems
 - frailty
 - cognitive impairment
 - vulnerabilities
- act as an advocacy tool
- inform service planning

Table 7 below shows the numbers of CHRISP assessments completed as of August 2020.

Table 7: CHRISP undertaken in London to August 2020. Taken from HLP (2020).

STP	No. of CHRISP completed	No. of rough sleepers	No. of CHRISP assessments remaining
NCL	60	1740	1680
NEL	409	969	560
NWL	155	1683	1528
SEL	149	784	635
SWL	285	636	351
Total	1058	5812	4754

The aggregated data from CHRISP has provided the HLP with evidence of the scale of health and care needs of rough sleepers; for example, that c. 20 per cent of those interviewed were not registered with a GP and c. 30 per cent reported having mental health problems. These results have been fed back to multi-disciplinary teams in London made up of health and care professionals, to organise care and support where required, including working with clients as they are moved on from hotels and hostels to other accommodation.

The CHRISP assessment was also carried out in Bournemouth, led by a local GP with special interest. The questionnaires have been carried out by GPs locally, funded by public health. They are

expecting this to provide some evidence to encourage the local CCG to provide more support for health services for this population.

The team behind the CHRISP assessment tool have produced a modified (shortened) version of the survey designed to be used beyond COVID-19.

Bevan Healthcare

[Bevan Healthcare](#) is a Social Enterprise providing NHS GP services to meet the needs of people who are homeless or in unstable accommodation. They operate in Bradford, Leeds and Hull. Prior to the COVID-19 outbreak a health and homeless service was already operating in Bradford and Leeds, although not in Hull. A health liaison lead was deployed in Hull, initially on a short-term basis, at the start of the pandemic to support the housing of the city's homeless population.

In response to COVID-19, Bevan worked with a health technology provider, Docobo, to create an online tool for capturing and reviewing live data collected from rough sleepers housed in the three cities. This consists of a set of questions to identify potential COVID-19 symptoms and assess the risk to housed individuals. The question software has been downloaded to several devices provided to support workers in hotels and hostels where rough sleepers have been housed. It can also be downloaded to their mobile phones. Support workers are asked to register new entrants and regularly run through the question sets with already registered patients. Responses are reviewed by the Bevan clinical team and interventions put in place if needed.

Bevan have requested funding from NHSE/I to launch this system with other organisations in England, and also develop a directory of services for each area to allow support workers to signpost registrants to non-clinical support.

4.4.2 Sharing learning during the COVID-19 response

Communities of interest and specialist organisations have also responded to the COVID-19 outbreak through the collection and dissemination of learning. These have been important in engaging places and people who had not previously delivered dedicated services to understand the needs of the client group and how services might be designed. The examples below represent ways to share rapid learning during the COVID-19 response that we have found to be important in communicating the changes described above.

Future NHS collaboration platform: Homelessness and Inclusion Health

This dedicated workspace has over 900 members and is regularly used to post questions to the community and share relevant resources. The NHSE/I team behind the workspace have hosted webinars on a number of topics throughout the response such as primary care, safeguarding and

mental health. These have also invited local areas to discuss their own response to health and homelessness.

Groundswell

Groundswell have published fortnightly briefings based on primary research focusing on the impact of COVID-19 on people experiencing homelessness, particularly in regards to health and human rights.

Faculty for Homeless and Inclusion Health

The Faculty held a webinar in June 2020 focusing on sharing innovative practices during the COVID-19 response to care for homeless patients with addictions.

Healthy London Partnership

The HLP released a podcast and case study in June 2020 describing its response to homeless health in London to COVID-19.

Homeless Link

Homeless Link provide regular updates to its network on funding opportunities related to supporting clients during the COVID-19 response and ran a conference (30 Sep – 1 Oct 2020) looking at how the sector might progress its experiences from the past six months.

4.5 Making sense of the findings

This chapter has described the changes to health and care services we have been informed of through our research survey and the reporting of the views of people experiencing homelessness. We have also discussed how these changes have been supported through innovation. The next chapter considers the impact these changes have had on this population's ability to access services.

5. Is the response an advance on previous practice?

5.1 Introduction

This chapter considers whether findings described in chapter 4 might constitute an improvement on previous practice: has the response to the pandemic stimulated useful innovation?

To move from a description of 'what is' to 'what ought to be', we held a stakeholder workshop in October 2020. This included representatives of the multiple perspectives (see Introduction for a list) needed to help make this transition from description to prescription. Here we summarise the results of the workshop. We also summarise the results of a related exercise to map reported changes against the FHIH standards for inclusion health specific to services for people experiencing homelessness (Appendix B contains the full results).

5.2 Stakeholder assessment of the most common changes

As the previous chapter showed, multiple service changes were found during this study. To focus the task of making a rapid evaluative assessment of them, we focused in on those that we had heard most about. These were:

- support for registering with a GP
- remote delivery of primary care services
- remote delivery of mental health services
- health and care services delivered through outreach
- joined-up working between health and non-health services

In the workshop, we presented summary descriptions and examples of each. We then asked for initial reactions against the following high-level framework:

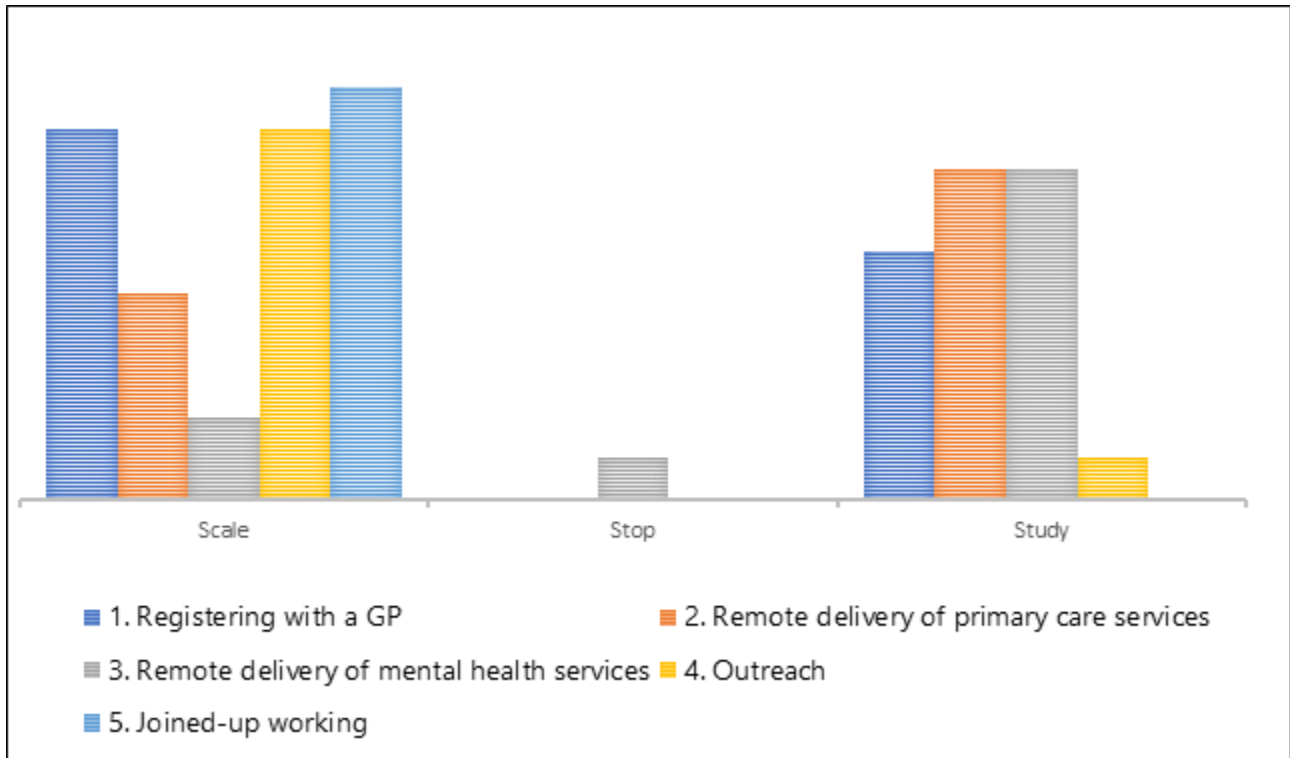
Scale - these are the things where the weight of opinion of our participants has been that they improve the ability of people experiencing homelessness to access health and care.

Stop - these are the things that were necessary at the time, but it is generally agreed that they have impeded access to health and care.

Study - these are the things where we have seen diversity of opinion in terms of their prevalence or impact. In the main, this is because they are new ways of working that are not yet supported by an evidence base or it is not agreed that they have become widespread practice. Also, they may be seen as necessary short-term solutions but not better than what went before in 'normal' times.

A summary of findings from this is presented in figure 3 below.

Figure 3: Views of workshop participants as to next steps for reported service changes



Stakeholders were then asked, in light of their initial reaction, to raise caveats and qualifying points. These responses are now explored in more detail.

5.2.1 Registering with a GP

Primary care is the gateway to many other health services. Registration for this group has been a historical problem and remains so. Despite many examples cited from the research that it has been given significant attention during the COVID-19 response, the workshop group were unconvinced that this change was widespread. Although there was support for scaling changes to improve GP access, a significant number of workshop attendees required more evidence to understand better how widespread this improvement was, and why barriers remained to GP registration for this group and how it could be supported nationally.

In order to support the widespread implementation of this change, workshop participants suggested:

- placing additional pressure on practices, for instance, through CQC inspections to register undocumented people;
- putting more onus on policy makers rather than the voluntary sector to facilitate registration;
- increasing training for GP practices to encourage registration;

- sharing best practice from places that have a proven record of removing barriers to registration across providers and commissioners;
- supporting primary care capacity to address concerns as to their ability to register more patients with potentially complex needs;
- doing more research into the experience of primary care once it is accessed.

5.2.2 Remote delivery of primary care services

Workshop participants reflected both the positive and negative impacts of this change and most argued that it needed to be studied before long-term implementation was considered. Broadly, it was considered that whilst this may benefit some, others would be impeded in accessing primary care services through remote delivery. Detailed comments included:

- the provision of phones to people experiencing homelessness that had taken place during the pandemic was important. This had predominantly been facilitated by the voluntary sector and so relied on their engagement;
- as in the wider population, IT literacy was an issue in shifting services online. National policy on the use of remote primary care by default would also be applied to specialist homeless services;
- personal preference as well as needs-based assessment should inform decisions as to the appropriate way of accessing care;
- clear communication about face-to-face options still being available was important;
- remote prescriptions was acceptable as long as people were supported to build confidence in the process.

5.2.3 Remote delivery of mental health services

Remote access to care has been divisive in this research. The provision of phones to make attending appointments easier has often been cited as vital.

There were significant concerns from the workshop that the remote delivery of mental health services was impacting negatively on clients. Most workshop participants wanted to study this change to understand better its impact on which areas of the service may respond better to remote delivery. Detailed comments made the points that:

- mental health services are diverse and some may be better suited to remote delivery than others. Considering what good mental health services look like for people experiencing homelessness should be the starting point;
- face to face options for mental health services are critical in some cases. They tend to be less transactional than primary care so a different approach may be needed;
- dual diagnosis barriers have been alleviated through greater use of remote support in some cases. This needs to be studied.

5.2.4 Health and care services delivered through outreach

Taking more health and care services to clients was seen as a positive change from the COVID-19 response by workshop participants, that should be scaled. This should operate both as support delivered to people on the street but also through drop-in centres and in temporary accommodation. This was viewed as a core value of inclusion health. Detailed comments were that:

- outreach services have often been led by providers and voluntary organisations. There needs to be more of a focus on strategic commissioning of these services;
- the role of those with lived experience is vital in designing and delivering outreach services;
- outreach should be conducted through a multi-agency approach, not just with other health and care services but housing and other stakeholders;
- delivering services in this way is important in supporting people with no recourse to public funds.

5.2.5 Joined-up working between health and non-health services

Working in a joined-up way, involving health, housing and other services has been the central pillar of services targeted at improving the health of people experiencing homelessness.

This change was viewed by the workshop participants as being closely linked to delivering services through outreach. The group were overwhelmingly supportive of scaling this way of working to support the health and care needs of people experiencing homelessness. Detailed comments included:

- commissioning strategies will play a significant role in enabling better joined-up working;
- joined-up working should be led at the STP/ICS level;
- this needs to involve multiple agencies including the voluntary sector, local authority, and police. Groundswell developed a planning resource for multi-agency working as part of their COVID-19 response (Groundswell [3], 2020);
- health services have developed considerable experience in multidisciplinary working and this should be drawn upon;
- joined-up approaches should be outcomes-based;
- improving data collection and sharing is a vital component of joined-up working.

The data issue is important and explored more fully in the report accompanying this study.

5.3 Mapping the changes against current standards

The workshop allowed us to undertake a rapid assessment of changes made. The expertise, experience and multiple perspectives of the stakeholders at the workshop gives us confidence that this assessment is as robust as it could be within the confines of study time and resources. To increase this confidence, we also mapped the main changes made against published standards for

inclusion health from the FHIH, introduced in chapter 3. The full assessment can be found in appendix B.

This mapping takes into account both positive and negative reporting against the standards. For example, the standards state that all homeless patients should be registered with a GP at first consultation. This research has found instances of this happening but also that GP registration remains an issue. The mapping suggests that the changes seen in primary care and drug and alcohol (substance misuse) services have most in common with the FHIH standards, whilst mental health has significant gaps. This is consistent with the findings from the peer workshop where the most significant change to mental health services – remote delivery – was not viewed as having benefitted patients in many cases. A lack of evidence around hospital discharge processes make it difficult to make an assessment of the secondary care response against the standards during the COVID-19 response.

6. What next?

This report has reviewed provision of health and care services for people experiencing homelessness, asking whether the response during the first national lockdown stimulated innovation that might usefully be learnt from. This final chapter makes recommendations based on the evidence presented.

Before coming to these recommendations, we make three general observations:

1. The study focused on innovations that might merit replication. Recommendations do not therefore touch upon broader approaches to reducing homelessness. Yet recommendations are made here in full knowledge that the best approach would be to end homelessness. Removing the need for services is better than improving access to them.
2. Practice has outrun policy. Restrictions under lockdown necessitated practical change. These changes were made locally and incrementally by frontline teams: they were not determined by policy or strategy. This study is therefore part of policy catching up with, learning from - and amplifying the best of - practice. This study is a contribution to this task, but it by no means completes it.
3. Recommendations are made mindful of the current – and likely future - strain on NHS services. The context is therefore not favourable: except that many of the conditions which spurred the innovations noted in this report remain present. Changes made under the first national lockdown are likely to remain fit for purpose.

With these points in mind, and drawing heavily on discussion at the stakeholder workshop, we offer the following recommendations.

RECOMMENDATION 1: NHSE/I should lead a programme of work to create a community of practice on health and homelessness

More needs to be done to make health and homelessness services a priority. National attention is required to do this. Yet care is also required: the problem is complex and requires multi-agency action; it is highly context specific, varying from area to area in cause and consequence. Action to improve access to and delivery of care is therefore better concentrated at the local level.

National decision makers should not seek a 'best approach' or a single model. Instead, NHSE/I should nurture work begun under the pandemic to convene and network local areas and organisations. What began as informal and improvised arrangements, using the NHS Futures platform and online events, should move to become a formal programme of work led by a dedicated team.

The aim should be to focus attention and improve practice. To convene people, to share intelligence and maintain a community of practice dedicated to improving care for people experiencing homelessness. It should be locally-led, but nationally supported and funded. It should

shine a light on good practice, help build and amplify the evidence base (see below). It should act as a visible source of guidance and expertise for areas only just beginning to realise the presence of a problem.

One early task would be to encourage changes noted in this study in relation to: enhancing outreach practices, better joined-up working and the way in which drug and alcohol services are delivered. These were seen as positive innovations under lockdown – albeit with the significant proviso that their implementation is patchy. More work should be done to help spread and scale these changes.

Influencing should also be an explicit aim of this team and programme. This includes influencing NHSE/I policy and programmes (e.g. to make people affected by homelessness a target group; to ‘head off’ the potential for other programmes to inadvertently worsen access). It also includes leading NHSE/I input to initiatives led out of other organisations and government departments. In short, NHSE/I should be playing a significant, strategic national leadership role.

RECOMMENDATION 2: NHSE/I should commission supporting research

Too little is known about health service support for people experiencing homelessness. The data are poor and previous mapping work provides very limited information. This will hamper progress on the programme recommended above, since it is hard to lead improvement from a highly uncertain starting position (and with limited sense for interested organisations). So more research is needed.

Notwithstanding the limitations of this study’s perspective, it seems that research of two main types is needed:

- *Research into what is.* Not enough is known, systematically, about health service support for people experiencing homelessness. There is a lack of information on topics such as: what is provided by ‘mainstream’ or specialist services; how it is experienced by the people it is designed for; how it compares to FHH standards; who is involved in providing it (etc.)? This combination – of mapping work and research into people’s experiences - would provide an essential starting point for the programme recommended above; and
- *Research into what could be.* This study uncovered potentially useful innovations, spurred by lockdown, in how people are supported to access a GP and ways of delivering mental health services. Yet we found too much uncertainty to recommend their wider adoption. Specific evaluation is needed. Again, this must include a significant focus on the experiences of people these services are designed to support.

RECOMMENDATION 3: NHSE/I should set clear expectations of local areas

Recommendations 1 and 2 are supportive. They would help areas to see what better might be. NHSE/I should also create demand for this by setting clear expectations of local systems that improving the health outcomes of people experiencing homelessness should be a priority.

In the immediate term, this means embedding the requirement to consider homelessness health in current and future COVID-19 response phases. This should be done knowing that the combination of factors in play – notably economic downturn and consequent rises in unemployment – means that (minus significant related policy changes) the most likely outcome is an increase in homelessness.

NHSE/I should consider tasking ICS/STPs with developing inclusion health plans, showing the nature and scale of problems in their area – and what they are doing/propose to do about them. This could be overseen by the reinstatement of the National Inclusion Health Board (or similar), with clinical engagement and multi-departmental involvement. The national homeless voluntary sector organisations could also support this, perhaps coordinated by the #HealthNow alliance.

RECOMMENDATION 4: STPs and ICSs should set a direction for local organisations to address health and homelessness

Leaders in STPs/ICSs have an important role to play. They set the conditions within which local action takes place. They should therefore give prominence and attention to this agenda. Depending on local conditions, this may be specific to homelessness or the broader 'inclusion health' agenda. In doing so, they should set clear expectations that local NHS organisations will play a full role, partnering with local government and the voluntary sector.

In approaching this, they should add value to local efforts. As far as possible, STPs/ICSs should act as conveners and coordinators rather than doers. They should set direction and create conditions, avoiding displacing or crowding out local (sub-system) efforts. This might then include: networking PCNs/clinicians with voluntary sector and housing experts; ensuring that 'system problems' are spotted and unblocked; supporting joint NHS-local government commissioning. Local conditions will determine the best path, but the principle of subsidiarity is essential: actions should be taken at the most local level possible.

RECOMMENDATION 5: STPs and ICSs should take intelligence-led approaches

Reflecting the character of the national programme recommended above, local systems should use their response to the health and homelessness agenda to develop increasingly intelligence-led approaches. This swims with the tide of other developments – on population health management (PHM) for example – and, because of the nature of the task, will allow many to improve current practice.

Systems are being encouraged to take a PHM approach: to gather data and insight into specific population groups, then devise and evaluate responses to the needs uncovered. Homelessness is an ideal topic to show the value of a PHM approach. This is partly because the territory is multi-faceted and multi-agency; partly because it will require the improvement of data and approaches to information governance in this area (the subject of a separate Strategy Unit report); and partly because – done properly – it requires the full involvement of the people affected.

In doing this, systems may also wish to test some of the innovations highlighted by this report. In particular, they may wish to focus on those innovations cited as needing further study: ways of supporting people to access a GP and remote ways of delivering mental health services.

Whatever the approaches taken, one foundational element of intelligence that must always be considered is the experience of the people involved. Those most affected are often least heard and – because of the inadequacy of current data – least seen. Leaders can therefore act to correct this. They should consider whether the voice of people experiencing homelessness is heard. If not, they will want to consider the role of the specialist voluntary sector in addressing this.

These recommendations should be shared at the highest level of NHSE/I and MHCLG, as well as voluntary sector organisations and researchers; specific plans should be put in place to enact them where they are agreed.

Glossary of terms

ACMD	Advisory Council on the Misuse of Drugs
CCG	Clinical Commissioning Group
DfCLG	Department for Communities and Local Government
DoH	Department of Health
DHSC	Department of Health and Social Care
EHIH	The Equality and Health Inequalities Hub
FHIH	Faculty for Homeless and Inclusion Health
GLA	Greater London Authority
HLP	Health London Partnership
MHCLG	Ministry of Housing, Communities & Local Government
NHSE/I	National Health Service England & Improvement
NICE	National Institute for Health and Care Excellence
ONS	Office for National Statistics
PHE	Public Health England
RSI	Rough Sleeping Initiative
RSS	Rough Sleeping Strategy
SETF	Social Exclusion Task Force

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Appendix A: stakeholder interviews topic guide

National Homelessness COVID response

Stakeholder interviews: topic guide

Purpose of interview (to be introduced at the beginning of the interview)

To introduce the project and the Strategy Unit's role; gather insight as to the five main research questions; request signposting to relevant materials known to the interviewee; and share intended process for 'call for evidence' and commitment to respond/share.

Format of meeting:

Telephone/Teams interview.

Supporting information

Interviewees will be sent a participant information form prior to the first interview stating the purpose of the interviews and how their contributions will be used in the evaluation.

Interviewers will have the initial policy and literature scan findings to support their line of questioning.

Topic guide

These questions are only a guide and other subjects may be discussed as they arise during the course of the interview.

Introductions

- 1) Can you please briefly introduce yourself and your role in health and homelessness?

Health and homelessness prior to COVID

- 2) In mind of current policy intentions around health and homelessness, prior to the COVID outbreak, what would you view as representing effective practice in delivering these intentions.
 - Please provide examples.
 - How widespread was this practice? – who/where?
 - How strong was the evidence-base for demonstrating their impact?
- 3) In terms of the role of the NHS, what would you consider to have been the significant gaps between policy intentions and service practice prior to COVID?
 - Reasons for gaps
 - Variation nationally

Health and homelessness during COVID

- 4) At a local level across England, what has been the response to homelessness during the COVID pandemic?
- How have you gone about ensuring people experiencing homelessness can access services? e.g.
 - Primary care
 - Hospitals
 - Smoking cessation
 - Drug and alcohol
 - Mental health
 - What innovations in practice have taken place?
 - What have been the enablers for these innovations (financial resource, human resource, local infrastructure etc).
 - How much local variation has there been in delivering innovation and why?
 - Is there any evidence of impact locally?
 - How has/is learning being shared and by whom?

Health and homelessness in the future

- 5) What, in your view, in terms of the NHS response to health and homelessness, should be sustained or replicated for the long-term?
- Why should it be sustained or replicated, why is it an improvement?
 - How do we capture learning and roll-it out more widely?
 - What might be the unintended consequences of sustaining an innovation for the long-term?
- 6) Given all of the above, what should future NHS strategies concentrate on in order to improve the lives and outcomes of people who are homeless?
- 7) Is there anything else you would like to add?

End of interview.

Appendix B: Research findings against FHIH standards

As referenced in chapter 5, we conducted a mapping exercise against the FHIH's [Standards for Commissioners and Service Providers](#). The results are in the table below.

Service area	FHIH standard	(+/-) COVID example found
Primary Care	All patients must be registered at first consultation	Yes: (+) Evidence of additional GP practices recruited to register homeless patients and checking registration of clients in emergency accommodation (-) Issues with registration persisted in places.
	Key Performance Indicators related to specialist inclusion health practices	No evidence
	There should be routine liaison with and provision of medical support to street outreach teams and provision of continuing care for recently housed and socially excluded patients, with a focus on enabling access to mainstream services	Yes: (+) Evidence of outreach teams supporting clients to access primary care; (-) where outreach capacity has been limited this has made access to services more difficult due to lack of face to face services
	Services should collaborate with case tracking, contact tracing, community treatment and public health measures, e.g. for TB, HIV, hepatitis C	Yes: (+) Evidence of hepatitis C services visiting emergency accommodation. TB specialist nurses supporting clients
	Concerted efforts need to be made to reach excluded groups and include them in routine vaccination programmes, with flexible outreach to improve coverage	Yes (+) Evidence of offering of vaccinations as part of additional outreach capacity
	GP receptionists should support homeless to register and engage with primary care	Yes: (+) Evidence of clients being supporting to register and navigate telephone triage systems (-) Reporting difficulties in engaging remotely with these services

Service area	FHIH standard	(+/-) COVID example found
Mental health	Services for homeless people should accept self-referral or non-health agency referral and respond to mental distress and dysfunctional behaviours. Diagnostic criteria should not be a means of gatekeeping services	Yes: (+) Evidence of thresholds for assessment being lowered (-) Evidence of referrals to community mental health services not being accepted. Evidence of increase of referrals but not matched by service capacity
	Complex trauma and personality disorders are significant drivers behind the poor mental health of homeless people, and the responses of mental health services and clinicians to this group should be designed with this in mind	No evidence
	In areas with high concentrations of Inclusion Health patients, specialist services should be provided to ensure the necessary expertise is available and that there is flexible service provision	Yes: (+) Evidence of additional specialist resource commissioned to provide flexible outreach to clients (-) Evidence of services being harder to access remotely
	All mental health services should be ready to work with people with drug and/or alcohol problems in addition to mental health issues, and mental health services should foster good partnerships with drug and alcohol services to ensure effective joint working. Mental health treatment should still be offered even when the patient does not wish to engage with substance use treatment	Yes: (+) Evidence of barriers around dual diagnosis being removed (-) evidence of mental health services re-referring clients back to drug services
	Sometimes initial assessments will need to take place by outreach, for example to hostels, drop-ins, Gypsy and Traveller sites and especially the streets, and services must be able to provide this	Yes: (+) Evidence of outreach workers providing service in emergency accommodation (-) Outreach resource support limited in some areas

Service area	FHIH standard	(+/-) COVID example found
	Local social services and mental health services arrange assessments under the Mental Health Act as appropriate	No evidence
	If concerns particularly relate to someone's mental capacity to make a decision around their housing, then incorporating the concerns of housing workers may be vital	Yes (+) Evidence of specialist services working with housing teams
	Geographical boundaries should not be a barrier to care. Nationally agreed and universally applicable standards of access for Inclusion Health patients should ensure treatment according to the needs and best interests of the person and prevent exclusion due to short-term address changes or street homelessness, lack of an officially recognised address	No evidence
	There should be enhanced and easy access to psychological ("talking") therapies for individual and tailored group work	Yes (-) Evidence of psychological therapies being suspended
	Support and training should be available for other health workers and for non-health key workers in understanding and working with people with mental health problems and histories of complex trauma	Yes (+) Evidence of mental health practitioner supporting other outreach workers and hotel staff to work with clients; evidence of support staff being trained to deal with challenging behaviour in hotels
	For homeless patients, there should be regular and structured meetings with hostel and outreach staff to discuss potential referrals and ongoing cases, improve conditions in chaotic hostels and encourage preventative work such as anti-bullying strategies, noise abatement and therapeutic groups	Yes (+) Evidence of multidisciplinary meetings to discuss specific patient needs (-) Remote working has made it more difficult to contact specialist mental health support in some cases
	Reflective practice is an essential part of effective working with people with complex trauma, and group and individual reflective practice should be developed by clinical, social care and multi-disciplinary teams	No evidence

Service area	FHH standard	(+/-) COVID example found
	The emerging issue of adults with attention deficit hyperactivity disorder (ADHD) may disproportionately affect homeless people, and these individuals need enhanced access to specialist care	No evidence
	A history of acquired brain injury due to physical trauma and the effects of alcohol is increasingly recognised amongst homeless people and will require new referral routes for further assessment	Yes: (+) brain injury included as part of CHRISP assessment
Substance misuse	Integrated drug and alcohol services should be easily accessible in places where homeless people go, such as drop-in centres and primary care centres. This should include easy routes into opiate substitution treatment, ideally provided on site. In areas with high levels of street homelessness consideration should be given to drug and alcohol workers carrying out street outreach	Yes: (+) Evidence of service being delivered directly into emergency accommodation (-) Reported lack of 'wet' facilities and detox services; Difficulty in dispensing prescriptions at the outset of the response
	People with drug and alcohol problems must be able to access active help with both problems from one key worker	Yes: (+) Evidence of dedicated drug and alcohol support; (-) Clients have found it more difficult to engage support workers working from home
	People dependent on drugs and alcohol should not be excluded from hostel accommodation because of their dependence	Yes: (+) Evidence of people with addictions being housed in emergency accommodation; (-) Evidence of safeguarding concerns in some emergency accommodation
	Where there are high levels of intravenous drug use, hostel accommodation staff should be trained in the administration of Naloxone and it should be available on the premises according to Homeless Link guidance. The project should have procedures covering the safe disposal of needles	Yes: (+) Evidence of outreach workers distributing Naloxone
	Naloxone should be prescribed for opiate users in primary care and on hospital discharge as a harm reduction measure	No evidence

Service area	FHIH standard	(+/-) COVID example found
	Drug and alcohol workers should recognise the high levels of poor mental health among homeless substance users and there should be easy referral pathways between mental health and drug and alcohol services	Yes: (+) Evidence of joined up working between mental health and substance misuse services (-) Report of poor communication between substance misuse and mental health services
	Many homeless people who use drugs or alcohol have co-existing physical health problems. In some cases, contact with substance misuse services may provide clients' only contact with healthcare professionals. Those professionals should therefore have sufficient expertise to make basic assessments of physical health problems and needs	Yes: (+) Evidence of support staff supporting clients to access other medical services (-) Reports of drug outreach workers not being able to refer clients for medical assessments
	Opportunistic provision of health promotion should be an integral part of substance misuse services	Yes: (+) Evidence of outreach workers encouraging clients to go to hepatitis C clinics
	Close links with services (ideally on the same site) providing benefits advice, housing support, and support into education, training and work are particularly important for homeless people in substance misuse treatment	No evidence
	Medically assisted recovery with harm reduction and maintenance substitute opioid prescribing remains the safest option with the best evidence base for most homeless drug users with complex needs	Yes (+) Evidence of innovation in delivery of prescriptions to support treatment
	Acute services should be actively supported to ensure timely provision of substitute prescribing for opiate-dependent patients admitted to hospital	No evidence
	The role of pharmacists in supporting people who are substance dependent, and particularly those on substitute prescribing, should not be underestimated, and pharmacists should be involved in local multi-disciplinary teams	Yes: (+) Evidence of community pharmacies being involved in COVID response. Pharmacy visits becoming more flexible (-) Some clients not able to access remote prescriptions

Service area	FHIH standard	(+/-) COVID example found
	Residential rehabilitation should be accessible to people who are homeless. This should involve flexible routes of entry into treatment, such as preparatory group work being offered in homeless hostels and day centres	No evidence
	Drug and alcohol treatment should be available and accessible for vulnerable migrants, including those with no recourse to public funds	Yes (+) Evidence of provision of services for people with NRPF
	Substance misuse services should above all be flexible and able to provide individualised care. Requirements for entry into treatment, particularly opiate substitution therapy, should be reviewed on an individual basis	Yes: (+) Evidence of more targeted support to address substance misuse
Secondary care	All hospitals should have protocols for discharge planning for excluded groups	Yes: (+) Emergency accommodation provision providing place to discharge to; ANP providing discharge support (-) Reports of clients being discharged too soon and returning to the street

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