Appendix 1 – Health care provision for people sleeping rough in the City of London

Housing services with a human face

Healthcare for people sleeping rough in the City of London

June 2018

Contents

1. Introduction

The City of London and City and Hackney Clinical Commissioning Group (CCG) want to ensure that healthcare services are part of the solution to enabling people who are rough sleeping in the Square Mile to move on in their lives, towards a home of their own.

Gill Leng (www.gillleng.co.uk) and the Revolving Doors Agency (www.revolving-doors.org.uk) were commissioned in April 2018 to work with local partners, providers and people with experience of rough sleeping to review the current health care offer, and to recommend practical local solutions that will best meet local needs.

The Healthy London Partnership's 'Health care and people who are homeless: Commissioning Guidance for London' provided the basis for the review, considering physical and mental health, and wellbeing. This short piece of work involved:

- Interviews with 19 individuals representing 11 local organisations (Annex A)
- Visits to, and conversations with staff at:
    - The Neaman Practice
    - The Dellow Centre (Providence Row)
    - The Lodge (St. Mungo's)
- Attendance at a Royal London Hospital Pathway Team multi-disciplinary team meeting (Barts Health NHS Trust)
- People with lived experience of rough sleeping
    - Two expert panel sessions to inform the review process, and recommendations (seven people in total)
    - A session with members of St. Mungo's *Outside In* group
    - The Lodge, St. Mungo's
- A review of available information provided by the local authority and partners

This short report and practical recommendations are intended to inform City of London and City and Hackney CCG joint plans to transform the local health and care system. It may also be relevant to joint working with other local authorities, CCGs and providers, given the movement across boundaries by the population of people experiencing rough sleeping.

2. Key findings and recommendations

Although not possible to complete a detailed analysis of the population of people experiencing rough sleeping in the Square Mile, available information suggests a population:

- Who has multiple needs i.e. relating to two or more of alcohol or drug use and mental ill-health.
- Who, although younger than in the past, are still seen rough sleeping multiple times in the City of London i.e. there is a greater 'stock' and potentially more opportunities to meet needs, if engagement is possible
- Of whom eligibility for services is unlikely to be as much of a barrier as elsewhere in London ie, a greater proportion of UK nationals are recorded. Also, the number of times some people have been seen rough sleeping suggests a greater likelihood of a local connection.
- That is small enough to target with an appropriate local response.

Challenges to understanding the population in the City of London are the lack of local services and clear pathways to meeting needs, that health services do not routinely record information about an individual's housing circumstances (this is a nationally recognised problem), and that there is no single record of information about the individual's needs and preferences.

This is a population that would benefit from the approach that is now commonly taken to other populations with long-term and/or complex health conditions, i.e. integrated and person-centred care. It may be that this brings to light existing provision that could be more accessible/appropriate. However, the terms of engagement to enable access to services, continuity of care and improved outcomes would need to reflect the population's behaviour and experiences of services in the past, and that they are not housed.

More specific suggestions to improve the current position are below, informed by working with people with experience of rough sleeping (Annex C):

Problem: Health needs and preferences of people experiencing rough sleeping are not known or shared between services working with them

Solutions:
- Specialist health professional e.g. nurse practitioner and/or peer worker completes assessments. These will likely be carried out over time, allowing for trust and relationships to form.
- This information should form a record that could be shared across organisations, perhaps using technology e.g. the approach BrisDoc is taking in Bristol[i].
- This outreach could form part of the new contract for the Greenhouse homeless health service i.e. individuals may be able to benefit from other services on offer here.
- Partners should make a public commitment to a 'no wrong door' approach.

Problem: People experiencing rough sleeping in the City of London are likely to be accessing health services elsewhere in Greater London. Although little is known about the circumstances, experiences and effectiveness of treatment received, evidence suggests that experiences and outcomes are unlikely to be positive. It is also unclear if care and support services on offer to housed residents in City of London are accessible to people sleeping rough e.g. those accessed through a Care Act assessment.

Solutions:
- Employ care navigators to co-ordinate care and support around an individual and enable individuals to access, and benefit from health services. Peer advocacy would also be appropriate for some individuals, including those who have moved off the streets but still have high health needs. These roles would follow an individual wherever they go in Greater London to access services.
- Care and support needs should be assessed through a Care Act assessment as it must be assumed that:
    - Physical and/or mental ill-health are associated with rough sleeping, and there are likely needs arising from this ill-health;

    - These needs are likely to prevent an individual sustaining a home and related outcomes eg, accessing work;
    - The needs and inability to achieve the specified outcomes cause or risk causing a significant impact on their wellbeing.[ii]
- The care navigator role would hold a 'care passport' for the individual which captures information about experiences, preferences and aspirations (including that gained through the health assessment)
- Enable access to health services (not just health care) in locations in the City of London. This could be:
    - At the proposed monthly 'hubs', alongside a range of other services. The care navigators should oversee the hubs i.e. it should be evident that the purpose of the hub is to improve an individual's health and wellbeing first and foremost (engagement with housing may not be an individual's priority)
    - Through the use of a mobile facility, either working in partnership with an existing providing to expand/enhance their offer, or with other local authorities/CCGs to develop a new mobile offer
    - Through the Neaman Practice. Although not a specialist practice, it has recently extended its hours and is required by the CCG to describe how it is reducing inequalities. There is space available here on Saturdays.
- Learning from the assessment and care navigator approach should inform pathways/transitions between services and across local authority and CCG boundaries.

Problem: Mental ill-health is a significant issue for people experiencing rough sleeping. There is no clear pathway to services, and gaps in services, across the spectrum of need, for people in this situation, and those who have moved off the streets eg, living in the Lodge, who may need continued support to sustain their homes.

Solutions:
- Assessments of need should identify needs for mental health and wellbeing services – these should not be limited to the treatment of ill-health but the promotion of good mental health, and opportunities for individuals to benefit from health-promoting activity e.g. physical activity, social interaction etc.
- With Healthwatch, and support from an appropriate organisation e.g. Groundswell, Providence Row, St Mungo's, complete an exercise with people experiencing rough sleeping/people who have moved on from rough sleeping, to identify what the ideal pathway would be for people experiencing mental ill-health, and enable this work to inform service redesign (including addressing gaps).
- Provide a spot-purchase fund to enable individual's needs to be met in a timely manner, and to buy-in services that are not otherwise available in the City of London. This would include mental health services that are not time-bound.

Problem: There are many services working across sectors that engage with people experiencing rough sleeping in the City of London, albeit to achieve different and potentially conflicting outcomes. Provision is weighted towards reactive and crisis management rather than planned and preventative. There is more than one meeting of partners to discuss individual cases and it is unclear how they relate, who is accountable for what, or how learning is applied.

Solutions:
- Review and revise the City of London strategy for ending rough sleeping, to secure a shared ambition, better understanding of collective resources, roles and responsibilities, and agreement over how to achieve the best possible outcomes for individuals.
- Implement a single multi-disciplinary team approach to people experiencing rough sleeping.
- Consider how the findings from the three integration work streams (planned care; unplanned care; prevention) apply to people with experience of rough sleeping and chronic homelessness to ensure these factors inform redesign.

3. Why carry out a review?

Homelessness is a health problem

As long as there is rough sleeping and other forms of homelessness in the City of London, the Corporation, City and Hackney CCG and other partners to the Joint Health and Wellbeing Strategy ***will not achieve their ambition for longer, happier, healthier lives in the City of London.***

We know this because:

- Socially excluded populations, of whom people experiencing homelessness are part, have a mortality rate that is nearly eight times higher than the average for men, and nearly 12 times higher for women.[iii]

- The average age of death of a single homeless person is 47 years old (43 years for female), compared to 77 years for the general population.[iv]

- Death by unnatural causes has been found to be far greater among the single homeless population eg, suicide, death connected with substance misuse traffic accidents and infections[v] and the prevalence of infectious diseases is also high among the homeless population.[vi]

- People who sleep rough experience poorer physical and mental health than the general population.
    - 73% of homeless people reported a physical health problem (with 41% reporting this was a long-standing problem).[vii]
    - Common mental health problems are over twice as high among people who are homeless compared with the general population.
    - Estimates of the prevalence of mental health conditions among homeless people suggest they have far higher rates of schizophrenia, anxiety disorders and depression, suicide and personality disorders than the general population[viii]
    - In Greater London, 57% of rough sleepers who had a support need assessment recorded in 2016-17 had a drug or alcohol need, 31% of whom were also assessed as having a mental health need[ix].

- Ill health may have contributed to them becoming homeless, but the experience of rough sleeping is likely to exacerbate existing conditions and/or result in physical and mental ill health.

- People can turn to alcohol and drugs as a mechanism to cope with homelessness, and symptoms of ill health, including chronic pain[x].

- 62% of rough sleepers report experiencing chronic pain, and homelessness and trauma compound the effects

- Mental ill health and negative experiences of accessing health care, and low literacy are some of the factors in people not seeking help with physical ill health, only accessing urgent health care when they are in crisis.

- It is estimated that 70% of homeless people receiving hospital treatment (not specialist homeless health service hospitals) are discharged onto the streets. Homeless people attend A&E five times as much, stay three times as long, and cost up to eight times as much as the general population[xi].

- Of a sample homeless population, half of the total acute care costs were incurred by 10% of people. Financial savings could be made, and quality of life improved by earlier intervention.[xii]

Framework for the review

Recognising rising homelessness and associated health inequalities as a significant issue in London, the Healthy London Partnership[1] established the London Homeless Health Programme in 2015. In December 2016 the programme published commissioning guidance for CCGs, for use by all London CCGs and anyone delivering health services to people who are affected by homelessness.

The guidance centres around ten commitments, of which eight formed the basis for the review[2]:

Service delivery

1. People experiencing homelessness receive high quality healthcare
2. Healthcare 'reaches out' to people experiencing homelessness through inclusive and flexible service delivery models
3. People experiencing homelessness are never denied access to Primary Care
4. Mental health care pathways, including crisis care, offer timely assessment, treatment and continuity of care for people experiencing homelessness
5. Wherever possible people experiencing homelessness are never discharged from hospital to the street or to unsuitable accommodation
6. Homeless health advice and signposting is available within all Urgent and Emergency Care Pathways and settings
7. People experiencing homelessness receive high quality, timely and co-ordinated end of life care

Commissioning

8. People with a lived experience of homelessness are pro-actively included in patient and public engagement activities, and supported to join the future healthcare workforce

The commissioning guidance primarily covers primary care services, mental health services, and hospital discharge. Other services are covered insofar as health checks, information and advice should be available. More detail is available in Annex B.

4. The needs of people experiencing rough sleeping in the Square Mile

It was an aspiration of the review to achieve a clearer understanding of the health care needs of people experiencing rough sleeping in the Square Mile, particularly through information provided by services that are seeking to meet those needs. In practice this has not been possible, reflecting a nationally recognised problem: health care services do not routinely collect information about the housing circumstances of their patients/service users.

Instead, this review has drawn on information made available through outreach teams in the City of London and elsewhere in London, analyses completed in other London boroughs, and anecdotal evidence from all those spoken to.

To begin with, stakeholders have a shared view that the City of London's population of people rough sleeping differs from elsewhere in London owing to the perceived 'peace and quiet' and safety offered by an area with a very small resident population and little in the way of a night-time economy compared to other boroughs. Its location enables the population to move into neighbouring areas, to access services during the day-time

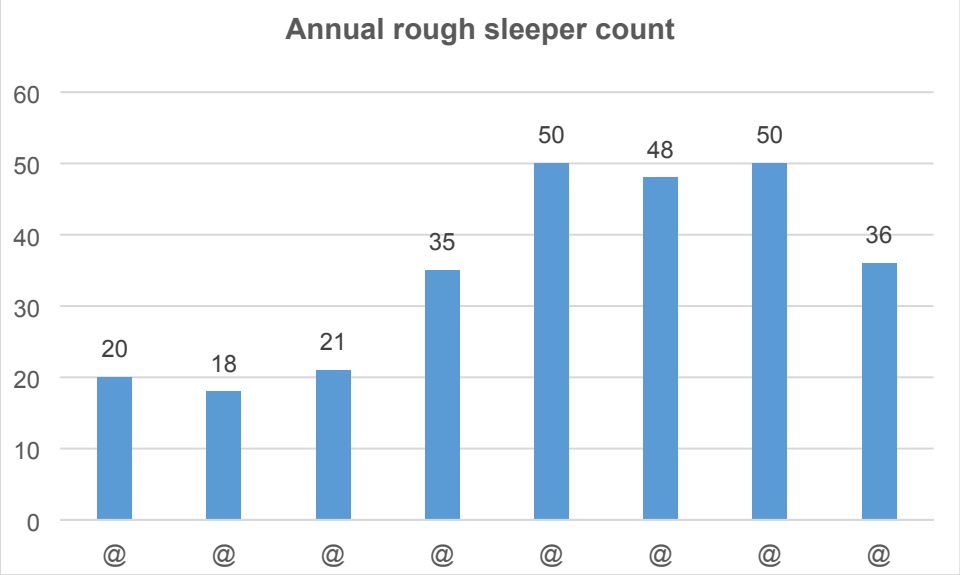
[1] Healthy London Partnership, a collaboration between all 32 London Clinical Commissioning Groups and NHS England London region

[2] The remaining two commitments are: data recording and sharing is improved to facilitate outcome-based commissioning for the homeless population of London; multi-agency partnership working is strengthened to deliver better health outcomes for people experiencing homelessness

(there is nothing specific for people experiencing rough sleeping in the City), but also to access an income or substances. Stakeholders also reported individuals coming into the City during the day to beg from the business community, who leave in the evening.

The number of people sleeping rough in the City of London

36 people were reported the annual, official, count completed in November 2017, a significant decrease (28%) from the previous year (50 people).



Source: MHCLG statistics https://www.gov.uk/government/statistics/rough-sleeping-in-england-autumn-2017

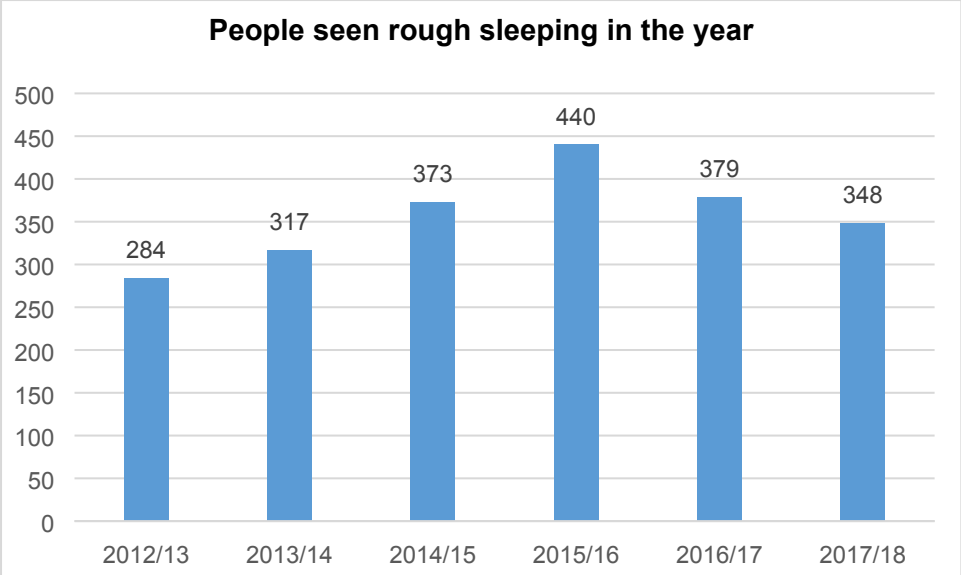
During this research, St. Mungo's reported c.30 people seen by the Outreach Team each night (with up to 50% of these with a local connection ie, they could be eligible for local services such as housing and social care), whilst the Street Triage Team suggested c.50 people, with many people out of sight of the Outreach Team. It was noted that Challenge meetings discuss between 11 and 13 individuals.

The City of London is unique in it's very small resident population, which is reflected in high rate of rough sleeping per 1,000 households reported in the Government's annual report; the rate in City of London was 7.08 per 1,000 households, compared to 0.20 for England, 0.31 for London, and 1.78 for Westminster.[3]

379 people were reported to have been seen rough sleeping in 2016/17, a decrease of 14% on the previous year. Although the total figure for 2017/18 has not yet been published (due 28 June 2018), quarterly reports suggest 559 contacts compared to 542 in 2016/17 ie, overall numbers may broadly remain the same as 2016/17 or be slightly higher.[4]

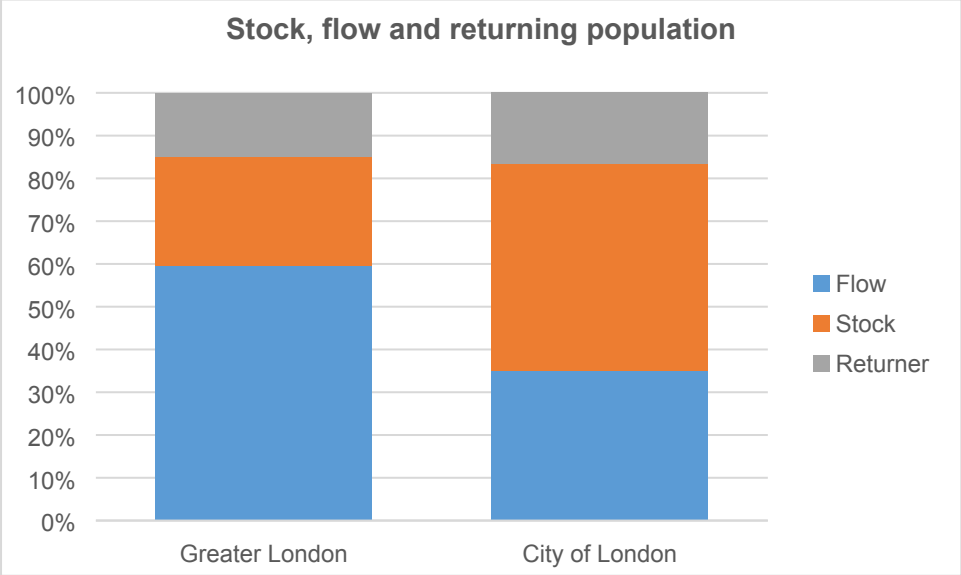
[3] MHCLG official statistics https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/682001/Rough_Sleeping_Autumn_2017_Statistical_Release_-_revised.pdf

[4] CHAIN data based on contacts made by the Outreach Team (St. Mungo's)



Source: CHAIN data, available https://data.london.gov.uk/dataset/chain-reports

Comparison with Greater London CHAIN statistics[5] suggest a bigger 'static' population ie, fewer new rough – flow - sleepers (35% compared to 60%)[6], a higher number of those seen in 2017/18 and 2016/17 (48% compard to 26%), and more reported contact with those who are seen (52% seen three or more times, compared to 27%).



Source: CHAIN data, available https://data.london.gov.uk/dataset/chain-reports

[5] 2017/18 CHAIN data

[6] The flow, stock and returner model categorise people seen rough sleeping in the year according to whether they have also been seen rough sleeping in previous periods

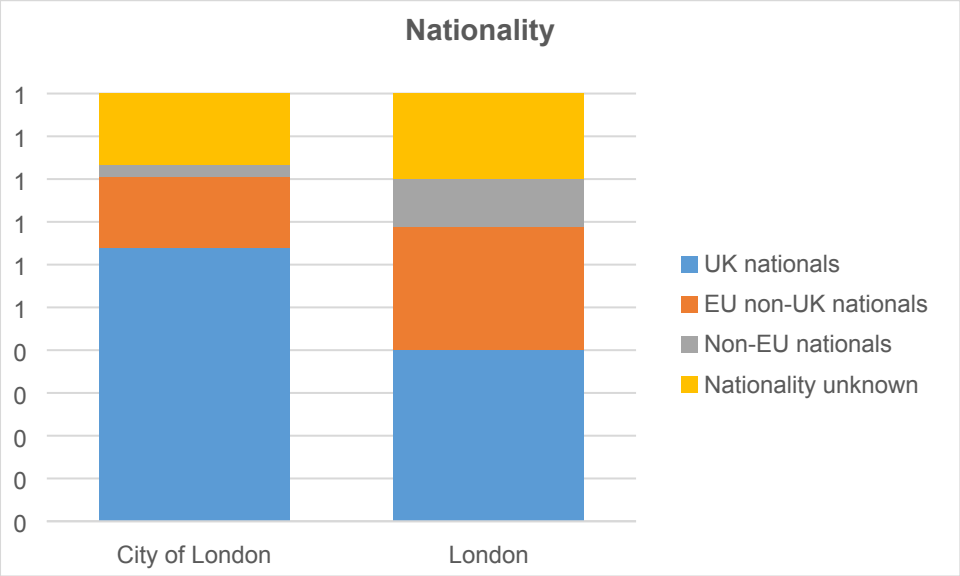
The demography of people sleeping rough in the City of London

Comparison with Greater London CHAIN statistics[7] suggest:

- Very little difference in the age profile.
- Fewer females (9% compared to 15%).

From 2017, government 'count/estimate' official statistics included information on age and nationality. This information relates to only 36 people on one night, so care must be taken with it's use, but it suggested:

- A much smaller proportion of 18-25 year olds than CHAIN data suggests for the City (3% - 1 person, compared to 8% - 30 people across the year).
- A higher proportion of UK nationals than in Greater London (nationality comparison isn't possible using available CHAIN information).



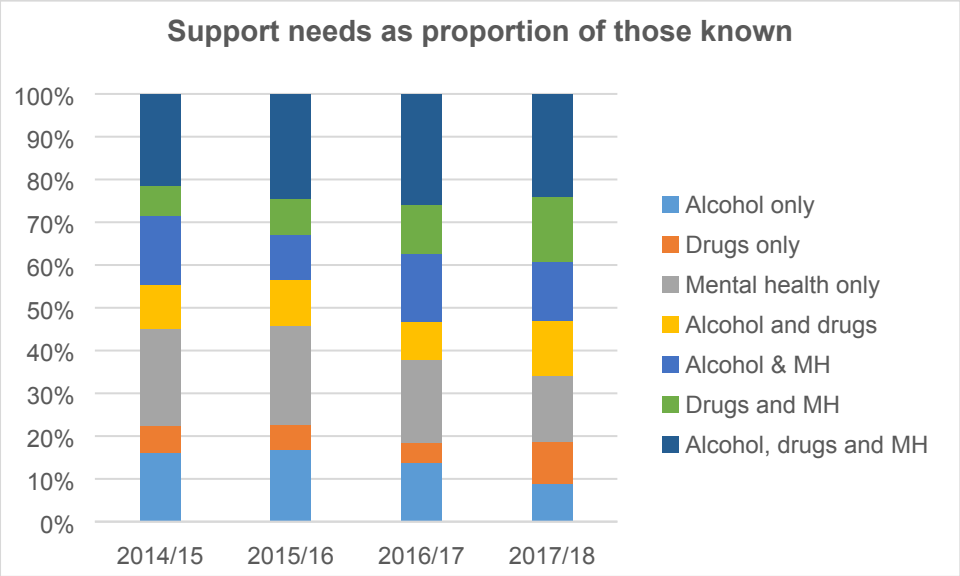
Source: MHCLG statistics https://www.gov.uk/government/statistics/rough-sleeping-in-england-autumn-2017

Anecdotally there has been a change in the age profile of people experiencing rough sleeping: until the opening of the Lodge(s) accommodation, there was a larger older population. Today, the population is proportionally younger but more akin to the profile of London overall.

[7] 2016/17 CHAIN data

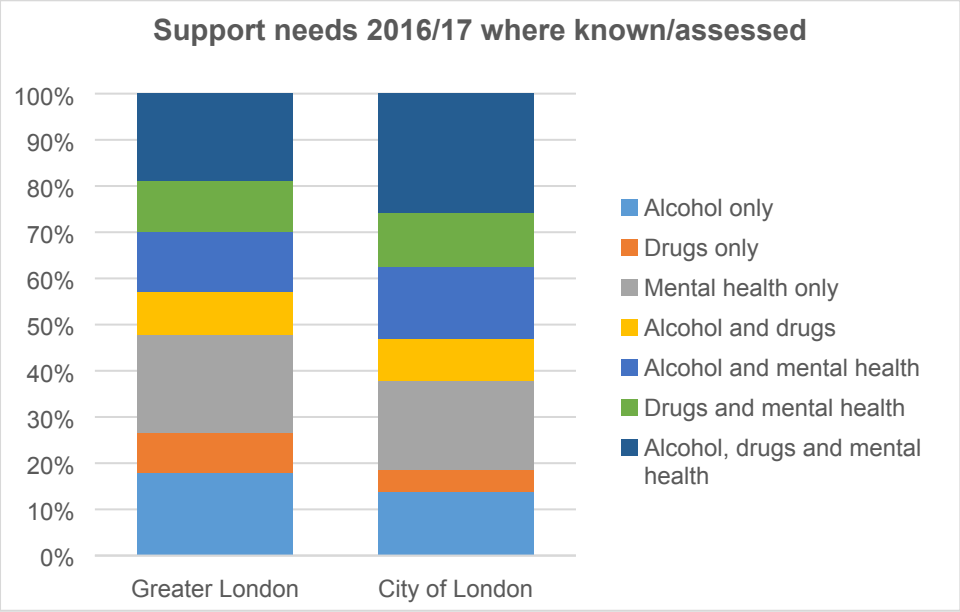
Health needs of people who are sleeping rough in the City of London

CHAIN data provides an indication of health-related needs, albeit these are self-reported. Data for City of London suggests that the profile of needs has changed over time, with an increasing number of individuals with two or more support needs.[8]



Source: CHAIN data, available https://data.london.gov.uk/dataset/chain-reports

Comparison with Greater London CHAIN statistics[9] suggests a greater proportion of those whose support needs are not known (38% compared to 32%). However, for those whose needs are known, there is a greater proportion of people with more than one support need (31% compared to 26%).



Source: Annual CHAIN reports https://data.london.gov.uk/dataset/chain-reports

[8] Note that 2017/18 data is based on quarterly reporting and not an annual figure ie, there may be some duplication in this information

[9] 2016/17 CHAIN data

Stakeholders recognise that the needs of people experiencing rough sleeping have changed. The older 'entrenched' population now accommodated in the Lodges, although living on the streets for many years, are reported to have had fewer needs associated with drug and/or alcohol use, and are less chaotic. The remaining younger population are however presenting with these needs, including chronic drug problems and under-lying mental ill-health.

5. Health care available to people experiencing rough sleeping in the Square Mile

It has proven difficult to understand exactly which services people experiencing rough sleeping in the City of London access, and benefit from ie, receive quality care and continunity of care. Individuals move across local authority boundaries on a regular basis and are felt likely to access services outside City of London.

Primary care

The ***Neaman Practice*** is the only GP practice in the City of London. It reports that it will register any NFA patient, it has taken on all Health E1 homeless patients in recent months, and most of the Lodge residents are registered here. The Practice has recently extended its opening hours to offer a Saturday service. A podiatrist is available one day a week can be accessed by all patients.

A meeting with the practice manager was positive (there was a suggestion that the recently extended practice hours could offer an opportunity for new services to be delivered for people experiencing rough sleeping), but further information was requested from clinicians (not provided) to understand:

- Number of people registered with who have 'no fixed abode' (or otherwise no fixed address)
- Experiences of being able to provide continuity of care to this population, including extent to which 'did not attend' was a feature of referrals to other care
- Experiences of access to mental health services

The Practice was rated as 'good' by the CQC in October 2016, including 'good' for people whose circumstances may make them vulnerable: they held a register of patients living in vulnerable circumstances and homeless patients could register; the practice regularly worked with other health care professionals in the case management of vulnerable patients; the practice informed vulnerable patients about how to access various support groups and voluntary organisations; staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

Some stakeholders feel that the Neaman Practice is unlikely to be providing a service to people experiencing rough sleeping, for example it is understood that it will not do scripting, that it has a waiting list and it is to capacity. This hasn't been possible to verify. Although not currently rough sleeping, three residents of the Lodge reported they were very satisfied, had been able to access services on the same or the next day, and that they had been visited by a doctor at the Lodge when they had been unable to attend in person.

The Greenhouse in LB Hackney is a long-established specialist homeless health service, one of 28 in England. Commissioned by the City of London and Hackney CCG it is accessible to people experiencing rough sleeping in City of London. It is co-located with Thames Reach and LB Hackney's Housing Advice as part of the Single Homeless Hub.

Services provided include: full health assessments; GP registration; housing advice; welfare and benefits support; help with access to employment, training, and volunteering; legal advice for people registered at the medical practice; and links to other support services. The service was rated as 'outstanding' by the CQC in August 2017.

The current caretaking contract with AT Medics expires in March 2019, and the CCG has begun a procurement exercise, starting with pre-procurment engagement in May 2018, to commission a new specialist homeless health practice (the patient list has increased from 860 patients to 1,076 patients in the last four years).

There appears to be scope in the new contract to deliver services in a different way, including to people experiencing rough sleeping in City of London, eg, through an outreach model, and/or integrated with other services – this would be supported by frontline workers in the City of London, who report that people will not travel to the Greenhouse practice. The intention is to implement Pathway's model and the Faculity for Homeless and Inclusion Health's standards, and to follow good practice on end of life care (resource pack being developed by St Mungo's, Marie Curie and Pathway. The model will be agreed with the Patient Particpation Group.

Finally, in recognition of the presenting physical health problems of people experiencing rough sleeping, St Mungo's is testing working with the ***Greenlight Medical Van*** in the City.

Dental services

It is not known where people access dental services: there is no specific provision in the City of London, nor is it known where else people will access dental services elsewhere.

A dental van was available as part of a health pilot delivered at the Dellow Centre in 2016/17. Providence Row reported difficulties in attracting a practitioner to begin with, but once in place, 18 patients were seen and all needed treatment. This service could not be continued without additional resources.

Mental health services

There is no single, shared understanding of available mental health provision for people experiencing rough sleeping in the City of London, when and how this can be accessed, whether this is proving effective in the care it provides and who is accountable.

- **EASL** is commissioned by the City of London to work with St. Mungo's Outreach Team to support them in identifying need, supporting 'lower end' mental health needs, and enabling assessments under the Mental Health Act and Mental Capacity Act. It is also providing supervision to the Team.
- **ELFT** employ a specialist homeless mental health practitioner. There are different views of what this role exists to achieve but it appears it works with St. Mungo's to assess mental health needs of people experiencing rough sleeping. Also, if an assessment is needed in working hours the role will call upon the City's AMHP.
- **The Street Triage Team** (funded by the City of London police and ELFT), has recently been resourced to deliver mental health care to people at risk of suicide or self-harm seven days a week). It does respond to referrals by St. Mungo's outreach team, but these are reportedly few. If an individual is not in immediate need or care or control, they are referred for an assessment, either to ELFT or AMHPs in the Homerton.
- The City of London employ an **Approved Mental Health Professional (AMHP)**, in a small team of social workers who, in working hours, can be called upon to complete a mental health assessment, and who will also support discharge from the Homerton, including for people who have no connection to the City. The AMHP is part of the South Hackney Community Mental Health Team for working age adults which enables a duty rota, cover for leave, and supervision. Outside of working hours the council commissions a service from Hackney. If someone who is rough sleeping is identified as needing a planned mental health assessment this often needs to happen out of hours, the assessment will be set up by the City's AMHP, but the actual assessment will be spot-purchased from the Hackney service.

- The council commissions ELFT's rehab-team to assess the need for specialist accommodation by people due to leave hospital. However, pathways from hospital appear problematic owing to the lack of specialist accommodation in the City; discharging an individual to specialist accommodation elsewhere triggers a local connection for social care in the receiving authority. For people experiencing rough sleeping they may be discharged to temporary accommodation; this may not be suitable or enable continuity of care.
- Access to mental health services in the community ie, when not in crisis, and access to mental health promoting activities would be, for the housed population, something that should be enabled through a Care Act 2014 assessment. This would 'unlock', for example, an individual budget to purchase counselling, gym membership etc. However, the assessment is reportedly rarely requested for people experiencing rough sleeping.
- Stakeholders report that reductions in funding over time have reduced capacity and capability to meet mental health needs, and that there are gaps in provision across the spectrum, from counselling to dual diagnosis and personality disorder services.

Following the death of someone experiencing rough sleeping, a group was established to regularly review individuals who are felt to be a risk of a mental health crisis and approaching the threshold for an assessment. The council is looking at ways they can improve the offer to this population, and is considering extending meetings to discuss safeguarding, particularly in light of the proposed revision to the London safeguarding policy. It is not clear how the mental health and homelessness meetings relate to the Challenge meetings; many of the same partners appear to attend.

Secondary care

It was not possible to identify the effectiveness of referrals to secondary care from primary care.

In an emergency most stakeholders felt that people experiencing rough sleeping would be taken to the Royal London hospital for treatment, not the Homerton (the focus of current unplanned care work, which may be extended to the Royal London).

There is no specific homelessness service at the Homerton. Also, a 'step-down' service from the hospital, delivered by St. Mungo's several years ago, was felt to be ineffective: people did not move on from the accommodation and it was felt to create a dependency culture. It was not possible to speak to A & E or hospital discharge teams at the hospital in this work (attempts were made).

People experiencing rough sleeping is a consideration of the City and City and Hackney CCG unplanned care workstream, particularly activity to understand frequent attendance, non-elective admissions and discharge. The current focus of work is the Homerton (may be extended to UCL/Barts), where a 'frequent attenders MDT', led by a nurse,. considers up to 30 people each month. There were no people of 'no fixed abode' considered in the most recent monthly meeting. Also, work is underway to audit 50 Delayed Transfer of Care cases: housing has emerged as a theme, but further information is not available in time for this research and this may just apply to the Homerton.

The Royal London is home to a 'Pathway model' homelessness service, commissioned by Tower Hamlets CCG. It provides care to inpatients who are homeless or at risk of becoming homeless, with a view to improving their outcomes after discharge. The stated outcomes in the service specification are:

Desired outcomes

- Improved health for homeless patients
- Improved self-efficacy in handling money, relationships and accommodation
- Reduced rough sleeping (as an outcome to which the service contributes through coordination with the work of other agencies)

Patient experience outcomes

- Trusting relationship formed with supportive team
- Improved self-efficacy in handling money and accommodation
- Joined up, integrated care

Efficiency outcomes
- Reduced average duration of stay (when assessed annually across whole patient group)
- Reduced admissions and emergency attendances

Positive recovery outcomes for individuals
- Increased ability to manage mental health
- Increased physical health and self-care skills
- Encourage social networks and peer support
- Increase in the ability to find work, training and access education
- Improvement in the ability to develop and maintain relationships / contact with family
- Reduction in addictive behaviours
- Increase in self-esteem, trust and hope.

In 2016/17 Pathway were notified of 306 inpatients, of whom 296 were unique cases. The average length of admission was 11.8 days, with an average of 10 days spent under Pathway management. 40% of the admissions were related to drugs, alcohol, or a combination[10].

Of the 629 patients managed by Pathway between November 2015 and July 217, 54% were registered in another part of Greater London, which could include City of London (data not available) [11][12]. Attendance at a monthly MDT in May 2018 did not identify any individuals from City of London (from 59 cases, in patients and those recently discharged).

The Pathway service works in partnership with the Routes to Roots service delivered by Providence Row. Funded by LB Tower Hamlets, Routes to Roots is working with an increasing number of individuals (146 in 2017/18 compared to 123 in 2016/17). It appears to be successful in enabling prompt assessments and establishing local connection for patients: 80% of new referrals were assessed within 24hrs with 95% of total assessed within 48hrs; 96% of local connections were determined within 48 hours; 100% of patients have been referred to a local authority when appropriate to do so and the team achieved 69 reconnections up 4 on last year. A new “step down” accommodation service was opened in 2017/18, enabling patients to move from hospital when their reconnection is not established at discharge; this would be available to people who have been rough sleeping in the City but do not have a connection to Tower Hamlets.

Other

City of London police: PCSOs and Community Police reportedly have a good understanding of where people sleep rough in the City, and play a part in enabling people to access the quarterly hubs, where people can access a range of services. They have also just established a ‘begging hub’, once a month, where individuals, some of whom sleep rough in the City of London, can access mental health support provided by the Street Triage team mental health nurse.

St. Mungo’s Housing First approach: St. Mungo’s outreach team, through funding from City of London, has recently been increased to enable additional capacity to provide a Housing First approach. The principles of Housing First are[13]:

[10] Pathway, service data 2017
[11] Pathway, service data 2017
[12] It is worth noting that this data was manually extracted, as the databases used by the two NHS trusts (East London Foundation Trust and Barts Health Trust) are not compatible.
[13] Homeless Link. 2016. Housing First in England: the principles.

1. People have a right to a home
2. Flexible support is provided for as long as it is needed
3. Housing and support are separated
4. Individuals have choice and control
5. An active engagement approach is used
6. The service is based on people's strengths, goals, and aspirations
7. A harm reduction approach is used

Support and services may relate to an individual's health and wellbeing, physical and mental: success in the Housing First approach will depend on the availability, appropriateness and effectiveness of these services.

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Annex A Research interviewees

Organisation	Name	Role
The Neaman Practice	Sue Neville	Practice Manager
St Mungo's	Laila Grinberga & Kathy Simms	Outreach team
	Isaura Abbas	The Lodge accommodation
EASL	Barney Wells	Director
Providence Row	Sarah Makhlouf	Manager, Dellow Day Centre
	Dominic Gates	Dellow Centre
	Phil Hennessy	Routes to roots project
Find and Treat	Dr. Al Storey	Clinical lead
Groundswell	Kate Bowgett	Director of Advocacy
City of London	Will Norman	Service Manager – Homelessness & Rough Sleeping
	Simon Cribbens	
	Ian Tweedie	Social care
City of London police	Mark Montgomery	Street Triage
Healthwatch	Jon Williams	Executive Director
ELFT	Denise O'Grady	Senior Nurse Practitioner Homelessness & Project manager NRPF
NHS City and Hackney CCG	Richard Bull	Programme Director, Primary Care
	Nina Griffith	Workstream Director, Unplanned Care

Annex B - Services in scope of the London Homeless Health Partnership CCG guidance

Service type	Service/function	Healthy London guidance?
Primary care services	GP/nurse practitioner	Yes
	Dental	
	Optician	Health checks and advice only
Allied health services	Podiatrists	
Mental health services	Counselling	Yes
	Talking therapies (IAPT, psychology, psychiatry)	
	Community mental health team	
	Assertive outreach	
	Crisis team	
	Personality disorder services	
Public health - protection and improvement	Sexual health	Health checks and advice only
	Diet and nutrition	
	Smoking cessation	
	Drug services	
	Alcohol services	
	TB treatment	Yes
Secondary care	Urgent and emergency care: 111; A & E; ambulance; urgent care	Health advice and signposting
	Hospital discharge	Yes
Other services/settings	Palliative care	
Social care	Care Act 2014 assessment	

Annex C Input from people with lived experience

People with experience of rough sleeping, including a small number who have spent time sleeping rough in the City of London, provided input at a number of points in the research:

- Before interviews were completed with partners: a desktop exercise informed an Expert Panel discussion to identify lines of enquiry
- During the research, enabled through St. Mungo's: through the Outside In group of people with experience of rough sleeping; at the Lodge accommodation
- At the end of the research: findings were presented back to the Expert Panel and recommendations discussed

The following section presents the findings from this part of the research, which was led and delivered by the Revolving Door Agency.

1. Lived Experience Panel (LEP)– Final Recommendations

Held on 12 June 2018, four people (2 women and 2 men) attended this session.

1. **The City of London and City and Hackney CCG should commission a health and social care needs assessment of all people who are sleeping rough in the Square Mile. This assessment should be carried out by a specialist nurse/health team and peer workers.**

- Evidence tells us that people experiencing homelessness have significantly worse physical and mental health than that of the general population and the longer a person experiences homelessness the more likely their health and wellbeing is at risk.
- The research has not been able to produce any in-depth data about the health needs of people who are sleeping rough in the Square Mile. Panel members suggest that in the absence of such data, evidence from elsewhere should be an adequate basis for investment in 'homeless health' in the first instance.
- Given the relatively small number of people who are sleeping rough in the Square Mile, the panel recommends that the City and Hackney CCG and City of London to work together to carry out **a full assessment of health and social care needs of every person sleeping rough in the next year.**
- **LEP recommended that the health needs assessment to be carried out by a specialist nurse (who can also carry out tests) and peer workers.** Panel members thought peer workers would be trust-worthy, reliable and empathetic to their needs, and they felt peer workers would be able to collect more in-depth and more accurate information than the professionals.

2. **Health and social care agencies and homelessness services should share information and work together to meet the needs of people who are sleeping rough in the Square Mile.**

- People who are sleeping rough in the Square Mile are likely to have been asked about their health and social care needs several times by several services. Therefore, this data should be collected just once, shared across relevant health and housing agencies as relevant, and should be updated by health services as part of ongoing record keeping processes.
- LEP expected this data to be kept safely (especially female members of the panel raised concerns about confidentiality and data leaks). However, they broadly agree that services will need to share information to provide the best jointed support for the individuals who are sleeping rough in the Square Mile.
- Reflecting on their personal experiences, they emphasised that the health needs (particularly mental health needs) can be multi-faceted and may span across experiences of childhood trauma, domestic abuse, and criminal justice contact and recommended the information sharing protocol should cover a broad range of local services people might access to.
- Some of the LEP members, who now work as peer support-workers and regularly attend to multi-agency meetings, suggest that sharing information between different agencies does not always change 'system behaviours' and that individuals can still find themselves fall through the gaps between services. LEP

therefore recommends that the information sharing protocol to support a principle for '**no wrong-door'** for people who are sleeping rough in the Square Mile.

3. Care passports for people who are sleeping rough in the Square Mile should be implemented.

- Some LEP members suggested that data sharing practices are unhealthily focused on needs and deficits, and fail to recognise differences in individuals' experiences, preferences and aspirations.
- LEP recommended that the City and Hackney CCG and the City of London to implement care passports for people who are sleeping rough. This passport should include a summary of health and social care needs and support needs, as well as information about the personal strengths and preferences.
- LEP recommended that this information is collected by a peer worker, alongside 'a care navigator' (or 'link worker') who will be ultimately responsible for coordinating support and care around the individual
- LEP saw care passports as an opportunity to implement a personalised and strength-based approach to multi-agency working practices.

4. Multiple needs should be met simultaneously

- LEP members shared the view that the health needs assessment should form the basis of all services working together to meet the need. People who are sleeping rough in the Square Mile should be able to find services that join-up to meet their personal combination of needs, not just one need in isolation. They should be able to get help with their alcohol problems and mental health difficulties at the same time, for example.
- LEP suggested that **a hub** that brings together benefits and housing advice, training and employment activities and health services would be beneficial for this group.
- LEP members understood that people who are sleeping rough in the Square Mile might access a variety of services in the neighbouring boroughs (including Tower Hamlets, Hackney and Westminster) during the day. However, currently we know very little about how frequently and how successfully they make use of these services.
- LEP queried piloting **pop up 'hubs'** (e.g. a tent/temporary space) to specifically engage with people in the Square Mile in the evenings (for example once a month). This pop-up service should be run by 'care navigators' (or 'link workers') alongside the same peer workers who help to develop the care passports.
- Currently, we know very little about how people, who are sleeping rough in the Square Mile, access services. LEP saw these 'pop up' hubs as an opportunity for 'care navigators' to build relationships with individuals, identify needs, understand the service use, and develop agreements to spot purchase services where necessary.
- LEP believed that money should follow the individual across the system, and across the commissioning boundaries. They felt that the services found it easier to 'pass the buck' and recognised that more incentives need to be in place for services to join up and help individuals move on with their lives. They understand administering funding across system/local authority/CCG boundaries is difficult to administer, but they felt options such as 'spot purchasing' services could help achieve better outcomes.

5. The City and Hackney CCG and the City of London Corp should consider better transition across services.

a. Transitions from custody to community

- Five out of seven LEP members have had experience of the criminal justice system, as well as experience of sleeping rough.
- People leaving prison are at high risk of homelessness for many reasons, e.g. they may have been homeless before entering prison, are dependent on drugs or alcohol or simply are unable to get support finding the right sort of accommodation on release. The Rough Sleeping in London report (CHAIN) showed that a third of people seen rough sleeping in 2015-16 had experience of serving time in prison.
- We do not currently know what proportion of people who are sleeping rough in the Square Mile had served time in prison, however the LEP asked the City and Hackney CCG need to consider the increased health needs for this population, including mental ill-health (and personality disorders), increased risk of suicide, substance misuse needs, physical health needs, TB and blood borne viruses.

- LEP members who have served time in prison, said that the medical notes are not always shared between community and custody healthcare settings, or the notes are not always up to date. On exiting prison, all services (but particularly mental health services) were reportedly fragmented, 'virtually impossible' to access. LEP recommends that health needs linked to other support needs, such as housing, should be prioritised for this group.
- Two LEP members reflected on their experiences of moving from streets to custody and from custody back to streets. They raised concerns about restrictions on housing eligibility of people who have previous criminal convictions and asked the City of London Corp to consider working with the criminal justice agencies to prevent homelessness. This may involve designing a specific housing pathway for people with criminal records, or integrating criminal justice contact in the multi-agency framework going forward.

b. Transitions from secondary mental health services

- While all LEP members reported to have experienced some mental health problems, four have had experience of being admitted to secondary mental health settings in the past three years. Their experiences of housing support following discharge from psychiatric hospital were varied.
- One member was a woman in their 50s, with experience of homelessness (including sleeping rough and sofa surfing), mental ill-health and substance misuse needs. She recently found herself street homeless, after having exhausted the accommodation offers from friends over the last six months. She attempted to take her own life, was picked up by the street triage team, and subsequently admitted to a psychiatric ward. She was offered a two-week step down accommodation following the discharge, and yet was not supported with finding an accommodation during this time. She was clearly distressed and told us that her mental health crisis was caused by 'a deep shame to admit that [she had] nowhere to go' and felt that the uncertainty about her housing situation made her mental health significantly worse. She was once again contemplating suicide.
- Another member was a man in his 40s, with experience of sleeping rough in Westminster and the City. While he was on the street, he was admitted to a psychiatric hospital and subsequently diagnosed with 'schizophrenia'. During his six months stay at the psychiatric hospital, he was offered a range of support with his physical health problems, including diabetes, musculoskeletal problems and dental treatment. He suggested that the good quality care that addressed both his mental health and physical health needs made him willing to move on from the streets and able to keep his accommodation.

6. How to involve people with lived experience in the commissioning and delivery of services

- The LEP recommends that commissioners and providers of service use the knowledge of people with lived experience as a valuable resource, and ask them to listen and act on people's views to make changes for the better.
- They feel strongly about the need to involve peer workers in both assessing the health needs of people who are sleeping rough and supporting people to their health appointments.
- They recognise that people who are sleeping rough may not be readily available to attend to consultations.
- Whenever possible, feedback on health care services should be collected on a real-time basis, for example by installing satisfaction buttons at the entrance/exit of healthcare services.
- When further and broader information is required, the consultation should be flexible and in places they already are (for example day centres, local parks, 'pop-up hubs' etc.
- The LEP also endorses the recommendations made by Outside In group.

2. Focus group with St Mungo's Outside In

Held on 6 June 2018, this group involved six participants: three men and three women with experience of sleeping rough. Formerly accepted as 'homeless' in two in Hackney, one in Tower Hamlets, two in Westminster and one in RBKC. They are now working as part of the St Mungo's Outside In group to advise policy and practice issues affecting people who are homeless, including for example, providing help and support via Streetlink).

1. Experiences with access to healthcare

- Participants told us that during the time they were sleeping rough, they tended to access health services only when there was an urgent health need. This included attending to wounds, severe lung/ breathing problems (e.g. bronchitis/pneumonia), and dental abscesses. Minor illnesses (e.g. cold, flu, low grade fever) or chronic problems (e.g. musculoskeletal problems, diabetes, blood borne viruses) were either not treated/or followed up, often because of not seeing the doctor for extended periods of time to collect test results, picking up the prescription or losing medication, or not attending follow up appointments.
- Attending only to what they consider 'major health issues' was often a consequence of accessing services in day centres, walk in clinics, or A&E departments, where the follow-on care was understood to be unavailable.
- Participants said they chose to use day centres, walk-in clinics or A&E departments, because of the inconvenience of seeing a doctor on the day, especially when they thought they needed urgent care. Some had the impression that the mainstream primary healthcare services were not available to them, and they were not asked if they wanted to register with a specialist 'homeless' GP while they were on the street.
- All suggested they had registered with a GP service after they were offered a supported accommodation/hostel place.
- Sporadic use of healthcare services also meant that their healthcare records are incomplete. Two participants suggested that their healthcare information has never transferred to the specialist GP (potentially via GP2GP service) and that their historic data is missing.
- Participants who are now taking calls from Streetlink line, suggested that accessing mainstream GP services and receiving treatment continue to be problematic. Despite the ongoing Healthy London campaign, often people are asked to provide proof of address and identification. They also reported negative attitudes of receptionists to dealing with people who are sleeping rough.
- Currently the healthcare services in daycentres, walk-in clinics and A&E departments are felt inadequate in moving people off the streets.
- The group's recommendations included:
    a. Ensure the Healthy London Partnership's 'My Rights to Access to Healthcare' card is made available across all day centres, foodbanks, Job Centres, libraries and any other public services that rough sleepers might access.
    b. Explore how GP services can identify people who are at risk of homelessness/or are not-street homeless (e.g. sofa surfing) and offer them assistance or refer to people who can provide that assistance. It was suggested that this should at the minimum include a referral to housing authority, and an up-to-date list of organisations, such as night shelters and foodbanks.
    c. Include a "housing" element in all MECC training for services/organisations that meet people who are homeless.

2. How to involve people with lived experience in the commissioning and delivery of services

Participants said that engagement process should:

- **Have a clear purpose** Commissioners and providers of services will need to make it very clear 'why they are engaging with people with lived experience' and regularly feedback on changes that are being made upon the recommendations of people with lived experience.
- **Offer beneficial outcomes for people who are experiencing/or experienced sleeping rough**. These need to include immediate benefits (e.g. being offered payment for their time/contribution, and/or training as part of the involvement process) and longer-term benefits (e.g. 'making a difference')

- **Account for support people might need.** Involvement in service design and delivery can be difficult and overwhelming for many people who are sleeping rough, or who have recently moved into accommodation. Many individuals will need to be supported by people who they already have relationships with (e.g. outreach team, daycentre staff, etc,).
- **Increase responsibilities gradually** All participants have started volunteering as part of a group, first shadowing meetings, and gradually became more involved in various parts of the system they were interested in.
- **Respect a variety of experiences and views** Many people with experience of homelessness have fears of being rejected, judged, ridiculed, often because of multiple adverse experiences. The engagement process will need to be based on a deliberate statement of mutual respect and recognition.
- **Make use of trusted places/trusted faces** People who are sleeping rough might find meeting rooms, service buildings intimidating, and therefore it was suggested that the involvement meetings are kept flexible and informal in places where people already are. This could include day centres, but also places such as the local church, local park, etc.

3. Interviews with Lodge guests

Held on 8 June 2018, three males in their 60s contributed, with experience of sleeping rough 10+ years, including in the Square Mile, before they moved into the Lodge(s) between two and three years ago.

1. Healthcare needs:

- While sleeping rough, the only healthcare service they accessed was in the Providence Row day centre. They reported to have good relationships with the GP and practice nurse, who have supported them with several needs over the years. On reflection, they think they only asked for help with what they consider to be serious health issues that cause severe pain and discomfort.
- Reflecting on the experiences of people they have met on the streets over the years, they think substance misuse, coupled with poor mental health is a very common experience; and the day centre has been helpful in getting some basic support in place, e.g. Needle Exchange, referrals to substance misuse treatment, getting access to script. However, they feel there was not enough help especially with mental health problems to get them off the street in the first place.
- They recall some, but not frequent/regular visits to A&E during the time they have slept rough. Pain management, e.g. with leg wounds, was a common cause of their visit. They felt that the A&E staff always attended to their immediate needs.
- The first time they registered with a GP was after they had moved on to Lodge. They were supported by a support worker to register.

2. Health needs

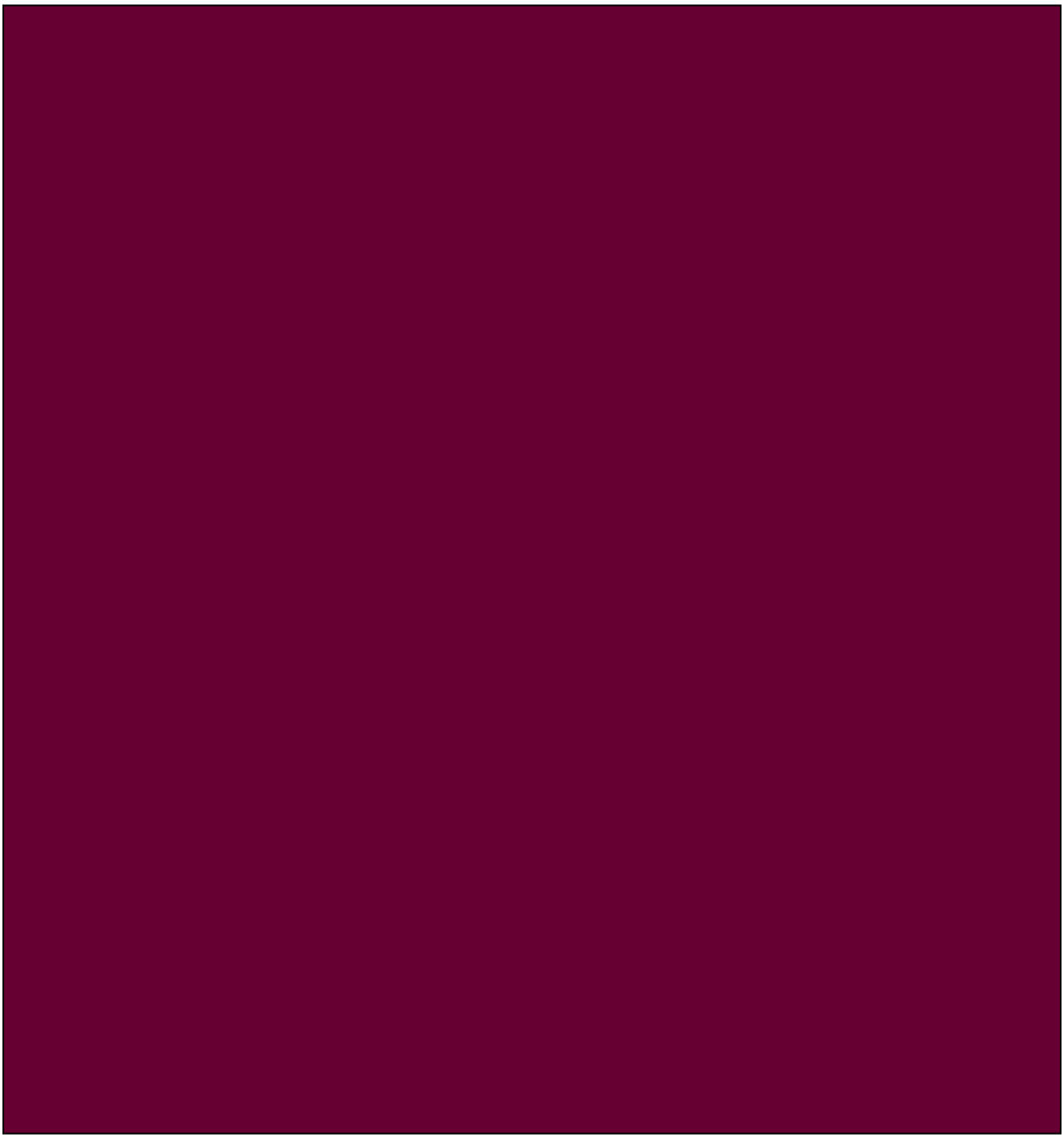
- All three reported chronic health conditions: Guest 1 reported Type 2 diabetes, high blood pressure, cardio-vascular problems; Guest 2 reported they had been treated for TB, and currently has COPD, and musculoskeletal issues that makes walking difficult; Guest 3 reported asthma, high blood pressure, limited sight.
- These issues have come to surface after they had registered with the Neaman Practice. Guest 1 thought he had not been previously tested for these conditions, partly because he suspects ‘these are not the sorts of things that can be treated on the street’. In comparison, Guest 2, thought that his ‘health problems started after [he] moved indoors’

3. Feedback on Neaman Practice

- All three said they are 'very satisfied' with the Neaman Practice. They found making appointments and seeing a doctor on the day or next day 'very easy'. They felt that their GP always treated them with dignity and respect and cared for them.
- They all talked about the occasions when they were unable/unwilling to go to the surgery, but the doctor visited them at the service and got the medication they needed to get better. This has not been always their experience with all services they have accessed to over the years.
- All three felt there was nothing that they needed to complain about, but they knew how to raise their concerns and they felt they were going to be listened to.

4. How to involve people with lived experience in the commissioning and delivery of services

- All three participants felt that commissioners and service providers will have to go to places 'rough sleepers' live and services they access. This echoed the suggestions of Outside In group who suggested engagement events to take place in 'trusted places'.
- They expressed they felt they had been let down by a number of services, rather than just physical health, mental health or housing services, so it is our view that the consultations should be based on how the 'system' on the whole operates to meet a particular need/or combination of needs, rather than focus just one service.
- They felt these meetings should be regular (four to six months every year, rather than every month, or every week) and people should be incentivised to attend. They felt, much like the Outside In group, that incentives should include vouchers (for their time) in the first instance, but they felt they would need to see 'something being done' with the information gathered after the meetings.
- We tested the idea from our forums about installing a screen to receive 'immediate feedback' as they go in/leave a health service. They felt this could be a good way of monitoring people's satisfaction more generally but suspected everyone accessing Neaman Practice would be happy with the health service they receive.



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