

Standards for commissioners and service providers

The Faculty for Homeless Health

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This document has been produced by the collective efforts of the faculty. It has been edited by Dr. Nigel Hewett, Medical Director, London Pathway.

The Faculty for Homeless Health

This Faculty is the first independent, multi-disciplinary body focused on the health care of homeless people. This new approach will allow us to improve care for extremely vulnerable people wherever they need help – in primary and community care as well as in acute hospitals.

We will put the patient back at the heart of healthcare, focusing on what the individual wants and needs. The Faculty will cross professional and organisation boundaries to shape care around the patient. People with an experience of homelessness will be included in our Faculty and in every level of our work. “No decisions about me without me” applies here just as much as in any area of health care.

The Faculty can be contacted through the web site at <http://www.collegeofmedicine.org.uk/faculties/faculty-care-homeless-people>



London Pathway is a new charity formed to transform the quality of health care for homeless people and other socially excluded groups. London Pathway is delighted to publish this first set of standards for health services for homeless people in partnership with the Faculty of Homeless Health.

For more information about London Pathway visit our web site at www.londonpathway.org.uk

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The College of Medicine is an alliance of doctors, nurses and health professionals with patients and scientists. Modern medicine depends on teams, not on a single profession, and patients are part of those teams. Yet the new College of Medicine is the only organisation to bring patients, scientists, doctors and all healthcare professionals together on an equal footing. That unique and powerful alliance allows it to develop a different perspective on how the health services operate and what they can and should deliver in the years ahead.

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A call to action

More than work, our home defines us. And without health, we have neither. The homeless lack all three: work, home and health. Their average age of death is 40.5¹ years. What would Aneurin Bevan say of his universal comprehensive NHS were he to witness the large scale premature death of the country's poorest and most abandoned? London Pathway did not begin with think tanks, committees and research documents. It began with people, passion, experience and story, not policy, statistics and theory. It has become credible not because of whom it claimed to represent but because of what it actually does. Too much time has been spent in well organised conferences looking at graphs and hearing about policies for change and endless statistics. Too much time has been spent in eloquent criticism of each successive administration, very little of which has translated into a benefit for those who most need it. The messy details of real people's lives and experience are often startlingly absent – no one actually mentions anyone with a name and no address. Martin Luther King famously said, "Our lives begin to end the day we become silent about things that matter". We who have the ability have the responsibility. Homeless health is a community problem, needing a community solution built on local ownership. This is a problem that cries out for compassion at the heart of the solution. The unacceptable has become the norm. We avert our gaze and have lost hope that anything can be done. As a first step on the road to embracing dispossessed homeless people, we publish these healthcare standards. We hope these standards will be enshrined in the expectations of all healthcare professionals when they come into contact with individuals who are homeless.

Levels of homelessness in the UK are an extreme symptom of wider levels of inequality in British society. The way we treat the most vulnerable and damaged is a basic test of our civilisation. We intend that this first version of a set of clear standards for health services for the homeless should begin to help us live up to our collective responsibilities.



Professor Aidan Halligan
Chair Faculty of Homeless Healthcare

Summary

This first set of standards for health services for homeless people has been written by a collaborative of professionals from a variety of disciplines in consultation with people with an experience of homelessness. We do not consider the standards presented here to be either completely definitive or comprehensive, but they are a start. Future versions of this document will enhance, improve and extend them. We therefore welcome comments, criticisms and suggestions for additions or amendments.

The purpose of this document is to set clear standards for planning, commissioning and providing health care for homeless people and other multiply excluded groups. This Faculty challenges all parties to work to these standards while undertaking to revise and improve them. London Pathway Charity will offer active support for those trying to deliver them.

Our primary purpose is to re-affirm the fundamental rights of homeless people to be treated with dignity, compassion and respect. But an increasing body of evidence provides an additional driver for change. At the sharp end of health inequalities, homelessness is associated with extremely high health care costs coupled with appalling outcomes – we have to be able to do better than this.

Part one outlines a national strategy for improving health care for homeless people, to be overseen by the Chief Executive of the NHS Commissioning Board.

Part two provides commissioning guidance to ensure high quality health services for homeless people. This guidance responds to DH commitments on health inequalities and is mapped onto the Public Health and NHS Outcomes Frameworks.

Part three presents generic standards for all services, followed by specific standard sets addressing primary care, migrant health, community mental health services, personality disorder services, psychology, counselling, prison medical services, dentistry, podiatry, substance misuse services and respite care. The Faculty for Homeless Health will offer clinical governance oversight for any member organisation that requests it, and evaluate services against these standards.

Introduction

This first paper of the newly founded Faculty for Homeless Health sets out to define the essential qualities required for effective health services for homeless people. The importance of the subject in sheer human misery and financial costs is emphasised.

The fundamental principles guiding this paper are Articles 1 and 25 of the Universal Declaration of Human Rights. All human beings are born free and equal in dignity and rights and everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control. Motherhood and childhood are entitled to special care and assistance.

Guidelines for policy makers and commissioners are set out in the context of an overarching national strategy. Clinical standards for service delivery in different settings are defined. At the heart of any service will be the encounter or consultation between a homeless person and a care giver. We recognise the central importance of nurturing and sustaining this relationship in order to provide effective care. In this approach generosity, kindness, and compassion combine with a passionate commitment to professional quality to become the defining characteristics of health services for homeless and multiply disadvantaged people.

These standards will be regularly reviewed and updated.

Homelessness is a national issue

Half of England's rough sleepers are in London² and over a third of No Fixed Abode (NFA) hospital admissions occur in the NHS London area⁴. But homelessness is a national issue - there are significant concentrations of homeless people in most large cities and the problem can be hidden and easily ignored in rural areas. There are similar trends for single young homeless people, and for homeless families.

There were 47,093 people using Supporting People funded hostel places in England during 2009/10 and rough sleeping in London increased by 30% over the five years to 2009/10³.

Outcomes are poor; for example the average age of death of a homeless person is between 40 and 42 years⁴, and a homeless drug user admitted to hospital is seven times more likely to die over the next five years than a housed drug user admitted with the same medical problem⁵. Homeless children and young people are likely to enter such a cycle without early intervention.

The root causes of homelessness are both complex and multifactorial. Simply providing adequate housing is of course a fundamental first step, but is not enough. Many people who go on to be homeless will have suffered significant emotional and/or physical trauma in childhood, will have suffered from poor familial relationships, and poverty in its many manifestations is an ever present factor. Other factors implicated in homelessness include the general lack of sufficient affordable housing, unemployment, mental ill health, physical ill health, low educational attainment and substance misuse. These factors operate at both individual and societal levels.

Addressing the health consequences of homelessness is a form of secondary prevention – reducing the harm resulting from long-standing and increasing inequality in society. We recognise that in the long term primary prevention is the only rational response – reducing poverty and inequality to tackle the root causes of homelessness and multiple disadvantage. By highlighting the direct costs to the health care system resulting from multiple disadvantage we hope to inform and support the drive to address inequality in our society.

Narrow definitions constrain

Homelessness is often the end point and consequence of multiple disadvantage. We are not constrained by a narrow definition. The standards obviously address rough sleeping homeless patients with entrenched addictions, compounded by mental health problems and chronic disease, but also patients in insecure or temporary accommodation, perhaps suffering lower level anxiety and distress because of their housing circumstances. These standards tend towards a focus on the more entrenched homeless people but also aspire to improve health services for those across the spectrum of multiple disadvantage.

Pockets of excellent practice constrained by commissioning boundaries

There is a variety of excellent primary care and specialist community services for homeless people across the UK, but the narrow and parochial approach of PCT based commissioning (responding to previous DH policy guidance) has resulted in services targeting only those patients with a local “address”. The patent absurdity of this approach, when dealing with a mobile and chaotic client group defined by their lack of an address, is particularly apparent in London; it has militated against a properly coordinated service and contributed to the high and growing use of unscheduled care by homeless patients - this is expensive and still results in poor outcomes.

Growing awareness of hidden costs to the NHS

Research by Professor Barry McCormick⁴, DH Chief Analyst, has shown that homeless people attend A&E six times as often as the housed population, are admitted four times as often and stay three times as long – because they are three times as sick. This results in secondary care costs that are eight times higher than average, largely consisting of unscheduled emergency admissions. The Nuffield Trust recently reported an overall increase of 11.8% in emergency admissions in England over the past five years at a cost of £330 million per year⁶. Professor McCormick’s analysis produces a conservative estimate of £85 million spent each year on secondary care for NFA patients, most resulting from emergency admissions. In fact this is likely to be a considerable underestimate, as many homeless people will give a hostel or “care of” address and not be revealed by this type of analysis.

Homelessness is a health care issue

There is a growing understanding, supported by international research⁷, that chronic homelessness is an associated but probably non-causative marker for tri-morbidity, complex health needs and premature death.

Tri-morbidity is the combination of physical ill health with mental ill health and drug or alcohol misuse. This complexity is often associated with advanced illness at presentation, in the context of a person lacking social support who often feels ambivalent both about accessing care and their own self worth.

Simply housing long-term homeless people (although an essential first step) does not, of itself, resolve the underlying problems. When homeless people die they do not commonly die as a result of exposure or other direct effects of homelessness, they die of treatable medical problems, HIV, liver and other gastro-intestinal disease, respiratory disease, acute and chronic consequences of drug and alcohol dependence⁷.

New standards for integrated health care for homeless people

Shared standards will improve care

Professor McCormick's paper highlights the potential for developing a new model of health care delivery for homeless patients, based on the highly successful service provided in Boston USA⁸. This model is of a fully integrated primary and secondary health care service including specialist primary care, out-reach services, intermediate care beds and in-reach services to acute beds.

The reorganisation of NHS commissioning offers a unique opportunity to improve arrangements for health care delivery for homeless people. We can empower front line workers and homeless people to work with Public Health and Local Authority colleagues to develop a comprehensive and integrated health response to homelessness, configured around a community of need to this shared set of standards.

Wider applications

This approach would provide a model for the commissioning of health care for patients who cross the boundaries of traditional GP practice areas, patients who are not registered with a GP and those with extensive and complex needs who require a time consuming and multi-agency response. This will also address the main Audit Commission criticism of GP Fund holding – that the principal beneficiaries were more affluent and less socially deprived patients⁹.

Part one

A national strategy for health care for homeless people

This document provides detailed standards to underpin a national strategy to significantly improve the health of homeless people. The key elements of a national strategy are as follows:

1. Commissioning will be led by the NHS Commissioning Board, with local service delivery. The accountable officer will be the Chief Executive of the NHS Commissioning Board or his delegated regional representative. A universally high standard of health care delivery for homeless people is central to addressing health inequalities. Regional coordination is needed to ensure integration and continuity of service delivery across geographical boundaries.
2. Joint Strategic Needs Assessments (JSNA) will include the impact of homelessness across health, housing, social care and the criminal justice system and include hostel dwellers and the insecurely housed as well as rough sleepers. A multi-agency steering group will inform the JSNA and oversee the local implementation of a health and homelessness strategy.
3. Service user involvement must be integral to commissioning and delivery.
4. Enhanced access to health care services for homeless people is essential and will have to be demonstrated for each area. This may include specialist move on and enhanced mainstream services according to local need.
5. Expenditure on health care services for homeless people across primary and secondary care will be reported to the NHS Commissioning Board and related to estimates of need from rough sleeping counts, homelessness declarations and uptake of supporting people funded hostel places.

The Faculty for Homeless Health and the London Pathway will hold national and local commissioners to account against this set of standards.

We believe that treating homeless people with dignity and respect, and equally to other patients should not be optional. The standards that follow have not been fully costed, but we also believe that treating homeless patients better may ultimately reduce their costs to the NHS and other services (and there is some evidence to support this assertion).

Part two

Why these standards are necessary

The coalition government have pledged to improve the health of homeless people by providing them with better NHS care¹⁰. This document presents a proven model of integrated care and standards built on national and international expertise¹¹ and the experience of homeless people.

Health outcomes are appalling: homeless people die of treatable medical conditions. The average age of death is between 40 and 42 years. The Secretary of State for Health has referred to this gap in life expectancy as a scandal¹². A recent survey of hostel users found that more than two-thirds were suffering from physical health problems such as acute or chronic respiratory disease, cardiovascular disease, skin and soft tissue infections, diabetes, asthma, epilepsy, liver and renal disease. There are also high levels of psychiatric co-morbidity. A homeless drug user admitted to hospital is seven times more likely to die over the next five years than a housed drug user admitted with the same medical problem⁵.

Barriers to care: homeless patients often have poor experiences of trying to access and use health services. A recent survey of hostel residents found 49% of those interviewed had experienced a negative contact with hospital or A&E.

Experiences of UK homeless patients



“...he told me I was constipated...and sent me back to the hostel, couldn't get out of my bed for two weeks...I couldn't eat. I was sent back to the hospital...we found out my kidneys were failing and I had TB in my spine and in my lungs. I had thrush all through my stomach, my throat, and abscess in my spine, my kidneys were only working one percent, my legs and my feet ended up swelling up, because of proteins that were leaking out my kidneys...”

“...one day I collapsed in the street, and someone phoned an ambulance. I went to the hospital. But as soon as the doctor heard I was a heroin addict they never even examined me...”

“It was horrible. I felt like a really dirty person. They did kind of treat me like a bit of a germ...I hated it over there.”

*“they asked me why I didn't come in sooner?
I said I was here but you sent me home.”*



Crisis management

Care is often characterised by crisis management. One study suggesting that this client group are forty times more likely not to be registered with a GP than the general population. A recent study found on average there was one ambulance call out for each six hostel bed spaces each year. These call-outs were mainly for acute medical emergencies arising from pre-existing medical conditions. Only 30% of those discharged from hospital and 11% of A&E visitors left with a care plan¹³.



...I hadn't been to see a doctor for about ten years and I thought it was just side effects of heroin or whatever. And I didn't realise I was ill...

I never knew I was ill til I collapsed



Health comes first

Recent funding arrangements have severed links between health and social care and confused frontline workers about their role in promoting health. This has resulted in a culture that too often ignores the fact that health is pre-requisite to independent living and employment.



At the moment I'm just sorting out my health, that is my priority at the moment, and then I can think about other things once I'm better... I live in a hostel.



The current approach is expensive and ineffective

In patient care costs of those with “no fixed abode” are approximately eight times greater than those of similarly aged adults; they have almost three times the average length of stay. This translates into a cost to the NHS of at least £85 million per year⁴. The real costs are considerably higher as these data ignore the majority of homeless people living in hostel accommodation, squats or other insecure tenure. There are around 47,000 people in the hostel system at any one time in England with around 100,000 people moving in and out of the system each year³.

The problem can be solved

International experience and research proves that providing high quality care for homeless people is not only achievable but makes sound financial sense. Shifting the emphasis of care from crisis management to prevention, service linkage, case management and respite reduces in patient stay and risk of future hospitalisation¹³. Furthermore, many targeted health interventions for homeless people have also been shown to reduce the amount of time that people spend homeless. England lags behind other affluent countries in having no co-ordinated strategic approach to address their health needs.

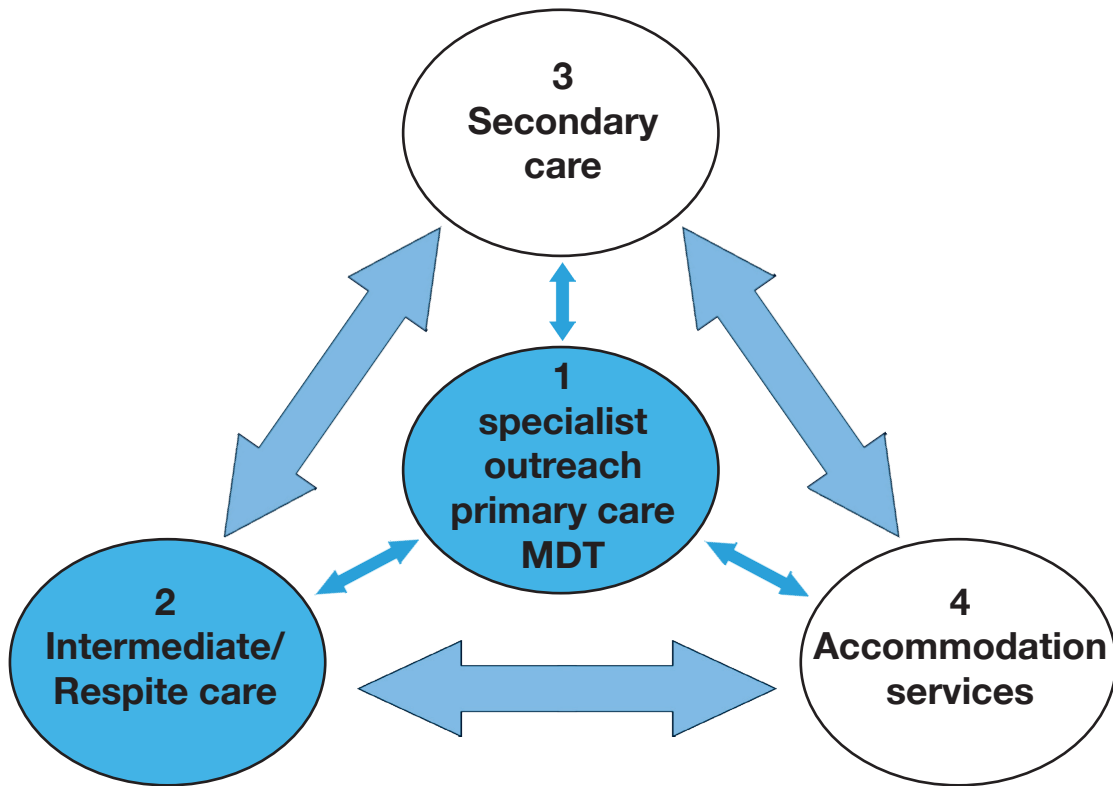
Homelessness is ubiquitous throughout the UK and some excellent primary care and specialist community services for homeless people exist. Overall standards vary considerably and many services are fragmented and work in relative isolation. Both efficiency and effectiveness can be improved through the active linkage of existing health and social care services. The fact that there are limited numbers of homeless people in each locality means that their needs are easily neglected. A more joinedup and strategic approach is essential.

Window of opportunity

The reorganisation of NHS commissioning, with the stated aim of 'improving the health of the poorest fastest' and increased emphasis on co-operative health and social care planning, offers a unique opportunity to improve arrangements for health care delivery for homeless people.

We have developed a proven model of integrated healthcare for single homeless people and rough sleepers including standards of care informed by the NHS, Public Health and Social Care Outcome Frameworks. Our approach is a model for commissioning health care for patients who cross traditional boundaries, are often not registered with a GP and whose complex needs and multiple morbidities require specialist input. This model is based on the best available evidence and the extensive collective experience of the members of the Faculty of Homeless Health. It is also informed by the lived experience of homeless people.

Figure 1 - Integrated approach to commissioning of homeless health services.



1: Primary Care Led Multidisciplinary Team (MDT) providing service linkage and case management. MDT case management requires a named patient advocate to assess needs and ensure access to a package of care by linking health, housing, social care and voluntary sector provided services.

2: Intermediate/Respite Health and Social Care to:

- a) avert unnecessary secondary care admission
- b) prevent inappropriate hospital discharge and emergency re-admission
- c) organise onward care and resettlement.

3: Inpatient and outpatient care.

4: Statutory and 3rd sector residential support services.

Measurement of outcomes

Outcomes for homeless populations need to be an integral part of the NHS, Public Health and Social Care Outcomes Framework allowing measurement of the proposed indicators within homeless populations. Appendix one maps these standards onto Public Health and NHS Outcomes Frameworks.

While the NHS is in a transitional phase between different commissioning arrangements it remains unclear where responsibility for commissioning health services for homeless people will lie. At the strategic level accountability must lie with the National Commissioning Board. This section addresses future commissioners of health services whatever the final future institutional structure.

Standards for commissioners

- A1.** The accountable officer for homeless health care (whether in a GP Consortium or NHS Board regional office) should be at Director level or above.
- A2.** Commissioners must publish evidence of partnership working with statutory and voluntary sectors and service user engagement at all levels.
- A3.** Standard data sets concerning the numbers of homeless people, their health and associated expenditure in primary and community care and secondary care should be collated, reported and acted on by commissioners at least annually. Data should be collated in such a way that targets do not distort outcomes.
- A4.** Means of enhanced/easy access to health care for homeless people should be described and publicised for each area – specialist services are not the only solution, enhanced access and outreach services from mainstream providers are also important. All primary care providers should be routinely tested for their willingness to register NFA patients.
- A5.** Appropriate service responses to homeless patients - to these standards - must be commissioned and performance managed for community, specialist primary care, mainstream primary care, dental care and secondary care.
- A6.** Commissioners should require proactive care planning, so encouraging a move away from gate keeping (spending time assessing and rationing entitlement) towards proactively planning to meet people's needs.
- A7.** Commissioners should require horizontal, patient-centred integration. By this we mean care planning and continuity across community settings and service provider boundaries, so that people can continue to receive continuity of care even if they lose the address that originally gave access to that care.
- A8.** Commissioners should require vertical integration. By this we mean care planning and continuity of care into secondary care and back into the community. A clear expectation of compassion, communication and continuity of care between secondary, primary and community care.
- A9.** Measures of success should be shared across multiple agencies, such as reductions in rough sleeping, anti-social behaviour, un-scheduled re-admission within 28 days, and unplanned A&E re-attendance within seven days.
- A10.** There should be specific commissioning plans for homeless children and young people, as their care pathways and service requirements may differ.

Part three

Detailed clinical standards for homeless health care in different specialities and situations

In this section we set out clinical standards for homeless health services in general, and specific standards for a range of specialist services that should be accessible to homeless patients.

These standards will be regularly reviewed and we encourage suggestions for improvement. Coordinated service provision across primary and secondary care is a requirement of these commissioning standards. Provision of good quality primary care, in the absence of integrated good quality secondary care would not meet these standards.

We start by setting out general clinical standards relevant to all settings. We then present specific additional standards for primary care and for a range of other services important or relevant to improving healthcare for homeless people.

The Faculty will offer, on request, clinical governance oversight and inspection for service providers who are members of the Faculty.

Principles for clinical standards in homeless health care

- B1.** Continuity – a trusting relationship formed with a familiar clinician.
- B2.** Multi-disciplinary collaborative care is central to effective care because many homeless people present with multiple healthcare needs.
- B3.** Person centred care with service user involvement in planning and delivery. For example the Care Programme Approach used in mental health services.
- B4.** The Recovery approach developed by users of psychiatric services should be incorporated into the design of all services. Summarised by the phrase – Hope, Agency and Opportunity for all¹⁴, this seeks to make shared decision making the norm. “No decision about me without me”¹⁶.
- B5.** Where specialist services are provided they should act as a catalyst to improve care throughout the local health service.
- B6.** Homeless services should provide the bridge linking hospitals and community care through hospital in-reach services.
- B7.** Homeless services should work closely with public health departments particularly with important communicable diseases (e.g. TB or blood borne virus transmission).
- B8.** Services should actively seek to offer treatment to refugees, asylum seekers, migrants and those with no recourse to public funds.
- B9.** Homeless services should include the provision of “respite care” (now in 50 Cities in USA and Canada) – community based residential medical facilities for homeless people with significant and complex health care problems. This could be achieved cost-effectively through joint working with local hostels and the voluntary sector. These services improve outcomes and reduce subsequent unscheduled hospital admissions^{14,17}.

All services meeting these standards should include the following

- B10.** Regular involvement in, and where necessary leadership of, multi-agency planning for rough sleepers. Visible service user involvement in planning and evaluation of services.
- B11.** Coordination of the health care of homeless people as they move between different organisations (hostels/drop-ins, shelters for homeless families, etc).
- B12.** Child and family services to be linked to homeless family hostels with children treated and recorded as individuals, not nameless adjuncts to the parent.
- B13.** Coordinated health care in hospital settings by collaboration with homeless ward rounds and attending multi-agency care planning meetings. Informative and timely discharge summaries should be standard even when the patient self discharges and should also contain information about any substitute opioid prescribing including date and quantity of last dose.
- B14.** Plans for assertive outreach for non-engaged clients in each area; e.g. specialist clinicians with flexible hours, able to provide street outreach.
- B15.** Recording of housing status with regular review.
- B16.** Consideration of security, including the set up and location of clinical services, access to notes and alerts, and chaperones where necessary.
- B17.** Participation in documenting, researching and publishing on the health hazards of homelessness, evaluations of service delivery models, continuous monitoring of longer term outcomes.
- B18.** Education and involvement in undergraduate and postgraduate training of medical, nursing, dental, psychological therapies and social work students. Develop links with relevant professional bodies.
- B19.** Promotion and encouragement of accessible provision of dental and podiatry care.
- B20.** Promotion of homeless health care as a viable and attractive career choice for staff.

Additional Standards for specific services

Standards for primary care services:

Services will need to be planned according to local and regional need. In some areas specialist services will be justified. Where there are fewer homeless people enhanced access to mainstream services may suffice, but these standards of care should apply in every setting.

C1.1 Information is the key – a unified electronic record accessible wherever the patient is seen (e.g. EMIS web or System One). All patients must be registered at first consultation. Ideally and usually this should be full registration, unless already registered with another homeless service, when temporary registration acceptable. For those only entitled to emergency treatment from the NHS, an immediate and necessary registration to be completed. In this way every patient is logged and costed and becomes visible to the NHS. Where current services are not able to register patients (e.g. sessional GP's, nurse only outreach services) they should move within 12 months to Alternative Provider Medical Services (APMS) contracts so that they can register patients and are obliged to provide the full range of services offered to non-homeless patients. Where this is not achievable, services should be managed by neighbouring homeless practices (this is analogous to the plan to have all Acute Trusts move to Foundation Status or be taken over by existing Foundation Trusts).

C1.2 QOF (Quality and Outcomes Framework) standards. Homeless practices should prioritise and support these standards, including:

- Managing long term conditions to QOF standards;
- Pro-active management of selected patients with high needs by – weekly multi-agency meetings to include local street outreach, statutory and non-statutory services;
- hospital in-reach ward rounds/visits for homeless patients where necessary in the local Acute and Mental Health Trusts;
- regular outreach clinics in local hostels and drop-in centres;
- collaboration with multi-agency review and care plans for all registered patients admitted to hospital twice or more in any six months period and when necessary those with Combined Homeless Information Network (CHAIN) or other rough sleeping record in the past month;
- all patients offered drop-in clinics with presenting problem addressed first, but offered health screening to include, physical health assessment, screening for dental/oral problems, BBV (Blood Borne Viruses), smoking, drug and alcohol problems, TB (Tuberculosis) screening, screening for mental health problems, diet and exercise;
- regular review of locally negotiated approach to ensure easy access, including drop-in clinics and outreach clinics at hostels and drop-in centres.

- C1.3.** An annual report should be produced including QOF data. With a mobile population QOF targets can be particularly hard to achieve and thresholds for payment in homeless practices should reflect this.
- C1.4** Individual service level measures should be defined by the service and defined by the question “What do we expect to change for our clients as a result of what we do?”
- C1.5** 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 until ready and able to access mainstream services.
- C1.6** Services should collaborate with case tracking, community treatment and public health measures e.g. TB, HIV, Hepatitis C

Standards for migrant health services

Migrants are at higher risk of homelessness and destitution than the general population and the need to prove rights of access to NHS care may challenge the human right to health care. This is a complex area, which will require further revision and improvement of these standards.

- C2.1** Full registration for migrants, including those without documentation. GP's should be aware that they can register anyone at their own discretion, regardless of documentation and that SBS (NHS Shared Business Services) have stated that they have no right to refuse a GP's request for registration. If someone is 'no fixed abode' (NFA) or effectively homeless then the GP can register the patient care of the practice address. However sensitivity is required as some patients will fear that registration will draw attention from the UK Border Agency or other official bodies.
- C2.2** Appropriate interpreting services should be available where needed.
- C2.3** Services for homeless migrants should promote and facilitate screening and treatment; for example of infectious diseases, particularly HIV, Hepatitis B, C and TB, and where appropriate haemoglobin electrophoresis and full antenatal screening.
- C2.4** Services should offer access to the full range of primary health care interventions, with referral to secondary care where appropriate. It is not the responsibility of the GP to ascertain eligibility for secondary care. Hospitals and primary care should be aware that antenatal care should always be considered immediate and necessary although the hospital may issue a bill for the cost of care provided.

Standards for community mental health services

Many homeless people also have mental health problems and experience difficulty in accessing mental health services. Where there are significant numbers of homeless people specialist services may be necessary, in other areas enhanced access to mainstream services may suffice. In both situations services should be provided to these standards. It is crucial that mental health services are integrated with other health services and that there is good communication between them.

- C3.1** Services for homeless people should accept self or non-health agency referral for initial assessment.
- C3.2** In areas with high concentrations of homeless people, specialist services should be provided to ensure the necessary expertise is available and there is flexible service provision.
- C3.3** All 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.
- C3.4** Access to care enhanced by outreach, for example to hostels and drop-ins.
- C3.5** A flexible approach centred on patient choice to overcome geographical barriers to accessing care. Nationally agreed and universally applicable standards of access for homeless people will ensure diagnosis and treatment according to the needs and best interests of the person and prevent exclusion due to short term address changes or street homelessness. This will include willingness to maintain therapeutic relationships with homeless patients who have temporarily moved out of the geographic boundaries of the Community Mental Health Team (CMHT).
- C3.6** There should be enhanced and easy access to psychological therapies for individual and group work tailored to the needs of homeless people.
- C3.7** 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.
- C3.8** There should be regular and structured meetings with hostel and outreach staff to discuss potential referrals and on going cases, improve conditions in chaotic hostels and encourage preventative work such as anti-bullying strategies, noise abatement and therapeutic groups.

Standards for Personality Disorder Services

Primary care, psychiatric, psychological and counselling services all need to take account of the particularly high incidence of personality disorder in the homeless population. NIMHE guidance¹⁸ offers specific standards for Personality disorder (PD) services. PD services for homeless patients should include:

- C4.1** Local specialist multidisciplinary teams offering specific interventions and consultation and supervision to other teams.
- C4.2** Specialist day services in areas of high concentrations of morbidity.
- C4.3** Local services at all levels should be able to recognise people who present with significant personality difficulties, and offer them equitable, accessible and appropriate services.
- C4.4** Local services should be accessible and responsive to people with personality disorder, offering a range of levels of support and intervention.

Standards for psychological services

Many of the problems experienced by homeless people are amenable to psychological treatment. But for services to be accessible they need to be designed and delivered to take account of the needs of homeless people.

- C5.1** Services should be flexible with open access by self-referral.
- C5.2** Provision should be made for specialist psychologists and psychotherapists to directly deliver psychological therapies and support all staff involved with those individuals through consultation and the provision of facilitated reflective practice.
- C5.3** Psychological therapies should include explicit phases of engagement and/or engage outreach workers to use psychological skills in engaging service users in the process of change, via the provision of training.
- C5.4** In order to increase use of such services, direct therapeutic input should be enabled in the environments in which homeless people are found, e.g. homeless healthcare teams, day services, hostels rather than solely on an outpatient basis in psychiatric services.
- C5.5** Psychological services should be carefully evaluated in terms of outcome. In order to address the paucity of evidence in the field, psychological services should adopt an 'evidence-generating practice' approach to interventions. All staff involved in homelessness services should be taught to monitor outcomes meaningful for the service user, and to enable them to perceive meaningful change as a result of their input.

- C5.6** The forms of psychological intervention used should make use of existing and developing research on the processes underlying the causes and maintenance of homelessness in order to target interventions effectively.
- C5.7** A flexible approach to the implementation of psychological therapies should be developed in order not to exclude on the basis of current alcohol and substance abuse, emotional lability or varying forms of self-harm.
- C5.8** Other services with which the service user is involved (e.g. social care, secondary care and third sector staff) should continue to support the person who engages in psychological therapy. In this way the therapy targets of the psychological intervention may be communicated to and reinforced and supported by a wider team of enabling staff.
- C5.9** Staff in primary and secondary care and third sector organisations should be enabled to formulate the interaction between mental health issues and the behaviours leading to homelessness using specific therapeutic frameworks, thereby increasing their understanding of the issues and increasing the range of responses available to them when dealing with challenging behaviours.

Standards for counselling services

Counselling may be particularly beneficial for homeless people, but a different approach is needed to encourage patients to move towards engagement with the process.

Services should:

- C6.1** Be flexible with open access by self-referral.
- C6.2** Offer flexibility of location for service provision.
- C6.3** Recognize the need to create a culture of trust and for 'opportunistic' outreach and 'pre-engagement' work in the form of non-clinical, but transitional activities (chatting, art groups, etc).
- C6.4** Recognize the need for flexibility in the face of lowered frustration tolerance thresholds and emotional outbursts, challenging/disengaging behaviour.
- C6.5** Incorporate a flexible counselling approach capable of offering an assessment of immediate, medium and longer term needs; a mix of crisis management, supportive counselling skills, problem clarification and solving skills, taking into account the dynamics of the therapeutic relationship, in order to support through the referral process to a more structured treatment.
- C6.6** Recognize people with Personality Disorder, engaging and supporting them through the referral process to more structured treatment.

Standards for prison medical services

Many homeless people spend time in prison and many prisoners become homeless on release. It is estimated that 15% of people are homeless when sentenced to a time in prison and 30% are homeless on release. It is important that health services for prisoners at risk of becoming homeless, and for formerly homeless prisoners, are connected to other health services involved in the patient/prisoners care¹⁷. There is a range of guidance already available in relation to prison health care and prison dentistry. Many of the standards set out elsewhere in this document will apply to prison medical services.

In addition they should include:

- C7.1** Full registration of patients treated.
- C7.2** Use of a standard primary care record system incorporating past medical records and passing on full record to the NHS primary care record system on release.

Standards for dentistry services

Access to dental care for homeless people is worse than access to general medical services. Homeless people have similar levels of dental disease to the housed population; however they have higher levels of untreated dental disease, which has considerable impact on their quality of life¹⁹. Most homeless people wish to have their dental needs addressed but face many barriers to accessing dental care which include: dental anxiety and fear, confusion about where and how to register with a dentist, confusion about entitlement to free or subsidised dental care, the requirement to meet other more pressing survival and welfare needs and fear of rejection or refusal of care from a dental practice. Most dental treatment needs of homeless people are not complex and may be readily treated in a primary dental care setting, however current arrangements within NHS Dentistry do not facilitate the flexibility required in managing the provision of dental care for homeless people²⁰.

Commissioning of dental care for homeless people

- C8.1** The commissioners for health care for homeless people in each area must identify an individual (Head of the Salaried Dental Services or Head of Special Care Dental Services or Consultant in Dental Public Health) who will champion access to dental care for homeless people and advise how access could be facilitated within local arrangements for NHS dentistry (appropriate local NHS primary dental care and/or salaried dental/special care dental services). This would include a focus on single homeless people and homeless families particularly children.
- C8.2** Dental care for homeless people should be included in an area's oral health strategy. Arrangements for dental care for homeless people should be specified in contractual arrangements with appropriate local NHS primary dental care and/or salaried dental/special care dental services.
- C8.3** Commissioners should ensure that homeless people are able to access emergency dental care within 24 hours for emergency care (pain, infection, trauma etc). Where the 24-hour guideline on emergency care cannot be achieved, an appropriate practitioner will see the patient within 24 hours to assess and outline a course of action. Homeless people should be able to access routine care within six weeks of first requesting it.

Integration of dental care with primary medical and social care

- C8.4** All homeless people attending for a health needs assessment with a member of the primary health and social care team should be asked about their dental health and be referred for a dental needs assessment as part of a single assessment process. The latter is particularly important for children in homeless families.
- C8.5** All members of a primary health and social care team in contact with homeless people should receive training on assessing dental health and prevention of oral disease.
- C8.6** Health promotion with homeless people should have an integrated oral health promotion element and use a common risk factor approach addressing nutrition and diet, smoking, alcohol and substance use and basic hygiene.
- C8.7** Dental services providing care for homeless people must be integrated with and complementary to other health and social services and agencies providing services to homeless people.

Local NHS arrangements for dental care for homeless people

- C8.8** Local NHS primary dental care and/or salaried dental/special care dental services within an area must work as an integrated team to share experience, and to network and facilitate referrals. This may be particularly important for primary dental care services that have limited knowledge of homelessness.
- C8.9** Dental services for homeless people should be delivered flexibly to enable and facilitate access. Different modes of delivery will be required to address different categories of need in different localities and should include a mix of safety-net services delivered at fixed site (based at facilities for homeless people) and outreach clinics (to include mobile dental clinics) and mainstreaming to local NHS primary dental care. Safety-net services delivered at outreach clinics and at fixed sites will be needed to ensure access for hard to reach and entrenched people and those with complex and multiple needs. All others should be helped to use local primary dental care services. Contractual arrangements will need to allow for these different modes of delivery.
- C8.10** A mix of 'drop-in' and appointment clinics should be offered.
- C8.11** Services should be non-judgemental and non-threatening providing reassurance particularly for the dentally anxious.
- C8.12** A dental clinical governance framework has been developed by the Department of Health to help set out criteria for the standard and quality of primary dental care to be commissioned and evaluated by Primary Care Trusts²¹. Dental care for homeless people would be expected to comply with these standards and quality guidelines. Standards and quality in relation to dental care provided in mobiles and in outreach clinics must comply with the themes in relation to: Infection control, child protection, staff, patient, public and environmental safety, clinical records, patient privacy and confidentiality .
- C8.13** All homeless people attending for dental care should receive an oral health assessment and timely provision of treatment. Evidence suggests that treatment plans based over short time frames are more likely to be completed. The dental health education provided should be sensitive and appropriate to the person's oral risk factors and housing situation.

Standards for podiatry services

Footcare is vital for homeless people. Where numbers of homeless people justify drop-in centres and other specific provision a specialist podiatry service is very likely to be necessary. In other areas enhanced access should be planned

- C9.1** 'Drop in' access by self referral with continuity of provision to build trust – including cover for leave. Appropriate and accessible advertising of service including EasyRead and translation and clinical access to translators and language line.
- C9.2** Provision at all main homeless drop-ins and homeless GP surgeries in area. New patients to be referred to GP/nurse for full health assessment.
- C9.3** Security should be considered, including set up and location of clinical room, access to notes and alerts, chaperones when necessary.
- C9.4** To apply standards of infection control, waste disposal, equipment, lighting and note taking equal to mainstream and delivery of equipment and stores in same way as mainstream although working in non NHS premises. Also provision of sample taking and collection (e.g. wound swabs and nail clippings)
- C9.5** Links with mainstream podiatry service. Lead clinician to work in both to maintain links and equitable standards. Equal access to other specialities to which podiatrist will frequently refer via GP, e.g. physiotherapy and surgical footwear. Arranging support to attend where necessary. To promote annual diabetic neurovascular foot checks and diabetic foot care advice on an opportunistic basis by all health team members. Screening for alcohol related neuropathy.
- C9.6** For recently housed patients services should ensure continuing care or refer on.
- C9.7** Modify treatment if necessary. e.g. the use of strong acids to treat verrucae needs care as the patient cannot rest, need to liaise with day centre staff with regard to possible temporary accommodation provision when patient is particularly vulnerable due to a foot problem,
- C9.8** Equal grading of post to other specialist podiatrists in the team. All podiatry teams to have a 'Specialist Podiatrist for Homeless AND Vulnerable People'. Podiatrists should have independent prescribing rights where appropriate.

Standards for substance misuse services

Not all homeless people have problems with alcohol and drugs, but for many people substance misuse becomes a significant barrier to moving out of homelessness. This Faculty broadly supports the 2010 Drug Strategy²², particularly acknowledging that recovery is an individual person-centred journey and recognising that many homeless people lack the social, physical, human and cultural capital listed as central to starting and sustaining recovery.

- C10.1** Integrated drug and alcohol services should be easily accessible in places where homeless people go, such as drop-in centres and primary care centres.
- C10.2** People with drug and alcohol problems must be able to access active help with both problems from one key worker.
- C10.3** Primary care delivered services may improve coordinated delivery of health care and preventative services.
- C10.4** Opportunistic provision of health promotion such as blood borne virus screening and hepatitis B vaccination should be an integral part of substance misuse services.
- C10.5** Close links (ideally on the same site) with services providing benefits advice, housing support, and support into education, training and work are particularly important for homeless people in substance misuse treatment.
- C10.6** 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.
- C10.7** Acute services should be actively supported to ensure timely provision of substitute prescribing for opiate dependent patients admitted to hospital.

Standards for respite care

Homeless services may include the provision of “respite care” (now in 50 Cities in USA and Canada) – community based residential medical facilities for homeless people with significant and complex health care problems. This could be achieved cost-effectively through joint working with local hostels and the third sector. These services improve outcomes and reduce subsequent unscheduled hospital admissions^{13, 16}.

- C11.1** Person centred case management to include physical health, mental health and drug or alcohol misuse when relevant.
- C11.2** A Psychologically Informed Environment, with regular reflective practice integral to daily practice²³.
- C11.3** On-site access to a full range of primary care services.
- C11.4** Integrated team working across medical treatment, social care and housing support, ideally from one provider organisation
- C11.5** Access to education, training, sports, arts activities.

Working with St Mungo’s, London Pathway is drawing up detailed service quality specifications and revenue models for respite care homes for homeless patients.

It is not for the Faculty of Homeless Health to propose standards for non-medical services for homeless people, but other services (hostel providers, skills and training agencies, benefit offices, housing staff), provided by local government, the third sector and national government (benefits for example) are vital to the wellbeing and long term life chances of homeless people. It is important that health professionals work closely alongside other services in the interests of their patients, integrating care packages and advocating for the best possible outcomes for our patients.

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Abbreviations

A&E – Accident and Emergency Department
BBV – Blood Borne Virus
CHAIN – Combined Homeless Information Network
DH – Department of Health
GP – General Practitioner
HIV – Human Immunodeficiency virus
HPA – Health Protection Agency
JSNA – Joint Strategic Needs Assessment
MDT - Multi-disciplinary Team
NFA – No Fixed Abode
NHS – National Health Service
NHSCB – National Health Service Commissioning Board
NIMHE – National Institute for Mental Health in England
NTA – National Treatment Agency
PCT – Primary Care Trust
PD – Personality Disorder
QOF – Quality and Outcomes Framework
SBS – the NHS Shared Business Service
TB – Tuberculosis

Appendix one

Public Health and NHS Outcomes documents from the perspective of health care for homeless people.

The public health outcomes framework consultation document has three explicit purposes: -

- To set out the Government's goals for improving and protecting the nation's health, and for narrowing health inequalities through improving the health of the poorest, fastest;
- To provide a mechanism for transparency and accountability across the public health system at the national and local level for health improvement and protection and inequality reduction; and
- To provide the mechanism to incentivise local health improvement and inequality reduction against specific public health outcomes through the 'health premium'.

There follows the Faculty response to the public health consultation document.

Faculty for Homeless Healthcare Response to Public Health White Paper Healthy Lives, Healthy People. 30th March 2011

As advocates for homeless people, faculty members are deeply concerned that the White Paper gives virtually no consideration to the needs of homeless people despite its stated aim to “improve the health of the poorest fastest”. The White paper highlights that people living in the poorest areas can expect to live for 7 years less than those in wealthy areas but makes no mention of the appalling statistics associated with homelessness. An average age of death of around 40 years is equivalent to that seen in the late 18th and early 19th century and lower than that of many resource poor countries. Most of these deaths are from treatable medical conditions. Tackling this grotesque disparity requires the joined-up efforts of health and social care services, the voluntary sector, the criminal justice system and the wider community. Public Health must play a key role in ensuring that these sectors work together to achieve better outcomes for homeless people. Health outcomes in the homeless will be a sensitive barometer of the new public health system’s ability to deliver on the promise of improving the health of the poorest fastest.

The Faculty recognizes opportunities and threats within the proposed arrangements for Public Health. Specifically:

Joint Strategic Needs Assessment (JSNA)

We welcome proposals to strengthen JSNA and the opportunities this provides to encourage commissioning of joined-up services. JSNA potentially provides a mechanism to encourage joint commissioning of progressive evidence based services such as specialist primary care and mental health services for homeless people, combined health and social care teams who can outreach care to the homeless community and intermediate care facilities supported by funds from health and housing. Such services have been proven to reduce emergency admissions and readmissions, allow safe discharge, reduce inpatient care costs and increase the chances of successful resettlement. We are however, concerned that in order to achieve efficiencies and provide joined up services across traditional boundaries the commissioning of such services requires oversight at a level higher than that of upper tier councils and unitary authorities. We are also concerned that requirements for JSNA make reference to statutory homelessness but no reference to single homeless people who by current definitions are not recognised by Local Authorities as statutorily homeless. There is currently no requirement for local authorities to measure this problem let alone take steps to address it – the cheaper option in the short term would be to ignore the issue, increasing the numbers of multiply disadvantaged people with consequences costs to the individuals and to society through health service and criminal justice expenditure.

Role of Local authorities and ring fenced funding

We welcome the increased emphasis on ensuring that local authorities take on responsibility for some public health functions and the concept of ring fenced funding for public health within local authorities. We are, however concerned that this ring fenced funding will be used to fund services such as homeless housing initiatives which should already be funded from within local authority budgets. The ring-fenced budget will be expected to meet the public health needs of all the resident population within a given local authority. There is no statutory requirement to address the public health needs of homeless people who perversely may find themselves further deprived by councils keen to ‘relocate’ the problem of homelessness as evidenced by recent attempts to ban soup runs in certain local authorities. The political complexion of a local authority is likely to have a major impact on how they prioritise homeless health issues.

We welcome the concept of a “Health premium” with extra public health funds for the most deprived areas. We note that these areas will largely be identified through census-derived variables but homeless people do not typically complete this.

Many homeless people live in areas that are relatively affluent. The health premium needs to include an element of funds related to homelessness. Public Health England should set clear expectations of the preventive services it expects to see in place for homeless people and other particularly mobile and/or severely excluded groups.

GP commissioning

GPs are ideally placed to assess needs and plan care for those who use their services. Homeless people often have poor access to primary care and consequently often rely on Accident and Emergency departments to meet their primary and acute care needs. We question the ability of all GP consortia to commission equitable and accessible health care for homeless people. Both efficiency and effectiveness can be improved through proactive linkage of existing health and social care services across geographical boundaries but local GP consortia are not well placed to recognise this. The fact that there are limited numbers of homeless people in each locality means that their needs are easily neglected. A more joined up and strategic approach is essential.

Role of Public Health England and NHS commissioning Board

We are concerned that Public Health England will not be independent from the Department of Health and that this lack of independence may stifle debate on health issues that are potentially politically controversial such as the health needs of homeless people, drug users, undocumented migrants and prisoners. We recognise that inclusion of both the HPA and the NTA within the same body has potential advantages for improving the control of infections in drug users. We welcome the role that Public Health England will play in monitoring health outcomes and health inequalities at national level and in providing data for national use. We recommend that they should also be charged with monitoring health outcomes in homeless and other marginalised populations.

We welcome the fact that “Public Health England and the NHSCB will work together to support and encourage GP consortia to maximise their impact on improving population health and reducing health inequalities” and that “This will include looking specifically at equitable access to services”. An early priority should be addressing commissioning of equitable health care for the homeless who represent the poorest in our society. There is a danger that unless Public Health England, (together with the NHSCB) is specifically tasked with this, homeless people’s needs will be overlooked by commissioning consortia. We think there is also an important opportunity for Public Health England to take on the direct commissioning of public health preventative programmes such as screening for infections which have proved difficult to commission through other routes. The 2010 Audit Commission Report on health inequalities stated that the “2003 health inequalities strategy lacked effective mechanisms to drive delivery against the target.” We are concerned that without specific drivers to ensure change this new strategy may also fail to deliver.

Emphasis on prevention

We welcome the emphasis on prevention within the White Paper. Sadly there is insufficient emphasis on primary or secondary prevention of disease in homeless people and care is too often characterised by crisis management. Prevention efforts need to be tailored to homeless populations if inequalities in mortality are to be addressed. We agree that adapting people’s environment to make healthy choices easier is central to public health and not that this is particularly true for homeless people. Provision of a safe and secure environment is a pre-requisite to more healthy lives. More widely we believe that a long-term increase in the provision of secure, affordable housing for rent must be a central part of any effort to eliminate homelessness.

Transitions between key stages of life

We note that the risk of becoming homeless is highest following key transitions for example transitions from being a child in care to independent adult living, between being employed and unemployed, between being a prisoner and being released are all highly vulnerable stages at which support is needed to prevent homelessness. The White paper should recognise these as opportunities for intervention.

Response to specific consultation questions

a. Role of GPs and GP practices in public health - Are there additional ways in which we can ensure that GPs and GP practices will continue to play a key role in areas for which Public Health England will take responsibility?

We believe that specialist GPs should take a leading role in multidisciplinary teams to address the health needs of the homeless. In order to achieve successful outcomes in highly mobile populations such innovative services will need to cross traditional boundaries and will require specialist commissioning input.

Public health evidence

b. What are the best opportunities to develop and enhance the availability, accessibility and utility of public health information and intelligence?

An important aim of public health information and intelligence is to monitor progress towards the goal of improving the health of the poorest fastest. Currently homeless people are largely invisible within routine public health information sources. This needs to be rectified. A quick win would be to analyse health service data using “No fixed abode” and registration with specialist homeless practices as a marker of homelessness. Although this provides an underestimate of the problem it can nevertheless provide a routine mechanism for monitoring progress. Linkage of existing data sources could allow more accurate intelligence to be collected on the health of the homeless and other marginalised populations. Public Health England should work with the proposed NIHR School of Public Health to establish mechanisms for measuring the outcomes of initiatives to improve the health of the homeless and to “normalise” these measures into routine use.

c. How can Public Health England address current gaps such as using the insights of behavioural science, tackling the wider determinants of health, achieving cost effectiveness and tackling inequalities?

We note that the NICE Centre for Public Health Excellence has a well established mechanism and track record in ensuring that these forms of evidence are considered and suggest that their work should continue and provide a key part of the evidence base driving the work of Public Health England. They are already developing guidance for tuberculosis control in hard to reach populations and should be commissioned to conduct further work on addressing the wider health needs of homeless and multiply disadvantaged populations.

d. What can wider partners nationally and locally contribute to improving the use of evidence in public health?

The proposed NIHR School for Public Health should encompass research that can bring together relevant multi-sector service and academic partners to investigate interventions that can address the health of the homeless and other severely disadvantaged populations.

Appendix two

The NHS outcomes framework 2011/12

This document has an emphasis on inequalities – but measured at a geographical level. This means that many homeless people may be excluded from consideration because their outcomes are not recorded.

www.dh.gov.uk/en/publicationsandstatistics/index.htm

Homeless people are often at the extremes of multiple disadvantage and their experience is of relevance to the following domains: -

Domain	Overarching Indicators	Improvement areas
<p>1. Preventing people from dying prematurely</p> <p>Homeless people have an average age of death of 40.2 and are twice as likely to die before the age of 75 compared to housed people</p>	<p>1a. Mortality from causes considered amenable to healthcare – a specifically targeted and coordinated primary healthcare response is necessary to make health care more accessible to homeless people.</p>	<p>Reducing premature mortality from the major causes of death. Homeless people have increased mortality resulting from cardiovascular respiratory and liver disease and tend to present late with Cancer with resulting increased mortality premature death and in serious mental illness also likely to be over-represented amongst homeless people</p> <p>Reducing deaths in babies and young children. These indices will be raised by the extremes of poverty and deprivation experienced by homeless families</p>
<p>2. Enhancing quality of life for people with long term conditions</p>	<p>2. Health related quality of life for people with long term conditions Drug and alcohol related conditions can be particularly problematic for homeless people and are identified by NICE standards as meriting particular attention</p>	<p>2.2 Employment of people with long term conditions and 2.5 with serious mental illness- this is particularly problematic for homeless people.</p> <p>Reduced time spent in hospital by people with long term conditions 2.31 unplanned admissions for chronic ambulatory care sensitive conditions and 2.311 unplanned hospitalisation for diabetes, asthma and epilepsy in under 19s. Lack of family support and chaotic lifestyles for homeless adults and young people make hospital admission more likely</p>
<p>3. Helping people to recover from episodes of ill health or following injury</p>	<p>3.a Emergency admissions for conditions that should not usually require hospital admission – suggest a particular role for close support from primary care teams for homeless people- more expensive than standard care, but cheaper than admission</p> <p>3.b Emergency re-admissions within 28 days of discharge from hospital. Rates are particularly high amongst homeless people and suggest a role for enhanced community support and treatment for homeless people (respite model)</p>	<p>3.2 Emergency admissions for children with LRTI's. Particularly likely amongst homeless children in temporary and/or overcrowded accommodation-suggests a role for enhanced support and health surveillance for this group</p>
<p>4. Ensuring that people have a positive experience of care</p>	<p>4.a Patient experience of primary care Access to GP services and dental services can be particularly difficult for homeless people and often requires services offering enhanced access – see standards</p> <p>4.b Patient experience of secondary care</p>	<p>Homeless people commonly report poor experiences from health care providers, specific surveys of their experiences in primary and secondary care should improve services approach to homeless people</p>
<p>5. Treating and caring for people in a safe environment and protecting them from avoidable harm</p>		<p>Homeless people by definition lack a safe home environment.</p>



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London Pathway is an independent charity formed to champion improvements in healthcare for homeless people, and improvements in the health of homeless people. London Pathway is pleased to be publishing this first set of standards for health services for homeless people. Setting clear standards should play an important part in improving health services for homeless people, but only if organisations and individuals working with homeless people feel able to implement them.

If you would like to find out more about London Pathway, about how we can help you to implement these standards, or make a donation to help us expand our work, please

visit www.londonpathway.org.uk

