Homeless and Inclusion Health standards for commissioners and service providers

FACULTY
FOR HOMELESS AND
INCLUSION HEALTH

Version 3.0 Revised February 2018

This is the third edition of the Faculty Standards. The first edition published in May 2011 considered healthcare for homeless people. The second edition published in September 2013 with the support of the National Inclusion Health Board included vulnerable migrants, Gypsies and Travellers and sex workers as well as homeless people. This third edition incorporates the latest evidence, and a full revision of the Standards.

Standards for commissioners and service providers
Version 3.0
Revised February 2018

Editor: Dr Nigel Hewett OBE FRCGP
Secretary to the Faculty for Homeless and Inclusion Health

With warm thanks to all those members of this Faculty, service users and professionals, who contributed so generously of their time and expertise to develop earlier versions and this revised edition. We would particularly like to acknowledge the following contributors to this edition:

Rachel Bingham
Angela Burnett
Stan Burridge
Martin Burrows
Liz Carney
Elizabeth Clowes
Sam Dorney-Smith
Janine Doughty
Jenny Drife
Suzanne Elliot
Anna Hiley
Briony Hudson
Sara Ketteley
Zoe Matthews
Pippa Medcalf
Clare Reeder
Caroline Shulman
Phil Timms
Barney Wells
Kenneth Wilson

The Faculty for Homeless and Inclusion Health

The Faculty is an inclusive membership organisation for people involved in healthcare for excluded groups. Membership is open to nurses, doctors, allied medical professionals, social workers, public health experts, health advocates and support workers, commissioners, researchers and people with a lived experience of exclusion.

Our aim is to improve the quality of healthcare for homeless people and other excluded groups. We do this by setting standards and supporting services in which 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. The Faculty is hosted by Pathway.

Pathway

Pathway is a registered charity, working to transform the quality of healthcare for homeless people and other socially excluded groups. Pathway is delighted to publish this revised set of Standards for Homeless and Inclusion Health on behalf of the Faculty for Homeless and Inclusion Health.

For more information about Pathway visit **www.pathway.org.uk**
Pathway, 5th Floor East, 250 Euston Road, London, NW1 2PG
Charity number: 1138741 Company number: 7210798

Contents

A call to action

Clinicians have come together to make a landmark statement about how we should respond to the Social Determinants of Health. In May 2017, the Academy of Medical Royal Colleges and the Faculty for Homeless and Inclusion Health published this Joint Position Statement:

Academy of
Medical Royal
Colleges

> ***“Inclusion health is a research, service, and policy agenda that aims to redress extreme health and social inequities among the most vulnerable and marginalised in a community.”***
>
> ***“To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. We call this proportionate universalism.”***

Inclusion Health is a universal concept but responds to local needs. The Academy of Medical Royal Colleges (the Academy) and the Faculty for Homeless and Inclusion Health are committed to high-quality care for all who use the NHS. Those who are living on the margins of society are too often poorly served. We believe that care must be tailored to reflect the particular needs of each patient, with clinicians addressing the patients’ total health, care and social needs.

There is a growing understanding of the impact of health inequalities on patients and healthcare providers. Whilst many people experiencing deprivation will face the health impact of inequality, this impact is particularly acute for the most marginalised. People in this situation may include homeless people, vulnerable migrants, sex workers, Gypsies and Travellers and those in contact with the criminal justice system.

The Academy and the Faculty of Homeless and Inclusion Health are committed to:

- Promoting ‘Proportionate Universalism’ – health resource distribution that favours the disadvantaged and actively reverses the ‘inverse care law’
- Meeting the health needs of excluded groups with respect, dignity, and compassion
- Ensuring prompt access to emergency care for all
- Offering GP registration to all who need healthcare
- Addressing cost recovery only after the patient receives urgent treatment
- Integrated care that considers patients’ physical, psychological and social care needs, with complexity managed by individual care coordination supported by a multi-disciplinary team
- Empowering patients to make decisions about their health, and involving patients in the design and delivery of care
- Improving awareness that healthcare alone cannot transform health inequalities. It requires societal change, reducing poverty and inequality to tackle the root causes of homelessness and multiple disadvantage
- A recognition that all clinicians must be involved in helping patients to improve their health, not just by medical treatment but through advocacy, inter-professional working and engagement with Public Health.
- National standards for NHS recording of key data to improve future planning of care, for example housing status and Gypsy and Traveller ethnicity
- Informing equality and equity in commissioning through ensuring data about the health of excluded people is gathered and included in Joint Strategic Needs Assessments
- Improving medical and nursing education so that healthcare professionals are equipped with the skills and confidence to address health inequalities and care for vulnerable patients with complex health and social needs.

Summary

The first set of Standards were published in 2011 and focused on healthcare for homeless people. In 2013 the Faculty for Homeless and Inclusion Health was established, and revised Standards were published, with an extended remit to include Gypsies and Travellers, vulnerable migrants and sex workers, as well as homeless people.

This is the third edition of of the Standards for Commissioners and Service Providers. It has been written by a collaboration of professionals from a variety of disciplines in consultation with people with a personal experience of health inequalities. We do not consider the standards presented here to be either completely definitive nor 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 minimum standards for planning, commissioning and providing healthcare for homeless people and other multiply excluded groups. The Faculty challenges all parties to work to these standards and to work with us to revise and improve them.

Our primary purpose is to re-affirm the fundamental rights of all 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 and other expressions of social exclusion are associated with extremely high healthcare costs coupled with appalling outcomes – we must be able to do better than this.

The introduction provides a background understanding of the social determinants of health, the changing NHS context and the values base for responding to the needs of particular excluded groups.

We then present generic standards for all services, followed by specific standard sets addressing a wide range of clinical settings and considering specific excluded groups.
The Faculty for Homeless and Inclusion Health offers evaluation of services against these standards, for any member organisation that requests it.

Introduction

At the heart of any service will be the encounter or consultation between a service user and a care giver. We recognise the central importance of nurturing and sustaining this relationship in order to provide effective care. For many disadvantaged groups, clinical encounters and contact with service providers are still too often characterised by suspicion, indifference and occasionally, hostility, rather than dignity and respect.

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.

Background – national context

"Inclusion Health is a research, service, and policy agenda that aims to prevent and redress health and social inequities among the most vulnerable and marginalised in a community."[1]

Health equity goes beyond inequality to embrace the ideal of social justice. In the words of Michael Marmot's World Health Organisation Commission on Social Determinants of Health "where systematic differences in health are judged to be avoidable by reasonable action they are, quite simply, unfair. It is this that we label health inequity. Putting right these inequities – the huge and remediable differences in health between and within countries – is a matter of social justice".[2]

Significant progress was made in the early 2000's to improve the social gradient in life expectancy[3] across the population. However, progress has stalled since then. Health inequalities persist, with the morbidity slope becoming a cliff edge of hugely increased indices of ill health for people sleeping rough and people excluded from society.[4]

The impact of austerity is becoming increasingly apparent, with social care provision at the point of collapse and huge strains on the NHS. Inclusion Health populations reveal the gaps in provision between fragmented services defending siloed and dwindling budgets. They reveal care that is too often characterised by crisis management at multiple disconnected points of episodic intervention, so that excluded people end up in the most expensive parts of the system – hospitals and prisons.[5]

Socially excluded groups are often invisible in national data sets. This may be in part because of the impact of transient lifestyles or the complexity of their problems. There are also few questions to help identify them in national health surveys. There are limited definitive statistics on access to healthcare for socially excluded people, but the literature indicates that points of access and service usage vary according to group, and the level and complexity of need.[6]

Many socially excluded people have low health aspirations, poor expectations of services and get little opportunity to shape their care.[5] There is a growing awareness of hidden costs to the NHS – the annual cost of the failure to address health inequalities to the NHS is estimated by the Institute of Health Equity to be £5.5 billion.

The 2010 Marmot Review 'Fair Society-Healthy Lives' states: "To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. We call this proportionate universalism."[7] Closing the gap in health inequalities requires outcomes for the most disadvantaged to improve faster than the most advantaged.

The Health and Social Care Act 2012 introduced, for the first time, statutory duties on NHS commissioning organisations to have regard to the need to reduce health inequalities in access to and outcomes achieved by services, and to integrate services where this will reduce inequalities. The National Inclusion Health Board, together with the RCGP produced commissioning guidance, based on this duty.[8] However, organisations struggling with austerity measures may overlook this duty, and it is not clear how they may be held to account.

Health professionals are increasingly aware of their responsibility for health equity, and all the professional bodies have collaborated with the Institute for Health Equity to describe how their members can contribute to challenging inequality.[9]

In 2014 the NHS came together to produce the Five Year Forward View[10] – a shared ambition for the future. Sustainability and Transformation Plans are intended to be the method of achieving these ambitions. "Place based planning" appears intended to replace competition with integration and collaboration. The direction of travel appears to be towards "accountable care organisations", in which the entire health budget for a defined population is managed by one organisation. But the 2012 legislation has not been repealed. Leaders of NHS providers, for instance, find themselves under significant pressure from regulators to improve organisational performance. This means focusing primarily on their own services and finances rather than working with others for the greater good of the local population. In this context, incentives for NHS providers to work together can be weak. The very real danger is that organisations take a 'fortress mentality' instead, acting to secure their own future regardless of the impact on others. The dissonance between place-based planning and the continuing focus on organisational performance in the NHS is therefore stark.[11]

The vision of Public Health England (PHE) expressed through the Public Health Outcomes Framework is “to improve the health of the poorest fastest”. The Faculty calls on public health professionals to ensure that the needs of excluded groups are included in Joint Strategic Needs Assessments (JSNA’s) and championed through Health and Wellbeing Boards. The Scottish Public Health Network provides an excellent example of active engagement of public health in tackling homelessness.[12]

Public Health England published its Strategic Plan in 2016. The plan sets out how the organisation intends to protect and improve the public’s health and reduce inequalities over the next 4 years. The Plan builds on the Shared Delivery Plan, the Five Year Forward View, and From Evidence into Action.[13] But Faculty vision of Directors of Public Health being the local champions of Inclusion Health has yet to be realised. The shift of public health teams into the Local Authority, along with budgets for drug and alcohol treatment and sexual and reproductive health seems to have largely resulted in a narrow focus on the housed population.

The Care Act 2014 includes a requirement to assess the needs of anyone who appears in need of care or support, with Safeguarding Adult Boards to protect adults from neglect and abuse. This may provide an opportunity to improve support for some vulnerable homeless people, but doubt remains that this really means a new deal for homeless people because needs still need to arise from a physical or mental health issue.[14]

The London Homeless Health Programme is part of the Healthy London Partnership and has developed commissioning guidance for London, including 10 commitments to improve health outcomes for people experiencing homelessness.[15]

Marginalised groups reveal fractures in planning of health and care services. An excellent example is the paucity of services to identify and treat severe alcohol dependency and particularly alcohol related brain damage. This is a common feature of long term homelessness but appropriate services are rare, despite clear guidance from a collaboration of medical Royal Colleges.[16]

In addition, austerity measures are having a devastating impact. Cuts to local authority funding are bringing the social care system to the brink of collapse in many areas, while flat line funding for the NHS against rising demand deprives the system of any financial flexibility to innovate. There is great concern from Faculty members that services for the most vulnerable are at particular risk.

Health of people experiencing homelessness

The annual cost of unscheduled care for homeless patients is eight times that of the housed population[17] and homeless patients are overrepresented amongst frequent attenders in A&E. High costs are associated with multi-morbidity, but can mask the fact that many homeless people have poor access to healthcare, with less resource allocation than they need. Despite this expenditure, the average age of death for homeless patients is just 43 for women and 47 years for men[19] and associated with the reduced quality of life caused by multi-morbidity.[18] Standardised mortality ratios for excluded groups, including homeless people are around 10 times that of the general population.[20]

Prevalence of multi-morbidity increases with deprivation and has an onset 10-15 years earlier in deprived groups than in the most affluent.[21] Homelessness is an independent risk factor for premature mortality[22] and is associated with extremes of deprivation and multi-morbidity.

There is a growing understanding, supported by international research,[23] that chronic homelessness is an associated 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. Tri-morbidity often has its roots in histories of complex trauma, including high levels of child neglect and abuse, that impact on developmental trajectories and mental health. The Five Year Forward View for Mental Health states that people of all ages who have experienced traumatic events, poor housing or homelessness, or who have multiple needs such as a learning disability or autism are at higher risk of mental illness.[24]

Oral health problems are very common amongst homeless populations. 32% of people who are homeless report dental pain.[25] This population have a greater number of missing and decayed teeth and fewer filled teeth. Almost half feel ashamed or embarrassed about their teeth. Like all successful services for people experiencing homelessness, oral health services need to be informal, adapt to patient needs and accommodate chaotic lives. The Scottish oral health improvement homelessness programme Smile4Life[26] recommends a 3-tiered approach to providing dental care for the homeless: emergency dental services, one off single-item treatments without a full course of treatment or the option to receive routine dental care.

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 dependence.[27]

There is increasing concern about an escalation in enforcement measures targeting people experiencing homelessness. Arrests, anti-social behaviour orders and assertive street outreach combine with benefit sanctions to displace homeless people without evidence that this improves outcomes.[28] The costs of failing to address single homelessness in England and Wales have been estimated by Crisis as £1.38 billion annually.[29] Housing First is emerging as a preferred approach, particularly for those with long term and multiple needs, and integrated, multidisciplinary care as the most effective approach.[1]

Health of Gypsies and Travellers

Who are Gypsies and Travellers?

- 'Gypsies and Travellers' is a commonly used catch all term that includes people from a variety of groups, all of whom were – or are – nomadic. These include: Romany (English/Welsh) Gypsies (the majority group in England and Wales (E and W), Scottish Gypsies/Travellers, Travellers of Irish heritage (Irish Travellers), Roma, Fairground and Show people, Circus people, New Travellers, and Bargee and water craft/canal boat Travellers.

- Today, although nomadism/'travelling' is an important part of Gypsy and Traveller people's culture and history, the word 'Gypsy' or 'Traveller' is more accurately a description of ethnic identity and distinct culture(s), e.g. social organisation, value system, shared history, language, traditions etc, rather than a description of actual daily activities or an identifier of nationality. An estimated two-thirds of Gypsies and Travellers in the UK today live among the 'settled community' in permanent housing, with a further significant portion living on permanent sites, either privately or publicly provided. Others, due to national shortages of sites, live on unauthorised sites (as of 2011, approx. 20% of Gypsy/Traveller caravans are stationed 'unlawfully' rendering the occupants technically homeless)[47.] The nomadic aspect of their culture is expressed in periods of 'travelling' from their home base to attend family events and annual fairs, rather than being a constant feature. Settlement in housing is often due to an inadequate supply of Traveller sites rather than preference[33].

- Gypsies and Irish Travellers are recognised ethnic groups under UK law, and were included as such in the 2011 National Census for the first time.

- Under the Race Relations Act, Romany Gypsies and Irish Travellers are recognised as minority ethnic groups, and should be afforded protection in law against discrimination.

The following points provide important context to issues of Gypsy and Traveller health

- Gypsies and Travellers have significantly poorer health outcomes, compared with the general population of England, and with other English-speaking ethnic minorities and are frequently subject to racial abuse and discrimination.[32]

- All Gypsies and Travellers have a legal right to access NHS and social care services whether they are nomadic or living in permanent settlements.

- There is a serious under provision of official trailer sites for Gypsies and Travellers across the country and so community members may find themselves living in irregular locations, for instance, under motorways or next to sewage works. Consequently they face health hazards that uncommon in the general population for example, lack of sewage disposal and limited access to water.[32]

- Many Gypsies and Travellers are not literate, therefore information concerning treatment and appointments may need to be explained. Ethnic monitoring based on self-categorisation or self-disclosure may well result in under-reporting, with many Gypsies and Travellers reluctant to disclose their identity due to fears of prejudice, and a deeply engrained mistrust of authority.

A 2012 report by the Ministerial Working Group on tackling inequalities experienced by Gypsies and Travellers[30] confirmed that they have the lowest life expectancy of any ethnic group in the UK and continue to experience high infant mortality rates (18% of Gypsy and Traveller women have experienced the death of a child)[31], high maternal mortality rates, low child immunisation levels (particularly where specialist Traveller Health Visitors are not available), mental health issues including suicide, substance misuse issues and diabetes; as well as high rates of heart disease, premature morbidity and mortality.[30,32,33]

In 2004, life expectancy was estimated at around 12 years less for Gypsy and Traveller women and 10 years less for men than in other populations.[31] The 2005 Leeds Racial Equality Council Baseline Census[34] found a greater disparity in life expectancy, with Gypsies and Travellers average life expectancy being 50 years, compared to 78 years among the general population of Leeds. Only 2.3% of Gypsies and Travellers were aged over 60 years. More recent Health Needs Assessments (e.g. Bedfordshire NHS Trust,[35] NHS West Sussex[36] in 2010) suggest little improvement. As well as lower life expectancy, Irish Travellers have consistently lower healthy life expectancy and disability-free life expectancy than the general population.[33] Even after controlling for socio-economic status, Gypsies and Travellers, including those in housing, have poorer health outcomes and more self-reported symptoms of ill-health than both other UK resident English-speaking ethnic minority groups and economically disadvantaged white UK residents.[33,37]

Travellers experience worse health and have significant health needs, yet are less likely to receive effective, continuous healthcare.[33] Identified barriers to healthcare access[33,38] include inequalities in registration with GPs (discrimination, mismatch in expectations, ‘expensive patients’, reluctance of GPs to visit sites), poor literacy, and lack of ‘cultural awareness/competence’ amongst service providers. There is significant evidence of missed opportunities for preventive healthcare, particularly among Gypsy and Traveller men, and for effective treatment for pre-existing conditions,[37,39] contributing to high rates of premature mortality.

Travellers have low expectations about health, accepting long-term illness and ill-health as a normal part of life, an inevitable consequence of adverse social experiences and perceptions of hostility and racism.[40,41] Just under half of Gypsies/Travellers in the East of England[42] perceive their own health to be good or very good compared to 77% of the general population.

For Gypsies and Travellers a house may not be the same as a home. In fact, for this group, living in a house has been associated with poorer health, long-term illness and high rates of anxiety and depression.[37] Despite being a recognised ethnic group, official statistical data are not collected on the health needs of Gypsies and Travellers, with a dearth of reliable national and local data, alongside the general lack of awareness of Gypsy and Traveller health issues in local health services.[43] Most data are based on health studies.

A recent simple cost-benefit analysis[44] based on a current experience of Gypsy and Traveller families shows that an improved health and social care pathway not only offers clear benefits to Gypsy and Traveller people themselves, but delivers greatly reduced costs to health and social care services. Up-front investment, for example in appropriate social work engagement, or in GP outreach work, can pay for itself many times over in the longer term.

Oral health

Poor dental health is also a problem for this population. Travellers have a high level of unmet need, low dental registration and very little use of preventive dental services, with more disadvantage being experienced by Travellers on unauthorised and transit sites.[45] There is anecdotal evidence[46] that Gypsies and Travellers delay access to medical and dental health services, which leads them to suffer significant oral and dental health problems that may result in hospital intervention. There is some suggestion from local Gypsy and Traveller Accommodation Assessments and casework that access to dental care and oral health for Gypsies and Travellers has worsened. In a Friends, Families and Travellers (FFT) delivered 'Collaborative Programme to Improve the Oral Health of the Gypsy and Travelling Communities in Sussex',[46] determinants of poor oral health were identified as: lack of accessible, culturally appropriate information; distrust and negative attitudes among the population and among professionals; a historical neglect of dental health services in reaching out to the Travelling community; raised levels of fear and anxiety about visiting the dentist; and challenges associated with being a transient population.

Examples of guidance for organisations working with Gypsy and Traveller communities include: the Republic of Ireland Pavee Point Primary Health Care for Travellers Project,[47] the Save the Children Early Years Outreach Practice,[48] Friends, Families and Travellers guidance for health practitioners,[49] and the DH guidance on developing cultural competence of health professionals working with Gypsy and Traveller communities.[50] Examples of practice for improving immunisation uptake among underserved groups across the EU (with specific examples for the Roma population) can be found on the website of an European Centre for Disease Prevention and Control meeting on immunisation in underserved populations.[51] Additional good practice examples can be found in the 2008 Race Equality Foundation briefing paper.[32]

Recommendations on improving access to healthcare for Gypsies and Travellers are well articulated by groups such as Friends, Families and Travellers with LeedsGate,[52] who have also produced guidance on the inclusion of Gypsy Traveller health needs in JSNA's.[53] Friends, Families and Travellers is also a member of the Department of Health sponsored Voluntary Community and Social Enterprise Health and Well-being Alliance, promoting inclusion health.

Health of vulnerable migrants

People migrate to the UK for diverse reasons, which makes migrants a very heterogeneous group. Vulnerable migrants include people who are seeking asylum, refugees, those with humanitarian protection and their families, separated children, Roma, Gypsies and Travellers, people who are undocumented, refused asylum seekers and those who are trafficked for various forms of forced labour, sexual exploitation and modern slavery. The term vulnerable is used to describe those who have been adversely affected by circumstances leading to or resulting from migration and refers to their circumstances rather than an attribute of people themselves.[54] New migrants from these different groups frequently face adversity before, during and after arrival in the UK, resulting in complex service needs.[55]

Health problems of vulnerable migrants are frequently related to destitution and lack of access to services, rather than to complex or long standing ill health.[56,57] Expert consensus asserts that European-wide failure to ensure access to healthcare for vulnerable migrants is contrary to existing treaty agreements and human rights standards and is not cost effective.[58]

Despite concerns voiced by the Faculty the “Overseas visitors NHS cost recovery programme” is now a legal obligation on Trusts. Although immediately necessary and urgent treatment should always be provided, concerns remain that vulnerable migrants may be dissuaded from accessing care because they fear charges or coming to the attention of immigration authorities. This concern is well founded: sharing of NHS data by NHS Digital with the Home Office, for the expressed purpose of finding undocumented migrants, is morally wrong, and opposed by this Faculty. Information given to healthcare providers by those seeking healthcare should be treated under principles of normal medical confidentiality (in which information is only shared where there is an immediate, identifiable risk of harm). To do otherwise is a conflict of interests with the role of healthcare provider.

Currently certain health services are currently free for everyone: Primary Care, Accident and Emergency, services for sexually transmitted infections including HIV, TB treatment and compulsory psychiatric treatment. Migrants from the EU, refugees and asylum seekers with an active claim have full access to the NHS. Some migrants (for example, refused asylum seekers not supported by the Home Office or local authority and undocumented migrants), are liable to be charged for secondary care. Migrants often face barriers when they try to access health services, as NHS entitlement rules relating to immigration status are complex and have given rise to much confusion. Everyone must be given ‘immediately necessary’ and ‘urgent’ hospital treatment regardless of their immigration status and ability to pay; a charge may be levied later if not qualifying for free care. New exemptions from charges have been recently introduced in respect of services provided to migrants as a consequence of torture, female genital mutilation, domestic violence and sexual violence. Children looked after by a local authority, including those unaccompanied, are also exempt.[59]

Refugees and asylum seekers may have high levels of psychological ill-health, which is not necessarily due solely to their experiences of conflict and related traumatic events, but is also likely to reflect the socio-political conditions in host countries that create discrimination and marginalisation. Improving these conditions would improve mental health outcomes.

Immigration detainees have been found to have high levels of post-traumatic stress that are very closely associated with their detention, and which frequently lead to anxiety, depression, self-harm, suicidal ideation and suicide attempts. Immigration removal centres are very challenging settings in which to provide mental health and wellbeing services. The mental wellbeing of people detained in an immigration removal centre is challenged by detention itself, and the risk to wellbeing increases with the length of detention.[60]

Survivors of torture and trafficking have often experienced extreme circumstances where they are exposed to uncontrollable and unpredictable events, which can result in severe and longer-term post-trauma disorders.[61] Migrants' high risk of homelessness and destitution creates circumstances that further exacerbate their already fragile mental health.

Oral health

Migrants are entitled to NHS dental treatment. What is often much more problematical, and difficult to ascertain, is if they are eligible to free or subsidised NHS treatment via the exemptions detailed on the PR form (this is the blue NHS charges / acceptance of treatment form used by NHS dentists and patients to declare that they want NHS dental treatment, and that unless they are in one of the listed categories then they will have to pay standard NHS dental fees).

Often English is not a language spoken, or spoken well, by migrants. This can cause problems with consent (explaining the options available), obtaining an adequate and relevant medical history, and ascertaining payment status or explaining payment options. In particular, when dealing with family or structured groups where language barriers exist between the group and the healthcare providers, an independent interpreter should be considered the gold standard, as the interpreting members of the group may have a different agenda to that of the patient, particularly if payment or other such issues are concerned. Commissioners should give specific guidance to service providers of what to do when presented with a vulnerable migrant with for example pain or swelling, but whose payment status cannot be ascertained at that particular point in time. Clinicians will need to feel supported by their institutions in providing care to vulnerable patients presenting in need of healthcare.

Commissioning guidance for vulnerable migrants has been developed in collaboration with MIND and Faculty members,[62] and the Department of Health has commissioned detailed guidance on including vulnerable migrants in JSNA's.[63]

Health of sex workers[5,64]

Sex workers are likely to experience poor health because of the risks associated with their work. Female sex workers in London suffer from a mortality rate that is 12 times the national average. Up to 95% of female sex workers are problematic drug users. 68% of female sex workers meet the criteria for post-traumatic stress disorder, in the same range as victims of torture and combat veterans undergoing treatment. Street sex workers have significantly higher rates of health service use compared to the general population, reporting visiting the GP 8.5 times (compared to 4 times for the general population), A&E 2.5 times, an STI clinic 2.7 times, an inpatient clinic 2 times and an outpatient clinic 4.3 times in the previous year.

Despite frequent use of health services, a comparatively low percentage have had routine health checks such as cervical screening, or attend antenatal checks when pregnant. Psychological and institutional barriers to accessing healthcare include: fear of criminalisation, institutional factors (e.g. opening hours, location), stigmatisation and discrimination.

In a sample of 207 trafficked women, 58% reported having dental problems described as “tooth pain”.[65] Many trafficked sex-workers in this study had experienced physical violence, 8% had experienced direct assault to the face, including punches, slamming into a wall or being hit with hard objects including bats. Such trauma will almost certainly have implications for the oral health. If physical violence or modern slavery is suspected, then adult safeguarding protocols should be followed by the dental practitioner. There is very little literature available to describe the oral health needs of the sex worker population and further research is recommended in order to develop services to meet the needs of this vulnerable population.

Standards for integrated care to address health inequity

Addressing health inequity 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 particularly in childhood to tackle the root causes of homelessness and multiple disadvantage. By highlighting the direct costs to the healthcare system resulting from multiple disadvantages we hope to inform and support the drive to address inequality in our society.

Shared standards will improve care

Integrated care is central to overcoming the problem of fragmented and uncoordinated services.[66] People with a lived experience of exclusion should be considered Experts by Experience (EBE's) and their involvement in planning and delivery of services is a core value of the Faculty, increasingly recognised by NHS England (NHSE),[67,68,69] and exemplified by Pathway's EBE involvement handbook.[70] A shared integrated care plan/formulation with individualised goals and strengths will be a key tool. Attention to the needs of excluded communities along with understanding of their culture, integration of services at the point of delivery, and care providers working towards shared outcomes, can result in better health outcomes for individuals, their families and communities, and reduced costs.

For example, Professor McCormick's paper highlights the potential for developing a new model of healthcare delivery for homeless patients, based on the highly successful service provided in Boston USA.[17] This model is of a fully integrated primary and secondary healthcare service including specialist primary care, out-reach services, intermediate care beds and in-reach services to acute beds.

The latest international evidence is summarised in a Lancet paper called 'What works in Inclusion Health: overview of effective interventions for marginalised and excluded populations'.[1] The key findings are: that integrated multi-component care – summarised as individual care coordination supported by a multi-disciplinary team – is the best healthcare response for excluded groups, involvement of experts by experience is vital, and ultimately the solution is eradicating child poverty.

Improving care requires that education in Inclusion Health should be included in all undergraduate clinical courses, and in postgraduate specialist training for all clinicians. Promising examples include the Royal College of Physicians online introduction to the social determinants of health,[71] and the Faculty MsC Inclusion Health 'module, with University College London's Institute of Epidemiology and Health Care.[72]

Health inequalities duties

The Health and Social Care Act 2012 imposed a number of health inequalities duties that are of particular relevance to service provision for marginalised groups. These duties apply to the Secretary of State for Health, NHS England and Clinical Commissioning Groups.

Secretary of State (SofS)

“In exercising functions in relation to the health service, the Secretary of State must have regard to the need to reduce inequalities between the people of England with respect to the benefits that they can obtain from the health service”. (Section 1C of the NHS Act 2006, as amended by the 2012 Act). The phrase “health service” incorporates both the NHS and public health. This duty will also impact on the Department of Health in terms of its role to establish NHS and public health systems.

NHS England (NHSE)

The Board must have regard to the need to reduce inequalities in access to health services and outcomes achieved by health services (Section 13G).

Clinical Commissioning Groups (CCGs)

CCGs must also have regard to the need to reduce health inequalities in access to and the outcomes achieved by services, (Section 14T) and to provide services in an integrated way where this will reduce health inequalities in access and outcomes (Section 14Z1). This service integration is not confined to primary and secondary healthcare, but includes social care and health related services.

“Health related services” are broadly defined and can include services related to the wider determinants of health such as housing, fuel poverty, debt, education, employment etc. The practical effect should be that services are integrated around the needs of the individual. There are equivalent integration-related duties for NHSE (Section 13N) and for Monitor (Section 62).

Planning

The Act requires NHSE (Section 13T) and CCGs (Section 14Z11) to include, in their business plan and commissioning plans respectively, an explanation of how each proposes to discharge their duties as to reducing inequalities.

Reporting

The SofS (Section 247D), NHSE (Section 13U) and CCGs (Section 14Z15) are required to include, in their respective annual reports, an assessment of how effectively they have discharged their duties as to reducing inequalities.

Assessment

The SofS, having considered NHSE's annual report, is required to make an assessment of how well the Board has discharged its duty as to reducing inequalities (Section13U). NHSE is required to undertake a similar annual assessment of how well CCGs have discharged their duty as to reducing inequalities (Section 14Z16).

Measurement of outcomes

Outcomes for excluded populations need to be an integral part of the NHS, Public Health Outcomes Framework (PHOF) and Adult Social Care Outcomes Framework (ASCOF) allowing measurement of the proposed indicators within homeless, vulnerable migrant, sex worker, and Gypsy and Traveller populations. This should start with ensuring that these groups can be identified and recorded by all NHS and Social Care computer systems to a shared typology.

Detailed clinical standards for Inclusion Health care in different specialties and situations

In this section we set out clinical standards for Inclusion Health services in general, and specific standards for a range of specialist services that should be accessible to excluded groups.

These standards will be regularly reviewed and we encourage suggestions for improvement. Coordinated service provision across primary and secondary care including mental health treatment is a requirement of these standards. Provision of good quality primary care, in the absence of integrated good quality secondary and mental healthcare 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 Inclusion Healthcare. The Faculty will offer, on request, evaluations against these standards for service providers who are members of the Faculty.

Clinical standards in any setting

Core values shared by Faculty members centre around valuing each individual, building a respectful and trusting relationship and working with their priorities to a position of hope.

> *“It is more important to know what sort of person has a disease than to know what sort of disease a person has”.*
> ***Hippocrates.***

> *“Those who have a ‘why’ to live, can bear with almost any ‘how’.”*
> ***Viktor E. Frankl.***

Section 1. Our values. Principles for clinical standards in Inclusion Healthcare

1.0 Continuity – a trusting and respectful relationship formed with a familiar clinician and team.

1.1 Ease of access also requires walk in provision, in-reach to hostels and street outreach to people sleeping rough – commonly described as “Street Medicine” and promoted by the Street Medicine Institute.[73]

1.2 Integrated, multi-disciplinary collaborative care is central to effective care because many homeless people present with multiple healthcare needs.

1.3 Person centred care with expert by experience involvement in planning and delivery.

1.4 Cultural competence and sensitivity.

1.5 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 all’,[74] this seeks to make shared decision making the norm; “No decision about me without me”.[75]

1.6 Where specialist services are provided they should act as a catalyst to improve care throughout the local health service.

1.7 Inclusion Health services should provide a bridge linking hospitals and community care through hospital in-reach services.

1.8 Inclusion Health services should work closely with public health departments particularly in relation to serious communicable diseases (e.g. TB or blood borne virus transmission).

1.9 Services should actively seek to offer treatment to vulnerable migrants and those with no recourse to public funds.

1.10 Homeless services should include the provision of “respite care” (now in over 50 Cities in North America and Europe) – community based residential medical facilities for homeless people with significant and complex healthcare problems. This could be achieved cost-effectively through joint working with local hostel providers and the voluntary sector. These services improve outcomes and reduce subsequent unscheduled hospital admissions.[76,77] Pathway has published standards for Medical Respite in England.[78]

All services meeting these standards should include the following auditable standards.

1.11 Regular involvement in, and where necessary leadership of, multi-agency planning for people sleeping rough.

1.12 Visible service user involvement in planning and evaluation of services.

1.13 Coordination of the healthcare of excluded people as they move between different organisations and settings (hostels/drop-ins, shelters for homeless families, Gypsy and Traveller sites etc.). This may be best achieved via a named liaison worker and supported by a shared integrated care plan/formulation emphasising individual goals and strengths.

1.14 Child and family services to be linked to homeless family hostels with children treated and recorded as individuals, not nameless adjuncts to the parent. Useful guidance for non-specialists on safeguarding vulnerable families is available at https://www.qni.org.uk/wp-content/uploads/2016/09/safeguarding_homeless_families.pdf

1.15 Coordinated healthcare in hospital settings – for homeless population – by collaboration with homeless ward rounds and attending multi-agency care planning meetings. For all excluded groups, informative and timely discharge summaries to primary care should be standard even when the patient self-discharges.

1.16 Plans for assertive outreach for non-engaged clients in each area; e.g. specialist clinicians with flexible hours, able to provide street outreach; specialist Health Worker/ Health Visitor for Travellers.

1.17 Using guidance on the Mental Capacity Act, Mental Health Act and Safeguarding Alerts for adults at risk of abuse, in assessing rough sleepers who refuse care. This guidance may also help in situations in which vulnerable people are not being offered care.[79]

1.18 Recording of housing status with regular review.

1.19 Recognition and support of the need to build an evidence base for what works for socially excluded groups. Participation in documenting, researching and publishing on the health hazards of exclusion, evaluations of service delivery models (including models of preventative healthcare), continuous monitoring of longer term outcomes, action research approaches to service development.

1.20 Education and involvement in undergraduate and postgraduate training of medical, nursing, dental, psychological therapy and social work students. Develop links with relevant professional bodies.

1.21 Promotion and encouragement of accessible provision of mental health, dental and podiatry care.

1.22 Promotion of Inclusion Healthcare as a viable and attractive career choice for staff.

Section 2. Specific standards for particular groups and settings

Standards for health services for migrant people

Standards for commissioners of services for vulnerable migrants have been developed by the Faculty in collaboration with Mind, and should be consulted for detailed guidance.[62] These Standards should apply to all vulnerable migrants, including undocumented migrants and especially victims of trafficking and slavery.

2.00 Appropriate skills. Health workers need to work flexibly and creatively with vulnerable migrants and have an awareness of the impact of immigration, torture, detention and the asylum determination process on mental health. Assessments should recognise natural psychological reactions to highly abnormal experiences and not over-medicalise what may be appropriate responses.

2.01 Gender and cultural sensitivity. For a comprehensive set of guidelines see Guidance for commissioning health services for vulnerable migrant women.[80] Culturally-competent staff should be available, as this promotes access and understanding of cultural nuances, alongside ongoing training of the whole workforce on cultural competencies and working with diverse and marginalised communities.

2.02 Protection and security measures are a priority when planning care for especially vulnerable migrant groups, such as survivors of trafficking and modern slavery, women and girls fleeing forced marriages and genital cutting.

2.03 Interpreting, advocacy and communication. Vulnerable migrants may need additional support in accessing services due to language difficulties, poverty, illiteracy, low confidence or lack of familiarity with the system. The use of informal interpreters, family members, friends and children should be avoided. Staff must be appropriately trained to be confident and competent in working with interpreters.

2.04 Literacy. Migrants (particularly older migrants, women, Roma, Gypsies and Travellers) may be illiterate in their first language, so DVD, podcasts and audio resources can convey health promotion messages. Social media and texting are useful ways of maintaining contact with mobile clients.

2.05 Peer mentor programmes may be particularly helpful in providing support and advocacy for migrant people.

2.06 GP registration. GPs may register anyone as an NHS patient, as long as they do not discriminate (see primary care guidance and training for receptionists above). However, sensitivity is required, as some patients will fear that registration will draw attention from the UK Border Agency or other official bodies. Doctors of the World have produced an excellent toolkit to help practices provide confidential and welcoming services for all their patients including refugees, asylum seekers and undocumented migrants.[81]

2.07 Collection of country of birth information is important in considering risks for particular health conditions.

2.08 Primary care practitioners play a vital role in early identification of infectious diseases; early identification of risk and diagnosis of infection can improve health outcome.[82] Services for homeless migrants should promote and facilitate screening and treatment, e.g. HIV, Hepatitis B, C and HIV, and where appropriate haemoglobin electrophoresis and full antenatal screening. The PHE online Migrant Health Guide (launched Jan 2011) provides both a checklist to extend the standard new patient check for migrant patients and country specific advice on infectious disease risks.[83]

2.09 Healthcare practitioners should ensure that migrants are offered full immunisation according to the UK schedule. PHE provides regularly updated guidance on vaccinations of individuals with uncertain or incomplete immunisation status.[84]

2.10 Services should offer access to the full range of primary healthcare 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.

2.11 Mental Health Services for vulnerable migrants should be provided according to the detailed specification published by Mind.[62] Stigma surrounding mental illness may be particularly marked in some migrant communities and may also inhibit some people from accessing services. Community based culturally appropriate health awareness programmes can reduce this stigma. Improving Access to Psychological Therapies (IAPT) services may not address the more complex long-term needs of vulnerable migrants and other options need to be available.

2.12 Migrants often come from countries with very different health and social care services to the UK and they may have no or poor experience of primary and mental health services. Whole population services which recognise migrants’ needs are more likely to reach them.

2.13 Liaison with voluntary sector organisations such as the Refugee Council can enhance support for vulnerable migrants.[85]

2.14 Documentation of evidence of torture or violence. Healthworkers may be requested to provide a medical report. Confine your report to areas on which you are qualified to give an opinion e.g. a person’s medical history and use of health services. Documentation in a medico-legal report of physical and psychological sequelae of torture requires specialist knowledge of the Istanbul Protocol.[86]

Standards for health services for sex workers

Sex workers are likely to intersect many of the groups identified within the Inclusion Health agenda and great care should be taken by health professionals to understand and address the multiple and complex health and social care issues that they are likely to present. Good healthcare services have greater potential for reducing the number of people in prostitution than criminal justice approaches.[87]

2.15 As with other excluded groups the attitude of staff can frequently discourage engagement with health services. Awareness training for A&E, primary care and clinical staff working within criminal justice settings should be widely available. This training can be accessed through numerous sex worker support services throughout the UK.
Contact www.uknswp.org for more information.

2.16 Specialist outreach services for sex workers are vital to improving access[87] and should include enhanced access to primary care and not be confined to sexual health and contraception. Depending upon local epidemiology, services should also create pathways into long-term condition treatments such as TB and respiratory health, mental health and specialist addiction services.

2.17 Criminal justice services can provide an excellent opportunity for engagement with healthcare if there is an appropriate non-judgemental attitude. Sex workers who are homeless and live chaotic lifestyles often have untreated conditions. When criminal justice services offer healthcare this can be a positive starting point at which to assess general health status, stabilise conditions and begin medication.

Standards for health services for gypsies and travellers

2.18 The Department of Health should issue a national ‘data change notice’ to include Gypsies, Roma and Travellers alongside the 16+1 other ethnic categories which are monitored by the NHS. This would bring the NHS in line with Gypsy and Traveller inclusion in the 2011 census.

2.19 ‘Gypsy or Traveller’ should be included as an ethnic category in national health surveys, such as the ONS General Lifestyle Survey.[88]

2.20 Services should be designed and commissioned in collaboration with communities, through inclusion in Health and Wellbeing Boards and consultation for Joint Strategic Needs Assessments.

2.21 Targeted preventative care. There is often a poor take-up of preventative healthcare by Gypsies and Travellers, particularly among men, with conditions usually well advanced before any type of healthcare is sought. Targeted services are needed to increase male engagement in preventative healthcare. Consider: fast tracking of Gypsies and Travellers to preventative services in recognition of high level of unmet need and health inequalities, peer/community health promotion workers.

2.22 Commissioning dedicated or specialist health workers. Research suggests that community members would welcome advice and care provided by trained/qualified community members, with trust in the individual being important for engagement.[89] Culturally appropriate educational materials and use of trusted community members as health advocates, including oral health (in line with work carried out with other BME communities) are anticipated to reduce negative health impacts of membership of Gypsy, Roma and Traveller communities. Support for initiatives that help Gypsies and Travellers to become health advocates, service providers and trainers within their own communities e.g. ITMB's Level 2 NOCN Health and Community Engagement Course,[90] LeedsGATE training. Friends, Families and Travellers has become a training centre for the RSPH level 2 training in Health Awareness.

2.23 Improve the cultural competence of health service staff, e.g. by providing Gypsy and Traveller community led training, including understanding the importance of kin-group responsibilities (e.g. family demands made by even quite distant relatives may be regarded as higher priority than professional expectations) and the impact this may have on care, attending appointments etc.

Standards for children and family services for excluded groups

2.24 There should be a local health strategy jointly with social services and housing departments, under the new public health remit of local authorities.

2.25 Operationally, child and family services should include: physical health, child mental health and social services, including child protection.

2.26 There should be clear care pathways between these services. Subsequent care requires evidence of follow up and not being lost when returning to the community (when they are most vulnerable and in need of services).

2.27 Measurement of outcomes across physical, developmental and psychosocial child domains.

Standards for primary care

2.28 **Services must be planned according to local and regional need. In some areas specialist services will be necessary. Where there are fewer excluded people, enhanced access to mainstream services may suffice, but the standards of care outlined should apply in every setting.**

Information is key – a unified electronic record accessible wherever the patient is seen (e.g. 'EMIS' or 'SystmOne'). All patients must be registered at first consultation. This should be full registration, unless the person is already registered with another primary care service, when temporary registration is acceptable. For those only entitled to emergency treatment from the NHS, an immediate and necessary registration should be completed. In this way, every patient is logged and costed and becomes visible to the NHS. Services which cannot register patients, such as nurse led community services, should have achieving GP registration for all their patients as a primary goal.

2.29 Quality of information recorded can be enhanced by shared protocols, such as the EMIS and SystmOne protocols developed by Pathway.

2.30 QOF (Quality and Outcomes Framework) standards. Locally designed Key Performance Indicators (KPI's) may be better suited to specialist Inclusion Health practices. KPI's should cover the following areas:

- Managing long term conditions to QOF standards.
- Pro-active management of selected patients with high needs by regular multi-agency meetings including 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 6 months period and when necessary those with Combined Homeless Information Network (CHAIN) or other rough sleeping record in the same period.
- All patients offered drop-in clinics with presenting problem addressed first, but offered health screening and access to treatment to include: physical health assessment, screening for dental/oral problems, blood borne viruses, smoking, drug and alcohol problems, TB 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 to include primary care based mental health treatment.
- QOF or KPI funding thresholds should reflect the challenges of working with excluded groups.

2.31 There should be routine liaison with and provision of medical support to street outreach teams and provision of continuing care for recently housed and socially excluded patients, with a focus on enabling access to mainstream services.

2.32 Services should collaborate with case tracking, contact tracing, community treatment and public health measures e.g. TB, HIV, Hepatitis C.

2.33 Concerted efforts need to be made to reach excluded groups – with specific approaches to improve coverage – in routine vaccination programmes.

2.34 Standards for GP receptionists in primary care

Registration with a GP practice is vital to ensure patients access primary care, and are referred on for secondary care as necessary. People experiencing homelessness are known to experience barriers to GP registration. A card detailing rights to registration is available from Groundswell.[91] In partnership with the London Healthy Partnership, Pathway has developed a training package and guidance for GP receptionists, which is available on the Pathway website.[92]

In summary, the guidance states that:

- Receptionists should be the patients' champion, ensuring that the most vulnerable patients in a practice's catchment area are able to access care.
- If a patient does not have ID this should not be a barrier to registration. Refusals of registration should only occur if a practice list is closed, or may be given if a patient lives out of area and the practice feels unable to accommodate this. All registration refusals should be recorded, and the patient should be given a letter to evidence the refusal.
- Receptionists should routinely ask if patients need assistance to fill in forms, and give help as required.
- Homelessness should be identified as early as possible in the registration, and recorded in the records.
- Even if a patient is street homeless every effort should be made to obtain a 'care of' address, contact and emergency contact details, as for all patients.
- Every effort should be made to assist patients to be able to obtain and attend appointments with ease. Consideration should be taken of personal or organisational barriers that may exist because of language or literacy issues; mental health or addictions problems; lack of access to a phone/credit or individual difficulties e.g. having a dog that the patient cannot leave.
- Patient should be made aware that they can bring support workers with them to appointments (and/or referred to peer advocacy services as appropriate).
- Professional interpreting services should be used unless a patient is fluent in English. Interpreting services should be used in preference to family or friends, and face to face interpreting should be used in preference to phone interpreting wherever possible.
- Longer appointments should be routinely offered to all clients with communication difficulties and/or complex needs.
- Practice staff should become familiar with common cultural practices found in the practice population, and develop practice protocols to accommodate these.
- Leaflets signposting homelessness and other relevant services should be available in simple language within practices.
- Receptionists should be involved in actively gaining service user feedback. Service user feedback should be sought on registration processes, and the reception experience.

Standards for mental health services

Many Inclusion Health patients have mental health problems and experience difficulty in accessing and maintaining therapeutic relationships with mental health services. The particular vulnerability of those who have experienced traumatic events such as homelessness is recognised in the Five Year Forward View for Mental Health[24] and the scandal of large numbers of long term rough sleepers experiencing mental illness has been highlighted by St Mungos.[93] There is a growing understanding that although psychosis is more prevalent amongst people experiencing homelessness, severe and enduring mental illness is not the main disease category. The mental health problems associated with social exclusion are predominantly anxiety and depression, complicated by underdiagnosed disabilities such as: autism spectrum disorder, learning disability, acquired brain injury and of course complex childhood trauma and personality disorder. Dependency on alcohol and/or drugs presents a common complication.

Standards for community mental health services

Where there are significant numbers of homeless or other excluded people, specialist services may be necessary; in other areas enhanced access to mainstream services may suffice. In both situations, services should be provided to the standards outlined. A willingness to work around relatively high rates of non-attendance at appointments will help to ensure that patients are not further excluded. It is crucial that mental health services are integrated with other health services and that there is good communication between them.

Assessments by mental health professionals can be pivotal in enabling someone who is homeless to access appropriate accommodation, or improve the ability of an existing housing service to understand and help someone. Mental health professionals should ensure that their assessments consider this and do not remain focused on gatekeeping access to particular treatments.

2.35 Services for homeless people should accept self or non-health agency referral and respond to mental distress and dysfunctional behaviours. Diagnostic criteria should not be a means of gate keeping services.

2.36 Complex trauma and personality disorders are significant drivers behind the poor mental health of homeless people, and the responses of mental health services and clinicians to this group should be designed with this in mind.

2.37 In areas with high concentrations of Inclusion Health patients, specialist services should be provided to ensure the necessary expertise is available and that there is flexible service provision.

2.38 All mental health services should be ready to work with people with drug and or alcohol problems in addition to mental health issues, and mental health services should foster good partnerships with drug and alcohol sevices to ensure effective joint working. Mental health treatment should still be offered even when the patient does not wish to engage with substance use treatment.

2.39 Sometimes initial assessments will need to take place by outreach, for example; to hostels, drop-ins, Gypsy and Traveller sites and especially to the streets, and services must be able to provide this.

2.40 Symptoms of mental illness can perpetuate people remaining street homeless (or in another situation where they face significant risk) e.g. where paranoid beliefs lead to someone refusing help. In such a situation an assessment under the Mental Health Act (1983) may need to be arranged by local social services and local mental health services, and this assessment may need to take place on the street or in another public area. This must not be refused on the grounds of lack of resources – this is merely a way of excluding from services some of the most vulnerable in the homeless population.

2.41 Decisions around whether to proceed with mental health interventions such as assessments under the Mental Health Act (1983) are often challenging and need careful consideration. If concerns particularly relate to someone's mental capacity to make a decision around their housing, then incorporating the concerns of housing workers may be vital. New tools and guidance have recently been published to support consideration of mental capacity, as well as mental health and safeguarding procedures for people who are homeless.[79]

2.42 Geographical boundaries should not be a barrier to care. Nationally agreed and universally applicable standards of access for Inclusion Health patients should ensure treatment according to the needs and best interests of the person and prevent exclusion due to short term address changes or street homelessness, lack of an officially recognised address (e.g. living on an unauthorised encampment) or lack of access to within-area culturally appropriate services. This will include willingness to maintain therapeutic relationships with homeless patients and other excluded groups who have temporarily moved out of the geographic boundaries of a service, including short stays in prison.

2.43 There should be enhanced and easy access to psychological ('talking') therapies for individual and tailored group work.

- There should be access to treatment at Level 4 of the Stepped Care model,[94] recognising the high incidence of complex trauma among homeless patients.
- For Gypsies and Travellers, there should be access to culturally appropriate talking therapies.

2.44 Support and training should be available for other health workers and for non-health key workers in understanding and working with people with mental health problems and histories of complex trauma, and in cultural awareness and community engagement training regarding the Gypsy and Traveller community.

2.45 Projects working with people with histories of complex trauma should be aware of and have regard to the Psychologically Informed Environments guidance.[95]

2.46 For homeless patients, 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.

2.47 Reflective practice is an essential part of effective working with people with complex trauma, and group and individual reflective practice should be developed by clinical, social care, and multidisciplinary teams.

2.48 The emerging issue of adults with Attention Deficit Hyperactivity Disorder (ADHD) may disproportionately affect homeless people and needs enhanced access to specialist care.

2.49 A history of acquired brain injury due to physical trauma and the effects of alcohol is increasingly recognised amongst homeless people and requires referral routes for further assessment.

2.50 Antenatal and post-natal mental health: see NICE guidance applicable to all patients.[96]

2.51 Understanding that – with certain excluded groups (e.g. vulnerable migrants, Gypsies and Travellers)– presentation of mental ill-health may be culturally bound/specific.

Standards for inpatient psychiatric services

Many people from excluded groups will only come into contact with mental health services when they are acutely unwell. It is important that homeless people are not excluded from crisis pathways, with provision of respite beds for intermediate care, even if a discharge address, or responsible GP cannot be identified at the moment of crisis.

2.52 Long term medication. Some homeless people have long histories with mental health services and have been on medication for many years, with periods of ‘non-compliance’, psychotic episodes, and returns to the streets and returns to hospital via section. For people with an established psychosis who have been on medication, regardless of brief periods of non-compliance, it is dangerous to stop medication. However, medication should always be reviewed after transition between accommodations, including hospital discharge, and a recovery-oriented plan worked out with the client. Medication should be reviewed regularly and frequently.

2.53 Discharge planning should begin on admission and involve as wide a network of health and social care as required. As with physical health services, there should be intermediate care discharge accommodation available, so that those who no longer need psychiatric support can continue to recover within a therapeutic setting. These projects should take into account the Psychologically Informed Environments guidance.[95] A CMHT should be involved as soon as possible so that there is care and support, clinical and social that bridges the transition from hospital to community. Discharge to the streets should be avoided wherever possible. If it is being considered, careful consideration should be given to capacity, with particular reference to the specific risks involved in street homelessness.

2.54 Emerging evidence suggests that Pathway style care coordination for homeless patients is equally effective in mental health settings, with improved outcomes and reduced costs.[97]

2.55 Psychiatrists have a key role to play in outreach services to socially excluded communities who do not use mainstream services, for example on Travellers' sites or on the streets. This should not just be attendance at Mental Health Act assessments. Assessments should be longitudinal and built up over a period of time.

2.56 Psychiatrists have a role in creating a picture of mental health within excluded groups and individuals over a period of time, offering leadership to local mental health service staff, expert opinion to commissioners and Health and Wellbeing Boards, and data to JSNA's.

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 (PD) in the homeless population. NIMHE guidance[98] offers specific standards for PD services. PD services for homeless patients should include:

2.57 Local specialist multidisciplinary team offering specific interventions and consultation and supervision to other teams. Treatment at level 4 of Stepped Care (NICE guidance),[94] recovery oriented, integrated with social care.

2.58 Specialist day services in areas of high concentrations of morbidity. 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.

2.59 Emerging evidence supports pre-treatment approaches to support patients with personality difficulties towards engagement, even if complicated by addiction.[99]

2.60 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 Inclusion Health patients are amenable to psychological treatment. But for services to be accessible they need to be specifically designed and delivered.

2.61 Services should be flexible and open access by self-referral and should avoid excluding potential service users on the basis of particular psychiatric diagnoses or even 'clusters'. Recognising the high incidence of other pathologies, psychologists should offer cognitive assessment for organic damage and developmental difficulties where appropriate.

2.62 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.

2.63 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.

2.64 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 – however provision of therapy away from accommodation should also be available.

2.65 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 should be taught to monitor outcomes individually formulated with each service user, and to enable them to perceive meaningful change as a result of their input. However, sometimes homeless people find paperwork a barrier to accessing services so it is important that our services have the flexibility to choose not to use outcome measurements if this not indicated

2.66 The critical importance of the therapeutic relationship in psychological therapies, which is common to all psychotherapeutic models should be explicitly recognised and supported in service design and delivery.

2.67 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.

2.68 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 liability or varying forms of self-harm.

2.69 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.

2.70 Staff in primary and secondary care and third sector organisations should be enabled to understand 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, in line with Psychologically Informed Environments guidance.[95]

Standards for counselling services

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

Services should:

2.71 Be flexible and open access by self-referral.

2.72 Offer flexibility of location of service provision.

2.73 Be culturally appropriate.

2.74 Recognise 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).

2.75 Recognise the need for flexibility in the face of lowered frustration tolerance thresholds and emotional outbursts, challenging/ disengaging behaviour.

2.76 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.

2.77 Recognise people with Personality Disorder, engaging and supporting them through the referral process to more structured treatment.

Standards for substance misuse services

Since 2012 the lead responsibility for commissioning drug and alcohol services has rested with local authorities. Drug and alcohol services are increasingly being put out to tender at two to seven year intervals. There is a danger that the drive to reduce costs results in less flexible services, with service users increasingly being asked to fit in with strict appointment schedules, and less access to consultant psychiatrists. Homeless people, for whom flexibility is especially important, may be disproportionately affected by these changes and less able to access services. Homeless people may also find a lack of continuity in services particularly difficult to navigate, partly because they may have more complex substance misuse problems necessitating a longer treatment journey, and also because it may take longer to build up a trusting relationship between client and keyworker. As a Faculty we would urge that consideration is given to longer commissioning cycles for substance misuse services.

2.78 Integrated drug and alcohol services should be easily accessible in places where homeless people go, such as drop-in centres and primary care centres. This should include easy routes in to opiate substitution treatment, ideally on site. In areas with high levels of street homelessness consideration should be given to drug and alcohol workers carrying out street outreach.

2.79 People with drug and alcohol problems must be able to access active help with both problems from one key worker.

2.80 People dependent on drugs and alcohol should not be excluded from hostel accommodation because of their dependence.

2.81 Where there are high levels of intravenous drug use, hostel accommodation staff should be trained in the administration of Naloxone and it should be available on the premises according to Homeless Link guidance.[100] The project should have procedures covering the safe disposal of needles.

2.82 Naloxone should be prescribed for opiate users in primary care and on hospital discharge as a harm reduction measure.

2.83 Drug and alcohol workers should recognise the high levels of poor mental health among homeless substance users and there should be easy referral pathways between mental health and drug and alcohol services. Ideally, initial assessments of mental health problems should take place within drug and alcohol services by staff with appropriate levels of training, to avoid inappropriate referrals, which can be costly and frustrating. Psychology services, both one to one and group, should ideally be available within substance misuse services. In areas with high levels of need consideration should be given to integrated mental health and drug and alcohol services.

2.84 Many homeless people who use drugs or alcohol have co-existing physical health problems. In some cases, contact with substance misuse services may provide clients' only contact with healthcare professionals. Those professionals should therefore have sufficient expertise to make basic assessments of physical health problems and needs. Primary care delivered services may improve coordinated delivery of healthcare and preventative services. Where there are separate services communication with the GP service about current medication doses, vaccinations and screening is vital. Links between substance misuse services and secondary healthcare providers such as liver specialists, respiratory physicians and STI/family planning clinics should also be established.

2.85 Opportunistic provision of health promotion should be an integral part of substance misuse services. This should include screening for blood borne viruses and vaccination against hepatitis A and B, particularly for injecting drug users and those with Hepatitis C. An accelerated schedule should be used without delay for pre-testing.[101] Substance misuse services should provide easy routes into treatment for those with Hepatitis C. Substance misuse services should be able to prescribe and administer IM Pabrinex injections for clients who are at particular risk of Wernicke's encephalopathy, and thiamine should be prescribed for other alcohol-dependent clients.

2.86 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.

2.87 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.[1]

2.88 Acute services should be actively supported to ensure timely provision of substitute prescribing for opiate dependent patients admitted to hospital.

2.89 The role of pharmacists in supporting people who are substance dependent, and particularly those on substitute prescribing, should not be underestimated, and pharmacists should be involved in local multidisciplinary teams.

2.90 Residential rehabilitation should be accessible to people who are homeless. This should involve flexible routes of entry into treatment, such as preparatory group work being offered in homeless hostels and day centres.

2.91 Drug and alcohol treatment should be available and accessible for vulnerable migrants, including those with no recourse to public funds.

2.92 Substance misuse services should above all be flexible and able to provide individualised care. Requirements for entry into treatment, particularly opiate substitution therapy, should be reviewed on an individual basis; for example, rigid requirements to provide multiple urine samples or attend pre-treatment groups may result in some clients being unable to access treatment. Clients with complex prescribing needs should be seen by clinicians with sufficient expertise and authority to be able to override treatment protocols when necessary.

2.93 Flexible entry requirements and prompt access are particularly important for clients directed into treatment by the criminal justice service.

Standards for police and criminal justice medical services

Responsibility for offender healthcare rests with NHS England (as the commissioner of offender healthcare services nationally), with providers of healthcare, and with prison governors. Ensuring the delivery of high quality healthcare in prisons is a contribution to reducing health inequalities specifically and also to improving the health of the whole community in general.

The Bradley Report (2009)[102] highlights the extent to which people with mental health or learning disability disorders are channelled into the Criminal Justice System. People who are homeless are often dealt with inappropriately, and at considerable expense, by law enforcement, with the additional problem that a number of low level offences (vagrancy, public order, antisocial behaviour, begging) are available for officers to target this group. In some situations, desperate people commit minor offences to obtain shelter and food. A complete narrative of any homeless person should take into account their relationship with police and courts and consider ways in which their needs can be addressed constructively. Many police stations now have input from drug workers and mental health liaison nurses, but general medical input is often lacking.

Irish Travellers (mostly male) make up between 0.6% and 1% of the entire prison population in England and Wales, and are regularly subjected to racism and discrimination in the prison system.[103] Almost two-thirds of female Traveller prisoners suffer from mental illness, and 26.1% of all Irish Traveller prisoners have one or more mental illnesses (compared to 10% of the prison population), with high rates of self-harm and depression.[103] Key factors which exacerbate the poor mental health of Travellers in prison include: lack of access to services (a major contributory factor in the high levels of detected mental illness amongst this group), disruption of family and community support, and prejudice and loss of self-respect.[103]

Irish Travellers generally enter prison at a higher risk of ill-health than other prisoner groups, are accepting of ill-health, and access healthcare only infrequently outside prison, thus any expression of ill-health by this prisoner group may indicate an urgent need. Many of the most serious difficulties facing this prisoner group are attributed (by prisoners themselves and prison staff) to the widespread inability to read and write, limiting access to health and other services in prison.[103]

“Rebalancing Act” is a useful report from Revolving Doors[104], it is intended to support a broad range of stakeholders at local, regional and national level, to understand and meet the health and social care needs of people in contact with the Criminal Justice System and through this engagement reduce offending and improve community safety. They point out that it costs around £60,000 to send a person to prison, and £34,000 a year to keep them there. If costs of care for children are included (mainly for women) then we are clearly spending hundreds of thousands of pounds a year to incarcerate people, many of whom need help.

2.94 Medical input to police stations should include mental health liaison, substance misuse workers and general medical care to treat wounds, treat medical conditions and screen for infectious diseases.

2.95 It is estimated that 15 percent of people are homeless when sentenced to a time in prison and 30 percent are homeless on release.[105] 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’ care.

The relationship between a clinician and patient in the prison setting is constrained by the environment and contradictory expectations and requirements from the criminal justice system, the clinician and the patient. For example, the challenges of potential diversion of medication, confidentiality, appropriate use of medical reports. The following approach has been summarised by an experienced Faculty member.

Approach

I'm here to help reduce the harm and risk of being in custody; to work with you to find a way to begin to tolerate living with yourself without so much medication/drugs, to normalize normal human experience and not over medicalise or medicate, to take the opportunities to engage you in improving your health through health education, realistic goal setting, motivation and encouragement, investigation, diagnosis and treatment. To model a good clinician/patient relationship, provide compassionate boundaries, build trust and be trustworthy.

What works?

- Team approaches and multidisciplinary teams.
- Protocol driven care – don't make exceptions.
- Reflect constantly with colleagues.
- Look after each other.
- Watch our for pedestals/favourites.
- Try not to get institutionalized.
- Spend time in other care settings.
- Know when to take a break.

There is a range of guidance already available in relation to prison healthcare and prison dentistry.[106,107,108] Many of the standards set out elsewhere in this document will apply to prison medical services.

In addition, they should include:

2.96 Full registration of patients treated, including documentation of ethnicity. See 2.18 – ensure the DH-issued national 'data change notice' to include Gypsies, Roma and Travellers alongside the 16+1 other ethnic categories which are monitored by the NHS is also applied to the prison medical care system.

2.97 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.

2.98 Active liaison with medical service outside prison on release and pro-active commitment to ensuring smooth transition of care.

2.99 Ensure the needs of Gypsy Roma Traveller prisoners are addressed:

- Awareness among healthcare teams that Travellers experience high levels of mental illness and suicide.
- Ensure literacy problems don't impact negatively on negotiating bureaucracy involved in accessing health and other services.
- Ensure literacy and nomadism don't impact on maintaining links with families e.g. writing applications for Visiting Orders, ensuring families can receive these if they live on an unauthorised site/possess no officially recognised address.

Standards for immigration removal centre (IRC) medical services

There are similarities between IRCs and with prison care. NHS England is also responsible and the client group may overlap through those who are transferred from prison. However, there are challenging differences. IRCs are more directly harmful to mental health due to the unpredictable and unstable nature of immigration detention and the 'culture of disbelief', particularly involving highly vulnerable detainees/survivors of trafficking/torture.

2.100 Highly vulnerable or unwell detainees should not be in IRCs (Home Office guidance).

2.101 Healthcare workers have a central role in identifying highly vulnerable or unwell detainees and need to be skilled and supported to do this.

2.102 Independent clinicians e.g. Medical Justice should be available to assess detainees at risk of inadequate care in detention.

2.103 Continuity of physical healthcare is vital e.g. secondary care appointments should not be misssed and medication should not be interrupted due to detention.

2.104 The impact of detention on mental health should be regularly re-assessed and treated (see Health of Vulnerable Migrants p14).

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; but higher levels of untreated dental disease, which has considerable impact on their quality of life.[109] Most homeless people wish to have their dental needs addressed but face 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.[110] 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 people.[111] There is a growing movement to promote socially inclusive dentistry within the NHS.[112]

Oral health promotion

2.105 Health promotion with excluded groups should have an integrated oral health element and use a common risk factor approach addressing nutrition and diet, smoking, alcohol and substance use and basic hygiene.

2.106 Dental health education/oral health promotion provided should be sensitive and appropriate to the person’s oral risk factors, housing situation, and literacy level (using visual aids where necessary, e.g. story sacks, puppets and games for the children, or models, pictures, and flipcharts for adults, it should also be culturally appropriate.

2.107 Where possible the skills of all members of the dental team should be used in the oral health promotion process: dental hygienists, therapists and nurses, as well as dentists.

2.108 All members of excluded groups 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.

Commissioning socially inclusive dentistry

2.109 Commissioners for healthcare for excluded groups in each locality are recommended to identify the local consultant in dental public health who will champion access to dental care and work collaboratively with heads of community and special care dentistry services to advise on 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).

2.110 Dental care for excluded groups should be included in an area’s oral health strategy. Services for excluded groups should be specified in contractual arrangements with appropriate local NHS primary dental care and/or salaried dental/special care dental services. The strategy should include raising awareness of the dental needs of excluded groups to those outside the dental profession, including local public health teams, health professionals, community workers, education service, and the service users themselves.

2.111 These standards recommend that each local authority undertake an oral health needs assessment of the socially excluded populations in their locality to understand both normative and subjective dental impacts in these groups. A mapping of existing services within and outside of the NHS is needed in order to understand the current capacity to manage the burden of dental disease in the socially excluded population.

2.112 Services should be commissioned to mapped oral health needs and should provide services that are appropriate to the service users and can adapt to their needs as these are revealed. This may include, but is not limited to, outreach services situated at locations convenient for the user, flexible opening hours (early mornings or later into the evening) and collaboration with pre-existing services.

2.113 Each service is recommended to have a policy as to what treatment will or will not be provided to those services users who are uncertain of the exemption status, especially those who present with a dental emergency such as pain or facial swelling.

2.114 There are a multiplicity of services across the country that are using a range of different models to deliver care – inter-service communication and an agreement of what constitutes best practice for delivering socially inclusive dentistry should be implemented. A central hub assimilating data and providing an overview of the oral health needs and services available to meet these needs should be produced. The ultimate aim is to target those areas with the greatest need for dental care and the fewest available resources to meet that need. In this way, funding and service development can be provided equitably.

2.115 The standards and quality of dental care provided in mobile and outreach clinics should seek to comply with Care Quality Commission best practice recommendations.

Integration of dental care with primary medical and social care.

2.116 All socially excluded 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.

2.117 All members of a primary health and social care team including key liaison workers (e.g. peer workers, Specialist Health Visitor for Travellers) in contact with excluded groups should receive basic training on assessing dental health and prevention of oral disease.

2.118 A common risk factor approach targeted at those factors which impact upon both general and oral health is recommended to “put the mouth back into the body” and to keep health promotional messages consistent with medical colleagues. Risk factors include: nutrition and diet, smoking, alcohol and substance misuse, and basic hygiene.

2.119 The dental setting also provides an opportunity to screen for other conditions for example hypertension or diabetes. If these tests are undertaken there should be clear pathways to link patients to services that can manage these medical conditions. It should be noted that trained dental nurses already undertake these tests for dental care, so the use of appropriately trained dental nurses to carry out these tests in the setting of outreach projects to socially excluded people would be an extension of their roles.

2.120 A cohesive approach between medical and dental care may include the collaboration of key services delivered alongside one another: TB screening, podiatry, dental, smoking cessation. This approach will enable multiple services to be accessed simultaneously rather than multiple appointments at different sites which may be problematic for those with chaotic lives.

2.121 Dental services providing care for excluded groups would benefit from being integrated with, and complementary to, other health and social services and agencies providing services to those groups.

Delivering socially inclusive local NHS dental services

2.122 Local NHS dental services within an area are encouraged to share experience, network, and facilitate referrals as well as collaborating with medical and social services; "putting the mouth back into the body". This may be particularly important for primary dental care services that have limited knowledge of the specific needs of excluded groups. For services working with specific groups (for example but not limited to Gypsies and Travellers), cultural awareness sessions for all members of the dental team may be necessary.

2.123 Flexible and iterative solutions should be sought when developing socially inclusive dental services. Services are recommended to have appropriate opening hours for the population that they are seeking to serve, that they are commissioned in areas of high need and are welcoming to the service users.

2.124 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 e.g. based at facilities for homeless people and outreach clinics (to include mobile dental clinics) and mainstreaming to local NHS primary dental care.

2.125 Peer support workers can be helpful in supporting people to make and keep dental appointments. Where possible this service should be developed.

2.126 Services should be non-judgemental and non-threatening, providing reassurance particularly for the dentally anxious.

2.127 Mainstream services must not deliberately prevent access by excluded groups; this should be regularly tested and refusal of access robustly contested.

2.128 With all excluded groups, the specific issues of dentures taking more than two appointments to complete should be considered. There is anecdotal evidence that socially excluded and vulnerable groups do not often complete the series of appointments required for the construction of dentures. This can lead to a waste of NHS resources in that clinician's time and laboratory fees are incurred to no benefit to the patient or the NHS. Commissioners need to consider what their stance on this issue is, and communicate this clearly to the service providers.

Standards for physiotherapy services

A national audit of people who are homeless revealed that 70% reported health problems involving chest pain, breathing problems or joint/muscle problems.[113]

Commissioners of healthcare for homeless people should recognise when homeless and vulnerable people struggle or fail to access mainstream physiotherapy services. Consideration should then be given on how to improve access to physiotherapy by this population. Physiotherapy may be important in the management of the physical health component of tri-morbidity, including musculoskeletal injury management, amputee care, cardiac and pulmonary rehabilitation and neurological rehabilitation.

2.129 Where need is identified, recruitment of a specialist physiotherapist for homeless and vulnerable people should be considered.

2.130 In multi-disciplinary teams where a specialist physiotherapist for homeless and vulnerable people does not exist, a member of the physiotherapy team should be identified as a homeless and vulnerable people "champion" for liaison and advocacy.

2.131 The training needs of specialist physiotherapists for homeless and vulnerable people should be considered. For example: conflict resolution, working with interpreters, the long and short term effects of illegal drugs and alcohol, mental health, domestic and sexual violence, child protection, the criminal justice system, immigration, torture.

2.132 To raise awareness of the potential for specialist physiotherapy services for homeless and vulnerable people within the profession of physiotherapy, various strategies should be considered, including: rotation of mainstream junior physiotherapists through the service, practice placements for physiotherapy students, liaison with university colleagues regarding inclusion of issues surrounding homelessness and vulnerability in undergraduate curricular, publications and conference presentations.

Standards for podiatry services

Footcare is particularly 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.

2.133 'Drop in' access by self referral with continuity of provision to build trust – including cover for leave. Appropriate and accessible advertising of service including easy read materials, translated materials and clinical access to interpretors and language line.

2.134 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.

2.135 Security should be considered, including set up and location of clinical room, access to notes and alerts, chaperones when necessary.

2.136 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).

2.137 Lead clinicians should work in both mainstream and specialist settings, to maintain links and equitable standards. Services should ensure 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.

2.138 Signposting to other services as in a position to build up trust rapidly due to instant relief of pain by non painful treatment, repeat consultations and opportunity for talking during treatment. Foot health and podiatry awareness training for day centre volunteers. Frequent care plan review according to patient's changing situation. Assertive outreach for non-engaged clients: Advise of drop-in podiatry clinics in local area if sleeping outside area. Encourage provision of free shoes and socks in day centres. Provide supporting letters for grants/loans for shoes from the Department of Health and Social Care if necessary. Service user involvement and patient satisfaction surveys.

2.139 For recently housed patients services should ensure continuing care or refer on.

2.140 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.

2.141 Training and education: Consider training need for homeless podiatrists in conflict resolution, working with interpreters, drugs and alcohol effects on lower limb, mental health, torture. Build links with other local agencies and services. Offer training to profession through mandatory rotation of mainstream podiatrists, placements for podiatry students, university guest lecturing and workshops on homeless healthcare with podiatry students, publications and conference presentations, audit and research.

2.142 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 palliative care

Homeless people often die young, their deaths being unplanned for and unsupported.

Recent research suggests palliative care services are currently rarely involved in supporting this population, except for some patients with cancer. The following challenges to palliative care delivery for this group have been identified:[114]

- Uncertainty around the prognoses of common illnesses e.g advanced liver disease.
- Difficulty accessing mainstream services due to behaviours associated with mental health issues and poorly managed addictions. These could include conflicting priorities, avoidance of healthcare settings, self-discharging and behaviour that results in exclusion from services.
- Lack of appropriate services and places of care, particularly for those with complex health needs in combination with substance misuse issues.
- The burden of supporting sick and dying people who are living in hostels is often left to hostel staff, who have no medical training and often minimal support from health and social services.

2.143 The importance of working with uncertainty.
Accepting and working with uncertainty is key in providing person centered care. Identifying homeless people who may be dying is complicated, so the focus of care and support should instead be triggered by those people whose 'health is a concern' or those who have deteriorating or advanced ill-health.

2.144 The need for a multidisciplinary team approach in order to offer the most appropriate care and support individual care planning is essential (see also point 2.150).

2.145 Regular multidisciplinary meetings should take place with input from medical teams, including GPs, specialist nurses, drug and alcohol teams, palliative care professionals and hostel and/or outreach and day centre staff. In these meetings, any homeless person with deteriorating or advanced ill health, or who is a concern to frontline staff, should be discussed. Someone should not need to be considered palliative to trigger the discussion,

2.146 Information exchange between medical teams and frontline staff should be encouraged. Hostel and/or outreach and day centre staff should be included/involved in communication with hospitals regarding the care of people they are supporting, including invitations to hospital discharge planning meetings.

2.147 The need for person centered care
Homeless people should be involved in discussions and decisions about their treatment and care, striking the right balance between continuing to offer and provide support while respecting individual choices (even when these choices include what we may consider as unwise, for example regarding continued substance use).

Emphasis should be on what "living well" means to an individual.

2.148 Conversations with people with deteriorating or advanced ill-health who continue to use drugs or alcohol, should aim to explore their insights and wishes rather than be 'warning' conversations such as "if you don't stop drinking you will be dead within 3 months".

2.149 Parallel planning should be considered for all homeless people with deteriorating or advanced ill health: i.e. planning for the end of life does not preclude continued active management.

2.150 All people with deteriorating or advanced ill health should have a personalised and emergency care plan to help hostel, outreach and day centre staff to support them. Care plans could be developed within multidisciplinary meetings. Support from the multidisciplinary meetings could also include how to talk to people about their insights into their health, what might help them to live well and what their wishes and preferences for care may be.

2.151 Extending in-reach into hostels and day centres
In-reach from a range of professionals is valuable and should be considered and extended. This could be provided by local hospice staff, drug and alcohol teams, specialist nurses and GP's etc.

2.152 In-reach into hostels or day centres could support staff in identifying and supporting people whose health may be deteriorating or is of concern.

2.153 In-reach could assist in the acquisition of funding for social care and continuing healthcare needs for people living in hostels.

2.154 All professional groups should receive training (which is appropriate to their role) regarding support for service users with advanced ill health, in addition to bereavement support.

2.155 One model for effective palliative care in-reach is the Palliative Care Coordinator role developed by St Mungos. Ways of extending or replicating this role need to be considered and explored.[115]

End of life care for excluded groups needs particular sensitivity to ensure that people are supported to make their own choices. Guidance is provided by St Mungos and Marie Curie.[116]

For Gypsies and Travellers, lack of facilities for terminal care on Gypsy/Traveller sites means that death may occur in hospital rather than (as may be preferred) amongst family at home.[117] Services should recognise the importance of family support and kin-group responsibilities, manage expectations, and avoid conflict over numbers of visitors or caravans/vehicles if people are gathering to support a person having medical treatment or following bereavement.[39]

Standards for medical 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 healthcare problems. These services improve outcomes and reduce subsequent unscheduled hospital admissions.[76,77] Recent reviews of medical respite services currently available in the UK,[78,118] made the following recommendations:

2.156 A detailed analysis of local need should be undertaken to define the nature of the service required.

2.157 Projects usually need integrated planning with the Local Authority, however any model requiring housing assessed local connection will limit the potential for usage of beds.

2.158 Projects should aim to provide holistic person centred case management covering physical health, mental health and drug or alcohol misuse needs as required.

2.159 Projects should ideally have on-site access to a range of primary care services. Close links to homeless GP practices will be beneficial.

2.160 Projects should ideally be dry, or aim to minimise alcohol and drug misuse behavior on site.

2.161 Projects should ideally be able to provide for patients with physical disabilities and substitute prescribing needs.

2.162 Projects should be able to actively provide or promote access to meaningful activity e.g. education, training, sports, arts activities.

2.163 Full consideration of potential move-on options, particularly for clients with complex needs or no recourse to public funds should be given when designing medical respite service

2.164 Pilot projects should be given adequate time (2-3 years minimum) to embed before being evaluated for outcomes and cost benefit.

2.165 Projects should ideally be Psychologically Informed Environments, with regular reflective practice.

Although not explicit in the recommendations, successful projects will require the support of non-medical staff with expertise in welfare, housing (including culturally specific needs) and getting clients back into meaningful activity including volunteering and paid work.

Homelessness is a health problem as well as a social one. Health and social care should be integrated in recovery pathways for homeless people, and to achieve this it is crucial 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.

Standards for secondary care services

The Homelessness Reduction Act 2017 will come into effect in April 2018. The Act places duties on local housing authorities (LHAs) to intervene at earlier stages to prevent homelessness in their areas and requires LHAs to provide new homelessness services to all those affected, not just those protected under existing legislation.

The Act places a new ‘duty to refer’ on Public Authorities to notify (if the person consents) a LHA of any person who they consider may be homeless or at risk of homelessness in the next 56 days. This presents a significant opportunity to radically improve collaboration between hospitals and the LHAs in their area.

Healthwatch England have highlighted the plight of many people being discharged to the streets.[119] No homeless patient should be discharged unsupported. To achieve this all admitted patients should be asked “do you have somewhere safe to stay when you leave hospital” and staff should be trained and supported to help people who say “no”.

For hospitals with significant numbers of inclusion health patients, the Pathway care coordination approach has demonstrated improved patient care and cost efficiency.[120,121,122] GP and nurse led ward rounds, multi-agency care planning meetings and involvement of Care Navigators are the key elements. Pathway teams have been commended by the RCP Future Hospitals Commission Report.[123]

2.147 All hospitals should have protocols for discharge planning for excluded groups, based on the guidance developed by St Mungos and Homeless Link.[124] An evaluation of hospital discharge projects for homeless people found better outcomes for integrated teams involving housing workers and health workers (essentially the Pathway approach), than for housing workers alone.[125] The Royal College of Physicians, working with the Faculty, recommends the following tiered approach to support in a hospital setting.[126] All patients presenting to A&E should be questioned about housing status and all street sleepers and rough sleepers identified immediately on arrival to any department at the hospital. All hospitals should have a system in place to support homeless people prior to discharge.

2.147.1 Tier 1. Hospitals with less than 30 homeless patients presenting each year: An identified member of staff who oversees the development of a referral protocol to LHA's in their area and ensures that all staff are aware of their duty to refer under the Homelessness Reduction Act. Also maintains an information pack with signposting to local volunteer agencies for homeless people, hostels, foodbank, free meals, etc. A small supply of clean clothing.

2.147.2 Tier 2. Hospitals with 30-200 homeless patients presenting each year: A dedicated housing officer with strong relationships with the LHAs, hostels, charities, etc. A named link hospital coordinator to maintain the referral protocol to the LHA and support the housing officer in obtaining necessary medical assessments (with the person's consent). An information pack for homeless people. Supply of spare clothing. Training and education of all hospital staff by the housing officer and named hospital coordinator.

2.147.3 Tier 3. Hospitals with > 200 homeless patients presenting each year: Full, clinically-led, Pathway team. See Pathway website for details.[127]

The Act sets out that the basic legal requirement for a referral to the LHA is the individual's name, contact details, consent and the agreed reason for referral (i.e. that the individual is homeless or at risk of homelessness). It is likely that LHAs will develop a standard referral forms in partnership with referring authorities.

Appendix 1 details a draft, more thorough, best practice referral. It has been developed by the Faculty for Homeless and Inclusion Health in collaboration with Crisis. An electronic version can be downloaded from the Faculty website.

Demonstrating that a service meets these standards

The Faculty has developed a peer appraisal methodology that will help primary care services demonstrate that they meet these Standards,[128] and an audit process for emergency departments.[129] We are ready to work with other groups of providers who would like to develop a similar process.

Homelessness Reduction Act 2017

English Public Authorities are required to notify people who they think are homeless, or may be at risk of homelessness in the next 56 days, to a local housing authority (LHA). Follow your local protocol for referral, but consent must be obtained and the person is entitled to choose which LHA is notified.

Consent to release information: (to be signed by the person referred)

I agree for information on this form to be released to my local housing authority for the purpose of obtaining advice regarding my housing need.

Signed: ______________________________ Date: ___________

Referrer details

Patient Location (e.g. ward):	
Name and contact details of Referrer:	

Details of person referred

Family Name:	Title:
Forename:	Preferred name:
DOB:	Gender:
Nationality:	Preferred language?
	Is an interpreter required?

Accommodation

Current Address: (if applicable)	Home Tel: Mobile: Email:
Postcode:	Borough

Has the person lived at this address for more than 6 months?
If NO, Please give all addresses in the last 5 years

Current Accommodation type: (tick most appropriate)

☐ Owner Occupier
☐ Living with parents
☐ Hostel
☐ Private Rented
☐ Staying with friends / family
☐ Night Shelter
☐ Council Tenant
☐ Sleeping Rough
☐ Other (please specify)
☐ Housing Association (please give name):

Employment status and benefits

Is the patient in employment? Please give details:
Is the patient in receipt of any benefits?
Which benefits does the patient get? Please specify including any DLA payments:

Does the person have any links to the LHA you are notifying?

Tick all relevant boxes	
☐ Currently resident	☐ Previously resident
☐ Parent or sibling in area	☐ Other family association (describe):
☐ Employed in the area	☐ Care Leaver in the area
☐ Rough sleeping in the area (please give location):	
☐ Other (please explain):	

Medical Information

Please list all medical diagnoses, social difficulties and mobility problems, and whether they are likely to be long or short term. Please include any mental health and substance misuse issues.
What date is the patient due to be discharged?

Aids and Adaptations/facilities

Is the Hospital OT involved? (please circle) Yes or No Name and contact details of OT:
OT assessment recommended: ☐ stair lift ☐ hoist ☐ through floor lift ☐ wetroom ☐ hand rails/grab rails ☐ ramp ☐ remote opening
On return to home without appropriate facilities, will there be serious risk to health of or accident to the person or the carer? (give details):
Without necessary or appropriate facilities the needs of this person will be affected long term? ☐ Yes ☐ No
The patient's long term ability to stay home is consequently compromised without aids/adaptations/facilities? ☐ unlikely ☐ possible ☐ likely ☐ probable ☐ definite

Reason why the client cannot return to current or last accommodation

For example, current accommodation is unsuitable/patient is homeless upon discharge, please explain:

This form can be downloaded in an editable format from the Faculty website: www.pathway.org.uk/standards

Glossary

A

ADHD	Attention Deficit Hyperactivity Disorder
A&E	Accident and Emergency Department
ASCOF	Adult Social Care Outcomes Framework

B

BBV	Blood Borne Viruses
BME	Black and Minority Ethnic

C

CCG	Clinical Commissioning Group
CHAIN	Combined Homeless Information Network
CMHT	Community Mental Health Team

D

DFLE	Disability-free life expectancy
DH	Department of Health
DHSS	Department of Health and Social Security
DsPH	Directors of Public Health

E

ECDC	European Centre for Disease Prevention and Control

F

FFT	Friends Families and Travellers

H

HHR	Hand Held Records
HLE	Healthy life expectancy
HNA	Health Needs Assessment
HSE	Health and Social Care Information Centre’s Health Survey for England
HWBS	Health and Wellbeing Board Strategy

J

JSNA	Joint Strategic Needs Assessments

K

KPI	Key Performance Indicator

L

LE	Life expectancy
LHA	Local Housing Authority
LRTI	Lower Respiratory Tract Infection
LREC	Leeds Racial Equality Council

M

MDT	Multidisciplinary Team
MH	Mental Health
MMR	Measles, Mumps and Rubella

N

NFA	No fixed abode
NHSE	NHS England
NICE	National Institute for Health and Care Excellence
NIMHE	National Institute for Mental Health in England
NOCN	National Open College Network

O

ONS	Office for National Statistics

P

PCT	Primary Care Trust
PD	Personality disorder
PHE	Public Health England
PHOF	Public Health Outcomes Framework
PHPQI	Prison Health Performance and Quality Indicators
PYLL	Potential years of life lost

Q

QOF	Quality and Outcomes Framework

S

SHA	Strategic Health Authorities
SofS	Secretary of State

T

TB	Tuberculosis

References

For ease of use all links have been shortened.

1. Luchenski et al. What works in inclusion health: overview of effective interventions for marginalised and excluded populations. Published Lancet Online November 11, 2017. **http://bit.ly/2mlaEUa**

2. CSDH (2008). Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health. Geneva, World Health Organization. **http://bit.ly/2CPmDQ8**

3. Buck D and Maguire D. Inequalities in life expectancy: changes over time and implications for policy. Kings Fund London. August 2015. **http://bit.ly/2CPMSpv**

4. Story A. Slopes and cliffs in health inequalities: comparative morbidity of housed and homeless people. Lancet published online September 2013. **http://bit.ly/2CL5TJB**

5. Bonner A editor. Social determinants of health. An interdisciplinary approach to Social Inequality and Wellbeing. Ch 20 Hewett N. What works to improve the health of the multiply excluded? Bristol Sept 2017. **http://bit.ly/2CN7Oxa**

6. Cabinet Office Social Exclusion Taskforce, Department of Health. Inclusion Health – Evidence Pack 2010. Available from: **http://bit.ly/2DgvfA3**

7. Marmot et al. The Marmot Review. Fair Society, Healthy Lives. Strategic Review of Health Inequalities in England post-2010. **http://bit.ly/2CPNPy5**

8. Gill P, Macleod U, Lester H, Hegenbarth A. Improving access to health care for Gypsies and Travellers, homeless people and sex workers. An evidence-based commissioning guide for Clinical Commissioning Groups and Health & Wellbeing Boards. RCGP September 2013. **http://bit.ly/2qOiJoR**

9. Marmot M, Allen M, Allen J, Hogarth S. Working for Health Equity: The Role of Health Professionals. UCL Institute of Health Equity. London March 2013. **http://bit.ly/2CPO6kB**

10. Five Year Forward View. NHS October 2014. **http://bit.ly/2CKuazv**

11. The King's Fund; Integrated care and sustainability transformation plans (STP's) explained. **http://bit.ly/2COg4xf**

12. Hetherington K, Hamlet N. Restoring the Public Health response to Homelessness in Scotland. Scottish Public Health Network. May 2015. **http://bit.ly/2CMuON3**

13. Public Health England. Strategic plan for the next four years: better outcomes by 2020. April 2016. **http://bit.ly/2CO8dzp**

14. Cornes, M., Mathie, H., Whiteford, M., Manthorpe, J. and Clarke, M. (2015) The Care Act, Personalisation and the New Eligibility Regulations: A discussion paper about the future of care and support services for homeless people in England, accessed online (Feb 2015): **http://bit.ly/2COgTpP**

15. Healthy London Partnership. Health care & people who are homeless Commissioning Guidance for London December 2016. **http://bit.ly/2CKw1UZ**

16. College report CR185. Alcohol and brain damage in adults With reference to high-risk groups. The Royal College of Psychiatrists, the Royal College of Physicians (London), the Royal College of General Practitioners and the Association of British Neurologists May 2014. **http://bit.ly/2CNTkND**

17. Office of the Chief Analyst. Healthcare for single homeless people. Department of Health, 2010. **http://bit.ly/2DgO7ii**

18. Zaretzky K et al. What drives the high health care costs of the homeless? Housing Studies 2017, DOI:10.1080/02673037.2017.1280777 **http://bit.ly/2DgYFy9**

19. Crisis 2011. Homelessness: a silent killer. London Dec 2011. **http://bit.ly/2DfNJAV**

20. Aldridge RW et al. Morbidity and mortality in homeless individuals, prisoners, sex workers, and individuals with substance use disorders in high-income countries: a systematic review and meta-analysis. Published Lancet Online November 11, 2017. **http://bit.ly/2Dfc61q**

21. Barnett K, Mercer SW, Norbury M, Watt G, Wyke S, Guthrie B. Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study. Lancet 2012; published online May 10. DOI:10.1016/S0140-6736(12)60240-2. **http://bit.ly/2DcwVKR**

22. Morrison DS. Homelessness as an independent risk factor for mortality: results from a retrospective cohort study. International Journal of Epidemiology 2009; 38:877–883 **http://bit.ly/2Df5FeT**

23. O'Connell et al. The Boston Healthcare for the Homeless Program: A Public Health Framework. American Journal of Public Health August 2010; Vol 100 No 8:1400-1408 **http://bit.ly/2DdOTwB**

24. The Five Year Forward View for Mental Health. A report from the independent Mental Health Taskforce to the NHS in England February 2016. **http://bit.ly/2Df66G3**

25. Hill, K & Rimington, D 2011, Investigation of the oral health needs for homeless people in specialist units in London, Cardiff, Glasgow and Birmingham Primary Health Care Research & Development, vol 12, no. 2, pp. 1-10. DOI:10.1017/S1463423610000368 **http://bit.ly/2Dcx8xD**

26. Smile4Life, the oral health of homeless people across Scotland, Report of the Homeless Oral Health Survey in Scotland, 2008-2009. **http://bit.ly/2DfN6Y8**

27. O'Connell JJ. Premature Mortality in Homeless Populations: A Review of the Literature, 19 pages. Nashville: National Health Care for the Homeless Council, Inc., 2005. **http://bit.ly/2DgZMOq**

28. Johnsen S, Watts B, and Fitzpatrick S. ESRC. FIRST WAVE FINDINGS: Homelessness May 2016. **http://bit.ly/2Dj2NOh**

29. Pleace N, Culhane DP. Better than Cure? Testing the case for Enhancing Prevention of Single Homelessness in England. Crisis 2016. **http://bit.ly/2DfFyV6**

30. Ministerial Working Group on tackling inequalities experienced by Gypsies and Travellers, 2012, paragraphs 3.1 – 3.4 **http://bit.ly/2DevOdI**

31. Parry G, Van Cleemput P, Peters J, Moore J, Walters S, Thomas K, et al. The Health Status of Gypsies and Travellers in England. Report of Department of Health Inequalities in Health Research Initiative Project 121/7500. 2004. Available from: **http://bit.ly/2DhHDjl**

32. Matthews Z. Better Health Briefing Paper 12: The health of Gypsies and Travellers in the UK: Race Equality Foundation; 2008. Available from: **http://bit.ly/2DgM1iL**

33. Cemlyn S, Greenfields M, Burnett S, Matthews Z, Whitwell C. Inequalities experienced by Gypsy and Traveller communities: A review: Equality and Human Rights Commission; 2009. Available from: **http://bit.ly/2DhhWiZ**

34. Baker M. Gypsies and Travellers – Leeds Baseline Census 2004-2005: Leeds Racial Equality Council (LREC); 2005. Available from: **http://bit.ly/2Dgbadn**

35. Gypsy and Traveller Communities in Central Bedfordshire: Joint Strategic Needs Assessment.

36. Office for Public Management. Health and social care needs of Gypsies and Travellers in West Sussex: Report to NHS West Sussex and West Sussex County Council. 2010. Available from: **http://bit.ly/2Dfevcs**

37. Parry G, Van Cleemput P, Peters J, Walters S, Thomas K, Cooper C. Health status of Gypsies and Travellers in England. J Epidemiol Community Health. 2007;61(3):198-204. Available from: **http://bit.ly/2DiNtBa**

38. Van Cleemput P. Health care needs of travellers. Arch Dis Child. 2000;82(1):32-7. Available from: **http://bit.ly/2DfeDIY**

39. Lehti A, Mattson B. Health, attitude to care and pattern of attendance among gypsy women - a general practice perspective. Fam Pract. 2001;18(4):445-8 **http://bit.ly/2CKP1mh**

40. Van Cleemput P, Parry G, Thomas K, Peters J, Cooper C. Health-related beliefs and experiences of Gypsies and Travellers: a qualitative study. J Epidemiol Community Health. 2007;61(3):205-10. Available from: **http://bit.ly/2CMtBVH**

41. Hodgins M, Millar M, Barry MM. "...it's all the same no matter how much fruit or vegetables or fresh air we get": traveller women's perceptions of illness causation and health inequalities. Soc Sci Med. 2006;62(8):1978-90. Available from: **http://bit.ly/2CM2JFE**

42. IpsosMORI. East of England lifestyle survey of Gypsies and Travellers, 2009: NHS East of England; 2009. Available from: **http://bit.ly/2CLvpON**

43. ITMB. The Health and Wellbeing of Gypsies and Travellers: An Irish Traveller Movement in Britain Briefing. 2012. Available from: **http://bit.ly/2CQ9Axu**

44. LeedsGATE. "Gypsy and Traveller Health – Who pays?" Health Pathways: Cost-Benefits Analysis Report: Leeds Gypsy and Traveller Exchange (GATE); 2013. Available from: **http://bit.ly/2CQa3zK**

45. Edwards DM, Watt RG. Oral health care in the lives of Gypsy Travellers in east Hertfordshire. Br Dent J. 1997;183(7):252-7. **http://bit.ly/2COMjvY**

46. Matthews Z, Edwards T, Sillman S, Benwel S. A Collaborative Programme to Improve the Oral Health of the Gypsy and Travelling Communities in Sussex: FFT for Brighton and Hove City Council Public Health Programme; 2010. Available from: **http://bit.ly/2CMwfe5**

47. Pavee Point Primary Health Care for Travellers' Project. A Review of Travellers' Health using Primary Care as a Model of Good Practice. 2005. Available from: **http://bit.ly/2CPNPOI**

48. Riches R. Early Years Outreach Practice – Supporting early years practitioners working with Gypsy, Roma and Traveller families: Save the Children UK; 2007. Available from: **http://bit.ly/2CQaGcA**

49. Friends Families and Travellers (FFT). Working with Gypsies and Travellers… A brief note for Health Practitioners. Available from: **http://bit.ly/2CMU5GV**

50. Francis G. Developing the cultural competence of health professionals working with Gypsy Travellers. DH; 2010. Available from: **http://bit.ly/2CPfQ8X**

51. European Centre for Disease Prevention and Control. Inform, protect, immunise: engaging underserved populations – ECDC consultation meeting, 4-6 Sept. Dublin, Ireland 2012. Available from: **http://bit.ly/2CMxoSV**

52. Wemyss R, Matthews Z, and Jones H. The National Gypsy and Traveller Health Inclusion Project 2012-15 **http://bit.ly/2CQbn5G**

53. Wemyss R. Inclusion of Gypsy Traveller health needs in Joint Strategic Needs Assessments: A review. Friends Families and Travellers. Feb 2015. **http://bit.ly/2CMGvmT**

54. Feldman R (2012) Guidance for commissioning health services for vulnerable migrant women Women's health and equality consortium and Maternity Action **http://bit.ly/2CMGBLh**

55. Zimmerman C, Kiss L, Hossain M (2011) Migration and Health: A Framework for 21st Century Policy-Making. PLoS Med 8(5): e1001034. doi:10.1371/journal.pmed.1001034 **http://bit.ly/2COaxq6**

56. Fitzpatrick, S., Johnsen, S. and Bramley, G. (2012) 'Multiple exclusion homelessness amongst migrants in the UK', European Journal of Homelessness, 6 (1): 31-58 **http://bit.ly/2CQkzHv**

57. Burnett A, Peel M. Health needs of asylum seekers and refugees. BMJ. 2001;322(7285):544-7 **http://bit.ly/2CNqfC6**

58. Ingleby, D and Petrova-Benedict, R. (2016) Recommendations on access to health services for migrants in an irregular situation: an expert consensus. Brussels: International Organisation for Migration (IOM) Regional Office Brussels, Migration Health Division. **http://bit.ly/2COb1MW**

59. Guidance on implementing the overseas visitor charging regulations. **http://bit.ly/2CMa87U**

60. Durcan G, Stubbs J & Boardman J. Immigration Removal Centres in England, A mental health needs analysis, Centre for Mental Health, 2017. **http://bit.ly/2CNqInQ**

61. Borland R and Zimmerman C (2012) Caring for trafficked persons – Guidance for Health Providers IOM and LSHTM. **http://bit.ly/2CO57eU**

62. Fassil Y and Burnett A. Commissioning mental health services for vulnerable adult migrants Guidance for commissioners. September 2015. **http://bit.ly/2CNAqXg**

63. Rose N, et al. Including migrant populations in Joint Strategic Needs Assessments: a guide. February 2011. **http://bit.ly/2CM46Eg**

64. Jeal N, Salisbury C. A health needs assessment of street-based prostitutes: cross-sectional survey. J Public Health (Oxford). 2004;26(2):147-51. **http://bit.ly/2CPnP5V**

65. Zimmerman C, et al. Stolen smiles: a summary report on the physical and psychological health consequences of women and adolescents trafficked in Europe. London School of Hygiene and Tropical Medicine 2006. **http://bit.ly/2CMbQpQ**

66. .Ham C. Walsh N. Making integrated care happen at scale and pace. The Kings Fund March 2013. Available from: **http://bit.ly/2CO5FkY**

67. Newell F. Framework for patient and public participation in primary care commissioning. NHSE March 2016. **http://bit.ly/2COWPTY**

68. Public Participation Team. NHS England and Patient and public participation equality and health inequalities – full analysis and associated resources. April 2016. **http://bit.ly/2CN4sul**

69. Involving people in their own health and care: Statutory guidance for clinical commissioning groups and NHS England. **http://bit.ly/2CKvKkP**

70. Experts by Experience Involvement Handbook. Pathway 2017. **http://bit.ly/2pHjknN**

71. RCP E-Learning: **http://bit.ly/2Di5GSt**

72. UCL MSc Population Health, Short course **http://bit.ly/2CLNzjx**

73. See the Street Medicine Institute at **http://bit.ly/2CLNOuX**

74. South London and Maudesley NHS Foundation Trust and South West London and St George's Mental Health NHS Trust (2010) Recovery is for All. Hope, Agency and Opportunity in Psychiatry. A Position Statement by Consultant Psychiatrists. London: SLAM/SWLSTG. Available from: **http://bit.ly/2DePpKH**

75. Department of Health (2010) Equity and Excellence: Liberating the NHS. The Stationary Office, Norwich. Available from: **http://bit.ly/2DeJup0**

76. Buchanan D, Doblin B, Sai T, Garcia P. The effects of respite care for homeless patients: a cohort study. Am J Public Health. 2006;96(7):1278–1281. **http://bit.ly/2DgHkW2**

77. Kertesz SG, Posner MA, O'Connell JJ, et al. Post-Hospital Medical Respite Care and Hospital Readmission of Homeless Persons. Journal of Prevention & Intervention in the Community. 2009; 37(2):129–142. **http://bit.ly/2Djt3I6**

78. Pathway Report 03.01. Medical Respite for Homeless People. Outline service specification. London May 2013. **http://bit.ly/2DgJzIW**

79. Mental Health and Homelessness Guidance. **http://bit.ly/2DfztYI**

80. Feldman R (2012) Guidance for commissioning health services for vulnerable migrant women, Women's Health and Equality Consortium and Maternity Action **http://bit.ly/2CMGBLh**

81. Doctors of the World. Safe Surgeries Toolkit. **http://bit.ly/2DcPjDn**

82. Health Protection Services. Migrant Health: Infectious diseases in non-UK born populations in the UK. An update to the baseline report – 2011. London: Health Protection Agency; 2011. **http://bit.ly/2Dhocr4**

83. PHE Travel and Migrant Health Section. Migrant Health Guide: Public Health England; 2013 [cited 2013 20 August]. Available from: **http://bit.ly/2Djof5L**

84. PHE Immunisation Department. Vaccination of individuals with uncertain or incomplete immunisation status: Public Health England; 2013. Available from: **http://bit.ly/2Dg3ZS9**

85. Refugee Council support for vulnerable migrants. **http://bit.ly/2DgMiCa**

86. UN Office of the High Commissioner for Human Rights (OHCHR), Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment ("Istanbul Protocol"), 2004, HR/P/PT/8/Rev.1, available at: **http://bit.ly/2DgNN3g**

87. Jeal N, Salisbury C. Protecting the health of sex workers: will the real agenda please stand up. Postgrad Med J 2013;89:369–370. **http://bit.ly/2DgPNZk**

88. Office for National Statistics. General Lifestyle Survey, 2011: ONS; 2013 [Release date: 7th March 2013]. Available from: **http://bit.ly/2DgI1yG**

89. Carr SM, Lhussier M, Forster N, Goodall D, Geddes L, Pennington M, et al. Outreach programmes for health improvement of Traveller Communities: a synthesis of evidence. Public Health Res 2014;2 (3). DOI: 10.3310/phr02030. **http://bit.ly/2DfgeyD**

90. The Irish Traveller Service; Health and Well-being Project **http://bit.ly/2COEFIb**

91. Groundswell UK; My right to healthcare card. **http://bit.ly/2COjCPW**

92. Working with homelessness. Standards for GP receptionists in primary care. Pathway 2017. **http://bit.ly/GPStandards**

93. St Mungos. Stop the Scandal: an investigation into mental health and rough sleeping February 2016. **http://bit.ly/2CQ0cdq**

94. NICE guidance on commissioning stepped care for common mental health disorders. **http://bit.ly/2CMWLnP**

95. Psychologically informed services for homeless people. Good practice guide. February 2012. **http://bit.ly/2CPyZrt**

96. National Collaborating Centre for Mental Health. Antenatal and Postnatal Mental Health: The NICE Guidance on Clinical Management and Service Guidance: The British Psychological Society and The Royal College of Pyschiatrists; 2014. Available from: **http://bit.ly/2CQjjUF**

97. Khan. Z. Clinical Lead SLAM Pathway team. Personal communication (publication pending)

98. Personality Disorder: no longer a diagnosis of exclusion - policy implementation guidance for the development of services for people with personality disorder. NIMHE. 2003. **http://bit.ly/2CNxidP**

99. Conolly, J., and Ashton, P. 'Staff and ex-service user co-working: a counselling service's enhanced response to multiple exclusion homelessness', 2011, Housing Care and Support, Vol 14, No. 14. pps 134 – pps141.

100. Naloxone in homelessness services **http://bit.ly/2CQMN53**

101. Guidance for hepatitis A and B vaccination of drug users in Primary Care and criteria for audit. RCGP 2005. **http://bit.ly/2CTewC1**

102. The Bradley Report Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system. Department of Health April 2009. **http://bit.ly/2CSehaj**

103. Mac Gabhann C. Voices Unheard. A Study of Irish Travellers in Prison: The Irish Chaplaincy in Britain; 2011. Available from: **http://bit.ly/2CNL7Jn**

104. Revolving Doors: Rebalancing Act A resource for Directors of Public Health, Police and Crime Commissioners, the police service and other health and justice commissioners, service providers and users. **http://bit.ly/2CPCVsb**

105. Williams K et al. Accommodation, homelessness and reoffending of prisoners: Results from the Surveying Prisoner Crime Reduction (SPCR) survey. Ministry of Justice Research Survey. March 2012. **http://bit.ly/2COpCYN**

106. Williamson M. Improving the health and social outcomes of people recently released from prisons in the UK. A perspective from primary care. Sainsbury Centre for Mental Health. January 2006. Available from: **http://bit.ly/2CPvH7m**

107. Byng et al (2012). COCOA: Care for Offenders, Continuity of Access. Final Report: NIHR Service Delivery and Organisation programme. **http://bit.ly/2CRDJgh**

108. IAPT NHS. Offenders Positive Practice Guide. March 2013 **http://bit.ly/2mOHddb**

109. Daly B, Newton T, Batchelor P, Jones K (2010) Oral health care needs and oral health-related quality of life (OHIP-14) in homeless people. Community Dent Oral Epidemiol. Apr;38(2):136-44 **http://bit.ly/2CRDWQB**

110. Pathway. Improving Access to Dental Care for Homeless People. **http://bit.ly/2CPwaXa**

111. Daly B, Newton JT, Batchelor P (2010). Patterns of dental service use among homeless people using a targeted service. J Public Health Dent. 201: Winter;70(1):45-51. **http://bit.ly/2CReavs**

112. Dickenson A, Doughty J. Socially Inclusive Dentistry Executive summary of the 1st National Conference. Health Education England. November 2016. **http://bit.ly/2CODMt1**

113. The health and wellbeing of people who are homeless: evidence from a national audit. Homeless Link 2010. **http://bit.ly/2CQhOpA**

114. Shulman C, Hudson BF, Low J, Hewett N, Daley J, Kennedy P, et al. End-of-life care for homeless people: A qualitative analysis exploring the challenges to access and provision of palliative care. Palliative Medicine. 2017;0(0):0269216317717101. **http://bit.ly/2CNM8kF**

115. Advanced ill health and homelessness: a complex issue.
Available from: **http://bit.ly/2CQi87M**

116. Kennedy P, Sarafi C, Greenish W. Homelessness and End of Life Care: Practical information and tools to support the needs of homeless people who are approaching the end of life, and those who are bereaved. Marie Curie Cancer Care and St Mungo's. 2013.
Available at: **http://bit.ly/2CPkfZy**

117. Jesper E, Griffiths F, Smith L. A qualitative study of the health experience of Gypsy Travellers in the UK with a focus on terminal illness. Primary Health Care Research and Development. 2008;9(2):157–6 **http://bit.ly/2COEmXJ**

118. Dorney-Smith S, Hewett N, Burridge S. Homeless medical respite in the UK: A needs assessment for South London. British Journal of Healthcare Management 2016 Vol 22 No 8. P 405-413. **http://bit.ly/2CTgzGd**

119. Safely home: What happens when people leave hospital and care settings? Healthwatch England Special inquiry findings July 2015. **http://bit.ly/2CPxcm0**

120. Hewett N, Halligan A, Boyce T. A general practitioner and nurse led approach to improving hospital care for homeless people. BMJ 2012;345:e5999.
Available from: **http://bit.ly/2DitaUc**

121. Hewett N, et al. Randomised controlled trial of GP-led in-hospital management of homeless people (‘Pathway’). Clinical Medicine 2016 Vol 16, No 3: 223–9
http://bit.ly/2DkoVYt

122. Dorney-Smith S, Hewett, N, Khan, Z, Smith R (2016) Integrating health care for homeless people—the experience of the KHP Pathway Homeless Team. BJHCM 22(4): 225–34
http://bit.ly/2DilXUh

123. Future Hospital Commission. Royal College of Physicians London. September 2013.
http://bit.ly/2DkeMuC

124. Homeless Link, St Mungos. Improving Hospital Admission and Discharge for People who are Homeless. March 2012 **http://bit.ly/2DllwZa**

125. Homeless Link. Evaluation of the Homeless Hospital Discharge Fund. January 2015.
http://bit.ly/2CQHjH9

126. Royal College of Physicians, Inclusion Health, Designing Services **http://bit.ly/2CMmb4T**

127. Pathway website link **http://www.pathway.org.uk/**

128. Faculty Peer Appraisal **http://bit.ly/2CQZooy**

129. Inclusion Health clinical audit, 2015. Pilot Report-Organisational Audit **http://bit.ly/2DfkjCK**
& Inclusion Health Clinical Audit 2015-16 Pilot Report- Patient Audit **http://bit.ly/2DiEnUT**

pathway

Healthcare for homeless people

www.pathway.org.uk

Registered Charity No. 1138741