Healthy London Partnership

NHS

Health care & people who are homeless

Commissioning Guidance for London

December 2016

10 commitments for London:

How to improve health outcomes for people experiencing homelessness

People who sleep rough, live in hostels, 'surf' on sofas, or who are chronically insecurely housed

Foreword

The London Homeless Health Programme [LHHP] was developed in response to the large and growing issues associated with homelessness and rough sleeping. The programme is part of the Healthy London Partnership - a collaboration between all 32 London Clinical Commissioning Groups [CCGs], and NHS England London region.

The numbers of people sleeping rough in London have been increasing steadily over recent years. Wellbeing and health are seriously compromised when you are affected by homelessness. The average age of death for someone who is sleeping rough is just 47, half that of the general population. Rates of drug and alcohol dependence are very high. Mental health, dental health and foot health are often poor. Respiratory disease is common. Important indicators for health outcomes are significantly worse than for the general population.

Many people who are affected by homelessness are very high users of NHS hospital services. They attend Accident and Emergency departments five times as often as the general population. When they are admitted to hospital, they stay three times as long and when they are ready to leave they are often discharged on to the streets without their underlying issues being addressed.

The work of LHHP supports the delivery of better health, improved health services and access to those services for people who experience homelessness.

This Commissioning Guidance outlines 10 commitments for improving health outcomes for homeless people in London. Each commitment includes ideas and practical tips.

The commitments were developed in consultation with a wide group of stakeholders including the views of people with lived experience of homelessness. We have also published powerful report More than a statistic based on an extensive peer-led consultation project led by Groundswell.

This Commissioning Guidance has been developed as a "once for London" tool that can be used by all CCGs and as an important reference document for anyone delivering health services to people who are affected by homelessness. We want to thank the people who so generously gave their time in the development of this Commissioning Guidance.

The scale of change we are aiming for needs strong commitment and clear purpose from commissioners. As the governance leads for the London Homeless Health Programme we are very pleased to be able to publish this report so that its insights can be used widely.

Kenny Gibson

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Commitments

Introduction

This commissioning guidance was produced by the London Homeless Health Programme to support commissioners in London's Clinical Commissioning Groups.

The guide outlines 10 commitments for improving health outcomes for homeless people in London which commissioners can use as guiding principles in their work to improve health services for homeless people in their localities. Each commitment includes ideas and practical tips on how to commission high quality, timely and co-ordinated healthcare for people who are experiencing homelessness.

To identify these 10 commitments for London, we engaged with more than 100 NHS and non-NHS organisations across London, including all CCGs and many service providers. Hundreds of previous reports, recommendations and research papers were reviewed and eleven workshops with key stakeholders, including CCGs and homeless charities, were held in the summer of 2016 to refine the content of this commissioning guide.

As the voice of people experiencing homelessness is rarely heard in public consultation, we commissioned homeless charity Groundswell to undertake a peer-led research project to enable people with lived experience of homelessness to contribute fully to this commissioning guidance. Extracts from Groundswell's final report, More than a statistic, have been used throughout this commissioning guidance.

This period of engagement and due diligence informed and shaped the 10 commitments for London, together with the 47 ideas and practical tips that will improve health outcomes for people experiencing homelessness.

There are many examples of good practice across London, often simple ideas that can be adopted locally within regular healthcare settings to ensure people experiencing homelessness have the same access to healthcare as people who are securely housed. These examples of good practice, and any useful documents, are also included under the relevant commitment in this guide.

Elements from the Preventing homelessness to improve health and wellbeing produced by Homeless Link on behalf of Public Health England, have also been used this guide.

This commissioning guidance is intended to be used in conjunction with the More than a statistic report from Groundswell and will enable commissioners to assess their own progress towards meeting the commitments.

Homelessness in London

Homelessness is bad for your health – Homeless Link's 2014 national health audit evidences that people experiencing homelessness have stark health inequalities, with rough sleepers' life expectancy more than 30 years shorter than the general population. People experiencing homelessness often have complex needs associated with co-morbidity (physical health, mental health, and substance misuse), and have poor health outcomes from treatable conditions. Up to 80 per cent of people experiencing homelessness have mental health problems; including personality disorders, depression and schizophrenia.

National work carried out by St Mungo's identifies that the number of people recorded as sleeping rough with an identified mental health support need has more than tripled over the last five years from 711 in 2009-10 to 2,342 in 2014-15.

Given the high prevalence of chronic disease and co-morbidity amongst the population of people who are homeless, and the financial cost this has on the NHS, CCGs should be commissioning healthcare to work more proactively with people experiencing homelessness and the agencies that support them. In 2010 the Department of Health reported on a range of costs that health services are estimated to bear as a result of the needs of homeless people.

Commitment No. 1

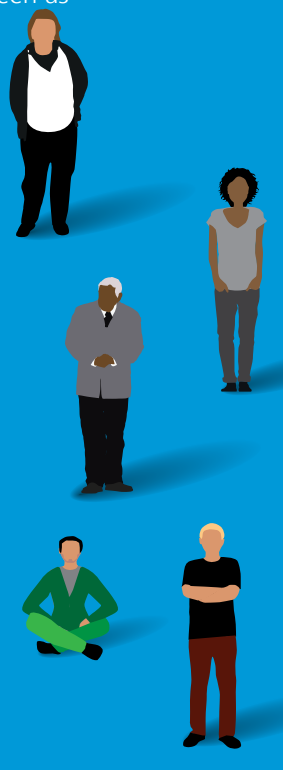
People experiencing homelessness receive high quality healthcare

What did people with a lived experience of homelessness tell us?*

"I think they have got to really start scratching below the surface of people that present [at health services]. People might well present looking a little bit rough and all that sort of thing and a bit incoherent or a bit aggressive or something. There are some issues there. You can't just take them at surface value. There is reasons why people are in this sort of situation and they need time, empathy, understanding. And actually sometimes just someone to just listen. Let it all out. And it takes time, you know? With me it took time to get through to me to understand what the hell was going on in my life. And then come to my own decision that I wanted to keep it going. Because that was a 50/50 at one point. So, you don't just look at the guy or the girl that turns up. And make a judgment. There's a hell of a lot of stuff going on underneath there. An incredibly valuable and sometimes horribly traumatic experience."

– Groundswell focus group participant

- Healthcare services are not meeting the needs of people experiencing homelessness, with the greatest impact upon the most vulnerable people, e.g. migrants, people with mental ill health and substance misuse issues.
- Specialist homeless health services are valued by people experiencing homelessness as they provide flexible appointments and holistic support that is tailored to the needs of homeless people. These services should help to bridge the gap with mainstream health services, including offering ideas and practical tips.
- Homeless people could make better use of mainstream healthcare, on a level with people who are 'housed', if service delivery models were able to offer improved consistency in service, flexibility, in-reach and outreach and utilise care navigation services. This would require clinical and non-clinical staff to have training around the causes and consequences of homelessness, delivered/co-produced by people with experience of homelessness themselves, as many participants had had negative experiences of unhelpful attitudes expressed by frontline staff, which had deterred them from accessing services. Greater knowledge of available services by NHS staff was also seen as necessary to support patients holistically.



Please see the full report from Groundswell More than a statistic on the Healthy London Partnership website for full participant feedback

Commitment 1: practical ideas and tips

1.1 **CCGs should promote high quality healthcare for the homeless population by addressing health inequality and exclusion at a local level**

1. Identify a Homeless Health Lead in every CCG area, to champion the local homeless health agenda and engage on a pan-London level with other Homeless Health Leads and with wider London Homeless Health Clinical Networks (such as the QNI, Faculty or LNNM). The London Homeless Health Programme will also be developing a wider clinical network for 2017/18.

Example:

2. Central London CCG's governing body has two members who amongst their broader duties champion the needs of homeless patients in the Clinical Commissioning Group area.

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Commitment 1: practical ideas and tips

1.2 **CCGs should be working in partnership with local stakeholders to build a better understanding of the local homeless population, and to improve the local evidence base on their health needs**

Create a local multi-agency homelessness forum/network that includes CCG and Local Authority commissioners, NHS and non-NHS providers and local people with a lived experience of homelessness.

The forum/network could be chaired by the Homeless Health Lead and used to:

- share good practice
- learn lessons following incidents and deaths of homeless people in the local area
- periodically assessment of the local homeless population and their needs through local CHAIN data, hostel numbers, A&E frequent attenders list, local health needs assessments. An example of a summary report used in Westminster can be found here
- review data from ambulance call outs to homeless hostels and homeless 'hot spots' in the area

The Homeless Health Lead and a local multi-agency forum/network could use the local homelessness data gathered via the forum/network, to identify gaps in service delivery and to build an evidence base to support commissioning arrangements and plans for future service provision. This could include co-commissioning and pooled resources to optimise service delivery, inform health and housing literacy within the workforce, guide clear and co-ordinated direction to all agencies and individuals, embed a prevention first approach and reduce organisational boundaries.

The forum/network could be a sub-group of the Health and Wellbeing Board and could sign up to the commitments in this guide or a charter such as the Charter for Homeless Health

Useful Documents:

1. 'Standards for commissioners and service providers, The Faculty for Homeless and Inclusion Health'
2. 'Preventing homelessness to improve health and wellbeing'

Examples:

1. Harrow Homelessness Forum

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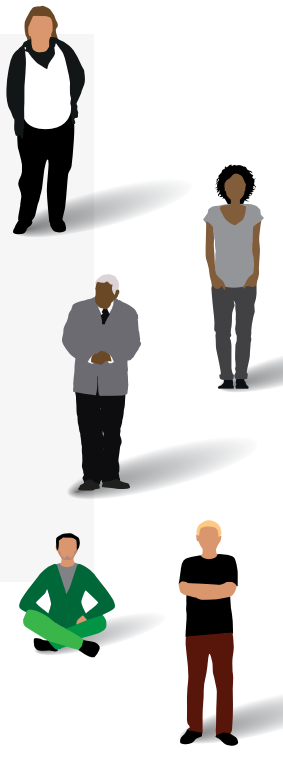

Commitment 1: practical ideas and tips

1.3 **CCGs should be working in partnership with the Local Authorities and key stakeholders to reduce homelessness as a consequence of social determinants of health (education, employment, housing, financial security and social exclusion)**

The needs of the local homeless population should be included in Local Commissioning arrangements and plans. This could be the Sustainability and Transformation Plan, Joint Strategic Needs Assessment or Health and Wellbeing Strategy.

Useful Documents:

1. A Memorandum of Understanding to support joint action on improving health through the home

Examples:

1. Health needs assessment of homelessness in Haringey
2. Brighton & Hove Rough Sleeping Strategy 2016
3. Brighton and Hove Joint Strategic Needs Assessment 2014: Rough Sleeping and Single Homelessness

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Commitment 1: practical ideas and tips

1.4 **CCGs should ensure that services they commission encourage their staff to complete training that addresses working with people who are homeless**

Training packages should be co-designed with people who have lived experience of homelessness to support frontline workers to better understand the rights of people who are homeless and the challenges they face trying access healthcare.

Training should encourage frontline workers to become gate-openers to healthcare rather than gate-keepers and give frontline workers some information on how to advise and signpost people experiencing homelessness to local community based services.

The London Homeless Health Programme is currently developing an e-learning package for NHS staff for 2016/17.

Example:

1. Doctors of the World offer training
2. Improving the patient experience

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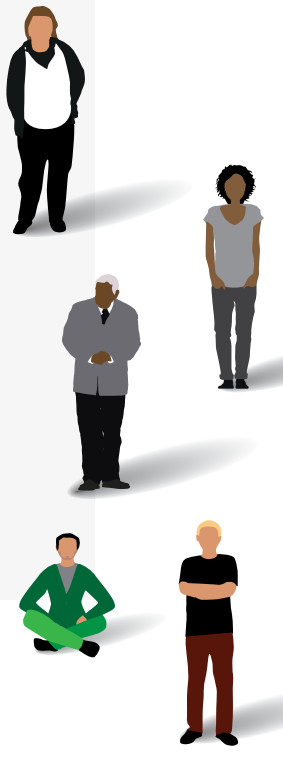

Commitment 1: practical ideas and tips

1.5 **CCGs should ensure that services they commission do not deny access to non-UK nationals when they are entitled to these services. This is a particular issue in London due to the size of this population, and the high prevalence of homelessness within it**

CCGs should work in partnership with local authorities to ensure that all frontline workers can provide homeless non-UK nationals with basic information about their rights to access health care, housing, employment, public funds and reconnection services; enabling individuals to maximise their options and make informed choices about staying in the UK or returning home.

Adequate provision of interpreting services should be available to prevent non-UK nationals from being excluded due to communication barriers.

'My Right to Access Healthcare' cards are currently being developed by the London Homeless Health Programme. These will be available at the end of 2016, with the aim of empowering people experiencing homelessness to access health services. NHS England is also developing a patient leaflet to inform homeless people and non-UK nationals about their rights to access healthcare.

Useful Documents:

1. NRPF Network - NHS healthcare for migrants with NRPF (England)
2. Resource pack to help general practitioners and other primary health care professionals in their work with refugees and asylum seekers

Examples:

1. Kensington, Chelsea and Westminster Homelessness Prevention Initiative
2. Wandsworth Homeless and Asylum Health Team
3. Doctors of the World UK

CCG self-assessment section
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Commitment No. 2

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

What did people with a lived experience of homelessness tell us?

"I think peer – the power of peer is phenomenal. It really is. As experience goes, it's just… It's the most enlightening and…. wonderful experience that sort of takes the burden of shoulders… Makes you recognise that you are not alone. And you can relate to other people. And oh what a relief that is, you know? You can even have a laugh about it sometimes. And then that helps build strength and confidence. And it's nice to help other people as well and share experience" -

Groundswell focus group participant

- Health is one of a number of competing priorities for people experiencing homelessness, but that does not mean people do not want to improve their health.
- By delivering services in a way that allows people who have experience of homelessness to be involved in making decisions on their own care, and by providing more opportunities for input into the way that services are run more generally, it will result in better quality care for all.
- Participants in the focus groups welcomed the opportunity to be involved in this study, as many felt that their opinions and choices were not ordinarily valued. On-going engagement with people with experience of homelessness was welcomed by all groups that it was discussed with, with many participants feeling that they would like to be meaningfully involved in health services.
- All of the participants who had been supported by a peer advocate or care navigator, particularly with experience of homelessness, reported having a positive experience, indicating that it had helped them to gain a sense of control over their health needs.

Commitment 2: practical ideas and tips

2.1 **CCGs should ensure that services they commission include in workforce planning people with a lived experience of homelessness and that they encourage them to join the healthcare workforce**

This involvement in the workforce could be through voluntary opportunities leading to paid employment and career pathways.

As part of this workforce planning, consideration must to be given to the specific needs of this expert group. Accredited standards, training and support must be provided as with any other expert group or profession.

Example:

1. Pathway will shortly be publishing a report on supporting 'Experts By Experience'

CCG self-assessment section
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Commitment 2: practical ideas and tips

2.2 Patient & Public Engagement Strategies specify that people with a lived experience of homelessness are included in public consultation as they are often deemed too 'hard to reach' and their voice is rarely heard

Local Healthwatch could proactively reach out to the homeless population in the local area by working in partnership with local providers of day centres, hostels and street outreach services.

Examples:

1. Healthwatch Waltham Forest
2. Healthwatch Kingston
3. Healthwatch Richmond

CCG self-assessment section
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Commitment No. 3

Healthcare 'reaches out' to people experiencing homelessness through inclusive and flexible service delivery models

What did people with a lived experience of homelessness tell us?

"I am just talking personally – there are some mornings you wake up and you don't feel you want to get out of bed, you don't want to get up and get dressed. You don't want to even face anyone in the hostel, you don't even want to step outside. And by having somebody come in, park up there, it would be great" **– Groundswell focus group participant**

- For people experiencing homelessness basic survival needs like food or managing a substance dependency often take priority over addressing health needs.
- Participants therefore spoke of the value of services that come to 'where they are' - in particular day centres, hostels and community centres. In addition to addressing immediate needs, such as preventing conditions getting worse or contagious conditions spreading, they effectively signpost individuals to building-based NHS services.
- Consistency in staff and service access is a key factor that can mean people experiencing homelessness build trust and receive more effective interventions. It avoids the need for homeless people to have to 'explain themselves' repeatedly, and can help in stabilising an individual's progress out of homelessness, and into accessing mainstream services.
- While frustrations with waiting times, appointments and methods of communication may be common among the general population, they can further compound homeless people's feelings of exclusion.
- A proactive approach is needed to involve people experiencing homelessness in shaping their own care. Participants felt that feedback processes were not always accessible. Despite many negative experiences of healthcare, few participants had any experience feeding back on their care. For some participants, not having an outlet for their frustration had resulted in negative consequences.
- When well informed and supported, individuals (whether homeless or not) can have more control over their care. If they can feel confident to feedback on their care, the level of service is ultimately improved. For this participant they had a positive experience of feeding back on their care.

Commitment 3: practical ideas and tips

3.1 **CCGs should ensure that services they commission have inclusive access policies that specifically address access issues for the homeless population**

Access policies should include reduced, removed or different performance targets and indicators for harder-to-reach groups including those experiencing homelessness.

Useful Document:

1. Guide to models of delivering health service to homeless people

Examples:

1. Specialist Podiatry service for Homeless and Vulnerable People - Central London Community Healthcare NHS Trust

CCG self-assessment section
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Commitment 3: practical ideas and tips

3.2 **CCGs should ensure that services they commission offer flexible healthcare delivery that includes flexible appointment times, drop-in sessions, in-reach to hostels and day centres and outreach to the street when needed**

Enhanced services or equivalent schemes can incentivise in-reach to local hostels and day centres, and outreach to the street can be an alternative way of providing flexible healthcare.

Examples:

1. The Health Inclusion Team in Lambeth, Southwark and Lewisham
2. Homeless Health Team
3. Community Dental Outreach Team

CCG self-assessment section
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Commitment 3: practical ideas and tips

3.3 **CCGs should ensure that services they commission offer extra support when needed to assist people experiencing homelessness to navigate the healthcare system e.g. registering with a GP, hospital attendance, community follow-up and completing courses of treatment**

This could be an existing advocacy or care co-ordination/navigation service with an extended role, or a specialist homeless care navigation service.

Useful Document:

1. Saving Lives, Saving Money – How Homeless Health Peer Advocacy Reduces Health Inequalities

Example:

1. Groundswell, Homeless Health Peer Advocacy

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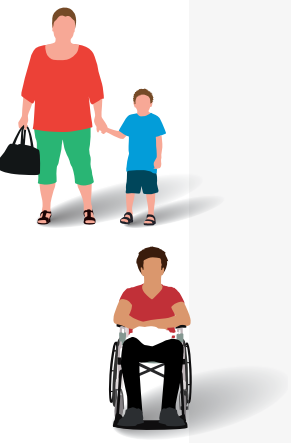

Commitment 3: practical ideas and tips

3.4 **CCGs should ensure that services they commission ensure 'every contact counts' by offering holistic assessments of need; covering physical health, mental health, and substance use**

Homeless Health Checks should be on offer that cover the main health concerns affecting the homeless population e.g. skin problems (especially foot trauma), respiratory illness and infections, blood borne viruses, diabetes, sexual health, oral health, eye checks, mental health and substance misuse. This should also include opportune vaccinations for flu immunisation, hepatitis B, streptococcal and numa.

Healthy Living and Wellbeing Advice should be on offer including mental health, substance use, alcohol use, smoking cessation, contraception, weight management and health eating, oral health and needle exchange, and foot care.

Useful Documents:

1. Homeless Link – Health Needs Audit
2. QNI Health Assessment – Tool and Guidance for Community Nurses
3. People faced with chronic homelessness have much higher rates of premature death than the housed population

Example:

1. Great Chapel Street Medical Centre
2. Central London Community Healthcare NHS Trust Homeless Health service

CCG self-assessment section
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Commitment 3: practical ideas and tips

3.5 **CCG-commissioned providers should make reasonable adjustments for those with complex needs, including behaviours associated with personality disorders and/or complex trauma and/or co-existing substance/alcohol use**

People experiencing homelessness can have complex needs and may be unreliable in attending appointments. Life experiences may mean that they lack of trust and willingness to engage with professionals and services.

Examples:

1. Westminster Homeless Health Counselling Service - offers 'pre-treatment therapy' to enable the homeless people of Westminster to access and make use of counselling. It understands that many homeless people have a history of trauma compounded by their homeless circumstances, and that their trauma response must be taken into account in order to help engage them. Drop in counselling sessions, regular counselling appointments, and drop in support & discussion groups, anger, women only, are on offer across a variety of homeless services.

1. Dr Hickey Practice - The practice has an active patients participation group maintaining open dialogue with the surgery.

CCG self-assessment section
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Commitment 3: practical ideas and tips

3.6 **CCGs should ensure that services they commission provide and maintain 'continuity of care' for people experiencing homelessness, including when they have temporarily moved out of the geographic boundaries of a service, including short stays in prison**

This could be achieved by proactively supporting people to take responsibility for their own health and wellbeing through making informed choices about personal data sharing with other NHS and non-NHS organisations. This would improve partnership working across agencies and enable safe continuity of care across organisational and borough boundaries, to stop people 'falling through the gaps'.

People with a 'Homeless Housing Status' should be asked about a 'safe address' to be used as point of contact - this could be a day centre or a GP Practice address. They should also be supported to give written consent for information about them to be shared with a 'trusted person', this could be a hostel worker, outreach worker or peer support worker.

Example:

1. St Mungo's, Homeless and End of Life Care Consent Form

CCG self-assessment section
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Commitment No. 4

Data recording and sharing is improved to facilitate outcome-based commissioning for the homeless population of London

What did people with a lived experience of homelessness tell us?

"I asked for the letter… for the council, I was under treatment and I was provided that letter by the psychiatrist and …yes. They talked to me about my housing situation and that I was homeless. They were supportive. The psychiatrist was really supportive. And I appreciate GP as well because he just passed my information to the psychiatrist and the mental health team"

– Groundswell focus group participant

- Data collection, recording and sharing was generally seen as a positive, with participants seeing a link between well-informed records accessible across NHS services, and service quality. A common rationale was that it meant that patients do not have to 'explain themselves' to medical staff repeatedly, particularly around accommodation and substance misuse.
- Participants also felt that it was important for people's accommodation status to be recorded on their NHS records so that medical staff could be aware of this support need at an earlier stage, and therefore plan appropriate treatment, trigger discharge procedures earlier, and increase accountability.
- When meeting with patients, healthcare professionals may be privy to personal information about unstable housing even before individuals have engaged with support services. At times of crisis they may also be best placed to support individuals to find relevant support before situations deteriorate further. Medical professionals identifying unstable accommodation status and linking up with local non-medical services, and primary care services offering a 'social prescription' to sources of support within the community, can offer an important intervention. One participant explained how "joined up" services, with clear communication between them, led to them being placed in more stable accommodation by the local authority.

Commitment 4: practical ideas and tips

4.1 **CCGs should ensure that services they commission record the housing status for all people accessing services at first contact, significant review points and at discharge**

People's housing status should be a trigger to activating pathways and services for early and holistic intervention. This status can change during admission or treatment, and health services are well placed to support partnership working.

Example:

1. Mental Health Services Data Set - accommodation status codes

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Commitment 4: practical ideas and tips

4.2 **CCGs should support the collection and analysis of housing status data locally to better understand the needs of the local population, and specifically the health needs of those experiencing homelessness**

Collection of an agreed data set across a local health economy will allow commissioners to work in partnership to improve the health of hard-to-reach groups such as homeless people.

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Commitment 4: practical ideas and tips

4.3 **Data on housing status should be shared with partner agencies locally and across London to support joint working and commissioning**

Data sets could include anonymised data for the purpose of prevalence and benchmarking, and to understand the needs of the local population.

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Commitment 4: practical ideas and tips

4.4 **Early identification of housing status should lead to early intervention to prevent the development of chronic health conditions and co-morbidity associated with homelessness**

Housing status should be flagged on clinical record systems to act as a trigger for a health intervention and/or 'social prescribing' – i.e. a flag that appears prominently on top of a record as a prompt to the next service who engages with the client (e.g. "referral to GP needed and chest X-Ray to be arranged").

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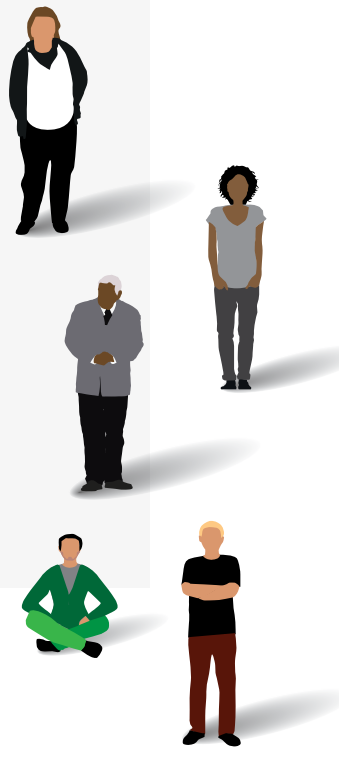

Commitment 4: practical ideas and tips

4.5 **CCGs should ensure that services they commission ask people if their housing status is 'affecting their health'**

This could act as a trigger for a health intervention and/or 'social prescribing', including:

- Homeless Health Checks
- Social prescribing - e.g. housing, financial, legal issues, immigration, reconnection, educational and employment support
- Referral to care navigation/advocacy services
- Signposting to appropriate services

Example:

1. The Royal College of Emergency Medicine, Inclusion health clinical audit

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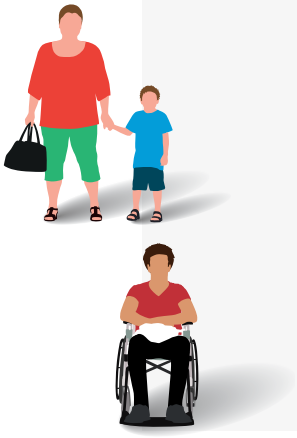

Commitment No. 5

Multi-agency partnership working is strengthened to deliver better health outcomes for people experiencing homelessness

What did people with a lived experience of homelessness tell us?

"What I have noticed in London, they haven't got a lot of information on what to do [when you are homeless]. See like yourself, coming from another country, unless you actually go and meet another homeless person you wouldn't have a clue where the things are. There is no information, nothing really like. Advertisements sort of thing"

– Groundswell focus group participant

- Data recording and sharing with agencies outside and within the NHS was generally seen as a positive, if done with consent from the patient, and likely to result in increased service quality.
- A key issue raised in focus groups was the need for information on healthcare and wider support services to be not only readily available, but be proactively provided for people with experience of homelessness.
- The same limited availability of relevant and helpful information was also held by healthcare and support staff, who could be in a prime position to direct people to appropriate support. This highlights the need for both better information on healthcare and on homeless services.
- A number of participants highlighted that it was other people who were homeless who were the best source of information, as they had already used services and could communicate in a way that people could understand. This raises the need for information to be delivered in a way that is clear and easily understood.
- While information on which services are available and how to access them was key, many participants felt that they simply did not know their rights around healthcare.
- Participants reported dislocation between physical and mental health services and support, including non-NHS services such as social care, housing, public health and substance misuse. There was also a particular emphasis on the lack of support for people with dual diagnosis (personality disorders and substance misuse).

Commitment 5: practical ideas and tips

5.1 **All CCGs should work in partnership with Local Authorities and other partners to ensure people experiencing homelessness are able to access timely care and support whilst disputes about responsibility are resolved both locally and across London**

The government's most recent mandate to the NHS states that homeless people should receive 'high quality, integrated services that meet their health needs'.

This could be taken forward locally by establishing a local Complex Need Forum and Register that has membership from local homeless providers and Safeguarding Lead(s), with an agreed escalation processes and reciprocal arrangements across London for people who wander and more around.

The Register could include people with:

- complex co-morbidity
- people at high risk of dying within the next 6-12months
- people at risk of becoming homeless in the local area due to health problems
- people at risk of homelessness due to leaving institutions, including hospital, care, prison, secure units and the armed forces.

Consideration could also be given to developing a local Homeless Health 'Trusted Assessor', an idea currently adopted within other healthcare settings (i.e. a person or a team within a non-NHS organisation appointed to undertake health, housing and social care assessments on behalf of multiple teams, using agreed criteria and protocols).

Useful Documents:

1. Rough Sleeping Commissioning Framework, Mayor of London, Sept 2015, Priority 8 Meeting the physical and mental health needs or rough sleepers
2. Trusted Assessor Competence Framework
3. NHS England, quick-guide to improving hospital discharge into the care sector (with referred to Trusted Assessors)

Example:

1. Enabling Assessment Service London

CCG self-assessment section
Please use this space to make notes

Commitment 5: practical ideas and tips

5.2 **CCGs should facilitate and support collaborative multi-agency working and information sharing between local services, including non-NHS providers**

Due to the transient 'wandering' nature of people with insecure housing, different ways of sharing clinical data are needed, as current clinical systems across London do not link up.

Local information sharing agreements and information governance should be put in place between local NHS and non-NHS Commissioners and Providers that reference people experiencing homelessness.

Pan-London safeguarding agreements should also be in place for those higher risk 'wanderers' who move between borough boundaries and often get lost to follow-up.

Examples:

1. Female Entrenched Rough Sleeper Project
2. London EMIS Project – link 1 and link 2

CCG self-assessment section
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Commitment 5: practical ideas and tips

5.3 **CCGs should work in partnership with Local Authorities to ensure that people experiencing homelessness have their needs assessed under relevant legislation and, if eligible, receive care and support, or if not are provided with advice and signposting**

Useful Document:

1. Mental Health Service Interventions for Rough Sleepers Tools and Guidance

Example:

1. Joint Homelessness Team

CCG self-assessment section
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Commitment 5: practical ideas and tips

5.4 **CCGs should work in partnership with Local Authorities to agree Health Promotion and Prevention plans for people experiencing homelessness, and the agencies that work with them**

These plans could include Homeless Health Checks and Healthy Living and Wellbeing Awareness Sessions in hostels, day centres and on the streets.

CCG-commissioned local activities and support groups for short and long-term conditions should also be proactively publicised to people in homelessness services to support preventative homeless health care – e.g. for diabetes and Chronic obstructive pulmonary disease [COPD].

Useful Documents:

1. NICE Guidance on behaviour change
2. Groundswell, Room-to-Breathe: A Peer-led heath audit on the respiratory health of people experiencing homelessness

Examples:

1. Hackney, SCT, Health MOT for the Homeless
2. Hackney and Whitechapel mobile dental van
3. Pan-London TB Find and Treat Service

CCG self-assessment section
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Commitment 5: practical ideas and tips

5.5 **CCGs should work in partnership with Local Authorities to ensure training and support is provided to non-NHS workers on basic health care screening, advice and raising concerns for homeless people not engaging with healthcare services**

Up-to-date information about local health services should be available at key gateways – Housing Departments, Libraries, CAB Offices, Hostels, Day Services.

Example:

1. Hammersmith and Fulham and Westminster, St Mungo's, Health and Homelessness Project

CCG self-assessment section
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Commitment No. 6

People experiencing homelessness are never denied access to Primary Care

What did people with a lived experience of homelessness tell us?

"You are homeless, you don't have proof of address, [so] to get a GP you cannot get this done. So when you come to [specialist homeless GP] they must work with you, so they count you as a human. Then you can have a place you can use as an address there as well."

– Groundswell focus group participant

- All focus groups were asked the question 'are you aware of your rights around healthcare': few could answer this question. There was a sense that while participants felt that they could access emergency care, many were unsure of their rights around accessing primary care, in relation to making choices about their own care, and about other rights such as accessing healthcare records.
- Strict access regulations, appointment slots and short windows for consultations, were a key barrier to using primary care.
- Another common issue was GP referrals to specialists, for further tests or prescriptions. Some justified their preference for using hospital A&E departments by explaining that A&E offered access to more diverse treatment.
- For those participants who had accessed specialist homelessness GP services there was a general feeling that the service offered by these practices was of high quality, supportive and met the needs of people experiencing homelessness. While these conversations were predominantly held in focus groups in central London boroughs, there were also examples of participants who were willing to travel long distances to use these practices. A key factor in this was that many participants who had been of no fixed abode had had difficulty signing up with general GPs, and specialist homelessness GPs were more willing to take on patients in these circumstances.

Commitment 6: practical ideas and tips

6.1 **CCGs should ensure all GP Practices adhere to the guidance contained in "Patient Registration Standard Operating Principles for Primary Medical Care (General Practice)"**

Key principles effecting the homeless population:

A patient does not need to be "ordinarily resident" in the country to be eligible for NHS primary medical care.

Where a GP refers a patient for secondary services (hospital or other community services) they should do so on clinical grounds alone. Eligibility for free care will be assessed by the receiving organisation.

The length of time that a patient is intending to reside in an area dictates whether a patient is registered as a temporary or permanent patient. Patients should be offered the option of registering as a temporary resident if they are resident in the practice area for more than 24 hours but less than 3 months.

Immediately necessary treatment - General Practices are also under a duty to provide emergency or immediately necessary treatment, where clinically necessary, irrespective of nationality or immigration status. The practice is required to provide 14 days of further cover following provision of immediate and necessary treatment.

Assessing patient ID at registration - If a patient cannot produce any supportive documentation but states that they reside within the practice boundary then practices should accept the registration.

Where necessary, (e.g. homeless patients), the practice may use the practice address to register them if they wish. If possible, practices should try to ensure they have a way of contacting the patient if they need to (for example with test results).

Useful Document:

1. Care Quality Commission (CQC) in their guidance entitled; GP Mythbuster 29; Looking after Homeless Patients in General Practice

Example:

1. Doctors of the World, Registration refused: A study on access to GP registration in England

CCG self-assessment section
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Commitment 6: practical ideas and tips

6.2 **GP Receptionists should be supported and trained to become champions of fair access to healthcare**

Training packaged should be designed jointly with people who have experience of homelessness to support frontline workers to better understanding the rights of people who are homeless and the challenges they face trying access healthcare.

The London Homeless Health Programme are currently developing an e-learning package for NHS staff for 2016/17.

Example:

1. Doctors of the World offer training
2. Improving the patient experience

CCG self-assessment section
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Commitment 6: practical ideas and tips

6.3 **CCGs should work in partnership with Local Authorities to ensure training and support is provided to non-NHS workers on basic health care screening, advice and raising concerns for homeless people not engaging with healthcare services**

Up-to-date information about local health services should be available at key gateways – Housing Departments, Libraries, CAB Offices, Hostels, Day Services.

Example:

1. Hammersmith and Fulham and Westminster, St Mungo's, Health and Homelessness Project

CCG self-assessment section
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Commitment 6: practical ideas and tips

6.4 **For those who say their 'Homeless Housing Status' is 'affecting their health', signposting and 'social prescribing' should be available**

This could include signposting to a 'one-stop-shop' offering advice and support around housing, financial, legal issues, immigration, reconnection, educational and employment support etc. It could also include referral to a care navigation/advocacy service.

Examples:

1. Hackney, Greenhouse Walk-In Centre
2. Brent, Ashford Place
3. SPEAR Homeless Health Link Service

CCG self-assessment section
Please use this space to make notes

Commitment No. 7

Mental Health Care Pathways, including Crisis Care, offer timely assessment, treatment and continuity of care for people experiencing homelessness

What did people with a lived experience of homelessness tell us?

"Again, my story – mental health and substance misuse went hand in hand. I don't think I was alone in that one. And the frustration for me was I couldn't talk to the psychiatrist and stuff until I was sober for at least a year almost. That's ridiculous. […] But … but I could have had other interventions that could have helped me. Like CBT or something. Or just awareness training or basic interventions that could have tried to convince me to build my own motivation up to do something about my situation. When I say situation, I mean housing, homeless, drinking, everything. And self-esteem, confidence the lot."

– Groundswell focus group participant

- The high levels of mental ill health among people experiencing homelessness means that participants felt that support should be offered to all, and not just those with a diagnosed mental health issue.
- Access to mental health support is made significantly more difficult by substance dependency. Difficulties and delay in securing funding, and being unable to fulfil access criteria for a service, frequently result in people not getting support or relapsing.
- For many participants an earlier intervention would have avoided a further decline in mental health, and would have prevented further development of substance misuse issues. Many participants spoke of the issues that they had personally faced when trying to access support.

Commitment 7: practical ideas and tips

7.1 **All CCG-commissioned talking therapy services (including IAPT, Psychology and Psychotherapy) should have multi-agency partnership working agreements in place for people experiencing homelessness, and the agencies that support them**

This could involve in-reach counselling, resilience training, drop-in sessions or pre-treatment interventions to day centres, hostels or specialist GP Practices.

CCG self-assessment section
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Commitment 7: practical ideas and tips

7.2 **All CCG-commissioned Community Mental Health Services should have working agreements to better support homeless people – this should cover the whole range of service models including services for Older Adults, Early Intervention in Psychosis services, Assertive Outreach, and multi-agency partnership services.**

Mental health conditions can have a significant impact on the people affected, their family carers, the health system, and the economy and society more widely. People with mental health conditions are more likely than others to be homeless, therefore working agreements must take into consideration the chronic impact that homelessness has on the individual and the long-term risks to health including physical health and the social determinates of health (feeling safe, resilience, relationships and meaningful activities).

Useful Document:

1. Five Year Forward View for Mental Health

Examples:

1. FOCUS in Camden
2. Thames Reach in Tower Hamlets

CCG self-assessment section
Please use this space to make notes

Commitment 7: practical ideas and tips

7.3 **Local personality disorder services have service delivery models that are accessible and responsive to the homeless population, and the agencies that support them**

In 2003, personality disorder was recognised by the government as a 'diagnosis of exclusion', because people with that diagnosis were frequently unable to access the care that they needed.

There is a high prevalence of Complex Trauma and Personality Disorder within the homeless population, with up to 60% of people who experience homelessness having personality disorders.

Example:

1. Lambeth Waterloo Project

CCG self-assessment section
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Commitment 7: practical ideas and tips

7.4 **All CCGs should work in partnership with Local Authorities to ensure the homeless population receive assessments under the Care Act (2014) and the Mental Health Act (1983) and, for those assessed as having eligible needs (including Section 117 aftercare), care and support is provided**

This could be through 'Section 75' agreements for integrated teams, or joint working agreements for others.

Useful Document:

1. Saving Lives

Example:

1. Westminster Joint Homelessness Team

CCG self-assessment section
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Commitment 7: practical ideas and tips

7.5 **CCGs should work in partnership with Local Authorities and the Police to ensure that people experiencing homelessness in Mental Health Crisis receive the same response as the housed population**

Homeless people in mental health crisis should be 'kept safe and helped to find the support they need – whatever the circumstances in which they first need help – and from whichever service they turn to first' - Mental Health Crisis Care Concordat.

CCGs should be focused on providing accessible and available help, care and support for all those who require it at the time they need it. CCGs should also be engaging with partners to foster strong relationships and to find innovative approaches to improve the experience of those in crisis.

Crisis Care should include alternative intermediate care options to prevent admissions based on social/housing crisis or as an option for home treatment/crisis resolution.

Useful Document:

1. 'Right Here, Right Now' - CQC
2. London mental health crisis commissioning standards and recommendations

Example:

1. Westminster Integrated Care Network, Mental Health Beds

CCG self-assessment section
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Commitment 7: practical ideas and tips

7.6 **Where there are high levels of rough sleepers and homeless hostel beds there should be consideration to commission specialist community mental health services or 'Trusted Assessor' roles**

People experiencing homelessness alongside mental health problems can be reluctant to engage with services. Psychosis, delusional disorders and paranoia lead people to mistrust street outreach workers and other professionals. Street outreach workers are unable to engage properly with people sleeping rough for months or years due to mental health problems. Negative symptoms of schizophrenia, depression and post-traumatic stress disorder can contribute to a lack of motivation and sense of hopelessness.

Rough sleeping makes it harder to access mental health services for several reasons. These include stigma, a lack of services that will work with people facing multiple problems including drug and alcohol use, difficulties getting an assessment or referral to secondary care without being registered with a GP and trouble making and keeping appointments while sleeping on the street.

Useful Documents:

1. Stop the Scandal

Examples:

1. Lambeth and Southwark, START
2. Pan-London, Enabling Assessment Service London

CCG self-assessment section
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Commitment 7: practical ideas and tips

7.7 **All CCG-commissioned mental health services, and Local Authority-commissioned substance misuse and alcohol services, have multi-agency and multi-disciplinary Dual Diagnosis partnership working agreements in place for people experiencing homelessness and the agencies that support them**

Useful Document:

1. Shelter, Good practice briefing: Service without substance; Addressing the gaps in service provision for street homeless people with a dual diagnosis

Example:

1. Single Homeless Project

CCG self-assessment section
Please use this space to make notes

Commitment No. 8

Wherever possible people experiencing homelessness are never discharged from hospital to the street or to unsuitable accommodation

What did people with a lived experience of homelessness tell us?

"My last experience of the hospital was really beneficial. Really beneficial, because they were able to…took a lot of the burden and expectation that they had in dealing with homeless clients, like myself so to speak. They had a homeless team based on site. And it was only through that that all that madness stopped. And that's when it stopped. At that weekend, at that time, I have never been in-patient since. What stopped it was … again it was the homeless team who actually helped me – they actually facilitated all of it –was the discharge from hospital to [hostel]. So that's what made the difference. Them having the expertise and… knowing what to do. And that's three years ago and I haven't been an inpatient since."

– Groundswell focus group participant

- A key barrier identified by participants when using hospitals was the 'intimidating' environment which resulted in missed appointments.
- Focus group participants shared many stories of going through hospital discharge processes. Negative experiences were widespread, with one of the key issues highlighted having been discharge to the street without any signposting to relevant services. This was particularly so with 'frequent flyers' who, due to their regular attendance can sometimes have their medical needs overlooked by staff at the hospital. For some participants, however, a decisive intervention at the point of discharge allowed them to change their lives in a positive way.
- The idea of respite care (intermediate care) was welcomed by many as an opportunity to stabilise and recuperate. It was felt that this was particularly the case with people who were 'entrenched' and unwilling to move off of the street, or people who lived chaotic lives and were unable to sustain accommodation. However, many participants also responded that they felt that this was only a 'sticking plaster' when people would be discharged to the streets or back into temporary accommodation.
- Another theme highlighted was the key role that healthcare staff can have in supporting individuals to access secure, appropriate accommodation. Whether this is through facilitating bed spaces, effectively signposting, or adding 'weight' to applications for accommodation with the local authority - healthcare staff can play an important role in improving access to appropriate support.

Commitment 8: practical ideas and tips

8.1 **CCGs should ensure that all hospitals (including mental health facilities) have protocols for admission and discharge planning that specifically address the needs of people experiencing homelessness**

In 2014, The Queen's Nursing Institute surveyed over 180 nurses who work directly with people experiencing homelessness to get their views on current discharge arrangements, and they identified the main challenge to be the 'transition of care' points between hospital and the community (Hospital Discharge for People who are Homeless).

Useful Document:

1. Healthwatch England (2015) Safely home: What happens when people leave hospital and care settings?

Example:

1. Richmond Homelessness Prevention and Hospital Discharge Protocol

CCG self-assessment section
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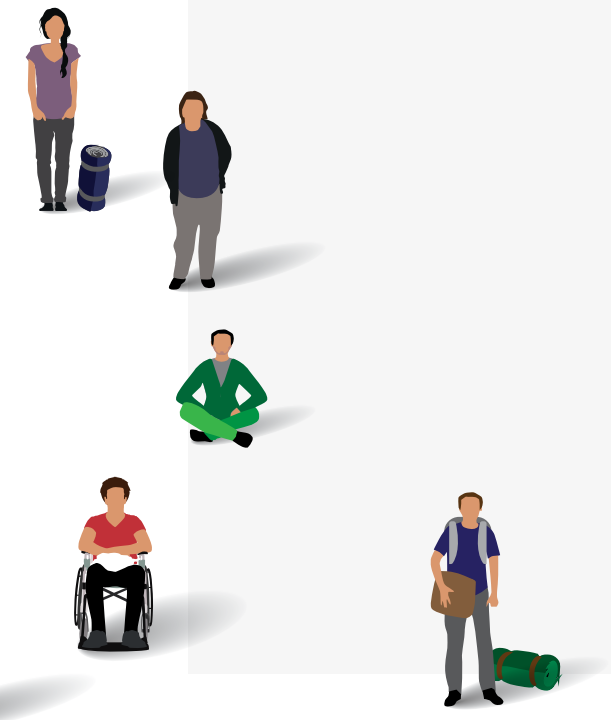

Commitment 8: practical ideas and tips

8.2 **CCGs should ensure that all hospitals (including mental health facilities) have Homeless Health Care Pathway arrangements in place for people who are flagged with a 'Homeless Housing Status' on admission, to maximise benefits of admission and to support timely discharge planning**

Homeless Health Care Pathways should be integrated and have multi-agency and multi-disciplinary planning to support 'transition of care' points, between hospital and the community.

For those with social care needs there should be referral options for reablement, intermediate care, suitable temporary accommodation and advocacy (as recommended by NICE in 'Safely home: What happens when people leave hospital and care settings?')

Where a hospital has a high volume of homeless inpatients there should be consideration for a dedicated Homeless Health Team/Worker.

Useful Document:

1. Integrating health care for homeless people: Experiences of the KHP Pathway Homeless Team

Examples:

1. Pathways Teams in UCLH, The Royal London, Kings Health Partners
2. SPEAR

CCG self-assessment section
Please use this space to make notes

Commitment 8: practical ideas and tips

8.3 **Care Navigation should be available to support homeless inpatients access post-discharge community health care and follow-up, especially for those with no GP**

Care Navigation should also be linked to a Homeless Health Care Pathway.

Examples:

1. Pathways Teams in UCLH, The Royal London, Kings Health Partners
2. SPEAR
3. Kensington, Chelsea and Westminster Homelessness Prevention Initiative

CCG self-assessment section
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Commitment 8: practical ideas and tips

8.4 **CCGs should ensure that all hospitals (including mental health facilities) have timely and informative discharge summaries sent to primary care even when the person self-discharges**

This should include a flag if the person has a 'Homeless Housing Status'.

There should be evidence of safe discharge planning arrangements for people not registered with a GP, this could be a referral to a Care Navigator or a hand-held record given to the individual or 'consent' obtained for discharge summaries to be sent to a 'trusted person'.

Useful Document:

1. 2016/17 NHS Standard Contract guidance on discharge summaries

CCG self-assessment section
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Commitment 8: practical ideas and tips

8.5 **CCGs should ensure that all hospitals (including mental health facilities) have Intermediate Care options available when a person is medically or psychiatrically fit for discharge but needs a secure place to receive home treatment or respite**

Intermediate Care could be used for the purpose of completing a Community Health Care Assessment.

Useful Documents:

1. Homeless Link and NHS London (2010) Fact sheet 5: Developing accommodation pathways for mental health in-patients who are homeless
2. Options for Delivering Medical Respite

Examples:

1. Hounslow, Hestia, Hospital Discharge Service
2. Westminster Integrated Care Network, Mental Health Beds

CCG self-assessment section
Please use this space to make notes

Commitment No. 9

Homeless Health advice and signposting is available within all Urgent and Emergency Care Pathways and Settings

What did people with a lived experience of homelessness tell us?

"I was starting to be recognised at the local A&E department on a first name basis, even the consultant knew who I was because of the number of times I would present myself. With trips in the ambulance or by the police this felt like my own private cab company at times. But the main reason was that I knew I would get all the help I needed at one place and fast.

On one visit I was lying in bed hooked up to the ECG machine because of my heart palpitations. The consultant, let's call her Tina, came and had a chat with me. Tina took time out of her busy schedule and made a connection on a personal level with me. She came and shared some of her own life story and told me of times when things weren't going too well for her. She also helped me to believe that my life was far from over. At the age of 36 I just need to get the help that a hospital can't deliver or provide. She talked me through some steps I could take to keep myself safe, and signposted me to the local drug prescriber to get myself stabilised. It was this that allowed me to begin to tackle the underlying mental health issues and the substance misuse problem that I had that was affecting every aspect of my life.

I know how busy the A&E is but the fact that I felt that I was receiving truly personal care was life changing for me. I felt valued and important for the first time in ages and I am not entirely sure where the motivation came from but that was the catalyst to changing my life. Maybe I wanted to go back one day and show to Tina that I had changed. Or it was just the right information at the right time. I may never know but being able to do more than just health is the best way to help with health. It sounds mad but it has to be joined up thinking to win the war on homelessness health."

– Groundswell focus group participant

- The open access nature and the opportunity to have multiple health needs attended to in an immediate fashion meant that many participants relied on emergency care to address health needs.
- People experiencing homelessness are well documented to be high frequency users of Accident & Emergency Departments, often going from borough to borough, to different hospitals and either being admitted or 'floating around waiting rooms' until the next day.
- A key issue raised was that individuals who live chaotic lifestyles experience increased risk and greater likelihood of needing emergency care when compared with the general population.
- A lack of access to primary care, or a feeling that primary care was not meeting the needs of homeless individuals, was also an influencing factor.
- When an individual accesses emergency care it offers an opportunity to tackle issues beyond just the immediate health needs, a chance for a more holistic intervention. While the individual accessing emergency care might be presenting with a specific ailment, it could be the route towards a life changing intervention.

Commitment 9: practical ideas and tips

9.1 **All CCG-commissioned providers of Urgent and Emergency Care, including 111, ambulance services, urgent care centres and accident and emergency settings, have protocols in place that include the provision of advice and signposting for those experiencing homelessness**

People experiencing homelessness are nearly five times more likely to attend Emergency Departments than the 'housed' population.

Useful Documents:

1. The Royal College of Emergency Medicine, Inclusion health clinical audit
2. Healthcare for Single Homeless People

CCG self-assessment section
Please use this space to make notes

Commitment 9: practical ideas and tips

9.2 **All CCG-commissioned providers of Urgent and Emergency Care identify people experiencing homelessness by asking and recording 'Housing Status' and 'GP Status' as part of the triage process**

Example:

1. King's Health Partnership Homeless Team - Guys and St Thomas' and King's College

CCG self-assessment section
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Commitment 9: practical ideas and tips

9.3 **All CCG-commissioned providers of Urgent and Emergency Care offer Homeless Health Advice and Signposting to all people seen with a 'Homeless Housing Status'**

This could be in the form of a leaflet detailing local homeless services, signposting to a website or it could be a referral to a Homeless Health Care Team/Worker onsite.

Useful websites:

1. Westminster Homeless And Health Coordination Project
2. London Street Rescue – a pan-London outreach service commissioned by the GLA
3. Streetlink - the service through which the public can report people sleeping rough
4. Homeless.org – a website of contact details for organisations working with homeless people

CCG self-assessment section
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Commitment No. 10

People experiencing homelessness receive high quality, timely and co-ordinated end of life care

What did people with a lived experience of homelessness tell us?

"We have lost four people in this one year, in this place [Hostel]. Just this year in the first five months. A lot of people have died here and other residents have been close with those people, close friends. And I have seen those people really, really down and I have said to staff and it's like have a chat with so and so because he looks a bit blah blah."

– Focus Group Participant

"If people come to the end of their lives and they are still homeless, I think there is a good calling for a support service for those people because a lot of them, I am sure the majority of them will have more or less no family, not many friends. But yeah I think people coming to the end of their lives definitely need a support services because you probably find that they don't have a lot of support coming from anywhere else."

– Focus Group Participant

- It was highlighted that whether there was a specialist palliative care service for people experiencing homelessness or not, the key is that people are given the choice to make decisions about where they pass away and how they are supported.
- The isolation that homeless people can face means that extra support for people in their final days (as well as those around them) is needed. Homelessness involves elements of isolation and social exclusion, and support networks tending to be fragmented or unavailable.
- It was common for participants to have had experiences where fellow residents in homelessness support services had passed away, either as an unexpected incident or following a protracted bout of illness. Participant felt there was a need for more support, particularly as staff at hostels are often unprepared (or unable) to offer emotional support to the individual who is passing away, or to the other residents in the hostel.
- Some participants felt that a lack of support from mainstream healthcare had resulted in people passing away. There was a feeling that if individuals were better supported to address health needs, there would not be a need for a specialist palliative care service for homeless people

Commitment 10: practical ideas and tips

10.1 **All CCG-commissioned providers of End of Life Care and Palliative Care should have multi-agency and multi-disciplinary partnership working agreements in place for those people experiencing homelessness in the local area, and the agencies that support them**

Working agreements should include the ability for palliative care services to be able to in-reach to hostels and outreach to the streets when needed. They should also include a regular multi-disciplinary and multi-agency interface to support personalised care planning.

Useful Documents:

1. CQC, People who are homeless, a different ending
2. Department of Health, End of Life Care Strategy: promoting high quality care for adults at the end of their life - Treatment of people who are homeless at the end of life is often undignified
3. Palliative and End of Life Care for Homeless People in London – Challenges and Recommendations, June 2016

Example:

4. St Mungo's Palliative Care Service

CCG self-assessment section
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Commitment 10: practical ideas and tips

10.2 **CCGs should ensure that services they commission have multi-agency care pathways in place that support those with chronic health conditions and co-morbidity issues - including mental health, brain injury, learning disabilities, substance use and alcohol**

Consideration should be given to developing, in partnership with the Local Authority, an End of Life Care Co-ordinator specific for people who are homeless within the borough.

CCG self-assessment section

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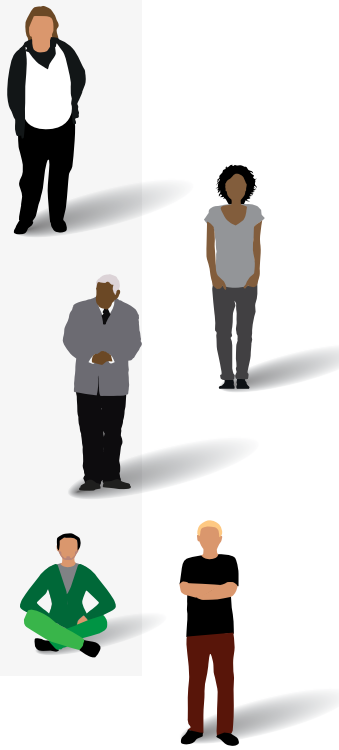

Commitment 10: practical ideas and tips

10.3 **CCG-commissioned providers of End of Life Care and Palliative Care should have care pathways and resources in place that enable people to die in their preferred place of death**

This could be in a hostel or on the street, dependent on the individual patient's circumstances and wishes.

Medication management protocols for hostels should enable controlled drugs to be safely held there and in other accommodation where the person is choosing to die.

Useful Document:

1. NHS Improving Quality - End of life care - achieving quality in hostels and for homeless people

CCG self-assessment section
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Commitment 10: practical ideas and tips

10.4 **CCG-commissioned providers of palliative care should proactively work with local multi-agency partners to identify people with chronic health conditions, in hospital or in the community, who may be approaching the end of life**

Some people who have been homeless for a long time and not in contact with mainstream services can have complex chronic health conditions but no formal diagnosis. This can become a barrier to accessing palliative care as referrals from non-NHS services are not accepted within formal diagnoses from a medical professional.

Adopting an End of Life Care Co-ordinator role to focus on homeless and marginalised groups would support personalised emergency care planning, including Fast Track referrals and Continuing Care Assessments between NHS and non-NHS providers for those people who remain homelessness through choice when they deteriorate unexpectedly and suddenly.

CCG self-assessment section

Please use this space to make notes

Commitment 10: practical ideas and tips

10.5 **Non-NHS staff working within hostels, day centres and street outreach should be supported with training to enable them to provide appropriate advice, care and support to people with deteriorating chronic health conditions who may not be accessing regular healthcare but have health related care needs**

Reciprocal arrangements could be in place for training to be available for hospice, palliative care and end of life care workers on how to work with people who have a history of homelessness and may still be homeless. This training should include what is an acceptable and safe environment to discharge someone to and how to accept someone's choices, however unwise they might be and how to plan care around their choices.

Example:

1. Marie Curie & St Mungos

CCG self-assessment section
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