

Delivering health and care for people who sleep rough

Going above and beyond

Overview

- People who sleep rough have complex and multiple health and care needs that all too often are not met. They have some of the worst health outcomes in England.
- The NHS alone cannot reduce poor health outcomes for people sleeping rough. Tackling rough sleeping involves improving people's health, social wellbeing and housing situation as well as supporting them to find long-term solutions.
- As part of current government efforts to reduce rough sleeping, there is a focus on improving health care for people sleeping rough. Our research explored how four different local areas are delivering effective health and care services to people sleeping rough and what other areas might be able to learn from them.
- We found five shared principles that the four areas had in common. We think that any area can make progress if it: takes steps to find and engage people sleeping rough; builds and supports its workforce to go above and beyond existing service limitations; prioritises relationships; tailors the local response to people sleeping rough; and uses the full power of commissioning.
- Local leadership is vital to crafting an approach that is relevant to a local place and population. Leaders need to model positive relationships and effective partnership working across a range of different organisations.
- All the relevant government departments need to build on positive examples of cross-departmental working with secure, longer-term resources both for their own work and for local areas to plan and provide services effectively and sustainably. Guidance is important but so too is supporting local areas to learn from each other.

The issue

The number of people sleeping rough in England has risen substantially over the past decade. People who are homeless have some of the worst health outcomes in England, and are more likely to experience and die from preventable and treatable medical conditions and to have multiple and complex health needs. Many people who sleep rough experience a combination of physical and mental ill health and drug or alcohol dependency.

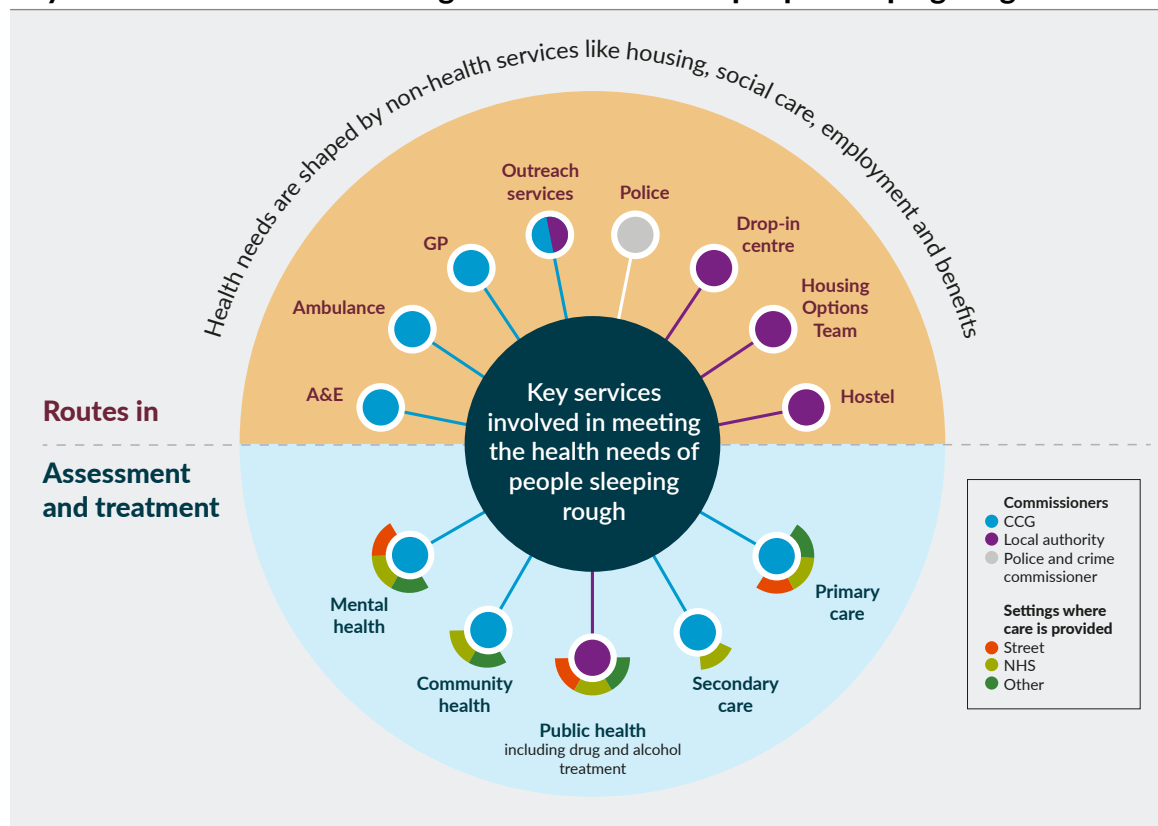
Alongside these needs, people who sleep rough face barriers to accessing health and care services, including attitudes of some staff, complex administration processes and previous negative experiences. This means continuity of care is a challenge and health issues may not be picked up until they become acute.

Multiple services are involved in meeting the health needs of people sleeping rough (see diagram). Many people sleeping rough will require support from several of these services at once and the effectiveness of any one service is dependent on that of the others.

This complex service landscape requires multiple stakeholders to work together: how services manage the handovers and links between them is crucial. Services therefore need to provide a coordinated, joined-up approach, recognising the breadth of health needs that a person sleeping rough might be experiencing.

Ultimately, a person cannot achieve good physical and mental health without a safe and stable home. However, health problems can also be a cause of homelessness or a barrier to exiting rough sleeping. Health, housing and wider support needs are deeply interconnected – there is a need for an integrated response across a wide range of partners including health services, local government and the voluntary, community and social enterprise sector (VCSE), as well as a range of other organisations such as the police, the wider local economy and the local community.

Key services involved in meeting the health needs of people sleeping rough



Our research

This work was commissioned by the Department of Health and Social Care and the Ministry of Housing, Communities and Local Government. We looked at what four nominated areas were doing to improve health outcomes for people sleeping rough repeatedly or on a routine basis and explore what insights they might offer to other areas.

We interviewed a set of key individuals in each area, which included commissioners and managers of health services, clinicians, public health, housing and adult social care, VCSE providers and elected councillors. Our research partners at the University of York conducted one focus group in each area with people who have lived experience of sleeping rough.

Our findings

Across the four areas, we identified five common principles of delivering effective health care to people sleeping rough that other areas may find useful to learn from.

Find and engage people sleeping rough

Because many people who sleep rough have high and complex needs, as well as facing barriers to accessing services, systems need to identify and address unmet need and design services that people who sleep rough can and want to use. People with lived experience were involved in the design and evaluation of many of these services in the four areas we looked at.

Each contact that someone has with any service provides an opportunity to establish a relationship, build trust and connect them to services that can help meet their needs. Our case study sites recognised both primary care and acute hospital visits as key opportunities for connecting people who sleep rough to community health services, mental health services, social care and housing support. Some areas embedded workers from these services into acute hospital discharge teams.

Multifaceted approaches to outreach, combining street outreach with 'inreach' in a range of settings, increased the range of opportunities that services had to engage people. Health workers were embedded in VCSE and local authority outreach teams. Peer advocates were commissioned to help people navigate the system and access the care they needed.

Some areas explicitly took an asset-based approach to care, enabling and training their staff to adapt to the specific circumstances and priorities of the individuals being treated. Some areas provided training to improve understanding and promote positive attitudes about people who sleep rough among staff in mainstream health services, including video training for GP receptionists.

Build and support the workforce to go above and beyond

Local areas are not yet functioning in a way that meets the needs of people sleeping rough. Staff often have to work around systems, rules and procedures rather than through them. Across sectors, staff working with this group have high levels of passion and knowledge. Leaders should work to nurture, sustain and capitalise on this.

Developing a shared sense of purpose across a system can bring people together and form a basis for integrated working. We saw senior leaders raising the profile of this issue and setting high expectations about service delivery. Different services came together to agree a common vision and approach, setting the tone for staff delivering services to work together towards a shared goal.

Giving staff permission to flex the system enabled people sleeping rough to access effective support. Senior leaders helped to foster a safe, supportive, 'no blame' approach: one that asks staff to use reasonable flexibility in the client's best interests.

The provision of ongoing support to staff enabled them to maintain the understanding, confidence and resilience needed to work effectively with this population. Across our case study sites this ranged from investment in staff wellbeing, to training across the local workforce to engage with people sleeping rough at any contact point. Specialist training for those in regular contact with people who slept rough often focused on trauma-informed approaches and reflective practice.

Prioritise relationships

People who sleep rough may not use conventional routes to access support. Staff need to connect individuals quickly across different services spanning housing, social care and health. This works best when staff know each other personally. Staff also need to be able to trust others when flexing normal practices to fit services around an individual.

Senior leaders modelled collaborative working and helped shape organisational cultures in which positive relationships were prioritised. This included demonstrating commitment to collective leadership in cross-organisational partnerships, and agreeing shared visions that resonated with staff.

Formal mechanisms for staff at all levels to build relationships face-to-face included co-locating teams, designing pilot projects that encouraged joint working, and both strategic and operational multi-agency meetings.

Tailor the response

Effective, joined-up services need to reflect place-specific characteristics, including local needs, assets and geographies. A generic, 'off-the shelf' approach to improving health and care outcomes for people sleeping rough will not work.

Our case study areas sought to develop thorough local insights about who was sleeping rough, their needs, their interactions with services, and how these changed over time. Decisions were informed by insights from people who had lived experience of sleeping rough and staff in homelessness services. Conducting specific health needs assessments for people experiencing homelessness created an opportunity to draw together existing data and get owners talking to each other about how to use and share it. Employing analysts to develop data collection and use made data significantly more powerful.

Leaders played a critical role in shaping the approach to rough sleeping, and yet many interviewees struggled to identify where overall leadership and accountability sat for meeting the health needs of this group. Active engagement with elected politicians and the public helped to cultivate and harness their support.

Co-ordinated local and regional approaches were at various stages of development. Some neighbouring areas worked together to facilitate a flexible response to people moving across boundaries. They focused on a duty of care to individuals in need, rather than eligibility criteria for services based on geography. One sustainability and transformation partnership had prioritised this area, framing it in terms of its role in tackling health inequalities and using it as an opportunity to bring partners across health and local government together.

Use the power of commissioning

Commissioners have a range of powers to bring about improvements in services and how people work together across a system. Commissioners should work together across the NHS and local authorities to deliver integrated services that truly address the complexity of need among the population who sleep rough.

Dedicated resources and inter-agency commissioning helped to create a momentum for change. All four areas had successfully accessed additional central funding for this work. Flexible contracts enabled providers to adapt to changing need and facilitated bottom-up innovation by frontline staff.

Contracts were designed to encourage specialist services, where they existed, to play a system leadership role. Some included an expectation of supporting mainstream services to work with people who sleep rough, including through advocacy, training and advice. We also saw contracts in which key performance indicators included numbers of patients discharged from specialist to mainstream services.

Retendering offered key opportunities to better co-ordinate and integrate care. Commissioners worked together to ensure that pathways joined up across services. In some areas, commissioners also had a process by which they could review and amend contracts and service specifications to prevent incompatible thresholds or eligibility criteria across service pathways.

Implications

There is no blueprint for how to improve the health of people sleeping rough, but these findings point to multiple ways that local and national leaders can support individuals to get better access to health and care. Local leaders need to understand the importance of leadership across a local system, with shared ownership for ending rough sleeping and responsibility for their individual roles in driving improvements. They should be committed to collaboration and clear accountability across health, housing and social care. They need to gain political buy-in and support, as well as asking themselves how well, as a team, they hear and act on the views of people sleeping rough. Finally, local leaders should develop the capacity of others and support them to lead change.

Government departments and arm's length bodies also have a key role to play in encouraging wider progress. Building on its commitments in the long-term plan for the NHS, NHS England and Improvement needs to support sustainability and transformation partnerships' and integrated care systems' plans to join up services and set local goals for improving the health of people sleeping rough, as well as ensuring rough sleeping is part of the measure of accountability for reducing health inequalities. Across departments, government needs to ensure secure and sustainable resources to deliver the Rough Sleeping Strategy, with a focus on upstream prevention. Attention also needs to be paid to the issue of local connection.

Public Health England is already developing new guidance for commissioners and demonstrator sites should also be considered to help draw out learning from applying this guidance in practice. The Ministry of Housing, Communities and Local Government and the Department of Health and Social Care could also support learning across areas through developing learning networks. The Ministry of Housing, Communities and Local Government needs to co-ordinate with other partners to embed core capabilities consistently across the workforce for frontline health and care staff working with people sleeping rough.

Finally, while recent funding commitments are welcomed, there is a need to ensure new funding is sufficient for the task and that areas are equipped to use it effectively. This also means ensuring a more strategic approach to funding with longer time frames and more flexibility for adaption to the local context.

To read the full report, *Delivering health and care for people who sleep rough: going above and beyond*, please visit www.kingsfund.org.uk/publications/delivering-health-care-people-sleep-rough

The Department of Health and Social Care and the Ministry of Housing, Communities and Local Government commissioned this independent research. The views in this report are those of the authors and all conclusions are the authors' own. The research was undertaken in collaboration with Professor Nicholas Pleave and Dr Joanne Bretherton from the Centre for Housing Policy at the University of York as part of The King's Fund and University of York partnership for responsive policy analysis and research (PREPARE) programme.

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