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health and care

Delivering health and care for people who sleep rough

Going above and beyond

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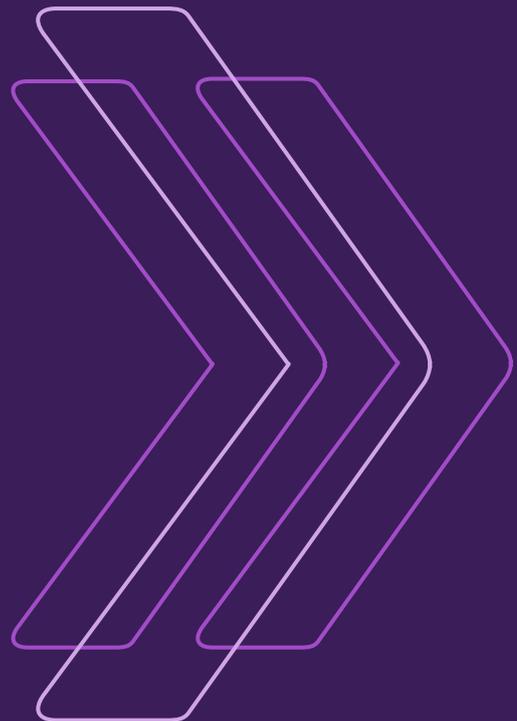
About this report

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 Pleace 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.

The King's Fund is an independent charity working to improve health and care in England. Our vision is that the best possible health and care is available to all.

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Foreword

An estimated 726 people died while experiencing homelessness in England and Wales in 2018, at an average age of 45 years for men and 43 years for women. Many people who sleep rough experience a toxic combination of struggles over personal safety, food, shelter and ill health that most of the wider population find difficult to truly understand. This may be why many routine health and care services – despite being designed with deep values of equity and fairness – fail to meet the needs of people sleeping rough.

In some places, staff have not tolerated this state of affairs and have reached out to provide additional support above and beyond their specific job description. At its best, this means listening and responding to the frustrations and needs of people sleeping rough as they try to access good care. Yet, while relying on the basic motivation of staff to provide good care can work in some places, all too often this requires staff to work around, or against, a system that was simply not designed to meet the needs of people who sleep rough.

This research starts to answer the question of what needs to be in place for the delivery of joined-up services to a population of people sleeping rough – as a system, rather than a discrete collection of services. The four areas described in this report offer their insights and provide valuable learning for other areas. But this does not mean that there is a single blueprint for how to achieve sustained improvements in health and care outcomes for people experiencing rough sleeping. Part of the learning points to the importance of understanding and adapting to the local context.

The health and care system has a critical role to play in improving health and care for people experiencing rough sleeping, just as it does for other groups in society that continue to have very poor physical or mental health. At The King's Fund we have made it a priority to use our resources to improve outcomes for those experiencing some of the very worst health and care outcomes. This will mean expanding our work on homelessness but also looking to target other people who – despite the best intentions – health and care services have struggled to help.

Richard Murray
Chief Executive, The King's Fund

Key messages

- People who sleep rough have complex and multiple health and care needs that all too often are not met. As a result, they have some of the worst health outcomes in England.

- Although good progress was made in reducing rough sleeping in the 2000s, this has reversed since 2010 and the number of people sleeping rough continues to increase. The government is committed to eliminating rough sleeping by the end of this parliament and has outlined action to achieve this in its Rough Sleeping Strategy, including a focus on improving health services for people sleeping rough.

- Health needs are closely intertwined with housing and other support needs. The solutions to improving health outcomes for people sleeping rough do not rest with the NHS alone – local authorities and the voluntary and community sector are essential partners. A population health approach is needed to address the full range of factors that influence the health and wellbeing of people sleeping rough.

- People who sleep rough face a range of barriers to accessing health and care, so services need to reach out proactively to find and engage them. It is important to involve people with lived experience of sleeping rough in co-producing services to ensure they are designed to meet the needs of this group effectively.

- A generic, 'off-the-shelf' approach to improving health outcomes for people sleeping rough will not work. A local, place-based approach is needed, recognising that the rough sleeping population is not static and geographical boundaries shape access and entitlement to services.

- Delivering integrated services that truly address the complexity of need among the population who sleep rough requires commissioners to work together across the NHS and local authorities, using the full range of powers available to them. Contracting has a particularly important role to play in ensuring services are effectively co-ordinated.

- Harnessing the commitment and passion of frontline staff to go 'above and beyond' is key. This can be achieved by fostering a safe, supportive environment that enables staff to use reasonable flexibility in their clients' best interests and by developing a shared sense of purpose across local systems. Staff need support to maintain the understanding, confidence and resilience needed to work effectively with this population.

- Local leaders need to manage complex interdependencies across multiple organisations and sectors. This requires them to take shared ownership and responsibility for tackling rough sleeping, and to model partnership working across different professional cultures.

- The NHS long-term plan identifies people sleeping rough as a priority group. The local implementation plans of sustainability and transformation partnerships/ integrated care systems are an opportunity to join up health services with housing and social care and set local goals for improvement in the health of people sleeping rough. NHS England and NHS Improvement should support this ambition and consider how to ensure accountability for improving the health of people sleeping rough in local plans for reducing health inequalities.

- Continuing commitment across government is needed, with secure resources in place to deliver the government's Rough Sleeping Strategy over multiple years across housing, social care and public health, as well as health services. Arrangements for sharing good practice and learning need to be improved and should be supported by government departments and national bodies.

① Introduction

I slept in a tent by the canal and I had three people decide to jump on the tent while I'm in it. So, I was literally getting jumped on inside this tent… I've actually seen people who've been kicked that hard in the head that they've actually got the imprint of the trainer on their face.

(Person who has slept rough)

For many people who sleep rough, the harsh reality is that fundamental prerequisites for health – such as personal safety, and access to food and shelter – are at risk. In addition, they often have highly complex physical and mental health needs, combined with poor access and ability to navigate the health care system. Overall, this group experience some of the worst health and care outcomes in the country. The average age of death for those who died while homeless in England and Wales in 2018 was 45 years old for males and 43 years old for females – more than 30 years below that of the general population (**Office for National Statistics 2019a**).

In this report, we look at how the health and care of people who sleep rough on our streets, often repeatedly or for extended periods of time, could be improved. People who sleep rough are a small subset of a much larger, and less visible, homeless population living in hostels, with friends and in temporary accommodation.

People sleeping rough are likely to have had repeated contact with public services – health, criminal justice, housing and care – as well as voluntary and community groups. But despite often frequent attempts of these services to provide support, this is a population that continues to experience multiple mental and physical health issues that often remain untreated.

The number of people sleeping rough has increased significantly since 2010, and the government's 2019 manifesto commitment sets out a clear ambition to end rough sleeping by the end of this parliament. This report aims to help local systems improve health outcomes among people who sleep rough and to support the ambition to end rough sleeping. It acknowledges that housing provision alone will not provide a sustainable solution to rough sleeping – and that health, care and a

range of other services have a critical role to play in supporting people who sleep rough to move into settled accommodation.

With this report, we shed light on the skills, leadership and resources required to respond to the needs of people sleeping rough.

Purpose of this research

The Department of Health and Social Care (DHSC) and the Ministry of Housing, Communities and Local Government (MHCLG) commissioned this research. It is independent King's Fund research and represents one of a number of projects commissioned to support the implementation of the government's 2018 Rough Sleeping Strategy (MHCLG 2018a).

It is designed to deepen an understanding of the gaps that exist in the provision of health and care for people sleeping rough – and what can be done to ensure that the health and care system better meets the needs of this group.

We were asked to look in particular at what four local areas were doing to improve two specific outcomes, as specified by the government's Rough Sleeping Advisory Panel:

- that people sleeping rough can access health services of equal quality to others, and the impact of rough sleeping on health is minimised

- that ill health does not prevent people moving off the streets or sustaining a settled lifestyle.

Scope and approach

This research focuses on four local areas that are all anonymous. These areas served as case studies for us to explore how a local area can come together and work as a system to deliver services that are joined up and effective. They offer insights into what has enabled them to make progress but they do not offer a blueprint.

A partnership consisting of DHSC, MHCLG, NHS England, NHS Improvement and Public Health England nominated these areas following an audit they conducted in 2018 of health and care provision for those who sleep rough. These four areas have

much to share, but there are many other areas around the country that have improved housing, care and health outcomes for people sleeping rough on their streets.

This is not an evaluation. We were interested in what key stakeholders, including people who sleep rough, think improves outcomes. We asked what they think makes for successful delivery of health and care, and what they had learnt about trying to work collectively to improve outcomes.

Who did we speak to?

Each area nominated a set of key individuals from across their system for us to interview and shared with us their rough sleeping data and strategies. We conducted semi-structured interviews with 10 to 12 people in each site and across a range of roles, which included clinicians; commissioners and managers of health services, public health, housing and adult social care, providers from the voluntary, community and social enterprise (VCSE) sector as well as elected councillors. Most of the people we interviewed were from a local authority – working in the areas of housing, public health, drug and alcohol services and social care. We note this bias and believe it serves to highlight how many stakeholders beyond the National Health Service (NHS) consider that they have a responsibility for – or a role in – improving the health of people who sleep rough.

Our research partner, the University of York, conducted one focus group in each area with people who had lived experience of sleeping rough, to capture their views about the services they had encountered. Their experiences inform this work and the full findings are published separately (Pleace and Bretherton 2020).

To distinguish between the two groups of people we spoke to, we refer to professional stakeholders as 'interviewees' and people with lived experience of sleeping rough as 'focus group participants'.

Each of the four areas faced substantial challenges in getting services to work together, and while these issues surfaced in our discussions, our approach was an appreciative one – teasing out what stakeholders felt led to their successes, and how barriers were overcome.

Full details of how we undertook this research can be found in Appendix 1.

Structure of this report

Section 2 describes the population of people who sleep rough, their needs and how the population has changed over time. The section also provides an overview of the commissioning landscape for rough sleeping and sets out the political and social context that has shaped the current Rough Sleeping Strategy (MHCLG 2018a).

Section 3 introduces our four case study areas, outlining their key features, before briefly laying the foundations for the sections that follow.

Sections 4 to 8 set out our findings from the four areas. They capture the practice and experiences of the areas, drawing on those working in the local area as well as people with lived experience of sleeping rough. We group the findings into five broad insights, as follows.

- Take steps to find and engage people sleeping rough (section 4).

- Build and support the workforce to go above and beyond (section 5).

- Prioritise relationships (section 6).

- Tailor the response to the local context (section 7).

- Recognise the power of commissioning (section 8).

Section 9 takes the research forward and offers our reflections on what local leaders need to consider to deliver effective, joined-up health and care services for people sleeping rough. It ends with a number of implications for national leaders.

Alongside this report we have published a set of 10 practical prompts for local areas to reflect on our findings and identify what learning they may be able to take from them (*see* Appendix 2). This will also be reflected in a toolkit for commissioners, which Public Health England will be launching in spring 2020.

Given the wide range of professional backgrounds we expect this report to appeal to, we have included a glossary of key terms from the health and housing sectors that we use in this report. This can be found at the end of the report in Appendix 3.

2 Background context

In this section we give an overview of who makes up the population of people who sleep rough and what their health and care needs are. We also set out how this piece of research fits within the wider policy context.

Who sleeps rough?

People are defined as sleeping rough if they sleep outside or somewhere not designed for habitation – including in tents, sheds, cars and stations. People who sleep rough are a small part of the total population of people experiencing homelessness, which comprises anyone without suitable and secure accommodation.

We have focused our research on one part of the population of people who sleep rough: those who sleep rough repeatedly or on a routine basis. People with an extended history of sleeping rough are sometimes described as 'entrenched', although no agreed or official definition currently exists. People who sleep rough on a sustained or recurrent basis often have high and complex needs, experiences of significant trauma, and are likely to have had multiple contacts with statutory services, including the NHS, the police and local authorities. Experiences of deep social exclusion and poverty throughout the life course are common, and many have spent time in the care system as a child, the armed forces or prison (**Local Government Association 2017**).

How many people sleep rough in England?

The number of people sleeping rough in England is rising. The government's 2018 count recorded 4,677 people who are experiencing rough sleeping, up 165 per cent from the 2010 figure of 1,768 (**MHCLG 2019**). Of these, 84 per cent were recorded as male. UK nationals comprised 64 per cent and European nationals from outside the United Kingdom accounted for 22 per cent. Those from outside the European Union comprised 3 per cent, and 10 per cent did not have their nationality recorded. Those aged 26 or over made up 80 per cent, with 14 per cent not having their age recorded (**MHCLG 2019**). Experience of rough sleeping is

unevenly distributed across England – the size and demographics of the population who sleep rough vary considerably across different areas as do changes over time (**Public Health England 2019**).

Although there is little dispute that numbers are rising, the official figures themselves are highly contested. The number of people sleeping rough over the course of a year is almost certainly significantly higher than the figures suggest. The figures represent a 'single-night snapshot' based on street counts or estimates conducted on one night in autumn (**MHCLG 2019**). They will be affected by a range of factors, including the weather, and exclude those sleeping in concealed locations, or those who choose not to bed down at night (**MHCLG 2019**). Furthermore, many more people will sleep rough over the course of a year than on any single night (**Shelter 2018**). Recent reports, drawing on data collected from outreach services in London throughout the year, found that official data underestimated the number of people sleeping rough in London by more than 800 per cent (**Local Government Association 2017**), while research by Crisis estimated that more than 8,000 people slept rough in England in 2016 (**Bramley 2017**).

There are some examples of local areas developing better ways of collecting and using data, including the Combined Homelessness and Information Network (CHAIN), a multi-agency database used in London and a small number of other areas. However, routine data is generally insufficient to understand local needs, plan and co-ordinate support, or monitor progress. Very few areas have taken the next step of developing capability for effectively analysing and using their data.

Rough sleeping policy

The United Kingdom has a long history of ambitious policy commitments around reducing and even ending rough sleeping (**Wilson and Barton 2019**). It is worth noting (bearing in mind the caveats around data noted above) that several of these interventions have been credited with significantly reducing rough sleeping in the late 1990s and the 2000s (**Mackie *et al* 2017**).

The rise in official numbers of people sleeping rough since 2010 has led to renewed commitments: in 2017, the Conservative government was elected with a manifesto commitment to halve rough sleeping by 2022 and end it entirely by 2027. The current government has renewed this commitment and plans to

end rough sleeping by the end of the next parliament. There have been two key developments since 2017:

- the Homelessness Reduction Act 2017

- the 2018 Rough Sleeping Strategy (**MHCLG 2018a**).

In April 2018, the Homelessness Reduction Act 2017 came into force, introducing new duties for local authorities to assess, prevent and relieve homelessness for anyone who is eligible for assistance, including people who are sleeping rough. This extended their pre-existing duties under the Housing Act 1996. While this was a positive change, meaning everyone can now access advice and assistance from their local authority, it does not mean they will be given accommodation – unless they are in priority need. The Act also introduced a duty to refer, meaning various public bodies – including those in the justice, defence and health and care sectors – are required to refer someone who is homeless or at risk of homelessness to a local authority housing/homelessness team of the individual's choice (**Wilson and Barton 2019**). This sets an expectation of closer working between the health and housing sectors.

At the same time, the Ministry of Housing, Communities and Local Government (MHCLG) launched its Rough Sleeping Initiative Fund to target support to areas with the highest numbers of people sleeping rough. It followed this by publishing the Rough Sleeping Strategy in August 2018 (**MHCLG 2018a**). This set out a programme of work to meet the government's manifesto pledge, including actions focused around prevention, intervention and recovery.

Rough sleeping was also an issue picked up in the NHS long-term plan in January 2019, as part of the commitment to action on health inequalities (**NHS England 2019b**). It commits up to £30 million to meet the mental health needs of people sleeping rough – focusing on specialist homeless NHS mental health support in areas with the highest rates of rough sleeping and integrating this with outreach and substance misuse services. In addition, all areas, whether or not they receive funding for new specialist mental health provision, should have a mechanism in place to ensure their mental health services can support people who sleep rough.

A range of recent changes to the benefits system, particularly the introduction of Universal Credit, have had an impact in this area and driven up the number of people experiencing homelessness. Universal Credit has been associated with

increased homelessness due to increases in rent arrears and the reluctance of private landlords to let properties where a person is receiving Universal Credit (**Kennedy *et al* 2019**). We heard about benefit changes leading to an increase in people sleeping rough in a number of our interviews and conversations, but not enough research has yet been done to evaluate their full impact.

More detail on policy changes directly addressing homelessness and rough sleeping can be found in our accompanying report on lived experience of sleeping rough in the four case study areas (Pleace and Bretherton 2020) and House of Commons' briefings on rough sleeping (**Cromarty *et al* 2019**; **Wilson and Barton 2019**).

What are the key health needs among this population?

The population of people who sleep rough is characterised by multiple and complex needs, severely poor health, deep social exclusion and early death. Poor health is often both a cause and an effect of homelessness, and the two tend to interact in complex and mutually reinforcing ways (**Cromarty *et al* 2019**; **Local Government Association 2017**).

Available national data on the health needs of people experiencing homelessness is limited, and data on the needs of people who sleep rough is particularly lacking. Much of the research around health needs does not distinguish people who sleep rough from the wider homeless population. This data nevertheless gives a sense of the breadth and severity of the health needs present in the population of people who sleep rough, as set out in Figure 1.

Figure 1 How do the health needs of people experiencing homelessness compare with the general population?

7x more likely to die from HIV and hepatitis (Crisis 2012)	**6x** more likely to have heart disease (Story 2013)	**14x** more likely to die by suicide (Office for National Statistics 2019b)
20x more likely to die as a result of drug use (Crisis 2012)	**7x** more likely to die from falls, at an average age of 45 (Crisis 2012)	**Up to 80 per cent** report a mental health need (Homeless Link 2014)
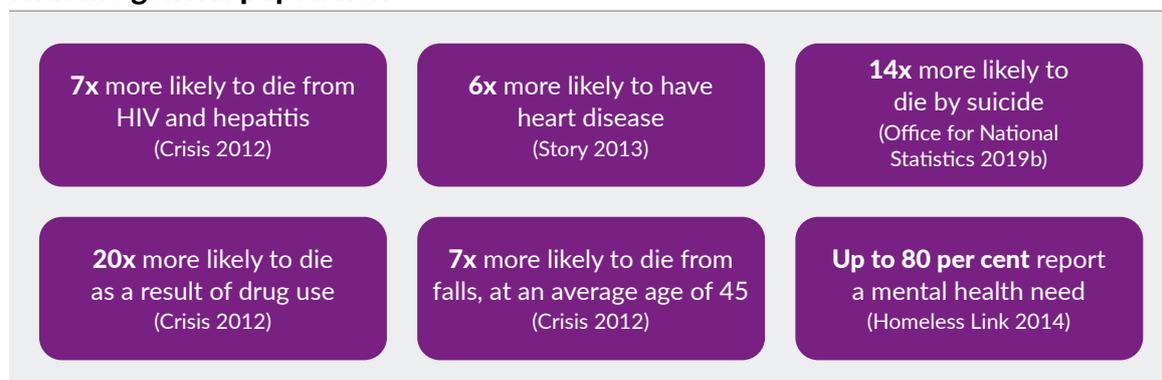
There were an estimated 726 recorded deaths of people experiencing homelessness in England and Wales in 2018. The average age of death for people who died while experiencing homelessness was 45 years old for males and 43 years old for females – more than 30 years below that of the general population (**Office for National Statistics 2019a**). Recent research suggests that around a third of these deaths are the result of treatable medical conditions, such as the human immunodeficiency virus (HIV), gastro-intestinal disease, respiratory disease and chronic consequences of drug and alcohol dependence (Aldridge *et al* 2019). Drug-related poisoning, suicide and alcohol-specific deaths accounted for around half of the estimated deaths of people experiencing homelessness in 2018 (**Office for National Statistics 2019a**).

Among people who experience homelessness, evidence suggests a high prevalence of a range of support and treatment needs, in particular for severe mental illness, alcohol or substance dependence, disability and physical ill health (Aldridge *et al* 2018; **Fransham and Dorling 2018**; **McDonagh 2011**). Almost all long-term physical health conditions, as well as musculoskeletal disorders, respiratory illness and infectious diseases such as tuberculosis and hepatitis C, are more prevalent among the homeless population than among the general population (**Public Health England 2019**). The term 'accelerated ageing' is often associated with people experiencing homelessness, particularly those who sleep rough, denoting a far earlier onset of frailty and morbidity compared with the general population, as well as premature mortality (Fazel *et al* 2014). According to a report by Crisis, for example, people experiencing homelessness are seven times more likely to die from falls, and do so at an average age of 45 (**Crisis 2012**).

Many people who sleep rough have multiple, co-occurring and compounding needs, and the experience of rough sleeping is associated with tri-morbidity: the simultaneous combination of physical ill health, mental ill health and problematic drug or alcohol use (**Medcalf *et al* 2018**; **St Mungo's Broadway 2014**).

Time spent sleeping rough may lead to the deterioration of mental and physical health and the exacerbation of existing conditions, which can in turn make it more difficult to exit homelessness and sustain a settled lifestyle. Effective health and care services are an essential part of the solution to long-term or 'entrenched' homelessness – but equally, addressing wider needs, including housing and welfare, is often a vital part of an effective response to health needs. A safe and stable home is necessary for good physical and mental health.

Access to services

Alongside their high and complex needs, people who sleep rough commonly face a range of barriers to accessing health and care services. These can include:

- difficulties navigating the health and care system, due to a range of different factors including low literacy skills, language barriers, complex administrative processes and lacking means of transportation

- reluctance to engage due to expectations of rejection or stigmatisation, or distrust of institutions, often based on negative past experiences

- 'chaotic' lifestyles, in which health and care needs are often not an immediate priority – service users can have difficulties keeping to appointments and can be difficult for services to contact

- attitudinal issues within services and among some staff, including the stigmatisation of people who are homeless, a lack of confidence and a lack of understanding around working with this population group, including being sufficiently trauma-informed (Medcalf *et al* 2018; St Mungo's Broadway 2014; Parker and Albrecht 2012).

These factors can mean that problems remain undiagnosed or untreated until they become acute, and that continuity of care is difficult to sustain (Cromarty *et al* 2019). This compounds the challenges around the effective treatment and management of conditions, which are already significant given the level and complexity of need set out above.

Health services for people sleeping rough

People who sleep rough often need support from a range of different providers of health services. Figure 2 maps out key health services that many people who sleep rough come into contact with, as well as their routes of entry into the 'system' of health services. It shows who these services are typically commissioned by, and the settings in which care tends to be provided.

Figure 2 **Key services involved in meeting the health needs of people sleeping rough**

Given that people who sleep rough often have multiple, overlapping health needs, many will require support from several of these services at the same time – and the effectiveness of the response by any one of these services will be dependent on that of the others.

The services might be 'specialist' (primarily directed at people experiencing homelessness), or part of an 'inclusion health approach' that is also targeted at other groups such as asylum seekers, sex workers and Travellers (Medcalf *et al* 2018), or 'mainstream' (available to the general population, sometimes with a particular element targeted at people experiencing homelessness).

Figure 2 is intended to be indicative rather than exhaustive. The picture of both service provision and commissioning is often more complex 'on the ground' and varies considerably between different areas. Health outreach services might be provided by a general practitioner (GP) or a voluntary, community and social

enterprise (VCSE) sector organisation, and might be commissioned by a clinical commissioning group (CCG), a local housing authority or public health, or any combination of the three (**Crane *et al* 2018**). Each broad service type shown in Figure 2 covers a range of specific services. For example, community health services that work with people sleeping rough include podiatry, midwifery, occupational therapy and palliative care.

There are four key things to take away from this:

- **The service landscape is complex.** There are many different commissioners, providers and funding streams involved, all of which need to work together to plan and deliver services.

- **Links between services are crucial.** There are many routes that people who sleep rough might take into and between services. Common entry points include both health and non-health services. Contact with any service should be used as an opportunity to engage people with the wider set of services available and support should be available to navigate the service landscape.

- **A co-ordinated, joined-up approach is needed.** Services need to work together to provide effective support to people with multiple, overlapping and changing needs.

- **There needs to be recognition of the breadth of health needs.** The range of health needs of people who sleep rough means that any NHS service could be treating people who sleep rough. Additional training and patient supporters/advocates may be required.

The need for a population health approach

The health needs of people who sleep rough cannot be properly addressed by health services alone. The lack of a safe, secure home and sleeping rough can lead to or exacerbate a range of health problems spanning mental health, physical health and substance misuse, and can complicate or impede effective treatment. Experience of rough sleeping is associated, for example, with a greater risk of being assaulted, of developing a range of conditions including infectious and respiratory diseases, and of developing substance dependence or relapsing (**Public Health England 2019**; **Local Government Association 2017**). As outlined above, people who

sleep rough also face a range of barriers to accessing services. In the absence of an adequate, secure and settled home, treatment effectiveness and continuity of care may be severely compromised.

Equally, health problems can be a cause of homelessness, and failing to address them can be a barrier to a sustainable exit from rough sleeping (John and Law 2011). Ill health and substance dependence can make retaining accommodation and employment more challenging and can contribute to relationships and support networks breaking down. People sleeping rough who experience mental illness are 50 per cent more likely to spend more than a year sleeping rough than those who do not (**Public Health England 2019**).

In other words, health, housing and wider support needs are closely inter-related and mutually reinforcing. This points to the need for an integrated response that addresses these needs in a holistic, joined-up way. A wide set of partners – particularly across health services, local government and the VCSE sector, but also including private sector organisations, the wider local economy and the local community – must work in partnership to provide the right package of housing and support. This is what we have described elsewhere as a **population health approach** – one that addresses the full range of factors that influence a population's health and wellbeing (**Buck *et al* 2018**).

Achieving this approach in reality is no straightforward task. In sections 4 to 8 we describe how four local areas developed a more integrated response to the health and care needs of people who slept rough locally. We also highlight the experiences of people who had slept rough in each of the areas.

3 An introduction to our case studies and findings – five insights

This research involved four case study areas. We have anonymised the areas and the people who we interviewed. We wanted to create a space where people would feel more able to speak freely about what worked, and their challenges both local and national. There were many similarities between the areas and we describe their characteristics in broad terms in this report as well as looking in more detail at the delivery of health services in the areas.

All the case study sites were urban, although one incorporated some rural areas. Three of the case study areas had a population of more than 300,000 residents and the fourth area had a smaller population of more than 150,000 residents. Three areas had relatively high levels of rough sleeping; one had a low prevalence.

Two areas were part of larger metropolitan authorities that had their own broader rough sleeping strategies. One area was a two-tier authority and operated at both a district and a county council level. The fourth was a unitary authority.

According to the official rough sleeping counts, which document broad trends in data, all four areas had experienced a rise in the numbers of people sleeping rough between 2010 and 2018 (ranging from a 16 per cent increase to a 52 per cent increase). However, and notwithstanding the controversy over the quality of statistical data on rough sleeping, noted in section 2, all of the areas reported lower numbers in 2018 than in 2017.

Three of the areas highlighted a significant flow of people sleeping rough from neighbouring authorities or from further afield in the United Kingdom. One area also had a significant number of non-European Union migrants.

This report focuses specifically on how each area delivered health and care services to people sleeping rough. Despite various pieces of guidance on aspects of providing health and care to people who are sleeping rough (for example, Medcalf *et al* 2018, Local Government Association 2017), there is no agreed way to deliver health and care to them and local areas have determined their own approaches and models. We have mapped some of the features of the case study sites in Table 1. This illustrates, at a high level, some of the similarities and differences between the four areas in terms of health service provision and who took on a system leadership role for health.

Table 1 **Features of the four case study sites**

The four case study sites	A	B	C	D
Specialist primary care contract	✕	✓	✓	✓
Specialist hospital discharge team/worker	✓	✓	✓	✓
Health outreach workers	✓	✓	✓	✓
Regular multi-agency meetings to discuss individuals and problem-solve	✓	✓	✕	✓
VCSE sector is supported to be a leader in the system	✓	✓	✓	✓
Aligned thresholds of access across drugs and alcohol, mental health and housing	✕	✕	✕	✕
Approach led by the NHS	✕	✕	✕	✕
Approach led by public health	✓	✕	✕	✕
Approach led by adult social care	✕	✓	✕	✕
Approach led by the local authority housing department	✕	✕	✓	✓

On paper, all four areas had a specialist GP practice that served people who were homeless. However, in practice, we found that one site did not operate in this way and focused more on supporting people sleeping rough to access mainstream GP services rather than use the one practice that was contracted to provide a targeted service.

Over the next five sections, we set out the key features found in the approaches the four local areas used to deliver effective health and care to people sleeping rough. We have drawn themes from across the four sites rather than identify each

area individually. This is because we think that, despite the different contexts and approaches, the sites had a number of shared principles in common, which other areas may find useful to learn from.

The themes, which we have characterised into five broad insights, are as follows.

- Take steps to find and engage people sleeping rough.

- Build and support the workforce to go above and beyond.

- Prioritise relationships.

- Tailor the response to the local context.

- Recognise the power of commissioning.

1 2 3 **4** 5 6 7 8 9

4 Take steps to find and engage people sleeping rough

People sleeping rough face significant barriers in accessing services to maintain their health and wellbeing. It can be more difficult to register with a GP, access community health services or receive continuity of care if you do not have a home address. In this section, we look at what local areas have done to proactively seek out people who sleep rough and design services that people feel comfortable using. We also consider how findings from the focus groups with people with lived experience of sleeping rough might confirm or challenge professionals' perspectives. We end the section by looking at two challenges that all case study areas were struggling to resolve.

First, though, we step back from the specific interventions aimed at improving access to health and care and look at the engagement of people sleeping rough. All areas placed great importance on understanding an individual's personal circumstances and what might, if anything, be preventing them from taking up offers of assistance.

Engaging individual by individual

Many people sleeping rough have had negative experiences of seeking support from statutory services, have experienced complex trauma, such as violence, abuse or loss, and have a high prevalence of both mental health and substance use issues that mainstream services are not always equipped to deal with. As a result, interviewees emphasised the need to understand what had led to an individual becoming homeless, and why it might be hard for them to take up offers of support or move into settled accommodation. They also reflected a shift away from punitive approaches towards a focus on harm reduction (**Pleace 2008**).

Every area prioritised opportunities to engage people. Any contact, whether a hospital attendance or a night in a hostel, could be a positive opportunity to engage and build rapport.

Three of the case study sites took what is sometimes described as an 'asset-based approach' to care. This approach seeks to draw on and build the strengths and resources both of the individual being treated, such as their knowledge and support networks, and of the local community, spanning the public, private and voluntary sectors. Care is adapted to the specific circumstances, challenges, resources and priorities of the individual being treated.

> *It's about listening to and understanding people's experiences... having different conversations, not giving up and looking to build relationships over time, that's the best hope we've possibly got of working with individuals to really gently and really carefully talk about alternative options for support.*
> (Director, social services)

Closely linked in some areas was a strong emphasis on 'trauma-informed care' and 'psychologically informed environments' to meet the needs of people who have experienced trauma, often in the form of adverse childhood experiences. Research has identified high rates of adverse childhood experiences among people who experience homelessness (**FEANTSA 2017**). These are quite broadly defined approaches, which still need local tailoring and design, but place the individual, and their experiences, at the centre of service delivery.

In the rest of this section, we look first at the proactive measures local areas took to find people who may not use conventional routes to access health and care. Second, we describe how services were designed to be welcoming and inviting.

Co-production

Co-production is when an individual, or a group of individuals, influences the way that services are commissioned, designed and delivered (**Department of Health 2014**). Using the knowledge and skills that people have developed through their lived experience of sleeping rough can help ensure that services meet people's actual needs and are acceptable to them, rather than being based on assumptions. We heard that this can be particularly important in services such as those for people who sleep rough, whose life experiences may be wholly outside of those of most health and care professionals.

Our focus group participants described services that are all but inaccessible to people sleeping rough, and perceived that the default for health services would be hostility towards them. There is a significant body of evidence that co-production can be important in making sure that services are effective for people who sleep rough (for example, Groundswell 2012; Heer 2004).

Finding people: the role of outreach

People who sleep rough are often characterised as 'difficult to reach'. However, staff working in this field were quick to challenge this label. They argued instead that local authorities and the NHS had a responsibility to design services that people who sleep rough could easily access. They wanted to create opportunities to find and connect with the population who sleep rough.

Each area had a track record of reaching out to people sleeping rough. Most used a combination of 'street outreach' and 'in-reach' services in an attempt to build relationships with people, not all of whom access building-based services.

Street outreach services

The predominant approach to street outreach involved embedding health staff within third sector or local authority outreach teams, who knew where people were likely to be found and might have pre-established relationships with them – for example, placing mental health nurses in street outreach or drug and alcohol teams.

In-reach services

In-reach services embed health and housing professionals within existing, building-based services that are used frequently by people who sleep rough. We heard how in-reach services enable staff with specialist knowledge to use any contact a person might have with a service to provide support. Examples included housing workers in hospital discharge teams or community mental health nurses holding sessions in a hostel.

While the range of outreach services varied across the case study areas, all four areas had specialist in-reach to hospitals to support the discharge of patients experiencing homelessness. Even the area with a lower prevalence of people sleeping rough had invested in this specialist service; but interviewees told us

that investing in this service was a key reason *why* it had a low prevalence, as it was effective in helping to reduce rough sleeping. A hospital stay provided a key opportunity for health, care and housing professionals to engage with an individual. This was often over a longer period than might be available on the street or in a hostel, and in some cases the individual might be less intoxicated and able to be assessed more effectively (*see* the box below).

How was hospital discharge managed as a key opportunity to provide support?

We saw two approaches to specialist hospital discharge across our sites. First, all areas embedded a diverse range of staff – such as primary care and community health workers, social workers or housing professionals – into a hospital discharge team to help plan for a patient's discharge from hospital. Two areas told us about housing or homelessness professionals being embedded in the teams. In the other two, we heard how other health staff, including specialist GPs, were also embedded, providing links to care outside of the hospital.

Second, there were variations in the availability of this support. For example, one area had a full-time member of staff based in its main acute hospital who spent one day a week in its mental health hospital. In another, there were four team members, not all full time, and they worked with discharge but also supported people experiencing homelessness who were admitted to the hospital.

Proactive hospital discharge teams used their clinical expertise to 'convince a hospital' that a longer admission period would be time well spent to give a patient a proper assessment and a safe and well-co-ordinated discharge.

All areas pointed to hospital discharge work as being effective in reducing the numbers of people discharged from hospital onto the streets, although most still had occasional examples of this happening.

For an example of a specialist homeless hospital discharge model, *see* www.pathway.org.uk/about-us/what-we-do/model-overview

In response to the rising complexity of health needs among hostel residents, one area was extending its in-reach capabilities and building clinical space in its hostels. Others, however, highlighted limits to the quality and impact of care delivered outside of a clinic and the difficulty of treating chronic conditions without an adequate, sustainable home.

Making services easier to access

Local areas were aware that they had to consciously identify ways to encourage people to take up offers of support. Here we describe five interventions, all designed to increase access to and use of health services:

- access to primary care

- tackling stigma

- peer advocates

- the location of services

- holistic provision.

Access to primary care

All four case study areas recognised that primary care was key to improving health, care and housing outcomes and that individual GPs could play a critical role in championing the needs of people sleeping rough. We observed the impact of GPs' clinical leadership and that their influence spread well beyond the health sphere.

Three areas had a contract with a specialist primary care provider, where a single GP practice offers health care for people who are homeless. These practices offered drop-in appointments and longer appointment times, as well as having the experience and expertise to deal with the complexity of care needs associated with this population.

> *We have a mental health practitioner who is a psychiatric nurse... We have a social worker... we have two addiction workers [who] will prepare a prescription and the GP will sign that off in accordance with guidelines. One day a week we have a dentist on site... a podiatrist... we have a psychiatrist running a clinic here once a month.*
> (Specialist GP)

Crane *et al* (2018) have mapped specialist primary care services across England for people who are experiencing homelessness. There clearly can be advantages to having these specialist services. For example, the researchers found that in areas

without local specialist primary care, most homeless services reported difficulties for their clients in accessing primary care. However, they also noted that there is a lack of information to guide commissioners making decisions about the most suitable model of primary care for their local population, and a lack of research about the effectiveness of different models to meet the health needs of people who are homeless.

One case study area, with a lower number of people who sleep rough, had a model in which specialists supported mainstream general practice rather than locating all specialist capability in one practice. In reality, GPs within several practices across key neighbourhoods took a particular interest in and acted as champions for patients experiencing homelessness. This model has the advantage of not concentrating services in a single practice and, as we note later in this section, we found in our focus groups that not everyone wanted to use a specialist service.

Many commissioners advocated a mixed system in which people were supported to 'move on' from specialist services into mainstream services when they were ready. Local areas were finding ways to build confidence among the wider primary care community to take on people who are homeless, in an attempt to reduce the length of time people remained at a specialist, and more costly, general practice. Commissioners in two areas had given their specialist primary care providers an explicit system leadership role in their contracts. These practices were also expected to provide training and support to mainstream colleagues. Moreover, commissioners monitored discharges to mainstream practices as well as the numbers of new registrations. Some commissioners had gone further in setting expectations for primary care.

> *What the CCG [clinical commissioning group] did... Even though they've got a specialist GP practice... they've put it in the contract that any person who is homeless could register anywhere... with a GP... they've actually written if a person who's homeless comes in, this is what you should be doing, so it's about the immunisations, the screening.*
> (Ministry of Housing, Communities and Local Government (MHCLG) adviser)

Tackling stigma

Overcoming cultural and attitudinal barriers, which shape staff and the wider public's beliefs about what people who sleep rough deserve, continued to be a challenge for local areas. It also emerged as a strong theme in the focus groups. Focus group participants reported being made to feel unwelcome and being denied access to health and care, for example being unable to register with a GP or a dentist, despite clear guidance that states that you do not need to have proof of address to register (**NHS England – Primary Care Commissioning (Central Team) 2017**):

> *You try to register [with a dentist] and the first thing they ask you is [your] address and you say you haven't got an address and they say, 'Well, we can't help you', because that's the first question they ask you, 'What's the address? What's your postcode?' 'I haven't got one.'*
> (Focus group participant)

Participants in the focus groups responded differently to the perceived stigma associated with being homeless. Some valued the specialist GP services dedicated to serving people experiencing homelessness, while others avoided them. Some kept their situation hidden for fear of being treated differently by mainstream NHS services, or felt more comfortable with an existing GP. Some also were keen to avoid using a surgery where they might come into contact with people using alcohol or drugs. 'I've got my own GP; I've had him since I've been in [city]. I won't go to [specialist service] because of the drug addicts, the alcoholics there. Just won't do that' (focus group participant). Providers echoed this view, as one voluntary, community and social enterprise (VCSE) sector provider described. 'I don't necessarily think it works for recovery and re-integration. So, you're only homeless for part of your life, not all your life, and sometimes you can be labelled as like, you go to a homeless GP, and it becomes very hard to leave those labels behind' (VCSE manager).

Others in the focus group said they avoided primary care altogether, instead using a busy accident and emergency (A&E) department to access health care. They felt more comfortable seeking help from staff who were 'rushed off their feet', accustomed to treating people from all backgrounds and less likely to make judgements on the basis of housing status.

To increase awareness about people's rights to health care, local areas had distributed cards to people sleeping rough, which explained their rights to accessing health care. For an example of these cards, *see* **https://groundswell.org.uk/what-we-do/healthandhomelessness/my-right-to-healthcare-cards/**

Areas also tackled stigma through staff training and awareness raising. 'There was an online video, that receptionists... had to look at and go through the quiz and everything, and it really raised the profile of homeless people in saying this is what you need to do if someone's homeless and comes in to your practice' (MHCLG adviser). For an example of this kind of training, *see* **www.pathway.org.uk/4403-2**

Peer advocates

Some systems used peer advocates or link workers to support people who sleep rough in getting their health needs met. Peer advocates take a proactive approach and accompany individuals to appointments, fill out forms and talk to health staff on their behalf. Advocates were used to build relationships and tackle a range of barriers to accessing care, including lack of a phone to arrange appointments, book appointments online or look for services, lack of transportation, intoxication, poor time-keeping and issues around self-confidence and the capacity to interact with health service professionals. 'It's up to us to make the connection, not them... we'd nominate one person that would be their link, so we would navigate them around the services rather than the other way round' (health partnership).

Several interviewees noted that peer advocates with lived experience of sleeping rough were particularly skilled in establishing relationships of trust and engaging with clients in a more direct, honest manner. '[VCSE organisation] staff are usually employees with lived experience... Their key strength has probably been to engage with these clients and they are also directing. And some of the patients are probably most honest with those colleagues' (specialist GP). In addition, many services provided broader advocacy support for people to navigate the health system and reach the 'next step' on the route towards accessing care. In one area, a GP had a group of volunteers who would accompany people to secondary care appointments.

For an example of a homeless health peer advocacy service, *see* **https://groundswell.org.uk/what-we-do/health/homeless-health-peer-advocacy**

The location of services

In most areas there are easily identifiable locations where some people sleeping rough congregate – for example, a town centre or around a hostel. The four case study areas purposely used these spaces to locate and often co-locate a range of health and care services. Co-located services ranged from 'hubs' and large specialist homelessness GP services, to individual GPs who employed addiction workers. This made it easier for people to access care, and professionals to deliver co-ordinated care.

> *On the medical side and health care side of things [there are] minor issues with everything but they are actually quite good. You see the ambulance there and the nurse comes in every Tuesday. You have a physio come in. You have a dentist come in. So, to be fair they are actually quite good that way.*
> (Focus group participant)

However, several areas were relocating, or had already moved, services further away from the highest concentrations of people sleeping rough, seemingly contradictory to the idea that grouping services together in the same location – and in an area known to be used by this group – improves access. Key reasons for this were the cost of providing services in expensive, central locations, as well as concerns about concentrating access to specialist health services. Local members of the public and commercial organisations had also raised objections about attracting large numbers of people who sleep rough. Commissioners need to balance these considerations with the need to avoid creating barriers to access for people sleeping rough, particularly if they have to negotiate appointments with multiple services in different parts of the locality. Creative approaches may be needed here.

Holistic provision

Some homelessness providers offered additional services or features on top of their core services specifically for this population, such as complementary therapies, art or yoga. These extra offers of support go beyond what is traditionally perceived to be a health and care service but can be an important way of encouraging engagement with health and care services.

[The GP offers] little touches like receive people's post for them if they need things sent.
(Public health analyst)

We commissioned an art worker to work at our multi-agency service hub... it's turned out to be a major factor in calming the space, sufficient for people to then have the conversations they need to have... so that we can do really good assessments.
(Housing manager)

Interviewees in all areas also expressed interest in the 'Housing First' approach, which provides intensive, holistic support – including a stable, permanent home – on an unconditional basis (**Homeless Link 2018**). This approach has a strong evidence base for its housing outcomes, although evidence for its associated health outcomes is not as established (**Mackie *et al* 2017**). Housing First was in varying stages of planning or development across the areas. In all, however, it was on a small scale and not described as a central part of their overall approach.

Paying particular attention to common challenges

We have described above how each of the local areas sought out people sleeping rough and thought hard about how to promote access to health services. But despite these efforts, we observed two issues, common across all areas, that continued to be challenging. These were difficulties in:

- providing access to mental health services

- managing different thresholds and eligibility criteria across a range of services.

We note that there are no obvious or easy solutions to these issues, and as such there is a high risk of them continuing unaddressed. However, based on what we heard, improving access and the management of eligibility criteria across services would form a key part of meeting people's needs.

Access to mental health services

Our focus groups and interviews in the case study areas confirmed that – in common with many other areas of the country – people have difficulties in securing mental health support. Within the context of rough sleeping, we think that at the heart of this issue is the current gap in mental health services for people with complex and multiple needs (**NHS England 2019b**).

Our research and the wider literature paint a picture of people sleeping rough who have severe mental health needs but are not in a psychotic state or at immediate risk of a major concern such as suicide. They may also have additional complexities caused by substance use rather than mental illness. At worst, this can mean that their needs are not severe enough to meet access criteria for specialist services, but equally are too severe for primary care. This problem exists for the wider population as well but is notable among people experiencing homelessness or sleeping rough because of the very high percentage who report significant mental health needs and the fact that their living situation may further contribute to their ill health.

> *It makes you run down because you're just in the same rut every day. You're just in a hole and you can't get out of the hole and the hole is getting bigger and bigger and bigger and you're stuck down the bottom. You can't see a way out of it.*
> (Focus group participant)

This gap in appropriate mental health services for people sleeping rough was expressed in various ways. For example, we heard the following.

- Eligibility criteria are too restrictive, with people unable to access support because the 'thresholds were set too high for this group'.

- People get discharged with high mental health needs without access to appropriate ongoing support and follow-up.

- There is a lack of early intervention and rapid access to mental health services, and it is hard to get people assessed on the street.

The gap in mental health services impacts heavily on those people who sleep rough and have co-occurring mental ill health and substance dependency. While the term 'dual diagnosis' is still used, it is increasingly recognised that people who sleep rough rarely have a diagnosis and that it is unlikely that they will only have these

two health needs. People with co-occurring conditions can fall between two care pathways that can feel mutually exclusive. One housing manager described how the clinical guidelines get translated at a local level.

> *Sometimes they find that mental health services are saying: 'Well, you have to go and sort out your drug problem first.' And then drug services will say: 'Well, we can't deal with this person because they've got such a severe mental health problem, that actually drug services aren't going to be able to deal with that alone.'*
> (Housing manager)

Mental health care also needs to be well co-ordinated with other services such as housing, physical health care, social care and substance use services (including co-occurring/dual diagnosis services). Interviewees in our case study areas spoke positively about improved joint working between drug and alcohol services and mental health services through having dedicated dual diagnosis workers and formal protocols being introduced. As part of this agreement, each service had designated leads tasked with supporting collaboration between organisations and resolving barriers to joined-up care for service users. It also included 'joined-up clinics' for people with overlapping substance misuse and mental health needs.

Three out of the four case study areas had specialist mental health teams. Interviewees placed great value on the interventions of mental health outreach staff and street psychologists, enabling people who sleep rough to access support earlier and receive a broader range of therapeutic interventions.

But the existence of those specialist teams did not mean they had solved the challenge of meeting the needs of people sleeping rough: there were still significant difficulties in accessing care. Although funding and difficulties in recruiting staff were highlighted, the difficulties of engaging mental health services – 'getting them to come to the table' – were noted. We observed a tendency for difficulties in providing and resourcing an effective mental health service for people sleeping rough to not always be owned collectively by the full range of local partners as a shared problem to work on together. One of the challenges for local system leaders is to further develop relationships, trust and a sense of shared endeavour so that all partners contribute to and support efforts to ensure adequate investment in mental health services as part of an overall system for people who sleep rough.

Thresholds and eligibility criteria

While most people experience access to NHS health care as freely available on the basis of need, people who sleep rough may have to pass multiple thresholds to be deemed eligible for health care.

We observed that they can be excluded from accessing health care in four key ways.

- An **address** is often required, for example, for registration with a GP or for the NHS Low Income Scheme (which allows for free prescriptions). Case study areas all had clear 'work-around' policies that enabled people to use an official address (such as a GP practice) for these purposes. They also distributed flyers to inform people sleeping rough that lack of an address would not be a barrier to care.

- Some services have incompatible **access criteria**. For example, some substance use services require accommodation, but accommodation may only be available to those who are sober. This particularly affects people with co-occurring conditions, as discussed in the previous subsection. These differences are a matter of policy (rather than the law) and highlight the importance of commissioners joining up their service specifications. They mainly affect housing services, mental health care and, in particular, substance use services. One NHS mental health provider was exploring the option of building their own housing for people sleeping rough (*see* 'A different approach to housing with embedded health support' below).

- Local authority rehousing services require a '**local connection**', for example a certain time spent living in the area. Social care and substance use services may also only be provided for recognised local residents and specified at-risk groups, including those at risk of gender-based/domestic violence. Councils may refer a person without a local connection back to their 'home' area, unless they would be at risk of violence there. Most of these thresholds are not set in law and there are usually allowances for individual circumstances such as a need to access local specialist health care.

- Many people from abroad are not eligible for homelessness services and other public funds. This group is sometimes known as those with **no recourse to public funds**. In one of our case study areas there were significant numbers of people in this situation who were sleeping rough (*see* 'Supporting people with no recourse to public funds' below).

A different approach to housing with embedded health support

In one area, an NHS mental health provider was developing a new housing approach for a small cohort of people who had a history of evictions and loss of housing as well as mental health needs. It had identified this cohort from a regular multi-agency meeting that discussed complex cases. It was aiming to emulate a Housing First approach but with a focus on mental health, and using off-grid 'micro-homes' as an affordable way to provide accommodation. There was some concern that its approach would not address the permanent housing needs of these individuals and therefore would not meet the criteria of Housing First, but those involved felt it would provide 'some form of stability' and gave them a way to begin to meet the needs of a cohort who had no other housing options open to them. They were exploring options for tailored outcome measures that would be meaningful for those using the service, but at the time of our fieldwork the project trial had not yet received formal approval.

Supporting people with no recourse to public funds

One case study area told us about how they reconnected people who wished to return to their home country with the relevant health service there to ensure continuity of care, paying for flights and accommodation after discharge from hospital. Another case study area described accessing specialised third sector services to support people from countries that are not part of the European Economic Area (EEA) in getting accommodation, employment advice, advice for complex immigration cases and reconnection with services in their home country.

Where these thresholds are set in law, uncomfortable as it may be, places need to find ways of working with them. We look at how local areas manage these conundrums in section 7.

In the next section, we explore how local areas build and support a workforce with the skills, compassion and empathy to deliver effective care.

Key learning

- People who sleep rough face many barriers to accessing services. They often have multiple and complex needs. A range of factors can make it difficult to navigate the health system, including complex administrative processes, low literacy skills, language barriers and challenges in keeping appointments. Expectations of rejection and negative past experiences with public services can lead to a reluctance to engage. Systems therefore need to take concerted steps to identify and address unmet need, and to design services that people who sleep rough want and are able to use.

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

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

- People with lived experience of rough sleeping were involved in the design and evaluation of services.

- 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 people 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.

- Although not yet mainstream in any site, staff viewed trauma-informed approaches to care positively where they existed.

5 Build and support the workforce to go above and beyond

Mainstream public services (such as health and social care) tend not to be designed for people who do not have a home. This means that staff have to find ways to make the available services work effectively for them. In this section, we consider how a local area can best build and support a workforce to continuously advocate for people sleeping rough. We explore how local areas provide both the culture and infrastructure to give staff the backing and the confidence to 'do the right thing' and keep services co-ordinated. In particular, we look at the role that leaders can play in setting expectations, driving change and supporting staff.

Stakeholders often talked to us about the commitment, goodwill and dedication of frontline staff. What struck us was the degree to which staff worked beyond their traditional roles, flexing and going beyond the 'standard offer' to meet the needs of people who slept rough. Fully exploiting this resource that local areas have, may be the most important (and potentially quickest) step that areas can take to make progress. 'The local service does an amazing job... I don't know what the magic bit is, other than communication and a lot of goodwill, there is a lot of goodwill, some really good people out there. Maybe that's the key, is people who go above and beyond' (public health commissioner).

Framing the issues (so that staff feel able to go above and beyond...)

People who sleep rough can be framed in a number of ways, from seeing them as a social nuisance, to a group who are vulnerable and needing to be helped, to individuals with unrealised potential. Case study areas were all closest to this final way of framing the issue, adopting variants of an asset-based approach (**Rippon and Hopkins 2015**). Nevertheless, in our focus groups and elsewhere, we also heard about negative and even hostile attitudes from some NHS and local authority staff, suggesting that framing needs ongoing attention.

Three areas also had an overarching strategic narrative, or set of principles, that informed how services were shaped and how staff at all levels approached their work. These narratives emphasised prevention, inequalities and integration and helped to shape an organisational culture in which staff felt they were given permission to work in new ways. 'If the founding principles of what we're doing and the values are right, we're not frightened to fail' (health partnership).

Frontline staff were also encouraged to take up leadership positions themselves. Staff reported that they felt confident to challenge and take risks to do things differently. We heard about leaders who enabled a workforce to 'go above and beyond' their own specific job role or service agreements by creating a safe, supportive culture with high expectations about service delivery.

Directors actively encouraged staff to innovate and advocate for local people. They publicly acknowledged that in a system that encourages 'bottom-up' innovation and flexibility, sometimes best efforts will not work. Senior leaders talked about providing 'air cover' – and giving organisational backing to do things differently and protecting staff from the fear of failure.

We have described elsewhere (Naylor and Wellings 2019; Timmins 2019) what this 'air cover' looks like in practice, at a system level, in a description of Wigan Council's journey of changing its culture and services (*see* the box below).

Six tips for leaders on creating a culture of person-centred services

- Create political *and* organisational support for the changes you want to introduce.

- Build a cohesive team around you.

- Constantly listen hard to staff and local people.

- Build trust with staff and give them permission to take risks.

- Identify champions early on and then seek to build momentum.

- Maintain your personal energy levels.

Source: Naylor and Wellings (2019), adapted from Wigan Council

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Our case study areas varied in how much they could be said to have a clear narrative for their approach to rough sleeping. However, the two areas with the clearest narratives – especially one area where the narrative was actively used as a tool to engage staff – talked more confidently and consistently about how they were working as one system with common values and goals. Indeed, a shared narrative of what the local approach is, and why, can help bridge the gaps between different professionals and sectors (Bezrukova *et al* 2012) and underpin attempts to provide collective leadership (**West** *et al* **2014**).

Each local area had examples of clinical and frontline staff driving change, supporting colleagues and advocating for their clients and their services. In various ways they stretched the system to meet the needs of people sleeping rough.

The impact of strong clinical leadership, particularly from GPs, was clear. In the subsection 'Access to primary care' in section 4, we mentioned that commissioners in two areas had given their specialist primary care providers an explicit system leadership role in their contracts. These practices were expected to be involved in city-wide leadership and offer support and training to frontline workers. They were also given permission to challenge the system. 'We've almost built in advocacy for homelessness within the [specialist primary care] contract… Part of the financial incentive in [the key performance indicator] is system leadership, and they are very good… Advocates for homelessness. And that voice isn't going to go away' (clinical commissioning group commissioning manager).

Frontline practitioners could also challenge services and system leaders to provide the most effective care possible. We heard about nursing and mental health staff who proactively took issues to their trust and ensured that the homeless population were taken into account in strategic decision-making. In some areas, specific roles had been particularly critical in driving change. In one, the safeguarding lead provided an effective route for staff to raise concerns over someone sleeping rough and was seen to be able to intervene swiftly, for example if someone was about to be discharged from hospital onto the street. This role was seen to have the authority to challenge the system. 'She's got a budget, she's got the authority and she gets people round the table' (housing manager). The use of safeguarding powers for people sleeping rough was also understood to be changing working practice and culture, particularly around understanding capacity to make decisions and perceptions of what is or is not a lifestyle choice to sleep rough.

Leaders, including politicians, played a key role in setting the tone and framing the local approach to homelessness and health. In turn, this was felt to have a strong impact on how frontline staff viewed their role. In two areas, interviewees spoke positively about the impact senior leaders had on focusing attention on rough sleeping after visiting services or going out with an outreach service. We found that all the case study sites placed great value on how leaders set cultural expectations about how people who sleep rough should be treated. The danger of relying heavily on strong individual champions was not missed and several interviewees recognised that their success was driven in large part by key people, rather than by a strong, embedded way of working at a system level.

The case study sites also recognised that having a skilled, empowered workforce, with shared aims, relied on recruiting and retaining staff with the right values and skills. We explore how this was achieved next.

Recruiting the right workforce

All the case studies reported difficulties in recruiting staff, particularly nurses, who were willing to work on the streets with people sleeping rough. Depressed wages and short-term contracts related to the short-term nature of funding through the Rough Sleeping Initiative made it hard to attract workers with the right level and type of expertise to make a real difference. This impact was felt across sectors – the NHS, the voluntary, community and social enterprise (VCSE) sector and local authorities.

In one of our sites we heard about a new approach to recruitment throughout the local authority that focused more on the values, attitudes and behaviours staff brought to their roles than experience. Other successful examples included recruiting a health worker into a homelessness team and a housing worker into a health team. These roles needed careful planning and an understanding of the complexity of getting buy-in across teams, particularly where funding was drawn from different services. For health staff seconded outside of the health service, ensuring their access to appropriate clinical supervision and support was a key challenge.

Investing in staff wellbeing

Supporting people who sleep rough, many of whom have experienced complex trauma and have high and complex needs, can be emotionally demanding. We heard how staff were offered support both practically and emotionally. This included monthly supervision and access to counsellors, chaplains, support lines and regular informal meetings (*see* the box below).

Supporting staff wellbeing

One specialist GP provider told us how support for frontline health staff was vital but often overlooked. In their service they aimed to support staff through a range of means, including a weekly informal meeting to discuss cases and any issues with other staff, providing mobile phones for lone workers, and monthly counselling with provision to increase the frequency for a period if required – for example if a member of staff experienced an incident. The costs of providing this support (in particular the cost of counselling) were included in the budget when providing a cost estimate for a worker.

One of the features of the homelessness sector is the number of frontline staff and volunteers with lived experience of homelessness themselves. Providers highlighted the need for specialist support for these staff who sometimes face their own ongoing challenges as well as those they encounter through their work.

> [T]he intricacies of having been homeless, for some of our staff, it seems that they continue indefinitely, they're never quite able to completely extricate themselves from the difficulties that they've had… We've got two people in rehab at the moment who were paid members of staff. So it takes quite a lot to support a team of peers.
> (VCSE chief executive)

Retaining a skilled, flexible workforce

A stable workforce can build up its expertise and experience over time. It can also provide continuity of care for a group that moves in and out of services, and in and out of homelessness. This is particularly critical for people sleeping rough. Relationships, often built up over a long period of time, act as a stepping-off point

for building trust and engagement with other services and support. However, short-term contracting and funding – sometimes a result of national project funding rather than local commissioning – makes it difficult to retain staff and the process of retendering contracts can cause significant barriers to progress. Commissioners need to actively manage and minimise these risks.

For example, we heard how commissioners had disrupted established groups to create new, integrated, flexible teams more aligned with the strategic direction. But, they did so in a way that maintained established relationships between staff. There were, however, limits to this staff flexibility; and resourcing issues posed a challenge to maintaining connections. Staff were sometimes contracted to work on a particular project, rather than being able to go where the need was. Some interviewees noted that non-statutory organisations were sometimes more able to work flexibly.

Training an integrated workforce

People who sleep rough may struggle to maintain their health and wellbeing. However, health services are often not the first point of contact for someone needing support. In an attempt to intervene early and effectively, we heard how staff in mainstream customer-facing roles from across a range of services were trained to offer support and signposting. Rough sleeping was incorporated into approaches such as 'no wrong front door' and 'every contact counts' and, for some, this was a key element in changing the culture. General practice was also targeted, and reception staff were made aware of the right of a person experiencing homelessness to register for a GP. Specialist GPs themselves delivered training to other GPs and medical students.

Staff working with people sleeping rough also had additional training, which they valued, and this was targeted at both those with and those without health training.

- Frontline homelessness workers, many of whom have little training in health, were offered training in mental health, care assessments, mental capacity and safeguarding. They were also given training on how to promote independence, including budgeting and healthy eating.

- Nurses and other frontline staff were supported to develop reflective practice. This allowed them time to reflect on their work and consider what they had learnt and how they might improve. Reflective practice is also a vital element of delivering psychologically informed environments. By providing training and time to engage with reflective practice, areas also facilitated engagement with people using services.

In this section, we have described how the case study areas were all building a workforce that was equipped to support people sleeping rough. While recruitment, training and retention were all key, what stood out to us was the way cultural expectations about how staff support each other, as well as about people experiencing rough sleeping, were defined and agreed. These 'ways of working' relied heavily on strong personal relationships. In the next section, we consider how local areas can create a culture in which staff are both expected and supported to develop these relationships with each other.

Key learning

- Local areas are not yet functioning in a way that fully meets the needs of people sleeping rough. Staff therefore often have to work around systems, rules and procedures rather than through them. There are high levels of passion and knowledge among staff working with this group in the NHS, local authorities and the VCSE sector. Systems need to work to nurture, sustain and capitalise on this.

- Developing a shared sense of purpose across a system can bring people together and act as 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, and this set the tone for staff delivering services to work together towards a shared goal.

- Giving staff permission to flex the system and do the right thing 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.

- Working with people who sleep rough can be emotionally demanding. The provision of ongoing support enabled staff 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.

6 Prioritise relationships

In this section, we describe how staff can work together effectively across organisations and sectors in providing health, care and housing-related services. We consider the importance of good interpersonal relationships, and a number of practical steps that areas can take to developing them.

Evidence from previous studies strongly suggests that system-wide, professional relationships are essential for the delivery of integrated, high-quality care (*see* for example **Hulks *et al* 2017**). Our research also reflected this, with interviewees across all sectors highlighting the value of personal relationships. This meant knowing colleagues on a first-name basis, meeting them face to face and having their telephone numbers.

> *It's just totally different, looking up an online directory and trying to get through to somebody about a problem versus if you're dealing with them week to week, day to day and you can pick up the phone or email someone and they know who you are and they know your face and you know each other. It's totally different in terms of getting stuff done.*
> (Specialist GP)

Staff used their personal connections with colleagues to make the system work around an individual. Referral alone did not appear to be an effective mechanism to secure care. The following comment made by a focus group participant suggests that services often remain unconnected. 'I think the most favourite word of services at the moment is: "We'll refer you." You go to them and they say: "We'll refer you to them."'

The informal relationships between staff made quick and trusted contact between them possible. However, it takes time, effort and resources to strengthen personal relationships across teams and sectors, and there is also the risk that when people move on, expertise and contacts are lost. To address this, each of the areas had put in place various formal mechanisms to deepen connections between staff. Here

we look at three strategic interventions that physically brought staff together: co-locating staff, regular multi-agency meetings and sharing data at the front line. We also consider the role that leaders play.

Co-locating staff

In section 4, we described how services were brought together in the same location to improve access and engagement. Co-location has long been used as a vehicle to help strengthen staff relationships. We found local areas purposefully using shared space and integrated teams to break down barriers and foster a common agenda. Examples included different functions, such as housing and drug and alcohol services, or mental health and dual diagnosis services, as well as different organisations (the clinical commissioning group and the local authority), being put together in the same location.

Putting different professionals together in the same team also helped to break down barriers and bridged professional and cultural divides. Close, trusting relationships were able to develop 'rather than doing everything by email'. One site described how embedding a non-health staff member in its hospital discharge team improved information-sharing and increased their ability to plan for people coming out of hospital. '[Voluntary, community and social enterprise (VCSE) staff] being embedded within our integrated discharge team, which is allied health professionals, district nurses, social workers, they're not seen as an addition or, oh, it's the voluntary sector and we're health professionals, they're one team' (director of public health).

Regular multi-agency meetings (at all levels)

Given the large number of agencies that need to work together to reduce rough sleeping in an area, co-locating all services is rarely practical. Instead, regular multi-agency meetings were used to facilitate information-sharing, joint planning and problem-solving. These meetings occurred frequently – some weekly – and typically involved:

- housing

- social care

- community, primary and mental health services

- hospital in-reach services

- drug and alcohol services

- the police

- outreach services

- other third sector partners.

The [name of multi-agency risk forum] is a fantastic thing. It gives the opportunity for professionals to all sit down and talk about individuals and formulate really concrete health care plans, and social plans. I think it's a great forum that needs to continue. We've had a couple of instances where we've had very high-volume ambulance service users that we've identified are calling, say, between six and nine in the morning and four and five in the afternoon. With that data we can go to the [forum] and we can ask the care team that are there to change their care time: 'Actually, you're not going out to them until 11. Can you go in earlier?' And we're instantly seeing that change in our prolific callers.
(Paramedic)

The forums were not free floating: they were part of a local model, even if that was not always formally articulated, and they were supported by and accountable to senior system leaders. But they seemed to have developed their way of working 'bottom up' rather than through top-down prescription. Members described to us how they were built on a common set of values and driven primarily by a shared

commitment to improve the lives of people sleeping rough, with any financial savings that resulted from improvements being seen as a by-product (*see* the box below).

Multi-agency meetings involving the ambulance service

In one area, interviewees highlighted an effective relationship between the ambulance service and other stakeholders (for example, the VCSE homeless outreach service) that enabled early identification of people experiencing problems or crisis. A paramedic had taken the lead role in the local ambulance station, providing advice and information to colleagues who were called out to people sleeping rough, and ensuring links with the police, the local hospital and the local outreach team. This relationship had emerged from the paramedic conducting an audit looking at the ambulance trust's data in relation to people sleeping rough. The audit identified a significant number of contacts with people sleeping rough, as well as repeated difficulties in connecting them to suitable options. To try to better meet their needs, the paramedic asked to be included in the local multi-agency meeting and particularly contributed by sharing data. This turned out to be a major contribution: up until this point, other agencies had been unaware of the extent of information that the ambulance service had from its many contacts and repeat contacts with people who sleep rough, and their knowledge of and relationships with the local population who sleep rough. It is rare for ambulance services to be involved to this extent; many other areas are likely to be missing out on the valuable insights that these services are able to provide.

Effective meetings were not a given, however. The volume of meetings and competing calls on time from working at a system-wide level caused some tensions. Staff struggled to work out which meetings were necessary, and got frustrated that meetings often clashed with clinic time. Other stakeholders expressed a similar level of frustration over colleagues' failure to attend multi-agency forums.

Sharing data at the front line

In all of the case study areas, finding effective ways to share intelligence about particular individuals was fundamental to the progress they were making. Regular multi-agency meetings were the key way in which they achieved this. These

forums served as a way to join up service provision across differing commissioning arrangements and offered professionals a way to share information about an individual in the absence of any shared digital information system.

> *[Frontline staff] can access their own system, so they can say: 'Oh, yes, this person's got a social worker... in the last six months, there's been a number of mental health interventions', or whatever it might be. So through that way, they're not accessing it to get the data from each other's systems but they can actually share it in the room.*
> (Health partnership)

These meetings required a 'cultural shift' to enable frontline staff to think as a system rather than focusing on their particular specialities, and training was provided to facilitate this. Interviewees highlighted the need to get informed consent when using data in multi-agency meetings, and mostly their experiences were of people willing to give consent. However, one interviewee described the 'minefield' of ensuring that information governance procedures behind this were adequate.

The role of leaders in fostering connections across a system

We noted in the last section how a shared narrative around rough sleeping can shape the culture and expectations around how staff work. When we asked people working in the case study areas what it was that enabled them to prioritise relationship-building, many found it hard to describe. The culture – the way things are done – often feels intangible and interviewees simply said that they were 'expected' to spend time getting to know colleagues and partners across the system.

Senior leaders recognised their role in actively supporting staff to develop closer relationships. 'It's about us investing energy into those relationships, so not distancing ourselves and saying: "Well, let them fight it out"' (director of social services). By encouraging and modelling collaborative working across organisations, leaders used their influence to demonstrate the value placed on relationship-building. They could also use their position to remove administrative and structural obstacles to joint working. 'Basically he's the enabler, he helps us to unplug areas of blockages that we might encounter, as you would when you've got all these people come together, wanting to do something' (mental health trust).

Three areas had also used pilots or new projects to explicitly change how staff worked together and had seen improvements in relationships. We heard how leaders exploited the opportunities provided by retendering or contract reviews to develop closer links across their area.

> *When the current contract was commissioned, it really changed everything. We do really work in partnership and there was a real buy-in from [the trust] and recognition that the voluntary sector were specialists. I think prior to that there'd always been a bit of that feeling that: 'We employ qualified staff; you don't.'*
> (Mental health partnership)

Throughout this section, we have emphasised the importance of relationships at all levels, and the level of investment and attention that needs to be paid, continuously, to getting them right. We turn next to what it means to create a 'place-based' system of care and how, at times, strong professional relationships are needed across geographical boundaries.

Key learning

- People who sleep rough have multiple and complex needs that span housing, social care and health, and they may not use conventional routes to access support. Staff need to be able to connect individuals quickly across different services, and that works best when staff know each other personally. Staff also need to be able to work with and trust others when flexing normal practices to fit services around an individual.

- Senior leaders visibly modelling collaborative working helped to shape organisational cultures in which positive working relationships were seen as key. This included showing a 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 locating teams in the same building, designing pilot projects that encouraged joint working, and holding both strategic and operational multi-agency meetings.

7 Tailor the response to the local context

In section 5, we highlighted the importance of individual staff going 'above and beyond' by flexing the service offer so that it meets highly person-specific needs. But a response cannot be dependent only on individuals. In this section, we describe how systemic approaches also need to be built in as core features of the approach. Such a move allows a system to accommodate local needs and assets and operate effectively within wider regional and national approaches.

In this section, we describe how each local area's strategy for improving outcomes was shaped by the nature of its population sleeping rough as well as broader local circumstances and local culture. We consider how flexible a system can be (as opposed to staff flexing their roles and services) and explore how these local authority/NHS systems can operate as part of wider regional systems.

A local, place-based approach

The four areas we looked at all had very different populations sleeping rough. But what united them was the depth of locally held knowledge of who was sleeping rough, including how this group had changed over time and across the local geography. Each area was to different degrees establishing a distinct place-based approach, in which services across organisations and sectors are co-ordinated and tailored to local circumstances.

With mixed success, the areas we visited all understood the value of developing an overall system, rather than a collection of disjointed services. Interviewees could see the tangible benefits of working together as a collective system.

> *Despite the inherent way that the system's designed not to join up, we're joining it up. And through the partnership and the way the council works with other broader partners, that principle of place-based provision is totally part of the model that the whole system is propagating. You can't unpick it now.*
> (Health partnership)

Learning from The National Lottery Community Fund's (2019) Fulfilling Lives programme is reflected in varying degrees in the four case study areas. This work highlighted five themes that need to be considered systemically (rather than ad hoc in each intervention or in each service) in a place-based approach for people facing multiple exclusion (*see* the box below).

Five key areas to consider at a systemic level for people facing multiple exclusion

- Develop and expand the role of co-production in creating effective system change.

- Embed a culture of system thinking and 'what works' in creating system change.

- Develop the workforce across the system, highlighting, for example, the importance of trauma-informed and strengths-based approaches.

- Improve access to services – particularly mental health services.

- Improve service transitions – including hospital discharge and prison release.

Source: The National Lottery Community Fund (2019)

In each area, we observed forums bringing together director-level leaders and, at the service level, we observed multi-agency groups that brought together leaders and practitioners of frontline services. These groups were the key resource for developing system-wide approaches, through joint approaches and co-ordination. However, it was sometimes hard to see how governance arrangements connected these strategic and service delivery levels, for example in terms of monitoring progress towards strategic plans, having a clear cascade of decisions or how service improvement was being considered alongside the co-ordination of activity and approaches.

Exploiting local characteristics

Distinct local features in each area influenced the characteristics of the group that slept rough, and were actively used to tailor a local response. For example, one area had a major trauma hospital that treated large numbers of people from outside the local area. The hospital used its experience of co-ordinating discharge with multiple local authorities to shape arrangements for those who had no fixed address and

no local connection. In another area, tourism was a significant part of the local economy. This created opportunities for building local politicians' commitment to helping people off the streets, and for engaging with local plans to develop and manage the night-time economy, including the sale of alcohol. A third area was near a major rail terminus; engaging with transport police meant that it could work with newly arrived individuals before the risk that they might end up on the streets was realised. Two areas with a high prevalence of rough sleeping trained people who had previously slept rough as peer volunteers to raise awareness of the support available and make referrals.

In all areas, there was an acute awareness of the wider community's potential roles, both as a provider of support and as a barrier to progress. In some areas we heard frustration that local residents had unrealistic expectations of the speed with which rough sleeping could be prevented or solved, illustrating how difficult it was to develop and embed a common way of framing the issues and the service response to them.

> *[X city] is seen as a very welcoming city, we've got an awful lot of activists who are very keen on supporting people who are homeless, which is great, but sometimes it means that people are being supported almost to stay on the streets than to move off and go to places where they could get more help.*
> (Housing manager)

The importance of political leadership

One of the interesting features of commissioning health services for people sleeping rough compared with other patient groups is the level of political interest. Rough sleeping was a local political issue in all four areas, and many interviewees highlighted the crucial role that local councillors and mayors could play in getting services for people who sleep rough on the local agenda, driving change and applying scrutiny. This influence extended beyond the local authority and we heard, for instance, examples of how scrutiny committee recommendations had led to the creation of new health posts for people sleeping rough.

Some interviewees recommended active engagement with councillors to cultivate support as well as informing and shaping their own work. We heard how, in a neighbouring authority of one of our case studies, a change in political leadership

had swung local opinion away from blaming people who sleep rough, towards the provision of new services. However, other areas noted the delicacy required to harness political enthusiasm. For example, interviewees in one area felt that local politicians' overambition resulted in resources being spread too thinly over numerous projects, which could not be sustained beyond the short term. Interviewees described the importance of developing skills to work with politicians: they needed to be able to frame discussions in terms that resonated with their audience, in order to channel the influence and energy of elected officials in productive directions. 'Sometimes you could present the same issue, but there's a slight slant on it, because you're aware of who you're speaking to, and how they'll see the world… you have to be really aware, you suss out who you're with, how you present an argument' (voluntary, community and social enterprise (VCSE) provider).

Ability to flex the system as well as services

In this subsection we set out some examples from our case study areas that illustrate how an ability to flex services for individuals was mirrored at a system level.

A flexible response to neighbourhood boundaries

Beyond their local 'place', all of the areas we visited had flexible arrangements with their neighbours – for example, across districts in a county, or across boroughs in a metropolitan area. Most arrangements focused on accessing additional accommodation, and reciprocal arrangements were in place to 'borrow beds' with neighbouring councils. This was not just to support people with no local connection to access services; it also reflected a wider need to use capacity creatively and manage limited resources. One area also had ambitions to develop this flexibility further and develop a regional approach to local connection, based on securing a regional budget. Interviewees hoped that by taking learning from the existing arrangements for pooling budgets across related county council and district council responsibilities for housing, they could go further in pooling resources in relation to accommodating and supporting people wherever they were from in the region.

Clarity over who to talk to regarding relevant decisions in each locality, good lines of communication between them, and in some cases a regular meeting to co-ordinate, were crucial to making this work. This was particularly important in two areas where we saw that a lack of affordable city-centre rents meant that

accommodation, and some residential or inpatient drug and alcohol support, was increasingly provided outside the local authority. Sometimes services in those areas were less accustomed to working with people who sleep rough.

> *The council have put some homeless populations in hostels in [a neighbouring local authority], which has caused a major headache for our primary care colleagues down there because they had to pick them up, and that's just mainstream primary care, but also because they are now detached from the homeless community. Unfortunately, we have had a few fatalities there.*
> (Primary care commissioner)

These services needed ongoing support from the neighbouring city-centre services in terms of linking them in to existing expertise, with for example specialist GPs going to those areas to work with staff.

A flexible response to eligibility criteria

All areas had some flexibility in making services accessible for people when it came to their health. We heard how leaders negotiated complex administrative or geographical boundaries to avoid having to refuse care to an individual sleeping rough. But as one interviewee explained, deciding who can get support when they have no recourse to public funds is often fraught with conflict.

> *A visa overstayer or a failed asylum seeker who has a big stroke and they're incapacitated and can't look after themselves at all – that would be a more straightforward example of there'd be no argument that that person couldn't just be discharged. But then there's a lot of grey around particularly the ones with cognitive impairment… they're the ones that take a lot of battling because it's like, no they look fine, no care needs.*
> (Specialist GP)

Thresholds (including those set in law) almost always have some flexibility to avoid being unduly rigid. We heard that staff benefit from clear principles on when and how to use flexibilities, and assurance of 'air cover' when they do so.

We heard examples of clinical commissioning groups taking a broad rather than narrow view of their responsibilities for funding services for their population. This

included providing help with accommodation so that a person could remain living in the area and complete a full course of treatment for tuberculosis, providing more than the minimum services to people with no recourse to public funds who sleep rough, and investing in new approaches (*see* the box below).

Step-down provision

One clinical commissioning group had commissioned 'step-down' accommodation for people experiencing homelessness who were medically fit to leave hospital but not yet ready to be discharged. This is an evidence-based model that some areas have started to implement. The accommodation had a small number of beds but needed careful management to ensure that people did not end up 'stuck' and unable to move on. The focus was on people with less complex needs. However, it had wide eligibility criteria (including no recourse to public funds) and gave the specialist discharge team more time to identify suitable long-term housing solutions for those individuals. One interviewee described the model as 'like residential reablement'. People using the service were also given wider support, for example with accessing benefits.

For an example of a homeless medical respite model, *see* **www.pathway.org.uk/ services/medical-respite-care**

How do places relate to local and regional systems?

Regional approaches to rough sleeping are receiving increasing attention. Upper-tier authorities at county level, or across the boroughs of a city, and potentially Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs), have a key role in providing an overall framework that can help manage levels of difference between places. STPs and ICSs are new types of partnerships between NHS bodies and local authorities in a given area, working together to improve local health and wellbeing. They offer a potential mechanism for greater collaboration across local authorities and the NHS. In particular, we heard about pooled budgets at county level (albeit under significant strain after several years of austerity), and the role of elected mayors, in setting an overall framework that local areas could then make use of as appropriate to their own situation.

An STP covering one of the areas had placed people who sleep rough at the top of their agenda. This partnership was signalling its role in addressing health

inequalities and framing its priorities to engage local authorities in what has often been perceived to be a health-dominated partnership. Other areas had yet to see specific added value from STPs/ICSs for rough sleeping and perceived that the national requirements for health and care strategies and for local rough sleeping strategies were being approached in parallel, missing the opportunity to make connections. In some areas, commissioners were anxious that the specific needs of people sleeping rough could get lost among other priorities and the broad focus of an STP/ICS. There was also concern that a rough sleeping plan at an STP/ICS level could cut across the highly localised, place-specific approaches needed for this client group. These concerns suggest a need for more dialogue and better understanding at place and system levels of how their respective plans can fit together (*see* **Robertson and Ewbank 2020**). One area also described how protracted local debate about potential mergers of local clinical commissioning groups up to STP level had distracted the NHS from bringing commissioned services closer together.

Although we heard various examples of areas co-ordinating direct service provision with neighbouring places, few examples were given of learning across neighbouring places – for example, where both had experience of commissioning a specialist primary care practice, or where learning from a safeguarding adult review (SAR) might have wider relevance. The examples we did hear were about frontline services, rather than sharing learning about commissioning or at a system level.

In this section, we have described how the case study areas used local knowledge and system flexibility to establish both their individual place-based approaches and their position in their wider regional systems. In the next section, we explore how commissioners used their unique position to shape service delivery for people sleeping rough, influencing relationships and new ways of working across their local systems.

Key learning

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

- Our case study areas sought to develop thorough local insights about who was sleeping rough, their needs, their interactions with services and how these things changed over time. Qualitative research with people who had lived experience of sleeping rough and staff in homelessness services informed decisions. One key catalyst for progress was conducting specific health needs assessments for people experiencing homelessness, which was used as an opportunity to draw together existing data and get data owners talking to each other about how to use and share it. Data was made significantly more powerful by employing analysts to develop the kinds of data collected and how it was used.

- 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 people sleeping rough. 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, with a focus placed on a duty of care to individuals in need, rather than geographical eligibility criteria for services. One sustainability and transformation partnership had prioritised addressing the needs of people sleeping rough, framing this in terms of its role in tackling health inequalities and using it as an opportunity to bring partners across health and local government together around an issue.

8 Recognise the power of commissioning

The population who sleep rough face many unique challenges, but they also have much in common with other high-need, complex patient groups. In this section we reflect on what this might mean for commissioners as they work together to shape service delivery. We explore the various levers at their disposal. Finally, we look at two practical – and challenging – issues: commissioning in a context of insufficient data, and commissioning at a time of financial pressure.

A commissioning function extends far beyond simply purchasing a service from a provider and we describe next how commissioners (from across the NHS and local authorities) shape relationships and encourage new ways of working across a system. It should be noted that most of these examples, although not all, are in relation to local authority commissioners.

What is different about commissioning services for people who sleep rough?

As a group, people who sleep rough present a distinct set of characteristics that create an unusual situation for commissioners of health and care. A key example is fluctuating service use. This is a highly mobile group and people can drop away after a period of engagement and then return, maybe years later. Commissioning a service to be continuously available – so a person can take up the offer when they are ready – can feel challenging when there is intense competition for finite resources. Also, for other patient groups, multiple attempts to intervene might be seen as a failure, whereas with people sleeping rough it may be a fundamental part of the approach. Other distinct characteristics include:

- the involvement of multiple commissioners (and multiple funding streams)

- a lack of high-quality data on the numbers of people sleeping rough and their health needs

- often intense political and public interest

- the degree of entitlement to health care – a person's status in terms of local connection and no recourse to public funds is a significant issue for some areas

- variability in the levels of priority and engagement that different NHS organisations and services give to this agenda.

While it can be argued that commissioning for a local population who sleep rough is distinctive, there are also many similarities with commissioning for other groups. Commissioners have an opportunity to apply what they have learnt works, or does not, from other services – both mainstream and specialist – to this group. For example, the increasingly complex health needs of a population that is growing older with multiple conditions are mirrored in both people who sleep rough and the population as a whole, albeit at a younger age in the population who sleep rough. Commissioners need to work out how the local approach to rough sleeping connects with other local strategies for improving population health and wellbeing, and how lessons learnt can be applied to commissioning for people who sleep rough.

Using commissioning powers to shape relationships

Commissioners are responsible for the way services are designed and delivered. They can use their powers to bring people together, create partnerships and focus on the best response for meeting the complex health needs of people who sleep rough.

A joint endeavour

Homelessness service providers – particularly from the voluntary, community and social enterprise (VCSE) sector and specialist primary care – were frequently described as equal partners. One mental health commissioner described how a new contract allowed more equal relationships to evolve. '[The VCSE organisation] are absolute equal partners here in addressing this issue. They have expertise we don't have, but we have the system expertise and the system leadership of place, which enables them to do their work well' (director of public health).

Hostels, day centres and GPs are the first point of contact for many people sleeping rough. In turn, these providers recognised their own role, and power, in shaping service configurations and influencing commissioners.

All four areas were also able to share examples of how listening to the experiences of people who sleep rough had led to new services and helped them understand why people were not taking up available offers of support. Health needs assessments that involved speaking to people with lived experience of sleeping rough enabled a better understanding of the needs and priorities of local population groups. But the degree to which service users were involved in the commissioning process, and the impact they had, was not always clear to us.

Creating flexibility

Trusted relationships between commissioners and providers enabled services to be more responsive and flexible without having to change formal agreements, as one joint commissioner explained.

> *Can we get a system to change or flex in a timely manner? If not, then we think actually how do we do it differently... In other places, you'd have a service specification with your provider, you'd then have to say well it's not within the service specification, so it's not our job to do.*
> (Public health commissioner)

Setting expectations around collaboration and reducing competition

National funding opportunities increasingly require agencies to come together and turn around an application in a very short timeframe. We heard that funding around rough sleeping from central government tended to be short term. Commissioners were proactively linking providers in an attempt to maximise their chance of success. However, the speed with which funding bids had to be turned around had an impact on the quality of services planned. Commissioners expressed concerns that there was more of a focus on government timescales than on longer-term outcomes.

Jointly agreeing measures of success that reflect the complexity of need

Commissioners and providers worked in partnership to develop service specifications that were 'fit for purpose' for people sleeping rough. Providers spoke positively about their involvement and the focus on outcomes compared with more traditional NHS approaches of 'counting widgets' or the number of client contacts. Significant challenges remain in measuring success for this group and even in areas

where providers described commissioning positively, collaborative working was sometimes fragile. Having multiple commissioners or partnership funding created tensions, and poor communication or a lack of trust between different partners was often at the root of these issues. One VCSE hostel provider reflected that it can be difficult to sustain mature conversations between all parties. 'Because of the way we're commissioned… the conversation will only go so far, and then we'll all become protective of our own stake, and we'll be reluctant and fearful that we might lose that stake if we actually start giving some of it away' (VCSE hostel provider).

Using data for commissioning

In this subsection, we look at how commissioners collected and used data across the local system to deliver more effective, integrated health care for people sleeping rough.

Areas acknowledged that good data on the local population of people sleeping rough, and their needs and use of services, was a work in progress. It was also a source of conflict. In section 2, we highlighted the limitations of the official data, which reveals broad trends rather than specific detailed information, and underestimates the extent of rough sleeping. In response, local areas in various ways gathered supplementary information about their local population who sleep rough to get a more accurate assessment of need. This included:

- interviews and focus groups with people sleeping rough and people in hostel accommodation;

- frequent street counts involving partners from different organisations, for example the VCSE sector or the police

- data from ambulance services and hospital admissions that captured a person's accommodation status.

All areas had carried out a health needs assessment, with varying degrees of rigour. In one area, this process had uncovered useful indicators that were not yet being measured (*see* the box below).

Use of data

Most of the data collected focused on contact with services, such as the number of people experiencing homelessness known to a homelessness service who are registered with a GP/engaged with other health or drug and alcohol services, or the number of ambulance contacts. An acute provider we interviewed at a hospital with a homelessness discharge initiative was also measuring referrals to other services, for example drug and alcohol services, and readmission rates.

In one area, a homelessness joint strategic needs assessment (JSNA) had been carried out in 2017 and interviewees told us they were looking to update this. They also had a data dashboard, which examined demand, outcomes and pressure points, although its remit was wider than rough sleeping, for example covering the needs of hostel residents. As part of a local council scrutiny review relating to homelessness, interviewees had also surveyed people sleeping rough, inquiring about health issues, and identified unmet health needs – mental and physical health as well as substance use issues. Its recommendations led to the appointment of a street psychologist. During the course of our fieldwork, the area was in the process of making a case to repeat this work. Additionally, the housing manager we interviewed described how they had a key performance indicator relating to GP registration for people sleeping rough. Through this they encouraged and enabled people to access both specialist and mainstream GP services as appropriate to the person's location and needs.

Another area was in the process of carrying out a homeless health needs assessment when we visited them. Interviewees described how this had been prompted initially by the recommissioning of a service but was intended to be used for multiple purposes by creating a baseline for future work. The assessment required conversations across organisations to understand what data they had and what would be useful, and it revealed gaps in their knowledge – such as the length of time some individuals had spent in homelessness pathways – that they could then begin to address. A key point of learning had been when analysts presented their initial analysis of the quantitative data to providers, who asked questions that enabled a more meaningful focus for the data.

For guidance on how to carry out a homeless health needs audit,
see **www.homeless.org.uk/our-work/resources/homeless-health-needs-audit**

We heard numerous examples of how shared data had been used to inform commissioning. Indeed, access to data allowed people from across the system to have conversations – to interrogate the data – and understand what it revealed about how people used services. Unpacking the data, however imperfect, had helped local areas question previous commissioning decisions as well as prompt discussion about what kind of data would be helpful in the future.

> [T]he commissioning framework, which says 18 months is a standard [length of stay in a hostel]. Because that is around where the median average lies for duration of stay. But what it doesn't tell you is how 'move-on ready' that person is.
> (Data analyst)

> So I don't know if it's 60 people from [the specialist GP] going up to the emergency department. I don't know if it's one person going 60 times.
> (Primary care commissioner)

Commissioning under austerity

Financial pressures were a constant concern in all four case study areas and in this subsection we show how commissioners used their financial resources to embed change.

Flexible resource models

All areas had some form of aligned or pooled budget arrangements in place, either specifically for homelessness – for example, a clinical commissioning group and a local authority both contributing to budgets for homeless health – or for wider public services of which homelessness was one element (underpinned by the concept of a 'public purse'). But the inherently cross-sector nature of the approach needed for people who sleep rough, coupled with different financial pressures in different parts of the system, was causing them to go further in looking for new ways to use resources to best effect across traditional administrative and organisational boundaries. We noticed highly unusual arrangements in how resources were distributed or shared to provide health services. For example, clinical professionals with expertise in dual diagnosis were funded by a grant

from central government to the local housing authority, managed by the social care department and provided with clinical supervision by the NHS. We heard of an NHS trust developing plans to fund the building of micro-houses and act as landlord, and overall leadership for homelessness and health sitting with public health or social care (rather than housing or the NHS). Once again, close relationships enabled collaboration across the system and were used to find ways to fill critical funding gaps.

Commissioning for sustainability

Interviewees highlighted the potential of funding from the government's Rough Sleeping Initiative for piloting new services such as integrated hubs or new specialist roles. However, they were sometimes struggling to use this funding in a way that did not destabilise existing successful services. We heard of areas being offered money for a new pilot project at the same time as money for an existing scheme was being cut. Both providers and commissioners were finding it difficult to retain skilled staff and high-quality services. Secondments were being used as one solution to this, but there was a danger that this was a short-term response to a broader workforce crisis.

We also heard concerns about the sustainability of local funding, and the instability caused by continual contract renewal, as well as clashing commissioning cycles of the clinical commissioning group and local authorities. Others reflected that the lack of stability from commissioning created particular challenges: when services were 'forever in a state of flux' it was hard to achieve good outcomes for people who need the space and time to recover from being homeless.

Interviewees also described the impact of changes to the welfare system and housing budgets in the past decade. This had created gaps in support systems – including the VCSE sector – that had previously acted as safety nets, and meant more people ended up sleeping rough. One area also highlighted that cuts to the police budget had led to their withdrawal from partnership working on rough sleeping.

In response to these pressures, commissioners were responding in different ways, including:

- using local 'pots of money' from the council to underwrite a project funded by short-term Rough Sleeping Initiative funding

- using Rough Sleeping Initiative money as leverage for additional local funding

- embedding aspects of a successful pilot programme through local funding and in ways that would not cost additional money, such as strengthening links between different services

- rolling a service that had proved its effectiveness into a longer-term contract.

In these past five sections, we have set out what emerged when we asked four local areas what they thought had enabled them to improve health and care outcomes for people sleeping rough – as well as what people in the focus groups felt about accessing health care.

We turn next to what our findings might mean for local and national bodies. We reflect on how local and national leaders can respond to the challenge of meeting the needs of people with very high levels of unmet physical and mental health problems. We set out what we think needs to be in place – across a system – for health and care outcomes to improve.

Key learning

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

- Dedicated resources and inter-agency commissioning helped areas to create a momentum for change. All four areas had been successful in accessing additional central funding for people who sleep rough.

- 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, such as through advocacy, awareness-raising, training and ad hoc telephone-based advice. We also saw contracts in which key performance indicators included numbers of patients discharged from specialist services to mainstream services.

- Contract renewals and 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 that created incompatible thresholds or eligibility criteria.

9 Our reflections

The government's Rough Sleeping Strategy sets targets for reducing and ultimately ending rough sleeping (MHCLG 2018a). However, as we – and the government strategy – have noted, this is by no means as simple as just reducing the count of people who are sleeping rough. Our case study areas were fully aware of the complex nature of the task. Tackling rough sleeping involves **simultaneously** improving people's health, social wellbeing and housing situation and, importantly, supporting them to stay off the streets over the long term and preventing new episodes of rough sleeping too.

We think this points towards what we have described elsewhere as a **population health approach** (Buck *et al* 2018). Population health approaches draw together the wide range of partners who can improve the health and wellbeing – including the determinants of health and wellbeing such as housing, education and employment – of a given population. The NHS is one among many partners, and communities and individuals have key roles as well as the public sector.

In this section, we draw on the findings from the case study sites and focus groups, together with the published literature, and suggest what local and national leaders can do to support people experiencing rough sleeping so that they get better access to health and care services.

Implications for local leaders

There is no blueprint for how to improve the health of people sleeping rough. Indeed, our research highlights the importance of local leaders crafting their own approach to rough sleeping based on their own local place and population. In the past five sections, we highlighted five key themes that enable local systems to make progress (*see* Figure 3). At the heart of each theme sits leadership. How leaders behave – and work together – across a local area is one of the critical factors that runs through the core of each theme and helps shape improvements for people sleeping rough.

Figure 3 **What does a local system need to focus on to improve health and care outcomes for people sleeping rough?**

Take steps to find and engage people sleeping rough

Build and support the workforce to go above and beyond

Prioritise relationships

Tailor the response to the local context

Recognise the power of commissioning
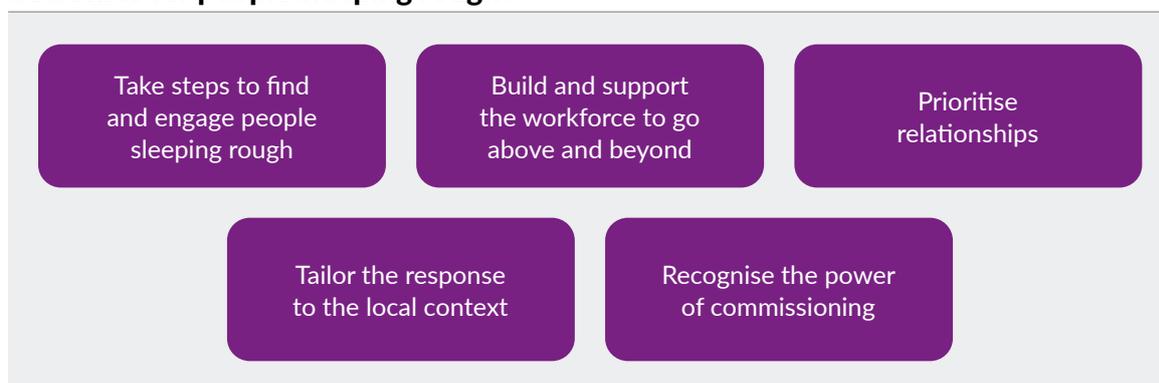
In this subsection, we reflect on how local leaders – across the NHS, local authorities and the voluntary, community and social enterprise (VCSE) sector in particular – can pay greater attention to these five themes.

Applying the learning locally

Most areas will be able to recognise activity that they currently do under each of the five themes. But stopping there would be to miss the point. We believe that success also depends on the quality of leadership present at all levels – and importantly, leadership across a local system.

Our emphasis on this stems from the understanding that housing, health and care are all inseparable ingredients of any approach designed to improve health and care outcomes for people who sleep rough. It is not enough to have strong leadership in one of these areas. Rather, success depends on leaders taking shared ownership for ending rough sleeping and taking responsibility for their own individual roles in driving improvements.

The King's Fund has published extensively on what makes for good system leadership, with distributed responsibilities and a culture of compassion and inclusion being key (Naylor and Wellings 2019; Timmins 2019). Much of this work has focused on leadership across a health and care system and the importance of having a shared narrative, relationships built on trust, deep engagement of staff and communities and strong partnership working across organisational and professional boundaries.

Our research on rough sleeping has forced us to reflect further on what system leadership looks like if it is to effectively span housing, health (including public health) and social care – as well as the VCSE sector. In addition, we note that housing often takes a lead for the system – with varying degrees of explicitness.

Success depends on leaders managing complex interdependencies across multiple organisations and sectors. Leaders need to understand and model partnership working across different professional cultures where often a shared common language, framework or approach does not exist.

Drawing on others' research on leadership for complex systems (for example, Senge *et al* 2015) and emerging thinking on leadership for population health systems (**Buck** *et al* **2018**), we suggest that there are five leadership characteristics that local leaders need to consider if they are to be effective in improving outcomes for people experiencing rough sleeping.

- **Leaders need to 'see the larger system'. Health outcomes cannot be improved by simply focusing attention on health services.** Change requires local leaders to invest time in understanding the interdependencies of different sectors, for example health and criminal justice, or health and housing. It requires a shared belief that the solutions lie in co-ordinating system-wide action.

- **Leaders should be committed to collaboration – and to taking responsibility.** Multi-agency working to tackle rough sleeping requires a commitment to collaboration across the system. But someone needs to take the lead, someone has to drive the strategy and someone has to have the authority to call people to account for delivering their individual responsibilities for improving outcomes for people sleeping rough. Particular attention needs to be paid to where responsibilities intersect or stop.

- **Leaders should work to gain political buy-in and support.** The problem of rough sleeping evokes a range of views about how individuals should be treated. As a group, they may not be afforded the same sympathies as other groups of patients who also have poor health outcomes. Local leaders can play a crucial role in developing a shared narrative – and a common purpose. This framing can set powerful expectations about how the local area will respond to meet the needs of people experiencing rough sleeping.

- **Leaders should ask themselves how well, as a team, they hear the views of people sleeping rough.** People who sleep rough can easily remain hidden. They may not feature in statistical returns or have the skills or motivation to advocate effectively for themselves. Those with lived experience of sleeping rough have an essential role to play in designing effective strategies and leaders need to continuously ask how their voice is heard and how they are engaged.

- **Leaders should develop the capacity of others and support them to lead change.** Much of the progress we saw in the case study areas was driven by initiatives from staff working directly with people sleeping rough. System leaders need to consider the ways in which they encourage and empower others to advocate and act to improve the lives of people sleeping rough.

Without aligned leadership across the system, there is a real danger that progress will not be realised. Our view is that collaborative leadership – at a system level – is a key enabler of change. And it is this that requires concerted effort from local leaders. Next, we consider what the implications might be for national leaders.

Implications for national leaders

Our case study areas illustrate a number of ways in which it is possible to develop services that improve the health of people who sleep rough and help enable them to move on from homelessness – but they are just four areas, they are not nationally representative and they are more active in this regard than many other places. In this subsection, we consider what could be done at a national level to encourage more areas to make the sort of progress seen in our case study sites.

We identify issues that national policy organisations – government departments and the health arm's-length bodies – should consider in order to make further progress towards improving the health and access to health care of people who sleep rough, as part of their overall goal of ending rough sleeping. People who sleep rough are the most visible part of a much larger population who experience homelessness. We note that a broader strategic response aimed at protecting and improving the health of people who experience homelessness is also required.

National policy

The NHS
The long-term plan for the NHS (**NHS England 2019b**) commits it to taking a more concerted and systematic approach to reducing health inequalities. There is a strong case for focusing on people who sleep rough as part of this, and indeed they are identified as a priority group within the plan. This is an important and welcome policy.

For this policy to lead to actual improvement, two things now need to happen.

• First, every sustainability and transformation partnership (STP)/integrated care system (ICS) has developed their own local implementation plans, which, collectively, will achieve the NHS long-term plan's objectives. These should include plans to improve access to mental health support for people sleeping rough, in line with the long-term plan and as set out in the Community Mental Health Framework (**NHS England et al 2019**). There is an opportunity to go further, however. NHS England and NHS Improvement should encourage and support STP/ICS plans – and the plans within them at place and neighbourhood levels – to join up health services with housing and social care and set local goals for improvement in the health of people sleeping rough. We consider ways of doing this below.

• Second, NHS England and NHS Improvement should consider how the health of people who experience homelessness, and people sleeping rough in particular, features in the way they ensure accountability for delivering on local implementation plans for reducing health inequalities.

Practical steps that NHS England and NHS Improvement could take include ensuring that the primary care networks contract can support practices to meet the needs of people sleeping rough, including by working closely with VCSE homelessness organisations. NHS England and NHS Improvement could also improve the availability of data on how people who experience homelessness use health services, how those services are co-ordinated with other support, and their health outcomes. A start has already been made in hospital episode statistics but there is considerable scope to go further and to develop input and outcome indicators of co-ordinated local services rather than just NHS activity.

There are some parallels between health services for people who sleep rough and those for people with learning disabilities. Both groups experience poor health outcomes and, over a long period, the NHS has struggled to respond to their specific needs effectively and has at times overlooked their needs (*see* for example **Department of Health 2012**). However, in recent years, NHS England and NHS Improvement have started to make concerted efforts to prioritise good care and health improvement for people with learning disabilities across the full range of their services, for example through the Transforming Care programme. This is by no means an automatic solution, and there is much to be learnt about how this has been implemented, but there are undoubtedly lessons to share about how a national system can ensure that an otherwise marginalised group is given priority. We believe that NHS England and NHS Improvement should develop a similarly wide-ranging strategic approach for improving health and health services for people who sleep rough, learning from their experience with people with learning disabilities.

Cross-government policy

We have argued elsewhere that, although the NHS has a major contribution to make to improving health and reducing health inequalities, for the greatest progress its contribution should be co-ordinated within a broader cross-government national strategy, with clear national goals (**Buck *et al* 2018**). People who sleep rough experience some of the most extreme health inequalities, but those cannot be solved by the NHS on its own.

This report shows that strong partnerships and collaboration lie at the heart of local endeavours to improve outcomes for people sleeping rough. The same argument applies at a national level. Government departments need to model collaborative leadership, with commitment from across government. There are already positive examples of this to build on through the government's Rough Sleeping Strategy (**MHCLG 2018a**), including joint working and embedded roles between the Department of Health and Social Care (DHSC) and the Ministry of Housing, Communities and Local Government (MHCLG) together with NHS England, NHS Improvement and Public Health England. However, many of these posts and programmes rely on short-term funding. The government needs to ensure that secure resources are in place to deliver its strategy over multiple years, and across housing, social care and public health as well as health services. Furthermore, much of the national activity has so far focused on reducing high numbers of people

who sleep rough, but our case study areas all identified that more also needs to be done to prevent rough sleeping – and its health consequences – in the first place. Although there are known risk factors that may cause someone to start sleeping rough, they often have roots in childhood or adolescence, many years before the person sleeps rough, and in the person's home place, which may be different from the place where they start sleeping rough. For local areas to progress the prevention agenda, some form of national framework of expectations and approach may be needed.

The government has already committed itself to reviewing all relevant legislation in 2020 as part of its Rough Sleeping Strategy Delivery Plan (MHCLG 2018b). In three of the case study areas, commissioners identified local connection as one area where they would welcome national intervention. They noted that local connection sometimes prevented the delivery of joined-up services to individuals in need of support and treatment. We note that English local authorities have the power, not a duty, to refer people back to an area they have a local connection with and that, in practice, several of the case study areas provided services for significant numbers of people with no local connection. There may be merit in sharing good practice on how local areas can either support reconnection or deliver appropriate services to those who remain in the local area – rather than refusing to provide help and support until a local connection is established. Furthermore, the Scottish government has recently consulted on, and decided changes to, when access to services requires a local connection. While recognising that Scottish legislation is different from that in England, we encourage MHCLG to consider whether there is any applicable learning from the Scottish government's monitoring of the impact of its changes on barriers to, and choice of, services to improve health and wellbeing.

The Homelessness Reduction Act 2017 introduced a new duty to refer, which requires public services (including a number of specified health functions in the NHS and local authority social services) to refer people who they think may be homeless or threatened with homelessness to a local housing authority. This has helped to promote a multi-agency approach and is starting to embed greater awareness of the need to routinely consider the impact of housing circumstances when assessing people's health care needs. We found, however, that there can still be an attitude of using referrals to 'pass on' (and therefore disown) people with complex and challenging needs, and that giving a person a piece of paper with a telephone number on it could be seen as discharging the duty to refer.

So, welcome as the duty to refer is, we think that MHCLG and DHSC should explore ways to develop it further with NHS England and NHS Improvement. Further legislation might be one option but realising the intent of the existing duty is more a matter of promoting good practice and monitoring referrals. Although the duty to refer does not currently apply to primary care services, MHCLG, DHSC, NHS England and NHS Improvement should consider ways of including them within good practice and the monitoring of referrals – our work clearly reveals the critical role primary care plays in shaping health and housing outcomes for people experiencing homelessness.

Guidance

We have highlighted in this report how important the role of commissioners – across a broad range of services, from health, care and housing services to drug and alcohol services – can be in improving access to health services and health outcomes for people sleeping rough. We have identified a range of levers available to commissioning organisations, with all of our case study areas making progress in some of these but none making progress in all. Public Health England will issue guidance in spring 2020 to spread good practice for commissioners in improving the health and access to services of people who experience rough sleeping. Local authorities and the NHS (through its regional centres, STPs/ICSs and local bodies) should consider and act on this guidance when it is published, together with their important partners in the VCSE sector.

We encourage Public Health England and its partners to go further than just issuing guidance and to also consider identifying demonstrator sites to help draw out learning from applying the guidance in practice. These should particularly include local health service providers and commissioners, working with partners such as NHS England and NHS Improvement and including third sector providers, to explore the implications of the emerging primary care network and integrated care system structures and changes in commissioning approaches and responsibilities (Robertson and Ewbank 2020). The demonstrator sites should also consider how health services are commissioned in co-ordination with housing and social care services, working with partners such as the Association of Directors of Adult Social Services, the Local Government Association and MHCLG.

Capability development

The government's Rough Sleeping Strategy Delivery Plan recognises MHCLG's role in ensuring training and development, in partnership with a range of national bodies, for some local organisations working with people who sleep rough (**MHCLG 2018b**). In this research we have identified two areas in which we believe more efforts in terms of capability development are needed.

'Core capabilities'
We have found variability in what we call 'core capabilities', by which we mean not the processes of delivering care but certain key abilities and understanding that underpin effective practice, particularly understanding how legal requirements apply to frontline health and care staff working with people who sleep rough, as well as staff with a broader health care role, for example:

- safeguarding processes, including 'legal literacy' (understanding who possesses relevant powers and duties), and applying the learning from safeguarding adult reviews

- assessment of mental capacity

- Mental Health Act assessments

- the Care Act, including entitlement to assessment and eligibility for care

- the duty to refer

- reasonable flexibility in assessing a local connection.

Given the emphasis on trauma-informed care in the NHS Mental Health Implementation Plan (**NHS England 2019a**), we believe further support for staff is also needed on why this approach is beneficial, as well as how to translate it meaningfully into systems and service delivery.

These 'core capabilities' are not just a matter of training individuals: they also require the development of organisational capability and infrastructure.

We ask MHCLG and DHSC to consider whether the Rough Sleeping Strategy Delivery Plan (**MHCLG 2018b**) can act as a vehicle for bringing together relevant

partners – such as the Association of Directors of Adult Social Services, Health Education England, the Local Government Association, NHS England and NHS Improvement – to consider what can be done to embed these core capabilities more consistently.

Learning across areas

We were surprised during our research that arrangements for sharing good practice and learning across areas were not better developed, given the clear enthusiasm and motivation of staff. We observed various ad hoc initiatives that individuals had arranged, and regional adviser roles in MHCLG, which could be a source of information and advice (but were sometimes also linked to performance management of nationally funded projects).

We observed that a series of nationally organised workshops, supported by DHSC and MHCLG, on adult safeguarding and homelessness was well received, suggesting that bringing people together (rather than just issuing more guidance) may be useful. Our four case study areas did not include examples of sharing learning as a whole system; however, The King's Fund's separate experience in facilitating learning between local systems (**Hulks** *et al* **2017**) indicates that this could be useful. We suggest that DHSC and MHCLG consider funding:

- cross-sector learning networks (including health, housing and social care organisations), either focused on specific core capabilities or run as a number of action learning networks for a period of time from which learning can be distilled

- support from the Local Government Association as part of its sector-led improvement programme.

Funding

Efforts to improve the health of people who sleep rough and help enable them to move on from homelessness, are currently receiving significant amounts of national funding, in particular from MHCLG, NHS England and NHS Improvement. We consider here funding in relation to health and health care, but that is not to disregard the importance of related funding (in particular, for adult social care and the supply of social housing).

We ask NHS England and NHS Improvement to closely monitor the impact of its £30 million to support access to mental health care for people who sleep rough. We heard that this funding is both important and strongly welcomed. But we also heard concern that:

- it may not be sufficient to address the gap that has been created between levels of funding and increases in demand

- its success would to some extent depend on mental health services joining up effectively with other services that are also under financial pressure

- spending the funding may be difficult in areas with shortages of mental health professionals.

There may also be a need to supplement it with practice guidance on the mental health needs of people who sleep rough – for example, on when conditions that are not regarded as severe mental illness may nonetheless require specialist services, and on diagnosing and supporting personality disorders among people experiencing homelessness.

Our research captured feedback that the national bodies' approach to funding under the Rough Sleeping Strategy (MHCLG 2018a) is experienced as often coming at very short notice, with an unclear rationale for priority (often described in terms such as 'piecemeal' or 'random'), and for projects that are specified with high levels of detail and prescription. Areas sometimes struggled with the short-term nature of funding for just one or two years:

- it made planning difficult

- it did not allow sufficient time for co-production of services with people with lived experience of sleeping rough

- it did not give them the secure funding they needed to rebuild infrastructure and relationships that declined during the years of austerity

- it contributed to difficulties in staff retention.

However, we also saw that this funding can make a significant difference in the areas that receive it. The government will need to provide further funding towards its target of ending rough sleeping, and we suggest that this funding should:

- be presented more clearly as an investment strategy, with longer timeframes, so that local areas can be clearer about opportunities that may be forthcoming and how national bodies will feed back their learning from the pilot schemes that they fund

- allow for greater adaptation to local circumstances

- strengthen provision for mainstreaming and sustaining pilot activity.

Endnote

For people to end up on the streets as they do... they've not just had a bad week... they've had a lifetime of hell.
(Rough sleeping and housing manager)

This research project has given us an insight into what can help deliver an effective response to health and rough sleeping. We have heard how local areas find their own distinct way of bringing services together to meet the needs of people with multiple and complex needs. In practice, this requires people from across health, housing and care to work together when designing and delivering services that are based on understanding the lived experiences of people sleeping rough. It also requires a quality of leadership that can drive improvements for this group across professional and geographical boundaries.

In all four case study areas, we found people in health, care, housing, the voluntary and community sector and the local community taking up leadership roles around rough sleeping. What unites these individuals was not their role or their professional status, but their ability to set clear expectations about the entitlement to health and care that every individual sleeping rough should have. These leaders took a firm stance on how people sleeping rough should be treated. They made it clear – and continuously challenged others – that individuals who found themselves sleeping rough were part of the local community and needed to be treated as such.

Their argument was a moral one – not a financial one – and it helped to set the tone for both how the local area was expected to respond and what was possible. Doing the right thing for people experiencing rough sleeping appeared to be more persuasive in galvanising support and driving improvement than building a business case for new services or redesigning care pathways.

Each of the four areas we studied had adopted their own distinct response to the health and care needs of people sleeping rough. Each was nominated because they appeared to be further ahead than many other areas in making progress. As we have argued throughout this report, there is no single blueprint that will work

everywhere. We have tried not to be prescriptive. Indeed, one of our key messages from this research is the need for local areas to develop an approach – as a local system – that reflects their local circumstances. We hope that the learning in this report from four areas will help leaders, across health, housing and care, to rise to the urgent challenge of addressing the needs of people who sleep rough.

Appendix 1: Methodology

The research for this report took place in three phases. Phases one and two were undertaken from May to August 2019 and phase three took place in September 2019.

Phase one comprised:

- literature scoping

- document review

- scoping conversations with appointed area leads

- interviews with Ministry of Housing, Communities and Local Government (MHCLG) advisers.

Phase two comprised:

- interviews in four case study areas with key stakeholders

- focus groups with people sleeping rough (conducted by our research partner, the University of York).

Phase three comprised:

- analysis

- sense-making conversations with appointed area leads

- sense-making conversations with three additional sites.

A partnership consisting of the Department of Health and Social Care, MHCLG, NHS England, NHS Improvement and Public Health England chose the case study sites, based on the findings of an audit survey conducted in 67 of the 83 areas that had received Rough Sleeping Initiative funding. Considering evidence against a number of measures – including their local assessment of health needs, range of

provision on offer, capacity and funding stability – the partnership longlisted areas that they felt were making good progress in delivering health and care services to people sleeping rough. They selected four areas from this list to represent a range of geographical and service types.

Phase one: initial scoping of issues to prepare for our site visits

Literature scoping

We conducted a literature search focusing on evidence about good practice in relation to health care provision for people sleeping rough, and 'grey' literature highlighting issues relating to rough sleeping, homelessness and health.

Document review

We requested documents from each area, including homelessness strategies, joint strategic needs assessments (JSNAs) and other documents relevant to their work on rough sleeping and health. Our aim was to understand each area's formalised approach and to identify key topics to follow up in each area. We reviewed each document in relation to the links made (or not made) between homelessness and health needs, any specific relevant strategies or actions and our project outcomes.

Scoping conversations with appointed area leads

Each area nominated a local lead for the research, and we conducted scoping conversations with these leads. We asked them to invite one or two senior leaders in their area to join the conversation. We used these conversations to introduce the research, to identify the overall approach to rough sleeping and health care in each area and to ask the leads what they felt were their area's key strengths and challenges. We also used the conversations to identify the six most relevant key stakeholders in each area, who we would seek to interview. We gave the leads a suggested list with three priority roles and other roles to consider, shown in the box below.

Suggested key stakeholder roles

Priority roles:

- clinical commissioning group
- director of public health
- local authority homelessness/rough sleeping commissioner (strategic and operational manager).

Other roles to consider:

- adult social care commissioner
- chair of the health and wellbeing board
- health care provider
- Healthwatch
- police and crime commissioner
- strategic planning (integrated care system/sustainability and transformation partnership)
- substance misuse commissioner
- voluntary, community and social enterprise (VCSE) providers involved in strategic partnerships.

Interviews with MHCLG advisers

We conducted interviews with MHCLG rough sleeping advisers working with each case study area to get an external overview of each area and their key strengths and challenges. We used these conversations to identify key topics to follow up in each area alongside what we heard from area leads and what we saw in local documents.

Phase two: site visits and interviews with key stakeholders

Interviews in four case study areas with key stakeholders

We conducted semi-structured interviews with key stakeholders that the area leads had identified (*see* example role types in the box above). Some interviews involved multiple participants (a maximum of three) and the number of people interviewed in each site ranged from 10 to 12 people.

Across the four areas, we spoke to people across a range of roles (*see* Table 2). As is evident from the table, these varied significantly from the roles we originally suggested. To some extent, this reflected availability, but also our iterative approach to the research (for example, deciding to include more providers).

Table 2 **Organisation/role of the stakeholder interviewees**

Organisation/role	Number of areas	Number of people
Local authority homelessness/rough sleeping commissioner (strategic and operational manager)	4	6
Director of public health	4	4
Public health commissioner	4	4
Other local authority commissioner/manager	3	4
Finance officer	1	2
Data analyst (local authority)	1	1
Elected member	1	1
VCSE provider	4	6
Clinical commissioning group	1	4
Mental health provider and staff	2	4
Acute care provider and staff	2	2
Health partnership	1	3
Specialist GP	3	3
Specialist health outreach team	3	3
Ambulance provider	1	1

Interviews lasted between 60 and 90 minutes. Where possible we conducted these interviews face to face and visited each area in person. However, due to time and travelling constraints, we conducted a small number of interviews by telephone.

We used what we had learnt in phase one to inform the interviews and focus on the most relevant issues for each area. The aim of the interviews was to give us an understanding of:

- how each area identified the health needs (met and unmet) of people who slept rough and how it assessed the performance of its health service provision for this group

- the extent to which commissioning is co-ordinated effectively, including the development of integrated strategic responses to rough sleeping at the local level

- why particular approaches were adopted, how decisions were made about the provision of specialist or mainstream services (including the role of elected members and the police) and how data was used to inform commissioning.

Focus groups with people sleeping rough

Our research partner, the University of York, conducted focus groups in the four areas with people with lived experience of sleeping rough. These each lasted an hour and involved a total of 23 people. Further details and full findings can be found in the accompanying report by Pleace and Bretherton (2020). In this report, we draw on the focus group findings to explore how people who sleep rough experience services that seek to remove barriers that prevent them from having equal access to health and care.

Phase three: analysis of the data and testing out findings with area leads and other stakeholders

Analysis

All interviews were audio recorded and transcribed (with the exception of one on request from the interviewee that only notes were taken).

We conducted a thematic analysis of the data, looking for common successes and challenges across areas, as well as variation, rather than conducting analysis by area. Two members of the research team developed an initial coding framework based on an initial three transcripts and informed by our original research questions. The team then reviewed and revised the framework using excerpts from other

transcripts and we undertook an iterative process of ensuring agreement between coders. Transcripts were coded to the new framework in Dedoose (a web application for mixed-methods research).

Sense-making conversations with appointed area leads

We conducted a sense-making conversation with the area leads who had taken part in our initial scoping conversations. The aim was to check that areas felt their contexts had been fairly represented as well as to get their reflections and comments. We gave a brief presentation of emerging themes and asked for their feedback. We incorporated this into our report writing.

Sense-making conversations with three additional sites

Because our findings are based on four areas that were identified as making good progress, we wanted to check their relevance and usefulness to areas experiencing more, or different, challenges. MHCLG, NHS England and NHS Improvement identified a further three areas for this purpose and we gave them the same brief presentation of emerging themes and sought their feedback.

Appendix 2: Ten prompts for local leaders

What are these ten prompts?

These prompts are designed to support local systems to improve the health and care outcomes of people sleeping rough. They are aimed particularly at those in leadership roles (such as commissioners, managers and clinicians) across health, public health, housing, social care and the voluntary and community sector in a local area.

They are designed to prompt system leaders on whether they have the right relationships, leadership and infrastructure in place to respond effectively to the needs of their rough sleeping population.

These prompts are drawn from The King's Fund research on what four local areas in England shared about how to improve outcomes for people sleeping rough. The need for collaboration across health, housing and social care – and across the NHS, local government and the voluntary and community sector – was one of the key findings emerging from this work.

We highlight some of the approaches local areas have used to make improvements. Further information can be found in the report.

Why use these prompts?

People who sleep rough experience some of the worst health outcomes in our society. The NHS long-term plan recognises the health inequalities that this group faces, and all local areas are expected to have a plan in place to improve support for people who sleep rough to access mental health services.

The solutions to reducing poor health outcomes for people sleeping rough do not rest with the NHS alone. Local authorities, the voluntary and community sector and the NHS need to work together as a system to improve access to physical and mental health, care and housing support.

How can you get the most out these prompts?

Most areas will be able to recognise activity that they currently do under each of the prompts. But stopping there would be to miss the point of the exercise: these questions are an opportunity for you to reflect on what more you could do collectively and how you could make existing activity better and system-wide. Success depends on leaders taking shared ownership for ending rough sleeping.

Please adapt and use these prompts in a way that works best for your local area.

Make it easier for people who sleep rough to access and engage with services

Prompt	Examples of approaches that local areas valued
1. How do we use every contact a person has – and across all services – as an opportunity to establish a relationship with people experiencing rough sleeping and offer ongoing support?	• Outreach staff (on the street and embedded in other services, such as housing workers in hospitals or mental health nurses in hostels) build strong relationships based on trust. • Champions actively advocate for people sleeping rough, for example a discharge team working with hospital ward staff to raise awareness. • Trauma-informed approaches – where care is delivered with an understanding of the impact of trauma, including that experienced in early life – were valued highly by staff although they are not yet mainstream.
2. How do we understand the paths that people take through our system, and identify any barriers, gaps or sticking points?	• Mapping of services (access and referral routes). • Specialist mental health teams, working on the street and in hostels. • Dedicated support for people with complex and co-occurring mental health needs and drug and alcohol dependency, such as dual diagnosis workers, formal protocols for referral, and joint clinics. • Peer advocates or link workers commissioned to help people navigate the system and access support. • Reciprocal arrangements and strong partnerships across geographical boundaries.

Prompt	Examples of approaches that local areas valued
3. Do we all make the most of key opportunities to improve health outcomes?	• **Primary care** taking on a key role in the strategy to improve access to all (health and non-health) services. Examples include: ○ a focus on increasing GP registrations, eg hostel key performance indicators included registration with a GP ○ contract renewals used strategically to shape primary care provision for people sleeping rough ○ GPs taking on a system leadership role (and built into the contract), with clinical leaders challenging system leaders – and also training other primary care staff ○ housing, drug and alcohol, and mental health services embedded with GPs. • **Acute hospital visits** (accident and emergency and/or admission) recognised as a key opportunity for connecting people to community health, mental health, social care and housing support as part of discharge planning. Examples include: ○ specialist workers (from health, social worker and housing) embedded into acute hospitals ○ weekly multidisciplinary meetings, including the voluntary and community sector, support discharge planning and connections with other services ○ step-down provision gave staff the time to sort housing and benefits and care once someone is medically fit to be discharged.

Read section 4 for further examples and insight.

How can we build and support the workforce to 'do the right thing'

Prompt	Examples of approaches that local areas valued
4. Is there a shared understanding of what 'doing the right thing' for a person sleeping rough looks like, with staff confident they have the permission to flex the system to achieve this?	• Senior leaders raise the profile of rough sleeping and set high expectations about service delivery. • Staff use reasonable flexibility in the client's best interests; recognising that there is no easy way to manage sometimes incompatible eligibility criteria. • Opportunities for staff to develop a shared understanding about different professional approaches, and how to work effectively together.
5. How do we provide support for staff carrying out a demanding role?	• Staff wellbeing built into provider contracts, including psychological support. • Training to raise awareness, eg training for GP reception staff, and specialised training for those working with people sleeping rough (mental health and mental capacity legislation and developing reflective practice).

Prompt	Examples of approaches that local areas valued
6. How do we model collaborative, compassionate leadership and show staff that spending time building relationships with each other across the local system is valued and expected?	• Senior leaders model collaborative working and demonstrate the value of partnerships across the system. • Leaders support staff to prioritise and attend regular multi-agency meetings to discuss how to best support specific individuals sleeping rough.

Read sections 5 and 6 for further examples and insight.

Fit the response to the local population and the local geography

Prompt	Examples of approaches that local areas valued
7. Are our local insights on this population good enough to shape decision-making?	• People with lived experience of sleeping rough involved and heard – even small sample sizes had a powerful impact. • A deep and regular commitment to understanding who is sleeping rough, and how the health and care needs of this group change, including a health needs assessment. • Dedicated analysts to make full use of the data they collected. • Commissioning decisions informed by insights from outreach/frontline staff. • Learning from incidents (such as deaths on the street, drug overdose in hostels, detention under the Mental Health Act, multiple ambulance call outs, and hospital discharge to the street) to improve access and co-ordination of care across a system.
8. Do we spend enough time together understanding how services fit together – both at a local and regional level?	• Key staff who got to know their counterparts in neighbouring areas who they might need to negotiate with over eligibility or no local connection. • Commissioners across sectors review and co-ordinate service specifications for retendering, and move towards alignment of commissioning cycles. • Using broad area-wide strategies such as integration or prevention to focus attention on the needs of people sleeping rough.
9. What is our local narrative and how do we engage local politicians and the public over the long term?	• Leaders invest time in building relationships with elected politicians and the wider public. • Leaders take responsibility for sharing a strong and relentless message that this group is part of the local community – and should not be left out or ignored.

Prompt	Examples of approaches that local areas valued
10. Where does overall leadership and accountability sit within our system?	• Shared accountability for ending rough sleeping across health, social care and housing, and directors from health, social care, housing and public health included on overall governance boards. • Clear expectations about the commitment to collective leadership that goes far beyond signing a strategy. • Rough sleeping prioritised at a sustainability and transformation partnership/integrated care system level in plans to address health inequalities, and close engagement of local authorities. • A lead person with the authority to drive improvements and hold other leaders to account for their contribution.

Read sections 7 and 8 for further examples and insight.

Appendix 3: Glossary

Adverse childhood experiences
Adverse childhood experiences are potentially traumatic events experienced before the age of 18. These can include both direct harms – such as abuse and neglect – and indirect harms, for example a parent who is in prison or has problematic substance use.

Dual diagnosis
When a person has a co-occurring mental health condition and substance or alcohol dependency, they are sometimes described as having a dual diagnosis.

Duty to prevent homelessness
The Homelessness Reduction Act 2017 introduced a duty for local authorities to prevent homelessness. The duty applies to any eligible person, regardless of priority need. Under this duty, local authorities 'must take reasonable steps' to help stop a person becoming homeless, for example helping a person stay in their current home or supporting them to find new accommodation.

Duty to refer
The Homelessness Reduction Act 2017 introduced a duty to refer, meaning various public bodies in the justice and health and care sectors are required to refer a person who is homeless or at risk of homelessness to a local authority housing/homelessness team of the individual's choice. The individual must consent to the referral and the sharing of their contact details.

The public bodies are:

- emergency departments

- hospitals in their function of providing inpatient care

- Jobcentre Plus

- prisons

- probation services (including community rehabilitation companies)

- secretary of state for defence in relation to members of the regular forces (the Army, Royal Air Force, Royal Marines and Royal Navy)

- secure colleges

- secure training centres

- social service authorities

- urgent treatment centres

- youth offender institutions

- youth offending teams.

Duty to relieve homelessness
The Homelessness Reduction Act 2017 introduced a duty for local authorities to relieve homelessness. As with the duty to prevent homelessness, it applies to any eligible person, regardless of priority need. Under this duty, local authorities 'must take reasonable steps' to help a person find somewhere to live. The help might be provision of information or advice, or a rent deposit. For a person in priority need, interim accommodation will also be provided. Local authorities also have a duty to secure accommodation for some groups under the Housing Act 1996, but this has strict criteria and only applies to people in priority need.

Harm reduction
Harm reduction refers to an approach in the context of substance use, which attempts to reduce harm that might be caused to a person or to others around them due to their substance use. It was developed as a pragmatic and rights-based response to people using substances.

Housing First
Housing First approaches provide a permanent home, in combination with intensive, holistic support, on an unconditional basis, rather than requiring recovery from (or participation in treatment for) substance use or mental health problems. Housing First was originally developed in the United States and aims to support people who have experienced repeated or long-term homelessness and have multiple and complex needs.

Integrated care systems

Integrated care systems have evolved from sustainability and transformation partnerships in some areas and take the lead in planning and commissioning care for their populations and providing system leadership. They bring together NHS providers and commissioners and local authorities to work in partnership in improving health and care in their area.

Local connection

Under the Housing Act 1996, local authorities have a duty to support people who are considered to have a local connection. Having a local connection to an area entitles an individual to support to try to relieve their homelessness and/or to secure accommodation for them. Local connection uses the last place of settled residence as the main criterion for reconnection. Normal residence is defined as a place where someone has lived for six out of the past 12 months, or three out of the past five years.

No recourse to public funds

No recourse to public funds describes someone who is subject to immigration control and lacks entitlement to mainstream housing or welfare benefits. This applies to anyone in this situation, whether or not they are homeless. It applies to benefits, homelessness assistance and social housing provided by the council. Those with no recourse to public funds may still have access to other publicly funded services depending on nationality and immigration status, but these are limited.

Peer advocates

Peer advocates are people with lived experience of sleeping rough who are trained to support others who are sleeping rough to access health care. They take a proactive approach and accompany individuals to appointments, fill out forms and talk to health staff on their behalf. The aim is to build the person's confidence and autonomy in accessing health care.

Population health

There is no single accepted definition of 'population health'. The King's Fund describes it as 'an approach aimed at improving the health of an entire population'. It is about improving the physical and mental health outcomes and wellbeing of people within and across a defined local, regional or national population, while reducing health inequalities. It includes action to reduce the occurrence of ill health,

action to deliver appropriate health and care services and action on the wider determinants of health, including housing. It requires working with communities and partner agencies. How all these contributions connect and work together defines a population health system.

Primary care networks
Primary care networks form a key building block of the NHS long-term plan. They bring general practices together to work at scale and typically cover populations of approximately 30,000 to 50,000 people. The networks are required to deliver a wide range of services and agree action to tackle inequalities.

Psychologically informed environment
A psychologically informed environment is a service, provided in a highly managed context such as a hospital or hostel that has been designed to respond to people's emotional and psychological needs. It is an approach that developed in mental health services but has relevance for working with people experiencing homelessness. Key features include paying attention to both the physical and the social spaces in a service, including staff interactions with people using the service, underpinned by a psychological framework that helps to develop a shared understanding of what they are trying to achieve.

Reflective practice
Reflective practice is an approach taken by professionals in various fields to learn from their experiences. It means considering your thoughts and actions in a particular situation, understanding what happened and why, and what you might learn to inform your future practice. Various different models are available to guide people through a reflective process.

Rough Sleeping Advisory Panel
The Rough Sleeping Advisory Panel was convened to develop and support the Rough Sleeping Strategy. Its membership includes various experts, charities and local government representatives.

Rough Sleeping Strategy
The Rough Sleeping Strategy is the programme of work set out to meet the government's manifesto pledge to halve rough sleeping by 2022 and end it entirely by 2027. It includes actions focused around prevention, intervention and recovery.

Specialist health services
Specialist health services are fully dedicated to certain groups of people, such as people who are experiencing homelessness/rough sleeping.

Sustainability and transformation partnerships
Sustainability and transformation partnerships are the latest iteration of what began as 'sustainability and transformation plans' in 2015. These involved NHS organisations coming together with local authorities and other partners to produce local plans for the future of health and care services. Forty-four areas of England were identified as the 'footprints' for sustainability and transformation partnerships. Every partnership is expected to become an integrated care system by April 2021. Sustainability and transformation partnerships have set out how, locally, they will help to achieve the ambitions and goals set out in the NHS long-term plan up until March 2024. These should include plans to improve access to mental health support for people who are sleeping rough.

Targeted health services
Targeted health services are mainstream health services with a dedicated/targeted service or services for certain groups of people, such as those who are experiencing homelessness – for example, a walk-in clinic or attached sessions of a nurse to an outreach team.

Trauma-informed care
Trauma-informed care is care delivered with an understanding of the impact that different types of trauma – including those experienced earlier in life – may have on an individual. This involves recognising or identifying that a person has been affected by trauma and providing care that takes this into account and helps them to recover. Trauma-informed care may be delivered as part of a psychologically informed environment.

Tri-morbidity
Tri-morbidity is the simultaneous presence of physical ill health, mental ill health and drug or alcohol misuse. The term is used in some health care settings; in the homelessness sector, this combination is more likely to be referred to as 'high and complex needs'.

Universal Credit

Universal Credit replaces six main benefits and combines them into a single payment. It was entered into legislation in 2012 and is gradually being rolled out across the United Kingdom. While first introduced only for new benefit applicants, people already in receipt of the previous benefits are now being transferred and this is expected to be completed by 2023. The six benefits are:

- Child Tax Credit

- Housing Benefit

- Income-based Jobseeker's Allowance (JSA)

- Income-related Employment and Support Allowance (ESA)

- Income Support

- Working Tax Credit.

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Deborah Fenney is a researcher in the policy team. Before joining the Fund in 2018, Deborah worked for two years as a senior analyst at the Care Quality Commission (CQC). While at CQC she worked on various projects including reviews of health and social care systems in local authority areas and a review of how NHS trusts investigate deaths of patients.

Deborah has a PhD in sociology and social policy from the University of Leeds, which explored disabled people's access to sustainable lifestyles.

Ethan Williams is a researcher in the policy team. Before joining The King's Fund, Ethan worked as a management consultant at the Good Governance Institute, supporting NHS providers on a range of projects covering clinical and corporate governance, strategy development and organisational change. He holds an MPhil in politics from the University of Oxford.

Ethan is a trustee of the Rural Urban Synthesis Society, a community land trust that builds sustainable, affordable homes in London. He also works as a mentor for ex-prisoners.

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Before joining the Fund he worked at the Care Quality Commission (CQC), where he led development of the framework and approach for inspecting and rating hospitals, and at the Healthcare Commission, where he introduced risk-based regulation in the independent sector. Alex also led CQC's work with the Department of Health on the policy and legal framework for quality regulation, and with the Department and other national bodies to agree roles and responsibilities for responding to serious concerns.

Before working in quality regulation, Alex worked in management in two NHS trusts. He has also worked at the Department of Health and at the World Health Organization Regional Office for Europe, Copenhagen.

Siham Dahir was an intern in the policy team at The King's Fund from February to November 2019. Her interests are public health, community engagement and public policy.

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The King's Fund is an independent charity working to improve health and
care in England. We help to shape policy and practice through research
and analysis; develop individuals, teams and organisations; promote
understanding of the health and social care system; and bring people
together to learn, share knowledge and debate. Our vision is that the
best possible health and care is available to all.

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The King's Fund〉 Ideas that change health and care

People sleeping rough have some of the worst health outcomes in England, dying on average more than 30 years younger than the general population. This coupled with a substantial increase in the number of people sleeping rough means that health and care services have a critical role to play in supporting the needs of this group of people.

Delivering health and care for people who sleep rough: going above and beyond considers how health and care services can deliver effective joined-up care for people sleeping rough and overcome the barriers preventing this from happening. Drawing on insight from four local areas making progress in this area and focus groups with people with lived experience, this report sheds light on the skills, leadership and resources required.

Key areas include:

• taking steps to find and engage people sleeping rough

• building and supporting the workforce to go above and beyond

• prioritising relationships across organisations

• tailoring the response to the local context

• recognising the power of commissioning.

The report concludes with reflections on how leaders can take this forward at a local and national level, from empowering staff and working across services to ensuring a broader strategic response to improve the health of people experiencing homelessness. It also provides a set of practical prompts for leaders to consider whether they have the right relationships, leadership and infrastructure in place to respond effectively to the needs of their rough sleeping population.