Framework for planning and commissioning of services related to health needs of people who are homeless or living in temporary or insecure accommodation

Communities and Local Government

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THE AIM OF THIS FRAMEWORK IS TO ENABLE AGENCIES TO ADDRESS THE HEALTH NEEDS OF PEOPLE WHO ARE HOMELESS OR LIVING IN TEMPORARY OR INSECURE ACCOMMODATION BY MEANS OF JOINT PLANNING, AND WHERE APPROPRIATE JOINT COMMISSIONING, OF SERVICES

This document provides a framework to involve local housing authorities, Directors of Adult Services, Children's Services and Social Services, Primary Care Trusts and Strategic Health Authorities, Directors of Public Health, acute, mental health and community trusts, Supporting People teams, drug and alcohol teams, prison health services and the voluntary sector in joint planning to improve access to local health services for people who are homeless or living in temporary or insecure accommodation and to promote joint commissioning of these services where appropriate.

DRIVERS

Meeting the aims of:

- *Our health, our care, our say*
- *Commissioning a patient-led NHS and,*
- *Sustainable communities: settled homes; changing lives*
- *Reaching out: an action plan on Social Exclusion*

Contribution to achieving:

- Homelessness Prevention Best Value Prevention Indicators 213, 214 and 225
- Health targets on health inequalities and reducing premature mortality

STRATEGIC CONTEXT

Our health, our care, our say[1] emphasises that PCTs and local authorities should work together to provide services for vulnerable groups such as homeless people. In addition, the issue of 'adults with chaotic lives and multiple needs' is attracting more attention within the social exclusion agenda, both in the context their care needs, in particular around mental health, and also their impact in terms of problematic drug and alcohol use. Guidance on joint commissioning is due to be published by the DH in December 2006 and this paper is designed to support the implementation of this guidance.

Commissioning a patient-led NHS – Delivering the NHS Improvement Plan[2] aims to offer a greater range of choices and information to enable people to make informed choice about their care and treatment. It also offers a process of integrating services across primary and secondary care to provide access to safe, high quality care for all sections of our society. This will be led through the development of much closer links between Health and Social Care and the joint commissioning of services for patients, including the vulnerable.

Sustainable Communities: settled homes; changing lives[3] highlighted that people who are homeless or living in temporary accommodation are more likely to suffer from poorer physical, mental and emotional health than the rest of the population. These health problems can be both a contributory factor to and also a consequence of homelessness. The joint planning of services and the development of joint commissioning are important ways in which functioning care pathways for homeless people can be ensured.

These client groups include:

- rough sleepers (for example, people sleeping on the streets, in cars, or buildings not meant for habitation etc)

- people in insecure or short term accommodation (for example, B+B, hostels, night shelters etc)

- people placed in temporary accommodation under the homelessness legislation (for example, in private sector leased properties, hostels etc) who are awaiting an offer of settled accommodation.

Many local housing authorities addressed the health issues of these client groups in their homelessness strategies in 2003. Homelessness strategies must be renewed at least every five years, so many authorities are likely to be working towards a revised strategy in 2008. There will be an expectation that the good practice of outlining clear pathways for service provision for these client groups will be included in revised homelessness strategies with action plans to deliver them.

1 *Our health, our care, our say: a new direction for community services*, Department of Health, January 2006 – http://www.dh.gov.uk/assetRoot/04/12/74/59/04127459.pdf

2 *Commissioning a patient-led NHS – Delivering the NHS Improvement Plan*, http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/Commissioning/CommissioningAPatientledNHS/fs/en

3 *Sustainable Communities: settled homes; changing lives*, Office of the Deputy Prime Minister, March 2005 – http://www.communities.gov.uk/pub/784/SustainableCommunitiesSettledHomesChangingLivesPDF796Kb_id1149784.pdf

Reaching Out: an Action Plan on Social Exclusion[4] was published in August 2006 by the Cabinet Office and describes the Government's strategy for tackling social exclusion. Particularly relevant in this context are the sections devoted to young people and to adults described as having 'chaotic lives and multiple needs' which brings the focus onto these groups which often find themselves at risk of homelessness and for whom there is now a plan to investigate appropriate solutions.

Commissioning by primary care trusts (PCTs):

PCTs need to ensure that these client groups are included in all their commissioning plans since they need access to primary and secondary healthcare according to their needs and these services need to be integrated with other services provided by social care and local authorities. Where people are registered with a GP, the introduction of **practice based commissioning** (PBC) is an additional opportunity to focus appropriate services on these client groups, with the potential for cost savings in terms of, for instance, reducing the impact of inappropriate attendance at Accident and Emergency, inappropriate reliance on hospital admission to provide both physical and mental health care and unduly lengthy stays in hospital due to lack of coordinated hospital discharge.

The introduction of **case management for people with long term conditions** in the community offers another mechanism whereby the health and social care of these client groups can be planned, coordinated and delivered.

WHY HAVE A JOINT PLANNING AND COMMISSIONING FRAMEWORK?

People in these client groups continue to find difficulty in accessing primary care services. Where they do, it is often in the context of a walk-in centre or emergency / immediately necessary treatment. Although a useful way to obtain emergency care, these settings do not allow for longer term engagement with the patient which is often necessary in order to address their multiple and enduring health needs. Access to a comprehensive primary care service is central to any care pathway in that it provides a potential setting for a holistic assessment of their medical and care needs and for their subsequent management.

Hospital admission offers another opportunity to assess and address the needs of these client groups in a holistic way. Early recognition of a housing need during hospital admission is essential in order to facilitate appropriate actions in terms of retaining / finding accommodation which will be available at the time of discharge, thus avoiding having to discharge a person on to the streets. Additionally, people in these client groups may have physical health problems or an addiction and/or mental health issues in addition to their presenting complaint, which need to be recognised and addressed quickly during a hospital admission in order to ensure that the person feels able to stay in hospital and complete the required treatment.

Some people in these client groups may also receive care for mental health and /or substance misuse and alcohol problems through teams dedicated to meeting their needs. These teams, where commissioned, need to form part of an integrated system to ensure that the physical health needs are also addressed.

4 *Reaching Out: an action plan on Social Exclusion, Cabinet Office August 2006*
http://www.cabinetoffice.gov.uk/social_exclusion_task_force/documents/reaching_out/reaching_out_full. pdf

Action to achieve the current government targets of reducing the number of families in temporary accommodation and maintaining the reduction in the number of rough sleepers will benefit from provision of appropriate healthcare, both by helping effective resettlement and reducing the risk of repeat homelessness. There are also significant resonances with the programme to improve the quality of hostel accommodation, both in terms of physical environment and services offered.

A joint planning and commissioning framework will help health, social care and housing authorities to:

- achieve joined-up service delivery.
- address current gaps in services.
- improve health and housing outcomes for these client groups, including reducing repeat homelessness.
- address the gaps identified in the first round of homelessness strategies in the area of meeting the health needs of these client groups.
- encourage spend-to-save solutions for addressing the health and housing needs of high cost patients and people who are frequently either in-patients or users of A&E and who do not have settled accommodation.
- ensure maximum cost-effectiveness of services to this client group, by reviewing the current provision and jointly planning future provision.
- have a positive effect in other areas of working with vulnerable adults though bringing together the individuals and agencies through the process of joint planning

POTENTIAL OUTCOMES AMONGST PEOPLE IN THESE CLIENT GROUPS MIGHT BE:

- The prevention of homelessness
- A reduction in repeat homelessness
- A reduction in the number of acute admissions for and inappropriate A and E attendances
- A reduction in the number of people with unaddressed health needs
- A reduction in premature mortality
- More appropriate and cost-effective local healthcare services.

In addition, locally defined outcomes may be set covering issues appropriate to the local profile of people in these client groups e.g. immunisation against hepatitis, waiting times for drug treatment, childhood immunisation, access to health visitors for families with children in temporary or insecure accommodation.

PRINCIPLES UNDERLYING THE FRAMEWORK

The principles underlying the framework can be summarised as follows:

1. Tackle and prevent homelessness.

2. Improve access to health services for people who are unable/unwilling to use more traditional routes.

3. Ensure equity of access to health services for everyone, regardless of housing status.

4. Develop locally agreed patient-centred access to all aspects of healthcare

DESIGNING YOUR FRAMEWORK THROUGH JOINT WORKING

Identify the number of rough sleepers, people in insecure accommodation and people in temporary accommodation locally.

Identify existing protocols/service level agreements/contracts relating to the 3 client groups.

Identify existing health and associated provision for people in these client groups, with associated costs. These could include:

- Primary Care

- Secondary medical and surgical services, including those where homeless people may present in higher numbers e.g. infectious disease, DVT, gastroenterology, A& E, neurosurgery

- Hospital discharge planning services

- Community services, especially those where people in these client groups may present in greater need: eg Health visitors, podiatry, dentistry

- Adult mental health services

- Child and Adolescent Mental Health Services

- Drug and alcohol services

- Outreach services

- Supporting People services offering support, for instance, as outreach, in hostels or once resettled.

- Voluntary sector services providing both accommodation and support services

Consult service users.

Process- map ideal, local, integrated health care pathways for people in each of the three client groups

Carry out a gap analysis.

Develop a joint action plan, to include resources, measurable outcomes and timescales, including business cases, service specifications and service level agreements.

Monitor and evaluate.

SUMMARY

Joint planning and commissioning of health-related services for people in these client groups will improve service delivery generally.

It will improve outcomes for both health and homelessness services.

It will improve the health of people in these client groups locally.

It will enable stakeholders to meet key government objectives on tackling health inequalities and social exclusion.

GLOSSARY

Main homelessness duty: Under the homelessness legislation, local authorities must ensure that applicants who are eligible for assistance, homeless through no fault of their own and who fall within a priority need group (e.g. families with children) have suitable accommodation available until a settled home becomes available. Accommodation must be made available in the short term until the applicant is offered a settled home, or until some other circumstance brings the duty to an end, for example, where the household voluntarily leaves the temporary accommodation provided by the housing authority or makes their own arrangements for accommodation or accepts the offer of a tenancy with a private landlord.

Rough sleeper: People sleeping, or bedded down, in the open air (such as on the streets, or in doorways, parks or bus shelters); people in buildings or other places not designed for habitation (such as barns, sheds, car parks, cars, derelict boats, stations, or “bashes”).

Temporary Accommodation: accommodation arranged by a local authority for a homeless household under the homelessness legislation. This can include local authority housing stock or housing association homes let on a temporary basis, privately leased or rented housing, B&B accommodation, hostels and refuges.