



St Mungo's Health Strategy for Homeless People 2008 - 2011

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I. Introduction

St Mungo's was set up in 1969 to tackle street homelessness in London and is the largest provider of hostel beds in the capital. In addition to providing temporary and permanent housing, we offer a wide range of non-residential services covering outreach; resettlement; employment and training; and drugs / alcohol / mental health.

It is widely known that homelessness, especially rough sleeping, has significant and negative consequences for an individual's health. Despite the NHS setting clinical priorities which reflect medical needs, there is no automatic match between medical and social priorities, so that certain socially-excluded groups continue to miss out on the healthcare they need. This is certainly St Mungo's experience of the predicament of those who are, or have been, sleeping rough. Each year we conduct a 'snapshot' needs survey across our projects. In our hostels last year, we found that:

- 32% of our residents had an alcohol dependency;
- 63% had a drugs problem;
- 49% had a mental health problem;
- 43% had a physical illness.

83% of all our residents have at least one of the above; and of those who need treatment, one in three are not receiving it. (In our temporary shelters, the figures were – unsurprisingly - higher: alcohol 44%; drugs 80%; mental health 76%; and physical health 51%).

Studies have for many years found strong correlations between homelessness and an increased severity of health conditions. This reduced health status can be exacerbated by an inappropriate use of healthcare services by homeless people, and by institutional neglect of the health needs of homeless people by the NHS and its agents.

This strategy aims to do three things: firstly, to elaborate the goal which is set out in our Business Plan 2007 – 2010 of focusing on health delivery in our hostels; secondly, of integrating into a single document our vision of service delivery across physical health, mental health, drugs and alcohol; and thirdly, of addressing our priority areas for promoting positive health and well-being.

As is implicit from the above, this strategy concentrates solely on our hostels¹. This is because their residents' health problems tend to be especially complex, being acute, overlapping and neglected; and because one of the critical access questions is – which services should be provided on-site? We hope during the life of this strategy to finalise a health strategy for our other projects, where the general thrust will be to encourage and assist residents to make use of community-based facilities.

We want all our hostel residents to have access to good standards of basic healthcare. We have the resources to pilot, for about one year, health services directly responsive to residents' needs in three hostels. Alongside the development of the pilot sites, we want to ensure that we have identified key indicators to monitor the pilots. The pilots will act as demonstrator sites which will assist our lobbying efforts to introduce successful service provision to our other hostels, and disseminate the lessons learnt more widely.

One of the constant dilemmas, and puzzles, is where exactly we fit within the health maze. We are essentially a social care organisation, not a medical one. We nevertheless observe the chronic – and acute – ill-health of most of our residents, and deduce from that that it is crucial to tackle poor health if the prospects of former rough sleepers are to be improved. What is clear is that we straddle intersections between primary care, public health and health inequalities – and it is the fact that we do not 'fit' neatly anywhere which compounds and exacerbates our residents' ill-health. As Revolving Doors Agency has trenchantly observed, "Projects that support people who fall through the gaps in services are themselves at risk of falling through the gaps in funding".

As well as not quite fitting within the framework of existing disciplines, we do not quite fit into existing structures either. Whilst we operate locally, we work cross-boundary on a regional dimension, and often to national priorities.

This strategy seeks to resolve these tensions. We have an established reputation for engaging with, and retaining in accommodation and treatment, some of the most vulnerable individuals in society – those with long histories of sleeping rough. We have also established

¹ Listed on page 42.

a specialist role in successfully supporting vulnerable individuals with complex mental and physical health problems. We recognise that the current changes to the statutory health and local authority sectors, in terms of structure, function and funding make it an ideal time to procure better healthcare for our residents. This strategy is designed to help that kind of partnership working become a reality, whilst also overturning the inverse care law².

We commissioned PHAST³ to overhaul our various strategies for us, advising also where the pressure points for successful influencing might lie within the system. We are grateful to them, and to Dr. Cecilia Pyper, Peter Gluckman and Dr. Catherine Brogan in particular for guiding us with patience, insight and good humour to the point where we are now ready to launch our strategy. They have worked closely with Peter Cockersell, our Director of Programmes, to produce a strategy which reflects our long experience and track record of innovation, and which we believe is both practical and ambitious.

It is not cast in stone, nor should it be – it will be a living document. The pace of change in the healthcare system is so rapid that our strategy needs to reflect that – but whilst some of the details will change, the overall focus on rough sleepers will remain unchanged.



Charles Fraser
Chief Executive

² Which states that those most in need of care are the least likely to receive it.

³ Public Health Action Support Team.

2. Executive Summary

From the very outset it is important to emphasise that when we refer to "rough sleepers" we do not mean people actually sleeping on the streets now, but rather those men and women currently living in hostels who have a recent history of sleeping rough.

We endorse the World Health Organisation's view that "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"⁴. Accordingly this strategy sets out how we will strive for both **health** and **well-being**.

Throughout, it is axiomatic that we are seeking to dismantle the barriers to homeless people accessing healthcare. Lord Darzi, in a written answer in the House of Lords on 18th March 2008, said that "Homeless people have the same access to National Health Services as the rest of the local population"; whilst theoretically true, this does not mean that homeless people, and especially rough sleepers, can access the healthcare that they need. The great majority of rough sleepers – over two-thirds – have multiple needs, often a combination of a mental health problem with (poly)substance misuse, usually involving multiple physical health problems, and sometimes accompanied by a non-compliant attitude falling into the 'challenging behaviour' category. 'Simple' dual diagnosis (the combination of mental health and substance misuse problems) was recognised in the Mental Health National Service Framework as the most challenging clinical problem; most rough sleepers have two or more other problems as well. The NHS often finds it very difficult to engage and treat these patients, perhaps because it tends to focus on clinical differentiation whilst treating patients with standardised uniformity. Thus there is a system of separate clinics for physical illness, substance misuse and mental illness, each with a different philosophy and funding stream – but very few of these clinics are well-suited to guiding and treating patients with dysfunctional lives and poor engagement skills. Waiting-lists for detoxification services, particularly alcohol, are often long, and drop-out rates for second appointments may be as high as 97% in mainstream services.

It is sometimes said that rough sleepers with multiple and complex problems are 'hard-to-reach'. We do not find them so – that is the group we mostly house in our hostels. It is in fact the services which are 'hard-to-reach',

and it is this unwelcome characteristic of healthcare in the 21st century which this strategy seeks to overturn. We wish to ensure that St Mungo's residents (and, eventually, rough sleepers everywhere) gain access to high quality NHS healthcare in order to obtain treatment for their illnesses.

In order to realise this, we consider a number of steps to be necessary:

- firstly, we want to see **rough sleepers recognised as a priority group** within health strategies, plans and budgets. To achieve this recognition will require coherent influencing of key audiences;
- secondly, we want to **develop and pilot service-models** which ensure that a reasonable basic service of a consistent standard is available on-site in each of our hostels, wherever they are located in London, and that this basic service is supplemented by other services which meet any specific needs prevalent in an individual hostel;
- thirdly, we want to see **world-class commissioning** in action, so that the decision about whether to commission locally or regionally derives from the needs of rough sleepers rather than from the administrative convenience of commissioners;
- fourthly, we want to see an **improvement in the effectiveness of health interventions** by improving cross-discipline communication and training, and by strengthening the collaboration between clinicians and social care staff so as to develop new models of care appropriate to people with multiple and complex needs;
- finally, we shall **strengthen the evidence base** about the health needs of rough sleepers and other homeless people, and the effectiveness of interventions in meeting them.

In addition, we shall focus on three areas of **well-being**:

- firstly, the **physical** well-being which is promoted by developing the help-seeking, self-caring attitude that can choose healthy options, such as a healthy diet and physical exercise;
- secondly, the **economic** well-being which derives from financial independence and proceeds from our on-site *Pathways To Employment* model of occupation, training and jobsearch in our hostels;

⁴ Preamble to the Constitution of the WHO signed on 22nd July 1946 by 61 countries; in force from 7 April 1948.

- thirdly, the **emotional** well-being which flows from our pilot projects with on-site counsellors and psychotherapists, rebuilding self-esteem and the ability to form healthy relationships.

As well as taking forward these priorities, we shall each year review the service specification for each of our hostels, reflecting the realities of translating our service model into practice.

Context

All of what follows is set within a context governed by two important principles:

Internally, we have embraced the Recovery Approach as the underlying theory guiding our work. Elaborated within the mental health field, the approach is capable of a broader application, and ours is located more in the social justice field than in a pure mental health one. The principles are, however, the same, and emphasise the importance of personal aspiration; believing that progress is possible; and assisting our residents to recognise (and then utilise) the personal resources which they possess.

Externally, we are enthusiastic about the personalisation agenda which is becoming paramount in how healthcare is designed and delivered. In a sense this entire strategy is a template of a personalised service for a deeply excluded client group. Current commissioning has to move on from simply focusing on the numerically most common health problems, and consider the needs of the smaller sub-populations who are left behind at the moment. This will involve a degree of bespoke commissioning; and our contention is that this is not only the right thing to do, but that it is also effective in reducing costly treatments. We would of course like to see personalisation taken even further, but the starting point has to be a recognition that rough sleepers have a legitimate call on the NHS.

We have sought to locate this strategy very firmly within the strategic aims of Our Health, Our Care, Our Say. We intend this document as a kind of blueprint of how Our Health, Our Care, Our Say could deliver significant improvements in healthcare to one of the most disadvantaged community groups in Britain. If

NHS London, and London's Primary Care Trusts (PCTs), are prepared to take up the challenge, we believe that in partnership we can transform current provision into a beacon of world class commissioning, showing how integrated medical and social care can transform the life-chances of those who have to live the reality of severe health inequalities.

2.1 Rough Sleepers as a Priority Group

Health Inequalities are the identified differences in, for example, life expectancy between the wealthiest and poorest sections of our community. We believe the term must also be applied to the differences in health status between excluded populations and the general population. Premature mortality is high among rough sleepers (the average age of death in our hostels is 41), and overall health is markedly worse than that of even the poorest section of the general population: mental illness is up to eight times more common, and substance dependency, TB, respiratory problems, renal failure and many other conditions which are considered to be national treatment priorities are all more prevalent than in the housed community. We therefore wish to see rough sleepers identified as a key sub-group within public health and primary care strategies and annual plans, as well as being a policy priority for Health Inequalities.

We also wish to see rough sleeping identified as a needs category (rather than simply being used to describe a population), in much the same way as is dual diagnosis, where it is recognised that one condition impacts negatively on the other; and that the combination is more severe than either condition independently. Our rationale for this is that the combination of multiple health stresses (such as chronic substance misuse, mental illness, and untreated physical health problems) creates an unusual and particular intensity of ill-health, and that the condition of sleeping rough intensifies this ill-health to such a degree that it amounts to a needs category in its own right.

We shall be putting these arguments to individual PCTs and Mental Health (& Social Care) Trusts; to NHS London; to the Mayor; whose Health Inequalities targets

will have statutory force; and to the Department of Health. We shall identify the best triggers for action, such as London Specialised Commissioning⁵, and the Community Profiles website.

2.2 Service Model of Healthcare for Rough Sleepers

The service model we wish to elaborate is likely to necessitate the co-ordination of locally - and regionally-commissioned services. The totality will constitute a healthcare pathway for rough sleepers, which will be ground-breaking in concept and practice. It is represented graphically further on.

This service model foresees (1) a basic service delivered consistently and to a high standard within each rough sleepers' hostel; (2) additional services only being delivered on-site if they address a predominant need amongst the hostel population (for example, visiting renal screening where there is a high proportion of chronic alcohol misusers; or testing for sexually transmitted infections (STI) where there is a high proportion of sexworkers); (3) access to other specialist services in the community being brokered by hostel staff through the GP; and (4) the development of facilities and services tailor-made for rough sleepers and other people with multiple needs where there is an identified gap, e.g. to facilitate hospital discharge for those with continuing care needs, or to provide drugs and alcohol-related rehabilitation for those with complex needs and challenging behaviours.

Notwithstanding that our overall goal is to see healthcare for homeless people mainstreamed, it is self-evident that hostels require a kind of crisis service which is tantamount to a specialist primary care service, and is delivered on-site. We wish to work in partnership with PCTs and others to promote such commissioning, thereby assisting PCTs to attain key NHS targets relating to health inequalities.

Priorities

Our lengthy experience and track record in working with the harder end of street homelessness leads us to position ourselves at that end of the spectrum. This is reflected in the service priorities which we set for physical health, mental health, alcohol, drugs and well-being. A relatively small investment in these priorities should yield wider social benefits - in the case of drugs, for example, investment which increases the effectiveness of our drugs work will lead to improved health and reduced criminality and anti-social behaviour; thus contributing to greater community well-being. The main service priorities are:

Physical health

Health-check for all following admission; on-site surgeries run by nurse practitioners, or nurses from Personal Medical Services (PMS) settings, with visiting GPs; health support staff in each hostel.

Drugs

On-site specialist staff, prescribing services and needle exchanges; easy access to reduction units, detox and rehab, which can cope with complex needs; occupational service for problematic drug users.

Alcohol

On-site specialist staff; dry areas; easy access to reduction units, detox and rehab, and to detox / rehab which can cope with complex needs; occupational service for dependent drinkers

Mental Health

On-site specialist staff; talking therapies; occupational service for people with a mental illness or disorder; accompaniment; advocacy

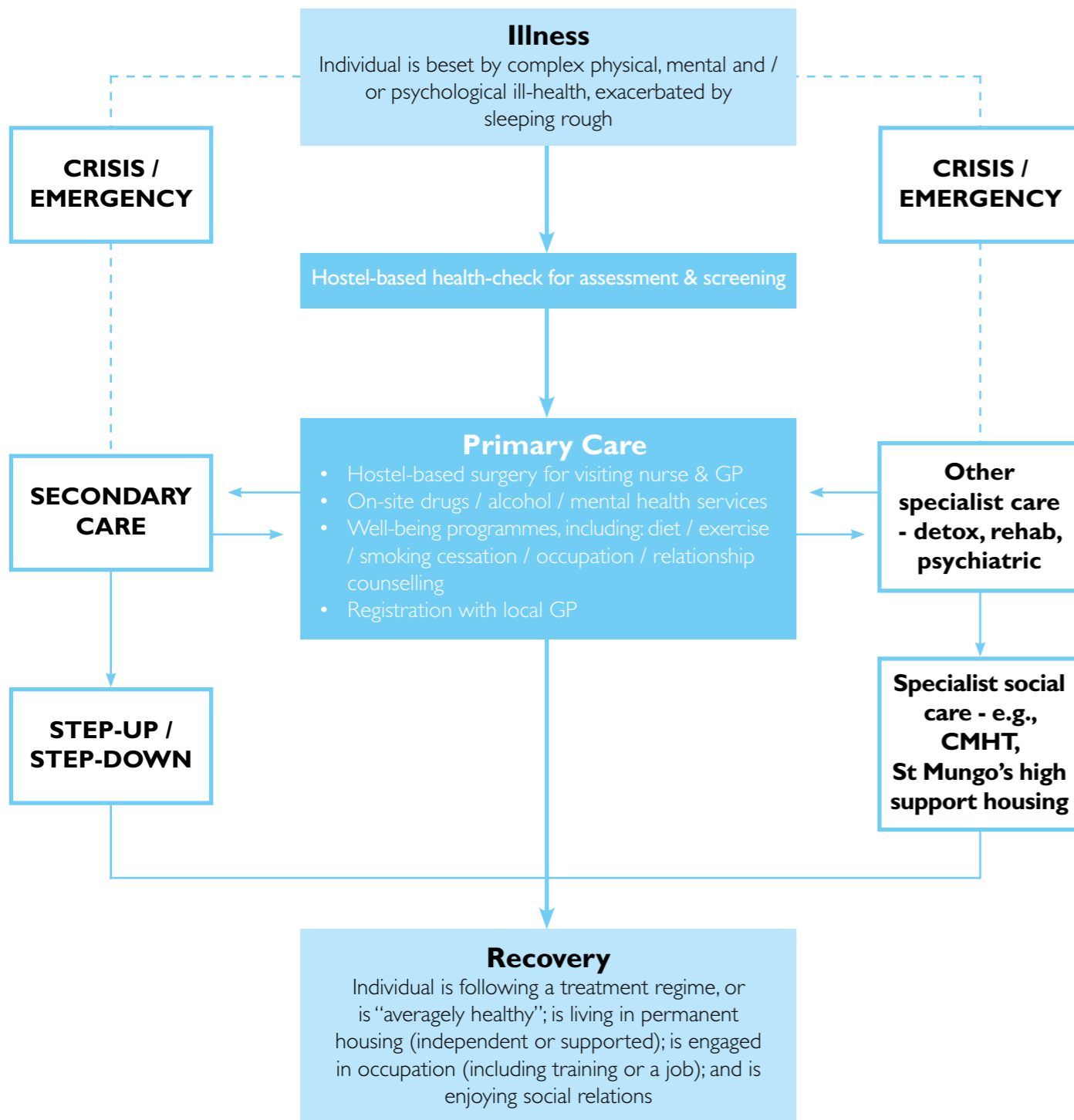
Well-being

Access to relationship counselling; *Pathways to Employment* programme on-site; healthy eating and exercise.

These priority services underpin the following rough sleepers healthcare pathway:

⁵ It co-ordinates specialised activities which require a pan-London perspective. Such services have a planning population of over 1 million (i.e. larger than PCTs), and are high cost, low volume. They are mainly provided in specialist centres within a "hub-and-spoke" network, and require specialist expertise to deliver.

Rough Sleepers Healthcare Pathway



2.3 World-class Commissioning

This is the NHS' ambition for the future commissioning of healthcare. We view it as like an engineering process, involving the way that different services connect with each other (for example, primary care for physical health being tied into a mental health or drugs and alcohol service), as well as the ways in which local and regional services dovetail.

St Mungo's would like to support initiatives to establish a London-wide forum to share and address health policy as it impacts on homelessness and, working in partnership with London Specialised Commissioning, develop a London-wide response to the particular needs of rough sleepers with complex and multiple needs.

Many gaps in care can be best addressed through pilots in the first instance. Whether they are most effectively commissioned locally or regionally will depend on the nature of the service proposal. Gaps we have provisionally identified whilst drawing up this strategy include:

- i) Psychotherapy for people who have had relationship breakdowns, traumatic childhoods, histories of abuse and violence, and substance dependency;
- ii) Tier 4⁶ rehabilitation services for people with complex needs and challenging behaviours, i.e. who may lack stability and motivation;
- iii) Post-discharge facilities for homeless people who, whilst no longer needing hospital treatment, do need continuing care at a level which exceeds what can be provided by hostels or other settings in the community;
- iv) Terminal care for those who die / wish to die in hostels, and support for hostel staff to enable this;

The important NHS principle of universality must be maintained, even (or, rather, especially) when addressing the health needs of numerically small and dispersed populations. In order to ensure consistency of service across PCT boundaries, and also secure value for money, it may be desirable and necessary to commission at a regional level.

2.4 Improving the Effectiveness of Healthcare Interventions

- i) In order to improve the health of rough sleepers we need to not just address their access problems via our service model, but also help them to use the service properly. To realise these twin goals will entail managing the expectations of both our hostel residents and of medical staff.

We have introduced a role of 'health champion' within our hostels, which is essentially an additional link-worker duty undertaken by existing staff. They will ensure that information about locally-available health services is disseminated within the hostel, and is easily accessible to residents.

We want to go further than that though, and offer specialist support which can maximise the beneficial effect of medical interventions. Our medium-term goal is to have a Health Support worker in each hostel: we are trialling this with charitable funds. These workers will assist keyworkers to fulfil their duties of brokerage between an individual resident and available health services, and take overall responsibility for the relationship between the hostel and the NHS locally.

We are hopeful that improved communication will also help to make the NHS more responsive to homelessness and rough sleeping.

- ii) Communication is not the only means of improving the effectiveness of interventions, however. We also wish to work in partnership with PCTs to promote the development of shared protocols (clarifying what both parties can expect of each other in terms of information-sharing, and the support which healthcare staff and keyworkers can expect from each other to maximise take-up); and to see whether there are things which we can do jointly to raise the quality of staff training and supervision on both sides.
- iii) St Mungo's wishes to ensure that all personal health data is managed according to NHS and data protection guidelines, and that health records can be

⁶ Residential specialised alcohol and drugs treatments (e.g. detox and rehab) which are care-planned to ensure continuity of care and after-care.

better accessed in a range of healthcare situations, from hostel-based nurse practitioners to acute trusts, by involving hostel residents in initiatives like the **Summary Care record** and **HealthSpace** (<https://www.healthspace.nhs.uk/>, and run by **NHS Connecting for Health**). We know that this will raise issues of information governance for us.

- iv) St Mungo's will support initiatives which are pan-London or PCT-led, and which facilitate NHS primary health care registration for homeless individuals. In the long term this would help the development of a pan-London registration scheme, as proposed in the Department of Health's 'Reducing Health Inequalities'.

2.5 Strengthening Our Evidence Base

In order to improve both the crispness of our policy work and the relevance of service delivery, we will need to ensure that we have reliable data about our residents' health needs. We will overhaul our annual needs survey, and supplement the results with data from our on-site services.

We will explore how we disseminate our evidence; and how it can be used to bridge the gap between practice and policy.

We will evaluate the effectiveness of the models we propose, using outcomes and targets derived from:

- use of ambulances / A&E departments
- emergency admissions, and their duration
- treatment compliance levels
- reduced mortality
- increased awareness and take-up of healthy options
- well-being measures (such as CORE⁷, or our Outcomes Star⁸)

Overall

Each section has its own Action Plan. We will also ensure that our overall approach embodies the following principles so that we:

- aim for the highest standards of service quality
- develop and apply Best Practice
- identify, and seek to fill, gaps in essential services
- maintain and develop our staff's levels of skill and expertise
- increase the range of options available
- deliver services which offer the best chance of recovery
- work professionally with all external partner agencies
- work in partnership where that is the best way of offering additional expertise
- promote choice and independence, with the aim of assisting as many of our residents as possible to function optimally in the community
- identify the appropriate panel within each Local Area Agreement for each service heading, and cultivate productive relations

Learning

We do not want to be static. We shall set up an internal health forum for ensuring that Best Practice is disseminated, and that lessons are identified and learned from. We shall also seek to set up a London Health and Homelessness forum, bringing together colleagues from a small group of homelessness and health delivery agencies in order to share best practice and to try to influence policy.

3. The Strategy

PCTs are the main vehicle through which the NHS assesses local needs; plans services; and commissions providers to meet those needs. As part of the fieldwork for this strategy, PHAST sought to identify who within key PCTs had the lead responsibility for homelessness; and the degree of importance attached to the topic.

The result was a mixed picture. The prioritisation of homelessness was variable, and in practice further diluted by changes in key personnel, by the conflicting pressures of other priorities, and by uneven levels of knowledge and capacity. It is worth emphasising, though, how horrified PHAST were at the great difficulties they experienced in making any sort of contact with many PCTs.

Whilst we do not underestimate the difficulties in having our message heard by PCTs, this simply emphasises the extreme importance of finding a way in which we can work in close partnership with them to implement and to evolve this strategy.

3.1 Rough Sleepers as a Priority Group

Rough sleeping is the most acute form of homelessness, itself amongst the worst forms of social exclusion. Ill-health is endemic. Whilst this strategy is mainly concerned with developing a service-model to tackle the health needs of rough sleepers in hostels, it is evident that St Mungo's needs to address policy as well as practice.

Our main disappointment with recent policy statements has been the absence of any awareness of the health problems of rough sleepers. Despite being specified as a priority group for cross-departmental action by the government in the Social Exclusion Unit's 1998 report, the reality is that the health world thinks that (a) rough sleepers are the responsibility of that part of government dealing with housing, i.e. CLG⁹; and (b) the problem of rough sleeping has been "solved".

As an organisation which daily confronts the excesses of our residents' ill-health, we are offended by this lack of concern. We want to address this in two ways:

- firstly, by emphasising at every opportunity the need for policy makers to make rough sleepers a priority group;
- and secondly, for this prioritisation to emanate not just from partial aspects of their ill-health, such as mental illness, but for rough sleeping itself to be seen as a needs category in its own right.

We set out below the actions we will take over the life of this strategy to promote these messages.

⁷ Clinical Outcomes for Routine Evaluation.

⁸ This is a tool originated by St Mungo's for residents to assess, with their keyworker, their progress in the 'softer' outcome areas, such as life skills, engagement and personal responsibility.

⁹ Department of Communities & Local Government.

Strategic	
08 / 09	Make the case to the Mayor and the Greater London Authority (GLA) for rough sleepers to be designated a priority group for healthcare in the Mayor's Health Inequalities Strategy (& beyond)
	Try to convince individual PCTs and NHS London to make rough sleepers a priority group for Primary Care
	Make the case to NHS London for a specialised primary care service for rough sleepers to be commissioned on a pan-London basis
	Raise awareness amongst commissioners and providers of the high level of ill-health of rough sleepers – homelessness is a health problem
	Press for the Community Profiles website to specify rough sleepers as a key group
	Urge the DH to create a high level indicator for multiply excluded groups, especially rough sleepers, when considering how to "refresh" the Health Inequalities strategy in 2008
	Press for Joint Strategic Needs Assessments to include rough sleepers
Position ourselves principally in the Public Health field, which covers health inequalities and access to healthcare	
Developmental	
09 / 10	Seek invitations to present to the annual conferences of: <ul style="list-style-type: none"> the Royal Institute of Public Health; the UK Public Health Association; the Faculty of Public Health in the Royal College of Physicians
	Raise our profile as an organisation with health expertise by entering for Public Health awards
Operational	
08 / 09	Assess the range of Primary Care services available from the PCT in each hostel
	Identify local PCT targets which St Mungo's could help the PCT to meet (e.g. reduction of ambulance usage; reduced usage of A&E; reduced psychiatric admissions, and post-treatment "bed-blocking"; smoking cessation; etc)
	Press for the prioritisation of rough sleepers in the queue for treatment of substance dependencies and mental ill-health: treatment should be targeted at the most problematic, not the easiest to work with

3.2 Service Model Priorities

i) Physical Health

Background

Homelessness exacerbates existing conditions, and may give rise to new ones. The most common illnesses to affect residents in our hostels include:

- Circulatory disease
- Cardio-vascular problems
- Epilepsy and neurological problems
- Gastro-intestinal disorders
- Liver disease
- Inflammation of the joints
- Pulmonary disease

There are also high levels of – TB, renal failure, abscesses, deep vein thrombosis, and blood-borne viruses, especially

Hepatitis C. Perhaps the most telling detail is that, in the middle of London in the 21st century, we are seeing cases of **trenchfoot**.

Research which we undertook earlier this year showed that just over half of interviewees had a long-term condition¹⁰. One in three interviewees had a condition for which they were not being treated; and over half of this group was estimated to have conditions which could deteriorate to the point where they would require urgent medical attention.

Ambulances were called to St Mungo's on average twice a week, with 44% of call-outs occurring out-of-hours. More tellingly, 85% of all ambulance calls were for illness or overdose, and our data show that most call-outs were for pre-existing conditions (asthma; diabetes; heart and circulation problems; epilepsy; respiratory difficulties; stomach or liver complaints; substance use crises) which had reached emergency status. Although we cannot quantify it precisely, it is undoubtedly the case that enhanced primary care could have prevented some of this usage of crisis services.

In addition to the prevalence of some illnesses indicated by this research, we are aware that there is a variety of reasons for homeless people failing to access the healthcare they need. Some of these are personal, and include low self-esteem and a lack of personal organisation and of motivation; and some are institutional barriers, which include a reluctance by parts of the NHS to take them on for fear that they will be disruptive and / or expensive; the patchy availability of GP services; an inflexible appointments system; and problems in sustaining treatments with their unsettled lifestyles.

Many of our residents do not prioritise health; and many parts of the NHS do not prioritise homelessness.

Our track record

In the distant past St Mungo's paid a GP to come into our main hostel once a week, this being the only way of obtaining any sort of service. In more recent years we have seen manifold improvements to the healthcare coverage of our projects, with the single exception of our hostels, the subject of this strategy. Here the picture

is inconsistent, with primary care input in the form of on-site surgeries being patchy. Some hostels have good GP coverage: others have none at all. We want to see a uniform and consistent level of service across all our hostels.

We have generally found it considerably easier to build relationships with GPs than with PCTs. Despite their having a duty to assess needs within their areas, we cannot recall a single occasion when we have been approached by a PCT commissioner to find out about and address the healthcare needs of the residents in any of our hostels.

Looking ahead

We want to raise the importance of health in the minds of all our residents (and staff), and thus will introduce a comprehensive, nurse-led health-check for everyone shortly after their arrival. We hope that this will tie into a longer-term prognosis whereby the individual's continuity of care can be optimised. This will be addressed in two ways: firstly, through better communication – we shall explore how to ensure that patient data is recorded electronically at first contact in a format which can be simply transferred to the registration questionnaire on the GP system, thus becoming part of the patient's health record; and secondly, through instilling a shared sense of priority so that keyworkers are made aware of what they need to do to help a resident remain involved with their own healthcare. As part of this emphasis on health, we shall also explore how people can be best motivated to have a health-check; how its findings could be recorded, and shared with other NHS staff, and possibly with social care staff; and how it could best be followed up.

We wish to find a way of measuring our residents' usage of NHS services so that we can achieve a reduction in their use of Emergency Care, and an increase in their timely use of Primary Care. Although the reported GP registration rate is high, there is a suspicion that this registration is historic, and that residents are not seeing their GPs as often as they need to.

¹⁰ Defined as "conditions which cannot at present be cured, but which can be controlled by medication and other therapies. The life of a person with a LTC is forever altered – there is no return to 'normal'." *Raising the Profile of LTC Care* (DH 2008). Long-term conditions range from hypertension to coronary heart disease, epilepsy and severe mental health problems.

As well as seeing better access to Primary Care on-site in our rough sleeper hostels, we also want to have a more co-ordinated approach to Public Health. This will cover our approach to Infectious Diseases (notably TB); to Health Improvement (e.g. sexual health, especially contraception and STI screening); to tackling substance and alcohol misuse; and to Healthy Living (e.g. nutrition and exercise).

We will also explore the relevance of different models of primary healthcare service delivery, such as Specialist Personal Medical Services¹¹ (SPMS) and National Enhanced Services¹² (NES), or social enterprises / Alternative Provider Medical Services (APMS), as the best solution for the provision of specialised Primary Care for rough sleepers.

We shall explore the possibilities of using an enhanced out-of-hours service in order to reduce ambulance call-outs (notwithstanding PHAST's finding that some of our managers found OOH unresponsive and lacking in respect towards the residents).

We are interested in exploring the benefits which telemedicine and e-health can bring to rough sleepers. We will ensure that each hostel has computer terminals for residents to access NHS Direct (<http://www.nhsdirect.nhs.uk/>) or similar, and we shall investigate the possibilities

of linking a nurse centrally with several locations via webcam. Our wish is to trial this across our three pilot locations, and to do so at week-ends, when healthcare access is that much harder than usual.

Overall Strategy – Physical Health

1. ensure that hostels offer primary care on-site which is (a) accessible to all residents, and (b) used by them;
2. improve preventative care, and reduce the usage of emergency services;
3. improve mutual understanding and the transfer of information between, St Mungo's hostels and the NHS;
4. promote the integration of healthcare so that people receive treatment for all their illnesses – physical and mental – and dependencies;
5. promote healthy lifestyles and well-being;
6. identify the best vehicle for delivering this basic primary care to a niche and marginal population.

Service Model

Service	Target
Our service model for our hostels is:	
Comprehensive health-check	within 14 days of admission
Registration with local GP	within 28 days of admission
A PMS - or practice-based nurse attending on-site surgery	twice p.w
On-site TB screening	twice p.a. / 100% take-up
On-site sexual health screening	twice p.a. / 50% take-up

Resources

Health Champion in every hostel	by December 2008
Health Support Worker in every hostel	by December 2009

¹¹ PMS enable locally-negotiated contracts as an alternative to the national General Medical Services (GMS) contract, allowing greater freedom to address patients' primary care needs in innovative and flexible ways. An SPMS (Specialist PMS) is a tool for targeting vulnerable groups who do not use traditional services and who over-rely on emergency / unscheduled services, by constructing bespoke services and possibly even extending the range of services delivered in primary care.

¹² LES are intended to improve patient convenience and choice, whilst delivering better value for money, and reducing the demand for secondary care. The emphasis is on meeting local need. A National Enhanced Service (NES) delivers services to meet a local need, but sets the standard nationally. This is considered a suitable model for (e.g.) enhanced care for homeless people.

Key Targets

In addition to those specified above, our targets include:

- achieving a year-on-year reduction in the use of ambulances and A&E in favour of Primary Care and out-of-hours cover
- reducing the number of deaths (baseline to be established)
- 90% of residents who need treatment receiving what they need
- 75% of residents with courses of treatment completing them
- improving the physical health outcomes of those referred from drugs and alcohol services
- reducing the number of hospital admissions, and their average duration

Action Plan

Our 3-year Action Plan is:

Strategic	
08 / 09	Develop a set of minimum standards for primary healthcare provision in hostels for rough sleepers
09 / 10	Draw up a model of a London-wide specialist primary healthcare service for rough sleepers Demonstrate the need for a 'step-down' ¹³ service, and devise a service model
Developmental	
08 / 09	Identify a means of reducing residents' usage of Emergency Services in favour of Primary Care and out-of-hours cover Establish a means of monitoring compliance with treatment Establish a standardised health assessment and referral procedure for new admissions (including assessment for /access to psychological treatments) Try to secure twice-weekly visits to all rough sleeper hostels by a nurse practitioner or GP
09 / 10	Evaluate the telemedicine pilot Ensure that every hostel has computer terminals for NHS Direct (or similar)
Operational	
08 / 09	Establish a thorough health check within 14 days of arrival for all new admissions; and registration with local GP Set up regular and systematic TB screening; and train staff in supervising TB treatment Set up sexual health screening Draw up a Service Map for each hostel, setting out how to access key services locally Determine what we monitor, and how, to evidence Public Health improvements Implement the NHS mid-life Life Check (once national pilot has been completed)

¹³ Medium level care in a non-acute bed.

ii) Mental Health

Background

Despite the efforts of many voluntary (and some statutory) agencies, the proportion of people sleeping on the streets who are reckoned to have a diagnosed mental illness has remained pretty much static at about 35%.

A significant minority of rough sleepers suffer from the "severe and enduring mental illnesses" such as schizophrenia and bipolar disorder. In recent years, however, it has become increasingly evident that the term 'mental illness' does not only apply to those with a diagnosed "severe and enduring mental illness" but also to other groups of people who have not yet crossed the threshold of needing full-blown psychiatric treatment. These include people with: undiagnosed mental health problems; emotional and psychological disorders; and 'lower level' mental illnesses.

St Mungo's approach to mental health thus has to embrace the psychological disorders – severe depression / anxiety, post-traumatic stress disorder (PTSD), and personality disorder (PD) – and to find ways of ensuring access to treatment for these as well as for the 'classic' psychiatric illnesses. A recent survey in one of our hostels by a clinical psychologist from Southampton University found levels of up to 85% of clients with personality disorders; around 40% with anxiety disorder; around 25% each with depressive disorder and / or PTSD. All also had substance use problems, and were characterised by 'avoidant' engagement patterns – in other words, they were actively help-shunning, not help-seeking, as part of their mental health condition.

A vicious circle operates whereby this group avoids services, and the services avoid this group.

A plethora of guidance and National Standards have been developed, including the Mental Health National Service Framework; *Personality Disorder: No Longer a Diagnosis of Exclusion; Our Health, Our Care, Our Say; Independence, Well-being & Choice*; and the development of mental health National Occupational Standards. All of these contain, either directly or by implication, reference

to delivering more person-centred services which can reach out to more socially-excluded groups of patients. Despite the call from both professionals and user-groups alike for more psychosocial treatment to be available, however, and the Government's recent decision to fund large-scale provision of Cognitive Behaviour Therapy (CBT) for people with mild to moderate depression through GP surgeries, treatment for psychological disorders remains scarce, and hard to access. There are almost no services for people with personality disorders who continue to use drugs and alcohol, for example – but such individuals make up the majority of the intake to many of our rough sleeper hostels.

Our track record

For many years, our largest specialism was mental health. The reduction in in-patient beds in the 1980s was supported by a drugs regime involving self-managed medication in the community. Casualties of this regime were those who could not self-medicate, and this inability to manage their illness left them needing the very kind of in-patient treatment which had been radically pruned back. Small wonder that they were prone to street homelessness; and thus it was that St Mungo's encountered a higher proportion of homeless people with a mental illness. When the Department of Health launched the Homeless Mentally-Ill Initiative in 1991, St Mungo's was chosen to run the access projects in two out of the three London sub-regions.

Much has changed since then (and unfortunately, much has remained the same). Tackling mental illness has remained a priority for St Mungo's, and we manage specialist accommodation at all levels (hostels; temporary and permanent housing; and Registered Care Homes). At the same time, we are witnessing some significant changes, viz. (1) a diagnostic shift from "illness" to "disorder", reflecting a shift from psychiatry to psychology; (2) a pronounced impact on mental ill-health from drugs and alcohol; and (3) an increase in the phenomenon noted by Revolving Doors Agency in its prisons work, namely of people with up to four co-occurring mental health problems. Overall, it is important to remember that people with a mental illness are still disproportionately represented amongst rough sleepers, and indeed the wider homelessness population.

In 2007 we committed to using the Recovery Approach to shape our provision of client-centred services. It now constitutes our unifying theory for service-delivery. We have piloted the London Development Centre's training in Essential Shared Capabilities, and we have decided to make this training a requirement for all staff working in our specialist mental health projects. We have devised an e-training tool ("Frontline" <http://www.frontline-training.org/about.aspx>), in partnership with SW London & St George's Mental Health Trust, for working with people with personality disorders. We have developed two new dual diagnosis projects in Brent; directly employ a psychotherapist; and have developed a relationship-counselling service in partnership with 'Relate'. We have also been successful in winning funding for one of the Cabinet Office-funded ACE (Adults facing Chronic Exclusion) national pilot projects, to develop a psychotherapeutic intervention for rough sleepers with complex needs and avoidant engagement patterns.

Looking ahead

Externally, we expect that the boundary between treatment and support will become less rigidly defined (the challenge will be whether the funding regimes can adapt to porosity), and that the effectiveness of existing mental health services will experience growing scrutiny. Services which we expect to come under particular threat are Registered Care Homes, and those which are perceived to lack personalisation (which often means those that lack a pricing gradient). New service-delivery opportunities are likely to arise from this, but they will need to reflect the new emphasis on achieving outcomes, in line with the Government's objectives as outlined in the Health and Well-being and Social Exclusion Public Service Agreements (PSAs). An ethos of 'rehabilitation' will increasingly, we believe, need to be demonstrated in practice by measurable improvements in users' well-being and social functioning that meets Local Area Agreement (LAA) targets. This is likely to develop further as Health and Social Care Trusts, themselves outcome-focused and target-driven, take a greater lead in the commissioning of local authority-funded services. Our task will be to achieve outcomes recognised by these high level targets which are applicable to or useful in working with people who are often at the very lowest levels of health and skills deprivation.

We will seek to define, implement and promote the set of interventions which we believe to be necessary in hostels to promote good mental health – in short: good assessment; accompaniment and advocacy; monitored / supported treatment completion; access to psychological therapies; wraparound services such as occupational and resettlement support; and a person-centred, recovery-oriented approach. We are also concerned by the relative lack of high support move-on for people with medium- or long-term mental illnesses; this provision needs to be available within the mental health pathways which various local authorities are either constructing, or have developed.

Mental health is one of the areas of healthcare with a National Service Framework¹⁴, and we wish to ensure that rough sleepers are an identified group within this NSF.

We are committed to devising and implementing occupational opportunities for residents with a mental illness. We welcome the Government's commitment to increase the proportion of adults in contact with secondary mental health services who achieve settled accommodation and employment¹⁵, and we look forward to the establishment of national targets for these.

Overall Strategy – Mental Health

1. reduce the proportion of people sleeping rough who have a mental illness;
2. enable rough sleepers to receive appropriate treatment for psychiatric illnesses or emotional disorders;
3. challenge any disqualification from services due to overlaps between mental illness and other problems (e.g. substance dependency);
4. promote independence through a choice of onward housing, and occupational opportunities;
5. increase the competency of St Mungo's staff in assisting and supporting residents with a mental illness.

¹⁴ NSFs are long-term strategies for improving areas of care, which set national standards and identify key interventions.

¹⁵ This is specified in *PSA Delivery Agreement 16: Increase the proportion of socially-excluded adults in settled accommodation and employment, education or training* (October 2007)

Service Model	
Service	Target
Initial psychiatric screening, as part of health-check	100% within 14 days of admission
Accessible psychological treatments	
On-site visits by homeless mental health teams (e.g. START)	
Psychiatric assessments	Completed within 7 days of referral
Advocacy	
Accompaniment	
Peer support networks	
Specialist move-on	
Occupational support	

Resources	
On-site specialist worker	
Specialist staff trained to <i>Essential Shared Capabilities</i> ¹⁶ standard	

Key Targets

In addition to those specified above, our targets include:

- nobody with a mental illness to be sleeping rough
- no suicides of hostel residents
- extending the provision of psychological and psychosocial treatment programmes, and avoiding inappropriate medication or hospitalisation (baselines to be established)
- 90% of residents complying with agreed treatment plans
- 60% of those referred to Basic Skills training achieving the basic skills which the Moser report identifies as the pre-requisites for social functioning, namely numeracy to the standard of NVQ entry level 3, and literacy to NVQ full level 1
- 80% of residents having a resettlement plan
- 15% being in work, or doing work experience or key skills training

Action Plan

Our 3-year Action Plan is:

Strategic	
08 / 09	<p>Press government to have a target for reducing to zero within 3 years the number of people sleeping on the streets who have a mental illness</p> <p>Press the Homelessness Directorate to review, with DH, the role and effectiveness of the original HMII outreach teams</p>
09 / 10	<p>Try to ensure that local authorities adequately address in their plans the rehousing needs of people with a mental illness, including for high support move-on</p> <p>Press for the Mental Health NSF to specify rough sleepers as a priority group</p>
Developmental	
08 / 09	<p>Use psychological profiling and psychology-informed interventions to target long-term rough sleepers who do not wish to come off the streets by finding new ways of engaging them and working with them – beginning with a pilot in Westminster</p> <p>Work with Mental Health Trusts to define service standards and professional roles for working with those with “complex needs” (which for us means rough sleepers with mental illness +), and to ensure that services can work effectively with people who have substance dependencies or display challenging behaviours</p> <p>Scope occupational opportunities (including e.g. trainee, mentoring and supported employment schemes) for residents with a mental illness</p> <p>Explore the extent to which St Mungo's can recruit and support staff with a mental illness</p>
09 / 10	<p>Develop proposals for rehabilitative and therapeutic projects for people with mental illnesses / psychological disorders and concurrent dependency problems</p> <p>Evaluate the ACE pilot, and plan for future roll-out on the basis of lessons learned</p> <p>Assess the differential incidence of psychiatric illnesses / psychological or emotional disorders / brain damage within each hostel; and plan referral routes to relevant services (e.g. Community Mental Health Teams (CMHTs); psychotherapies; scans)</p> <p>Explore, with 'Outside In', the possibilities of peer support in promoting recovery for residents with a mental illness</p> <p>Develop an advocacy project to help residents obtain the services they need</p>
10 / 11	<p>Identify the level of brain damage in rough sleeper hostels, differentiating between learning difficulties and injuries sustained as a result of stroke, head injury, or alcohol abuse, and work with NHS Trusts to devise appropriate pathways out of the homelessness 'system'</p>

¹⁶ From the National Service Framework in Mental Health.

Operational	
08 / 09	<p>Arrange access to counselling and psychotherapy for residents who have experienced significant relational difficulties (e.g. family and relationship breakdown, childhood trauma, physical and sexual abuse)</p> <p>Monitor access to psychological services</p>
09 / 10	<p>Introduce competencies in line with Essential Shared Capabilities for all staff working in specialised mental health projects, and provide training (including a Continuing Professional Development programme)</p> <p>Launch an occupational service for residents with a mental illness which fits within the Recovery Approach</p> <p>Set targets for employing people with mental health problems</p>

iii) Alcohol

Background

London has a higher proportion of dependent drinkers than nationally¹⁷, while at the same time alcohol treatment is a relatively low priority. Alcohol-related kidney and liver failure remains one of the commonest causes of death of rough sleepers.

Furthermore, residential treatment options concentrate on a fast-track to abstinence, meaning that slower paths through continued drinking within a harm-minimisation approach are not fundable as treatment.

Our track record

We have always accommodated a high proportion of drinkers, not least because alcohol-dependency is such a feature of homelessness, especially rough sleeping. Over the years we have evolved from being merely tolerant, doing not much more than containing, to providing services intended to either reduce consumption, or at least to reduce harm. Working with Equinox, we pioneered the establishment of a drinkers' detox in a temporary shelter. Two of our Registered Care Homes cater specifically for drinkers, and we have a variety of projects working to help street-drinkers: we developed, for example, the first alcohol arrest-referral service in London; and our street population services target street-drinkers to bring them into treatment and other support networks.

We focus our efforts on tackling drinking at the harmful end of the alcohol-dependency spectrum. On the one hand, we have a number of rough sleepers who are primary alcohol users, and who have been so for a prolonged time; on the other hand, we have residents who have mental ill-health or are drug-dependent for whom alcohol is also a problem.

Looking Ahead

St Mungo's strategic aims include helping people to move on from homelessness, and working with dependent drinkers is critical to us achieving this aim. Alcohol dependency is a key trigger of homelessness, keeps people on the streets for longer, makes resettlement more difficult, and increases the risk of tenancy loss and a return to street-life after resettlement.

We wish the initial health-check which will be available to all within 14 days of admission to routinely include a brief screening assessment to determine whether someone has a pattern of alcohol consumption which is hazardous, harmful or dependent. If the nurse has a concern, this will trigger a more in-depth assessment. This will also ensure that, where there is problematic drug use and / or mental illness, alcohol consumption is not overlooked.

In the rough sleeper hostels, where we expect more residents to have a co-mingling of harmful alcohol usage with drugs and possibly mental illness, we will seek to establish comprehensive assessments on-site, and refer onwards to other provision of our own, or to an agency which can work with these clients. Harmful usage is compounded by both a too narrow range of treatment options and a shortage of treatment providers with the skills and experience to work with this client group.

Where we see the biggest need is for new forms of treatment which (1) are easily accessible to people in hostels; (2) lead to rehab and post-rehab support; and (3) recognise that people who have been alcohol-dependent for fifteen or twenty years will not usually become independent either rapidly or smoothly. We currently run a successful reduction unit which takes account of this; and we would like to develop, in partnership with the NHS or another specialised provider, more accessible detoxes and rehab projects which can successfully work with our client group. One of our priorities is to better understand the patterns of usage amongst the different sub-populations we work with.

An area we would like to develop during the term of this strategy is that of dry accommodation, including dry clusters in hostels. One of the difficulties to date has been the staffing levels (and costs) required to oversee this. A short-term priority is thus to clarify what is possible in relation to abstinence.

We expect to be recognised as a provider of Tier 3¹⁸ and Tier 4 services by the end of this strategy term. We will ensure that any services to our residents, whether delivered by us or by partner organisations, will be set up and run within fully-developed competency and quality management frameworks.

Structurally, there is some confusion about where tackling harmful and dependent drinking fits. While government sees much alcohol-related behaviour as antisocial, it has not gone down the route of criminal justice-directed treatment in the way it has with drugs, so that the gatekeeping of treatment remains within the domain of social services and health and social care trusts. Yet while some London boroughs place the responsibility for setting and overseeing alcohol policies with their Crime &

Disorder Reduction Partnerships (CDRPs), others place it with their Drugs & Alcohol Action Teams (DAATs). We will work through Local Area Agreements to ensure that, wherever responsibility is located, there is a joined-up agenda of community safety and health / social care: we know that unless we treat the individual through person-centred care and support, the antisocial behaviours will continue.

We are committed to devising occupational opportunities for harmful and dependent drinkers, and for developing move-on opportunities with local and regional providers.

Overall Strategy – Alcohol

1. ensure that all dependent drinkers can access the services they need to contain and reduce their consumption, so as to mitigate the harmful effects of alcohol;
2. explore how to develop an in-house range of services spanning reduction, treatment, detox, rehab and post-rehab support;
3. help drinkers improve their overall health, and to obtain work and permanent housing;
4. promote an understanding of the special problems which rough sleeping adds to harmful alcohol use, and which St Mungo's is particularly well-placed to address.

¹⁷ Chronic, or dependent, drinkers are reckoned to comprise 3.6% of the population nationally, but 5% in London.

¹⁸ Community-based specialised alcohol misuse assessment, and structured, care-planned treatment, incl. day programmes.

Service Model	
Service	Target
Our service model for our hostels is:	
Initial screening for hazardous drinking as part of health-check	100% within 14 days of admission
AA on-site, or locally accessible	
Thiamine scripts / B 12 injections available	
Peer support networks	
Assessment / case management / referral to treatment (detox and rehab)	
Development of long-term support networks for residents with long histories of alcohol dependency	
Occupational support	
All practice & procedures to be QuADS ¹⁹ -compliant	

Resources	
On-site specialist worker	
Specialist on-site staff trained to DANOS ²⁰	
Development of new reduction / detox / rehab units – requires capital and revenue funding	

Key Targets

In addition to those specified above, our targets include:

- year-on-year reduction in the proportion of hostel residents identified in the Annual Needs Survey as having an alcohol problem but not being in treatment
- 50% of those referred to Basic Skills training achieving the basic skills which the Moser report identifies as the pre-requisites for social functioning, namely numeracy to the standard of NVQ entry level 3, and literacy to NVQ full level 1
- 70% having a resettlement plan
- 20% being in work, or doing work experience or key skills training
- reduction in alcohol-related deaths (baseline to be established)
- reduction in alcohol-related hospital admissions²¹ (baseline to be established)

Action Plan

Our 3-year Action Plan is:

Strategic	
08 / 09	<p>Explore with NHS Social Care Trusts and the National Treatment Agency for Substance Misuse (NTA) how to create a new model of treatment for homeless dependent drinkers (including long-term support)</p> <p>Advocate for increased provision of reduction, detox and rehab funding & facilities for dependent drinkers, and those whose alcohol misuse exacerbates other problems</p> <p>Promote the recognition that harm minimisation and reduction remain key approaches, even though abstinence is our ultimate goal</p> <p>Clarify what we can realistically achieve in relation to abstinence</p>
09 / 10	<p>Ensure that our competency and quality management frameworks support Tier 4 services by 2011, and that our QuADS-compliance matrix for management processes is up-to-date</p> <p>Promote awareness of the other factors (relationship breakdown; low skills & unemployment; poor physical health; low self-esteem / mood disorders; insecure housing) which have to be addressed in conjunction with alcohol treatment</p> <p>Try to ensure that local authorities adequately address in their plans the rehousing needs of drinkers, including for high support move-on</p> <p>Try to ensure that the community safety and the social care agendas "join up" when it comes to tackling harmful and dependent drinking</p>
Developmental	
08 / 09	<p>Develop by 2011, alone or in partnership, reduction, detox & rehab services which can work effectively with rough sleepers and others with complex needs, challenging behaviours, and primary alcohol dependency</p> <p>Ensure that housing management and support procedures incorporate and promote clinical Best Practice</p> <p>Ensure close links to local AA groups for all our hostels, or have on-site groups where users want them</p> <p>Explore the viability of controlled drinking areas and dry / abstinent beds</p>
09 / 10	<p>Explore the need for a refuge for women with alcohol problems who are fleeing domestic violence</p> <p>Devise occupational opportunities for dependent drinkers</p> <p>Explore, with 'Outside In', the possibilities of peer support in promoting recovery for residents with harmful and dependent drinking patterns</p> <p>Seek commissioners' support for developing new reduction, detox and rehab units, with a special emphasis on those with complex needs</p>

¹⁹ Quality in Alcohol and Drugs Services – a national standard for effective services.

²⁰ Drugs & Alcohol National Occupational Standards – a qualification for staff.

²¹ This is a key target in PSA Delivery Agreement 25: Reduce the harm caused by Alcohol and Drugs (October 2007)

Operational	
08 / 09	Ensure all St Mungo's staff in services / projects working primarily with alcohol users are trained to DANOS; and that service procedures are QuADS-compliant
	Ensure that brief screening assessments on harmful and dependent drinking are carried out as part of the initial health check
	Establish the capacity to carry out comprehensive assessments on-site, where drinkers have co-mingled dependent alcohol use with drugs and / or mental illness
	Advocate (in line with harm minimisation) for all drinkers to have thiamine scripts / B12 injections available
	Review the action planning cycle, which may need to be weekly to support more intensive interventions
09 / 10	Provide training in working with dependent drinkers with complex needs
	Develop and promote our model of street population work, targeting street-based alcohol use and associated anti-social behaviour; and work with a broad range of agencies, incl. the police, to ensure that enforcement always co-exists with social care measures
	Launch occupational service for drinkers

iv) Drugs

Background

Although drug use is widespread in the general population, only 0.5% become homeless – drug use alone is thus not the direct cause of homelessness, but drug use is very prevalent amongst those who are homeless. It has been estimated that from 50% to 75% of rough sleepers have drug problems, and in some areas we have identified over 80% of new admissions to our hostels as having problematic drug use, either primarily, or in conjunction with mental illness or harmful alcohol usage.

As with alcohol, the funding streams favour those on a fast-track to abstinence, rather than the problematic end of the spectrum, which is where St Mungo's focuses. "Problematic" means not just poly-use, but also refers to the particularly dysfunctional and disadvantaged backgrounds which tend to characterise this population in our hostels - backgrounds of abuse, violence, parental substance misuse, and often institutional care and prison; many also have psychological and emotional disorders such as personality disorder or PTSD, and many have experiences of psychosis. They are typified by help-rejecting and other avoidant behaviours.

Our track record

We were one of the first homelessness agencies to work coherently with drugs users, and in 1993 developed a legal and practical policy to guide our work. Unlike many landlord agencies, we want to engage, not evict. Our ethos of accepting homeless drugs users as people, even if they do inject illegal substances, is fundamental to our approach.

We have achieved some remarkable successes with this client group, bringing just over 500 individuals into treatment last year (2006 / 2007). Where we have needle exchanges, we achieve more than 100% recovery, i.e. we receive more than we distribute, helping in a practical way to eliminate dangerous syringes from the community. We have also set up in-hostel substitute prescribing services for rough sleepers, bringing into treatment a group of users who had never previously been reached. This service won the runners-up Andy Ludlow Award for "Innovation in Homelessness Services", and an NHS "Innovations in Care" prize, both in 2004; we now have three services, in different PCT areas, and continue to produce high access and retention figures while working with individuals who were, prior to service-entry, among the most chaotic of street-based users.

We also work with specific populations where drug use is tied up with other problems, e.g. sex workers. We run a culturally-specific service for Portuguese drug users in our Lambeth hostel because of the large population in Brixton of Portuguese poly-users with English as a second language, often no ID, and living on the streets or in squats. We have run a 'Substance Reduction Unit' in one of our central London hostels, successfully supporting chronic users to begin the process of change. By developing services targeted at the specific needs of these socially excluded groups, we have been able, in partnership with local NHS services, to develop successful treatment solutions.

Our approach has to date concentrated on making 'low-level' treatments easily available, and all members of St Mungo's Substance Use Team are trained in assessment, auricular acupuncture, motivational interviewing, relapse management, cycle of change, and safer injecting practices. All meet the DANOS requirements of the NTA. Many are also trained in solution-focused short-term interventions, group facilitation, and interventions derived from other professional training, such as social work or addictions counselling. These interventions are available to clients across St Mungo's.

Looking Ahead

Our strengths include the quality of relationship we build with clients, but our efforts can be undermined by a lack of "next step" provision. Beyond having needle exchanges and substitute prescribing in each hostel, we need to develop an alternative form of treatment for people to aspire and move on to – current approaches are too often provision-led, with access to treatment being dependent on the very qualities which our client-group do not have in abundance, namely motivation and stability.

Our overall aim is to enable as many homeless drug users as possible to access treatment options, and thus we wish to explore providing, in partnership with the NHS or third sector providers, the full range of services: reduction, treatment, detoxification, rehabilitation and resettlement with post-rehab support. To do this, we want to design services that are easy to access but hard to be excluded from - a "wide net with a narrow mesh".

We recognise that we also have responsibilities. We know that the earlier that people are engaged, the longer they stay. This illustrates the vital importance which early interventions have in reducing abandonments, itself one of our critical goals in tackling rough sleeping.

A successful drug detoxification project must have five things: (1) specialist management; (2) sufficient specialised staff; (3) good clinical governance and control; (4) local statutory support, and be linked into the network of local treatment/support services; and (5) staff who possess, in addition to the more traditional professional and therapeutic skills, the ability to work with people with complex needs, challenging behaviours, and deeply traumatised personal histories. We have a unique expertise in working with this group.

A consequence of this approach is that we aim to become a provider of Tier 4²² services by the end of this strategy term. We will ensure that any services to our residents, whether delivered by us alone or with partner organisations, will be set within fully-developed competency and quality management frameworks. As with drinkers, we are committed to developing occupational opportunities for drugs users over the life of this strategy; and to developing a full range of move-on opportunities.

Overall Strategy – Drugs

1. ensure that all problematic drug users can access the services they need to contain and reduce their usage;
2. develop an in-house range of services spanning reduction, treatment, detox, rehab and post-rehab support;
3. help drug users improve their overall health, and to obtain work and permanent housing;
4. promote an understanding of the special problems which rough sleeping adds to problematic drug use, and which St Mungo's is particularly well-placed to address;
5. reduce the harmful effects of drug misuse on communities.

²² Residential drug-misuse specific projects.

Service Model	
Service	Target
Our service model for our hostels is:	
Initial screening by keyworker	100% within 48 hours of admission
Assessment for problematic drug usage as part of health-check	100% within 14 days of admission
Peer-support networks	
On-site needle exchange	
On-site substitute prescribing	
Aural acupuncture	
Overdose training for residents	
Blood-borne virus screening	At initial health-check, then at intervals determined by the nurse / GP
On-site reduction programme	
Assessment / case management / referral to treatment (detox and rehab)	
Development of new detox & rehab units, with a special focus on those with complex needs	
Occupational support	
All practice & procedures to be QuADS-compliant	

Resources	
On-site specialist worker	
Specialist on-site staff trained to DANOS	
GP/ nurse prescriber support for issuing scripts	

Key Targets

In addition to those specified above, our targets include:

- year-on-year reduction in proportion of hostel residents identified in the Annual Needs Survey as having a drugs problem but not being in treatment
- 40% of those referred to Basic Skills training achieving the basic skills which the Moser report identifies as the pre-requisites for social functioning, namely numeracy to the standard of NVQ entry level 3, and literacy to NVQ full level 1
- 60% having a resettlement plan
- 25% being in work, or doing work experience or key skills training
- 30% reduction in offending by drug users (baseline to be established)
- reduction in drugs-related deaths (baseline to be established)

Action Plan

Our 3-year Action Plan is:

Strategic	
08 / 09	<i>Position ourselves as experts in working with problematic and street-based drug users with complex needs</i>
	<i>Promote, at policy and commissioning levels, the message that tackling the problematic end of the drug use spectrum needs to be a priority</i>
	<i>Promote the recognition that harm minimisation and reduction remain key approaches and stepping-stones, even though abstinence is our ultimate goal</i>
	<i>Devise, and argue for the implementation of, new forms of treatment for drug users which can offer hope and realistic opportunities for change to rough sleepers who may initially lack motivation and a stable lifestyle</i>
	<i>Try to ensure that local authorities adequately address in their plans the rehousing needs of drug users, including for crisis services, rehab and high support move-on</i>
	<i>Ensure that our competency and quality management frameworks support Tier 4 services by 2011, and that our QuADS compliance matrix for management processes is up-to-date</i>
Developmental	
08 / 09	<i>Draw up a pilot proposal under the government's new Drugs Strategy for personalised treatment planning and commissioning for rough-sleeping drug users</i>
	<i>Explore the possibility of a pan-London crisis service for rough sleepers (similar to City Roads detox)</i>
	<i>Promote the concept of Recovery in our work with drug users – that people with histories of drug dependency, however problematic, can and do lead lives no longer blighted by dependency</i>
	<i>Ensure that all St Mungo's staff working in projects / services for primary drug users are trained to DANOS, and that practice and procedures are QuADS-compliant</i>
	<i>Ensure that housing management and support procedures are reviewed in relation to clinical Best Practice</i>
	<i>Evaluate our projects for sex workers, and develop a service model which is progressive and of national significance</i>
09 / 10	<i>Explore, with 'Outside In', the possibilities of peer support in promoting recovery for residents with problematic drug usage</i>
	<i>Devise move-on models (including in the private sector) with structured support for users who are not yet abstinent, and with a focus on occupational activities</i>
	<i>Develop rehabilitative services for drug users with additional problems, such as personality disorders</i>
	<i>Devise occupational opportunities for problematic drug users</i>
	<i>Develop a residential rehabilitative model for drug users who are not yet ready for detox, so as to enable them to go forward in their lives and to prepare for the next steps in their journey to recovery</i>

Operational	
08 / 09	Promote our model of very early engagement and harm reduction interventions
	Organise systematic and regular blood-borne virus screening in every hostel
	Evaluate the Gt. Guildford St. Naloxone pilot – if successful, extend
	Ensure that rehab is offered as a resettlement option
	Review the action planning cycle which may need to be weekly to reflect legislative standards for drug users
	Ensure that all work with drug users takes place within a recovery approach
09 / 10	Ensure that generic (and not just drug-related) counselling is available to problematic drug users so as to help them to re-acquire motivation, address their personal development, and overcome difficult personal histories
	Introduce, in every hostel where drug usage is common, treatment options which are rapidly and easily accessible to rough sleepers, namely: substitute prescribing; needle exchange; and overdose prevention training

v) Well-being

The DH's *Choosing Health* paper promotes healthy lifestyles. This needs to be contextualised for homeless people, and we are in a strong position to carry out this work for the DH as part of its efforts to address health inequalities.

In addition to tackling illness and poor health, we shall promote physical, economic and emotional well-being in all of our hostels. We anticipate that such initiatives will have a beneficial and demonstrable impact on individuals' self-esteem. The link between occupation and improved well-being (physical and mental) is well-known and well-recognised, which is why the hostel-based *Pathways to Employment* programme has been launched, together with a range of social enterprises.

Just as the NHS wishes to make sure that the patient voice is heard, we expect that increased levels of well-being will flow from our client involvement work, including 'Outside In'. We shall try to evaluate the extent to which well-being increases as a result of an increase in involvement, as we suspect that client involvement is a key means of increasing well-being.

Motivational interviewing and solution-focused problem-solving techniques derive from CBT. They are the kinds of skill which are relevant to our Recovery Approach, and

we shall determine whether they should form part of core training for staff.

Health-promoting activities which are greatly valued by the residents included the "Cook-and-Eat" group; *Putting Down Roots*; and organised excursions away from the hostel. Other activities recommended by staff included art activities, and running a newspaper group to promote discussion.

Overall Strategy – Well-being

1. promote opportunities for residents to undertake physical exercise;
2. ensure that dietary advice is available;
3. secure access to relationship-counselling;
4. embed in every hostel the *Pathways to Employment* programme (ranging from an activities programme run by hostel staff, through basic & key skills training, to job-search);
5. extend client involvement opportunities.

Service Model	
Service	Target
Our service model for our hostels is:	
"Choosing Healthy Options" service for each hostel, delivered in partnership with local PCT's	50% take-up
Access to relationship - and other counselling and psychotherapy	20% take-up
Development of the Recovery Approach in all services	
Access to exercise programmes	
Access to smoking cessation programmes	
Relaxation classes	
<i>Pathways To Employment</i> programme on-site	by mid-2009

Resources

Qualified <i>Pathways to Employment</i> staff	
Qualified relationship-counselling staff	

Key Targets

In addition to those specified above, our targets include:

- 100% of residents being made aware of healthy eating options
- 10% of residents taking up regular exercise
- 100% of residents who smoke being offered access to smoking cessation programmes
- year-on-year increases in satisfaction of those participating in client involvement
- 10% of residents being in paid employment
- 80% of residents engaging in activities

Action Plan

Our 3-year Action Plan is:

Strategic	
08 / 09	Identify, and work with, the partnership group within each Local Area Agreement which addresses well-being
Developmental	
08 / 09	Provide wraparound services, recognising that well-being affects whole people and whole lives, not just subsections of them defined as needs categories
	Draw up, in partnership with PCTs, a Healthy Living programme for every hostel, with specific targets for exercise; diet; and smoking cessation
	Continue to promote and develop client involvement
10 / 11	Assess the relevance of complementary / alternative medicines
Operational	
08 / 09	Develop and promote the Recovery approach in all our projects and services, and promote an ethos of recovery in our partners
	Assess the extent to which staff training in some Cognitive Behaviour Therapy (CBT) is desirable, and secure accordingly
09 / 10	Offer routes into psychotherapy or counselling for every resident who is a survivor of childhood abuse or other trauma
	Offer every hostel resident access to relationship-counselling with 'Relate', or similar
	Embed our Pathways To Employment project in every hostel

4. World-Class Commissioning

London Priorities

Our emphasis on a 'niche' client group which is numerically small does create difficulties for any "mass market" commissioning, but securing an on-site targeted service within a hostel ought to be achievable.

In order to make our case for London-wide commissioning, the solidity of our evidence base will be critical. It will also be essential to have the support of e.g. in the case of drugs, the NTA and the London DAATs, or in the case of physical health, NHS London and the Mayor, and our influencing priorities will be directed at these audiences. We suspect that the onus will nevertheless be on us to show how local / borough-based 'pathways' can, with little effort or cost, be reconfigured to become a regional 'highway'. This reminds us that as well as each individual needing a pathway, strategically what is required is a map.

Multi-disciplinary Priorities

The untreated ill-health of the rough sleepers who use our services does not derive solely from a lack of self-care, or exclusion from medical services. Social and occupational disadvantage also play a role. In this sense cross-boundary commissioning refers not only to the imperative for cutting across geographical boundaries, but also disciplinary boundaries. This is why commissioners from housing, work and education need to support St Mungo's overall endeavour, as in so doing they will be underpinning our health plans.

Hospital Discharge

Hospital discharge is still a fraught area, with some very poor practice in London. There are three aspects to this:

Firstly, we will press for every resident discharged from hospital to have an appropriate treatment plan with follow up. We shall monitor these, as we wish to work with Hospital Trusts, and others, to develop or implement protocols which ensure safer discharges.

Secondly, we have particular concerns about the small number of people who are discharged each year for whom there is absolutely no suitable destination in the

community, and many of whom die without dignity as a result. We wish to work with NHS London and local Trusts to develop a residential social care / medical hybrid (a 'step-down' facility) which can help people to reach the medical stage where they will be able to cope with the social care facilities available in the community.

Thirdly, we wish to pilot a 'hospital at home' project which can both offer sufficient medical care to make hospitalisation unnecessary, and act as a 'soft landing' for residents being discharged from hospital.

Gaps in Services

Throughout this strategy we have identified a number of gaps in services. These usually make commissioners nervous by virtue of their being by definition untried and untested. To make our case will require us to plan our evidence base in advance, but will also require commissioners to take a less risk-averse approach. World-class commissioning implies taking managed but real risks to support genuine innovation.

Commissioning

We wish to work with and alongside PCT commissioners to test some of the new approaches, and in particular:

- Focusing on outcomes, not on inputs / outputs;
- Having a tripartite approach to designing services, involving commissioners, service users, and providers;
- Piloting individual budget-holding

Key Target

- 100% of residents having an appropriate treatment plan, with follow up, on discharge from hospital

Action Plan

Our 3-year Action Plan is:

Strategic	
08 / 09	<i>Press for the creation of a London-wide homelessness commissioning body, led by the Mayor and NHS London, and advised by a lead PCT, specialist London providers, and service users</i>
	<i>Promote the establishment of joint ventures with the NHS to deliver service improvements which are tied to healthcare targets</i>
	<i>Promote individualised, needs-led commissioning in line with 'Independence, Well-being and Choice'</i>
	<i>Look into the potential of individually-held budgets for rough sleepers</i>
	<i>Press for regional targets for reducing health inequalities affecting vulnerable adults with complex needs, and specifically rough sleepers</i>
09 / 10	<i>Identify (and provide evidence of) gaps in service, and draw up proposals for filling them</i>
Developmental	
08 / 09	<i>Propose outcome frameworks for physical health, mental health, and drugs and alcohol dependency</i>
09 / 10	<i>Draw up proposals for enhanced convalescence facilities within (some) hostels, in conjunction with local hospitals – a variant of 'hospital at home'</i>
	<i>Try to influence the design of commissioned services so that they become needs-led and person-centred</i>
	<i>Contribute to joining-up services locally and regionally (PCTs, specialist dependency services, local authority social care and housing)</i>
	<i>Strengthen user involvement and build up users' capacity to influence commissioning decisions and service design</i>

5. Improving the Effectiveness of Healthcare Interventions

Training

Leaving aside the question of whether or not the right services are in place and accessible, the effectiveness of interventions is diminished by various factors including, for example, inadequate knowledge of available health services in the case of our staff, and of the specific needs of homeless people in the case of NHS staff, and poor communication between our staff, NHS staff, and our residents.

A better mutual understanding and respect between St Mungo's and the NHS is essential. We believe that two-way training can go a long way towards achieving this, as can the joint development of protocols and SLAs (Service Level Agreements), and joint service-delivery ventures (such as our hostel-based prescribing services). We shall explore the possibilities of working in partnership with NHS Health Promotion Teams.

Ways in which we shall overhaul our training programme include:

- Develop training programmes for our staff and for health professionals working with rough sleepers, in partnership with local PCTs, Mental Health Trusts (MHTs), NHS London, and other providers
- Agree competency levels for all hostel staff, Health Support Workers, and Health Champions
- Develop the capacity of residents to identify their own health-care needs so they can recognise illness; have the confidence to self-diagnose and self-medicate; overcome fear and embarrassment when discussing symptoms; and are able to describe them to third parties
- Develop a CPA²³-style approach with health and social services through joint-working protocols where residents have complex health problems
- Explore with the teaching hospitals the possibility of St Mungo's offering placement opportunities for trainee health and mental health professionals, such as medical students or assistant psychologists, building on the success of our excellent placement support work with social work trainees
- Review training in confidentiality to ensure that residents can have increased faith that medical and personal confidentiality are respected

- Ensure that housing management and support procedures reflect and promote clinical Best Practice

Barriers to access for homeless people

These are known, and include:

- institutional factors, such as opening times, the way appointments are managed, location and discrimination;
- financial disincentives for GPs to register rough sleepers;
- lack of integration between primary care and secondary care, and between healthcare and other local, non-health services;
- lack of personal skills from both NHS staff and rough sleepers themselves;
- transport costs; and
- lack of accompaniment.

Specialist support

We have created a role of 'health champion' in our hostels, the purpose of which is to develop a basic knowledge about local NHS services and how residents can access them; spread that knowledge amongst keyworkers; and act as a nominated contact point for those local services with the hostel. It is an additional role for an existing hostel worker.

What we hope to do is to secure the funding to enable us to upgrade this role into a full-time post of Health Support worker in each hostel. Post-holders would have a comprehensive knowledge about health services available both locally and regionally; would advise and oversee health training for project staff; help keyworkers act as 'brokers' between their residents and NHS services; and monitor needs levels, compliance with treatments, and progress towards meeting key targets. This is an important role which will help residents and staff to navigate a care system which is complex and not particularly user-friendly. If we can train key staff to be health advocates for our residents and facilitate access to specialist services and customized hostel-based health interventions delivered by the PCT, then we will be making a substantial contribution to increasing the effectiveness of healthcare. We will also be saving wasted time, and thus money.

²³ The Care Programme Approach was introduced in 1991 as the basis for planning and delivering the through-care and after-care of people with mental health problems. CPAs have four stages (systematic assessment; development of a care plan; identification of a key worker; and regular review), and operate at four levels – minimal; more complex; full, multi-disciplinary; and the Supervision Register. CPAs link into the Care Management practised by local authority social services departments.

Just as the *Supporting People* funding stream addresses housing-related support, so we see a clear need to address health-related support – the logic of which argues for a funding stream parallel to *Supporting People* to enable this.

Use of Services

Good health is not just attained by providing services – people also have to use them. We know that many of our residents do not use services which are available, which is why a vital part of our staff's role is to accompany them to appointments if needed; to attend case conferences; to support planned hospital discharges; and to encourage people to remain with prescribed treatments. This will be an important development in the role of keyworkers, and it is crucial that funders allow for sufficient staff to enable effective out-of-project support.

Self-management of Health

An often-overlooked dimension is that of strengthening an individual's capacity to access healthcare by using advocacy and counselling to build up their resources so that they can:

- ✓ navigate the system themselves;
- ✓ recognise the onset and development of illnesses;
- ✓ and (by helping them develop their self-esteem) make improving their health a personally-owned priority.

Training

There are two key training areas. The first is to improve St Mungo's staff knowledge about the following areas:

- health services within the hostel, and how to access them
- NHS health services in their area, and how to access them
- basic health needs assessment and knowledge about what health conditions should be prioritised
- how to advocate for residents to receive NHS health services
- supporting residents' discharge from NHS care

The second key training area concerns NHS staff. Many St Mungo's staff and residents mentioned incidents when residents had received substandard services from the NHS,

or there had been a significant event with adverse health consequences due to poor communication from NHS staff.

PHAST recommends that NHS staff should have better training about the health needs of homeless people, as well as better communication and consultation skills which are sensitive to the sorts of health problems which homeless individuals have. A significant barrier to residents accessing NHS services was the attitude of NHS receptionists, and inflexible NHS appointment systems.

St Mungo's wishes to train keyworkers in the fundamentals about ill-health, and develop simple protocols which identify signs and symptoms that should alert the need for urgent care. In addition, St Mungo's wishes to ensure that keyworkers receive training in advocacy skills to support their residents access mainstream services.

The question of record-keeping, and the rigour of confidentiality which should surround personal records, was examined particularly closely by PHAST.

The concept of residents having their health records in one place, in electronic format, was generally welcomed. There seems to be value in residents using the NHS *Connecting for Health HealthSpace* website (<https://www.healthspace.nhs.uk/>), as well as their using the **Summary Care record** so that their details can be accessed by whichever health service they use.

There are interesting issues about patient confidentiality. St Mungo's clearly has to absolutely guarantee confidentiality. At the same time, integrated care / support pre-supposes information-sharing between professionals. This cannot be done without the individual's approval, and thus the notion of **informed consent** is likely to become more important to us.

The reality is that health professionals routinely share concerns with hostel staff about residents' health. The confidence of staff that confidentiality is maintained is not necessarily shared by residents, as PHAST discovered. Some residents had concerns that permission was assumed. They recommended that residents' permission should be sought if information is used other than in an emergency, and this has highlighted an area for further training in St Mungo's.

Action Plan

Our 3-year Action Plan is:

Strategic	
08 / 09	Establish St Mungo's Health Forum to keep strategy implementation under close review; analyse emerging policies; and keep abreast of issues emerging in hostel Health Forums Identify key contacts (especially in commissioning) within each PCT area where we run hostels
09 / 10	Ensure that St Mungo's IT strategy includes computer terminals in each hostel for residents to access health advice websites (NHS Direct; Dr Foster); and to participate in the development of London-wide health information recording, such as on HealthSpace Make the case for a funding stream for health-related support (similar to "Supporting People")
Developmental	
08 / 09	Map local (& regional) healthcare services useful for rough sleepers, and access routes into them Define the role of Health Support Worker and the role of Health Champion; and train accordingly Establish health forum within each hostel to monitor trends, access to services, outcomes and unmet needs: and link these into St Mungo's Health Forum Devise basic training for our hostel keyworkers to: <ul style="list-style-type: none"> • enable them to recognise the signs and symptoms of ill-health, incl the need for urgent care and treatment; • ensure they are familiar with local services, and how to access them; • ensure they (and night workers) are familiar with "out of hours" services, and how to access them
09 / 10	Make the case for a Health Support worker in each hostel Devise joint training for our staff and key healthcare staff in each PCT & MHT Work with the local NHS to develop rough sleeper-friendly treatment pathways Develop the capacity of residents to identify their own health-care needs so they can recognise illness; have the confidence to self-diagnose and self-medicate; overcome fear and embarrassment when discussing symptoms; and are able to describe them to third parties Develop joint working protocols with health and social services through a CPA-style approach where residents have complex health problems Explore with the teaching hospitals the possibility of St Mungo's offering placement opportunities for trainee health and mental health professionals, such as medical students or assistant psychologists
Operational	
08 / 09	Review staff competencies, and plan and develop tailored training so as to ensure that St Mungo's healthcare priorities are delivered Ensure health issues are regularly featured in managerial monitoring and performance systems

6. Strengthening our Evidence Base

We will collect routine data about the extent of our residents' healthcare needs, and the extent to which these are being met, using the performance targets set out in this strategy. These will be reinforced by data collected from our annual Needs Survey (which we will overhaul to improve its reliability), and from 'ad hoc' surveys. We will undertake broad health surveys of our residents from time to time, and more in-depth health surveys at individual hostels or within specific client sub-groups, working in conjunction with NHS commissioners and providers to ensure that the most useful data is collected.

We will develop clear Performance Indicators against which to measure our progress, and which will; be incorporated into our performance management systems, including our organisational KPIs. As part of our organisational KPIs, performance against health targets will be reported to the Board.

We will ensure that there is regular dissemination of best practice across our hostels; and that our Quality manual procedures are kept up-to-date.

We wish to ensure that all personal health data is managed according to NHS guidelines; and that hostel residents have access to the new opportunities being offered by NHS *Connecting for Health*, such as the **Summary Care record** and **HealthSpace**.

We will also explore how to measure our health-related impact on the communities where we work. We will record key public health data (the incidence of BBVs, STIs and TB), as well as our successes in keeping people housed and in treatment.

We will ensure that our drugs / alcohol interventions are being entered onto NDTMS²⁴ each month.

Advocacy is an important component of St Mungo's approach to helping homeless people obtain better access to healthcare. Part of this advocacy is monitoring cases when things go badly wrong, up to and including making formal complaints on behalf of individual residents to hospitals or other NHS providers. This is time-consuming, but will be one of the priority areas for our Health Group Manager:

Evidence must not be confined to outcomes defined by commissioners or providers. We shall work with our residents to better understand the outcomes which they consider valuable, and shall include these in our future data-gathering.

Action Plan

Our 3-year Action Plan is:

Strategic	
08 / 09	Overhaul our annual Needs Survey
	Develop clear Performance Indicators, and incorporate them into our organisational KPIs
	Settle on a measure of Well-being which has credibility with commissioners and is easy to train staff in
Developmental	
08 / 09	Devise a method for routinely collecting health data in our hostels (with the IT systems to support it)
09 / 10	Review our confidentiality policy and practice, ensuring consistency with the Data Protection Act and with NHS guidelines
	Undertake in-depth health surveys within the hostels to measure the impact of better access to better healthcare
	Ensure that there is a means of capturing Best Practice; and that it is relayed back into our Quality procedures
10 / 11	Agree information-sharing protocols with hostel-based and other primary care services
	Work with 'Outside In' to define measures which indicate evidence of success in service delivery
Operational	
08 / 09	Monitor and challenge poor practice in hospital discharges, or social services or mental health assessment
	Record use of ambulances, A&E and other acute services
	Record length of stay in hospital
	Record treatment plans and compliance levels
	Monitor all suicides, and attempted suicides
	Undertake routine and periodic health surveys
	Report on healthcare interventions prior to any deaths

²⁴ National Drug Treatment Monitoring System – a centralised database maintained by the NTA which collates interventions by drug agencies.

7. Influencing Priorities

We will back up the development of our service-delivery model with a programme of campaigning and lobbying.

Our target audiences and messages are:

Department of Health

- Rough sleepers to be a priority group
- Review, with CLG, the roles and effectiveness of ex-HMII outreach teams
- Serially-excluded groups (including rough sleepers) to be a high level indicator in the "refreshed" Health Inequalities strategy
- Funding stream for health-related support

CLG

- Proportion of people on the streets with a mental illness to reduce to zero in 3 years
- Review, with DH, the roles and effectiveness of ex-HMII outreach teams

Cabinet Office

- Press for joined-up government which links housing, health and work
- Rough sleepers to be a priority group for government programmes on social exclusion

Greater London Authority

- Rough sleepers to be a priority group in Health Inequalities targets

NHS London

- Rough sleepers to be a priority group
- Specialised Primary Care service for rough sleepers to be commissioned on a pan-London basis
- Establish a London-wide forum to address health policy as it impacts on homeless people (and perhaps develop commissioning of specific specialized secondary services at this level)
- Support a London-wide 'step-down' facility for rough sleepers
- Discuss with Public Health colleagues the opportunities for St Mungo's to contribute to targets which address *Choosing Health*

PCTs

- Rough sleepers to be a priority group
- Approach London Specialised Commissioning to make rough sleepers a priority medical group
- Press Community Profiles website to acknowledge rough sleepers
- Identify which PCT targets we can contribute to

Local Authorities

- LAA targets to include health-care needs of rough sleepers
- LAA Health and Well-being panels to include rough sleepers as a priority group
- Joint Strategic Needs Assessments (JSNA) to include rough sleepers
- Housing strategies to include the rehousing needs of people with a mental illness, and / or drugs or alcohol problems
- Join up community safety and social care agendas in relation to alcohol
- Tackling drug users at the problematic end of the spectrum should be the main priority for DAATs

National Treatment Agency

- New forms of treatment needed for rough sleepers
- Treating drug users at the problematic end of the spectrum should be the main priority for DAATs
- Increased provision of alcohol treatment
- People with chronic dependency problems should be able to have individualised treatment plans

8. Costings

We have costed the service model in this strategy according to our best available information. Some of costs are fixed, others variable: in addition, some elements of the service are already in place. Overall, the *per annum* costs for a 60-bed hostel are:

	Fixed (i.e. per hostel)	Variable (i.e. per person)
Physical Health	£15k	£890
Mental Health	£29k	£967
Alcohol	£20k	£941
Drugs	£47k	£941
Well-being	£26k	£67

For the pilot phase, we have identified three hostels (Cedars Rd (120 beds), Cromwell Road (56 beds), Endell Street (56 beds) – total 232 beds) in which to test a pilot for up to 15 months. The total cost comes to £1.6 m, which equates to £106 per person per week. This includes an amount of £40 k for evaluating the pilot.

APPENDIX I - External Context

The aim of our strategy is to find practical ways to improve the health of rough sleepers and other homeless people, especially those with complex needs. At the same time as working with the NHS to help develop its capacity to meet the needs of this client group, we will also be working with the NHS to meet its own targets on health inequalities, life expectancy, TB, infectious diseases, palliative care etc. It is only by working together that we can both meet our objectives.

Overall NHS / DH priorities in health and social care have been set out in a number of White Papers and Strategies over the past few years. The most significant ones for St Mungo's are:

1. **Choosing Health: making healthier choices easier** (2004) outlines the government's approach to public health. Underpinned by 3 principles (Informed choice; Personalisation; and Working Together), it sets out over-arching priorities covering: smoking reduction; reducing obesity and improving diet; encouraging and supporting sensible drinking; improving sexual health; and improving mental health. These areas will be addressed by focusing on "marketing" and the dissemination of health information; an early-years approach to health promotion; supporting local communities to take action; and helping people to make healthier choices.
2. **Our Health, Our Care, Our Say: a new direction for community services** (2006) emphasises the need to become more responsive to patient requirements, and the promotion of healthy lifestyles in order to prevent ill-health and dependency. It seeks to ensure that people have choice in their care services, and that these are delivered closer to home. Highlighted areas include: addressing mental well-being, especially via talking therapies; improving ease of access to GPs; linking healthcare to social care; improving the availability of information; introducing Life Checks; personalising health care plans for people with long-term conditions; supporting carers; smoothing out "postcode lotteries"; and improving choice and accountability.

3. An outcome of **Our Health, Our Care, Our Say** was the **Commissioning Framework for Health & Well-being** (2007) which recognised that NHS commissioning is too focused on volume and price, and insufficiently on quality and outcomes. A new framework is proposed which concentrates on people in the context where they live their lives – i.e. work, housing and social care – in order to promote personalised services, well-being and partnership working to reduce health inequalities. **Vision for World-class Commissioning** (2007) is a statement of intent, setting out an ambition for delivering better care and better value by taking a strategic, long-term approach. The expectation is that evidence-based decisions will deliver more personalised and better quality services. The profile of world-class commissioners is set out as (1) local NHS leaders; (2) community partners; (3) knowledge experts; (4) strategic planners; (5) market innovators; and (6) process managers.
4. **The Next Stage Review: Our NHS, Our Future** (due to report in June 2008) seeks to identify the way forward for a 21st century NHS which is clinically-driven, patient-centred and responsive to local communities. It is considering the role of the Third Sector in delivery in the context of ensuring more accessible and convenient care, integrated across primary and secondary providers, so that we all have a health service based on patient control, choice and local accountability.
5. **Tackling Health Inequalities: A Programme for Action** was launched in 2003 and focuses on reducing the gap in infant mortality across social groups; and the difference in life expectancy at birth between those living in the most disadvantaged areas and the rest of the population. It is a cross-government strategy, backed by 12 departments, and sets out targets to be reached by 2010. Since then, the Mayor of London has been authorised to produce a **Health Inequalities Strategy** for London, which has statutory force for PCTs. Entitled **Living Well in London**, the draft sets out key aims of encouraging physical activity; supporting long-term investment to reduce poverty; improving access to primary care and NHS services; supporting individuals to make healthier choices; and promoting well-being in the workplace.

6. Lord Darzi is leading a review called **Healthcare for London** which recognises the challenges posed by greater usage of the NHS, the increasing cost of drugs and new technologies, and growing longevity; and sets out draft proposals for improving the quality of care, improving access and reducing inequalities of care.
7. The Home Office has published a new 10-year drugs strategy **Drugs: protecting families and communities** which explores the idea of new approaches to treatment (whilst affirming existing pathways), but places the emphasis on better integration of enforcement, prevention and family work.
8. **Safe. Sensible. Social** is a progress report on the government's **Alcohol Harm Reduction Strategy** (2004) aims to minimise the health harms, violence and anti-social behaviour associated with alcohol. It focuses on 3 groups of problematic drinkers – young people under 18 / 18-24 yr-old binge drinkers / harmful drinkers.

The Mayor's report on drinking (**London Agenda for Action on Alcohol**, 2006) identified the main focus of the local London strategies as:

- Increasing awareness of risks of alcohol, particularly in target populations of young people, pregnant women etc
- Reducing alcohol-related crime, especially violent crime and disorder and anti-social behaviour
- Preventing underage drinking
- Improving alcohol treatment services in line with MoCAM²⁵

9. **Improving Access to Psychological Therapies in Primary Care** (2007) sets out the government's commitment to improving access to psychological therapies, backed up by increased funding over three years. This initiative includes guidance on how the NHS can implement NICE's²⁶ computerised CBT. This document was backed up by a **Commissioning Toolkit** (2008), designed to help those with depression and anxiety disorders. This work is still in development, and St Mungo's hopes to influence its approach to people with complex needs through the ACE pilot.

10. **Independence, Well-being and Choice** (2005) was a social care consultation document which, although it never led to a formal policy response from government, has nevertheless been used to inform many of the papers and policy positions outlined above.

Overall

These are important documents which set the agendas with which St Mungo's will have to engage. Our fear is that their complexity will make it difficult for organisations which are not predominantly medical to be taken seriously by policy- and decision-makers. It remains to be seen whether government's faith that the healthcare needs of all can automatically be met by combining an ethos of personalisation with local prioritising is justified. In the meantime, we shall continue to highlight the shortcomings of access to services.

²⁵ *Models of Care for Alcohol Misusers* (NTA, 2002).

²⁶ National Institute for Health & Clinical Excellence.

APPENDIX 2 - Hostels List

Short-term Shelters

		Beds 2008 / 09	2009 / 10	2010 / 11
Southwark	Rushworth Street	31	31	31
Westminster	Seymour Place	32	32	32

Hostels

Brent	Pound Lane		78	78
Camden	Endell Street	57	57	57
	Endsleigh Gardens	57	57	57
	Birkenhead Street		35	35
	9 St Pancras Way	22	22	22
	Gray's Inn Road	15	15	15
Hackney	Church Walk	29	29	29
	Mare Street	60	60	60
Haringey	Vartry Road	23	23	23
K&C	Cromwell Road	56	56	56
Westminster	Harrow Road	31	31	31
Lambeth	Cedars Road	120	120	120
	Palace Road		18	18
Southwark	Great Guildford St	47	47	47
	Grange Road	38		
Lewisham	Pagnell Street	43	43	43
	Ennersdale House		40	40
	Garden House	22	22	22
Total	beds (hostels)	683 (16)	816 (19)	816 (19)



We are London's largest charity for homeless people and people whose complex needs mean they are at real risk of street homelessness. We provide over 100 accommodation and support services day in and day out.

We run **emergency** services – including street outreach and emergency shelter. We support homeless people in their **recovery** – opening the door to safe housing, health care and work. We help more homeless people into lasting new homes, training and employment than any other charity.

We also **prevent** homelessness through our complex needs housing and support teams for people at real risk.

By opening our doors, and our support services, we enable 1000s of homeless and vulnerable people to change their lives for good every year.

For more information contact:

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www.mungos.org

Charity exempt from registration

I&P Society No.20598R

Housing Association No. LH0279

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St Mungo's 
Opening doors for London's homeless