Integrating the NICE Guidelines on Integrated Health and Social Care for People Experiencing Homelessness

Examples of best practice

March 2025

VCSE health & wellbeing alliance

Groundswell – Out of homelessness

Homeless Link

Pathway – Homeless & Inclusion Health

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Contents

Introduction

The following case studies have been gathered to showcase good practice in delivering on the principles behind the NICE Guidelines on Integrated Health and Social Care for People Experiencing Homelessness (NG214).

The case studies were gathered by the Homeless Health Consortium, a collaboration between Groundswell, Homeless Link and Pathway, leading VCSE organisations working to reduce health inequalities for people experiencing homelessness.

The work was delivered on behalf of the Department of Health and Social Care (DHSC) as part of the Health and Wellbeing Alliance (HWA). The HWA is a joint programme funded and administered by DHSC, NHS England (NHSE) and UKHSA. The DHSC-led Alliance programme is designed to facilitate collaboration and co-production between the voluntary and community sector and health system partners – DHSC, NHSE, and UKHSA – by bringing the voices and expertise of the sector, and the people and communities they represent, into national policy and delivery.

We are very grateful to the organisations represented within the case studies for giving up their time to speak with us.

Case Study 1 – Integration of services

NICE recommendation: *Provide intermediate care services with intensive, multidisciplinary team support for people experiencing homelessness who have healthcare needs that cannot be safely managed in the community but who do not need inpatient hospital care.*

Case study: Discharge to Assess Pathway Intermediate Care unit for people experiencing homelessness, South of England.

33 step-down and 7 step-up out-of-hospital beds delivering support to people at risk of street discharge for up to six weeks. The service hosts a Social Worker, Psychologist, Occupational Therapist, Housing Officer and Support Workers, with oversight and coordination from a programme manager. Peer support workers with experience of homelessness are an integrated part of the service delivery.

The service was set up in 2021 after research found an estimated 7 in 10 people experiencing rough sleeping would be discharged to the street after a hospital admittance. The team has supported over 600 safe, planned and timely discharges from hospital since the service began.

The service has achieved significant impacts, with an overall reduction in street discharge, increased quality of life measures among those the service works with and reduced burden on frontline staff. There has been a culture shift towards integrated care, and patients are now active attendees at their multi-disciplinary team meetings. The impact of the service reaches beyond the immediate system, with reduced criminal activity and increased engagement with drug and alcohol services among the patient group

The service monitors its impact through intelligent data analysis. Leaders reflected the need for flexibility in performance monitoring, as traditional or population-wide measures are often poor at reflecting success for people with experience of homelessness.

"It can be hard to measure preventative work, but we do. For example, we track elective and un-elective hospital usage - ED, general acute and mental health - pre and post our service. You can see significant reductions in emergency presentations and crisis admissions across the board, breaking cycles that are, in some cases, decades long."

Leaders reflected that, while data helped make the case for the service, it is patient stories which truly reflect the significance of the support delivered by the service.

"It saved her life. She had spent decades going in and out of hospital, and had nowhere to go by the end of it. [The service] really saved her life. Now, she's got two jobs, she sees her kids again, she's got her own flat. It's a life changing intervention."

The service is currently funded until March 2025 following a grant awarded through the Better Care Fund, with additional funding through the local Integrated Care Board. This was a significant investment and one of few examples of Better Care funding being targeted to support people experiencing homelessness.

Case Study 2 – Multidisciplinary teams, role of the peer

NICE recommendation: *Provide care through specialist homelessness multidisciplinary teams across sectors and levels of care, tailored according to local needs; Involve peers (experts by experience) in delivering and designing services.*

Case study: An infectious disease outreach team working across London.

The service delivers assertive infectious disease diagnosis and treatment for people experiencing homelessness. But infectious disease is, in many ways, a "trojan horse" that opens a door to support with biosocial health risk factors such as housing, addiction and welfare, through which they are able to promote treatment adherence and increase resilience against future infections. The team are deliberately assertive in their approach, going out to treat people where they are rather than expecting them to attend a service or pre-planned appointment.

"If we're going to address health equities, you have to do that in a proactive and targeted way. It doesn't happen by magic."

The team house a wide variety of professions, including clinical staff, nurses and social workers. At its core the service is peer-led, ensuring people with direct experience of homelessness are included at every stage of its design and delivery. Peers often began as patients of the service and are trained and supported to deliver advocacy, health testing and research.

The service works closely with other community-based charities and organisations to bolster local support networks and deliver care around the patient. Within service, the multidisciplinary approach cuts across all staff members, including peers, to ensure that everyone can deliver point-of-care testing across diseases.

"We had a [temp staff member] and it was only on the day he left that he realised I wasn't a nurse. He thought the whole time that I was a nurse because I was doing the exact things the nurses were doing. Being a peer can be fully involved – it doesn't have to be tokenistic."

The service has been evaluated multiple times since its inception in 2002 and has demonstrated its impact and effectiveness through this. Service leaders have taken a conscious choice to embed a research agenda to ensure the credibility of the service and demonstrate value and return on investment. The service has been found to be cost effective and likely cost saving by reducing severe multimorbidity. Service leaders emphasised the replicability and scalability of the service model: "What we do is relevant to every nook and cranny in this country".

Case Study 3 – Data led integration between health and homelessness

NICE recommendation: *Local homelessness health and social care needs assessments should quantify and characterise the population experiencing homelessness or at risk of homelessness, including health inequalities, diversity and inclusion issues and specific needs and identify trends.*

Case study: Data-led integration between health and homelessness sector in London.

One borough in London has invested in an innovative approach to data monitoring to improve their understanding of rough sleeping in their local area. The approach is facilitated by a third-sector organisation and enabled via engagement from the local authority, health teams and other homelessness providers.

The project involves a detailed live database of people sleeping rough in the borough, with case data fed in weekly by local partners. Enabled by a strong history of partnership working across the borough, the project allows for in-depth analysis of trends and changes locally, and enables the wider system to adapt delivery to more accurately adapt to needs locally.

The project has improved data capture around who and how people sleep rough. This includes the capacity to monitor people who self-identify as rough sleeping without having been verified, meaning the data management approach is more inclusive of 'hidden' homelessness and women's experiences. Between Oct 2023 - June 2024, the project had 34% more referrals than individuals captured on CHAIN, with 54% more referrals for women. This shows the gender informed definition in action, capturing more people, especially women, who would not have been recorded as rough sleeping.

"Partner agencies have a better understanding of what each of their teams do and their structure. I know it sounds basic, but if the drug and alcohol service have a rough sleeping outreach worker, it helps understanding what they do, and how they can link in with other services."

The impact of the project is, in part, evidenced through the improved partnership working at local level. The engagement of partners across the system has allowed the area to embed a system-change approach during fortnightly meetings, identifying overarching trends and system blockers. This includes from within health systems, with hospital inreach teams, mental health teams and the ASC commissioner all included in the partnership.

"The methodology works, but there needs to be resource investment in it, services that buy in, understand where we're trying to get to and see the benefit of it."

The project is funded through a private grant. Delivery partners recognised that maintaining the database is relatively resource intensive, and recognised that, for other agencies, finding that resource with their already stretched time was a challenge. However, the local innovations permitted by the project have already improved service delivery and relationships with commissioners, and delivery partners advocated strongly for its rollout across more places in England.

Case Study 4 – Multidisciplinary hospital teams

NICE recommendation: *Provide care through specialist homelessness multidisciplinary teams across sectors and levels of care, tailored according to local needs.*

Case study: A nurse-led hospital team designed to support safe discharge and bridge the gap between primary and secondary care in the North of England.

The team aims to reduce unsafe discharge, unscheduled A&E presentations, reduce stigma and maximise the benefit of a hospital admission as a chance to support people towards recovery.

"All through the service, we've tried to get the hospital to think about how it operates around our clients with unmet need, and we've tried to highlight what it is that life is like for them."

The team support discharge and follow up with clients after 2 and 6 weeks to ensure discharge plans are working and prevent readmission. The team consists of a non-clinical manager, a lead nurse, 2 GPs, a care coordinator, support worker, and nurses. The team are spread across the hospital and community. The team advocates for their clients to different teams within the hospital, promoting an understanding of how trauma and multiple disadvantage can affect patients' behaviour and how services should adapt to meet their needs.

"I'm always going to have to be challenging people and trying to do that in the most supportive way that I can to get the right outcome for the patients."

The team works closely with other agencies such as MEAM, social care, justice, primary care, housing, social services, the rough sleeper team and a specialist sex worker charity. They have a data sharing agreement via Changing Futures and share information through FutureNHS, over email and at multi-agency meetings. They have more localised sharing arrangements, such as with the frequent attendance service and other teams across the hospital.

"We're a little piece of a big jigsaw. We can be working with 10 or 12 other agencies or individuals from other agencies."

The team presents impact data every 3 months to their commissioners. The team reported that a few quarters ago, the figured showed that they had reduced rough sleeping among their clients by 50%, but that more recently the effectiveness had reduced for a number of reasons – a lack of step-down beds, a lack of facilities, the increasing number of people experiencing homelessness, and the increasing complexity of the situations facing their clients.

In their first year, the team saw 253 patients, with a 77.5% decrease in rough sleeping seen among those patients, and a 100% increase in the number of people in secure accommodation on discharge. 21 people non-registered with a GP on admission were registered with a GP on discharge, and 83 people had their contact details accurately updated to enable follow up. The team was able to refer 85.5% of eligible people with their consent, and identified 50 frequent attenders to the hospital, with 20 receiving detailed care plans. The impact of the pandemic and Everyone In must be taken into account when considering this data.

Initially commissioned in 2019, a third sector partner now leads the team alongside the NHS and local council, funded for 5 years until 2026. The team acknowledged that having this relatively stable funding has had a very positive impact on how they have been able to work.

Case Study 5 – Multidisciplinary community teams

NICE recommendation: *Provide care through specialist homelessness multidisciplinary teams across sectors and levels of care, tailored according to local needs.*

Case study: A specialist primary care service for people experiencing homelessness in London.

They aim to operate as a one-stop shop for homeless health, with a multi-disciplinary model that includes nurses, counsellors, a mental health nurse, a psychiatrist, GPs, a podiatrist, and physiotherapy clinics. Emerging local needs means they now also run a specialist Roma clinic.

"We have a team meeting every Tuesday morning for 2 hours where everybody comes, we often have external agencies dropping in as well, and we use that time to discuss patients who really need that team input [...] The multidisciplinary element of it is the cornerstone of what we do."

They have 29 health beds across 4 different sites, with 20 funded through the Rough Sleeping Initiative, 4 additional beds through a different NHS pathway, and 5 women's health beds as part of a new women's health project. They employ a Health Pathway Coordinator with lived experience of homelessness, whose role is to triage referrals and work out the best possible placement for clients, as well as linking in with other services. The Coordinator attends a wide range of meetings such as discharge planning and outreach meetings in hospitals, multidisciplinary meetings within rough sleeping pathways, meetings at GP practices and meetings in hostels. This provides a level of continuity to clients, supporting their navigation of services and ensuring they don't have to repeatedly describe traumatic experiences.

"When the referral comes to me, I triage and I send to the appropriate hostel. I attend their weekly meetings while they're in a health bed and I'm part of the MDT discussing what happens there. [...] I'll stay with them until hopefully whatever health need they've come in with has been addressed [...] From beginning the journey to the end, I'm the constant all the way through that."

More widely, service representatives work closely with other homelessness sector services, rough sleeping mental health services, local authority commissioners, day centres, outreach services and other third sector organisations. They have strong links with adult social care and safeguarding leads at the local authority, and attend various multidisciplinary teams. Their work is informed by key guidance such as the NICE guidelines. The service aims to be responsive to new pieces of research, such as a forthcoming thematic review of homeless deaths, and uses their local intelligence or anecdotal evidence to decide on new research or data that may be required. Representatives also attend the council's quarterly deaths monitoring meetings.

The team produce quarterly and annual reports for their commissioners about the outcomes and impact of their health beds.

The organisation receives block funding from the ICB, but also has different staff roles funded through various funding streams, including through the Rough Sleeping Initiative. Leaders spoke of the freedom that the ICB's block funding affords – it enables them to work intensively with a relatively small cohort of people, and in a way that best serves the needs of this group, for instance by being flexible about where they see patients, offering long appointments, walk-ins, and spending a full hour checking over new patients. It also enables a service that can flexibly respond to emerging need, such as a sudden influx of a particular migrant population experiencing homelessness.

Case Study 6 – Strong senior leadership

NICE recommendation: *Developed as an example of **strong senior leadership in inclusion health** by request of DHSC – cutting across the guidelines as a whole.*

Case study: An inclusion health-focused ICB in the North of England.

The ICB have expanded their inclusion health work, including with people experiencing homelessness. Their Inclusion Health Unit was established in 2023, aiming to achieve high quality healthcare for inclusion health populations, through collaboration, promoting equitable access, experience, and outcomes across the integrated care system footprint. The Unit works to better understand and meet health needs, ensuring joint resources are used effectively by planning and delivering together, and sharing learning between Places. They have an Inclusion Health Strategy which includes the NICE guidelines. The work has been enabled by strong buy-in from their CEO and other system leaders, partnership working, and a relatively well-resourced team focused on delivery.

"I think [the key driver] is obviously the leadership within the partnership. [...] and that then dissipates throughout the system".

The ICB's priorities for the 2024-26 strategy align to what they have heard from inclusion health communities, and include mental health, palliative care, housing, dental, and the clinical priority areas of Core20PLUS5. Programmes for people experiencing homelessness were partly dictated by findings from a piece of peer research conducted with people with experience of homelessness about their use of health services and the barriers to accessing them. Leaders acknowledged the challenges with having complete data relating to inclusion health groups, and spoke about the need for flexibility to use anecdotal evidence and other sources of intelligence. The peer research and other available intelligence had led the ICB to focus on mental health, dentistry, peer support and tackling stigma, and they are also soon to launch a respiratory health pilot.

The ICB's CEO was described as a driving force behind the inclusion health agenda, as well as its Chair and other senior individuals such as the Director of Public Health. They described good links with colleagues at local and regional government level, and the Mayor's office. Health inequalities are also a regular agenda item at ICB/ICP board meetings, so inclusion health issues are given regular space in decision making forums.

"...when I first started in this role five years ago, I'd be the one banging on about inequalities all the time, and now I go to meetings and it's the other way."

Leaders noted the challenges around collecting baseline data for this cohort of people and identifying appropriate metrics to use to record impact, and that this is currently an active work in progress. Current pilots are being used to collect baseline data. Their dental pilot to provide targeted and supported appointments for inclusion health groups has been picked up nationally as part of a task and finish group

With the respiratory project, they are looking to record the numbers of people seen, the number of respiratory conditions diagnosed, prescriptions issued, and potentially vaccinations provided. There will also be a qualitative element, speaking to staff and service users. They will be seeking to understand the impact of earlier diagnosis on the wider service.

What We Do

Homeless Link is the national membership charity for frontline homelessness services. We work to improve services through research, guidance and learning, and campaign for policy change that will ensure everyone has a place to call home and the support they need to keep it.

Homeless Link

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