

Understanding the new NHS

A guide to the new NHS for voluntary homelessness organisations

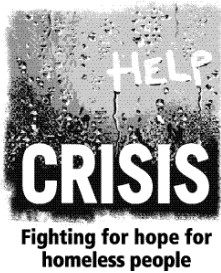


CRISIS
HEALTH ACTION
Fighting for hope for
homeless people

Understanding the new NHS

A guide to the new NHS for voluntary homelessness organisations

Bolaji Bank-Anthony



Crisis is the national charity for solitary homeless people. We work year-round to help vulnerable and marginalised people get through the crisis of homelessness, fulfil their potential and transform their lives.

We develop innovative services which help homeless people rebuild their social and practical skills, join the world of work and reintegrate into society.

We enable homeless people to overcome acute problems such as addictions and mental health problems.

We run services directly or in partnership with organisations across the UK, building on their grass roots knowledge, local enthusiasm and sense of community. We also regularly commission and publish research and organise events to raise awareness about the causes and nature of homelessness, to find innovative and integrated solutions and share good practice.

Crisis relies almost entirely on donations from non-government organisations and the public to fund its vital work. Last financial year we raised £5.5m and helped around 17,000 people.

Much of our work would not be possible without the support of over 3,000 volunteers.

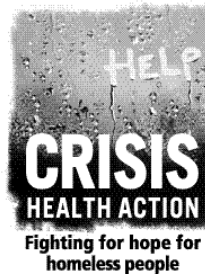
Crisis was founded in 1967 and has been changing the lives of homeless people for 35 years.

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Crisis Health Action is a specialist team within Crisis. It aims to improve homeless people's access to the full range of quality health and social care services. It undertakes research and evaluation work for voluntary and statutory agencies and produces reports, practice guides, leaflets and a newsletter to promote awareness of new solutions and share good practice.

Other Crisis Health Action publications

Outcry

Outcry is the regular newsletter of Crisis Health Action, the newsletter can be downloaded from the Crisis website by visiting www.crisis.org.uk/healthaction.

For a full list of Crisis publications and an order form please contact 0870 011 3335 or visit the Crisis website at www.crisis.org.uk/publications.

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Foreword

The NHS has been through major changes in recent years with power devolving to local level. As such the structures become ever more complex, whilst the health needs of homeless people remain ever present. Access to health services for homeless people has never been a high priority for the NHS with the many pressures on them to deliver accessible services to the general public. If we are to reduce homelessness and ensure equal access, we must remind NHS staff of the particular needs of homeless people.

With the new NHS and the health inequalities agenda of government, never has there been a better time for voluntary homelessness organisations to get involved in the new NHS structures and ensure that the needs of homeless people become and remain a priority.

Crisis Health Action have worked hard to produce to produce this guide which clarifies what the new NHS structures are as well as giving guidance on how to get involved.

I hope that you will find this guide simple and accessible. It is important that at both national and local levels we work closely in partnership to deliver health services to one of the most marginalized groups, homeless people. To do this we need to understand the structures and get involved both at a strategic and practical level even though the complexity of the structures can make this task seem daunting and off putting. However upon reading this guide I now feel armed and ready to become involved in the new NHS and can assure you that you will feel the same.

Shaks Ghosh

A handwritten signature in black ink that reads "Shaks Ghosh". The signature is written in a cursive, slightly slanted style.

Chief Executive
Crisis

Background

Health and Homelessness

Research has shown that living in poor housing or being homeless can greatly affect physical and mental health. The most severe health problems are experienced by those who sleep rough whilst those in temporary accommodation can also suffer from poor health resulting from the lack of good quality accommodation.

Homeless people are amongst the most vulnerable and socially excluded people in our society. Poor health is one of the major problems they face. Tackling these health problems and ensuring that they have access to good quality healthcare is an essential step towards their reintegration into mainstream society.

Crisis Health Action works to improve access to health and social care for single homeless people and childless couples. This guide explains what the new NHS structures are and how they work. Its purpose is to enable voluntary organisations to participate in the setting of the local health priorities and policies to secure improvements in service provision. It also looks at how the health needs of homeless people are being addressed within the new structures and concludes with recommendations for homelessness voluntary organisations on how to influence local health services so that they meet the needs of their client group.

Over the years there has been increased recognition of the need to address the question of access to appropriate healthcare for homeless people. Since 1997, the Government has developed initiatives to tackle health inequalities, shifted the balance of power within the National Health Service from the centre to local service delivery enabling services to meet the health needs of local communities.

The health needs of homeless people are multiple and complex. It is important that voluntary organisations working with homeless people have a good understanding of the new NHS structures, how they work at a local level and ways of influencing the local health agenda to ensure the health needs of homeless people are recognised and incorporated into local health service delivery.

The NHS has been engaged in a process of modernisation since the publication of the white paper *The New NHS: Modern and Dependable*. This set out the development of a system of 'integrated care' based on partnership and driven by performance, and a greater role for the NHS to work with those providing social care, housing, education and employment to improve health and reduce health inequalities.

Saving Lives: Our Healthier Nation set out the priorities for improving health and reducing health inequalities, which demand action across health and local government, the voluntary and community sectors.

The Health Act 1999 provided the freedoms and flexibilities for the NHS to work in partnership and the *NHS Plan* set out the detailed priorities, action and targets to be tackled. National health inequalities targets have been set for the first time, and the NHS is expected to lead the development of local inequalities targets and action plans to achieve them across sectors. This is set out in *Tackling Health Inequalities - Consultation on a Plan for Delivery*.

The government has also required local areas to develop local strategies to tackle particular health issues. For example, National Service Frameworks (NSF) have been developed to focus on both service development and opportunities for treatment and prevention across sectors in key areas including coronary heart disease, mental health and the health of older people.

Most recently changes in the structure of the NHS set out in *Shifting the Balance of Power within the NHS: Securing Delivery* provide a new framework for partnership working. Primary Care Trusts (PCTs) will act as the main link to local government as they develop a new role, responsibilities and resources for service modernisation, commissioning and health improvement. *Shifting the Balance of Power: The Next Steps* sets out how these changes will be implemented.

The real power and resources has moved to the NHS frontline, locally run by Primary Care Trusts (PCTs) who will by 2004 have control of 75% of the NHS budget.

28 new Strategic Health Authorities the new local headquarters of the NHS with the responsibility and accountability for local health service provision. They are also responsible for building capacity within trusts and PCTs as well as supporting them in improving their performance.

The NHS

The National Health Service

The National Health Service (NHS) was set up in 1948 to provide healthcare for all citizens, based on need, not the ability to pay. It is made up of a wide range of health professionals, support workers and organisations. The NHS aims to bring about the highest level of physical and mental health for all, within the resources available, by:

- Promoting health and preventing ill-health
- Diagnosing and treating injury and disease
- Caring for those with a long-term illness and disability, who require the services of the NHS

The NHS is funded by the taxpayer and accountable to parliament. It is managed by the Department of Health, which is directly responsible to the Secretary of State for health.

The Department of Health

The Department of Health is the government department responsible for delivering health and social care services to the people of England. It has offices in Leeds and London and is responsible for:

- Management of the overall health and social care system
- Developing policy and managing major changes in the NHS
- Regulation and inspection of the NHS
- Intervention, should problems occur in the running of the NHS at any level

NHS Regional Offices

NHS regional offices due to be abolished in April 2003, have had their roles reviewed with many of their responsibilities devolved to Strategic Health Authorities.

The new regional focus will lie with three new Department of Health divisions:

- Health and social care standards and quality group, headed by the chief medical officer for England Professor Liam Donaldson
- Corporate management and development group

to be headed by Hugh Taylor, currently director of external and corporate affairs

- Health and social care delivery group whose head had not yet been named

Under this re-organisation the Department of Health will have a new management board which will be chaired by Nigel Crisp and made up of the new divisional directors as well as directors of policy, communication and finance. These regional Directors will oversee the development of the NHS and social care, linking with central government, local authorities and Government Offices of the Regions. They will also ensure health and social care planning and performance assessment are integrated, and promote joint provision at local level, including the development of Care Trusts.

There will also be a health and social care delivery unit with 11 members who will manage the department of health's relationship with strategic health authorities and the NHS.

Strategic Health Authorities (SHAs)

Strategic Health Authorities are new organisations, larger than the previous health authorities, each covering a population of around 1.5 million. They provide a strategic framework for developing and improving all NHS services and reducing health inequalities, including capital investment. Their role is to ensure all NHS organisations work together, oversee and improve the performance of NHS Trusts and Primary Care Trusts (PCTs), and work with national bodies such as the Commission for Health Improvement (CHI). They support (PCTs) and NHS Trusts in involving patients, the public, local communities, voluntary sector and health and social care staff in developing and carrying out plans for better quality services.

They also support the PCT and NHS Trust contribution to improving health through Local Strategic Partnerships (LSPs), which bring together private, public, voluntary and community sectors together to co-ordinate services. Strategic Health Authority boundaries contain several local authorities and cross local authority boundaries. London has 5 SHAs.

Primary Care Trusts

PCTs are the cornerstone of the local NHS and are responsible for:

- improving health
- securing the provision of services to meet the needs of local people
- building partnerships with other agencies and engaging local communities.

They have been set up to improve the health of local communities through community development, health promotion, service planning and commissioning. They are also responsible for assessing local health needs and responding to diversity; preparing plans for health improvement and making sure national priorities are carried out locally.

PCTs are the lead NHS organisation for partnership working with local authorities and other agencies in

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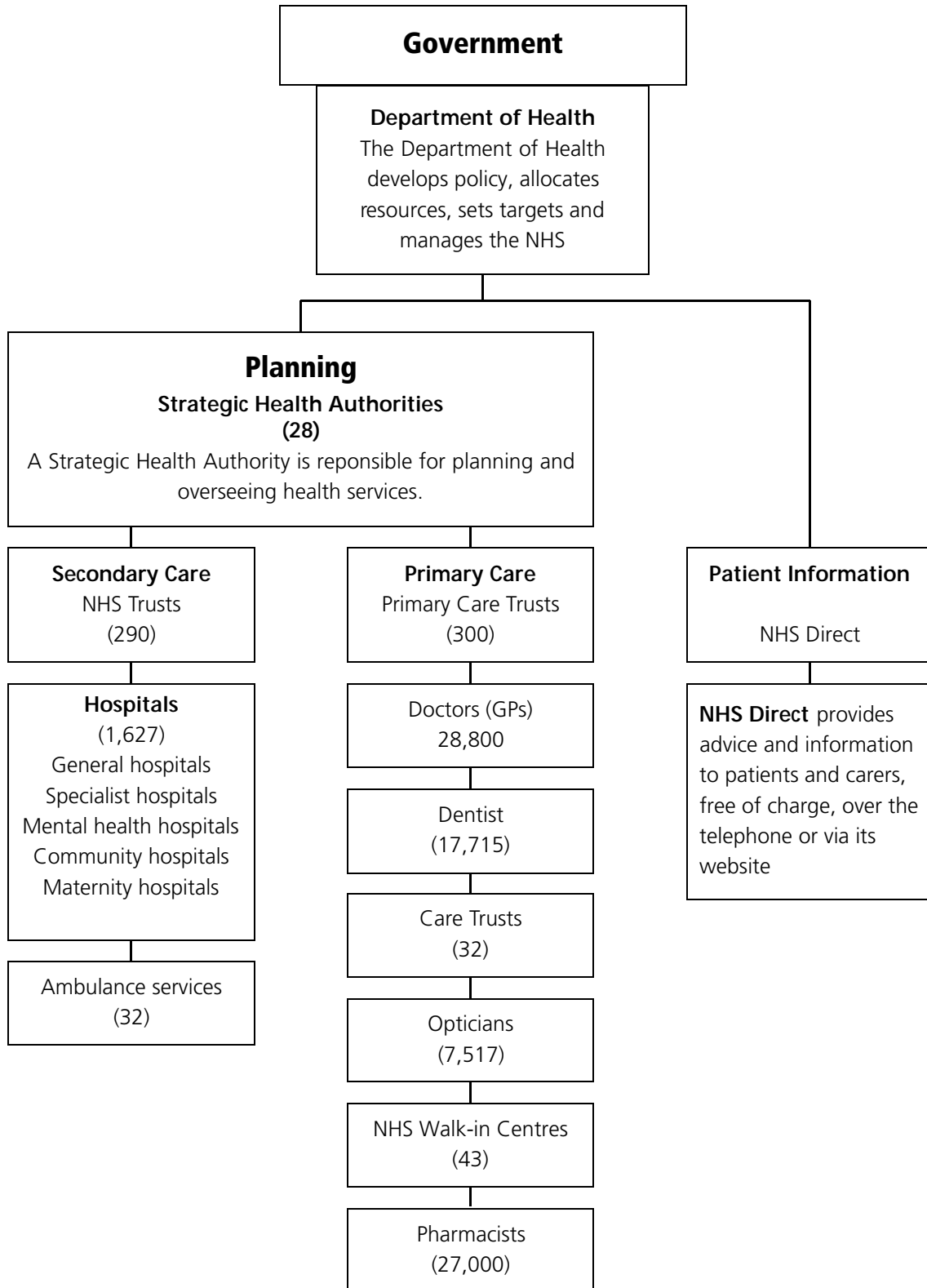
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has a right to be registered with a local GP however, a recent Crisis survey found that the homeless people interviewed were almost 40 times more likely not to be registered with a GP than the average person. There is no reason why homeless people should not be registered permanently with a GP but the current shortage of GPs has resulted in closed lists which has increased the barrier to homeless people's access to GPs. If a preferred GPs list is closed, the PCT contracts team will provide an alternative GP who list is open.

NHS Trusts

NHS Trusts commonly known as hospital trusts are found in most large towns and cities, and usually offer a general range of services to meet most people's needs. Some trusts also act as regional or national centres of expertise for more specialised care, while some are attached to universities and help to train health professionals. Trusts can also provide services in the community – for example through health centres, clinics or in people's homes. Except in the case of emergencies, hospital treatment is arranged through the GP and this is called a referral.

Schematic of the new NHS structure



Health service funding

The United Kingdom spends just under 7% of its gross domestic product on the health service. Within that figure there are regional variations. Scotland and Wales spend a greater amount per head of population than England and Northern Ireland.

In the 2000 budget, the Government committed to increase spending on the NHS from £50 billion to £70 billion.

GMS contracts

For the first time since 1948 general practice/primary care and community care, has been incorporated into a single organisation with a unified budget with the introduction of a new mandatory scheme, which brought GPs into groups to commission all primary care except mental health.

GPs are currently negotiating a new contract, which is intended to identify their responsibilities and reward them for delivering high quality care.

Examples of the Old GMS contract and the new proposed contract

Old GMS contract	New Proposed GMS contract
Income based on: <ul style="list-style-type: none"> • Number of patients • Number of GPs in the practice • Fees claimed 	Income based on number of patients and is influenced by: <ul style="list-style-type: none"> • Their age, sex, • Remoteness of population
GPs not able to opt out of providing the majority of primary care services	Practices can now opt out of providing certain primary care services. Where this happens, the PCT has to directly provide these services or commission another practice to provide the service
Open 24 hours a day, 365 days per year	Practices can now opt out of 24 hour, 365 days per year responsibility for patient care <ul style="list-style-type: none"> • Core responsibility will be from 8am to 6.30pm Monday to Friday excluding bank holidays • PCTs will be responsible for arranging 'out of hours' services if practices opt out
GPs responsible for patient home visits	GP practices can now opt-out of home visits The PCT will then have the responsibility for organising patient home visits where a practice has opted out
No salaried GP option	Full salaried GP option will be available

The proposed new GMS contract has the potential to encourage significant additional resources and services to primary care. The contract will be a practice-based allowing practices to control their workload by providing them with the ability to choose the services they provide and the level of quality to which these services will be provided.

The contract will allow practices to provide appropriate and flexible services to meet the needs of homeless people within the locality of the practice. Examples can include flexible opening times, flexible registration procedures, comprehensive assessments of physical, psychological and social needs and longer appointment times for homeless people with multiple and or complex health needs.

Where there is a large population of homeless people including people in hostels and Bed & Breakfasts, homelessness voluntary organisations should promote the need to provide specialist GP services, under the new GMS contract to the homeless population within the locality.

Personal Medical Services (PMS's)

A new alternative to the classic GPs' individual contract is 'Personal Medical Services' (PMS). PMSs are a response to some doctors' dissatisfaction with the traditional contract and more importantly because of the need to encourage GPs to work in deprived areas. The NHS (Primary Care) Act 1997 passed shortly before Labour came into power, made it possible for Health Authorities to commission primary care services and GPs were able as a group or practice contract with the NHS to deliver a defined package of services.

The intention of the PMS is to move the focus away from list sizes and workload volume to concentrating more on quality and addressing local service issues and needs by introducing increased flexibility making it easier for local solutions to be created for local problems.

There are some good examples of where PMS contracts have narrowed the barriers to primary care services. These include GP's holding surgeries in hostels, longer appointment times, one-stop-shop health service where

homeless people can access GP's, nurses, podiatrist and dental services.

The PMS contract is designed to support strategic health authorities and PCTs in promoting quality and enabling local arrangements to address local health needs.

There are now 1,300 PMS pilots operating across the country and 19% of patients in England are registered with PMS practices. 71 PMS practices specialise in or have a special interest in homeless people and hard to reach groups like refugees and asylum seekers.

Good practice:

Some PMS's including one in Brent has homeless people on their steering group

Patient and public involvement in health

Patient and public involvement in health is important to ensure needs are reflected in service provision and delivery. Health service users can identify areas for improvement and raise concerns on current service delivery. Voluntary homelessness organisations should be involved in the different local structures described below which will enable them to promote and influence services, which will address the needs of homeless people.

The NHS Reform and Health Care Professions Act, which contains legislation to set up new patient and public involvement arrangements, and abolish Community Health Councils (CHCs), was passed in June 2002. Key points include:

In every PCT and NHS Trust there is a **Patients and Public Involvement Forum (PPI Forum)** that will:

- monitor and review the services arranged and or provided by the trust from the perspective of the patient - not just the operation of services, but the range too
- seek the views of patients receiving services provided or arranged by the trust
- inspect premises where NHS services are delivered
- make reports and recommendations to the management of the trusts
- refer matters of concern to Overview and Scrutiny Committees, Strategic Health Authorities, Commission for Health Improvement, National Patient Safety Agency and any other person or body the forums deem appropriate including the media
- be represented on the board

In addition PCT Patient and Public Involvement forums:

- have a wider membership, including representatives of other patients' forums in the area and other relevant groups.
- promote the involvement of the public in decisions and consultations on matters affecting their health
- provide or commission independent complaints advocacy

- collect information about patients' experiences, identify trends, such as an increase in rough sleeping, overcrowding etc and make reports to decision-makers

Historically, patient involvement in the NHS has excluded homeless people in having a voice in health service delivery. Homelessness groups can influence the work of patient forums through representation on the forum where matters affecting the health of homeless people can be addressed. Information on your local forum and membership criteria can be sought by contacting your local PCT.

In every NHS trust and PCT there is a **Patient Advice and Liaison Service (PALS)** that will:

- Resolve problems on the spot
- Provide information to patients, carers and their families about local health services and put people in contact with local support groups
- Inform people about the complaints procedure and direct people to independent complaints advocacy support
- Act as an early warning system for trusts and Patients Forums by monitoring trends and highlighting gaps in service and making reports for action to trust management.
- PCT response will be included in the annual patients' prospectus for the trust/PCT in question

Empowering homeless people by providing information and support when they encounter problems when using the National Health Service is one of the many services voluntary homelessness organisations already provide. However, homelessness voluntary organisations can extend this provision by supporting homeless clients through the new complaints and advocacy services delivered by PALS, which will identify gaps in health service delivery to homeless people and also they can contact PALS to talk to them about making their service accessible to people who are homeless.

Good practice

In Lambeth, Southwark and Lewisham, the PCT has developed a long-term user involvement process for homeless people who will through training build up their confidence and self-esteem and be able to provide opinions and views on health care requirements, reasons for under usage of current health services as well as suggestions on improving services. The project will use ex-homeless facilitators who have completed the Thames Reach Peer Education programme. This programme is about people who have been homeless learning from others who have had the same experience.

Local health care – local involvement

Local Strategic Partnerships (LSPs)

LSPs will bring together public, private, voluntary and community sectors to co-ordinate services and target mainstream funding to meet the needs of local communities. Tackling health inequalities are at the core of LSP strategies. They will:

- develop and deliver neighbourhood renewal strategies
- help prepare and implement local authority community strategies
- involve voluntary and community organisations and local people
- use the community empowerment fund to set up local networks and facilitate voluntary and community participation in LSPs

LSPs provide a means for voluntary homelessness organisations to work with other community, voluntary and statutory organisations in identifying needs and priorities of their clients within their local area. Homelessness voluntary organisations can support their homeless clients feed directly into work on tackling health inequalities. Voluntary homelessness organisations can be actively involved in neighbourhood renewal, as there are opportunities to contribute to areas such as housing. Voluntary organisations will find that local Council for Voluntary Services (CVS's) will have links and some representation on local strategic partnerships. Where homelessness voluntary organisation are finding it hard to get involved in these bodies, they can identify the CVS representative and influence them to promote the needs of homeless people.

Commission for Patient and Public Involvement in Health (CPPIH)

The new NHS in recognising the need for services to respond to local need through patient and public involvement established the Commission for Patient and Public Involvement in Health (CPPIH).

The CPPIH an independent non-departmental public body sponsored by the Department of Health is responsible for establishing, funding, staffing and managing independent Patients' Forums.

CPPIH will:

- Empower the public to have their say by training them with the skills they need to get involved;
- Support patients and the public to make sure their voices are heard;
- Work with traditionally marginalized groups to ensure that getting involved is as easy as possible

Homelessness voluntary and community organisations have the opportunity to be part of the backbone of this new independent system of patient and public involvement by being involved in the development of the Patient and Public Involvement (PPI) forum. As local network providers, there is opportunity to use existing knowledge on current health needs and gaps in health service provision for homeless people to help shape the future of health at the local level. These forums will be independent of the NHS and are another health network set up to increase local involvement in delivering local health services. However, whether these will actually be responsive to the needs of homeless people will depend on local needs, local pressures and funding.

The Duty to Involve and Consult

Section 11 of the Health and Social Care Act aims to strengthen NHS organisations' community accountability by requiring all NHS organisations to make arrangements to involve and consult patients and the public in service planning and delivery.

This is additional to statutory requirements for formal consultation about 'substantial changes' in services, and emphasises ongoing involvement and dialogue to implement the vision of patients and the public at the heart of the NHS.

Section 11 will be a useful tool for voluntary homelessness organisations to use if local NHS bodies make substantial changes to health service provision to homeless people. This will include decisions made by the local PCT in their role as commissioners of services and can also include changes made by the local NHS trust in the provision of hospital services affecting homeless people. Organisations can ensure that they are consulted in the planning and delivery of new

services to enable the accessibility of homeless people.

Overview and Scrutiny Committees

On the 1st of January 2003, local authorities have become responsible for keeping an eye on everything from ward closures to GPs waiting lists. To do this 150 social service authorities are now able to set up health overview and scrutiny committees to review the planning, provision and operation of health services.

This is all part of the government's drive to modernise the NHS and restructure patient and public involvement in health.

OSC's are made up of councillors and supported by officers who are expected to:

- Ensure that people's needs and wishes for health and health related services inform local health services
- Ensure that health services meet residents needs (including excluded groups such as homeless people)
- Scrutinise whether services that affect residents health are accessible
- Scrutinise whether services are equally good for all residents

Some voluntary homelessness organisations and community groups already have links with local authority councillors and staff. There is a need to extend links and develop a process where there can be on-going dialogue on the gaps in health service provision to homeless people within the local authority area. Access to appropriate health care has always been a major gap in service provision for homeless people. OSC's can scrutinise gaps in accessing services. Homelessness voluntary organisations can provide them with information on the lack access to services for homeless people.

Health needs of homeless people and the new NHS

The burden of ill health does not fall equally across society. Some people like the homeless face a far higher risk than others in suffering from avoidable illnesses such as depression.

Inequalities in health are closely connected with inequalities in wealth, power and participation in society, all of which apply directly to homeless people. The link between poverty and health is often direct - e.g. living in overcrowded housing or sleeping rough can lead to respiratory illness and depression. The link can also be indirect – e.g. rough sleeping or living in insecure accommodation can increase anxiety and stress.

Assessing health need

Assessment of needs is an integral part of providing services in the public and social housing and care sectors. People looking for assistance may take a variety of different routes into housing and community care services depending on the profile of their needs, their existing contacts and their understanding of the system. These can include:

- Initial contact with social work may undertake community care assessments to identify needs for care services for those already living in the community, or those being discharged from hospital, whether long stay or acute
- Initial contact with housing departments as a result of impending or actual homelessness or other housing problem. Housing departments or Homeless Persons Units may then assess the person's needs in relation to statutory homelessness responsibilities or to identify the level of priority for re-housing.
- Through their GP or other medical practitioner, such as a district nurse, or community psychiatric nurse who may then form the 'route in' to a wider range of health or social care services
- Through hostels or voluntary bodies from whom they already receive services or accommodation, particularly when their needs are or become complex and exceed the capacity of existing provision.

- Often a person's needs cannot be met wholly by a single service, and this is the case with many homeless people who have multiple health needs, and a single-issue service assessment will not be appropriate. It is in this situation that inter-agency co-operation is essential.

There are a number of opportunities for avoiding fragmentation of assessment and processes by:

- agreeing an approach to assessment
- undertaking joint assessments
- developing a system of shared assessments
- incorporating opportunities for self assessment

An initial assessment procedure for homeless people who present with multiple needs should:

- clarify the person's immediate accommodation and personal needs, including any obvious support/care needs
- Assess the need for referral and for collaboration, including the option of a joint assessment, if this would assist with the identification of needs and effective planning solutions

Community Care

Providing effective community care is still the major challenge facing mental health services. The decrease in the number of institutional beds available continues to place additional pressure on mental health workers to expand their professional boundaries and expertise.

The *NHS Community Care Act 1990* created a framework for a unified system of community care provision. It imposed specific duties on local authorities to assess the particular needs of individuals for accommodation and support services. In addition the *Mental Health Act 1983* contains a duty to provide after care services for people who have had mental health problems and have left hospital.

For people to receive the best possible care, the old divisions between health and social care need to be addressed. For homeless people, partnership working between the NHS and local authorities has not always worked effectively together as partners and has

resulted in inadequate care provision. The creation of Primary Care Trusts (PCTs) is seen as a unique opportunity to foster closer working between the NHS and local government, particularly social services.

Care Trusts

Care Trusts are NHS organisations to which Local Authorities can delegate health-related functions, in order to provide integrated health and social care.

To ensure integrated services that are focused on the needs of patients and users, Care Trusts announced in the NHS Plan in July 2002, are intended to offer a pragmatic way forward as important vehicles for modernising both health and social care.

Care Trusts will be able to commission and provide health and social care services for particular groups, such as people with disabilities, mental illness, or older people. Homeless people with mental health problems will benefit from a more integrated health and social care service if this service is accessible and takes a holistic approach to their needs.

They will be established on a voluntary basis and in partnership where there is a joint agreement at a local level to offer the best way to deliver health and social care services.

Four Care Trusts went live in Bradford, Camden and Islington, Manchester and Northumberland on 1st April 2002.

Mental Health

Although a plethora of evidence suggests the extent of mental ill health among homeless people is considerably higher than the general population, it is difficult to demonstrate if homelessness is the cause or an outcome of mental illness. However, most research has shown that mental ill health precedes homelessness.

Social services are the lead agency for planning and arranging community care for people with mental health problems. Under the 1983 Mental Health Act this extends to people with mental health problems on discharge from hospital.

In 1999 the Government launched the Mental Health

National Service Framework (NSF) for services in England for the next 10 years. This was set up to address the mental health needs of working adults up to the age of 65.

The Mental Health NSF:

- Sets national standards and defines service models for promoting mental health and treating mental health
- Puts in place underpinning programmes to support local delivery
- Establishes milestones and a specific group of high-level performance indicators against which progress within agreed time-scales will be measured.

It covers health promotion, assessment and diagnosis, treatment, rehabilitation and care, and encompasses primary and specialist care and the roles of partner agencies.

Community Mental Health Teams

Community Mental Health Teams are run jointly by the health service and social services, and deal with people's health and social care needs. They help people in the community, whether they have just become ill, have a short-term illness, or need on-going support.

Doctors and other health specialists can see people as and when it is necessary and 'care co-ordinators' - who can be Community Psychiatric Nurses (CPNs) or social workers - draw up a care plan for each patient and arrange the care that is needed. Care can include medication, sessions at a day centre, or help at home from a 'support worker' who can give emotional support and help with day-to-day living.

Mental Health and Primary Care

With the rise in the provision of care in the community, primary care has begun to shift from being simply a filter or referral pathway to specialist care to being a site of specialist mental health activity itself. This has been reinforced by national policy during the last decade, significantly altering the role of primary care as the lead commissioner and, increasingly, a provider of mental health services.

Primary Care is now a key partner in developing mental health services, with PCTs driving the change in service structure, delivery and outcomes.

Ninety per cent of all patients with mental health problems (including 30 to 50 per cent of all those with a serious mental illness) only use primary care services

Changes in the delivery of mental health services to homeless people, to working in a holistic way will address access and appropriateness of services through:

- a commitment from primary care to mental health as an issue
- good communication across the sectors, particularly on referral and discharge

Drugs and Alcohol Services

The government has recognised the need to address the complex interlinked issues of drug and alcohol use and homelessness. Recognition of this need is seen in the national drug strategy *Tackling Drugs to Build a Better Britain (1998)*, *The Draft National Alcohol Harm Minimisation Strategy (2003)* and the strategy on rough sleepers *Coming in from the Cold (1999)*.

The Government established Drug Action Teams (DATs) in every local area to co-ordinate the local response to drug use. DATs and their Drug Reference Groups (DRGs) provide a network of key planners, commissioners, and service providers to inform local Drug Action Team Plans. Voluntary homeless organisations are an important part of this structure because of their primary contact with a key group of drug and alcohol users.

A large number of Drug Action Teams (DATs) now undertake alcohol-related activities, despite the fact that alcohol is not covered by the Government's Drug Strategies. Many have formally taken on alcohol, often with the support of a specific Alcohol Reference Group, because a need has been identified and there is no other similar body, which brings together the key players, taking a lead on alcohol policy at a local level. These are called DAATs.

Homeless individuals often experience marginalisation, isolation, insecurity, vulnerability and lack of choice. The

effect of this experience makes the general health of homeless people poorer than the general population. Research indicates that homeless drug and alcohol users are at a greater risk of harm in their drug taking and alcohol patterns and behaviour. However, many specialised drug services find it difficult to engage homeless people with drug and alcohol problems due to poor compliance and chaotic lifestyles.

Partnership Working

Partnership working is a central feature of health and social care provision, both at a local and a national level. Following the election of new Labour in 1997, there has been an increased recognition on the need of 'joined-up' government and 'joined-up' solutions to 'joined-up' problems. This can range from complex and overarching social issues such as crime, substance misuse and social exclusion to the experience of user groups such as the homeless, whose needs often call for a co-ordinated response from a range of agencies.

Partnership working is a 'must do' for voluntary organisations that work in health and homelessness and in particular mental health and homelessness because:

- mental health services are complex with a range of different agencies involved service provision
- homeless people with a mental health problem are very vulnerable and have limited capacity to negotiate complex bureaucracies that can exist. They therefore need services that are well integrated at the point of contact, are easy to negotiate and are focused on their needs
- integrating the Care Programme Approach and care management should be a high priority and is simpler and more effective when joint working arrangements are in place
- partnership working can help minimise bureaucracy and duplication as well as maximising integration for service users and staff

Health inequalities

The Government has used both health policy and its wider powers to address health inequalities. It has acknowledged the link between poverty and ill health and pledges to tackle it. The NHS Plan set for the first time, local targets for reducing health inequalities to be enforced by the creation of national health inequality targets.

Tackling the causes of health inequalities requires action at both national and local level, involving government departments, NHS organisations and local authorities. To date, health inequalities have been seen as primarily an issue for the NHS, however, addressing the underlying causes requires co-ordinated action, bringing together health services with a range of other interventions and programmes.

The national target for reducing health inequalities announced in 2001 is to *reduce inequalities in health outcomes by 10% by 2010, as measured by infant mortality and life expectancy at birth.*

This single target is supported by the following two targets:

- starting with children under one year, by 2010 to reduce the gap in mortality by at least 10% between 'routine and manual' groups and the population as a whole
- starting with local authorities, by 2010 to reduce the gap by at least 10% between the fifth of areas with the lowest life expectancy at birth and the population as a whole

However, these concerns do not apply to homeless people.

Reducing health inequalities will be tackled by:

- mainstreaming action to tackle health inequalities
- breaking the cycle of health inequalities
- tackling the major killers
- improving access to public services and facilities
- ensuring that health services work in a multi-disciplinary way with people with multiple needs
- strengthening disadvantaged communities
- supported targeted interventions
- being responsive

The Government's cross-cutting review of health inequalities highlighted the importance of community involvement, and joint working between agencies and between government departments, to ensure action on health inequalities is effective in the long term.

The review developed a long-term strategy to tackle health inequalities by setting out what needs to be achieved through partnerships with individuals, organisations, government departments, the NHS, local government, the community and voluntary sector. Areas for focus include tackling cancer and heart disease; improving access to services; a focus on disadvantaged areas; and supporting targeted intervention for specific groups. These include people from Black and Minority Ethnic communities, older people, people with long-term illness or mental health problems, homeless people and travellers.

The strategy also suggests the need for developing services to meet the multiple needs of homeless people who have a high level of poor health outcomes through taking a holistic approach and joining up services at the point of delivery.

The health inequalities faced by homeless people has been the focus of much research and many campaigns. Studies have consistently shown that the levels of poor health are far higher amongst homeless people than in the general population. Poor health is a cause as well as a consequence of homelessness. Overcrowded, cold, damp and unsanitary living conditions are highly conducive to physical and mental ill health. The predominance of drink and drugs in the homelessness subculture is also a growing area of concern.

Local NHS structures all have a role to play in reducing health inequalities and it is at this level voluntary homelessness organisations and community groups should be working at to raise the health needs of their client group. The PCT will have a named person leading on health inequalities with which contact should be made. The specific barriers to local health services faced by homeless clients should be fed into any local work being done on reducing health inequalities.

Locality based initiatives

Health Action Zones

Health Action Zones (HAZs) were set up as a part of a new way of tackling health inequalities in some of the most deprived areas in England. The HAZ initiative brings together organisations within and beyond the NHS to develop and implement a locally agreed strategy for improving the health of local people.

HAZs are intended to not only address inequalities in health but to also develop services that are more responsive to patients and users.

They are a partnership between the NHS, local authorities, the voluntary and private sectors and local communities. This partnership will take forward challenging work programmes which represent a new approach to public health by linking health, regeneration, employment, education, housing and anti-poverty initiatives aimed at responding to the needs of vulnerable groups like the homeless as well as deprived communities. There are currently 26 HAZ's nationally.

All HAZs are based on 7 key founding principles:

- Engaging communities
- An evidence-based approach to service planning and delivery
- Equity: in resource, allocation, in reducing health inequalities and promoting equality of access to services
- Partnerships/multi agency working
- A whole systems approach to taking forward change engaging stakeholders across the local health and social care systems
- Staff involvement
- Person centred services

Local Delivery Plans

The Department of Health (DoH) developed a new planning framework to deliver a three-year planning cycle for health and social care. The guidance details roles and responsibilities for Primary Care Trusts (PCTs) and builds on the Planning and Priorities Framework guidance issued on 2 October 2002.

Planning and Priorities Framework (PPF) set out what

organisations need to do by identifying priorities and targets which organisations need to build in to their local plans.

The framework is designed to:

- achieve a clearer deliverable set of targets
- with greater flexibility at a local level

The framework changes the way services are planned and delivered by moving to a system of enhanced local accountability. They will be collated by Strategic Health Authorities and detailed into a report for the health authority area.

Other than the targets outlined in the PPF, arrangements for the delivery of Local Delivery Plans (LDPs) will be determined locally. There will no longer be a formal requirement for PCTs to produce Health Improvement and Modernisations Plans (HIMPS).

PCTs will now have the freedom to determine whether they wish or need to develop any further plans covering locally agreed planning priorities, which are not covered by the PPF.

The LDP may build on or retain the structure of a HIMP and development areas might cover:

- key health improvement issues drawn from national priority areas for locality
- local priorities for PCT action agreed through partnership arrangements
- potential for alignment with health chapters in the Community Strategy
- presentation of the local picture, appropriate for and understandable to an Overview and Scrutiny Committee and public involvement fora.

The links between Local Strategic Partnerships, community planning and health improvement are set out in the following key policy guidance documents:

- Preparing Community Strategies: Guidance to Local Authorities (DETR, 2000)
- Power to Promote or Improve Economic, Social or Environmental Wellbeing: Guidance to Local Authorities
- Local Strategic Partnerships (DETR, 2001)

- National Accreditation Guide for Local Strategic Partnerships (DTLR, 2001)
- Health Improvement and Modernisation Plans (HIMPs): Requirements for 2002 (DH, 2001c)
- Tackling Health Inequalities: Consultation on a Plan for Delivery (DH, 2001a)
- Local Authority Health Overview and Scrutiny Consultation (DH, 2002)
- Shifting the Balance of Power: The Next Steps (DH, 2002a)

Ideally, Local Delivery Plans should be linked with the Homelessness Strategy of each local authority, to ensure that the numbers and health profiles of homeless people are identified. The levels of met and unmet needs should be clearly identified, and plans made to ensure inclusion of the health needs of homeless people.

Getting involved

Local NHS Bodies

Homelessness voluntary organisations can promote the health needs of their clients and influence the local health agenda to include the health needs of homeless people by:

- identifying the 'lead commissioning' role within the PCT for services that affect your client - such as mental health. It is important to support work that affects your client group as well as involving your clients in consultations.
- making contact with PALS services in local trusts; PALS officers are likely to be in the forefront of work to implement Section 11 of the Health and Social Care Act as this will enable involvement and be consultation on local service planning and service delivery
- promoting local compacts as a basis for links between NHS trusts, PCTs and local voluntary and community groups

CPPIH

Homelessness voluntary and community organisations should focus on the following areas of work of their local Commission for Patient and Public Involvement in Health (CPPIH):

- patient and public involvement across the NHS - from service planning to delivery, including quality audit and staff training
- the new structures for participation add value to existing structures, for example services for homeless people and people with mental health needs;
- ensure that the new structures involve people who use or have used particular NHS services; and
- support for the involvement of people often excluded from the NHS and other arenas, for example practical support such as advocates, buddies and interpreters

Overview and Scrutiny Committee's (OSC's)

Local Authorities in London are at different stages of developing and implementing OSC's. Once in place they will review performance and make changes, but

now is the best time for voluntary organisations to influence the agenda for reviews and ways of working.

Your organisation should:

- inform the agenda for OSC reviews. Use existing contacts with local councillors
- keep in touch with the OSC work
- support OSC's in finding out about local views – invite OSC's officers to inform your organisation about the OSC agenda and hear views of your client group; provide platforms for the distribution of information and encourage and support your clients to attend open meetings
- work with other homelessness voluntary sector organisations to share out the agenda of OSCs

DAATs

The homelessness voluntary sector are in an ideal position to form a bridge between this hard to reach population and drug and alcohol services. This can be achieved through the voluntary sectors involvement in the local drug and alcohol strategies and other action forums which work to develop effective local solutions to drug and alcohol problems. Partnership working and consultation with local Drug Action Teams (DATs) or the evolving Drug and Alcohol Action Teams (DAATs) will allow for the development of homelessness specific responses to access and treatment issues. Joint working will also provide voluntary homelessness organisations with the opportunity to raise practical matters of concern.

Homelessness Forums

Homelessness organisations should be actively involved in their local homelessness forums. Where no forum exists, homelessness voluntary organisations can work together with the local authority to develop a forum, which can feed into homelessness strategy reviews and ensure that health needs are incorporated into these reviews and strategies.

Council for Voluntary Service (CVS)

CVS' are voluntary organisations, set up, owned and run by local groups to support and develop voluntary and community sector organisations through offering

organisational support and working strategically to support the interest of the sector.

CVS' provide a range of services and act as a voice for the local voluntary and community sector. They can co-ordinate voluntary homelessness organisations work and feed this into Local Strategic Partnerships, homelessness reviews and strategies as well as act as a voice for the sector. Some CVS' will service homelessness forums as well as health and homelessness sub-groups. They can also influence the work of the local Primary Care Trust by promoting the health needs and identifying gaps in service provision for homeless people in the local area.