

January 2021

Housing and health

Working together to respond to rough sleeping during Covid-19



St Mungo's
Ending homelessness
Rebuilding lives

Acknowledgements

We would like to thank everyone who contributed to this report, especially the St Mungo's hotel managers whose insights were invaluable. We are also grateful to the St Mungo's clients who participated in the forums to help shape this report. Additionally, we would like to thank the health and homelessness professionals, policy makers and researchers who shared their expertise.

Foreword from Nathaniel

(St Mungo's client and member of Outside In)

During these unfortunate times of a global pandemic, homelessness and rough sleeping should be at the forefront of national debate – but more so, action should be taken.

This has been a really tragic situation. But there has been one blessing in progress of government measures allowing some homeless people new accommodation like hotels.

When I was homeless, systematic engagement while I was in Recovery House was vital at a time when I was vulnerable. I was able to build a rapport and trust and establish lines of communication to build bridges to alleviate my homelessness. Having this positive experience during that point in my life helped me establish a pathway to helping others out of homelessness and working in care and support. It turned my negative experiences into driving me to positive work and change. This was all because I was somewhere with active engagement and my health and wellbeing was being looked after.

If others could also get support like I did, countless people could benefit from help with being homeless but also having long term health care and rebuilding their lives. Having healthcare interlinked from the initial contact point helped me hugely and should be provided for others. Short term and long term plans must be put in place to allow homeless people to flourish in society as well as be safe during the pandemic.

We can make a better future, by understanding the present and learning from the past.

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Executive Summary



Covid-19 has exposed, and in some cases exacerbated, existing health inequalities in the UK.¹ People who are homeless have worse health than most, and yet they find it harder to get the healthcare they need.² During the pandemic, the Government rightly recognised the significant threat to health posed by sleeping on the street and in communal shelters. Through focusing on getting ‘everyone in’ and providing safe accommodation, many lives were saved. Furthermore, it connected people sleeping rough to the care, support and treatment they desperately need.

In their 2019 manifesto, the Government pledged to end rough sleeping by 2024 and to “bring together local services to meet the health and housing needs of people sleeping on the streets.”³ During the coronavirus pandemic, both the health and housing needs of many of those sleeping on the streets have been addressed in tandem. The Everyone In initiative – which, according to Government estimates, has led to more than 33,000 people being moved into safe, emergency accommodation in England - was a monumental, collaborative effort involving both health and homelessness services, as well as national and local government, corporate partners and community volunteers.

“It’s taken the coronavirus crisis for people to see rough sleeping for the public health emergency it is.”⁴

Baroness Louise Casey

Everyone In has redefined what can be achieved when there is a singular shared goal of saving lives. International comparators highlight the success of this approach. Analysis in August 2020 found there were at least 25 times fewer laboratory confirmed cases of Covid-19 amongst the homeless population in London than in New York.⁵

This report presents the findings of new research into the health needs of people sleeping rough in England and their vulnerability to Covid-19, and the approach taken to address the health and housing needs of this group during the pandemic. The report is also informed by our detailed knowledge as a service provider and by the lived experience of our clients. The aim is to help inform decision makers in government, local authorities and the health service and offer solutions to rough sleeping, both during the ongoing pandemic and beyond.

1 Public Health England (2020) *COVID-19: review of disparities in risks and outcomes*

<https://www.gov.uk/government/publications/covid-19-review-of-disparities-in-risks-and-outcomes>

2 St Mungo's (2014) *Homeless Health Matters: the case for change* <https://www.mungos.org/publication/homeless-health-matters-case-change/>

3 Conservative Party (2019) *The Conservative and Unionist Party Manifesto 2019*

https://assets-global.website-files.com/5da42e2cae7ebd3f8bde353c/5dda924905da587992a064ba_Conservative%202019%20Manifesto.pdf

4 Casey L., Mohan N. (2020) *It's taken the coronavirus crisis for people to see rough sleeping for the public health emergency it is*

<https://www.kcl.ac.uk/news/its-taken-the-coronavirus-crisis-for-people-to-see-rough-sleeping-for-the-public-health-emergency-it-is>

5 Hayward, A., Story, A. (2020) *Public Health rationale for not opening/re-opening communal airspace sleeping facilities for homeless people during the SARS-CoV-2 pandemic*

<https://www.pathway.org.uk/wp-content/uploads/UCL-CCIH-Faculty-Position-Statement-Aug-2020-Communal-Airspace-Sleeping-Facilities-AS-AH.pdf>

Key findings

People who sleep rough frequently have extremely poor health and are very vulnerable to severe cases of Covid-19.

- A Covid-19 health assessment carried out across St Mungo's services – covering 4,924 clients, 939 of whom were in the emergency hotels -- found that between July and December 2020 a quarter (24%, 1,005 people)⁶ had an underlying health condition which put them more at risk of suffering from acute cases of Covid-19, for instance severe respiratory conditions such as chronic obstructive pulmonary disease (COPD).
- 18% (132 people) of St Mungo's clients supported in emergency Covid-19 hotels were not registered with a GP when they moved in. In comparison, 98% (1,907 people) of clients across St Mungo's supported housing and Housing First, were registered with a GP.
- A Covid-19 health assessment, carried out by the University College London Hospital (UCLH) Find & Treat team, found that 6% of people accommodated in emergency hotels in London between July and October had extreme clinical vulnerability in relation to Covid-19 — nearly double that of the general population. 33% had moderate clinical vulnerability. Again, this is more than double that found in other cohorts of the population, for example, ONS data showing 15% of key workers have moderate clinical vulnerability.⁷

St Mungo's clients living in supported housing and Housing First services have even higher health support needs than those in emergency hotels, which is to be expected given the tailored support provided by such services for people with the highest needs.

- 28% (203 people) of clients in emergency hotels were classed as vulnerable or extremely vulnerable to Covid-19. This rose to 54% (85 people) of clients in St Mungo's Housing First services.
- Just over a third (37%, 270 people) of clients in emergency hotels required a regular prescription compared to 74% (1412 people) of clients in Housing First and supported housing services.
- 37% (243 people) of clients in emergency hotels had mental health support needs compared to 82% (1588 people) of clients in Housing First and supported housing services.



1 in 4 of St Mungo's clients have an underlying health condition which puts them at risk of more severe cases of Covid-19



Almost a **fifth** of St Mungo's clients in emergency hotels were not registered with a GP when they moved in



28% of St Mungo's clients in emergency hotels were classed as vulnerable or extremely vulnerable to Covid-19

	Emergency hotel clients	Housing First and supporting housing clients
Vulnerable or extremely vulnerable	28%	54%
Required regular prescription	37%	74%
Mental health support needs	37%	82%
Physical health support needs	36%	58%
Drug support needs	31%	55%
Alcohol support needs	36%	38%
Underlying health condition (Covid-19 specific)	19%	30%

⁶ The percentages are based on the total number of people excluding unknowns.

⁷ ONS (2020) *Coronavirus and key workers in the UK*
<https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/earningsandworkinghours/articles/coronavirusandkeyworkersintheuk/2020-05-15>

People who have started sleeping rough, or who have remained on the streets during the pandemic also have high levels of comorbidity and complex needs.

- Data from the July-September Combined Homelessness and Information Network (CHAIN) report of rough sleeping in London showed 44% (1011 people) seen sleeping rough during July to September 2020 had mental health support needs. 33% (761 people) had drug support needs.⁸
- A third (33%, 744 people) of people seen sleeping rough in the capital during the same period had at least two identified support needs in addition to their homelessness. These related to mental health, alcohol or drug problems, with 9% having all three additional support needs (210 people).⁹

The response to rough sleeping during the pandemic has saved lives, as well as producing other positive outcomes for many of those housed in hotels.

- Research published in *The Lancet Respiratory Medicine* journal found that 266 deaths were avoided in the homeless population in England during the first wave of Covid-19, owing to the action taken. Furthermore, 1,164 hospital admissions and 338 ICU admissions were also avoided.¹⁰
- The UCLH Covid-19 health assessment found that more than a third (35%) of those assessed in the emergency hotel accommodation in London said their physical health had improved since moving into a hotel.
- Significant numbers of people who had not previously accessed treatment have been supported by drug and alcohol services during the pandemic. Between April and September, the Homeless Hotel Drug & Alcohol Support Service (HDAS) in London supported 75 new people who had never accessed treatment services before.¹¹

Through semi-structured interviews with individuals from health and homelessness services, government departments and agencies, and people who had experienced rough sleeping, we identified the key factors driving improved health outcomes for people who had been rough sleeping and were housed in hotels. These were:

- Safe, secure and clean accommodation, with meals provided. The use of self-contained accommodation reduced the risk of transmission of Covid-19 and helped ensure people could self-isolate if needed.
- Having support workers on site to help people follow public health guidance, manage any issues with their accommodation and cope with complex problems related to their homelessness, such as drug and alcohol and mental health problems.
- The close involvement of health services to provide support and healthcare in the emergency accommodation where people were staying.¹² This support has been provided regularly and consistently, and from a position of understanding the full extent of an individual's support needs, rather than trying to treat related problems separately.
- The triage, assess and cohort model which ensured people were grouped on the basis of their clinical vulnerabilities and medical needs, including separate accommodation for people with Covid-19 symptoms. This reduced the risk of infection and allowed focused medical support to be provided – the benefits of which extended beyond maintaining people's immediate welfare during the pandemic. Stretched health services could be targeted at concentrated populations of people who needed them the most.

Notwithstanding the many positives for those previously sleeping rough who came into hotel accommodation, for others, this period has seen significant challenges. For those who remained, started or returned to rough sleeping during the pandemic, the closure of normal services such as day centres and communal night shelters, as well as the reduction in drop-in health clinics, has been hugely difficult. Some St Mungo's clients also reported feeling isolated and lonely during the lockdown, and that the anxiety and stress from this period, and their lack of social interaction, exacerbated existing mental ill health.

8 GLA (2020) *CHAIN Quarterly Report Greater London July - September 2020* <https://data.london.gov.uk/dataset/chain-reports>

9 Ibid

10 Lewer, D., et al. (2020) *COVID-19 among people experiencing homelessness in England: a modelling study* [https://www.thelancet.com/journals/lanres/article/PIIS2213-2600\(20\)30396-9/fulltext](https://www.thelancet.com/journals/lanres/article/PIIS2213-2600(20)30396-9/fulltext)

11 Pan-London Homeless Hotel Drug & Alcohol Support Service (HDAS) (2020) *Lessons Learned* <http://osf.io/7cdbx/>

12 In May 2020, 17 out of 23 emergency hotels being managed by St Mungo's had support from local health services.

Recommendations

There are still many people sleeping rough and more are at risk of joining them as the recession bites. In light of the health needs and increased vulnerability to Covid-19 of those sleeping rough, we must ensure that the lessons from the last few months are used to inform future plans to achieve our collective aim of ending rough sleeping.

Immediate action needed while the Covid-19 pandemic continues

- 1 Encourage stronger partnerships between housing and health services** – The Ministry of Housing Communities and Local Government (MHCLG), the Department of Health and Social Care (DHSC), Public Health England (PHE) and NHS England and NHS Improvement (NHSE/I) should maintain the close working arrangements developed during the Covid-19 pandemic to support local authorities and local health services to continue with the assessment, triage, cohort and care approach that saved lives in the first wave Covid-19.
- 2 Secure the successes of the principles of Everyone In by ensuring that sufficient, safe accommodation is in place for everyone that needs it** – The discovery of the new, highly transmissible variant of Covid-19, in addition to the cold winter weather, means there is an urgent need to protect the health of everyone sleeping rough. Moving forward the Government should provide additional funding and support to local authorities to ensure they are able to offer sufficient, self-contained emergency accommodation for everyone who is sleeping rough, or at risk of doing so while the pandemic continues. This includes accommodation with high levels of support and medical input for those with multiple and complex needs, or for those who are clinically vulnerable who need to shield. This approach should be a core aspect of any future emergency response that impacts upon those who are homeless or at risk of sleeping rough.
- 3 Ensure continued access to emergency accommodation, immigration advice and employment support for people with No Recourse to Public Funds (NRPF) who are sleeping rough** – A key principle of the Everyone In initiative was that homeless people were able to access support and accommodation regardless of their immigration status. This was particularly important for people who do not usually have access to homelessness assistance, or welfare support, due to NRPF conditions. The Government should build on the progress made during the pandemic to help end rough sleeping for everyone, including non-UK nationals. In particular, the Government should ensure continued access to emergency accommodation, and increase investment in specialist immigration advice and employment support services that support people to find a route out of homelessness.

- 4 Ensure that people who are homeless are prioritised for the Covid-19 vaccine** – It is extremely positive that frontline workers who support people experiencing homelessness are among the first groups able to receive a Covid-19 vaccine, along with other health and social care workers. It is also crucial that those who are homeless are prioritised. As a result of the significant barriers to healthcare faced by people who are homeless, many will not have been identified as clinically vulnerable and therefore requiring priority access to the Covid-19 vaccine. As part of the vaccine roll-out, the Government should ensure there is a comprehensive plan to identify and deliver the vaccine to people who are homeless. As part of this, the Government has rightly identified the need for a GP registration drive, but the plan must also include proactive and sustained outreach by health services working in partnership with local authorities, homelessness services and people with lived experience of homelessness. There is also a strong case for ensuring all homeless people are prioritised for the vaccine given their vulnerability to severe cases of Covid-19.

Beyond the pandemic

Our recommendations to national government

- 5 Strengthen joint work on homelessness across government** – A new inter-ministerial working group or cabinet committee on homelessness and rough sleeping should be established. Ministers across government need to be able to offer solutions, and be held accountable for the Government's goal to end rough sleeping by 2024. Furthermore, the Government should always consider homelessness and rough sleeping when responding to national emergencies, particularly where there is an immediate risk to health.
- 6 Extend the coverage of specialist homeless health services** – There should be more multi-disciplinary teams providing integrated mental health and substance use services that are joined up with housing and homelessness services in order to reach people with multiple and complex needs. Existing programmes must continue and funding must be provided to ensure services can reach people in every part of the country, not just some areas.
- 7 Restore £1 billion per year of lost funding for homelessness and housing related support services** – MHCLG and HM Treasury should restore the funding for homelessness and housing related support services¹³ that has been cut from local authority budgets over the past decade via a specific grant to local authorities in the next Comprehensive Spending Review.

- 8 Expand the Rough Sleeping Accommodation Programme (RSAP)** – 6,000 homes with support for people who have slept rough have been promised by March 2024 and the 2020 Spending Review confirmed £87 million capital funding would be made available in 2021-22 to support the delivery of these homes. However, further investment will be needed to ensure everyone housed in emergency accommodation gets the right housing and support they need to leave rough sleeping behind for good.
- Our recommendations to local leaders**
- 9 NHS organisations should work with local authorities and homelessness organisations to develop and implement effective delivery plans to ensure that people who are homeless are able to access the Covid-19 vaccine.**
This includes tailored communication, alongside proactive in-reach and outreach programmes, such as replicating the mobile vaccine units deployed to care homes for hostels and day centres.
- 10 NHS organisations should ensure their work to reduce health inequalities always considers people who are homeless.** The NHS Chief Executive, Sir Simon Stevens, has asked all parts of the NHS to “*take urgent action to increase the scale and pace of progress of reducing health inequalities*”. NHS organisations should ensure their plans explicitly cover steps to reduce the health inequalities experienced by people who are homeless and sleeping rough.
- 11 Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs) should develop clear plans for delivering integrated housing, mental health and substance use treatment pathways for people sleeping rough.** This will help to deliver the goals of the NHS Long Term Plan which identifies people sleeping rough as a priority group, and support the Government’s goal to end rough sleeping. The plans should be informed by the rapid audit of health provision targeted at people sleeping rough, which was carried out in 2018 by DHSC and MHCLG in order to identify gaps.
- 12 Local authorities should ensure their homelessness and rough sleeping strategies address health needs.** Working with the local Health and Wellbeing Board, every local authority should ensure their homelessness and rough sleeping strategy includes an assessment of the health needs of people who are homeless. Local strategies should also include measures to reduce health inequalities experienced by people who are homeless, and ensure people get the support they need to improve their health and move on from homelessness.
- 13 Health services should take steps to improve digital inclusion.** NHSE/I has said that all GP practices must offer face to face appointments at their surgeries as well as continuing to use remote consultation.¹⁴ However, online consultations remain a principal option for many services and more must be done to prevent further exclusion among people who struggle to access services remotely, including people who are homeless.
- 14 Local authorities and Clinical Commissioning Groups (CCGs) should increase the number of jointly commissioned services** - Jointly funded and commissioned services help ensure support is well integrated and better able to respond to a range of needs such as homelessness and poor health. Jointly commissioned services are also important for building strong relationships across different parts of the local ‘system’ and commissioners are well-placed to help improve service pathways, ensuring they are person-centred and not focused on trying to address a single problem.
- 15 Providers of drug and alcohol services should consider a range of options to speed up scripting for opiate problems.** Scripting services should be more flexible to ensure that people are engaged as early as possible, as we have seen with same-day scripting during this period.

13 WPI Economics (2020) *Local authority spending on homelessness 2020 update*
<http://wpieconomics.com/site/wp-content/uploads/2020/02/WPI-Economics-local-authority-homelessness-spending-2020-update-FINAL-images.pdf>

14 Pritchard, A., Stevens, S. (2020) *Third phase of NHS response to Covid-19*
<https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/07/Phase-3-letter-July-31-2020.pdf>

Methodology



This research has been carried out to better understand the health needs of people sleeping rough in England and their increased vulnerability to Covid-19, and to learn more about the approach taken to address the health and housing needs of this group during the pandemic. This report is intended to inform future service provision from positive practices which have emerged. We also hope it will help inform decision makers in government, local authorities and the health service and offer solutions to rough sleeping, both during the ongoing pandemic and beyond.

For this research, we carried out an analysis of new data sets including:

St Mungo's Covid-19 assessment

- This assessment is carried out by St Mungo's staff with clients from all St Mungo's housing related support services including, but not limited to, emergency hotels, supported housing and Housing First services in the south and south west of England including Brighton, Bristol, Oxford and London. This includes 939 clients in the emergency Everyone In hotels. The data set we analysed covered the period from 1 May to 4 December. In this period it has been completed for 4,922 clients.

St Mungo's Covid-19 assessment data

This was completed for 4,924 clients. This included:

- 939 clients in the emergency Everyone In hotels
- 2051 clients in Housing First and supported housing services (these services continued to run with measures introduced to keep clients and staff safe)
- 1,343 clients with floating support (tenancy support provided to people in their own housing)
- 586 clients who engaged with St Mungo's through other services such as staging post accommodation (interim accommodation often for people with more complex cases while they wait for a longer-term housing outcome)

Data from St Mungo's outreach teams on clients' use of health services

- St Mungo's outreach services in London use the CHAIN database to record the use of health services by the clients they are supporting to move away from rough sleeping. The 'events' recorded show the number of times health services were attended rather than the number of unique clients accessing a service. For example, one person may have attended a GP appointment five times and this is recorded as five 'events'. The data analysed compares 'events' recorded during the period September 2019-February 2020 and the period March 2020-August 2020: the six months prior to lockdown in March and the six months following lockdown in March.

St Mungo's hotel health partnerships survey

- This was a survey sent to 23 emergency Everyone In hotels managed by St Mungo's in May 2020. This provides a snapshot of the health and social care input to the St Mungo's hotel provision. 17 of the 23 hotels provided a response to the survey.

COVID-19 Homeless Rapid Integrated Screening Protocol (CHRISP) assessment

- This was an in-depth health assessment of clients in hotels across London led by the University College London Hospital (UCLH) Find & Treat team. 1,148 people are included in the data analysed. The data was gathered between July and October through a questionnaire completed for clients by medically trained staff, all of whom were foundation doctors, GPs or consultants. The majority were carried out via telephone but some were also carried out face to face in hotels.

In addition to the data analysis, we carried out semi-structured interviews with 24 individuals from health and homelessness services and four civil servants working in different Government departments and agencies. These were all carried out by telephone. Quotes from these interviews are included throughout the report but have been anonymised.

We also consulted St Mungo's clients who attended our regular Policy and Campaign Forum meetings in August and October, and spoke separately to four clients who had all stayed in emergency hotels. These meetings were held virtually, with assistance from our client involvement team and hotel managers.

Finally, we carried out desk-based research of publications related to rough sleeping, homelessness and health, although this was not a full literature review.

Policy context



Before the Covid-19 pandemic, homeless people were dying on the streets

Rough sleeping is the most visible and dangerous form of homelessness and dying on the streets is its most appalling consequence. People who sleep rough commonly have extremely poor health and poor access to health services.

Poor health and homelessness are closely related problems, and addressing people's health needs has to be part of the solution to homelessness.

Government action prior to Covid-19

In recent years, in response to rapid increases in rough sleeping, the Government has recognised that *"too many people still sleep rough on our streets"* and that *"the human cost of this, in broken lives too often cut short, is unacceptable,"*¹⁵ and has taken action to help reduce rough sleeping and improve health outcomes for those experiencing homelessness.

Through the Rough Sleeping Initiative and other pilots and programmes initiated as part of the 2018 Rough Sleeping Strategy, the Government has invested in providing emergency support to people who are sleeping rough. This investment has enabled local authorities, working in partnership with service providers, to scale up services such as street outreach, emergency accommodation, assessment and rapid rehousing services, including No Second Night Out and Somewhere Safe to Stay, tenancy support and Housing First services.

The strategy also pledged *"up to £2 million in health funding to enable access to health and support services for people who are sleeping rough"* and underlined the fact that local authorities were 'legally obliged' to house *"those who are vulnerable as a result of their health."*¹⁶ The Homelessness Reduction Act (2017) introduced a duty for certain public bodies, including social services and hospitals, to refer anyone who is homeless or at risk of homelessness to their local housing authority, setting *"an expectation of closer working between the health and housing sectors."*¹⁷

In 2019, the NHS Long Term Plan identified people sleeping rough as a priority group as part of its commitment to tackle health inequalities. It committed to invest up to £30 million extra in specialist mental health services, integrated with existing homelessness outreach services. Funding has so far been provided to seven areas in England and there are plans to fund services in a total of 20 areas by 2023/24. Crucially, the NHS Mental Health Implementation Plan, also published in 2019, states that *"all areas, whether or not they receive funding for new specialist mental health provision, should have a mechanism in place to ensure their mental health services can support rough sleepers."*¹⁸ Local plans should include a mental health needs assessment for rough sleepers which will identify need and increase access to mental health services, and ensure such services adopt a trauma-informed approach.



In 2019, **778** people died while sleeping rough or in emergency accommodation, an increase of 7% from 2018.

15 MHCLG (2018) *Rough Sleeping Strategy 2018*

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/733421/Rough-Sleeping-Strategy_WEB.pdf

16 Ibid.

17 The King's Fund (20220) *Delivering health and care for people who sleep rough: going above and beyond*

<https://www.kingsfund.org.uk/publications/delivering-health-care-people-sleep-rough>

18 NHS (2019) *NHS Mental Health Implementation Plan 2019/20 – 2023/24*

<https://www.longtermplan.nhs.uk/wp-content/uploads/2019/07/nhs-mental-health-implementation-plan-2019-20-2023-24.pdf>

Section 3

In 2019 the Government made a renewed commitment in their General Election manifesto to end rough sleeping by 2024 by “*working to bring together local services to meet the health and housing needs of people sleeping on the streets.*”¹⁹ The 2020 Spring Budget announced funding of £262 million for specialist substance use treatment services for people sleeping rough, although this has yet to be spent. The 2020 Spending Review went further, confirming funding from the Shared Outcomes Fund to provide improved support to individuals experiencing multiple and complex needs, such as homelessness and substance use (£46m) and step-down accommodation and support from hospital for individuals who are homeless (£16m).²⁰ This has now been allocated through the Changing Futures Fund (£23 million 2020/2021 with a further £52 million in 2021 to 2022), announced on 11 December 2020, in which 43 areas across England will receive support to help improve the way that systems and services work to support individuals experiencing multiple disadvantage.²¹

These are significant, positive steps towards a truly cross-government approach to ending rough sleeping. However, much of this work has also been disrupted or delayed by Covid-19.

Everyone In: responding to the threat of Covid-19 for people sleeping rough

There is no doubt that the progress described above helped lay the foundations for a swift and decisive response to rough sleeping when the first wave of Covid-19 arrived in the UK. In particular, the newly expanded rough sleeping and homeless health services were well placed to respond.

At the start of the first national lockdown in March 2020, acting on a very legitimate concern for the health of people sleeping rough, the Government launched the Everyone In initiative. Government Ministers tasked local authorities in England with supporting everyone sleeping rough, or in accommodation where it was difficult to self-isolate (such as communal shelters), to move into emergency accommodation including hotels, hostels and B&Bs. According to the Government, this initiative has led to more than 33,000 people being moved into safe emergency accommodation.

The action was critical, not only because those sleeping rough are particularly vulnerable to severe cases of Covid-19, but also because they are some of those least able to follow public health advice. Advice to stay at home is meaningless to those without one.

St Mungo's has been heavily involved in this effort, supporting clients to find emergency accommodation, follow public health guidance, and access services including mental health support and drug and alcohol services. As of the beginning of December 2020, St Mungo's had managed 30 emergency hotels, of which 11 were still open. In total, since the start of the pandemic, we had supported 3,364 people staying in emergency Covid-19 accommodation. 32% of clients supported in emergency accommodation were BAME, 16% were women.

For those who did come inside, the hotels have also provided a foundation for further recovery. As of the beginning of December, St Mungo's had helped 1,300 people move on from emergency accommodation to longer term housing, including homes in the social, supported and private rented sectors.

One of St Mungo's clients, Ian, moved from an emergency hotel into a flat through the Clearing House programme, which provides social housing and tenancy sustainment support for people who have slept rough in London. “*They gave me a home, they got my Universal Credit going, I've got a studio flat now - I have the keys... I have a house, in a nice neighbourhood, by the Thames.*”

The crisis continues

During the first wave of Covid-19, the number of people seen sleeping rough plummeted thanks to the Everyone In initiative. According to the Government, more than 90% of rough sleepers known to councils at the beginning of the pandemic were offered safe, emergency accommodation, in the space of two months.²²



32% of clients supported in emergency accommodation were BAME, 16% were women

¹⁹ Conservative Party (2019) *The Conservative and Unionist Party Manifesto 2019*
https://assets-global.website-files.com/5da42e2cae7ebd3f8bde353c/5dda924905da587992a064ba_Conservative%202019%20Manifesto.pdf

²⁰ HM Treasury (2020) *Spending Review 2020*
<https://www.gov.uk/government/publications/spending-review-2020-documents/spending-review-2020#shared-outcomes-fund>

²¹ MHCLG (2020) *Extra help for rough sleepers with drug and alcohol dependency*
<https://www.gov.uk/government/news/extra-help-for-rough-sleepers-with-drug-and-alcohol-dependency>

However, thousands of people have still slept rough during the pandemic. Interviews conducted for this report revealed that hotels filled up prior to finding a room for everyone. As one homeless health nurse reported: “*Their names had been put on waiting list to go into hotels but they filled up quickly and funding ran out.*”

Crucially, the number of people sleeping rough is not static and there has continued to be a flow of people onto the streets during the pandemic. The CHAIN report on rough sleeping in London covering the period from April to June 2020 showed an initial surge in rough sleeping during the first lockdown, with a 77% increase in the number of people found sleeping rough for the first time in the capital, and a 33% increase in the total number sleeping rough compared to the same period in 2019 (up from 3,172 in Q1 2019/20 to 4,227 in Q1 2020/21).²³

Since then, the number has decreased with CHAIN data for July to September 2020 showing 3,444 people were seen sleeping rough during the summer, which is 14% lower compared to the same period in 2019. However, 55% of those seen were new to the street.²⁴ Elsewhere in the country, local authorities and outreach services have reported a rise in the number seen sleeping rough following the initial drive to get ‘everyone in’.²⁵ National StreetLink data for January-September 2020 shows an 82% increase in requests for help from individuals rough sleeping (self-alerts) compared to 2019 (from 5,503 to 10,006).²⁶

While the Government has stated that Everyone In continues, Ministers haven’t re-issued the same clear expectations, guiding principles and the levels of funding needed, which were core ingredients of the approach to providing safe, emergency accommodation for everyone, including those with no recourse to public funds, during the first wave.²⁷

In previous years, communal shelters have been widely used to provide emergency accommodation to people sleeping rough, particularly during the winter months. However, communal shelters are also known to put people at high risk of contracting Covid-19. In a study by the Coalition for the Homeless it was found that the mortality rate from Covid-19 for people staying in homeless shelters in New York City was 61% higher than the rate among the general population.²⁸ In October 2020, the Government published guidance on the use of winter shelters for people sleeping rough, but stopped short of ruling out the use of communal shelters altogether, saying instead they should only be used as a last resort.

To support this approach, the Government has provided specific funding to help local authorities continue to provide self-contained emergency accommodation for people sleeping rough, as well as longer-term housing and support, through the Next Steps Accommodation Programme, the Cold Weather Fund and the Protect Programme. The latter of which was announced at the start of the second national lockdown in November 2020. However, several local and combined authorities have said that the funding is not enough to ensure that everyone who needs it can access safe, individual accommodation.²⁹

In January 2021, the Government announced a further £10 million to help local authorities provide accommodation for people sleeping rough, and to assist with GP registration to help with access to the Covid-19 vaccine.

Saving the lives of some of the most vulnerable in our society has been at the core of the Government’s response to rough sleeping during Covid-19. The risks of sleeping rough during the coronavirus pandemic are further exacerbated by cold weather. It is vital that everyone who is on the streets, or who is at risk of rough sleeping, can continue to access self-contained accommodation immediately, with adequate support where it is needed.

22 MHCLG (2020) *6,000 new supported homes as part of landmark commitment to end rough sleeping* <https://www.gov.uk/government/news/6-000-new-supported-homes-as-part-of-landmark-commitment-to-end-rough-sleeping>

23 GLA (2020) *CHAIN Quarterly Report Greater London April - June* <https://data.london.gov.uk/dataset/chain-reports>

24 GLA (2020) *CHAIN Quarterly Report Greater London July - September 2020* <https://data.london.gov.uk/dataset/chain-reports>

25 BBC (November 2020) *Bristol homeless: ‘Toughest winter yet’ for rough sleepers* <https://www.bbc.co.uk/news/uk-england-bristol-54936668>

26 Homeless Link (November 2020) *Bring Everyone In again: lessons and leadership for lockdown two to prevent a homelessness crisis* https://www.homeless.org.uk/sites/default/files/Briefing%20Everyone%20In%2020_final_clean.pdf

27 MHCLG (March 2020) *Letter from Minister Hall to local authorities* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/928780/Letter_from_Minister_Hall_to_Local_Authorities.pdf

28 Coalition for the homeless (2020) *Covid-19 and homelessness in New York City* <https://www.coalitionforthehomeless.org/wp-content/uploads/2020/06/COVID19HomelessnessReportJune2020.pdf>

29 Griffiths N. (October 2020) *Government’s new £12m winter fund for rough sleeping ‘not enough’, say Manchester council and charities* <https://www.manchestereveningnews.co.uk/news/greater-manchester-news/governments-new-12m-winter-fund-19101806>

The health needs of homeless people



People who are sleeping rough face some of the worst health inequalities in society

People sleeping rough are at much greater risk of mental and physical health problems than the general population and their experiences of sleeping on the streets often make it more difficult to access the healthcare they need.

Evidence strongly suggests that people who sleep rough often experience even worse health outcomes than the wider group of people who are homeless.³⁰ For instance, in one recent study in the United Kingdom, drug and alcohol problems were significantly higher among people sleeping rough than the wider definition of 'single homeless' people.³¹

Furthermore, the longer that people sleep rough, the worse their health needs become as these needs are compounded by the traumatic experience of sleeping rough. Research published by St Mungo's earlier this year revealed that people who sleep rough for longer are more likely to have drug and alcohol problems.³²

Although this report focuses specifically on people who have experienced, or who are, rough sleeping, some of the studies referred to do not distinguish people who sleep rough from the wider homeless population. However, they still give an overview of just how extensive and severe the health needs amongst those rough sleeping are, and the health inequalities they experience when compared to the wider population.

People who have slept rough have high levels of respiratory illness and frailty, and die far younger than the general population

Crucially for the current Covid-19 crisis, people who have slept rough report extremely high levels of respiratory illness when compared to the general population. One study found that 64% of participants who had slept rough reported having had chest infections, 30% of participants had been admitted to hospital for 'frightening breathlessness', and 20% of participants reported that they had asthma compared to 8.4% in the general population.³³

Further, research by a group of Pathway Fellows found that in a complex needs hostel in south London for people who had been sleeping rough, the average age of hostel residents was 56 but the level of frailty was equivalent to an 89 year old in the general population. They also established an average of more than seven long term conditions per person, which is far greater than the average for even the oldest people in the general population.³⁴

On 14 December 2020, the ONS released data which showed a record number of people dying while sleeping rough or in emergency accommodation. 778 people died in 2019, a 7.2% rise on the previous year.³⁵ That is more than 16 people dying every week.

Further, these deaths were overwhelmingly premature and largely preventable. The ONS data showed that the average age of death for those sleeping rough or in emergency accommodation was only 45.9 for men. For women it was 43.4.³⁶ A study in 2019 showed that after adjusting for age and sex, nearly one in three of the deaths among people who were homeless were due to conditions such as tuberculosis and gastric ulcers which are amenable to timely and effective health care.³⁷

30 Elwell-Sutton T., Fok J., Albanese F., Mathie H., Holland R., (2017) *Factors associated with access to care and healthcare utilization in the homeless population of England* <https://academic.oup.com/jpubhealth/article/39/1/26/3065715>

31 Ibid.

32 St Mungo's (2020) *Knocked Back: Failing to support people sleeping rough with drug and alcohol problems is costing lives* https://www.mungos.org/app/uploads/2020/01/StM_Knocked_Back_DA_Research_Report_Final_2901.pdf

33 Groundswell (2016) *Room to Breathe* <https://groundswell.org.uk/wp-content/uploads/2018/10/Groundswell-Room-to-Breathe-Full-Report-2016.pdf>

34 Rogans-Watson R., Shulman C., Lewer D., Armstrong M., Hudson B. (2020) *Premature frailty, geriatric conditions and multimorbidity among people experiencing homelessness: a cross-sectional observational study in a London hostel* https://www.emerald.com/insight/content/doi/10.1108/HCS-05-2020-0007/full/html?mc_cid=58daf4f026&mc_eid=f60669dcec

35 ONS (2020) *Deaths of homeless people in England and Wales: 2019* <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsofhomelesspeopleinenglandandwales/2019registrations>

36 ONS (2020) *Deaths of homeless people in England and Wales: 2019* <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsofhomelesspeopleinenglandandwales/2019registrations>

37 Aldridge RW., Menezes D., Lewer D. et al. (2019) *Causes of death among homeless people: a population-based cross-sectional study of linked hospitalisation and mortality data in England* <https://wellcomeopenresearch.org/articles/4-49/v1>

There are significant barriers to accessing timely health care and this exacerbates health inequalities

Many people who are homeless — both those sleeping rough, and those who fall under a wider definition of homelessness — experience significant barriers in accessing the timely health care they need. Groundswell's 'More than a Statistic' research revealed that one of the key barriers that people who are homeless face to getting healthcare is registering and making use of a GP practice.³⁸

This is very important as a GP is a gateway to access other health services, as well as a preventative measure to avert increased A&E visits. Difficulties in seeing a GP also mean that homeless people are often not participants in NHS vaccination and screening programmes, such as influenza vaccinations. Amongst the homeless population, "vaccine uptake levels are less than half those seen among eligible GP patient groups in England".³⁹ This is also most likely an underestimate due to the prevalence of undiagnosed health conditions.⁴⁰ Without a concerted effort, the same issues are likely to arise with the Covid-19 vaccine.

Access to GPs is especially low amongst people who sleep rough. A study in 2016 showed that 66.5% of those rough sleeping were registered with a GP compared with single homeless people in accommodation and people who are hidden homeless (83.1% and 88.4%, respectively).⁴¹

A persisting problem with GP registration is that people are refused on the grounds of lacking ID, having no fixed address or not being able to prove their immigration status. This is despite NHS guidelines stating: "You should not be refused registration or appointments because you do not have a proof of address or personal identification at hand. It's not considered a reasonable ground to refuse registration."⁴²

Research for this report also revealed problems associated with people sleeping rough being registered with a GP in a different area to the one they were staying in, which also made it harder to get the help they needed.

People sleeping rough also find it difficult to access other health services, including mental health and substance use services. Such difficulties are likely the result of a combination of factors, which include inadequate signposting; a lack of knowledge of services; fear of stigmatisation; attitudinal issues within services; and financial barriers such as paying for travel to appointments.^{43 44}

There are also barriers which are a result of the nature of sleeping rough and the daily challenges this causes. Due to the reduction in drug and alcohol outreach services in recent years, and fewer specialist workers able to engage people where they are, people are often required to attend drop-ins followed by structured appointments in order to access substance use services. This problem was highlighted by St Mungo's 'Knocked Back' research into drug and alcohol problems and rough sleeping, published in February 2020, in which one interviewee noted that "My God, and I don't have an alarm clock, I don't have a diary, I don't have a phone, I don't have any way to even know what day it is some days."⁴⁵

38 Groundswell (2016) *More than a Statistic* https://groundswell.org.uk/wp-content/uploads/2018/10/NHS100012_More-than-a-statistic-Final-2017-1.pdf

39 NICE (2018) *Flu vaccination: increasing uptake* <https://www.nice.org.uk/guidance/ng103/evidence/expert-paper-3-homeless-outreach-pdf-6532123791>

40 Ibid.

41 Elwell-Sutton T., Fok J., Albanese F., Mathie H., Holland R., (2017) *Factors associated with access to care and healthcare utilization in the homeless population of England* <https://academic.oup.com/jpubhealth/article/39/1/26/3065715>

42 NHS (2019) *How to register with a GP practice* <https://www.nhs.uk/using-the-nhs/nhs-services/gps/how-to-register-with-a-gp-practice/>

43 Burwood, S., Chandan, S., Gunner, E., Marwick, S., Paudyal, V., Saunders, K., and Yahyouche, A., (2019) *Provision and accessibility of primary healthcare services for people who are homeless: a qualitative study of patient perspectives in the UK* <https://bjgp.org/content/69/685/e526>

44 Groundswell (2016) *More than a Statistic* https://groundswell.org.uk/wp-content/uploads/2018/10/NHS100012_More-than-a-statistic-Final-2017-1.pdf

45 St Mungo's (2020) *Knocked Back: Failing to support people sleeping rough with drug and alcohol problems is costing lives* https://www.mungos.org/app/uploads/2020/01/StM_Knocked_Back_DA_Research_Report_Final_2901.pdf

Difficulty in accessing health services can lead to people's health problems becoming more acute, or to them trying to access healthcare in other ways. A study in Birmingham, which looked at patient data from a specialist primary healthcare service, found that homeless people were 60 times more likely to visit A&E than the general population.⁴⁶ This problem is increasing. A study by the British Medical Association (BMA) found that the number of recorded visits to emergency departments by patients classed as having no fixed address almost trebled between 2010-11 and 2017-18.⁴⁷

This is extremely concerning given that A&E services are less able to provide holistic support for individual's with multiple and complex needs, whilst costing far more than primary care.⁴⁸

In response to the difficulty in accessing health services and in order to tackle health inequalities among people who are homeless, some specialist GP practices and homeless health services have been established. These are set up to ensure that health services are available for marginalised groups, such as people who are homeless, sex workers and Gypsies, Roma and Travellers. One such example is Great Chapel Street, which is a walk-in medical centre for homeless people in Westminster. Some services have been established for a long-time, others have been set-up more recently in response to rising rough sleeping. However, there is still not sufficient, or consistent provision of these specialist services across the country.

Changes in access to health services during the Covid-19 pandemic will be explored in Section 7.

Non-UK nationals face specific challenges

It is important to note that non-UK nationals who are homeless face considerable difficulty accessing health services. Some health services such as community mental health services and some aspects of drug and alcohol treatment are not free for certain non-UK nationals and must be paid for up front, restricting the number of people who can access them. There are further problems for this group in terms of language barriers and a lack of understanding among all concerned about the effect of an individual's immigration status on their eligibility for certain services.

And yet we know non-UK nationals make up a significant proportion of people sleeping rough in England. According to government statistics, 26% of people sleeping rough in England on a single night in autumn 2019 were non-UK nationals. A recent report by LSE found that more than a quarter of those accommodated in London between April-June under Everyone In had 'no recourse to public funds' conditions as a result of their immigration status.⁴⁹

Although published and academic literature suggests that migrants sleeping rough tend to have less complex needs this difference is becoming less pronounced: in 2014-2015, 41% of non-UK nationals sleeping rough in London had drug and alcohol problems compared to 52% in 2018-2019. Further, sleeping rough takes a significant toll on a person's physical and mental health. Difficulties in accessing health services compound this and can lead to a downward spiral of ill health.

46 Bowen M., Marwick S., Marshall T., Saunders K., Burwood S., Yahyouche A., et al. (2019) *Multimorbidity and emergency department visits by a homeless population: a database study in specialist general practice* <https://bjgp.org/content/69/685/e515#xref-ref-6-1>

47 BMJ (2019) *Homeless people's A&E visits treble in seven years* <https://www.bmj.com/content/364/bmj.l323>

48 Centre for Policy Studies (2014) *How much do we use the NHS?* <https://www.cps.org.uk/files/reports/original/141028143252-HowMuchDoWeUseTheNHS.pdf>

49 Scanlon K., Whitehead C. (2020) *London local government expenditure on 'Everyone In'* <https://blogsmedia.lse.ac.uk/blogs.dir/119/files/2020/11/Costs-of-Everyone-In-LSE-London.pdf>

Assessing the health needs of homeless people during Covid-19





Covid-19 has meant an increased focus on the health needs of people sleeping rough. As a result of this, updated evidence has emerged. This section looks at data from two health assessment tools used to help support people during Covid-19: St Mungo's own Covid-19 Assessment; and the COVID-19 Homeless Rapid Integrated Screening Protocol (CHRISP) assessment. These assessments are used to better understand the needs of clients and whether they are being met. They also enable service providers to follow the Public Health England approach to triaging, assessing and accommodating clients in defined cohorts during this period based on their vulnerability to Covid-19 or whether they have symptoms of the virus.

CHRISP assessment data

The CHRISP assessment was carried out for people in emergency hotels in London, those accommodated under Everyone In as they had previously been sleeping rough or in accommodation where it was difficult to self-isolate (such as night shelters). There were generally three types of hotel for differing needs:

- Covid-Care hotels for people who were symptomatic or had tested positive;
- Covid-Protect sites for those who were asymptomatic but at increased risk from Covid-19
- Covid-Prevent sites for asymptomatic individuals with no increased vulnerability.

The CHRISP assessment covered all three types of hotel. It was carried out by medically trained professionals, the majority of whom were doctors.

The CHRISP assessment found that 37% of clients had mental health problems, 19% (223 people) had self-identified drug problems, and 166 people self-declared problematic alcohol use.⁵⁰ 15% had dual diagnosis of mental health and drug and alcohol problems; close to 40% of those assessed had chronic dental pain; and around 40% had memory cognition problems.⁵¹

⁵⁰ Pan-London Homeless Hotel Drug & Alcohol Support Service (HDAS) (2020) *Lessons Learned* <http://osf.io/7cdbx/>

⁵¹ Healthy London Partnerships (2020) *Homeless health - next steps for London: health needs assessments & the importance of MDTs* <https://www.youtube.com/watch?v=SLOGllhDXus&feature=youtu.be>

It also found that 6% of people accommodated in hotels had extreme clinical vulnerability, nearly double that of the general population. 33% had moderate clinical vulnerability. Again, this is more than double that found in other cohorts of the population. For example ONS data showed 15% of key workers have moderate clinical vulnerability.⁵² The CHRISP assessment's definition of extremely clinically vulnerable is: severe asthma/ COPD which is not controlled by medication, or has led to hospital admission in the last year; HIV; Sickle Cell disease; currently has cancer; since the start of the pandemic has been advised to shield by their GP. Moderate clinical vulnerability is people who have: a severe brain disorder; diabetes; high blood pressure; chronic kidney problems; chronic liver problems such as Hepatitis; asthma or COPD; have had a heart attack, stroke or angina; are pregnant; or are aged 60 or older.⁵³

St Mungo's Covid-19 assessment data

St Mungo's own Covid-19 assessment was used in all service areas across London, the South West and South East of England. This data shows more than a third of clients (36% - 247 people) in emergency hotel accommodation had a physical health support need; 37% (243 people) of clients had a mental health support need; 31% (215 people) of clients had drug support needs and 36% (244 people) had alcohol support needs.

28% (203 people) of clients in emergency hotels were found to be extremely clinically vulnerable or vulnerable. It is important to note the definition of vulnerability is slightly different to the one used in the CHRISP assessment. In the St Mungo's Covid-19 assessment vulnerability included being aged 55 or older rather than 60 or older, or having a BMI of 40 or above.



A **quarter** (24%, 1,005 people) of all St Mungo's clients were recorded as having an underlying health condition which puts them more at risk of suffering from acute cases of Covid-19, for instance severe respiratory conditions such as chronic obstructive pulmonary disease (COPD).

	Emergency hotel clients	Housing First and supporting housing clients
Vulnerable or extremely vulnerable	28%	54%
Required regular prescription	37%	74%
Mental health support needs	37%	82%
Physical health support needs	36%	58%
Drug support needs	31%	55%
Alcohol support needs	36%	38%
Underlying health condition (Covid-19 specific)	19%	30%

⁵² ONS (2020) *Coronavirus and key workers in the UK*
<https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/earningsandworkinghours/articles/coronavirusandkeyworkersintheuk/2020-05-15>

⁵³ Find & Treat (2020) *Homeless COVID Risk Assessment (Mini-CHRISP tool) for non-clinical staff*
<https://www.healthylondon.org/wp-content/uploads/2020/11/COVID-19-Risk-Assessment-tool-FINAL-191120.pdf>

Previous research shows that people who are homeless experience stark health inequalities, particularly those who have experienced rough sleeping. This new evidence collected during the Covid-19 pandemic provides further proof. It also shows that these health inequalities have been exacerbated by the pandemic, revealing this group to be more vulnerable than the general population to a public health crisis, while they are also less likely to be able to protect themselves from it.

People in supported housing and Housing First services have even higher health needs

The same St Mungo's Covid-19 assessment was also used for clients in all St Mungo's housing related support services, including supported housing and Housing First services not just the emergency hotels. The assessment data revealed higher health needs amongst those in supported housing and Housing First services than for those in emergency hotels. For example, 38% of clients in supported housing services were classed as vulnerable or extremely vulnerable to Covid-19 (680 people). This rose to 54% of clients in St Mungo's Housing First accommodation (85 people). Similarly, a third (37%, 270 people) of clients in emergency hotels required a regular prescription whereas three quarters (74%, 1412 people) of clients in Housing First and supported housing accommodation did. 82% of clients in Housing First and supported housing accommodation had mental health support needs (1588 people) – more than double the percentage of those in emergency hotels.

Services such as supported housing and Housing First are specifically for people who have support needs, which means that they need extra support to cope with complex problems such as poor mental health, domestic violence and substance use. It is therefore not surprising to see an even higher proportion of clients with underlying health problems and vulnerability to Covid-19 when compared to clients in the emergency hotels. Some of our housing related support services are specifically for people who have slept rough for long periods of time, often over many years, and the longer someone spends sleeping rough, the worse their health is likely to become, often with lasting consequences.

People who have started or remained sleeping rough during the pandemic have high support needs

The complex health needs amongst different cohorts is also pertinent when we look at the health needs of those who remained sleeping on the streets, or who left hotel accommodation – either voluntarily or because they were asked to leave.⁵⁴

As of 12 December 2020, 13% (423 people) of clients St Mungo's had been supporting in emergency hotels had abandoned their hotel accommodation, with many likely to have returned to rough sleeping. It is evident from the CHAIN database of rough sleeping in London that the cohort of people who have remained on the street during the pandemic have very high health needs. CHAIN figures for July-September 2020 show that nearly half (44%, 1,011 people) of those seen sleeping rough in London during that period had mental health support needs.⁵⁵ A third (744 people) had more than one of the following support needs in addition to their homelessness – mental health, alcohol and/or drug problems, with 9% (210 people) having all three additional support needs.

This data helps to confirm reports from outreach services that those who remained rough sleeping throughout the pandemic were people with highly complex needs who require more intensive support than the emergency hotels could provide. Some health needs, such as substance use problems and mental ill health, can result in challenging behavior and will have made it difficult for some to adjust to hotel accommodation. Everyone In has provided further evidence that some people need specialist accommodation and support that could not be provided in empty hotels, or similar emergency accommodation services.

⁵⁴ Allison E., Walker A., (2020) *Quarter of Manchester homeless people housed in hotels for lockdown have left* <https://www.theguardian.com/society/2020/apr/27/quarter-of-manchester-homeless-people-housed-in-hotels-for-lockdown-have-left>

⁵⁵ GLA (2020) *CHAIN Quarterly Report Greater London July - September 2020* <https://data.london.gov.uk/dataset/chain-reports>

Addressing the health needs of homeless people during the Covid-19 crisis





6.1 Health outcomes for people who were brought in to hotel accommodation

Saving lives from Covid-19

Research published in The Lancet Respiratory Medicine journal found that the policy of bringing everyone in to self-contained accommodation “may have avoided more than 21,000 infections, 266 deaths, 1,164 hospital admissions and 338 ICU admissions among the homeless population.”⁵⁶ As the Healthy London Partnership noted, in London “infection rates among the rough sleeping community...at the peak of Covid-19 stood at around 5-6%, compared to similar international cities such as Chicago and San Francisco, where this has been 50-60%.”⁵⁷

Three St Mungo's clients have died from Covid-19 and 16 people recorded as homeless had died from Covid-19 in England as of 26 June according to ONS data.⁵⁸ Although every death is a tragedy, this is far lower than originally predicted.⁵⁹

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- 56 Aldridge, R., Braithwaite, I., Bullock, M., Max T., Lewer, D., White, P. et al (2020) COVID-19 among people experiencing homelessness in England: a modelling study [https://www.thelancet.com/journals/lanres/article/PIIS2213-2600\(20\)30396-9/fulltext](https://www.thelancet.com/journals/lanres/article/PIIS2213-2600(20)30396-9/fulltext)
- 57 NHS England and Improvement (2020) Case study: Homeless health in London – the response to Covid-19 https://www.healthy london.org/wp-content/uploads/2020/04/COVID-19-Homeless-Health-in-London-case-study-v1.pdf?mc_cid=2cbd1f3bae&mc_eid=e3c037e9c5
- 58 ONS (2020) Coronavirus and deaths of homeless people, England and Wales: deaths registered up to 26 June 2020 <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/coronavirusanddeathsofhomelesspeopleenglandandwalesdeathsregisteredupto26june2020/2020-07-10>
- 59 WLM (2020) Fears of 'catastrophic coronavirus outbreak' among homeless in hostels <https://www.wlm.org.uk/news/fears-of-catastrophic-coronavirus-outbreak-among-homeless-in-hostels>

As of August 2020 there had been 28 laboratory confirmed cases of Covid-19 amongst the homeless population in London.⁶⁰ In comparison, in New York 700 homeless people had been diagnosed with Covid-19 as of 6 May. 69 people are known to have died.⁶¹ In Los Angeles, 455 homeless people had been diagnosed with COVID-19 as of the end of May. 13 people are known to have died.⁶²

As well as protecting people sleeping rough from Covid-19, the Everyone In initiative has also led to improved health outcomes in other areas.

	London	New York	Los Angeles
Homeless people diagnosed Covid-19	28	700	455
Homeless people died of Covid-19	6	69	13

Drug and alcohol problems

The pandemic period has seen an increase in referral to and uptake of drug and alcohol services.

- The Homeless Hotel Drug & Alcohol Support Service (HDAS) in London received new referrals for 75 people staying in emergency hotels who had never previously accessed treatment services.⁶³
- Data from St Mungo's outreach teams on our clients' use of health services shows the engagement rate with drug and alcohol services increased during the Everyone In initiative. The number of times clients have been recorded as accessing a drug and alcohol service has increased from 216 times during September 2019-February 2020, to 254 times during March-August 2020.⁶⁴ The number of times clients have been recorded as being scripted has increased from 37 to 86 during the same periods of time.
- Between March and 15 June 2020, the homeless health service in Bristol (funded by Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group) reported that engagement in substance rehabilitation services amongst people sleeping rough, or in emergency hotels, quadrupled.⁶⁵

As well as increased engagement with drug and alcohol services, this period also saw an increased number of people scripted.

Going on a script is a form of Opioid Substitution Treatment (OST) where an individual is put on methadone or buprenorphine prescription (a 'script') as a substitute. This to stabilise opiate use in a controlled way. As the Drug Misuse and Dependence UK Guidelines on Clinical Management state, scripting "*has a well-established evidence base for the management of heroin dependence*".⁶⁶ Scripting also helps to bring people to services and encourage people to engage in treatment.⁶⁷ It is crucial that people are brought onto a script at the earliest window of opportunity. The increased flexibility in scripting has been one of the significant beneficial changes of this period.

60 Hayward A., Story A. (2020) *Public Health rationale for NOT opening/re-opening communal airspace sleeping facilities for homeless people during the SARS-CoV-2 pandemic* <https://www.pathway.org.uk/wp-content/uploads/UCL-CCIH-Faculty-Position-Statement-Aug-2020-Communal-Airspace-Sleeping-Facilities-AS-AH.pdf>

61 The Pavement (2020) *Lifesaver* <https://www.thepavement.org.uk/>

62 The Mercury (2020) *Coronavirus in homeless communities: How bad is it in Bay Area shelters, camps?* <https://www.mercurynews.com/2020/06/08/coronavirus-in-homeless-communities-how-bad-is-it-in-bay-area-shelters-camps/>

63 Pan-London Homeless Hotel Drug & Alcohol Support Service (HDAS) (2020) *Lessons Learned* <http://osf.io/7cdbx/>

64 This does not include residential.

65 NHS Bristol, North Somerset and South Gloucestershire (2020) *Surge in number of homeless people engaging in substance misuse services during coronavirus outbreak* <https://bnssgccc.nhs.uk/news/surge-number-homeless-people-engaging-substance-misuse-services-during-coronavirus-outbreak/>

66 Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group (2017) *Drug misuse and dependence* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/673978/clinical_guidelines_2017.pdf

67 St Mungo's (2020) *Knocked Back: Failing to support people sleeping rough with drug and alcohol problems is costing lives* https://www.mungos.org/app/uploads/2020/01/StM_Knocked_Back_DA_Research_Report_Final_2901.pdf

Evidence points towards a decrease in both drug use, arguably as a result of the increase in access to drug and alcohol services, and the increase in the number of people scripted. A recent evaluation of the HDAS-London service revealed that 44% (99 people) of hotel residents who undertook a CHRISP assessment reported that their drug use since moving into a hotel had reduced and only 11% (24 people) said that it had increased.⁶⁸

The evaluation suggested a reduction in alcohol consumption as well – although perhaps not as stark as the decrease in drug use. 213 people reported drinking less, however 72 reported drinking an increased amount.⁶⁹ This may have been because of the harm reduction approach taken in many hotels, meaning clients were supported to maintain alcohol use to avoid unplanned withdrawal. As HDAS-London reported, “there were significant concerns about the potential for high rates of acute unplanned alcohol withdrawal when the hotels began operating.”⁷⁰ Indeed, these concerns were reflected in alcohol being the most common treatment referral via HDAS-London, accounting for 57% of all referrals, and was “the subject of many contacts from hotel staff seeking advice and support.”⁷¹

One St Mungo’s Hotel Manager in London commented on the changes they had seen in clients’ alcohol consumption: “We’ve had a good four or five clients in the hotel who were incredibly chaotic and drinking litres of vodka daily. Through programmes the nurses set up they were able to provide alcohol but slowly reduce it so they got the point where they were only drinking two cans a day.”

Smoking

During this period, research shows that there has also been a real drive to help people stop smoking. This was often aided by the rules preventing smoking in the emergency hotel rooms.

- The CHRISP assessment shows that more than one in four of those surveyed said their tobacco consumption had decreased during this period. This is a quarter of the total number surveyed rather than a subsection of those who smoked initially.

Lead homeless health nurse: “Smoking cessation has been unprecedented”.

HDAS-London distributed more than 3,000 electronic-cigarette starter kits, over 20,000 electronic-cigarette refill pods, and nicotine replacement products to the emergency hotels.⁷² In their report ‘Lessons Learned’, it was reported that “Tobacco harm reduction resources were universally well received”.⁷³ CHRISP data reported that 297 residents said their smoking had reduced; 280 said it was “about the same”; and 96 said their smoking had increased.⁷⁴

Between July and October 2020, King’s College London carried out a rapid research project to gain an understanding of the experiences of people accommodated in two of the London hotels, one of which was a Covid-Protect hotel, the other was a Covid-Prevent hotel. They interviewed 35 hotel residents about their experiences. They found that, amongst the nine participants who said that they were smoking less, the main reasons were “having an electronic cigarette, and also having no money and not being allowed to smoke in the hotel.”⁷⁵

68 Pan-London Homeless Hotel Drug & Alcohol Support Service (HDAS) (2020) *Lessons Learned* <http://osf.io/7cdbx/>

69 Ibid.

70 Ibid.

71 Ibid.

72 Pan-London Homeless Hotel Drug & Alcohol Support Service (HDAS) (2020) *Lessons Learned* <http://osf.io/7cdbx/>

73 Ibid.

74 Ibid.

75 Neale, J., et al. (2020) *Experiences of being housed in a London hotel as part of the ‘Everyone In’ initiative. Part 1: Life in the hotel*

Physical health

Lead homeless health nurse: *“What we found over time with people being in hotels was that their health needs changed: their skin conditions and things we would associate with rough sleeping would decrease...”*

Our research shows that the physical health of people in hotel accommodation has generally improved during the Covid-19 crisis.

Over a third (35%) of those surveyed for the CHRISP assessment reported that their physical health had improved.

“I was so thin but because of the kindness of St Mungo’s I put on weight and became better... You can see images of the skin and bone I was on the streets to where I am now.”

Ian, St Mungo’s client

There was also a reduction in the use of emergency health services recorded in London.

- Data from St Mungo’s outreach teams on clients’ use of health services shows that the number of times clients, including those in the emergency hotels, have been taken to A&E by ambulance has dropped, from a total of 68 times during September 2019-February 2020 to 43 times during March 2020-August 2020. The number of times clients have attended A&E (without being taken by ambulance) has dropped from 29 to 14 during the same periods of time.

Mental health

Overall, for those who have gone from sleeping on the streets to hotel accommodation there was an initial improvement in mental wellbeing, as reported by health and homelessness teams in interviews for this report.

- In the CHRISP assessment, 36% of people in hotel accommodation reported improvements in their mental health.

A report from Riverside (a large provider of supported accommodation which ran an emergency hotel in Manchester) showed improvement in wellbeing amongst people who moved from sleeping rough to the hotel: *“All seven residents feel that their health and mental health is better. Their overall feeling of wellbeing has increased and their nutrition has improved. Residents feel safe, secure and protected and they feel more positive about their future.”*⁷⁶

However, for those in hotels, the uncertainty around the next steps and availability of more permanent accommodation created stress and for some of our clients has exacerbated existing mental health conditions.

⁷⁶ Riverside (2020) *Manchester Emergency Accommodation Evaluation Interim Report*
https://www.riverside.org.uk/wp-content/uploads/2020/06/Riverside_MCREmergency_Accommodation_FINAL.pdf

6.2 Challenges for those in existing homelessness services

Notwithstanding the many positives in health outcomes for those previously sleeping rough who came into hotel accommodation, for others, this period has seen significant challenges.

For those who remained sleeping rough or have started or returned to rough sleeping, the closure of normal services such as day centres, drop-in health clinics and communal night shelters has been hugely difficult. It has led to reduced support; food shortages since soup kitchens were closed for large parts of lockdown; and delays in housing offers.

Homeless health nurse: *“They were running out of food because they couldn’t beg, they couldn’t get any showers so their body lice were difficult to treat, they didn’t have a phone so couldn’t contact anyone.”*

A similar picture emerges for those who were moved into other forms of emergency accommodation without support.

St Mungo’s hotel manager, Brighton: *“One of the issues I’ve noticed is that it’s fine if you’re in the system and in a hotel and then you’ve also been given a housing offer. It’s all those clients who have been moved into emergency accommodation that have been left without the support structure hotels had, normally because they were considered low support. They’re falling through the gaps.”*

Making supported housing and hostels Covid-19 secure

St Mungo’s, like other supported housing providers, made significant efforts to ensure vital accommodation services could continue to provide housing and support to vulnerable individuals and remain open throughout the pandemic. Supported housing services took steps to keep clients and staff safe from Covid-19, including supporting clients to follow public health advice on infection control, ensuring appropriate use of personal protective equipment (PPE) and prioritising the safety of clients at all times. In addition, services also adapted to try to ensure clients were supported as much as possible and activities provided in spite of very difficult circumstances.

For example, phones and credit were provided to make it easier to stay in touch with keyworkers and our Recovery College service moved online providing a variety of courses and opportunities to access peer support. Staff also strived to facilitate face to face contact with social distancing guidelines in place when deemed essential for the clients’ wellbeing.

Despite these efforts, in the meetings held with St Mungo’s clients to inform this report, those living in supported housing services, reported feeling isolated and lonely during the lockdown, and that the anxiety and stress from this period — and their lack of social interaction — exacerbated existing mental ill health.

This reflects reports in the general population of worsening mental health as a result of the pandemic. The Mental Health Foundation reports that *“as of the end of June, one in ten people in the UK reported having had suicidal thoughts or feelings in the past two weeks”*.⁷⁷ Crucially however, as they note, *“we are all in the same storm, but we are not all in the same boat”*⁷⁸ — there has been a divergence of experiences during the pandemic and *“in certain disadvantaged groups there are even higher proportions of people with suicidal thoughts and feelings.”*⁷⁹

Others in our discussion found health services such as GPs difficult to access, either because appointments have been cancelled since they were not considered priority cases, or because they have not had the same in-reach from health services as hotels. This was described as a knock back to progress. A briefing from Groundswell about the impact of the pandemic notes *“the cancellation of appointments and treatment for existing health needs is concerning, especially when we know that many deaths of people experiencing homelessness are preventable through adequate health interventions.”*⁸⁰ Further discussion on difficulty accessing services will be on pages 39-41.

77 Mental Health Foundation (2020) *Coronavirus: The divergence of mental health experiences during the pandemic* <https://www.mentalhealth.org.uk/coronavirus/divergence-mental-health-experiences-during-pandemic>

78 Ibid.

79 Ibid.

80 Groundswell (2020) *Monitoring the Impact of Covid-19 Fortnightly Homelessness Briefing 2* <https://groundswell.org.uk/wp-content/uploads/2020/05/COVID-19-Fortnightly-Briefing-2-4.05.20.pdf>

What has led to this improvement in health outcomes for those in emergency hotel accommodation?





As we have seen in the previous chapter, there have been significant, and largely positive, changes to the health outcomes of people who had previously been sleeping rough and were given hotel accommodation under the Everyone In initiative. On the other hand the pandemic has created new challenges for those who continued to sleep rough, and those in other accommodation-based homelessness services. This chapter explores the factors behind such changes.

7.1 The response put saving lives first and foremost

In a letter written on 26 March 2020, Luke Hall MP, the then Minister for Local Government and Homelessness, updated local authorities on plans to protect people sleeping rough during the pandemic. The letter spoke of the need to get everyone in, thus “preventing deaths during this public health emergency.”⁸¹

Crucially, the letter set out the key principles of the Everyone In initiative, which provided a clear framework for local authorities to follow. These principles were:

- Focus on people who are, or are at risk of, sleeping rough, and those who are in accommodation where it is difficult to self-isolate, such as shelters and assessment centres.
- Make sure that these people have access to the facilities that enable them to adhere to public health guidance on hygiene or isolation, ideally single room facilities.
- Utilise alternative powers and funding to assist those with no recourse to public funds who require shelter and other forms of support due to the COVID-19 pandemic.
- Mitigate their own risk of infection, and transmission to others, by ensuring they are able to self-isolate as appropriate in line with public health guidance.

Baroness Louise Casey was tasked with leading the Government’s Covid-19 rough sleeping response, which she did until August 2020. In an interview that same month, she said:

“We were chasing the virus just trying to stay ahead of it... We just went for it, everybody went for it. We had to get everybody in, we cannot have people dying on the streets.”⁸²

81 MHCLG (March 2020) *Letter from Minister Hall to local authorities* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/928780/Letter_from_Minister_Hall_to_Local_Authorities.pdf

82 The Big Issue (2020) *Homelessness tsar Dame Louise Casey awarded a peerage* <https://www.bigissue.com/latest/homelessness-tsar-dame-louise-casey-awarded-a-peerage/>

Everyone In was supported by increased funding through an initial £3.2 million given to councils at the start of the pandemic, specifically for immediate action to support people off the streets. Since the start of the pandemic the Government has also provided local authorities with £4.6 billion to support their response to Covid-19 and the increased pressure on their services.

Further specific funding of £105 million was announced in June 2020 – as part of the Next Steps Accommodation Programme – to “support rough sleepers and those at risk of homelessness into tenancies of their own, including through help with deposits for accommodation, and securing thousands of alternative rooms already available and ready for use, such as student accommodation.”⁸³ This helped give councils the confidence to extend hotel bookings and help ensure no one brought into the emergency hotels was forced to go back to sleeping rough.

MHCLG also brought forward and increased the Rough Sleeping Accommodation Programme announced in the 2020 Budget – a £433 million commitment for 6,000 new supported accommodation units for people who have slept rough over the next four years.⁸⁴ A total of £150 million has been allocated to local areas to deliver 3,300 homes with support for people moving on from rough sleeping by the end of March 2021.⁸⁵

7.2 There was a huge collaborative effort at national and local level

Homelessness services, health services, national and local government quickly recognised that protecting people who were homeless during the pandemic would require a major collaborative effort and close partnership working was quickly established at the national and local levels.

Many health and homelessness services have also reported an unprecedented level of engagement and collaboration during Covid-19.

Case study: HDAS-London

The Homeless Hotel Drug & Alcohol Support Service (HDAS-London) was an example of successful multi-agency working during Covid-19. Set up as a pan-London partnership, HDAS-London brought together a number of local substance use services to support people who came into the hotels funded by the Greater London Authority (GLA). The service was jointly commissioned by Public Health England (PHE) and the GLA. It provided a 24/7 single point of access to experienced substance use workers and clinicians who offered advice and guidance to healthcare and support staff in the hotels and created a more streamlined referral system between front-line workers and treatment services.

In interviews for this report we heard that previous relationships between substance use service providers existed but were not always as strong as they could be, with different approaches across the 33 local authorities in London. During the pandemic, a twice weekly provider forum was attended by the heads of the different services involved which helped address any difficulties. The group agreed principles of transferring care across boroughs which the clinical lead for the service told us “*hugely reduced administrative burden on services, and largely ameliorated any ‘turf wars’ of ‘this person belongs to your service’*”. The improved relationships and communication were instrumental in the success.

⁸³ MHCLG (2020) *£105 million to keep rough sleepers safe and off the streets during coronavirus pandemic*
<https://www.gov.uk/government/news/105-million-to-keep-rough-sleepers-safe-and-off-the-streets-during-coronavirus-pandemic>

⁸⁴ MHCLG (2020) *6,000 new supported homes as part of landmark commitment to end rough sleeping*
<https://www.gov.uk/government/news/6-000-new-supported-homes-as-part-of-landmark-commitment-to-end-rough-sleeping>

⁸⁵ MHCLG (2020) *Funding allocated for 3,300 new homes for rough sleepers*
<https://www.gov.uk/government/news/funding-allocated-for-3-300-new-homes-for-rough-sleepers>

What has led to this improvement in health outcomes for those in emergency hotel accommodation?

Interviews with some housing and homelessness teams, however, demonstrated that this partnership approach has not been consistent across all parts of the country. In areas where there was a lack of joined up working between homelessness and health services prior to the pandemic, communication and multi-agency working during Everyone In were more challenging. An evaluation of the HDAS-London service highlighted that “in some areas, treatment services were not aware of where people experiencing rough sleeping had been accommodated until several weeks after lockdown.”⁸⁶

We heard that the best collaboration came where good, multi-agency relationships had already been developed.

Case study: Hull

In Hull, the existing multi-agency and multi-sector approach meant services were well positioned to respond quickly at the outset of the pandemic. The city has a number of structures in place which have helped to embed the multi-agency response to rough sleeping. The primary operational group – the Rough Sleeper Action Group – conducts fortnightly meetings to discuss the ‘top ten’ people sleeping rough and develop a key action plan around each individual with all of the partners around the table, including social landlords, prison and probation services, public health and the CCG. Each partner takes away action plans from the meeting to ensure the needs of the individual clients will be met. There are further operational and strategic groups attended by all cross-sector partners to help improve partnership working and the response to rough sleeping in Hull.

Due to this, at the start of the pandemic, the area already had rough sleeping assessment hubs in place, with input from primary health services, drug and alcohol services and housing teams and these services were able to continue to work together to deliver the Everyone In initiative locally. It was the strength in their partnership working which enabled the rapid response to Covid-19.

The pandemic has also resulted in closer collaboration between government departments, and helped bring to life the intention set out in the 2018 Rough Sleeping Strategy for government departments to “work seamlessly together”.⁸⁷ The increased collaboration between departments, and the hope for this to continue, was raised in the interviews with civil servants.

In one interview, it was noted that there has been a substantial focus on rough sleeping during Covid-19 and a focus on homelessness in the parts of government responsible for health “like never before” at national level.

Officials pointed to an existing trajectory of increased cross-departmental working on rough sleeping prior to March 2020, but also said joint work increased dramatically during Covid-19. This was illustrated by the introduction of cross government ‘cells’ on homelessness and Covid-19 which included the Department for Health and Social Care (DHSC), PHE, NHS England and NHS Improvement (NHSE/I) and MHCLG, which met daily during the first wave of the pandemic to discuss priorities and support the delivery of government policy. Meetings continued to be held regularly even beyond the first lockdown.

We were told by one civil servant that the increase in sharing departmental priorities and in supporting one another influenced their approach to the Comprehensive Spending Review. Another said that one of the legacies of this crisis will be the cross-departmental working that was sped up due to the pandemic.

Collaborative, multi-agency working is vital for the delivery of high-quality effective care, as highlighted in the Kings Fund report on ‘Delivering health and care for people who sleep rough’: “This research project has given us an insight into what can help deliver an effective response to health and rough sleeping... In practice, this requires people from across health, housing and care to work together when designing and delivering services”.⁸⁸

During the pandemic we have seen the removal of barriers between services and teams, leading to a more efficient response. The increased integration between sectors and services has meant people’s needs were approached more holistically and there has been better continuity of care reducing the risk people will fall between the gaps in provision. There is no doubt this is an approach which must continue beyond the pandemic as well.

86 Pan-London Homeless Hotel Drug & Alcohol Support Service (HDAS) (2020) *Lessons Learned* <http://osf.io/7cdbx/>

87 MHCLG (2018) *Rough Sleeping Strategy 2018* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/733421/Rough-Sleeping-Strategy_WEB.pdf

88 King’s Fund (2020) *Delivering health and care for people who sleep rough: Going above and beyond* [kingsfund.org.uk/sites/default/files/2020-02/Delivering-health-care-people-sleep-rough.pdf](https://www.kingsfund.org.uk/sites/default/files/2020-02/Delivering-health-care-people-sleep-rough.pdf)

Where there was a lack of integration between services this led to problems

Our research also revealed problems arising where services were not so well integrated. We heard in interviews for instance that where people were already engaged with services in one area that they could struggle to maintain support if they were moved to accommodation in a different local authority area, and in some cases this led to people not being able to access prescriptions.

One St Mungo's client said: *"Last month they didn't send the repeat script over. I'm running all round the place and I don't know where they are. A whole month prescription missed - I was in pain."*

The HDAS-London service partners agreed that clients would stay with the same substance use treatment provider even if they moved borough, helping to reduce this problem for people in need of drug and alcohol services in the capital.

Unfortunately, a similar approach was not set up for mental health services and there has been less flexibility in this type of provision. For many years mental health services have struggled to meet demand and this has hampered integration, which has led to people falling between the gaps.⁸⁹

7.3 Eligibility rules were more flexible, allowing more people to move into accommodation

Due to the focus on protecting the lives of people sleeping rough during the public health emergency, some of the barriers to accommodation and support usually faced by some groups of people were temporarily lifted. For example, people have been able to access emergency accommodation regardless of their immigration status or connection to the local area. In interviews, staff from health and homelessness services, unanimously welcomed the move to have much more flexible rules surrounding eligibility which have enabled a significant proportion of people to be accommodated despite their NRPF status, as discussed on page 14.

Everyone In has been run using similar principles to those that apply when the Severe Weather Emergency Protocol (SWEP) is triggered. SWEP ensures emergency accommodation is made available to everyone sleeping rough in order to save lives during severe weather – again regardless of immigration status or restrictive geographical criteria.

It is worth noting that move-on options for many non-UK nationals remain limited, and they are at serious risk of returning to rough sleeping once emergency accommodation is no longer available unless the right support is in place. Specialist immigration services that support people to find a route out of homelessness, and specialist employment support are particularly important for people without access to benefits due to their immigration status, or not having sufficient documentation to prove their entitlement.

7.4 There was increased support available

In some areas the Everyone In hotels were jointly managed by hotel staff and experienced staff from homelessness services. The closer collaboration between health and homeless teams mentioned previously ensured many people in emergency accommodation were supported in many different aspects of their lives. The collaboration gave clients better access to health and substance use services and improved continuity of care. In interviews, health and homelessness teams said that this support was critical given the difficulties experienced during the lockdown and included practical support, for example helping people get appointments for services, and emotionally, in terms of giving people the time and attention needed to build trusting relationships and overcome isolation.

St Mungo's client: *"I have bad asthma and at the beginning of lockdown I had a chest infection... Here we have a nurse for a full day once a week... You can have an asthma attack any time – if you have a nurse here in the daytime you can go and talk to them and they will see you straight away you don't have to be dying for them to do something."*

This has been reflected in the recent study by King's College. They found that *"participants particularly appreciated the hotel staff and referred to their kind and caring approach. They also said that they valued being 'looked after' and treated 'without discrimination.'"*⁹⁰

⁸⁹ St Mungo's (2016) *Stop the Scandal: the case for action on mental health and rough sleeping* <https://www.mungos.org/publication/stop-scandal-case-action-mental-health-rough-sleeping/>

⁹⁰ Neale, J., et al. (2020) *Experiences of being housed in a London hotel as part of the 'Everyone In' initiative. Part 1: Life in the hotel* https://kclpure.kcl.ac.uk/portal/files/136655170/Neale_et_al_Homeless_Hotel_Study_part_1_October_2020.pdf

“I’ve witnessed and experienced some really positive client outcomes from not being on the street or taken out of services where the support is low. When they’ve been removed from that and put in a setting where support and time is available, there’s a room with food and showers, staff conversations... it’s almost like respite care. To actually invest time, support and focus on clients in a way a lot of them haven’t experienced before has been great.”

Hotel Manager, Brighton

The hotel provision often had in-reach health services

The in-reach of health teams into Everyone In hotels was key to meeting the needs of those accommodated. Crucially, initial health assessments by medical professionals helped people to start to address a wide variety of health problems.

Interviewees reported that having health teams often on site made it easier for people to access services because, for example, they did not need to walk long distances to get to them due to not being able to afford transport.

Further, many of the onsite services were drop-in, meaning people did not have to stick to inflexible appointments made difficult by their circumstances.

The staff from health and homelessness services that we interviewed said that, as well as making appointments easier to access for people, Everyone In meant it was easier for teams to contact clients and maintain relationships, as people had a stable place to stay. This increased the ability to build trust, which in turn could encourage, for example, engagement with drug and alcohol services. Further, it meant teams were able to remind clients about appointments meaning progress is not knocked back.

The increased in-reach over this period also meant that people could quickly get diagnoses and treatments for symptoms that they would not have attended drop-ins for, either because they did not notice the symptoms, they did not think they were serious, or they found it difficult to attend GP surgeries.

“I really believe that this is one of the major reasons why the hotels have been a brilliant success – bringing all the partners under one roof.”

Hotel Manager, London

7.5 Safe, clean and reliable accommodation was provided

People in hotel accommodation felt safe enough to address longer-term problems

People sleeping rough often talk about being focused first and foremost on the immediate need for survival.⁹¹ Moving to a safe and reliable place where basic needs were being met helped create the time and “headspace” required to start to resolve other issues.

Hotel Manager, London: *“One of the clients had been really unwell for years rough sleeping but she always slipped through the net - it took her being in the hotel and months working with a local health team to get that result. Those long term outcomes need long term spaces being available, especially with mental health.”*

This has been reflected in the recent study by King’s College: *“Many participants also reflected on how the hotel offered them safety, privacy, warmth, security... this had enabled them to establish a daily routine, make contact with a solicitor, get advice on benefits, and progress their ‘recovery’ from addiction... several said that they were drinking or using drugs less often. The main reasons for these reductions were not having money; less social interaction; feeling stable and more relaxed in the hotel...”*⁹²

The hotel accommodation gave health services the ability to do preventative work

In our interviews, health staff working in hotels also reported that they were better placed to do more preventative work since they were able to set up screening and testing in advance and on site, as well as help people with appointments and prescriptions, rather than only seeing people during an emergency.

Homeless health nurse: *“When people are on the streets there’s more chaos - they themselves are also firefighting so thinking of long-term management of a condition is not a priority... With hotels we were able to stop and think about the health inequalities and actually do some of the work around prevention...we were able to provide some health prevention like BBV screening in three of the hotels in Westminster, and helping people get appointments with sexual health clinics to get long term contraception.”*

The hotel accommodation was a better environment to meet physical health needs

A GP interviewed for this report said, people sleeping rough frequently visit the GP for help with open wounds. Wound dressing is therefore very important.⁹³ This is far easier to do in clean and safe accommodation than on the streets, where risk of infection is high.

Homelessness service director, Manchester: *“We had people arriving and checking in with open wounds that they had had for a while and just would keep getting infected. It was a chance to heal people.”*

“A lot of people have experienced better health. You give someone their own front door, their own toilet, a bed, and three meals a day and lo and behold their health improves.”

GP working in homeless and inclusion health

91 Leeds Safeguarding Adult Board (2020) *Executive and Oversight Report, City Wide Learning: Understanding and progressing the city’s learning of the experience of people living a street-based life in Leeds* democracy.leeds.gov.uk/documents/s210886/Street%20Based%20Life%20Report%20Appendix%20091020.pdf

92 Neale, J., et al. (2020) *Experiences of being housed in a London hotel as part of the ‘Everyone In’ initiative. Part 1: Life in the hotel* https://kclpure.kcl.ac.uk/portal/files/136655170/Neale_et_al_Homeless_Hotel_Study_part_1_October_2020.pdf

93 King’s Fund (2020) *How can health and care services better support people who sleep rough?* <https://www.kingsfund.org.uk/blog/2020/02/health-care-services-support-people-sleep-rough>

Further, evidence shows that sleeping rough often means people have poorer diets,^{94 95} find it difficult to maintain personal hygiene⁹⁶, have poor sleep patterns, and are more exposed to extreme weather. All of these contribute to poorer health outcomes. However, they were largely addressed through the hotel provision.

Having your own room can provide the dignity and safety needed to address mental health needs

For those who had previously been sleeping rough and moved into hotel accommodation, having their own room was a strong force for good in improving wellbeing. Research shows that sleeping on the streets is toxic for mental wellbeing.⁹⁷ We heard how the dignity people felt as a result of having their own front door was important to their wellbeing. Further, the vulnerability that many felt — from shared spaces in night shelters, as well as from sleeping on the streets — was eased.

Luke Hall MP: *“Living in a safe and secure home is a protective factor in good mental health.”*⁹⁸

7.6 Push factors encouraged people sleeping rough to engage with the support on offer

The immediate urgency of the situation in March 2020 encouraged those who had previously resisted engaging with services to do so, some for the first time. In the City of London, one hotel manager said that they had long-term clients come into the hotel who, cumulatively, had been sleeping rough for 200 years. The immediate health concern of Covid-19 motivated people to act, as did the deterioration of conditions on the street due to a lack of food, income from begging, and other buildings and services closing during the first national lockdown.

For people with drug problems, the lockdown created further problems. Interviewees reported that it became harder to purchase drugs partly because footfall in city centres was lower, meaning less income, and partly because supply was more restricted. In May 2020, 69% of people who responded to a drug market survey by the Scottish drug charity Crew reported drug shortages and 38% noted a price increase.⁹⁹ This pushed some people to engage with services to, for instance, prevent withdrawal. Scripts began to be seen as a more readily accessible and safer option.

St Mungo's Service Development Manager: *“Clients have started to see others get housed. One client said “Everyone's getting flats where's my flat?” But to get on 'clearing' [social housing scheme for people who have slept rough in London] you need to show engagement with drug and alcohol services - I've never known one person go to so many appointments in a week.”*

Further, in interviews with staff and clients, one clear message that emerged was the importance of better quality accommodation than many had been offered previously.

St Mungo's Brighton Service Manager: *“It has been massive pull to have a room which will be cleaned, will be high quality, you get health needs met. I've been to some places in the city and they're shocking... One guy came in, stayed in two weeks ... The thought of going back to his accommodation... he cried and said 'I'll die if I go back there.”*

94 Story A. (2019) *Findings from a cross-sectional nutritional study of homeless people in London* http://www.homelessnessandhealth.co.uk/events/wp-downloads/2019/presentations/Pathways_from_Homelessness_2019_Plenary_Dr_AI_Story.pdf

95 Sprake E, Russell J, Barker M. (2013) *Food choice and nutrient intake amongst homeless people* <https://onlinelibrary.wiley.com/doi/abs/10.1111/jhn.12130>

96 Pathway (2014) *Mental Health Service Interventions for Rough Sleepers Tools and Guidance* <https://www.homeless.org.uk/sites/default/files/site-attachments/Mental%20Health%20Interventions%20for%20People%20Who%20Sleep%20Rough%20-%20v2.pdf>

97 Reeve, K., McCarthy, L., Pattison, B., Parr, S., Batty, E., Maye-Banbury, A., Bashir, N., Dayson, C. (2018) *The mental health needs of Nottingham's homeless population: an exploratory research study* <http://shura.shu.ac.uk/21958/1/mental-health-nottinghams-homeless-population.pdf>

98 MHCLG (2019) *Homelessness and rough sleeping update* <https://questions-statements.parliament.uk/written-statements/detail/2019-10-01/HLWS1802>

99 Crew (2020) *Covid-19 Drug Market Survey Summary* <https://mk0crewscotb6dvcp91y.kinstacdn.com/wp-content/uploads/2020/06/Crew-COVID-19-Drugs-Market-Survey-Month-2-Summary-May-2020.pdf> (50 people responded in total)

This was echoed by LSE's recent report on the Everyone In initiative: "Some who had been on the street for many months or even years were prepared to go to a good quality hotel room."¹⁰⁰

Previous research by St Mungo's has revealed how cuts to local authority funding since 2008/9 have resulted in cuts to vital homelessness services for people who need extra support. In 2018/19 councils in England spent nearly £1 billion less on services supporting single homeless people compared to a decade ago. This has reduced the availability of supported housing services that help people to cope with complex problems like poor mental health, substance use and domestic abuse. While recent government funding programmes have seen investment in homelessness services increase, in some areas, there are still not sufficient options for people sleeping rough.¹⁰¹ As discussed above, these supported housing services are also not usually available to people without access to benefits, including many non-UK citizens who were able to go in to the emergency hotel accommodation under Everyone In.

7.7 The impact of Covid-19 on healthcare services forced new ways of working with mixed results

During this period there was faster scripting for people who were rough sleeping and an increased number of professionals were able to script

In interviews for this report, health and homelessness services reported that significantly faster scripting was available during the pandemic both for people rough sleeping and in hotels, as discussed in section 6 of this report. This has been due to: in-reach to hotels through an increased number of on-site health professionals; on the spot scripting; and a greater number of professionals able to script.

Prior to this, multiple appointments were often required to access a script. Of 24 substance use services surveyed in 2019 as part of St Mungo's 'Knocked Back' research, only six were able to achieve same or next day scripting.¹⁰² Substance use workers say that getting someone on a script as soon as a so-called 'window of opportunity' is identified is crucial to starting the process of recovery. This is what makes it so important that scripts are available in a timely and accessible way.

Rapid scripting has been helped by the increased pool of professionals able to provide substitute prescriptions, or support the process. One homeless health nurse told us that over this period her team learned to take urine samples on the street and then could immediately call the drug and alcohol team for an assessment to get the client scripted.

Reduced waiting times for scripting, and increasing the number of people able to script, was suggested by many interviewed for this report as a key beneficial outcome of the collaboration seen during the Everyone In initiative.

St Mungo's regional manager: "We brought the treatment service to people – this is the ideal model for community based scripting with hard to reach groups."

During this period scripts often covered longer periods of time

Where previously it was standard practice for scripts to be picked up on a daily basis, during the pandemic many people have moved to picking up their scripts weekly or fortnightly. This was to avoid the added health risk of going to the pharmacy every day. There have been mixed reactions to this change, with some health and homelessness professionals reporting in interviews that it has created a black market in opioid substitutes amongst clients in hotels, and expressing concerns that it could lead to increased numbers of overdoses.

Other health and homelessness workers, however, have argued that this approach increases trust between the client and the worker, and gives people more autonomy over their own use.

We have yet to see data which evidences either viewpoint. Ideally, more flexibility in the way scripts are provided will result in further progress towards person-centred care where each individual is treated according to their own individual needs and circumstances.

¹⁰⁰ Scanlon K., Whitehead C. (2020) *London local government expenditure on 'Everyone In'* <https://blogsmedia.lse.ac.uk/blogs.dir/119/files/2020/11/Costs-of-Everyone-In-LSE-London.pdf>

¹⁰¹ St Mungo's (2020) *Home for Good campaign briefing. Fixing funding for homelessness services – update* <https://www.mungos.org/publication/home-for-good-fixing-funding-for-homelessness-services-update/>

¹⁰² St Mungo's (2020) *Knocked Back: Failing to support people sleeping rough with drug and alcohol problems is costing lives* <https://www.mungos.org/publication/knocked-back/#:~:text=Failing%20to%20support%20people%20sleeping,preventable%20drug%20and%20alcohol%20problems.>

Online engagement with services proved challenging

During the Covid-19 crisis health services have seen a significant shift towards online communication, due to concerns that in-person appointments could lead to the virus spreading. For instance, to register patients many GP surgeries requested forms be filled in online via a website or app, or email. Mental health services also moved predominantly online, with appointments done via phone or video calls. Similarly, drug and alcohol services often carried out assessments via the phone, and group activities such as Alcoholics Anonymous meetings moved online.

Unlike other service adaptations mentioned, which had a largely positive impact, this change caused significant problems. It affected people in hotel accommodation, as well as those sleeping on the streets and in other forms of accommodation – although to varying degrees. Digital exclusion was a common theme throughout all interviews for this research, and the digital exclusion of clients was highlighted in a recent St Mungo's staff survey about the impact of Covid-19. Making Every Adult Matter's (MEAM) rapid evidence gathering project in June 2020 also highlighted problems accessing services online experienced by people with multiple and complex needs.¹⁰³

People lacked access to phones and computers

A report by Doctors of the World said that "30% of the homeless people who moved into hotels did not have access to a phone".¹⁰⁴ Some interviewees also reported that they had problems with very slow WiFi due to having too many people trying to access at once; or the hotel only had a limited amount of free WiFi, sometimes only 30 minutes. Groundswell reported that "people frequently do not have access to the technology to complete online registration forms as they are without access to a smartphone, tablet or computer and often do not have access to WiFi."¹⁰⁵

There have been efforts to address this problem. For example, Tesco Mobile and Clarion Housing Group donated 550 smartphones to St Mungo's clients. Crisis and Tesco Mobile also started a two year partnership to provide £700,000 worth of phones, devices and connectivity over a twelve month period and Greater Manchester Combined Authority and Greater Manchester Homeless Action Network coordinated donations and distribution of mobile phones to hotel residents. St Mungo's staff also supported clients to apply for charity funds which would support them to gain access to devices/laptops and internet.

People were unfamiliar with the technology

Efforts were made to help people with accessing online services. For example St Mungo's Recovery College ran a course which supported clients to learn how to use their new smart phones or tablets and Diversity & Ability provided digital inclusion training for frontline staff to support clients.¹⁰⁶ However, many people still struggled to make use of technology (where it was available) having been used to pre-paid phones, or due to poor literacy.¹⁰⁷

¹⁰³ MEAM (2020) *Flexible responses during the Coronavirus crisis: Rapid evidence gathering* <http://meam.org.uk/wp-content/uploads/2020/06/MEAM-Covid-REG-report.pdf>

¹⁰⁴ Doctors of the World (2020) *A Rapid Needs Assessment of Excluded People in England During the 2020 COVID-19 Pandemic* <https://www.doctorsoftheworld.org.uk/wp-content/uploads/2020/06/covid-full-rna-report.pdf>

¹⁰⁵ Groundswell (2020) *Monitoring the Impact of Covid-19 Fortnightly Homelessness Briefing 5: Focus on Primary Care* <https://groundswell.org.uk/wp-content/uploads/2020/06/COVID-19-Fortnightly-Briefing-5-18.06.20-.pdf>

¹⁰⁶ Diversity and Ability (2020) *Digital Inclusion, Homelessness & Covid-19: Lessons Learned* <https://diversityandability.com/blog/digital-exclusion-covid19>

¹⁰⁷ Ibid.

People did not have the money to access online or telephone services

Few people sleeping rough have a phone contract and therefore it costs each time they need to call and they have little or no data allowance. With services only accessible online or by phone this limits options if they do not have access to free WiFi.

The Doctors of the World research found that *“for many the expense of phone credit and data is a significant barrier to remote healthcare access.”*¹⁰⁸

One St Mungo’s client told us: *“I phoned my GP and I’m 9th in line in the queue. I sit there burning my pay as you go. When I eventually get through 45 minutes to an hour later and all the receptionist does is take my telephone number. I can’t afford to just sit on the phone.”*

People found certain services more difficult to engage with virtually

In interviews, St Mungo’s clients and staff reported that mental health services do not work as well when done remotely due to the nature of the service. It is much more challenging to build the human relationships and trust necessary in improving wellbeing and helping with mental ill health. Groundswell: *“people told us that they struggle to engage with digital methods of mental health support, where available, with a number of people significantly preferring face-to-face methods of support.”*¹⁰⁹

St Mungo’s client: *“I know loads of people who’ve gone to support groups - gambling etc - where you speak to people and have coffee, but all of it went online and it cut off so many people and probably some aren’t even with us anymore unfortunately.”*

HDAS-London’s report on lessons learned from the Covid-19 pandemic also note the difficulty of online engagement with substance use services: *“The remote nature of most support certainly impacted on HDAS and treatment services’ ability to use this unique opportunity to engage...”*¹¹⁰

However, some interviewees from health and homelessness services told of some clients preferring virtual access to services. This was because they felt more comfortable being in their own space, and used to feel stigmatised going to the service in person.

Online engagement with health services looks likely to continue, especially in the wake of the Health Secretary’s speech to the Royal College of Physicians: *“From now on, all consultations should be tele-consultations unless there’s a compelling clinical reason not to.”*¹¹¹

While online engagement with health services creates an opportunity to give people a choice on how they wish to communicate, it will also be crucial to ensure face to face appointments are genuinely still available for people who require or prefer this method of interaction with the services they require.

108 Doctors of the World (2020) *A Rapid Needs Assessment of Excluded People in England During the 2020 COVID-19 Pandemic* <https://www.doctorsoftheworld.org.uk/wp-content/uploads/2020/06/covid-full-rna-report.pdf>

109 Groundswell (2020) *Monitoring the Impact of Covid-19 Fortnightly Homelessness Briefing 7: Final* <https://groundswell.org.uk/wp-content/uploads/2020/07/COVID-19-Fortnightly-Briefing-7-FINAL.pdf>

110 Pan-London Homeless Hotel Drug & Alcohol Support Service (HDAS) (2020) *Lessons Learned* <http://osf.io/7cdbx/>

111 BBC News (2020) *‘More Zoom medicine needed’ in NHS says Hancock* <https://www.bbc.co.uk/news/health-53592678>

Access to GPs was mixed for people during this period

The St Mungo's Covid-19 assessment found that around a fifth of the people in the Everyone In hotels were not registered with a GP when they moved in (132 people). In comparison, 98% of clients across St Mungo's Housing First and supported housing are registered with a GP (1907 people).

In interviews, health and homelessness teams told us that they still had significant difficulties registering people with GPs over this period. One issue related to the sheer volume of people who were not registered or who needed to register with a GP in a different area. Research carried out by specialist homeless health nurses in North West London reported that their local GP surgery has been refusing to register their clients at all.¹¹²



18% of clients when they first moved in to emergency hotels were not registered with GPs; only 2% of clients in St Mungo's Housing First and supported housing were not registered.

Mental health services struggled

Several interviewees reported mental health services struggling to cope during this period because of a chronic lack of capacity combined with increased need due to the Covid-19 crisis, and the uncertainty and isolation it has caused.

“Mental health services seem to have collapsed over this period”

St Mungo's Service Development Manager

St Mungo's client: *“This will be the next pandemic of the nuclear fallout of mental health.”*

Research by The Royal College of Psychiatry found that two-fifths of patients waiting for mental health treatment during the pandemic contacted emergency or crisis services, with more than one in ten patients ending up in A&E.¹¹³

There were, however, some discrete examples of mental health services working well during the pandemic. These were again due to reasons previously highlighted: multi-agency partnership work and relationship building which had already been developing prior to Covid-19 and could be built on in this period; and an increased amount of healthcare in-reach to work with. For example, one of St Mungo's London hotel managers talked positively about work done during this period with the Enabling Assessment Service London (EASL). Through a mixture of telephone and in-person assessments, EASL worked closely with around 50 St Mungo's clients in emergency hotels, providing support to engage with NHS services.

St Mungo's hotel manager, London: *“With EASL we were able to achieve those long-term outcomes that are possible through long-term spaces being available. This led to three people who had mental health assessments and went on to be detained. One of those clients had been unwell for years sleeping rough but always slipped through the net. It took her being in the hotel and months working with the EASL team to get that result.”*

The lead for the EASL service told us that *“We already had an existing relationship with St Mungo's, providing assessment and advice to the pan-London projects which were redeployed into hotels. Our existing role and relationship translated effectively into hotels. Our assessments were at times able to demonstrate to locally stretched NHS services why their input in terms of intervention or treatment were warranted. There was also more primary healthcare input to the hotels than was often the case with pan-London projects like No Second Night Out (NSNO) before – we were able to work alongside them and St Mungo's in a way that has been less common outside Covid-19.”*

112 NHS North West London (2020) *NWL Homelessness Health Project: the NWL Response to the 'Everyone In' Campaign April to July 2020* https://mcusercontent.com/c4876cb152fa1983ef265ad1b/files/0723c314-3902-4604-9f47-8ccc28008fba/NWVL_20Homeless_20Health_20Project_20_20FINAL.pdf?mc_cid=08300de86e&mc_eid=e3c037e9c5

113 Royal College of Psychiatrists (2020) *Two-fifths of patients waiting for mental health treatment forced to resort to emergency or crisis services* <https://www.rcpsych.ac.uk/news-and-features/latest-news/detail/2020/10/06/two-fifths-of-patients-waiting-for-mental-health-treatment-forced-to-resort-to-emergency-or-crisis-services>

Conclusions and recommendations



This research provides further evidence of the poor health experienced by people who are homeless, particularly among those with experience of sleeping rough. Covid-19 has shone a further light on these health inequalities. However, our research has also identified ways of working during the Covid-19 pandemic which have produced positive outcomes for people who have previously found it extremely difficult to get the help they need to manage their health.

We found that many people who came into the Everyone In hotel accommodation experienced improved outcomes in terms of their health, as well as their housing. Increased engagement with drug and alcohol services has been one of the clearest areas of improvement we have identified.

Our findings suggest there were two overarching factors driving improved health and accommodation outcomes amongst those helped under the Everyone In initiative. First, the provision of safe, clean ensuite accommodation alongside support to help address other problems. Second, the integrated working between health and homelessness teams during this period, and, as part of this, the increased in-reach by health services. This improved the continuity of care so people were less likely to slip through the cracks in service provision.

A continued focus on what has worked under Everyone In is needed to help ensure these gains can be sustained once people have moved on from the emergency accommodation. Without this there is a real risk that improvements in individual health and wellbeing will slide backwards.¹¹⁴

Unfortunately, we also found that these positive health outcomes were not experienced by those still stuck sleeping rough, people who were new to sleeping rough who were not able to get in to the hotels, or those in other homelessness services where normal services were disrupted by Covid-19 and already stretched mental health services struggled to keep pace with demand.

There are many important lessons that we must take forward from the response to rough sleeping during the pandemic. Our recommendations below are focused on the changes needed to reduce the health inequalities experienced by people who are homeless and ensure the collaborative approach needed to end rough sleeping is truly embedded at the national and local levels.

“In the aftermath of this pandemic, the street homelessness response will never be the same again. Perceptions of homelessness have been transformed, and it is now seen for what it is: a major public health issue.”¹¹⁵

Baroness Louise Casey

114 Neale, J., et al. (2021) Experiences of being housed in a London hotel as part of the 'Everyone In' initiative. Part 2: Life in the month after leaving the hotel <https://osf.io/x73am/>

115 Casey L., Mohan N. (2020) *It's taken the coronavirus crisis for people to see rough sleeping for the public health emergency it is* <https://www.kcl.ac.uk/news/its-taken-the-coronavirus-crisis-for-people-to-see-rough-sleeping-for-the-public-health-emergency-it-is>

Recommendations

Immediate action needed while the Covid-19 pandemic continues

- 1 **Encourage stronger partnerships between housing and health services** – The Ministry of Housing Communities and Local Government (MHCLG), the Department of Health and Social Care (DHSC), Public Health England (PHE) and NHS England and NHS Improvement (NHSE/I) should maintain the close working arrangements developed during the Covid-19 pandemic to support local authorities and local health services to continue with the assessment, triage, cohort and care approach that saved lives in the first wave Covid-19.
- 2 **Secure the successes of the principles of Everyone In by ensuring that sufficient, safe accommodation is in place for everyone that needs it** – The discovery of the new, highly transmissible variant of Covid-19, in addition to the cold winter weather, means there is an urgent need to protect the health of everyone sleeping rough. Moving forward the Government should provide additional funding and support to local authorities to ensure they are able to offer sufficient, self-contained emergency accommodation for everyone who is sleeping rough, or at risk of doing so while the pandemic continues, and especially during periods of severe weather. This includes accommodation with high levels of support and medical input for those with multiple and complex needs, or for those who are clinically vulnerable who need to shield. This approach should be a core aspect of any future emergency response that impacts upon those who are homeless or at risk of sleeping rough.
- 3 **Ensure continued access to emergency accommodation, immigration advice and employment support for people with No Recourse to Public Funds (NRPF) who are sleeping rough** – A key principle of the Everyone In initiative was that homeless people were able to access support and accommodation regardless of their immigration status. This was particularly important for people who do not usually have access to homelessness assistance, or welfare support, due to NRPF conditions. The Government should build on the progress made during the pandemic to help end rough sleeping for everyone, including non-UK nationals. In particular, the Government should ensure continued access to emergency accommodation, and increase investment in specialist immigration advice and employment support services that support people to find a route out of homelessness.
- 4 **Ensure that people who are homeless are prioritised for the Covid-19 vaccine** – It is extremely positive that frontline workers who support people experiencing homelessness are among the

first groups able to receive a Covid-19 vaccine, along with other health and social care workers. It is also crucial that those who are homeless are prioritised.

As a result of the significant barriers to healthcare faced by people who are homeless, many will not have been identified as clinically vulnerable and therefore requiring priority access to the Covid-19 vaccine. As part of the vaccine roll-out, the Government should ensure there is a comprehensive plan to identify and deliver the vaccine to people who are homeless. As part of this, the Government has rightly identified the need for a GP registration drive, but the plan must also include proactive and sustained outreach by health services working in partnership with local authorities, homelessness services and people with lived experience of homelessness. Similarly, there should be no barriers to accessing a Covid-19 test for people experiencing homelessness.

There is also a strong case for ensuring all homeless people are prioritised for the vaccine given their vulnerability to severe cases of Covid-19. High levels of multi-morbidity and the high risk of Covid-19 transmission in services with shared sleeping spaces, or other shared facilities, in which homeless people often live, compounded by poor access to health care, mean they are still at greater risk of serious illness if exposed to the virus. In the context of Covid-19, homelessness can be used as a proxy for vulnerability, mirroring the public health principles which underpinned JCVI's use of age as a proxy. A small number of local areas have started to offer people who are homeless priority access to the vaccine, but the Government should ensure this approach is mirrored across the country in line with the aim of preventing Covid-19 mortality and protecting health and social care systems.

Beyond the pandemic

Our recommendations to national government

- 5 **Strengthen joint work on homelessness across government** – A new inter-ministerial working group or cabinet committee on homelessness and rough sleeping should be established. A ministerial working group on preventing and tackling homelessness, was set up in 2010 under the Coalition Government, but no longer exists. This had the aim to bring *“the relevant government departments together to share information, resolve issues and avoid unintended policy consequences.”*¹¹⁶ Ministers across government need to be able to offer solutions, and be held accountable for the Government's goal to end rough sleeping by 2024. Furthermore, the Government should always consider homelessness and rough sleeping when responding to national emergencies, particularly where there is an immediate risk to health.

116 Casey L., Mohan N. (2020) *It's taken the coronavirus crisis for people to see rough sleeping for the public health emergency it is* <https://www.kcl.ac.uk/news/its-taken-the-coronavirus-crisis-for-people-to-see-rough-sleeping-for-the-public-health-emergency-it-is>

- 6 Extend the coverage of specialist homeless health services** – DHSC, NHSE/I and PHE should continue to assess the current coverage of health and substance misuse services for homeless people and ensure that gaps are identified and addressed. There should be more multi-disciplinary teams providing integrated mental health and substance use services that are joined up with housing and homelessness services in order to reach people with multiple and complex needs. Existing programmes within NHSE/I and PHE to fund homeless health services must continue and funding must be provided to ensure services can reach people in every part of the country, not just some areas.
- 7 Restore £1 billion per year of lost funding for homelessness and housing related support services** – MHCLG and HM Treasury should restore the funding for homelessness and housing related support services¹¹⁷ that has been cut from local authority budgets over the past decade via a specific grant to local authorities in the next Comprehensive Spending Review.
- 8 Expand the Rough Sleeping Accommodation Programme (RSAP)** – MHCLG and Homes England have recognised the need for revenue funding alongside capital investment in order to provide the homes and support services people need to manage their housing and avoid a return to rough sleeping. 6,000 homes with support have been promised by March 2024 and the 2020 Spending Review confirmed £87 million capital funding would be made available in 2021-22 to support the delivery of these homes. However, further investment will be needed to ensure everyone housed in emergency accommodation gets the right housing and support they need to leave rough sleeping behind for good.

Our recommendations to local leaders

- 9 NHS organisations should work with local authorities and homelessness organisations to develop and implement effective delivery plans to ensure that people who are homeless are able to access the Covid-19 vaccine.** This includes tailored communication, alongside proactive in-reach and outreach programmes, such as replicating the mobile vaccine units deployed to care homes for hostels and day centres.
- 10 NHS organisations should ensure their work to reduce health inequalities always considers people who are homeless.** The NHS Chief Executive, Sir Simon Stevens, has asked all parts of the NHS to “take urgent action to increase the scale and pace of progress of reducing health inequalities”.¹¹⁸ NHS organisations should ensure their plans explicitly cover steps to reduce the health inequalities experienced by people who are homeless and sleeping rough.
- NHS Trusts, CCGs and ICSs should also work together to ensure that people who are homeless get equal access to influenza

vaccinations. Currently the NHS has outlined that it is “essential to increase flu vaccination levels for those who are living in the most deprived 20% of neighbourhoods, those from BAME communities and people with a learning disability” but does not refer to people who are homeless.

- 11 Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs) should develop clear plans for delivering integrated housing, mental health and substance use treatment pathways for people sleeping rough.** This will help to deliver the goals of the NHS Long Term Plan which identifies people sleeping rough as a priority group, and support the Government’s goal to end rough sleeping. The plans should be informed by the rapid audit of health provision targeted at people sleeping rough, which was carried out in 2018 by DHSC and MHCLG in order to identify gaps.
- 12 Local authorities should ensure their homelessness and rough sleeping strategies address health needs.** Working with the local Health and Wellbeing Board, every local authority should ensure their homelessness and rough sleeping strategy includes an assessment of the health needs of people who are homeless. Local strategies should also include measures to reduce health inequalities experienced by people who are homeless, and ensure people get the support they need to improve their health and move on from homelessness.
- 13 Health services should take steps to improve digital inclusion.** NHSE/I has said that all GP practices must offer face to face appointments at their surgeries as well as continuing to use remote consultation. However, online consultations remain a principal option for many services and more must be done to prevent further exclusion among people who struggle to access services remotely, including people who are homeless.
- 14 Local authorities and Clinical Commissioning Groups (CCGs) should increase the number of jointly commissioned services** – Jointly funded and commissioned services help ensure support is well integrated and better able to respond to a range of needs such as homelessness and poor health. Jointly commissioned services are also important for building strong relationships across different parts of the local ‘system’ and commissioners are well-placed to help improve service pathways, ensuring they are person-centred and not focused on trying to address a single problem.
- 15 Providers of drug and alcohol services should consider a range of options to speed up scripting for opiate problems.** Scripting services should be more flexible to ensure that people are engaged as early as possible, as we have seen with same-day scripting during this period.

¹¹⁷ MHCLG (2015) *Ministerial Working Group on Preventing and Tackling Homelessness* <https://www.gov.uk/government/collections/ministerial-working-group-on-preventing-and-tackling-homelessness>

¹¹⁸ WPI Economics (2020) *Local authority spending on homelessness 2020 update* <http://wpieconomics.com/site/wp-content/uploads/2020/02/WPI-Economics-local-authority-homelessness-spending-2020-update-FINAL-images.pdf>

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Some of the photographs used in this report are file pictures, taken pre-social distancing measures, at a time when it was not a requirement to wear a face mask

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