Public Health England

West Midlands Homeless Health Resource

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Health and Wellbeing Team
Public Health England West Midlands (PHEWM)

March 2020

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Purpose of the Resource

- To summarise recent work on homeless health in the West Midlands, conducted in collaboration with a wide range of stakeholders, including the West Midlands Association of Directors of Public Health; the Mayor's Taskforce; NHS and voluntary sector
- To inform local strategic priority setting
- To highlight good practice locally and nationally

Feedback and comments should be sent to karen.saunders@phe.gov.uk

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1. Key Facts and Data in the WMs

Source: Dr Caroline Shulman

Public Health England

Homeless Health

- Bidirectional relationship: ill health can be both a contributory factor to homelessness, as well as a consequence of homelessness
- Rising levels of homelessness and rough sleeping
- Lower life expectancy and higher levels of health needs
- Diversity – every person / ‘case’ is unique –multiple needs and marginal population groups
- Myth busting (e.g. lifestyle choice) and negative attitudes
- Complexity of this area of work, range of policies and laws
- ‘Safeguarding’ –general safety and specific statutory safeguarding of adults with care and support needs

Public Health England

Those who sleep rough have complex and multiple health and care needs, often unmet. These are some of the worst health outcomes in England.

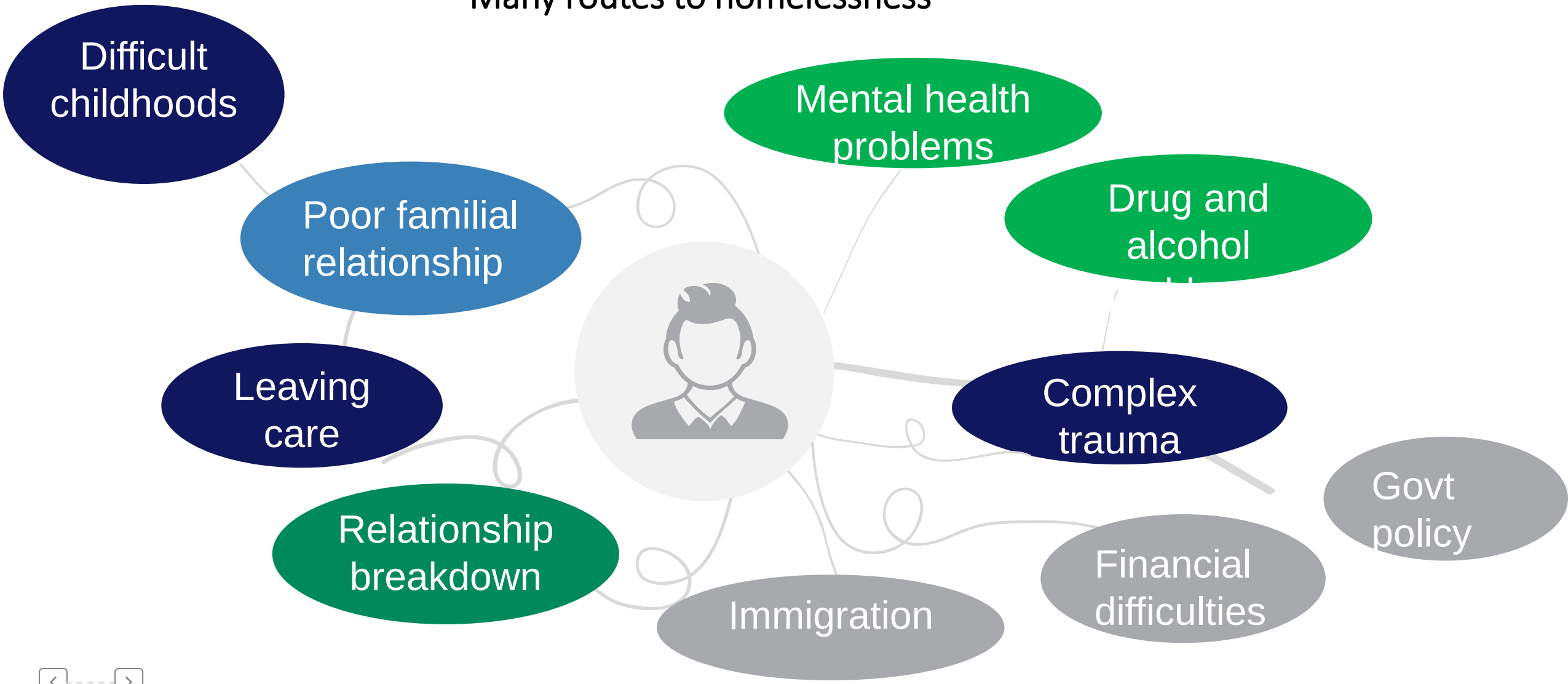
Average age of death in the UK for single homeless people:

47 for men 90%
43 for women 10%

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

Underlying Causes of Homelessness

Many routes to homelessness



Neurological:
Traumatic brain injury
Alcohol withdrawal seizures, epilepsy
Korsakoff – Wernicke syndrome
Cerebellar degeneration
Syphilis

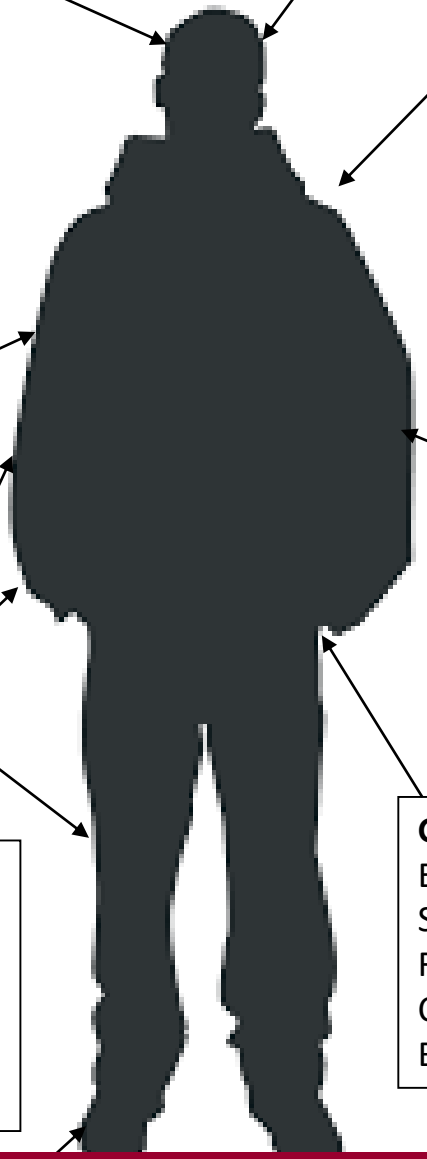
Dental

Respiratory:
COPD / asthma
Pneumonia
Crack lung
TB

Mental health:
Substance misuse
Depression / anxiety
Self harm / suicide
Personality disorder
Psychosis

Skin:
Cellulitis
Abscesses
MRSA
Eczema
Psoriasis
Fungal infections
Scabies
Lice

Cardiac:
Endocarditis
Cardiomyopathy
Hypertension
Myocardial infarction



Gastrointestinal:
Malnutrition Thiamine deficiency
Gastritis Pancreatitis
Peptic and duodenal ulcers
Alcoholic liver disease and cirrhosis
Oesophageal varices
Cancer of the oesophagus and stomach

Vascular:
DVT PE Stroke
Leg ulcers

Systemic:
BBVs
Septicaemia
Anthrax
Diabetes
Overdose

Genitourinary:
Erectile dysfunction
STIs
Recurrent UTIs
Cervical cancer
Bladder cancer

Feet:
Trauma, cellulitis
Athletes foot
Venous stasis, oedema, infection
Peripheral neuropathy
Frostbite

HOMELESS HEALTH MORBIDITY

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West Midlands: Statutory Homelessness

Area	Value	Lower CI	Upper CI
England	2.4	2.4	2.4
West Midlands region	3.3	3.3	3.4
Birmingham	7.8	7.5	8.0
Coventry	3.9	3.5	4.2
Dudley	0.5	0.4	0.6
Herefordshire	0.6	0.5	0.8
Sandwell	3.9	3.5	4.2
Shropshire	2.4	2.1	2.7
Solihull	4.6	4.1	5.0
Staffordshire	1.1*	-	-
Stoke-on-Trent	1.8	1.5	2.0
Telford and Wrekin	0.7	0.6	1.0
Walsall	1.9	1.7	2.2
Warwickshire	3.0*	-	-
Wolverhampton	4.3	3.9	4.7
Worcestershire	2.7*	-	-

Source: Department for Communities and Local Government

Statutory homelessness: rate per 1,000 households, 2017/18

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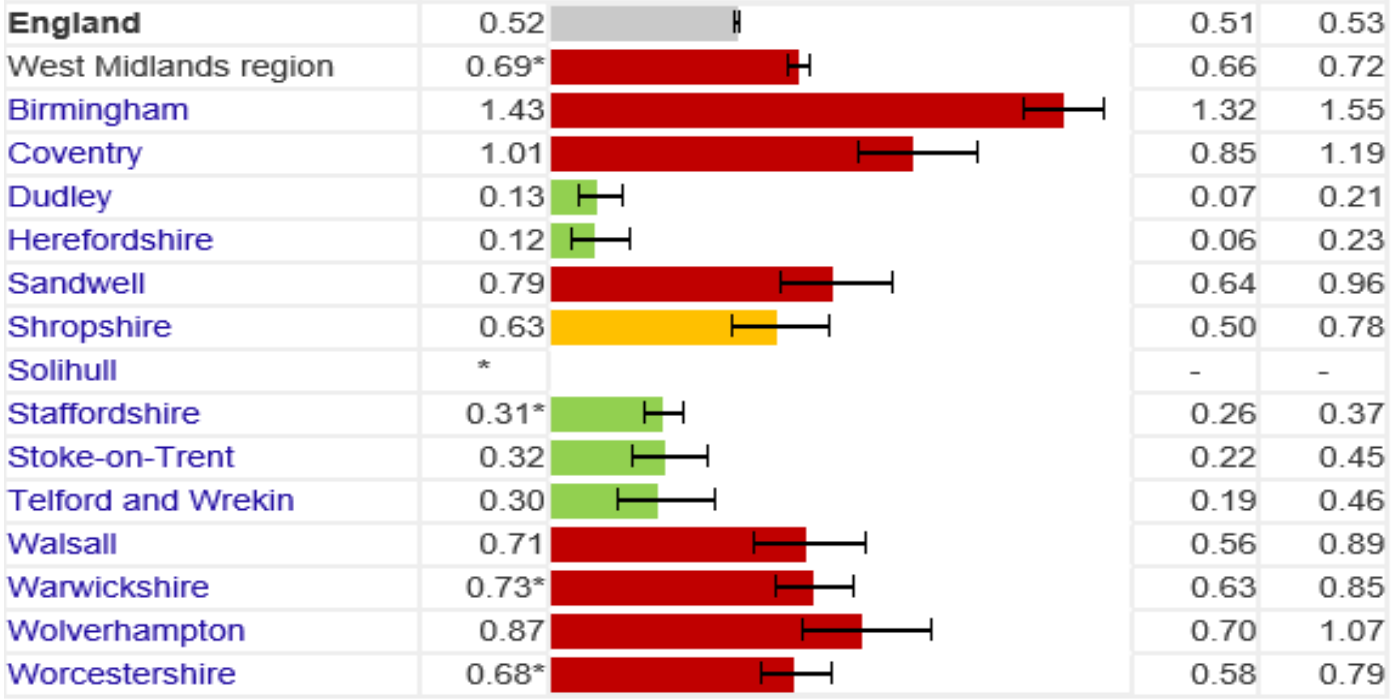
Public Health Profiles

Area	Value	Lower CI	Upper CI
England	0.52	0.51	0.53
West Midlands region	0.69*	0.66	0.72
Birmingham	1.43	1.32	1.55
Coventry	1.01	0.85	1.19
Dudley	0.13	0.07	0.21
Herefordshire	0.12	0.06	0.23
Sandwell	0.79	0.64	0.96
Shropshire	0.63	0.50	0.78
Solihull	*	-	-
Staffordshire	0.31*	0.26	0.37
Stoke-on-Trent	0.32	0.22	0.45
Telford and Wrekin	0.30	0.19	0.46
Walsall	0.71	0.56	0.89
Warwickshire	0.73*	0.63	0.85
Wolverhampton	0.87	0.70	1.07
Worcestershire	0.68*	0.58	0.79

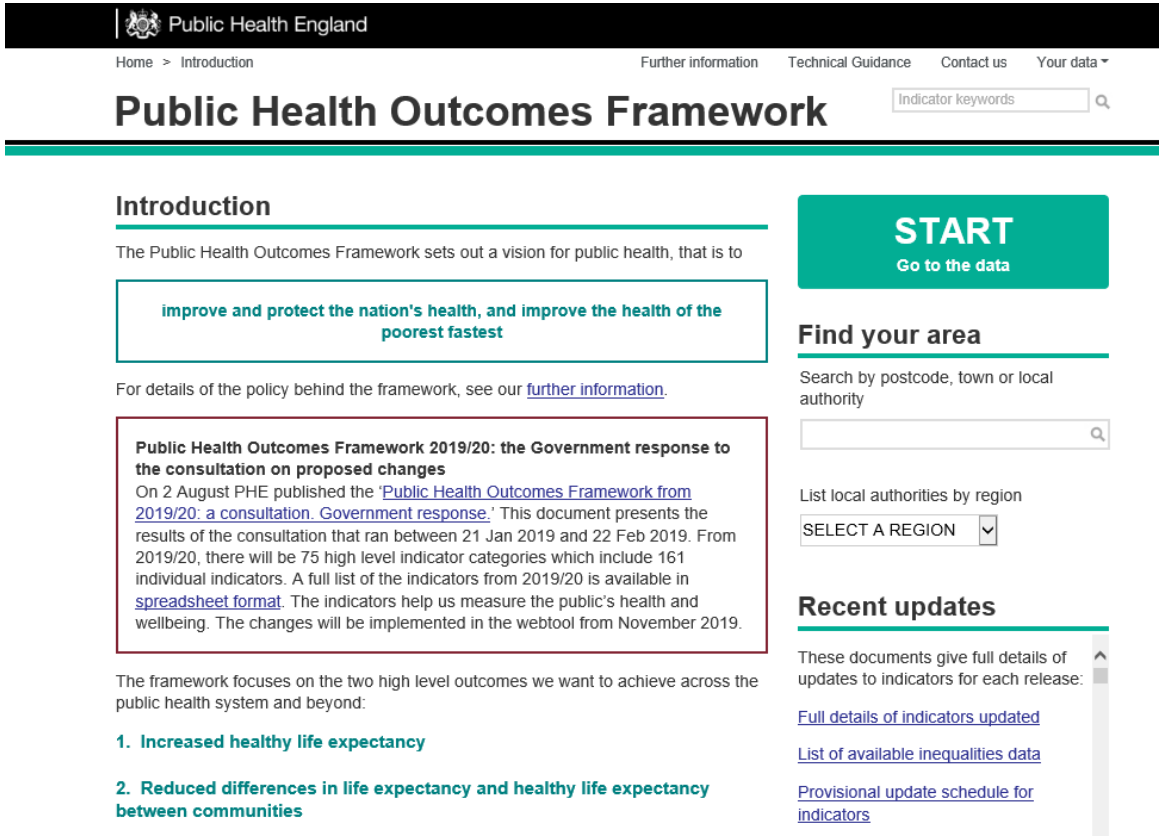


Source: Department for Communities and Local Government

Homeless young people aged 16-24, 2017/18

Public Health England

PHE Fingertips



 https://fingertips.phe.org.uk/profile/public-health-outcomes-framework

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ONS: Deaths of Homeless People

 https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsofhomelesspeopleinenglandandwales/2013to2017

Public Health England

2. Health Needs Assessments produced by/with PHEWM

2.1 Health Exchange with the University of Birmingham

2.2 Young Homeless People - presented At The “Pathways from Homelessness Symposium” 2020

Public Health England

2.1 Health Exchange Health Needs Assessment

Health Xchange (specialist GP for the homeless in Birmingham) research found that there was a higher prevalence of alcohol dependence, substance dependence, mental health disorders and Hepatitis C in this homeless population vs general population. Multi-morbidity was comparable to 60-69 year olds in general population despite average age of this group being 38years old. A&E attendances 60x higher than general population

FINAL STUDY REPORT

Healthcare issues amongst the homeless in Birmingham

Analyses of routinely collected data from a specialist homeless healthcare centre

UNIVERSITY OF BIRMINGHAM

ROBERT GORDON UNIVERSITY ABERDEEN

Birmingham and Solihull NHS Mental Health NHS Foundation Trust

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Public Health England, West Midlands
and
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WEST MIDLANDS COMBINED AUTHORITY

Public Health England

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UNIVERSITY OF BIRMINGHAM

BIRMINGHAM POLICY LAB

Homelessness and rough sleeping

Birmingham, UK

4 October 2019

publicaffairs@contacts.bham.ac.uk

> “Austerity has led to the social security threads being snipped away, so that when vulnerable people’s shallow support networks fail, the system lets them down.

Participants

(Chair) Professor Andy Lyner, Director of CHASM, University of Birmingham
(Rapporteur) Jeremy Swan, Public Affairs Manager (Policy Impact), University of Birmingham
Janette Beckett, Director of Support Services and New Business, Spring Housing
Professor Nicholas Crowson, Professor of Contemporary British History, University of Birmingham
Dr Jean Cumming, Reader, University of Birmingham
Carly Jones, Chief Executive, Sifa Fireside
Dr Sarah Marwick, Lead GP, The Homeless Health Exchange Primary Care Service; Associate Medical Director, NHS England/ Improvement, Midlands
Dr Vibhu Paudyal, Senior Lecturer, University of Birmingham
Thea Raisbeck, Honorary Research Associate, University of Birmingham; Associate, Spring Housing
Neelam Sunder, Programme Manager - Homelessness (Policy & Implementation), West Midlands Combined Authority
Jean Templeton, Chief Executive, St Basils; Chair, West Midlands Homelessness Task Force
Geraldine Taskiricia, Community Manager, Emmaus Coventry and Warwickshire

On 4 October 2019, the University of Birmingham convened a roundtable on the subject of homelessness, bringing together experts from academia, local government, the NHS and civil society. The session was chaired by Professor Andy Lyner in his role as Director of the Centre of Household Assets and Savings Management (CHASM).

What are the key drivers behind rising levels of homelessness?

There is a lack of affordable homes. More people are finding they do not have the necessary income to meet the rising cost of housing. Recent welfare reforms have not helped; housing benefit has been frozen in the last few years, while housing costs have continued to rise.

The welfare system seems to be set up for people to fail. Homeless people are finding it harder to meet the criteria for support and so more people are falling out of the system without a safety net. Austerity has led to the social security threads being snipped away, so that when vulnerable people’s shallow support networks fail, the system lets them down. This is a national issue that is visibly playing out in our core cities, such as Birmingham where 23 homeless people died in 2018.[1]

Years of austerity measures have hit public services hard. Prevention services and economic regeneration schemes have been cut back and this has fuelled the rise in homeless numbers.

Of particular concern is the lack of preventative services around issues such as mental health and substance misuse. Funding cutbacks have ensured that the focus has shifted from tackling the underlying issues to managing a crisis. Where funding is available, it is too often channelled into short-term programmes that do nothing to tackle the systemic issues.

What are the main challenges?

Attitudes towards homeless people have changed in recent decades. Back in the 1970s, there was an emphasis on providing vulnerable people with good and affordable homes in places where you could bring up a family and find work. We have gone from that to a short term social subsidy that is only available to the ‘deserving’ poor.

As a society, we have regressed in terms of what we are willing to accept. A roof over people’s heads is not good enough; people need to have a home where they feel safe, secure and connected to a community. Further emotional and financial support is also necessary once people do move into accommodation.

Serious issues exist around our accommodation offer for homeless people. In some cases, people are housed in unsuitable settings where they don’t feel safe or feel socially isolated, which can drive people back onto the streets where there is at least a sense of community. Others can become trapped in supported accommodation. They may be able to secure paid employment, but still struggle to pay the costs of their rent.

Access to housing and employment is important. But the problem is that we expect people to cope with the benefits system and the demands of work on top of all the other issues they may be dealing with such as mental ill

1 British Journal of General Practice, Online First 2019

Research

Ellie Gunner, Sat Kartar Chandan, Sarah Marwick, Karen Saunders, Sarah Burwood, Asma Yahyouche and Vibhu Paudyal

Provision and accessibility of primary healthcare services for people who are homeless:

a qualitative study of patient perspectives in the UK

Abstract

Background
Anecdotal reports of people who are homeless being denied access and facing negative experiences of primary health care have often emerged. However, there is a dearth of research exploring this population’s views and experiences of such services.

Aim
To explore the perspectives of individuals who are homeless on the provision and accessibility of primary healthcare services.

Design and setting
A qualitative study with individuals who are homeless recruited from three homeless shelters and a specialist primary healthcare centre for the homeless in the West Midlands, England.

Method
Semi-structured interviews were audiorecorded, transcribed verbatim, and analysed using a thematic framework approach. The Theoretical Domains Framework (TDF) was used to map the identified barriers in framework analysis.

Results
A total of 22 people who were homeless were recruited. Although some participants described facing no barriers, accounts of being denied registration at general practices and being discharged from hospital onto the streets with no access or referral to primary care providers were described. Services offering support to those with substance misuse issues and mental health problems were deemed to be excluding those with the greatest need. A participant described committing crimes with the intention of going to prison to access health care. High satisfaction was expressed by participants about their experiences at the specialist primary healthcare centre for people who are homeless (SPHCPH).

Conclusion
Participants perceived inequality in access, and mostly faced negative experiences, in their use of mainstream services. Changes are imperative to facilitate access to primary health care, improve patient experiences of mainstream services, and to share best practices identified by participants at the SPHCPH.

Keywords
health services accessibility; homeless persons; primary care.

INTRODUCTION

Homelessness manifests itself in many forms including rough sleeping, squatting, sofa surfing, and residing in hostels or council housing.[1] Homelessness is a national concern in the UK, with >115 550 homeless applications being submitted to local authorities in England during 2016/2017.[2] The number sleeping rough in some urban areas has doubled in the last 6 years.[3]

Significant healthcare disparities remain for the homeless community, standardised mortality ratios for females and males who are homeless are reported to be 11.9 and 7.9 respectively, compared with the general population.[4] The Inverse Care Law, that is, *‘the availability of healthcare is inverse to the health needs of the population’*,[5] is often applicable to the homeless as these individuals face barriers when accessing mainstream primary healthcare services.

Those who are homeless are known to be 40 times less likely to be registered with a mainstream general practice compared with the general population.[6] In an attempt to address such disparities, specialist primary healthcare centres for people who are homeless (SPHCPH) have been established. Such centres provide a multitude of services including GPs, dentists, specialist nurses, and psychotherapy counselling services, usually under one roof.[7] Patients who are homeless are expected to relocate from the centre to mainstream primary care providers once permanently housed.[8]

Barriers to accessing health care can contribute to the worsening of health issues experienced by people who are homeless, due to delayed diagnosis and treatment. It is known that this population is up to 60 times more likely than the general population to attend an accident and emergency (A&E) department,[9] with substance and alcohol misuse commonly linked to such visits. This may indicate points of weakness in the primary healthcare system for people who are homeless.

Exploring reasons for underutilisation or non-access to primary care services, experiences that deter or facilitate such use, and potential reasons for frequent A&E visits by those who are homeless are imperative in order to improve the health of this population. Use of primary care services is particularly important, as seeing a trusted healthcare professional (HCP) is essential to ensure continuity of care.[10] Standards for service providers and commissioners have been published by the Faculty for Homeless Health that focus on the need for cross-sector collaboration, including outreach where facilitated access to the sites are not practical or successful.[11]

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Research

Matthew Bowen, Sarah Marwick, Tom Marshall, Karen Saunders, Sarah Burwood, Asma Yahyouche, Derek Stewart and Vibhu Paudyal

Multimorbidity and emergency department visits by a homeless population:

a database study in specialist general practice

Abstract

Background
Estimating healthcare needs of the homeless is associated with challenges in identifying the eligible population.

Aim
To explore the demographic characteristics, disease prevalence, multimorbidity, and emergency department visits of the homeless population.

Design and setting
EMIS electronic database of patient medical records and Quality and Outcomes Framework (QOF) data of all 928 patients registered with a major specialist homeless primary healthcare centre based in the West Midlands in England, from the period of October 2016 to 11 October 2017.

Method
Prevalence data on 21 health conditions, multimorbidity, and visits to emergency departments were explored and compared with the general population datasets.

Results
Most homeless people identified were male (89.5%), with a mean age of 38.3 (SD = 11.5) years, and of white British origin (22.1%). Prevalence of substance (13.1%) and alcohol dependence (21.3%), hepatitis C (6.3%), and multimorbidity (21.2%) were markedly higher than in the general population. A third (32.5%) had visited the emergency department in the preceding 12 months. Emergency department visits were associated with a patient history of substance [odds ratio (OR) = 2.69] and alcohol dependence [OR = 3.14].

Conclusion
A high prevalence of substance and alcohol dependence, and hepatitis C, exists among the homeless population. Their emergency department visit rate is 60 times that of the general population and the extent of multimorbidity, despite their lower mean age, is comparable with that of 60–69-year-olds in the general population. Because of multimorbidity, homeless people are at risk of fragmentation of care. Diversification of services under one roof, preventive services, and multidisciplinary care are imperative.

Keywords
epidemiology; general practice; healthcare utilisation; homeless persons.

INTRODUCTION

Homelessness is a widespread issue in the UK,[1] with an estimated 250 000 people known to be homeless in England alone.[2] More than 4000 people sleep rough on any given night in England, with numbers of rough sleepers rising, particularly in urban areas; in London, for example, the number of rough sleepers has doubled in the last 6 years (up to and including 2017).[3]

There is a dearth of literature investigating healthcare issues among homeless people in the UK. Findings from international literature suggest that those experiencing homelessness are significantly disadvantaged in achieving and maintaining a healthy lifestyle.[4] They face up to 12 times higher mortality rates than the general population, mostly due to opioid overdose, accidents, heart failure, and infectious diseases.[4] The negative health consequences of social exclusion are noted to be greater in females than males.[4] A UK study in 2012 identified that rough sleepers and those occupying homeless shelters die at an average age of 47 years.[5] Health status worsens with increasing length of time as homeless.[4] Historical estimates have suggested that homelessness is independently linked with high emergency department use.[7] However, there is limited literature exploring the rate of emergency department visits and the characteristics within homeless populations associated with this increased use of emergency care.

Primary healthcare service provision for homeless people

There has been an emergence of some specialist primary care support for homeless people across the UK. There is at least one such practice in most major cities in the UK that offers primary healthcare centres for homeless people and some general practices have particular expertise in homelessness.[8]

The lack of studies in the UK that have investigated the prevalence of key health conditions necessitates the strengthening of the evidence around the primary healthcare needs of homeless populations. Identifying the burden of disease is often challenging in socially excluded populations as social disadvantage is often not recorded in medical records and the UK general register of births and deaths. Homeless populations also have very limited coverage in routine health surveys due to their often secluded and unstable locations. There is also a need to address the current gap in the range of methodology that has been used to explore the healthcare issues of homeless people. Gathering and analysing healthcare utilisation datasets from a large specialist

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Provision and accessibility of primary healthcare services for people who are homeless: a qualitative study of patient perspectives in the UK

Ellie Gunner, Sat Kartar Chandan, Sarah Marwick, Gunveer Plahe, Karen Saunders, Sarah Burwood, Asma Yahyouche and Vibhu Paudyal*
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University of Birmingham · Birmingham and Solihull NHS Mental Health NHS Foundation Trust · Public Health England

BACKGROUND

- Homelessness is a national concern in the UK with more than 115,550 homeless applications submitted to local authorities in England during 2016/7 [1]
- Significant health disparities exist for the homeless community.
- There is a dearth of research exploring views and experiences of persons experiencing homelessness regarding their access to primary healthcare services.

AIM

This study aimed to explore the perspectives of individuals who are experiencing homelessness on the provision and accessibility of primary healthcare services.

METHOD

- Qualitative study
- Persons experiencing homelessness recruited from three homeless shelters and a specialist primary healthcare centre for the homeless (SPHCH)
- Based in West Midlands, England
- Convenience sampling method
- Semi-structured interviews were audio recorded and transcribed verbatim
- Data was analysed using a thematic framework approach
- The Theoretical Domains Framework (TDF) was used to map the identified barriers in framework analysis.

RESULTS

22 participants were recruited. Participants' experiences and associated barriers and facilitators around their experience and access to primary care services are presented as per the TDF domains in table 1 and illustrative quotes are also provided.

Table 1: Barriers and facilitators of access to primary care

TDF domain	Sub-theme	Facilitator	Barrier
Beliefs about capabilities	Patients' perceived ability (or lack of) to find a healthcare provider	✓	✓
Beliefs about consequences	Consequences of continuity of care (or lack of)	✓	✓
	Consequences of being discharged onto the streets with no primary care providers		✓
Emotions	Feelings of embarrassment when seeking healthcare		✓
Environmental context and resources	Lack of patient 'fixed abode' and photographic ID		✓
	Signposting (or lack of) to appropriate services	✓	✓
	Patients' lack of resources to pay for public transport or make calls for appointments		✓
	Patients' lack of resources to search services in their local areas		✓
	Availability (or lack of) facilities to promote medication adherence	✓	✓
	Discharged from hospitals on to the streets		✓
	Unfavourable eligibility criteria for access to substance misuse and mental health services		✓
Goals and Intentions	Patients' intentions to seek healthcare	✓	✓
Knowledge	Patients' knowledge (or lack of) of mainstream services available in their areas	✓	✓
	Lack of knowledge amongst mainstream frontline staff about eligibility for registration of homeless patients		✓
	GPs' knowledge of (or lack of) the complexity of homeless patients' health conditions	✓	✓
Memory, attention and decision processes	Committing crime to go to prison to get healthcare		✓
Skills	Patients' lack of skills in completing paperwork and navigating through the system		✓
Social influences	Support from friends and families in registration process	✓	
	Social network to facilitate appointments and engagement	✓	
	Perceived stigma and discrimination from other patients		✓
	Perceived stigma and discrimination from healthcare staff		✓

'I went to about four or five in my postcode. Err all of them says that I couldn't sign up because I had no fixed abode, but none of them give me the details about this [SPHCH]'. (M, aged 43 years)

'I think [healthcare professionals] probably need to be made more aware of [homelessness] because there's a lot of erm things that you can face on the streets, you can face a lot of illness more than you would do in like a house.' (M, aged 24 years)

'I got self-sent to prison for 3 weeks so they could help detox me.' (M, aged 34 years)

'Most days at one o'clock it's a drop-in, ask for a nurse or a doctor other surgeries you've got to wait 2 to 3 weeks to get an appointment, that doesn't happen [SPHCH] .' (M, aged 64 years)

'if you've self-harmed within the last 6 months [the mental health services] won't touch you as well as if you're on the alcohol or drugs as well they won't touch you because they think you're too high of a risk … you shouldn't be using [recreational drugs] to self-medication but when you don't have access to the services what else are you meant to do?' (M, aged 24 years)

DISCUSSION and CONCLUSION

Persons experiencing homelessness perceived inequality in access to mainstream primary healthcare providers and faced mostly negative experiences at these services. The SPHCH service delivery model was perceived as best practice that could be shared with mainstream services.

Recommendations grounded in study findings:

Short-term

- Education of staff at mainstream general practices on registration rights and entitlements to ensure NHS access guidance is being implemented [2].
- Distribution of 'My right to access healthcare' cards to facilitate self-advocacy. NHS England is currently working on this area.
- Provision of material to mainstream practices to aid signposting to homeless services.
- Review entry criteria to mental health services for homeless people to ensure PHE guidance on care for people with co-occurring conditions is being implemented. [3]
- Compliance with the Homelessness Reduction Act 2017, including duty to refer and collaboration [4]

Long-term

- Provision of a health-needs assessment tool for use by primary care practitioners to ensure a holistic approach to care for homeless people.
- Incorporation of healthcare for homeless people into the curriculum for healthcare professionals.

Obtaining views of wider stakeholders would provide further insight into the barriers and facilitators faced by homeless people when accessing primary healthcare services.

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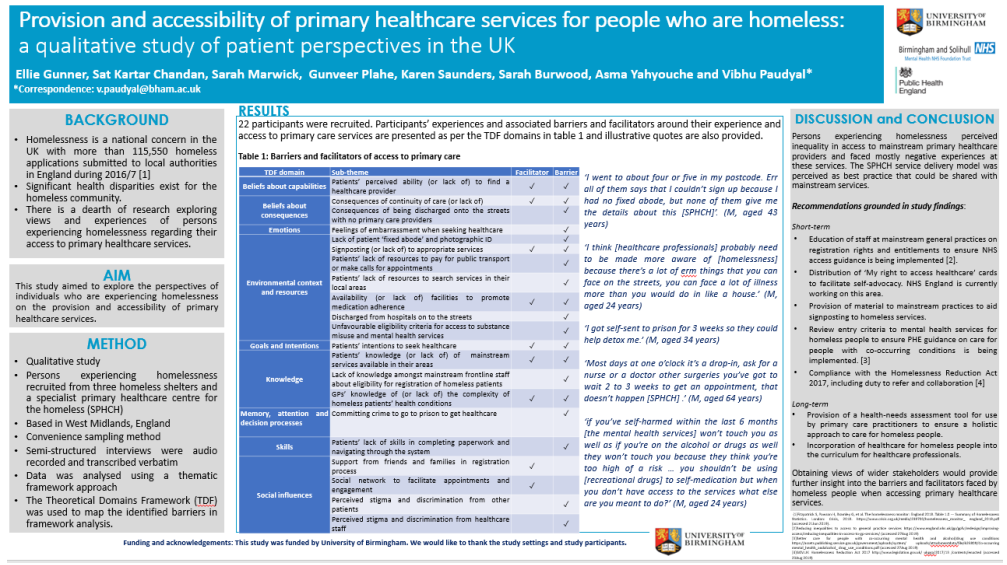
University of Birmingham



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Research

Provision and accessibility of primary healthcare services for people who are homeless: a qualitative study of patient perspectives in the UK

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Abstract

Background Anecdotal reports of people who are homeless being denied access and facing negative experiences of primary health care have often emerged. However, there is a dearth of research exploring this population's views and experiences of such services.

Aim To explore the perspectives of individuals who are homeless on the provision and accessibility of primary healthcare services.

Design and setting A qualitative study with individuals who are homeless recruited from three homeless shelters and a specialist primary healthcare centre for the homeless in the West Midlands, England.

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SPEAK UP FOR CHANGE

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Data/information toolkit

Karen Saunders, Gunveer Plahe, Alex Elliot, Liz Bates

Public Health England

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Public Health England

Homelessness and young people

What can the data tell us?

Alex Elliot, Karen Saunders, Gunveer Plahe

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Public Health England

8 relevant indicators on PHOF

	Indicator	Period	England	West Midlands region	Birmingham	Coventry	Dudley	Herefordshire	Sandwell	Shropshire	Solihull	Staffordshire	Stoke-on-Trent	Telford and Wrekin	Walsall	Warwickshire	Wolverhampton	Worcestershire
*	Statutory homelessness: rate per 1,000 households	2017/18	2.4	3.3	7.8	3.9	0.5	0.6	3.9	2.4	4.6	1.1*	1.8	0.7	1.9	3.0*	4.3	2.7*
*	Statutory homelessness - households in temporary accommodation	2017/18	3.4	1.4	4.7	2.0	0.1	0.5	0.3	1.0	1.1	0.2	0.2	0.5	1.0	1.3	0.7	0.4
	Hospital admissions due to substance misuse (15-24 years)	2015/16 - 17/18	87.9	71.1	56.0	55.4	98.5	80.9	87.5	61.4	89.7	73.8	94.3	41.0	107.1	78.2	101.7	57.6
	Family homelessness	2017/18	1.7	2.6	6.6	2.9	0.4	0.4	3.0	1.2	3.1	0.8	1.4	0.5	1.3	2.0	3.6	1.9
	Statutory homelessness - Eligible homeless people not in priority need	2017/18	0.8	1.1	0.9	0.6	3.6	0.1	0.5	2.8	1.4	0.3	1.8	*	0.1	1.2	2.2	0.9
*	Homeless young people aged 16-24	2017/18	0.52	0.69*	1.43	1.01	0.13	0.12	0.79	0.63	*	0.31*	0.32	0.30	0.71	0.73*	0.87	0.68*
	Proportion of supported working age adults with learning disability living in unsettled accommodation (%) New data	2017/18	18.4	22.6	32.6	20.0	17.7	23.8	17.9	14.4	21.6	24.4	26.5	8.8	12.0	17.9	23.5	19.1
	Proportion of supported working age adults whose accommodation status is severely unsatisfactory (%) New data	2017/18	0.15	0.08	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

Public Health England

England: overall trends

	Indicator	Period	England count	England value	Recent trend
*	Statutory homelessness: rate per 1,000 households	2017/18	56,600	2.4	↑
*	Statutory homelessness - households in temporary accommodation	2017/18	79,880	3.4	↑
	Hospital admissions due to substance misuse (15-24 years)	2015/16 - 17/18	17,761	87.9	–
	Family homelessness	2017/18	40,990	1.7	↑
	Statutory homelessness - Eligible homeless people not in priority need	2017/18	18,430	0.8	↓
*	Homeless young people aged 16-24	2017/18	12,010	0.52	↓
	Proportion of supported working age adults with learning disability living in unsettled accommodation (%) New data	2017/18	24,200	18.4%	–
	Proportion of supported working age adults whose accommodation status is severely unsatisfactory (%) New data	2017/18	200	0.15%	–

Public Health England

More than half of young people become homeless because of a **relationship breakdown,** mainly with their parents.

https://www.homeless.org.uk/connect/blogs/2014/oct/01/when-young-people-become-homeless-they-need-help-not-hurdles

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“Thousands of children growing up in shipping containers, office blocks and B&Bs”

Children’s Commissioner 2019[1]

https://www.bbc.co.uk/programmes/p0761l5v

https://www.bbc.co.uk/news/education-49412835

[1] https://www.childrenscommissioner.gov.uk/publication/bleak-houses/

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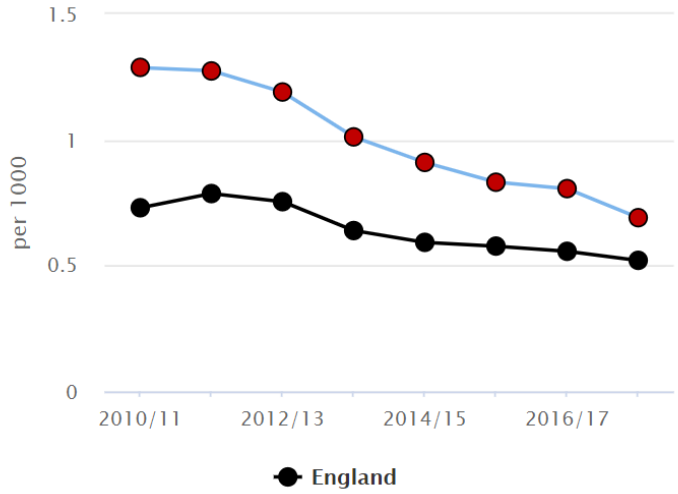
https://www.childrenscommissioner.gov.uk/publication/bleak-houses/

Public Health England

Homeless young people aged 16-24: *West Midlands trend*

Homeless young people aged 16-24 West Midlands region — Crude rate - per 1000

Export chart as image | Show confidence intervals | Export table as CSV file



Recent trend: ↓

Period	West Midlands region					England
		Count	Value	Lower CI	Upper CI	
2010/11	●	2,934	1.29	1.24	1.33	0.73
2011/12	●	2,929	1.27	1.23	1.32	0.79
2012/13	●	2,755	1.19	1.15	1.24	0.75
2013/14	●	2,358	1.01	0.97	1.05	0.64
2014/15	●	2,139	0.91	0.87	0.95	0.59
2015/16	●	1,970	0.83	0.80	0.87	0.58
2016/17	●	1,926	0.81	0.77	0.84	0.56
2017/18	●	1,645	0.69*	0.66	0.72	0.52

Source: Department for Communities and Local Government

Public Health England

Homeless young people aged 16-24: *West Midlands*

Homeless young people aged 16-24 2017/18 — Crude rate - per 1000

Export table as image | Export table as CSV file

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	↓	12,010	0.52	0.51	0.53
West Midlands region	↓	1,645	0.69*	0.66	0.72
Birmingham	↓	602	1.43	1.32	1.55
Coventry	↓	144	1.01	0.85	1.19
Dudley	↓	17	0.13	0.07	0.21
Herefordshire	↓	10	0.12	0.06	0.23
Sandwell	↓	99	0.79	0.64	0.96
Shropshire	↓	86	0.63	0.50	0.78
Solihull	–	-	*	-	-
Staffordshire	↓	115	0.31*	0.26	0.37
Stoke-on-Trent	↓	35	0.32	0.22	0.45
Telford and Wrekin	↓	21	0.30	0.19	0.46
Walsall	↑	79	0.71	0.56	0.89
Warwickshire	→	175	0.73*	0.63	0.85
Wolverhampton	→	91	0.87	0.70	1.07
Worcestershire	↓	170	0.68*	0.58	0.79

Source: Department for Communities and Local Government

Public Health England

Rough sleeping

Public Health England

Definitions

"people sleeping, about to bed down (sitting on/in or standing next to their bedding) or actually bedded down in the open air (such as on the streets, in tents, doorways, parks, bus shelters or encampments)

people in buildings or other places not designed for habitation (such as stairwells, barns, sheds, car parks, cars, derelict boats, stations, or 'bashes')." [1]

- Complex
- Data recording difficult
- Underestimated
- No specific data on 'young people' 16-24 years

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

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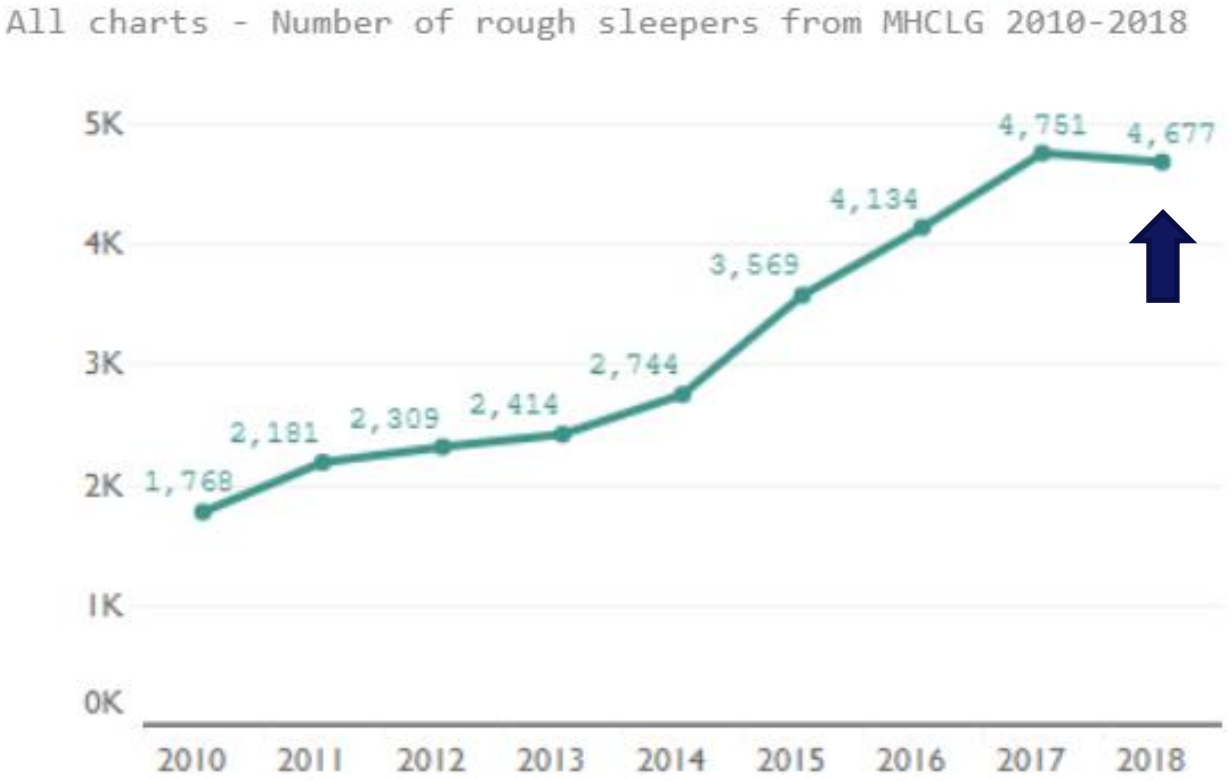
The number of people sleeping rough is rising nationally



https://www.homeless.org.uk/facts/homelessness-in-numbers/rough-sleeping/rough-sleeping-explore-data

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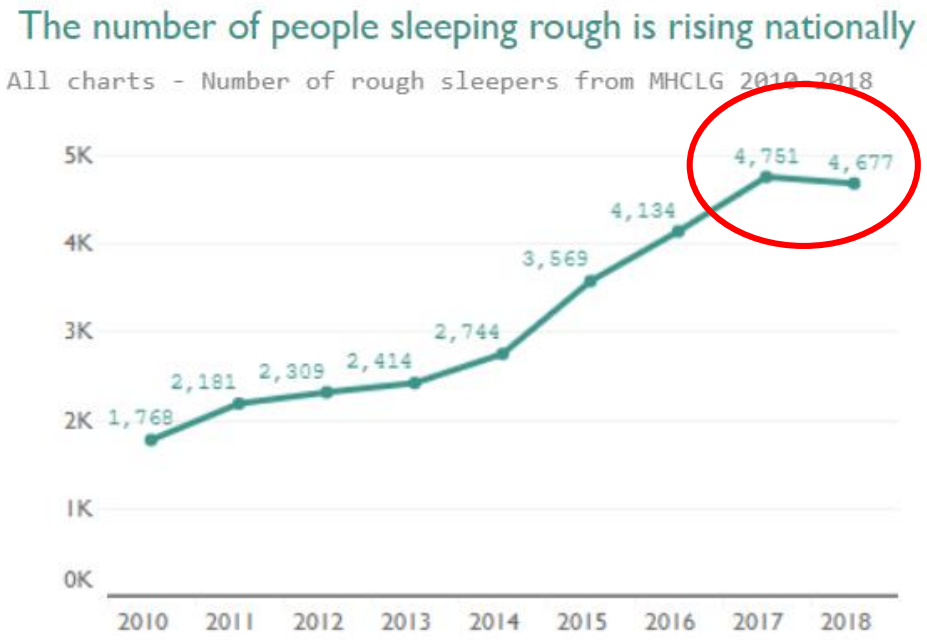
Data quality?



- 2018: move from '*estimates*' to '*street counts*'
- '*Estimates*': agreed by agencies who work closely with rough sleepers in the area all year round
- '*Street counts*': one-night snapshot
- ? artificial decrease in numbers
- ? "deliberate misrepresentation"
- ONS now doing good work on homeless deaths

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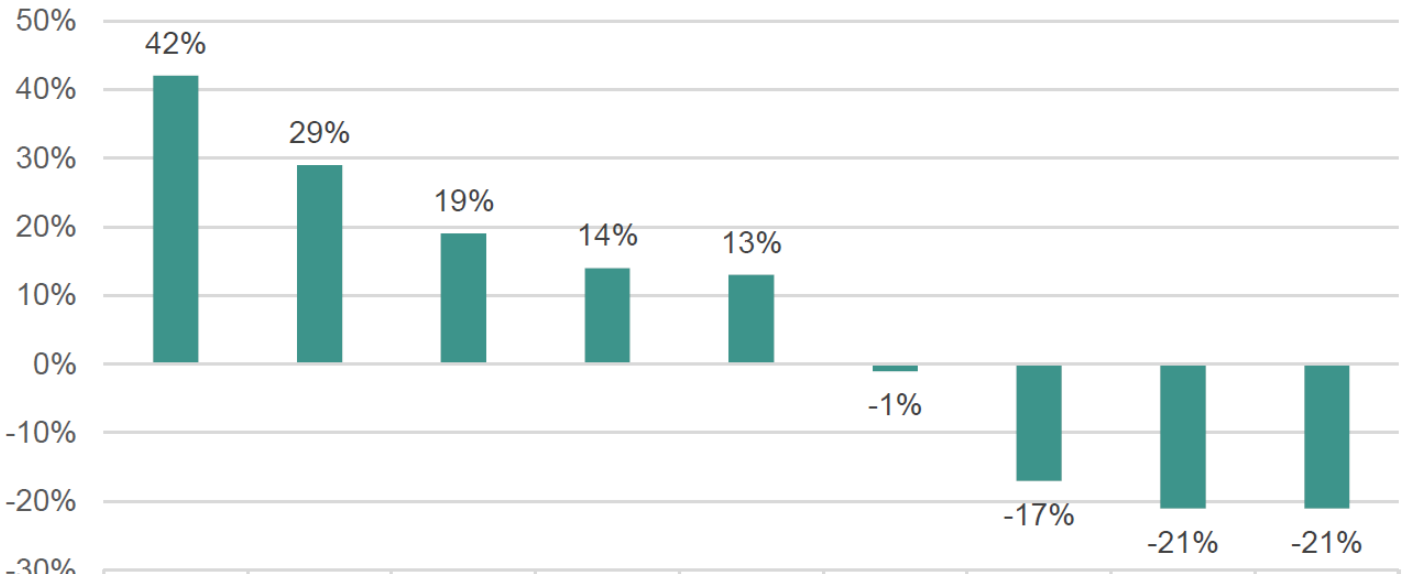
Regional changes in rough sleeping 2017-2018



	West Midlands	North East England	Yorkshire & the Humber	East Midlands	London	North West England	South East England	South West England	East England
Change in Rough Sleeping %	42%	29%	19%	14%	13%	-1%	-17%	-21%	-21%

https://www.homeless.org.uk/sites/default/files/site-attachments/Homeless%20Link%20-%20analysis%20of%20rough%20sleeping%20statistics%20for%20England%202018.pdf

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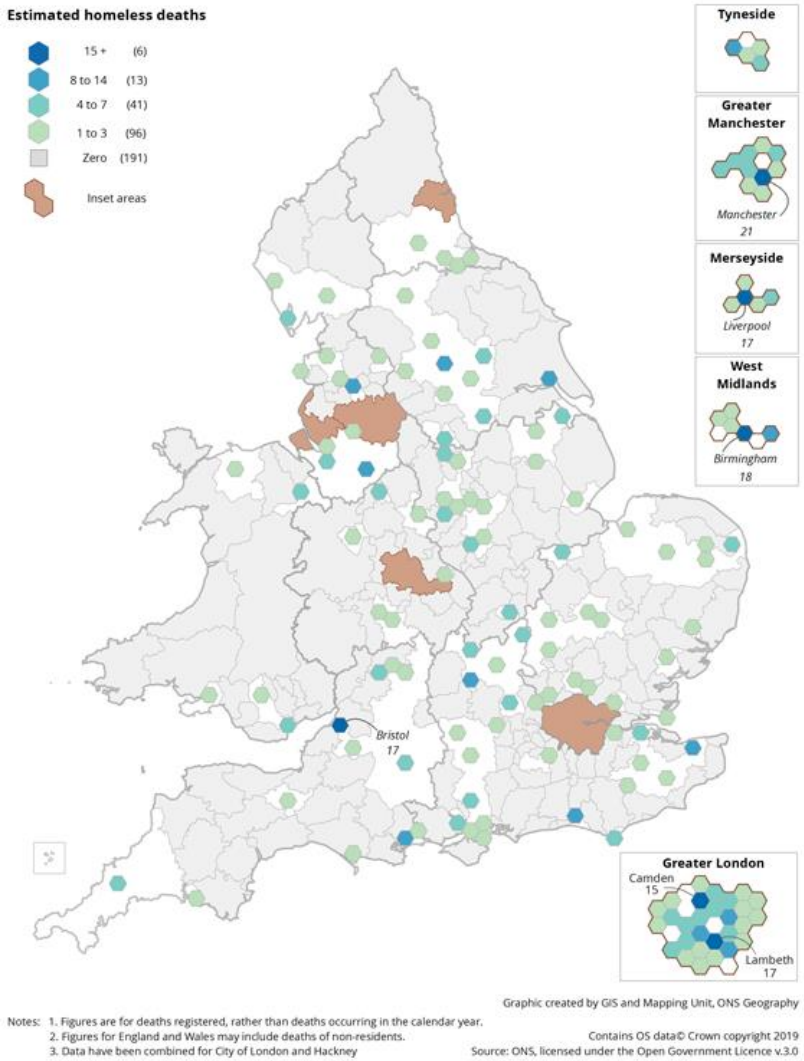
Estimated homeless deaths 2017



- Manchester (21 deaths)
- Birmingham (18 deaths)
- Bristol (17 deaths)
- Lambeth (17 deaths)
- Liverpool (17 deaths)
- Camden (15 deaths)

Source: Office for National Statistics

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Table 1: The five local authorities with the most deaths of homeless people

England and Wales, 2013 to 2017

	2013		2014		2015		2016		2017	
1	Camden	21	Birmingham	18	Birmingham	20	Camden	23	Manchester	21
2	Birmingham	16	Lambeth	14	Westminster	19	Birmingham	18	Birmingham	18
3	Lambeth	16	Bristol, City of	13	Camden	19	Liverpool	17	Lambeth	17
4	Tower Hamlets	12	Manchester	12	Tower Hamlets	12	Brighton and Hove	13	Liverpool	17
5	Bournemouth	12	Newcastle upon Tyne	12	Leeds	12	Southampton	12	Bristol, City of	17

Source: Office for National Statistics

https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsofhomelesspeopleinenglandandwales/localauthorityestimates2013to2017

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Birmingham Named As Worst In England For Homeless Deaths

25 June 2019, 06:44 | Updated: 25 June 2019, 06:47

168

Deaths of homeless people have been highest in areas with the biggest council cuts, Labour analysis shows.

The highest number of estimated deaths in England was in Birmingham, with 90, where council cuts per household have hit £939.80 - more than three times the national average -

https://www.heart.co.uk/westmids/news/local/birmingham-named-as-worst-in-england-f/

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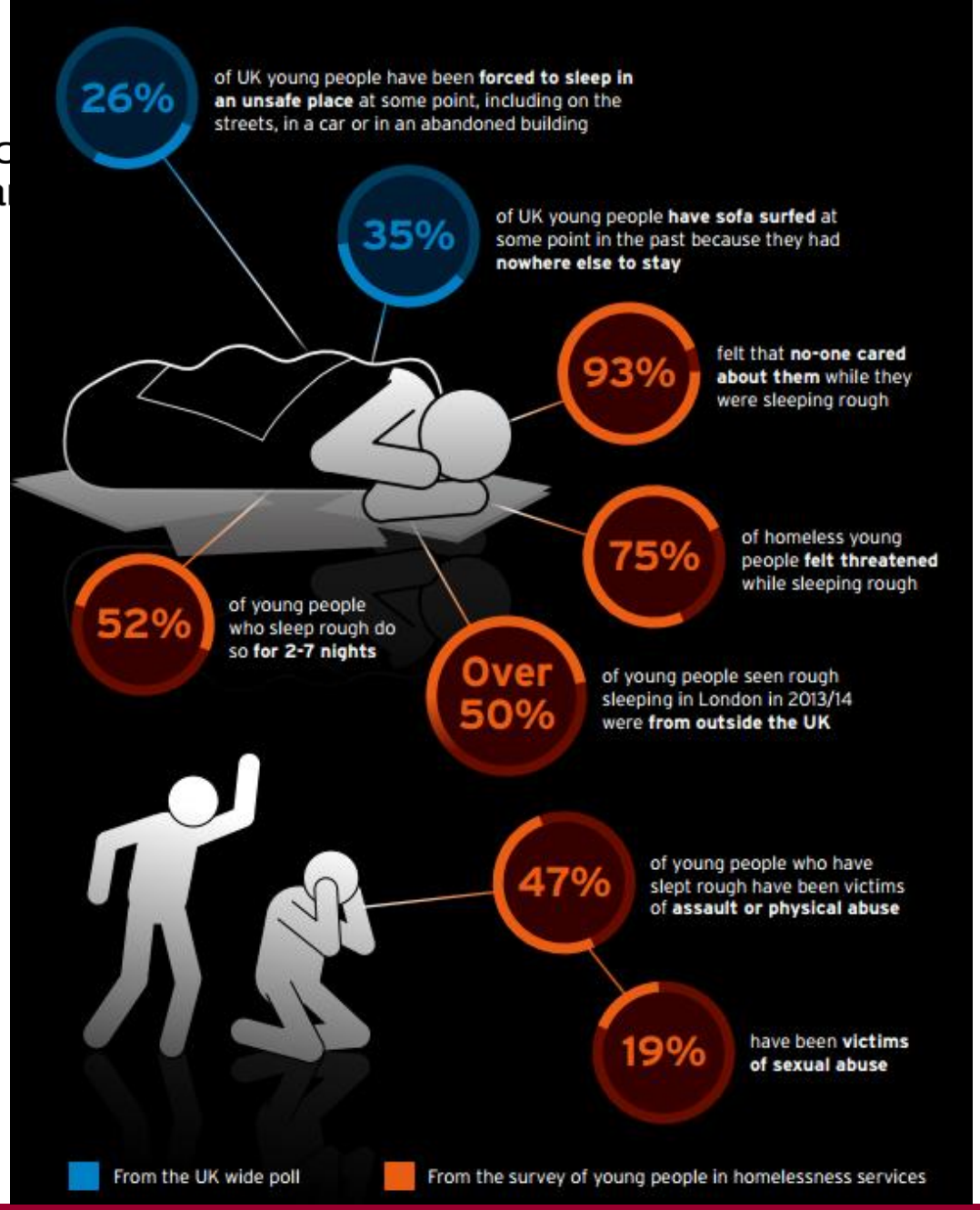

Rough sleeping *young persons*

"My parents were unable or unwilling to accommodate me (21%)"

"I left home due to the negative environment there (17%)"

"I split up from my partner (15%)"

"I have slept in a car (55%) or in a tent (34%)"

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Actions/recommendations

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Homelessness Reduction Act 2017

2017 CHAPTER 13

An Act to make provision about measures for reducing homelessness; and for connected purposes

[27th April 2017]

BE IT ENACTED by the Queen's most Excellent Majesty, by and with the advice and consent of the Lords Spiritual and Temporal, and Commons, in this present Parliament assembled, and by the authority of the same, as follows:—

- Marks a significant change in homelessness legislation
- Includes all eligible homeless applicants irrespective of ‘priority need’ or ‘intentional homelessness’
- Needs-led personalised housing plans should contain the steps to be taken to prevent or relieve the applicant’s homelessness

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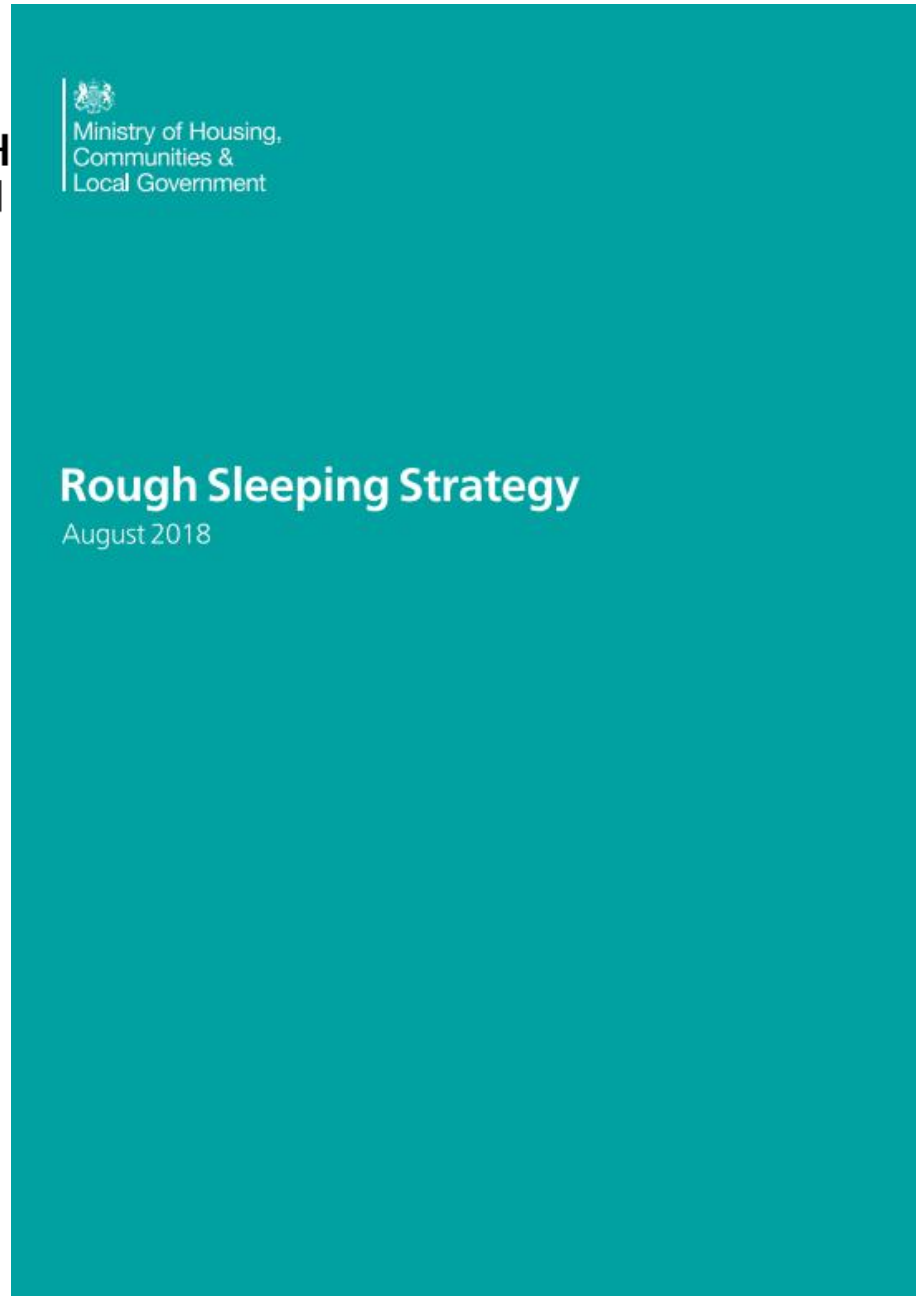

Strategic aims

- Halve rough sleeping by 2022
- End it by 2027
- £100 million funding
- Homelessness Reduction Act
- Affordable housing
- Accurately measure numbers

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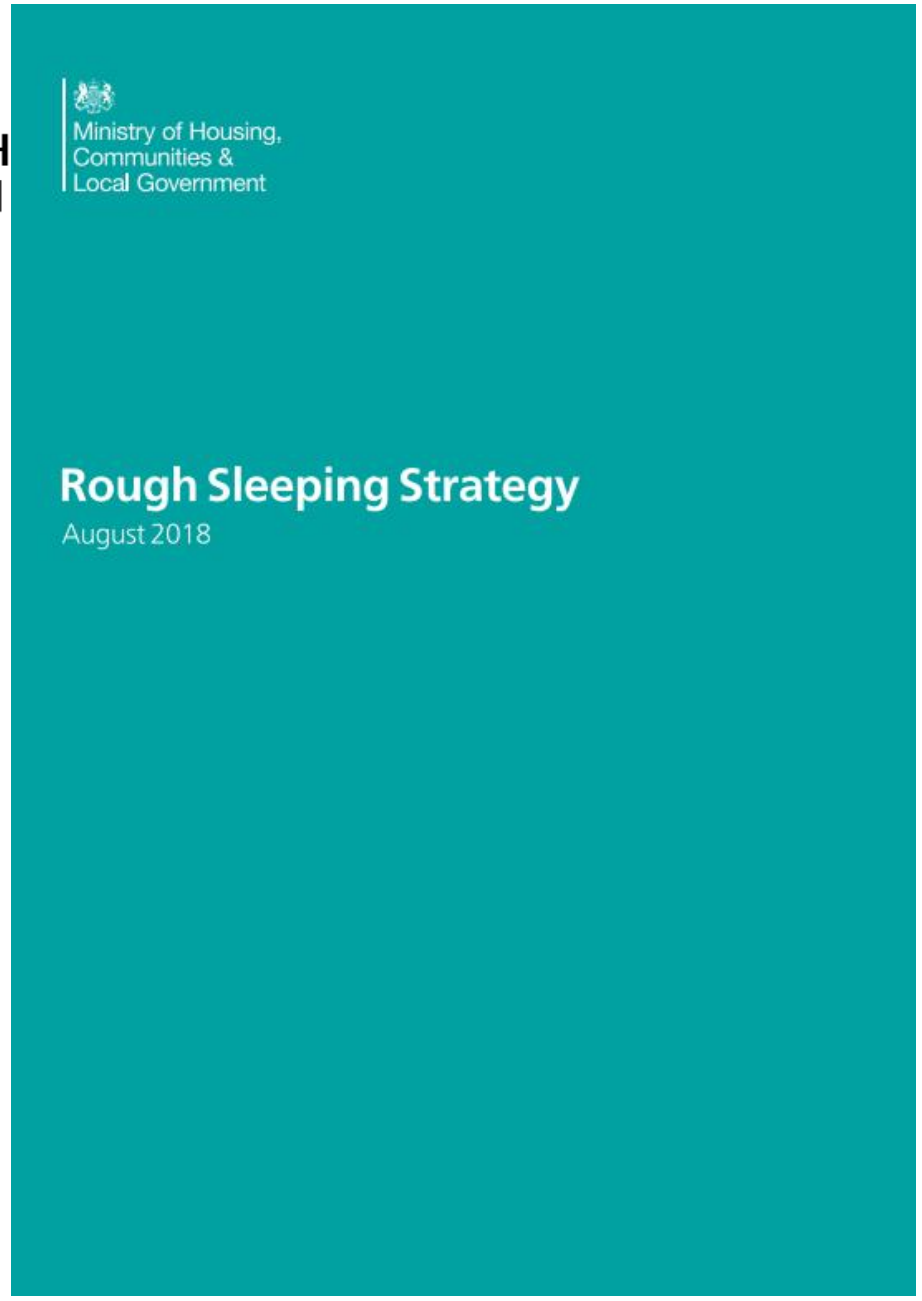

Interventions

- Rough Sleeping Initiative
- ‘Somewhere Safe to Stay’ pilots
- Funding for Rough Sleeping Navigators
- Mental health and substance misuse treatment
- Funding for ‘StreetLink’

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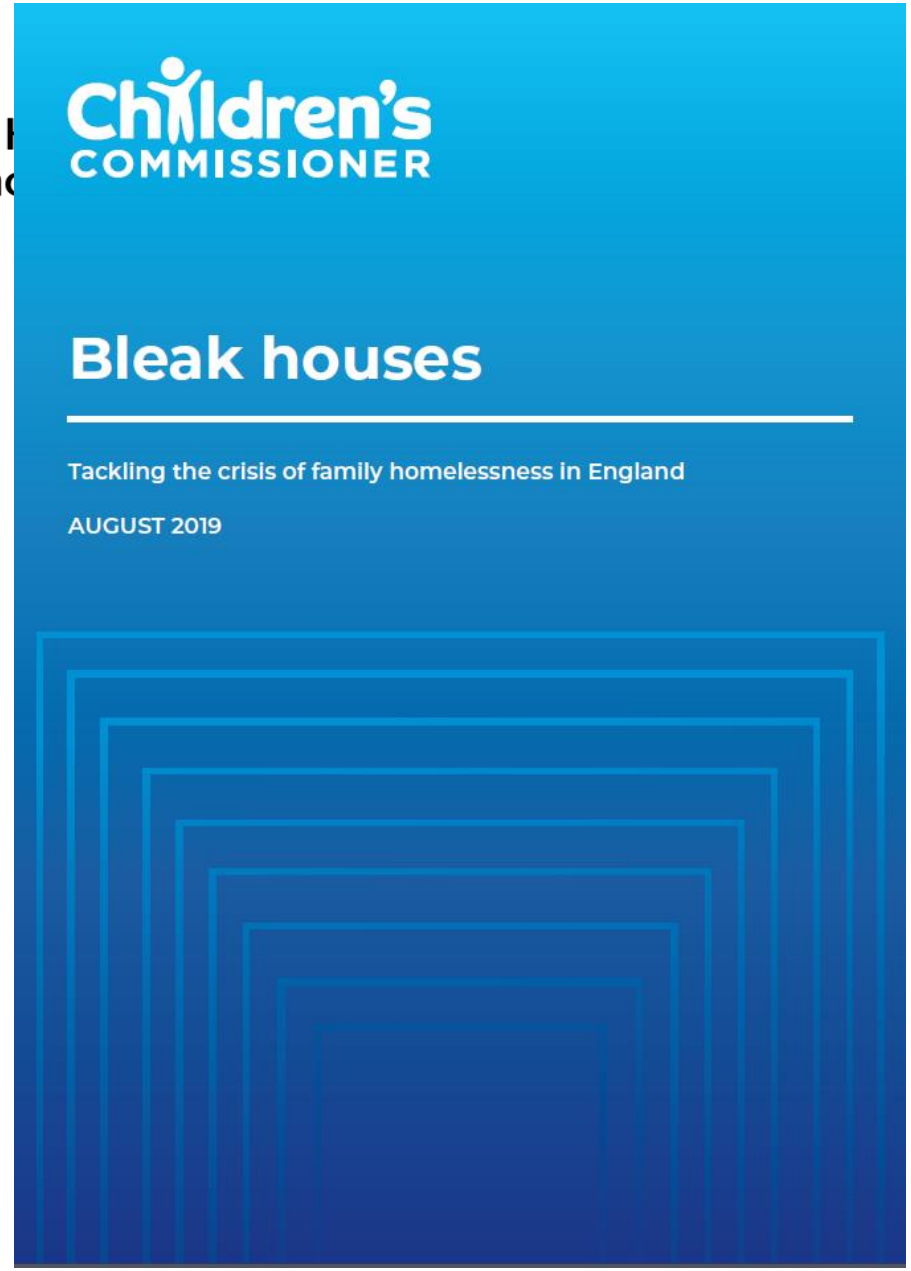

Prevention

- Govt must invest in housing
- Formal targets introduced

Improving experiences

- Increase minimum tenancies to 24 months
- Ease access to private sector
- Eliminate use of B&B for families

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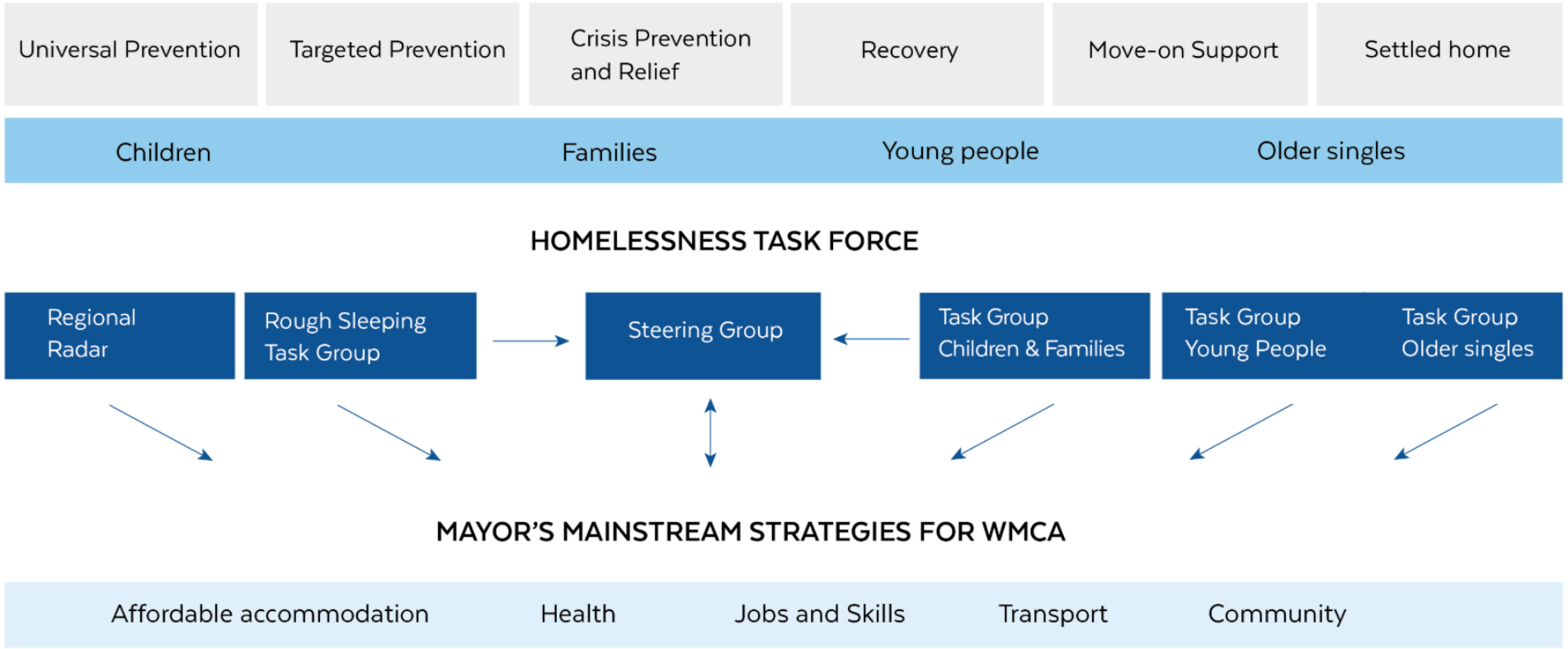
DESIGNING OUT HOMELESSNESS
IN THE WEST MIDLANDS



https://www.wmca.org.uk/who-we-are/meet-the-mayor/homelessness-task-force/

Tackle the problem *collaboratively*

https://www.wmca.org.uk/who-we-are/meet-the-mayor/homelessness-task-force/

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Opportunities to work together:
‘*a collective voice*’

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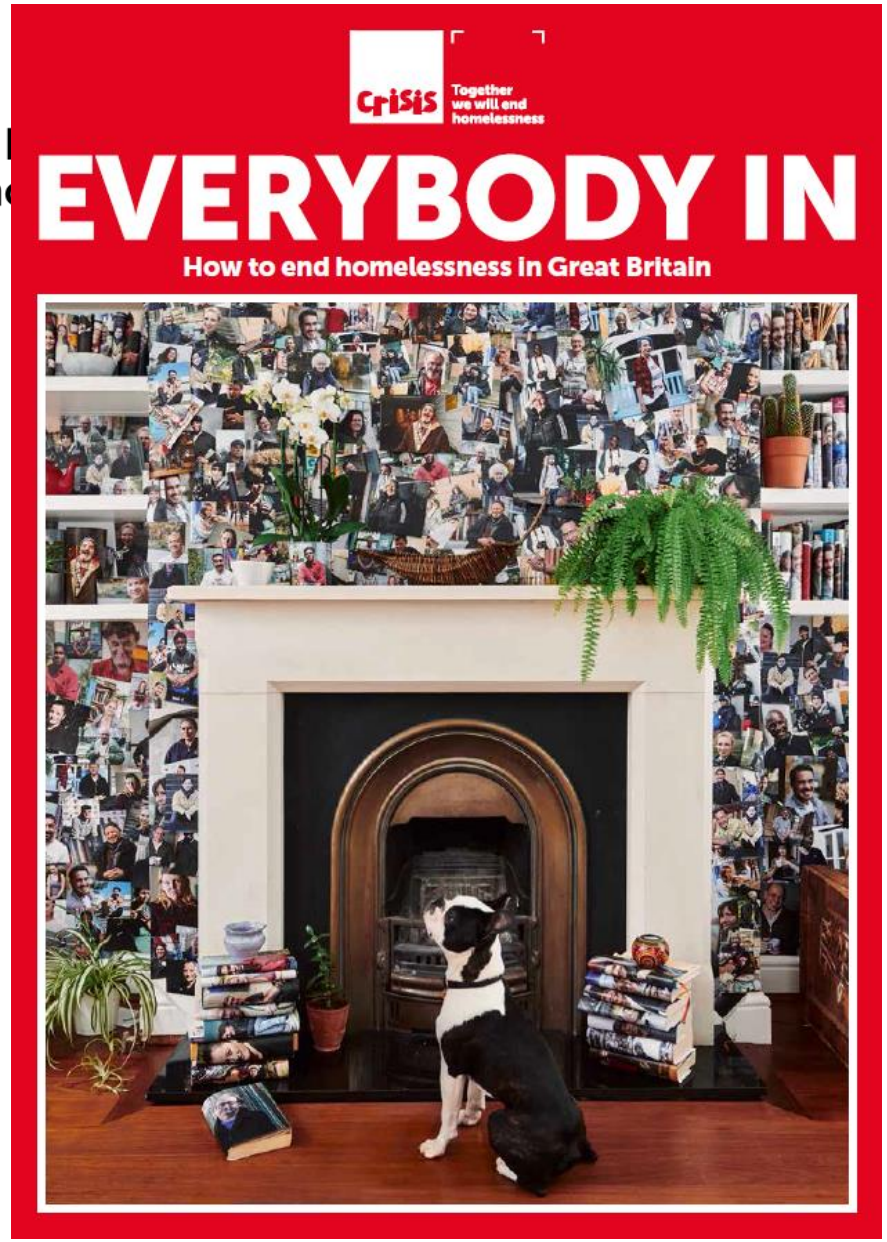
YOUTH VOICE

SPEAK UP FOR CHANGE

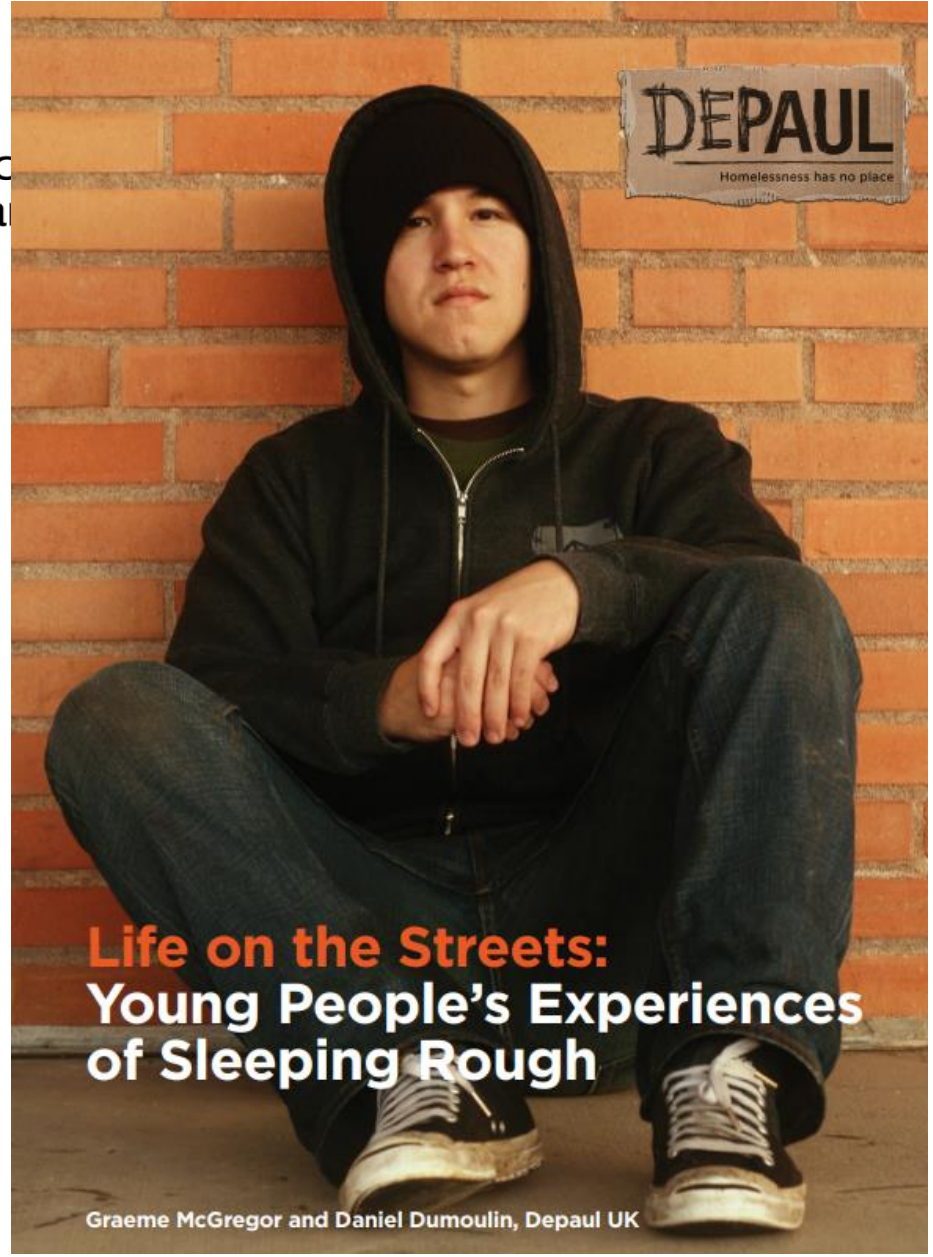
- *Have your questions/recommendations been addressed?*
- *What more can be done ‘to be heard’?*



Range of recommendations under headings:

- Prevention
- Rapid rehousing
- Rough sleeping
- Welfare
- Migrant homelessness
- Housing First
- Homelessness legislation
- Housing solutions
- Data

https://www.crisis.org.uk/media/239951/everybody_in_how_to_end_homelessness_in_great_britain_2018.pdf



- Make more accommodation available for young people at risk of sleeping rough
- Increase the level of financial support available through the benefits system, particularly the 'Shared Accommodation Rate'
- Work with private and social landlords to make more housing available to young people at risk of homelessness

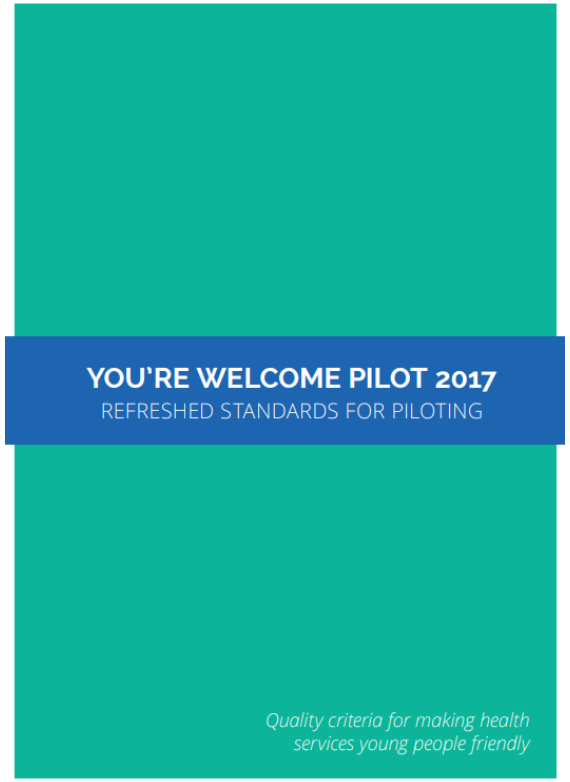
[1] https://uk.depaulcharity.org/sites/default/files/Rough%20Sleepers%20report%20-%2020.08.2018.pdf

Public Health England

YOU'RE WELCOME STANDARDS AND CRITERIA

YOU'RE WELCOME is split into 7 separate standards:

1. Involving young people in their care and in the design, delivery and review of services
2. Explaining confidentiality and consent
3. Making young people welcome
4. Providing high-quality health services
5. Improving staff skills and training
6. Linking with other services
7. Supporting young peoples changing needs



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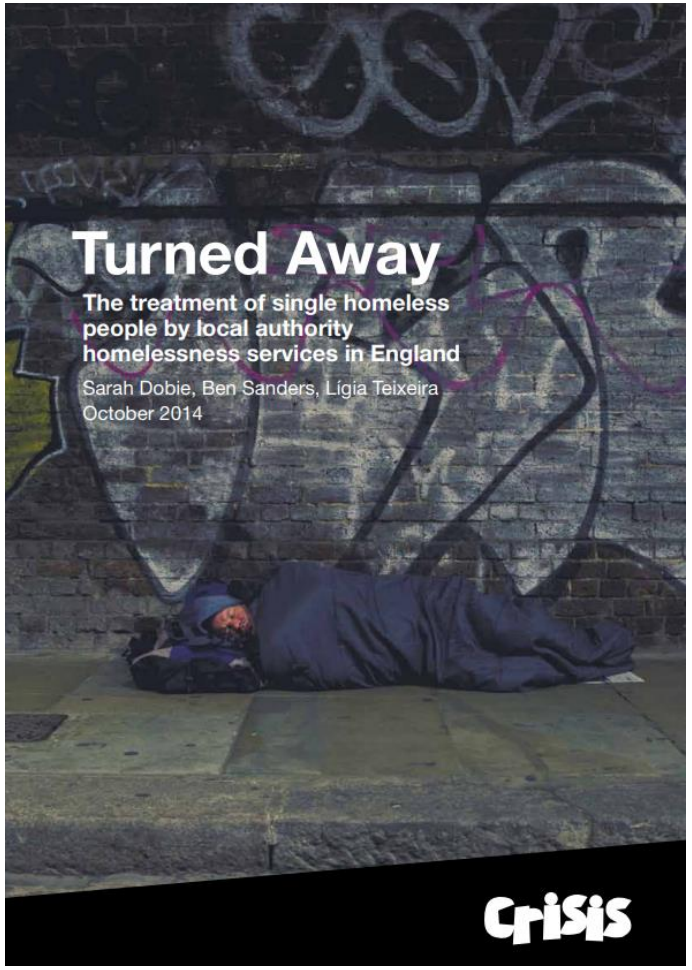
‘Mystery shoppers’

- 8 actors ‘shopped’ 16 local authorities
- Actors had experience of homelessness
- 37/87 visits: LAs made arrangements to accommodate mystery shoppers
- The remainder had inadequate help
- Raised a number of key issues including: lack of initial assessment; lack of privacy; interactions with staff



https://www.crisis.org.uk/media/20496/turned_away2014.pdf

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CINEMA & EVENT SCREENINGS

Tackling Homelessness + Q&A

Wed 11 Sep

Info

90 mins | 2019 | Director: Sam Taylor

There is a homelessness crisis in Birmingham. This short 15 minute documentary style film, featuring interviews with people who have lived through the experience, illustrates the depth and scale of the crisis. What is being done to tackle the issue and what we can do, as human beings and as citizens of Birmingham, to help?

Join us for this special screening at MAC followed by a Q&A hosted by Councillor Sharon Thompson and Sam Taylor, Creative Director of Tinker Taylor Productions. The Q&A will also feature some of the people interviewed in the documentary.

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On the 10th of October 2019 people around the world will mark **World Homeless Day** in many varied ways and change the lives of homeless people in their local community.

http://www.worldhomelessday.org/

What are we all doing to support WHD?

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Doctors of the World Presentation

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Doctors of the World UK

Safe Surgeries Initiative

Dr Liz Bates

GP Champion for the West Midland

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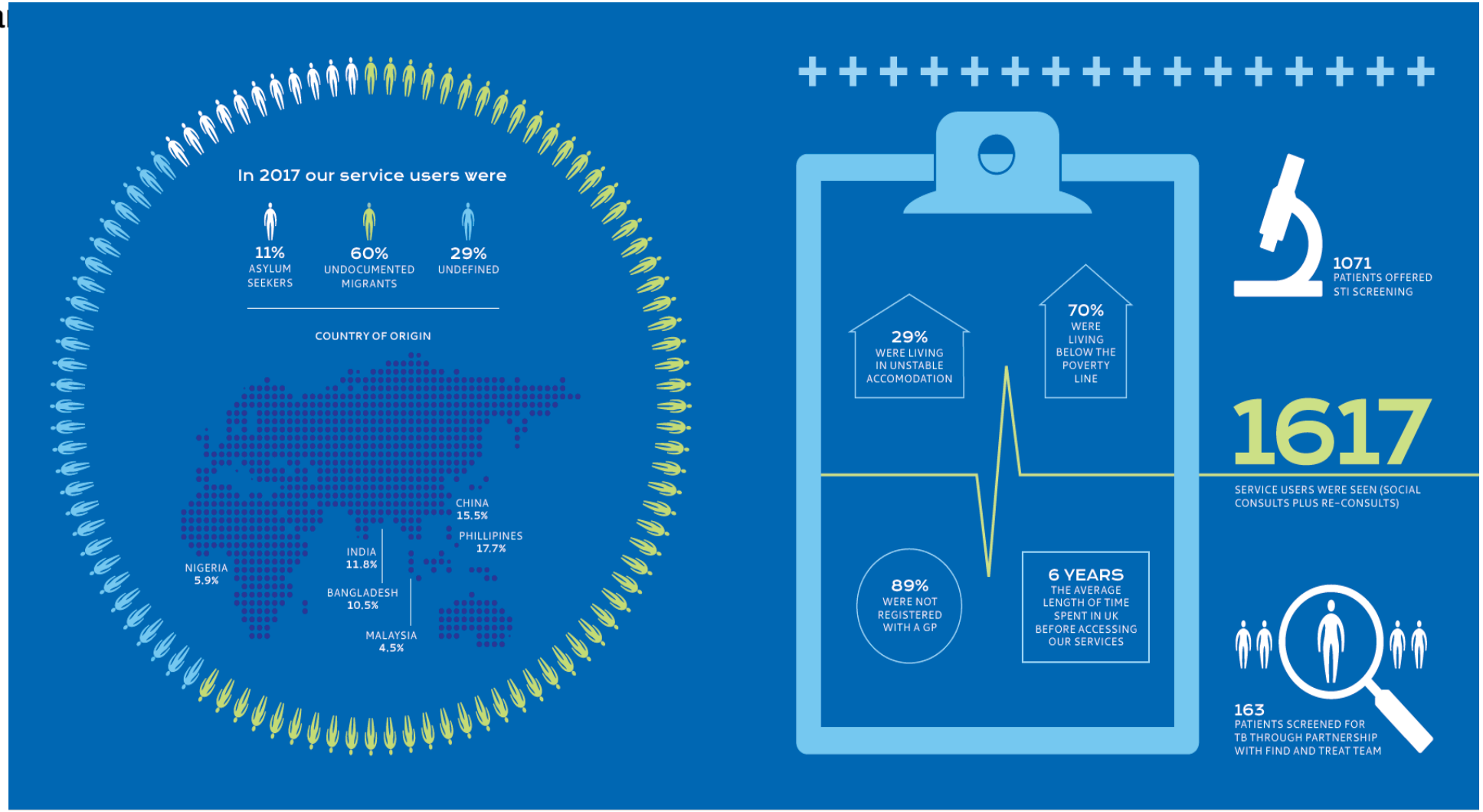

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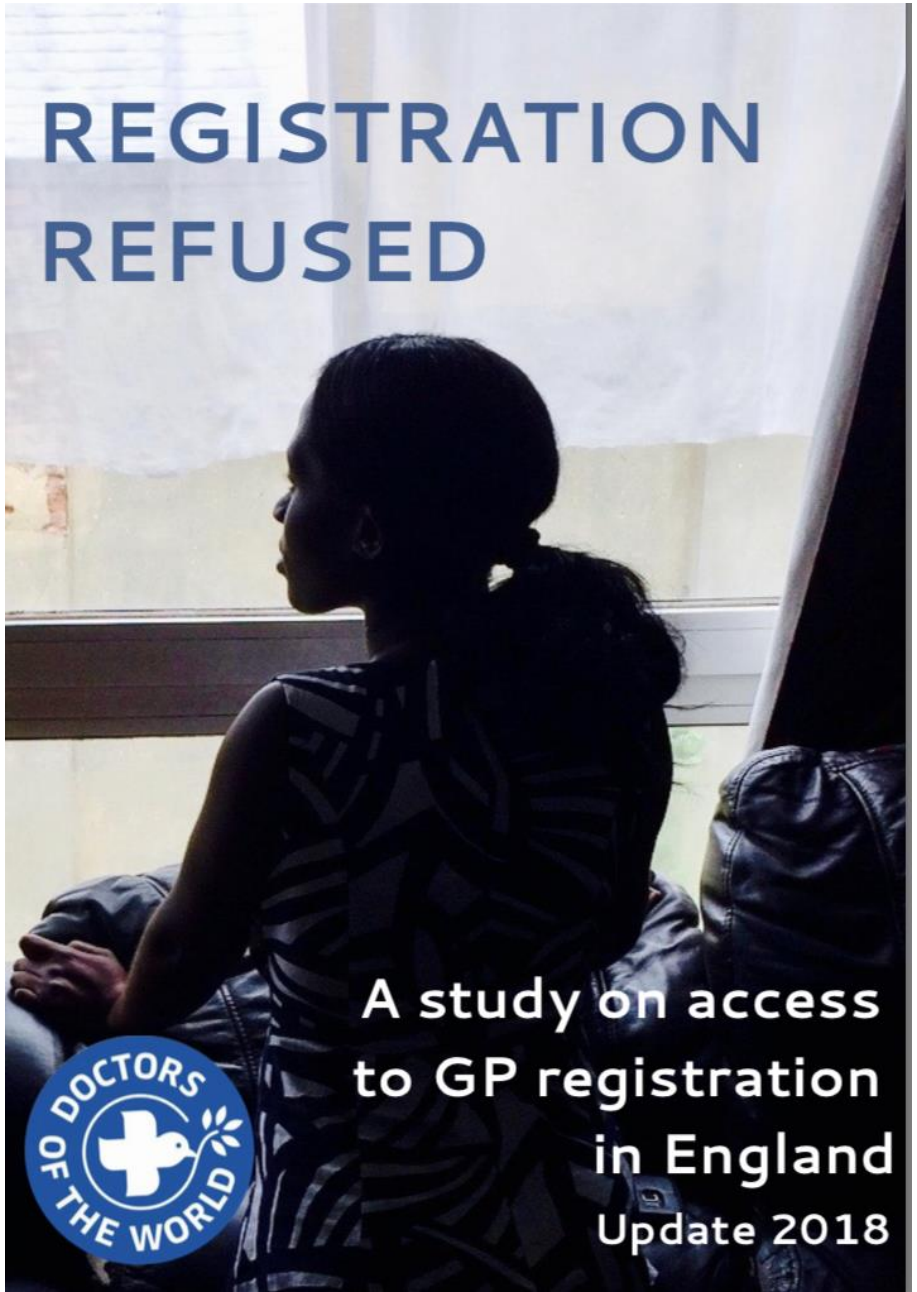
Primary Medical Care Policy and Guidance Manual
(NHS England, 2017):

Inability by a patient to provide **proof of address/ID** **“**would not be considered reasonable grounds to refuse to register a patient” or withhold appointments”.

Key findings of the 2018 *Registration Refused* study include:

- Of the 2189 attempts by DOTW caseworkers to register patients with their local GP in 2018, **one-fifth were refused.**
- **Lack of ID** or proof of address was the most common reason for refusal (**affecting over two thirds of attempts**) and **7%** of attempts were refused based on the patient's immigration status.
- When registration was successful POA was requested in 84% of cases
- Inconsistency in decision-making indicates patchy understanding of healthcare entitlement: 13% of practices accepted some registrations and refused others, while 17% always refused.



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SAFE SURGERIES

NEED SUPPORT?
JOIN SAFE SURGERIES

A Safe Surgery is any GP practice which commits to taking steps to tackle the barriers to healthcare access

Safe Surgeries…

- is a supportive national network of practices;
- supports staff learning and skills-building;
- gives members advice when needed from DOTW experts;
- supports successful CQC inspections.

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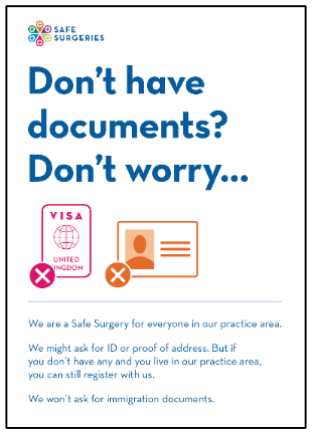
For inclusive and protective patient registration..

Our aim is to improve GP registration practices nationally, and bring them in line with NHS guidance.



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August 18 → August 19

36
Safe Surgeries across the UK

71
Safe Surgeries across England

>220
Safe Surgeries

4 Cities → 28 places

Birmingham and the West Midlands now have 58 Safe Surgeries

- Building good geographical coverage in areas of high diversity
- Large Practices and Super-partnerships with reputation for excellent care
- We now have “ Word – of – Mouth” sign ups
- BSOL and SWB CCGs endorse the initiative and become “ Safe CCGs”

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For more information:

Tel: 0808 164 7686

clinic@doctorsoftheworld.org.uk

safesurgeries@doctorsoftheworld.org.uk

@DOTW_UK

Do you want to be involved in further projects about the health needs of young homeless people?

Public Health England

Contact: Karen Saunders
Email: karen.saunders@phe.gov.uk

YOUTH VOICE
SPEAK UP FOR CHANGE

Contact: Tamzin Reynold-Rosser
Tel: 0121 772 2483
Email: youth-voice@stbasils.org.uk

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Public Health England

Youth Voice Public Health England Workshop Friday 30 August 2019 Focus group work

Key questions asked:

1. What are the specific health needs of young homeless people?
2. Do healthcare services meet the needs of young homeless people?
3. How can healthcare services for young homeless people be improved?

Feedback from Youth Voice group.

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What are the specific health needs of young homeless people?

- Mental health
- Substance misuse
- Crisis intervention
- Basic hygiene including access to sanitary products
- Physical disabilities
- Long term health conditions
- Prescription costs
- Sexual health
- Vaccinations
- Dental
- Antenatal and maternal care

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Do healthcare services meet the needs of young homeless people?

GP services

- do not meet the needs
- staff very unfriendly and unhelpful.
- difficult to register despite there been a duty for the practice to do this.
- ‘Safe surgeries’ sometimes not close by – long distances by public transport

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Do healthcare services meet the needs of young homeless people?

Emergency department services

- Long waiting times challenging during a mental health crisis
- Further waiting time to be seen by the local mental health team
- No separate ‘quiet’ areas to wait in
- Discharge difficult if on own – need someone to sign your discharge papers

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How can healthcare services for young homeless people be improved?

- Improved training for health care service staff (including non-medical e.g. receptionists) on the needs and vulnerabilities of the homeless.
- The use of trained volunteers within a range of healthcare services i.e. A friendly person to speak to, sit with, comfort and give advice to.
- Easier access to longer GP consultations to deal with the complex needs of homeless people.
- Mobile health services visit hostels to give advice/treatment

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Accessing Health Services

Click an image to access information

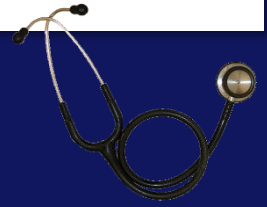
Making a complaint?

healthwatch

Dental health

"You have the right to access NHS services" [The NHS Constitution]

NHS



Help with NHS prescriptions

'My right to healthcare' card pilots

Set of quality **criteria** for young people friendly health services

Standards

YOU'RE WELCOME

Have you experienced poor care?

CareQuality Commission

#DeclareYourCare

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NHS

- The NHS Constitution states “you have the right to access NHS services”: https://www.gov.uk/government/publications/the-nhs-constitution-for-england
- NHS app: https://www.nhs.uk/apps-library/nhs-app/
- Find your local A&E: https://www.nhs.uk/Service-Search/Accident-and-emergency-services/LocationSearch/428
- Find your local GP surgery: https://www.nhs.uk/Service-Search/GP/LocationSearch/4
- Getting help with NHS prescriptions: https://www.gov.uk/help-nhs-costs
- Make a complaint to NHS England: https://www.england.nhs.uk/contact-us/complaint/complaining-to-nhse/

Healthwatch

- Make a complaint about any health care service in your area: https://www.healthwatch.co.uk/?gclid=EAIaIQobChMI25PRue7p5AIVRlXTCh2nPgzcEAAYAyAAEgJInPD_BwE

My right to healthcare cards

- Everyone has the right to register with a GP practice in England. The ‘My right to access healthcare’ card can be used to remind GP receptionists and other practice staff of the national patient registration guidance from NHS England, which states that “people do not need a fixed address or identification to register or access treatment at GP practices. Where necessary, the practice can use its address to register the patient.
- My right to healthcare cards are being piloted across England: e.g. https://www.healthylondon.org/our-work/homeless-health/healthcare-cards/

Safe surgeries

- A Safe Surgery can be any GP practice which commits to taking steps to tackle the barriers faced by vulnerable groups, ensuring that lack of ID or proof of address are not barriers to patient registration.
- Email: safesurgeries@doctorsoftheworld.org.uk
- Visit: https://www.doctorsoftheworld.org.uk/what-we-stand-for/supporting-medics/safe-surgeries-initiative/

Dental health

- Find an NHS dentist: https://www.nhs.uk/service-search/Dentists/LocationSearch/3

‘You’re Welcome’ Standards

- All young people are entitled to receive appropriate health care wherever they access it. The You’re Welcome quality criteria aim to lay out principles that will help health services to ‘get it right’ for young people.
- http://www.youngpeopleshealth.org.uk/yourewelcome/

Public Health England

3. Policy and System Opportunities

Public Health Priorities: West Midlands

Local leadership is important to develop approaches relevant to local places and populations. PH leaders have an important role in partnership working. PHEWM discussed homeless health priorities with our local authorities and Directors of PH and identified some collective priorities described below. How these priorities were addressed are described in this resource:

a) Policy opportunities to address health inequalities through the Mayor's Taskforce, Homelessness Reduction Act and Rough Sleepers Strategy taking opportunities to integrate health priorities and *Make Every Contact Count*

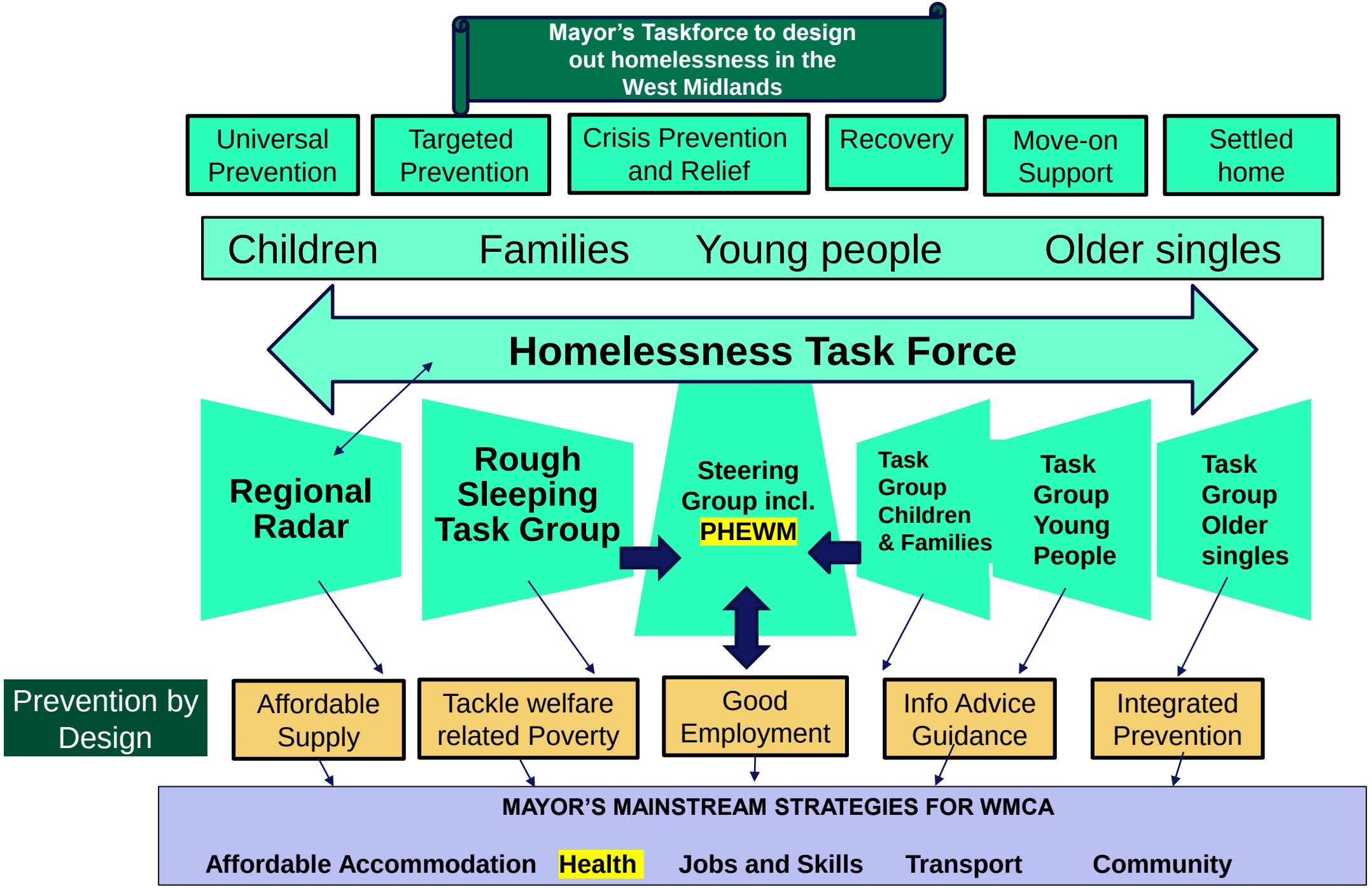
b) Undertake local Health Needs Assessments

c) Reinforce guidance and describe what good looks like to address multiple needs (alcohol, drugs, mental health)

d) Maximise upon NHS opportunities for prevention and improve service delivery in primary care access and hospital discharge, including what good looks like

e) Use lived experience and voice to inform decision making and service delivery

f) Support national funding opportunities


Mayor's Taskforce to design out homelessness in the West Midlands
Universal Prevention
Targeted Prevention
Crisis Prevention and Relief
Recovery
Move-on Support
Settled home
Children
Families
Young people
Older singles
Homelessness Task Force
Regional Radar
Rough Sleeping Task Group
Steering Group incl. PHEWM
Task Group Children & Families
Task Group Young People
Task Group Older singles
Prevention by Design
Affordable Supply
Tackle welfare related Poverty
Good Employment
Info Advice Guidance
Integrated Prevention
MAYOR'S MAINSTREAM STRATEGIES FOR WMCA
Affordable Accommodation
Health
Jobs and Skills
Transport
Community

Designing Out Homeless: Taking a Public Health Approach

Gunveer Plahe, Karen Saunders, Steve Philpott, Neelam Sunder, Jean Templeton, Sean Russell, Vibhu Paudyal

Public Health England

Protecting and improving the nation's health

BACKGROUND

Homelessness, including rough sleeping, has been increasing since 2010. 56,600 households were classed as statutory homeless during 2017-18 in England.

People who are homeless often experience stark health inequalities with poorer physical and mental health. The average age of death of a homeless person is 44 years old, which is 32 years lower than that of the general population.

There are many structural and individual factors that can contribute to homelessness. Partnership working and better integration of services to prevent and respond to homelessness is needed.

WEST MIDLANDS CONTEXT

The rate of homelessness acceptances in the West Midlands is significantly higher than the average for England, though there is variation between local authority areas (figure 1).

There were 169 rough sleepers identified in the November 2018 count on the streets of the West Midlands on a single night.

Area	Value	Lower CI	Upper CI
England	2.4	2.4	2.4
West Midlands region	3.3	3.3	3.4
Birmingham	7.8	7.5	8.0
Coventry	3.9	3.5	4.2
Dudley	0.5	0.4	0.6
Herefordshire	0.6	0.5	0.8
Sandwell	3.9	3.5	4.2
Shropshire	2.4	2.1	2.7
Solihull	4.6	4.1	5.0
Staffordshire	1.1*	-	-
Stoke-on-Trent	1.8	1.5	2.0
Telford and Wrekin	0.7	0.6	1.0
Walsall	1.9	1.7	2.2
Warwickshire	3.0*	-	-
Wolverhampton	4.3	3.9	4.7
Worcestershire	2.7*	-	-

Source: Department for Communities and Local Government

Figure 1: Statutory homelessness: rate per 1,000 households, 2017/18 (PHE fingertips)

WEST MIDLANDS COMBINED AUTHORITY APPROACH

During the Mayoral election campaign people of the West Midlands strongly voiced their concerns about the level and nature of homelessness. In 2017, the West Midlands Combined Authority (WMCA) Mayor's Homelessness Task Force was created, with representation including local authorities, PHE, first responder organisations, the Department for Work and Pensions and the voluntary sector. Additional task groups have been formed concentrating on challenges faced by specific groups.

The ambition of the taskforce is to design out homelessness in all its forms applying key principles of:

- Achieving System Change
- Working Collaboratively
- Connecting Mainstream Strategies
- People Centred/Preventative Approach

Through the work of the taskforce, 5 key objectives were identified as fundamental to designing out homelessness (figure 2):

- Accessible affordable accommodation
- Tackling welfare related poverty
- Access to good employment
- Information, advice and guidance
- Integrated prevention

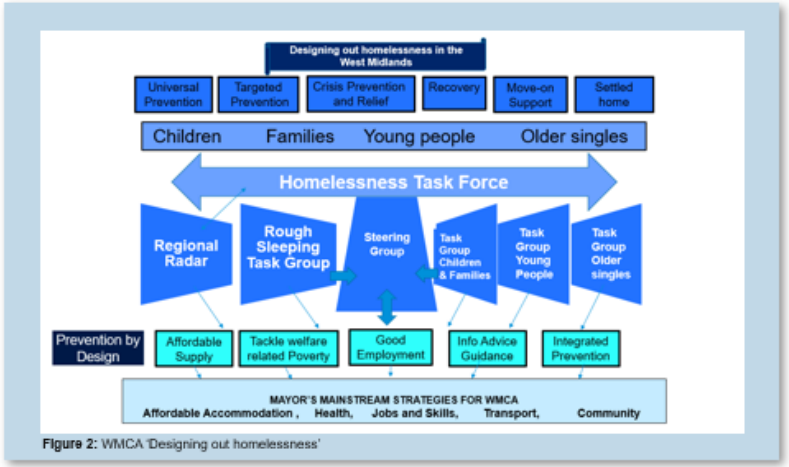


Figure 2: WMCA 'Designing out homelessness'

HOMELESS HEALTH

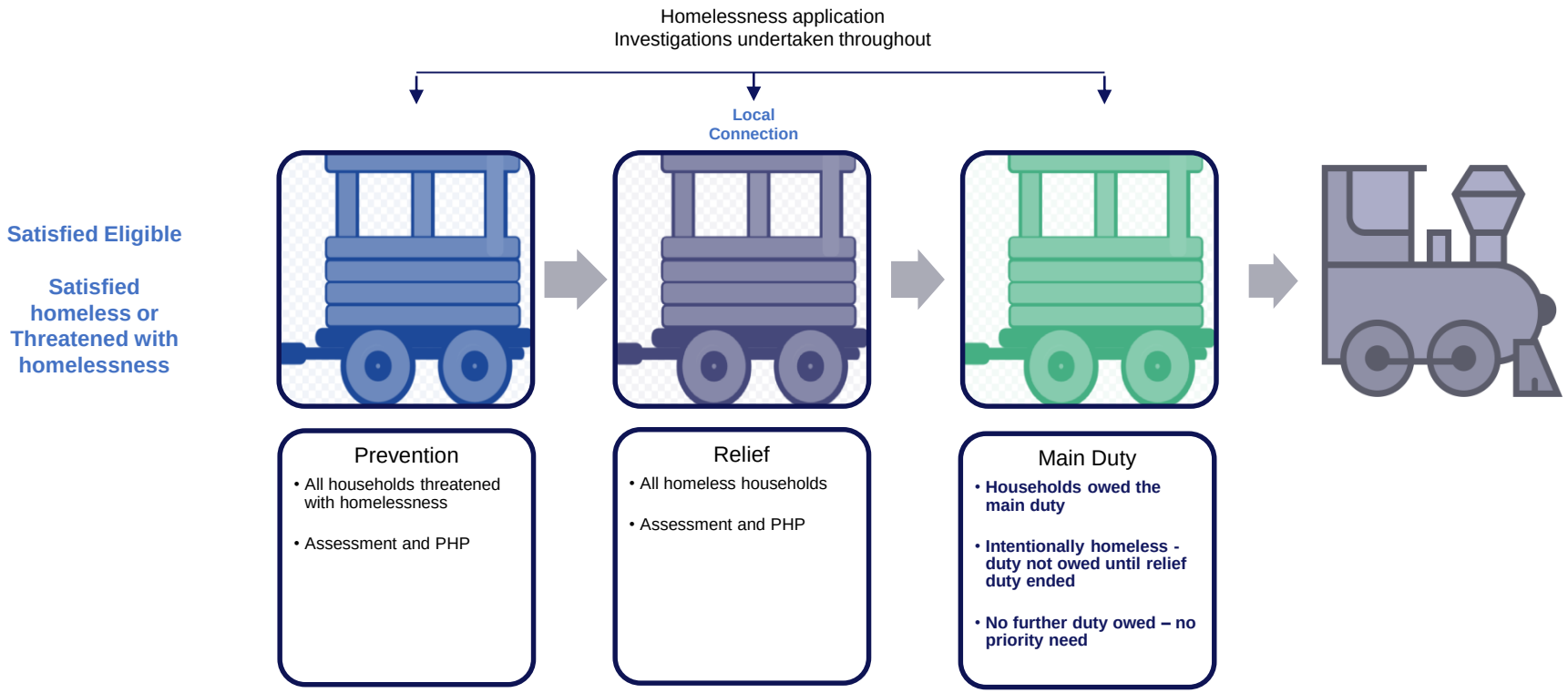
Ill health can be both a cause and a consequence of homelessness. PHE in the West Midlands has led and delivered on a range of strategic priorities to add value to local work and the work of the Task force, working with local authorities, the voluntary sector and clinical commissioning groups, amongst others. There have been significant public health impacts and plans including:

- A local stocktake of Public Health work on homeless health
- Providing public health outcomes data
- A health needs assessment in a Birmingham specialist GP practice (published in British Journal of General Practice)
- Supporting NHS England and local areas with access to primary care, including 'right to access' healthcare cards and mystery shopper exercises
- Addressing access to healthcare issues working with Doctors of the World "Safe Surgeries" programme
- Sharing guidance and building best practice on complex needs, mental health and co-occurring conditions, as well as alignment with wider drug and alcohol work
- Working with NHS Trusts, including on hospital discharge
- Assessment of progress with the duty to refer and collaborate and publication in the Lancet on the Homelessness Reduction Act and Health
- Informed a "Housing First" evaluation with a spotlight on health outcomes for clients
- Advocating 'All Our Health' and 'Making Every Contact Count' working with pharmacies and employers
- Contributing to a severe weather plan for people who are homeless
- Identifying where housing and health related priorities can be amplified in the NHS Long Term Plan
- Connecting with health protection to better understand how health protection issues in the homeless can be addressed
- Working with the Ministry of Housing, Communities and Local Government to support localities and inform guidance
- Health needs assessment on youth homelessness and working with St Basil's on 'youth voice' on homeless health
- Integrated approaches across multiple risk factors and vulnerabilities, including modern slavery; asylum seekers; migrants; and children

REFERENCES

- PHE: Homelessness: Applying all our health https://www.gov.uk/government/publications/ homelessness-applying-all-our-health/homelessness-applying-all-our-health (accessed Aug 19)
- PHE Public Health Profiles https://fingertips.phe.org.uk (accessed Aug 19)
- WMCA: Homelessness Task Force https://www.wmca.org.uk/who-we-are/meet-the-mayor/homelessness-task-force/ (accessed Aug 19)
- Better care for people with co-occurring mental health and alcohol/drug use conditions https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/ file/825809/Co-occurring_mental_health_and_alcohol_ drug_use_ conditions.pdf (accessed Aug 19)

Homelessness Reduction Act (HRA) 2017



Section 188 Interim accommodation provided if reason to believe
Section 1 Localism Act 2011 Discretionary power to accommodate
Section 193(2) Temporary accommodation provided if main duty owed
Source: NPSS

Health Opportunities in the HRA: DUTY TO REFER

UNIVERSAL PREVENTION	TARGETED PREVENTION	CRISIS PREVENTION & RELIEF	RECOVERY	MOVE ON SUPPORT	SETTLED HOME
ACCESS TO GPs – ensure GP surgeries are accepting people who are homeless – current practice varies better awareness needed i.e. can use GP practice address to register – implement a no missed opportunity approach – focus on workforce culture, professionalism, skills **EMPLOYER** - who can we employ? – flexing recruitment/safeguarding policies – Ban the Box **APPRENTICESHIPS** – increase the number, get better at spending the money available (apprenticeship levy) – integrate live/work models	**EMPLOYER** – create jobs for people with lived experience and peer approaches – Ban the Box **PIE** – use and link to workforce **TARGETING INJECTING PRACTICES** **PERSONALISED HOUSING PLANS** – training from housing authorities on how the HRA works	**HOSPITAL DISCHARGE** - step down accommodation/support needed for hospital discharge , create more discharge liaison officer posts **ALCOHOL/DRUG SERVICES** – create alcohol /drug liaison services in hospital to facilitate successful hospital discharge	**MULTIPLE & COMPLEX NEEDS** – consider thresholds for services, implement talking therapies **CULTURE CHANGE** - deliver services from buildings/places that people frequent rather than surgeries & hospitals - tap into community goodwill, faith groups **TRANSITION** - from residential care	**EXPLORE HEALTH NEEDS** - impact of TA on children and families what are the health needs of this population?	**NHS ESTATES** (land and buildings) – empty unused public buildings bring back in use and contribute to housing supply – use to increase step down accommodation, more live/work schemes - How? work with someone who is prepared to take a risk find a partner to run it for you charge a peppercorn rent - working with a charity - access Homes England £

Homeless reduction act in England: impact on health services

The Homeless Reduction Act,[1] an act of the UK Parliament that legally mandates city authorities and health service providers to provide anticipatory and corrective measures for the reduction of homelessness, came into force in England in April, 2018. It places new legal duties on English city councils (legislative bodies that govern a city) and the National Health Service (NHS) to enable strengthened homeless prevention and management work across partners.

Among the changes for local authorities is the mandate to act early in offering support to those threatened with homelessness and providing free homelessness advice and information. The act requires that health-service providers have an active role in the prevention and management of homelessness. There is a duty on these services to refer service users they consider may be homeless or threatened with homelessness to a local public housing authority of the city council who will be responsible for supporting them with appropriate assistance.[2] The duty to refer comes into force from October, 2018.

There is now an impetus for health services in England to develop effective mechanisms to identify and refer homeless and vulnerably housed people. For example, hospitals are expected to formulate and implement formal admissions and discharge protocols so that an appropriate mechanism for referral and transition of care is agreed with local

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Public Health England

Rough Sleeping Strategy

- The Rough Sleeping Strategy set out a plan to halve rough sleeping by 2022 and end it by 2027
- Following £30 million of new funding for areas with the highest numbers of rough sleepers and the launch of the Housing First pilots, the strategy was developed across government
- It sets out a three-pillared approach:
  - Prevention: understanding the issues that lead to rough sleeping and providing timely support for those at risk
  - Intervention: helping those already sleeping rough with swift support tailored to their individual circumstances
  - Recovery: supporting people in finding a new home and rebuilding their lives
- Includes research into hospital discharge and primary care; health funding to test models of community-based provision designed to enable access to health and support services for people who are sleeping rough and how to improve access to primary care for people who sleep rough

https://www.gov.uk/government/news/rough-sleeping-strategy-prevention-intervention-recovery

Public Health England

WMs Rough Sleepers Task Group (1)

PHEWM worked with the Task Group on the following priorities:

- Duty to refer: contributed to a stocktake of the health sector response, exploring opportunities to expand and integrate health outcomes and pathways into personalised housing plans
- Included health outcomes in the WMCA Housing First evaluation
- Aligned local priorities with the NHS Long Term Plan
- Worked with the NHS on access rights cards and a mystery shopping exercise with Healthwatch
- Mapped discharge pathways from secondary care to highlight best practice
- Mapped Mental Health Trust support for this cohort to highlight best practice
- Explored ongoing challenges in accessing mental health and substance misuse services (including thresholds) and described best practice
- Supported national grant applications

Public Health England

WMs Rough Sleepers Task Group (2)

- Connected health protection colleagues to street outreach services
- Co-produced severe weather protocols
- Contributed to the Reconnection Protocol
- Highlighted the role of pharmacies and equity of access to pharmacies
- Informed work on access to employment, including feedback on the toolkit for employers
- Informed local work on veterans
- Worked to improve hospital data and data sharing, including linking with ONS consultations
- Promoted resources to build health capacity and awareness including ‘All Our Health’, Making Every Contact Count

Public Health England

PHEWM maximised upon the NHS Long Term Plan (1)

The NHS cannot alone address health inequalities for homeless people. Improving outcomes involves health, social wellbeing and housing considerations and requires long-term solutions.

PHEWM:

- Supported a successful local CCG bid to the £30 million identified to meet the needs of rough sleepers to ensure better access to specialist homelessness NHS mental health support
- Reinforced that a range of health conditions are exacerbated or caused by poor quality housing or rough sleeping
- Described good practice to improve hospital discharges and primary care access
- Connected with social prescribing (SP) developments through the Regional SP Network e.g. with Youth Voice
- Worked with social enterprises, local charities and community interest groups to increase support to vulnerable groups and partnered with the NHS e.g. Doctors of the World; access cards
- Shared learning from the Healthy New Towns programme

PHEWM maximised upon the NHS Long Term Plan (2)

PHEWM:

- Conducted local health needs assessments
- Used policy levers to highlight opportunities to accelerate progress on service integration including Mayoral work and national policies
- Produced resources based on the needs and wants of young homeless people; increased engagement and recommended ways to improve access and outcomes (Youth Voice health needs assessment)
- Supported a local health needs assessment for veterans
- Worked with the voluntary sector to support delivery and development of services to vulnerable and at-risk groups
- Supported skills and knowledge development through training, interprofessional learning and sharing of PHE resources

Public Health England

3.1 Primary Care Access:

Road test NHS access cards
Collaboration with Doctors of the World

Road Test Primary Care Access Cards with NHS Midlands

Current provision nationally supporting inclusion groups needed improvement

Piloted in London for homeless communities

The cards

- Plastic credit card size
- NHS logo and branding
- Contact centre telephone number
- Website address
- Additional needs addressed on the back

Information

- NHS.uk website

Escalation process

- Contact centre

Roll out

- Voluntary sector
- CCG's
- Primary care

Source: NHS Midlands

Doctors of the World UK
Safe Surgeries Initiative

Back to contents page

Public Health England

3.2 Hospital Discharge:

Examples of good practice and new tools

Public Health England

Hospital discharges: what does good look like?

- A recent development was workshops on out of hospital care for people who are homeless to pick up the challenge, centred on recent research and a new tool to support local assessments of how good the system is: https://kclpure.kcl.ac.uk/portal/en/publications/transforming-outofhospital-care-for-people-who-are-homeless-support-tool--briefing-notes(fca232e9-1d6c-44f7-a477-c69963393807).html
- It is crucial to work in partnership across health, social care, housing and the voluntary sector in order to best support homeless patients and ensure, once medically fit, they are safely discharged to an appropriate setting where they can be supported back into healthy, independent and economically active life.
- As highlighted in section 2.32 of the NHS Long Term Plan, some hospitals such as University College London Hospitals have set up a specialist team and a pathway to support homeless hospital patients to coordinate their discharge arrangements. The hospital created teams to support homeless patients admitted to hospital. In-hospital GPs and dedicated nurses, along with others, work to address housing, financial and social issues. A and E attendances of supported individuals fell by 38% and there was a 78% reduction in bed days. Other hospitals have since adopted this model

Public Health England

Healthy London Partnership

Safe and effective discharge of homeless hospital patients

January 2019

Introduction

Checklist for staff

A simple checklist for hospital staff on the practical steps they can currently take to support effective discharge of homeless patients is provided below, which can be adapted and aligned to local admission and discharge arrangements.

Public Health England

E·S·R·C ECONOMIC & SOCIAL RESEARCH COUNCIL | NIHR | Policy Research Unit in Health and Social Care Workforce | Local Government Association | KING'S College LONDON

Improving transfers between hospital and home

Integrating Health, *Housing* & Social Care in *Home First* approaches

New Support Tools & Best Evidence Workshops

These four free regional workshops will update commissioners and senior frontline practitioners on the best evidence for reducing delayed transfers of care and improving outcomes for people leaving hospital. They include presentations by national Programme Leads and case studies of local good practice, including 'Home First' approaches.

- The **Local Government Association** (LGA) will provide an overview of the refreshed **High Impact Change Model (HICM) for Improving Transfers Between Hospital and Home** including an update on the new *Change for Housing*. They will also seek your views on a new HICM focused on reducing unnecessary admissions to hospital or care.
- **King's College London** will introduce the new **complementary Support Tool** for delivering safe and timely transfers of care for patients who are homeless, including information on the new statutory 'duty to refer.'

Public Health England

3.3 Supporting multiple needs, alcohol, drugs and mental health:

PHEWM priorities and wider good practice

Acknowledgements: PHE national teams

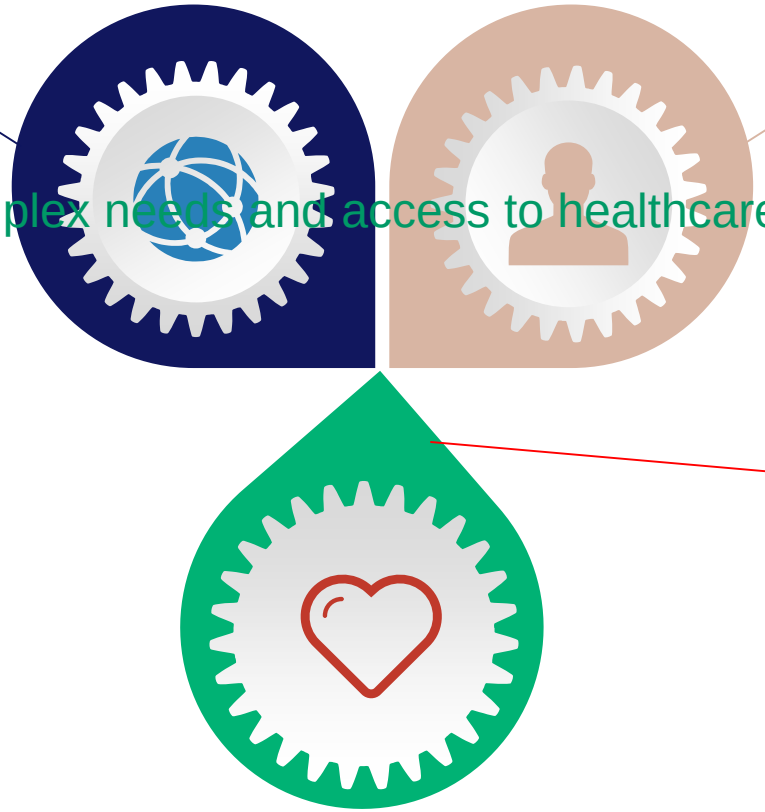
Homelessness and Health
Complex needs and Tri-morbidity

Substance Misuse

> 60% history of substance misuse

Mental Health

70% reach criteria for personality disorder



Physical Health

>80% at least 1 health problem, 20% have more than 3 health problems

St Mungos (2010), Homelessness, it makes you sick, Homeless Link Research (n = 700)

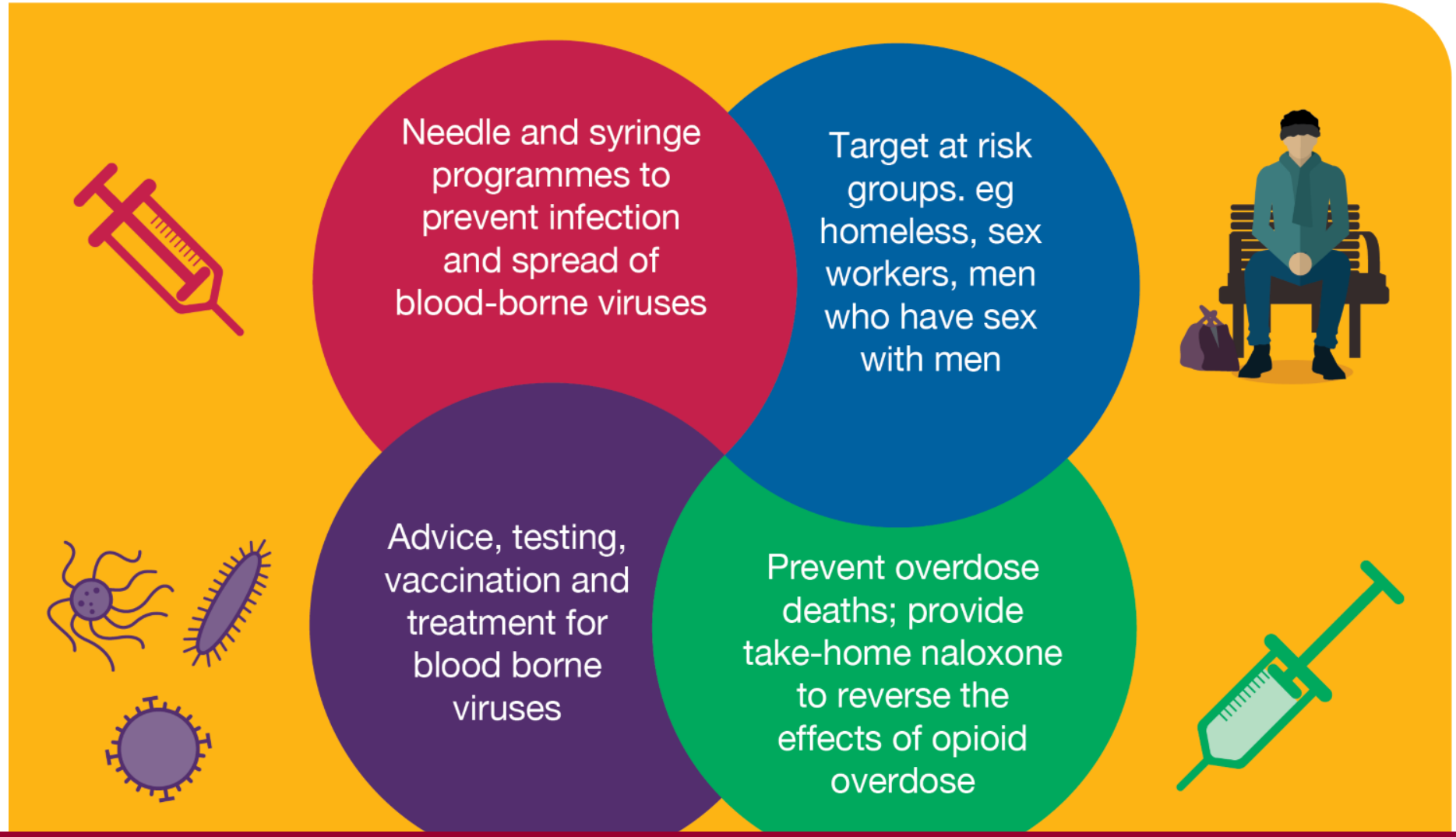
Suzanne Fitzpatrick et al (2010) Census survey multiple exclusion homelessness in the UK (n= 1268)

Public Health England

Drug and alcohol misuse and homelessness

Public Health England

Targeted prevention and harm reduction – drugs



Public Health England

Specialist treatment and recovery (alcohol & drugs)

Recovery focussed services that address housing, employment, offending and health & wellbeing

Services address dependence at different severity levels, and address changing patterns of use

Services address parenting and children's needs. Parental treatment has major benefits for the child

Support sustained recovery: develop peer support, build relationships, make use of community resources

NICE compliant, community based, inpatient and residential treatment based on assessed need

Ensure recovery plans integrate psychological with pharmacological interventions where needed

Public Health England

Complex needs and access to healthcare (1)

"I want services to be able to address all my problems, not to have to see one person here, and another person there and different organizations who do not know what the other is doing"

(http://www.turning-point.co.uk/media/1138757/dual_dilemma.pdf)

- High proportion with mental health problems / dual diagnosis
- Often not mentally unwell enough for mental health services and excluded if intoxicated
- Often a separation of drug and alcohol services from mental health services
- Difficulty engaging / discharged from service due to non attendance (a particular challenge for many homeless people with very chaotic lifestyles)

Public Health England

Complex needs and access to healthcare (2)

Barriers to accessing primary care

- Difficulties registering with GP
- Chaotic behaviour
- Health not a priority
- Fear / distrust / feel unwelcome / feel as though they are not listened to
- Inflexibility / appointment system
- Exclusion if miss appointments

Secondary care

- Only seeking treatment when problems reach advanced stage
- High A and E attendance
- Danger of serious conditions being missed
- IV drug users/unusual infections/deemed to be drug seeking/challenging behaviour
- High rate of self discharge or unsafe discharge

Public Health England

PHE action to reduce the demand for drugs (prevention onset/escalation)

A universal approach across the life course:

- PHE and wider government action: early years help and Best Start in Life programme; Early Intervention Foundation and wider youth policy action, through to PHE support to local areas to build health and wellbeing across life course
- Confidence and resilience and risk management: supporting schools to support enhanced PSHE education, PHE commissioning ADEPIS (Alcohol and Drug Education and Prevention Information Service)
- Update *Talk to Frank* service.

Targeting most vulnerable

- Identifying vulnerable groups and patterns of use (e.g. young people at risk, range of vulnerabilities; image and performance enhancing drug (IPED) use; LGBT and chemsex; homeless; young offenders)
- New central government action (e.g. Liaison and Diversion for offenders; ACMD reviews, Troubled Families; toolkits + comms, inc on new psychoactive drugs & RIDR) as well as support to local areas

Local action supported by: Government to share evidence of what works, and what doesn't, including monitoring existing pilots; PHE toolkits to support local action and enhanced provision of data on prevalence and local need

Public Health England

Action to ensure individuals have the best chance of recovery includes:

Improving treatment quality and outcomes for different groups

- Sending clear message on ambition through enhanced range of measures
- PHE review of the treatment system and how its performance can be enhanced
- New UK Guidelines (‘Orange Book’) on clinical management.

Promoting joined up commissioning and service integration

- Encourage integrated commissioning - through jointly owned measures across mental health, employment, housing, criminal justice etc.
- Action on Dame Carol Black Review employment recommendations
- Enhance access to mental health provision-Mental Health Taskforce, new guidance

Supported by stronger governance

- Enhanced transparency on LA spend, and publication of outcomes
- Stronger inspection and regulation through the Care Quality Commission
- Progress reports into a cross-gov Home Secretary chaired Board
- A National Recovery Champion

Public Health England

PHEWM Work Programme 2020/21

To reduce drug related deaths through improved access to healthcare we will:

- Identify local data sets that can be used to identify drug users at risk of long term limiting illness
- Share learning from Telford and Wrekin's healthcare needs assessment for drug users
- Support local action to increase GP registration by drug users
- Share regional and national good practice in the early identification and treatment of COPD among drug users through effective joint working between drugs treatment and COPD secondary care services
- Host a national conference on access to smoking cessation support through drugs services
- Improve the co-ordination of PHE WM responses to infectious disease outbreaks among drug users, including HIV, TB and Group A Streptococcus
- Contribute to the development of and support the local implementation of the forthcoming PHE injecting wound and infection toolkit

Public Health England

Good Practice: i. Screening and Assessment (London)

Service description

- Central and North West London (CNWL) NHS Trust has developed the 'Substance use frequency and risk identification' (SUFARI) tool, a **standardised questionnaire to enable mental health staff to routinely ask patients about alcohol misuse, drug use and smoking**. In line with NICE guidance (NG58, CG120) and in order to meet CQUIN targets, SUFARI is intended to **drive the identification and assessment of substance misuse on the wards and support pathways into community drug and alcohol treatment services**.
- This case study focuses on how SUFARI has been used in one borough of operation, Harrow.

Why it works

- A **trust-wide Substance Use in Mental Health group** meets to steer the pathway.
- The trust has a **Substance Use in Mental Health policy** which requires SUFARI to be used for all referrals to 'dual diagnosis' services and encourages its use for all mental health patients.
- **Clear lines of communication and a culture of responsiveness between mental health and community drug and alcohol services** facilitates care for people who have mental health and substance use problems.

Service outline

- Ward staff screen patients for risky drug and alcohol use using the SUFARI tool and assess risk levels, giving **brief interventions** where appropriate. Where screening identifies a substance misuse treatment need, the ward and community services liaise directly with the community drug and alcohol treatment team (WDP), who promote **engagement** for new referrals and stay in touch with people already known, including **ward visits** where appropriate. Community drug and alcohol treatment staff can also contact the mental health team with concerns about a service user's mental health.
- Referrals are made directly to the identified WDP project lead. Staff from both the Trust and WDP meet monthly to discuss significant cases and monitor need.
- **Hours of operation**: Mon to Fri 9am to 5pm with some weekend daytime provision.
- **Staffing**: Responsibility for leading the pathway is incorporated into the existing roles with identified leads in both services.

Impact

- Harrow has achieved a **95% compliance** with SUFARI on wards.
- CNWL conducts an **annual audit of how many people on wards are using substances**.
- A recent audit of 100 admissions to Harrow wards found that **just under one in three patients reported substance misuse** and **one in four patients reported alcohol misuse at levels requiring an intervention**.
- CNWL has an on-going quality improvement project in progress to drive up the rate of screening in other boroughs of operation.

Public Health England

ii. Integrated care (Derbyshire)

Service description

- South Derbyshire Liaison Psychiatry Team - Derbyshire Healthcare NHS Foundation Trust set up a **liaison psychiatry team** at the Royal Derby Hospital in 2013 using the CORE 24 model based on Rapid, Assessment, Interface, Discharge Model of liaison psychiatry.
- The liaison psychiatry service **works with patients in the Royal Derby Hospital who have mental health and substance misuse needs**. The service ensures that **mental and physical health problems are treated equally and not separately**. The team replaced three smaller services within the hospital.

Why it works

- **Close working relationships between liaison, acute and community teams** is essential to helping people receive appropriate community care, reduce hospital readmissions, and cut delays to hospital discharges.
- A **good relationship with the community substance misuse service** facilitates pathways and information sharing.
- A research post helps to **continually evaluate everyday practice**.
- Whilst clinicians were initially apprehensive about what the new model would mean for their specialities, clinicians have found that they've retained their specialities while developing **a core set of generic skills to provide integrated care**.
- As the liaison team has become integrated, **mental health and substance misuse training for hospital staff has improved**.

Service outline

- **Access and hours of operation**: **24/7 rapid response** to requests with quick response targets: 1 hour for the emergency department, 24 hours for hospital wards.
- Around 600 adult patients engaged per month
- **Staffing**: Band 6 nurses or allied health professionals (x16), consultant psychiatrists (x2.5), staff grade psychiatrist (x1), Band 8 specialist mental health non-medical prescriber pharmacist (x1), Band 7 clinical leads (x3), CBT therapist (x1), and administrative support. The staff team has a range of specialist knowledge including mental health, substance misuse, self-harm, suicidal thoughts, dementia and delirium.
- **Costs**: £1,655,219

Impact

- An economic evaluation of an associated model showed **reduced hospital stays and a cost to benefit ratio of more than 4 to 1**.
- In the first year, the **number of contacts rose to over 8,000**, compared to around 5,000 recorded by the three former services in the previous year. The number of contacts then fell in the second year to around 6,500 (in line with the findings related to a similar service model, namely RAID) and it has stayed fairly constant.
- Over the first two years, the **average length of stay in hospital decreased by 1.16 days for nearly all patient groups with mental health or substance misuse related diagnoses**.

Public Health England

ii. Integrated care (Doncaster)

Service description

- **Doncaster Complex Lives Alliance** delivers **integrated support** for people locked in a cycle of rough sleeping, mental ill health, poor physical health, offending behaviour, often underpinned by childhood trauma.
- The service has been developed to deliver a **person-centred and asset-based model** to address the **complex interdependencies** of issues facing this group.
- A new **whole system operating model** joins up **strategic commissioning** by the Council and Clinical Commissioning Group (CCG)**, operational planning and frontline delivery** across **physical and mental health, primary care, housing and offender rehabilitation** in an Accountable Care **Alliance**.
- The central aim is to support people into **stable accommodation** with a **structured and secure wraparound support plan**, and ultimately support people **reintegrate into community life**.
- The service has been operational since November 2017 and is still evolving as agencies see the benefits of integrating resources and efforts.

Why it works

- "*If it wasn't for the Complex Lives Team I would still be on heroin. But now I can see my kids. And I'm confident I will get a house of my own and my kids back."* (service user)
- *"Where would I be if it wasn't for the Complex Lives Team? On the streets, definitely. I'm looking forward to Christmas now, my own house and tree.'"* (service user)
- *"It makes a massive difference working with an integrated team, just helps us get a plan in place and get things sorted whilst people are motivated to act."* (staff member)
- *"The difference with this model to other integration we've tried is that it is systematic and deliberate – underpinned by a joint commissioning agreement, a provider collaboration agreement and a system specification – that supports delivery and accountability."* (Director)

Public Health England

ii. Integrated care (Doncaster) continued

Service outline

- **Staffing**: An integrated Complex Lives Delivery team with a **team leader**, **intensive case management workers** (x6) **homelessness single point of access staff** (x2), **assertive outreach team** (x2), **mental health nurse** (x1**), Probation workers** (x2), **specialist trauma worker** (x1), **housing benefits staff** (x1), **sex worker support staff** (x2) and **business support** (x1).

- The service includes **an asset menu of support services across the community; monthly pop-up hubs, GP and nurse drop-ins; Housing Plus accommodation pathway with a developing range of options to meet needs; and a small discretionary fund to remove barriers faced by service users.**

- The service uses a **bespoke ICT case management solution**, the **Homelessness Outcomes Star** and has **information-sharing protocols** in place with key partners.

- **Costs**: The service has core costs of £311,000 for intensive case management support, alongside the secondment of additional

Impacts

- A deep dive analysis was conducted to inform the development of the service. This analysis estimated the **cost of public services of 57 people with complex interdependencies at almost £1m**. When scaled to the estimated 4,400 people in Doncaster with complex interdependencies, the **annual cost associated with this cohort is around £39m**.

- The team currently works with **115 people with complex lives**.

- Since engaging with the service:
  - **80% of service users have shown improvement in offending behaviour;**
  - **70% have reported their substance use was less problematic.**

- A service evaluation has been commissioned to track impact on range of metrics.

Public Health England

iii. Whole system approach (Plymouth)

Service description

- Plymouth City Council, partners and people who use the services have **co-designed** a **complex needs system** that enables people to be supported flexibly, receiving the right care, at the right time, in the right place. The Plymouth '**Alliance for people with complex needs**' contract for complex needs is a single contract commissioned by **Plymouth Integrated Commissioning Team** (which has pooled budgets (£638m), is co-located with and is made up of CCG, Council staff and Public Health).
- The service is for **adults who have support needs in relation to homelessness or at risk of homelessness and/or substance misuse, who may also have mental health support needs or be ex-offenders**,
- Services in the alliance use and share **common risk, confidentiality and core assessment processes**.
- The service went live on 1st April 2019.

Why it works

- The service has agreed **offers to and asks from system interface services, such as mental health, employment, criminal justice, primary and secondary care**.
- The Alliance has developed a **common knowledge and skills framework**. The workforce training programme includes, for example, drugs and alcohol, mental health, end of life care, hidden harm, domestic abuse.
- Two key structures support the on-going development of the system: 1) **System Optimisation Group** (SOG), which brings system leaders together to prevent people from 'falling through the gaps' and reduce repeat revolving door referrals and deliver system change; 2) the **Creative Solutions Forum** (CSF), which brings practitioners together to review and understand risk, report on system blockages to the SOG and identify creative solution options for people with highly complex needs.

Service outline

- **Access**: Via professional or self-referral.
- **Offer**: The Alliance service offer includes **assertive outreach, assessment, brief interventions, a menu of meaningful activity, supported housing, substitute prescribing, peer support, and access to employment, training and education opportunities**.
- **Hours of operation**: six days per week with some Sunday and evening services available,
- **Staffing**: The service brings together around 400 posts, including **nurses, social workers, housing workers, drug and alcohol workers, hostel staff, outreach workers and volunteers**.
- **Costs**: £7.7 million per annum contract

Impact

- Taking a **value-based approach to assessing impact**, the current system measures include fewer avoidable deaths; less rough sleeping; saved bed days; increased employment; more people in settled accommodation; reconnection with family; improved mental health and well being; and service user's sense of safety, control and being listened to, as well as measures of the health of the system itself. The measurement system will be adapted over the life of the project.

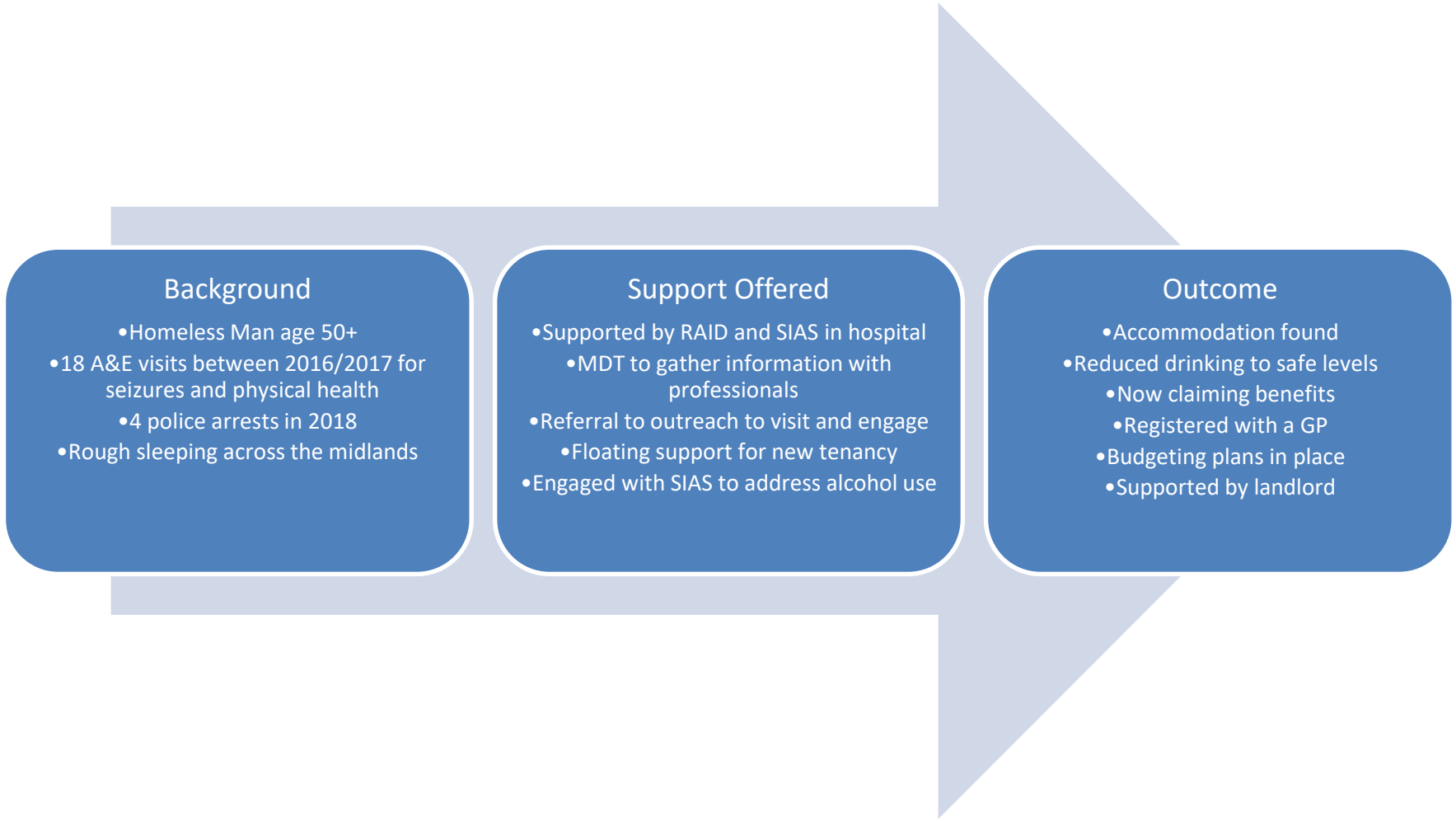
Public Health England

4. West Midlands Local Good Practice

Public Health England

Solihull: Housing Support for Vulnerable Adults Service

Case Study:



Public Health England

Solihull Youth Hub

Case Study

Background: 17 year old female, diagnosed with bi-polar and autism, in full time college, referred by boyfriend's family.

D had to leave the family home due to domestic violence and was sleeping on the sofa at her boyfriend's parents. D suffered historical abuse and neglect.

Support offered by SYH: A safeguarding referral and a joint assessment was completed with D. Youth Hub staff signposted D to her family support worker to make a claim for benefits. She was also referred on to SIAS to receive support relating to the effects that drug use and abuse had had upon her.

D was referred to supported accommodation. It was agreed that D could remain with her boyfriend's family while she waited for a place and hub staff maintained regularly contact with D and her boyfriend's family during this process.

Outcomes: D moved in to supported accommodation and regularly engaged with support staff, sustaining her tenancy and succeeding with independent living. She was subsequently successful in securing a place at Birmingham University and has been supported by staff at the supported accommodation to apply for student finance and source student accommodation. D has also been supported to find accommodation during the summer months when she is required to leave student halls of residence. An agreement is in place for her to be accommodated at a St Basils scheme during this period.

Case Study

Background: 18 year old male with substance misuse issues. Family asked him to leave due to the company he was keeping and the impact it was having on siblings and the family dynamic.

Support offered by SYH: The focus with the YP was improving self-esteem so as to limit risky behaviour and engagement with negative associates. He would consistently return to St Basils even when accommodation was not needed to simply sit and talk with staff and engage with support sessions, sharing concerns about the criminal activity he was involved in.

Outcomes: The YP has since engaged with SIAS and SOVA in order to help support him through substance misuse and get him into employment. He has completed a qualification to enable him to work on building sites and has left shared accommodation to move back into the family home. The family are being mediated through this transition to enable the relationship to maintain. The stability within the family home has been positive in enabling him to stay grounded and out of trouble.

Public Health England

Wolverhampton: dental health case study

“Patient B is a male in his 20’s who has spent a lot of his time growing up on the streets; coming from a dysfunctional family hadn’t been taken to the dentist as a child and had lived a very chaotic life. Patient B had been in and out of prison and struggles with substance misuse such as mamba and heroin, patient B also has a mental health issue.

I met Patient B at the soup kitchen late last year and found him very difficult to engage with, many weeks went by and Patient B started to recognise me and would also see me in other organisations as he also engaged with P3.

One Thursday afternoon whilst I was working on outreach, Patient B was complaining of toothache. I spoke with him and tried to reassure any anxiety issues that he had, it soon came apparent that he was dental phobic. Patient B hadn’t disclosed just how nervous he was prior to getting into surgery as his friend was with him, for the fear of been laughed at and judged, his nerves got the better of him and he had a panic attack during this treatment.

Patient B did really well and the surgery staff made him feel at ease and managed to localise the area to remove his tooth that was causing him pain. After treatment, patient B returned to the waiting room where his friend was waiting and made him react negatively and started shouting and swearing outside in front of staff and other patients.

The following Thursday patent B returned to the soup kitchen and thanked me and apologised for his behaviour and asked if he could return to the clinic for further treatment which he did and completed what was required.

This was a fantastic result.”

Public Health England

Sandwell: Langar Bus

- Midland Langar and SMBC joint project: **Langar Bus**
- Over 6 weeks, there were 138 attendees from West Bromwich and 33 attendees from Smethwick
- Agencies involved in achieving outcomes:
  - Job Centre
  - Welfare
  - Housing solutions
  - Nashdom (translation service)
  - Floating support
  - Benefits team
  - Think Local
  - Locals (Oldbury, West Bromwich)
  - Direct Hostel: Walsall

Public Health England

Sandwell: Langar Bus

Of 22 of the people that used the Bus service there are a number of key outcomes:

Attendee circumstance	Key outcomes
3 people were living in a Garage without benefits.	• A hostel and benefits are now in place for two of these people, as well as English lessons for one. • The third person, supported by the Refugee and Migrant centre returned to Poland.
Another person was street homeless for 3 months.	They received accommodation in James Bagnal (MH), benefits and donations from staff.
1 was working but had lost accommodation.	They received accommodation and benefits.
There were 3 cases of individuals living in a tent, one has medical issues.	• One now lives at Oxhill house. • Another is in a Birmingham hostel and is receiving medical assistance, both are receiving benefits. • The third was re-housed in Wednesbury and secured accommodation and employment and was given staff donations.
5 people were street homeless.	• One is awaiting an outcome. • Another was rehoused and is working. • The third is now at Oxhill house. • Two are at a Birmingham Hostel with one in claim of benefits. • Another person transferred to a Birmingham Hostel but left for London the next day after a phone call.
There was also a case of someone sofa surfing.	This individual has moved from Sandwell as partner is working.
A council tenant couldn't access home to collect belongings.	Appointment arranged with local team for next day access.
1 tenant has an unwanted lodger.	No further contact was made despite messages by Officers.
2 people were seeking work.	• One didn't show to appointment, not seen on bus again. • The others details were passed to the staff line agency.
Another attendee was given donations from the bus.	Assistance through donations.
Another person had been living with a friend.	This person subsequently moved to Dudley.

Public Health England

Healthwatch Warwickshire: Rights to access

- The Rights to Access Project, launched by Healthwatch Warwickshire, aims to help people who are experiencing homelessness to access healthcare when they need it. It is being rolled out in waves.
- The Warwick District wave of the Rights to Access project is ending soon which means we will be moving on to Stratford-Upon-Avon District. This wave will run from May until July 2019.
- They have produced:

- A plastic Rights to Access card with information for people to keep with them when accessing primary care
- A booklet with further information
- Free workshops for any community/voluntary/statutory organisation who supports anyone experiencing homelessness on rights to access and NHS guidelines

healthwatch Warwickshire

Public Health England

Stoke-on-Trent Primary Care Outreach

- Partnership between Brighter Futures and Hanley Primary Care Access Hub
- Peripatetic service
- Delivered from purpose-built mobile unit
- Joint funding from the CCG and City Council
- Visits key venues in the City to a schedule
  - Homeless hostels
  - Foodbank
  - Day centre
  - Evening drop-in

Case study 1

- 40-year-old male
- Long history of street homelessness
- Concerns about cognitive impairment from support worker
- Liaised with GP and secured appropriate assessment
- Diagnosis confirmed
- Secured access to social care and accommodation
- Patient has sustained tenancy

Public Health England

Case study 2

- 45-year-old male
- Long history of intravenous drug use
- Presented with extensive ulceration to both legs, largest 17 cm x 8 cm
- He felt hopeless
- He engaged in treatment with outreach service
- Some wounds now completely healed and others reduced in size
- He has renewed hope and engaging better in other services
- Has attended an appointment with drug services

Public Health England

Stoke-on-Trent

- GP mystery shopper exercise and follow up exercise with CCGs
- Rights to access card launched by partnership between Expert Citizens, Healthwatch and Voices group
- Working on rights to access posters for GP surgeries

Public Health England

5. Resources and Publications

Public Health England

All Our Health

 https://www.gov.uk/government/publications/homelessness-applying-all-our-health/homelessness-applying-all-our-health

Public Health England

Health Matters: Rough Sleeping

Public Health England

Guidance

Health matters: rough sleeping

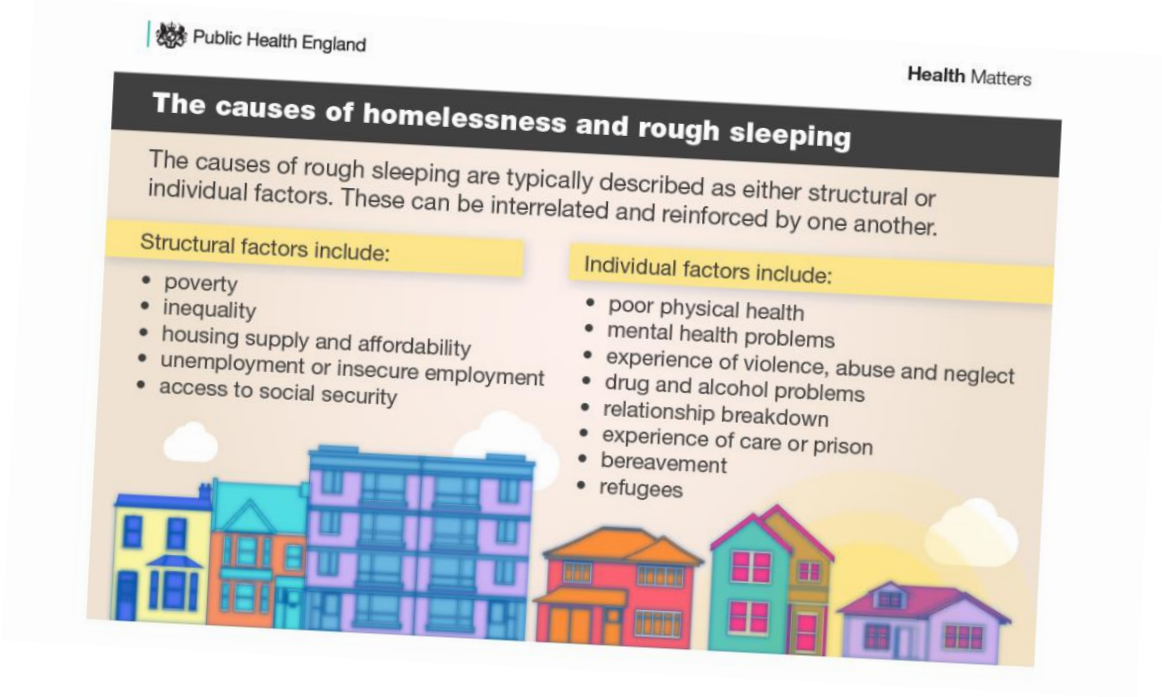
Published 30 September 2019

Contents

Summary

This edition of Health Matters focuses on the scale of rough sleeping in England, the causes and consequences of rough sleeping (including the links with poor physical and mental health, prevention and effective interventions) and relevant calls to action.

Ill-health can be both a cause and consequence of homelessness, although it is not always identified as the trigger of homelessness. For example, ill-health may contribute to job loss or relationship breakdown, which in turn can result in homelessness.



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Health Matters

The causes of homelessness and rough sleeping

The causes of rough sleeping are typically described as either structural or individual factors. These can be interrelated and reinforced by one another.

Structural factors include:

- poverty
- inequality
- housing supply and affordability
- unemployment or insecure employment
- access to social security

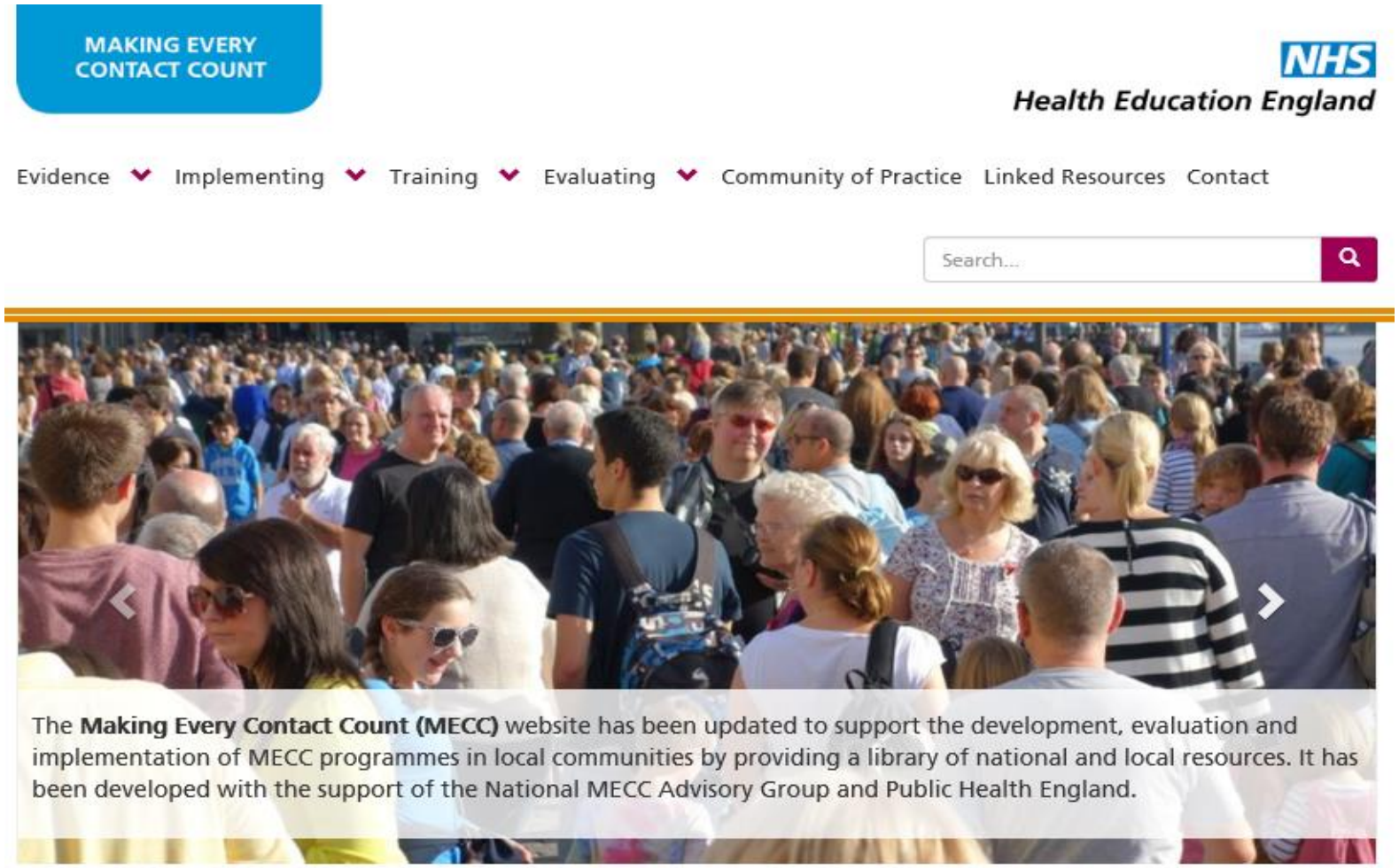
Individual factors include:

- poor physical health
- mental health problems
- experience of violence, abuse and neglect
- drug and alcohol problems
- relationship breakdown
- experience of care or prison
- bereavement
- refugees

 https://www.gov.uk/government/publications/health-matters-rough-sleeping/health-matters-rough-sleeping

Public Health England

Making Every Contact Count



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