CITY COUNCIL **7 July 2015**

REPORT OF THE HEALTH & SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE

Homeless Health

1. INTRODUCTION

1.1 The links between housing and health are well known and this Inquiry set out to explore how health outcomes for homeless households differ from the wider population and what can be done to close the gap.

1.2 Being homeless has an extremely detrimental impact on health with the result that people who are homeless experience some of the worst health problems in our society. They are vulnerable to illness, poor mental health and drug and alcohol problems and are more likely than the general population to have multiple and complex physical and mental health needs. Those experiencing homelessness are also more likely to have unhealthy lifestyles which can cause long-term health problems or exacerbate existing issues.

1.3 In spite of suffering worse health than the general population, homeless people face significant barriers to accessing the healthcare services they need. Even where they do manage to access health services, the often transient nature of their lifestyle can make it difficult to maintain engagement with health services.

1.4 All of these factors combine to mean that often health problems can go untreated until they have escalated to a point where they become critical. This delay in accessing treatment can mean that problems are likely to have become increasingly serious and are more likely to require more intensive and expensive treatment, which of course has cost implications for the NHS.

1.5 Failure to support homeless people to access the healthcare they need when they need it also leads to more reliance on treatment at Accident and Emergency which leads to avoidable emergency admissions to hospital or to homeless people presenting at primary health services with multiple and entrenched problems. Homeless Link found that homeless people report an average of 1.66 A&E visits a year, compared to 0.38 among the general population.

1.6 Health and Wellbeing Boards have a duty to act to improve the health of all local people and the Birmingham Health and Wellbeing Board is actively prioritising homelessness and is using the data from the Homeless Health Needs Audit together with further data from stakeholders on the health needs of the street homeless and using the findings to help the Health and Wellbeing Board and the Birmingham Clinical Commissioning Groups to inform priorities and better shape service provision for homeless people.

2. FINDINGS

2.1 The experiences related to the members of the inquiry by a group of rough sleepers made a considerable impression on the inquiry members. The main issues raised by them were access to information, advice and support in the city centre and a means for people sleeping rough in the city centre to have their voices heard. The fact that elected member advice surgeries have already commenced in the city centre based at SIFA Fireside demonstrates the high degree of commitment from elected members from across the political spectrum to supporting this vulnerable group.

2.2 Access to primary care services by the homeless population was another important issue which emerged from the evidence given to the inquiry. GPs are the primary point of access to health services but one of the striking issues highlighted in the Homeless Health Needs Audit was the fact that only 75% of those responding were registered with a GP. There are many barriers which prevent homeless people from being able to access primary care services. They may be living a chaotic lifestyle, may not have the perseverance to navigate the system, they may not be good at filling in forms, they may not deal well with complexity or may not have any identification. If a GP surgery asks a homeless person for a utility bill or proof of their name which they cannot provide the result is often that they cannot register. The Homeless Health Exchange Primary Care Service do excellent work to combat this problem by registering homeless people care of the surgery and by using other organisations such as SIFA Fireside or a day centre in order to get people registered with a GP but there is a wider issue with general practices across the city in relation to the registration process for general practice.

2.3 Even if a homeless person manages to register with a GP they don't necessarily keep appointments and may be banned from using or discharged from services for not complying with rules or for behaviour which is deemed to be unacceptable. More work is needed to ensure that every homeless person can register with a GP and to ensure that once a homeless person has registered with a GP, services need to be as flexible and tolerant as possible to enable a person to remain on a list with a GP with whom they have built a relationship. The Birmingham Clinical Commissioning Groups have taken on full delegated responsibility for the commissioning of general practice from 1st April 2015. The response to Recommendation 2 received from the Clinical Commissioning Groups demonstrates a willingness to work collaboratively to explore this issue and has been added to the end of the executive response for information.

2.4 There was evidence of much existing good practice and collaborative working that is already happening in the city, some of which has been highlighted in the report such as the excellent work being done by the StreetLink multi-agency group working in the city centre to tackle the housing and health problems of people sleeping rough in the city centre. The services involved need to continue to work together in new and creative ways to ensure that as far as possible statutory services are increasingly

placed where vulnerable homeless people attend. The new welfare service which is being modelled on the basis that statutory and non-statutory health and other services will be available in one location is a good example of this new approach to the way that services for homeless people need to be designed.

2.5 There is no easy answer to providing services which address the health needs of homeless people. However the signs in Birmingham are encouraging. The local authority and homelessness and health services are beginning to listen to the voices of the vulnerable homeless. They are beginning to recognise and prioritise their health needs and to work together better to provide more flexible and person centred services which are designed to meet the health needs of the homeless and which are provided in a place where the vulnerable homeless frequent for basic welfare services. This good work needs to develop and continue and the Health and Social Care Overview & Scrutiny Committee will monitor progress with the implementation of the recommendations contained in this report with considerable interest.

3. COMMITTEE RECOMMENDATIONS

Summary of Recommendations

	Recommendation	Responsibility	Completion Date
R01	That potential locations in the city centre be explored to find the most suitable venue which can be made available to be used as a central point where homeless people can go to access information, advice and support on accommodation, benefits (including accessing a computer to start the process of registering to make a claim) and be referred to available health services without needing to make an appointment or travel to one of the customer service centres.	Cabinet Member for Neighbourhood Management and Homes Cabinet Member for Health and Social Care as Chair of the Health and Wellbeing Board	30 September 2015 for final version of Welfare Specification and new service to start 1 April 2016 31 July 2015 for remodelled Housing Advice Centre options
R02	That the three Birmingham Clinical Commissioning Groups should explore: 1. How they can make it easier for homeless people to register with a GP even if they are only temporarily residing in an area and have a permanent address elsewhere or have no permanent address. 2. How homeless people can be facilitated to maintain registration on a GP list once they have registered even if, due to the transient nature of their lifestyle, they subsequently move out	Birmingham Cross City, Birmingham South Central and Sandwell and West Birmingham Clinical Commissioning Groups	31 March 2016 Health and Wellbeing Board Agenda 13 October 2015

	of that area.		
R03	That the multi-agency working that is already starting to happen to tackle the housing and health problems of people sleeping rough in the city centre by connecting rough sleepers to local support and services is strengthened. Groups already in existence need to be reviewed to establish whether they are working together effectively with a view to building on the existing protocol and the work already being done by the StreetLink multi-agency working group, to ensure that relevant agencies are alerted before major regeneration work starts, to provide an opportunity to support homeless people squatting or sleeping rough in the area.	Cabinet Member for Neighbourhood Management and Homes Cabinet Member for Health and Social Care	31 October 2015
R04	That services should be commissioned in a joined up way wherever possible, specifically when commissioning services for people with a dual diagnosis of either: 1. mental health and substance misuse or 2. people with alcohol problems who also suffer from dementia, where there is currently a gap in service provision.	Cabinet Member for Health and Social Care	31 January 2016
R05	That wherever possible services for homeless people should be designed to reach out to homeless groups who need them by moving away from a silo culture and exploring options for placing statutory services where homeless people already attend, such as the Homeless Health Exchange or SIFA Fireside, along the lines of the Inclusion Healthcare Social Enterprise Model.	Cabinet Member for Health and Social Care Cabinet Member for Neighbourhood Management and Homes	31 October 2015
R06	That a forum or other appropriate mechanism be established between HM Prison Birmingham and Birmingham City Council to facilitate more joined up working with prisons and the probation services to provide improved pathways between prison and the general community with a view to: 1. Linking prison healthcare provision better to wider community healthcare services on release from prison in particular for prisoners with serious mental health, drug and/or alcohol problems; 2. Supporting prisoners into appropriate accommodation before and after discharge from prison; 3. Prioritising appropriate	Cabinet Member for Health and Social Care Cabinet Member for Neighbourhood Management and Homes	31 March 2016

	accommodation for homeless women in contact with the criminal justice system. 4. Supporting prisoners to link into the benefit system before and after release from prison. 5. Providing/sharing information about services available in the community to facilitate improved pathways between prison and the general community.		
R07	That the Joint Commissioning Team should examine the feasibility of commissioning an emergency and/or out of hours specialist homeless primary care service for the city.	Cabinet Member for Health and Social Care Birmingham and Solihull Mental Health NHS Foundation Trust Cabinet Member for Neighbourhood Management and Homes	31 December 2015
R08	That the best way to provide a direct line of communication between the City Council and people sleeping rough in the city centre who have a problem or a complaint, for example through advice surgeries in the city centre, be explored	Cabinet Member for Neighbourhood Management and Homes	Already commenced Progress Update 31 October 2015
R09	That an assessment of progress against the recommendations made in this report be presented to the Health and Social Care O&S Committee	Cabinet Member for Neighbourhood Management and Homes	31 October 2015

MOTION

That the report and its recommendations summarised above be accepted, and that the Executive be requested to pursue implementation.