

Information briefing

Report From: Strategic Director for People

Report To: Health, Wellbeing and the Environment Overview and Scrutiny Committee

Date: 21 February 2017

Title: Homeless Health

Summary:

The Homeless Health report from Overview and Scrutiny was published in July 2015 and since then the homeless landscape has significantly changed.

Homelessness has continued to rise nationally, regionally and locally. Priority homelessness continues to increase and the recent release of the National Rough Sleeping Statistics has seen further significant rises in the numbers of people rough sleeping. Birmingham's rough sleeping figure for 2016 was 55, a 53% increase on the previous year in line with national trends.

Health inequalities amongst people experiencing homelessness, and in particular those sleeping rough, continues to be an area of concern.

Based upon self-disclosed information obtained by the Outreach Service

- 72% of rough sleepers have a substance misuse issue
- 44% of rough sleepers have a mental health issue
- 19% of rough sleepers have a physical health issue

The growth in the use of legal highs over the last 3 years has also exacerbated the situation.

Homelessness and its impact is societal and requires a societal response.

Recent Activities

- A homeless review has been completed that is informing change..

- A homeless summit was held with key partners and stakeholders in October .
- A homelessness transformation programme has been introduced to deliver a comprehensive change to preventing and tackling homelessness in Birmingham. This programme is multi-agency and sets out to deliver the shared vision for Birmingham –“In Birmingham we will work together to eradicate homelessness.”
- A rough sleeping review has been undertaken by Housing and Homes Overview and Scrutiny.
- Birmingham has been successful in two bids to DCLG drawing in £2.1 million towards tackling rough sleeping and homeless prevention.

Future Work

- Undertaking a mapping exercise of health services and surgeries available for rough sleepers.
- Update the Homelessness Health Needs Audit
- Develop the new Homelessness Strategy 2017-2022
- Strengthen the links with the Health and Wellbeing Board
- Need to define how the STP can respond and inform health responses to homelessness as part of the Homelessness Strategy development.

Background information:

Appendix 1 – Overview and Scrutiny Homeless Health Report
Appendix 2 - Recommendations Updates
Appendix 3 – Homeless Welfare Service Performance report

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Homeless Health



A report from Overview & Scrutiny





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Reports that have been submitted to Council can be downloaded from www.birmingham.gov.uk/scrutiny.



Preface

By Councillor Sharon Thompson

Member, Health and Social Care Overview & Scrutiny Committee



As many of you will be aware, homelessness is a topic in which I have a considerable personal interest and to which I have a great personal commitment. I am very grateful to the previous Chair of the Health and Social Care Overview and Scrutiny Committee for allowing me the opportunity to present this report on a topic about which I feel very passionate.

I know from personal experience that being homeless is physically and mentally difficult and that homeless people are among the most vulnerable in our society. They suffer worse health than those living in settled accommodation and yet despite suffering worse health than the general population, they often struggle to access healthcare services. This is starkly illustrated by the fact that, in spite of improvements in the health of the general population over the last 15 years, the average age of death for homeless people is just 47 years old with the average age for homeless women being even lower at just 43. This compares to 77 for the general population. This is a truly shocking statistic and we need to take action now to ensure that homeless people are able to access to the healthcare services they need.

I would like to thank members of the Health and Social Care Overview & Scrutiny Committee together with health partners and a wide range of organisations from across the City who have given their time and effort to contribute to this Inquiry. I would also like to say a particular thank you to the small group of rough sleepers who agreed to participate in the inquiry and who made a considerable impact on the members who listened to their experiences with the result that the recommendations emerging from the Inquiry have tended to focus mainly, but not exclusively, on aspects of the health and housing needs of the single homeless who find themselves sleeping rough. I make no apologies for this.

A Scrutiny Committee Inquiry alone cannot hope to solve the problems of homeless people in the City. However the committee can and have made recommendations for improvements which I sincerely hope will go some way towards highlighting some of the areas where action needs to be taken to ensure that help is available to homeless people where and when they need it and that no one is left in the position of having to sleep rough. I hope that these recommendations will go some way towards starting to improve the lives of homeless people in the City.

Councillor Sharon Thompson



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: <ol style="list-style-type: none"> 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 of that area. 	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
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	Cabinet Member for Health and Social Care	31 January 2016



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	<p>dual diagnosis of either:</p> <ol style="list-style-type: none"> 1. mental health and substance misuse or 2. people with alcohol problems who also suffer from dementia, <p>where there is currently a gap in service provision.</p>		
R05	<p>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</p>	<p>Cabinet Member for Health and Social Care</p> <p>Cabinet Member for Neighbourhood Management and Homes</p>	31 October 2015
R06	<p>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:</p> <ol style="list-style-type: none"> 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 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. 	<p>Cabinet Member for Health and Social Care</p> <p>Cabinet Member for Neighbourhood Management and Homes</p>	31 March 2016
R07	<p>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.</p>	<p>Cabinet Member for Health and Social Care</p> <p>Birmingham and Solihull Mental Health NHS</p>	31 December 2015



		Foundation Trust Cabinet Member for Neighbourhood Management and Homes	
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



1 Introduction

1.1 What is homelessness?

- 1.1.1 Not having a home damages people's lives and there are thousands of people who don't have the right accommodation to allow them to lead healthy and fulfilling lives. A lack of commitment to ending homelessness just increases the costs to the public purse and postpones the problems associated with homelessness to be dealt with in the future.
- 1.1.2 The wider definition of homelessness covers a multitude of situations and includes people sleeping rough, single homeless people living in hostels, shelters and temporary supported accommodation as well as statutory homeless households. Statutorily homeless households are households who seek housing assistance from local authorities on the grounds of being currently or imminently without accommodation. The term also includes the 'hidden homeless' households. That is people who may be considered homeless but whose situation is not 'visible' either on the streets or in official statistics. This would include households living in very overcrowded conditions, squatters and people who are 'sofa-surfing' with friends or relatives.
- 1.1.3 Homelessness is about so much more than just not having suitable accommodation.

Homelessness is about more than rooflessness. A home is not just a physical space, it also has a legal and social dimension. A home provides roots, identity, a sense of belonging and a place of emotional wellbeing. Homelessness is about the loss of all of these. It is an isolating and destructive experience and homeless people are some of the most vulnerable and socially excluded in our society.¹

1.2 Focus of Inquiry

- 1.2.1 This Inquiry into homelessness set out to explore how health outcomes for homeless households differ from the wider population and what can be done to close the gap. The aim was to develop a clear understanding of the health issues experienced by vulnerable and excluded homeless households in terms of outcomes and service provision with a view to informing the future commissioning of health services, whether by the local authority or health commissioners, for this group of people.
- 1.2.2 The scope was initially defined in terms of the cohort of households whose health outcomes are worse than the wider population with a likely focus on vulnerable and excluded single person and couple households for whom the local authority does not have a statutory duty to accommodate.

¹ Crisis



Typically this would include those living in insecure accommodation, 'sofa-surfing', squatting and sleeping rough.

- 1.2.3 Although evidence was presented about homelessness in the wider sense and much of this has been included in this report, as the evidence gathering progressed it became increasingly clear that the recommendations emerging from the Inquiry were likely to be more narrowly focused. Much of the evidence was around the health and housing needs of a group of single homeless who have slipped through the net and find themselves sleeping rough and about the services that are available to them and their use of and access to those services. Members were mindful that there are other important aspects of homelessness which would merit closer examination and scrutiny which may be covered in a future scrutiny inquiry.

1.3 Impact of homelessness on health

- 1.3.1 Homelessness and health are inextricably intertwined. Being homeless is physically and mentally difficult and homelessness has significant negative consequences 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.
- 1.3.2 Those who experience homelessness are also more likely to have unhealthy lifestyles which can cause long-term health problems or exacerbate existing issues. Analysis of the latest data found that 77% of homeless people smoke, 35% do not eat at least two meals a day and two-thirds consume more than the recommended amount of alcohol each time they drink.²

1.4 Barriers to accessing healthcare

- 1.4.1 In spite of suffering worse health than the general population, homeless people often struggle to access healthcare services. There are many reasons for this which need to be understood if inequalities in service access are to be addressed.
- 1.4.2 Some of the barriers include difficulty in accessing primary care such as the inability to register with a GP. This is often due to lack of proof of identity or inability to prove permanent residence in the catchment area or to provide other documentation required to register with a GP.
- 1.4.3 Health services are designed to treat one condition at a time but homeless people often experience multiple and complex health problems. This means that support needs to be accessed through different parts of the health system which can be difficult to navigate for people who are often leading chaotic lifestyles and dealing with issues relating to mental health and substance misuse and who may also not trust and not understand the system.

² Homeless Link Report "The unhealthy state of homelessness: Health audit results 2014"



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- 1.4.4 Undiagnosed or untreated mental health problems can also be a barrier to seeking help as can fear and denial of ill health, difficulty communicating health needs and fear of stigmatisation or of being labelled. People with complex problems can often find it difficult to comply with treatment and fail to attend appointments which can then lead to them being excluded from services.
- 1.4.5 In order to improve the healthcare that homeless people receive staff need to be able to identify and understand and work with homeless patients. Sometimes healthcare staff remain unaware that a patient is homeless, either because the patient has not been asked or because they are afraid of admitting to being homeless and sometimes staff may lack the skills to deal with people who are exhibiting challenging behaviour.
- 1.4.6 Homeless people are often living more transient lives than other people which can make it difficult to maintain engagement with health services especially where staff may not have had the opportunity or time to be able to build up a trusting relationship with a homeless patient.

1.5 The financial cost

- 1.5.1 The combined effect of the factors mentioned above, means that health problems frequently go untreated until they have escalated to a point where they become critical. This failure to improve health at an early stage can often mean that problems have become more serious and are therefore likely to require more intensive and more expensive treatment due to the delay in accessing treatment. This has cost implications for the NHS. The Department of Health estimated that the annual cost of hospital treatment alone for homeless people is at least £85 million a year. This means costs of more than £2,100 compared to £525 per person among the general population³
- 1.5.2 Failure to support homeless people to access the healthcare they need before they need urgent hospital treatment also leads to more reliance on treatment at Accident and Emergency (A&E) leading 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. The latest data from Homeless Link indicates that the number of A&E visits and hospital admissions is four times higher for homeless people than for the general public.⁴

1.6 Health Inequalities

- 1.6.1 In addition to suffering worse health than those living in settled accommodation, homeless people face significant inequalities in accessing health services. This is starkly illustrated by the shocking fact that, in spite of recent improvements in the health of the general population, the average age

³ McCormick B (2010) Healthcare for single homeless people, Office of the Chief Analyst, Department of Health

⁴ Homeless Link Report "The unhealthy state of homelessness: Health audit results 2014"



of death for homeless people is just 47 years old with the average age for homeless women being even lower at just 43, compared to 77 for the general population.⁵

- 1.6.2 The Health and Social Care Act 2012 introduced duties to improve health and reduce health inequalities. The Act gives responsibility for public health to local authorities and requires them to take appropriate steps to improve the health of people in the area and to provide assistance to individuals to help them to minimise any risks to health arising from their accommodation or environment.⁶ Local authorities are also required to produce an assessment of local health needs which should identify the needs of all people in the local area. These Joint Strategic Needs Assessments (JSNAs) should identify the health needs of homeless people, including single homeless people and the gaps in current services.
- 1.6.3 Health and Wellbeing Boards have a duty to act to improve the health of all local people and Clinical Commissioning Groups (CCGs) have a duty to reduce health inequalities in health outcomes and in access to health services. In order to improve the poor health experienced by homeless people services need to be designed to overcome the barriers to accessing healthcare experienced by people who are homeless.

⁵ Crisis study on mortality amongst homeless people "Homelessness: A silent killer"

⁶ Health and Social Care Act 2012 Section 2B



2 Homelessness in Birmingham

2.1 The Birmingham context

- 2.1.1 In his evidence to the committee, the Birmingham Cabinet Member for Health and Wellbeing who also chairs the Health and Wellbeing Board (HWBB) acknowledged that homelessness is a major issue for the city and that the links between homelessness and health inequalities are clear and stark. What not many people realise however is that Birmingham has actually grown by 10% in the last 10 years. That means approximately 100,000 extra people living in Birmingham in the last 10 years, which puts homelessness into an even sharper context. The city has seen an increase in homeless applications and increases in the numbers of rough sleepers in the city.
- 2.1.2 Although there have been improvements in the health of the general population over the past 15 years the statistics relating to the health of homeless people remain unacceptably poor compared with the general population.
- 2.1.3 In order to design effective services the local HWBB need to ensure that data is collected about local health needs, including the health needs of homeless people and they do this through the JSNA. The Birmingham Director of Public Health gave evidence that homelessness is a key indicator of how good public health is and, until recently, there was no other local authority with more statutory homelessness of households per thousand population than Birmingham. Statutory homelessness has since been prioritised by the HWBB and improvements in outcomes are starting to be made and, although Birmingham is still towards the bottom, it no longer takes the most applications in the country.
- 2.1.4 As a first step towards demonstrating commitment to improve the health of homeless people, the Birmingham HWBB have signed St Mungo's Broadway Charter for Homeless Health (Appendix A). This commits the HWBB to:
- **Identify Need:** identifying and including the health needs of homeless people in the JSNA. This includes people who are sleeping rough, people living in supported accommodation and people who are hidden homeless.
 - **Provide leadership:** providing leadership on addressing homeless health. The Director of Public Health has a key leadership role to play in tackling health inequalities and will lead in promoting integrated responses and identifying opportunities for cross-boundary working.
 - **Commission for Inclusion:** the local authority working with the CCGs to ensure that local health services meet the needs of people who are homeless and that the services are welcoming and easily accessible.



2.2 Identify Need: Birmingham Homeless Health Needs Audit

2.2.1 With a view to gathering more accurate data on the health needs of homeless people, a Homeless Health Needs Audit was carried out in Birmingham during 2014. The intention was to review a sample of homeless people and to use their views when designing services. This took the form of a survey distributed to homeless shelters, housing support agencies and related services during 2014 with a view to reviewing the health needs of a random sample of those with priority housing needs or homeless to establish a picture of the current health and mental well-being and of the service provision for this group. A pilot survey ran during May 2014 with a further survey from July to 31 October 2014.

2.2.2 A total of 342 responses were received. Of the responses:

- 77% were aged 25 years or under, the male female split was approximately 60:40 overall but with a majority of females under 25 years.
- 56% were white or other white ethnicity with the under 25 years being 42% white, 18% black and 15% Asian. Of the over 25s 68% were white, 10% black and 3% Asian.
- 18% had a mental health disorder.

2.2.3 **General Health** - Overall health was OK (34%) or good (34%), their living situation appeared to be stable (40% in hostels, 14% in accommodation) and many did not abuse drugs to cope with their situation (83%). But 16% rated their health as poor.

- Diet and nutrition seemed to fare reasonably well with the majority eating regular meals and having access to fruit and vegetables.
- However only 75% were registered with a GP, 60% were registered with a dentist with the over 25 group less likely to have registered with a dentist.

2.2.4 **Mental Health** - Both groups had significant mental health issues, with higher representation for the over 25 groups.

- Both groups suffered anxiety, depression and stress (20%) overall.
- The under 25s experienced suicidal thoughts (30%) and ADHD.
- The over 25s exhibited more violent behaviour/anger (2% of survey cohort; 18% of over 25 age group) and schizophrenia.

2.2.5 **Well-being** - The under 25 age group stated that friends and environment have a positive effect on their lifestyle, with friends providing financial and health support.

- The over 25 age group highlighted family as having a negative effect on their well-being, which supports data given on housing application acceptances where family breakdown is one of the main reasons given.
- Over 25s rate unhappier with all the environmental and personal influences.



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- There is good general awareness of sexual health services, with 52% having had a sexual health check in the past 12 months.

2.2.6 **Support** – There was a higher number of rough sleepers in the older group; twice as many as under 25s sleeping on sofas.

- Under 25s receive more financial support from family and friends; over 25s mostly rely on benefits.
- Under 25s receive more help from family and friends regarding health.

2.2.7 **Vaccinations/screening** – There is some confusion regarding vaccinations, screening and tests, especially around hepatitis. Many are not sure if they have had tests or what tests they were. Screening, vaccinations and subsequent treatment received a low response and it is unclear whether this is due to the respondents not suffering from these conditions or not having been appropriately signposted.

2.2.8 **Substance Use** – Alcohol use was high although the majority stated that they did not drink every day (95%) and did not consider themselves to have a drinking problem (93%). Alcohol consumption was greater in the older group, although it was significant in both groups. The over 25s had higher drug use across all drugs, but significantly more Class A. The under 25s have higher cannabis use.

2.2.9 **General** - 26% state they have a disability, half mental health, a quarter have a learning disability.

10% on bail, recently left prison or under probation

6% left care in the last 12 months

6% actively in drug treatment, 8% in recovery from drug misuse, 18% taking drugs

9% used legal highs in the last month.

2.3 Provide leadership: What is being done in Birmingham?

Tackling homelessness is a key priority for Birmingham City Council⁷

2.3.1 The Cabinet Member gave evidence that the Birmingham HWBB are actively prioritising homelessness and will be taking the data gleaned from the Homeless Health Needs Audit which will be analysed by the Director of Public Health and the findings used to produce recommendations which will help the HWBB and the CCGs in the city to inform priorities and shape services. Data from the Homeless Health Audit will be incorporated into the JSNA together with further data from stakeholders on the health needs of the street homeless which is being collated.

⁷ First line of Birmingham City Council Homelessness Strategy 2012+



The aim is to give the JSNA a stronger emphasis on homelessness in order to better shape and direct service provision.

- 2.3.2 The Cabinet Member stressed his commitment to improving the health and wellbeing of all people affected by homelessness including statutory homeless and including rough sleepers and people living in unsuitable or insecure accommodation such as squats and hostels with a view to reducing health inequalities for all homeless people. Investment in homeless activity has been prioritised for 2015/16 and improved results had already been achieved at the time the evidence was given, in delivering additional temporary accommodation and opening a new homeless temporary accommodation centre in order to reduce the number of households in the city in B&B accommodation. The snapshot evidence at the time (January 2015) was that only 25 households were in B&B accommodation which was an 85% reduction from earlier in the year when there were over 150 households in B&B accommodation in the city. 19 of the 25 households were families and none were single 16 or 17 year olds.
- 2.3.3 There are various initiatives which are being introduced to tackle homelessness in the city. These include the development of a regional Housing First model for which the City Council is the lead partner. The idea of the Housing First Model is based on the premise that housing is a basic human right and entrenched rough sleepers and people with complex needs will be offered a tenancy directly from the streets with a support package and the initiative is contributing to Public Health England's population healthcare development project for single homeless people. The idea is that if people are given a tenancy then they will be more inclined to work with support agencies to go on and accept any support needed to maintain the tenancy. The package will provide a holistic support package of care for individuals who are entrenched rough sleepers and suffering from complex needs around mental health, community safety, ongoing drug or alcohol treatment and support to deal with behavioural issues. Reference was also made to reviewing the homelessness community mental health service (paragraph 8.4) and primary care services to support the needs of single homeless people, to the Homeless Hospital Discharge pilot (paragraph 9.3) to support single people back into the community when they are discharged from hospital and to the remodelled support provided within the new Public Health Lifestyle Service in which homeless groups are prioritised.
- 2.3.4 Birmingham's Supporting People programme commissions a wide range of supported housing services for vulnerable customers. These services include hostels for single homeless people, step down schemes and specialist schemes for single people who have experienced homelessness, accommodation schemes for offenders, domestic violence refuges and floating support services to support those who need extra help to continue to live independently or people who have difficulties due to drug or alcohol problems.
- 2.3.5 These services are provided by a range of voluntary sector organisations and access to the schemes is via the Birmingham Gateway which is a service provided by Birmingham City Council which assesses the needs of people requesting access to housing related support services and



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based on a needs and risk assessment the service will seek to match service users to available support services. A bedspace may be allocated in an accommodation based scheme or a floating support worker may be allocated to provide housing related support at the person's current or future address.

- 2.3.6 The type of housing related support to help to develop and maintain a person's ability to live independently can include helping someone to get their correct benefits, to learn to budget properly for rent and bills, to access a GP or dentist, to get on a training or education course, to maintain a tenancy or to get a permanent home.
- 2.3.7 It was acknowledged that there are real issues about the depletion of the council housing stock and about how best to try to expand the supply of affordable housing. The Municipal Housing Trust is now the biggest house builder in the city in an attempt to increase supply and there is ongoing proactive work with the private rented sector through the Birmingham Social Lettings Agency 'Let to Birmingham' to increase the supply of housing and to provide more options for people.
- 2.3.8 The suitability of the housing stock the Council has available also presents an additional challenge for the city. The Council has in excess of 200 tower blocks in the city which makes up a substantial proportion of the overall housing stock. This obviously has an impact in terms of restricting the types of properties available. Homeless households have an opportunity to bid for properties on Birmingham Home Choice and tower blocks go for significantly fewer points than houses. This means that although a house is often the type of property of choice for most people, the large proportion of tower blocks in the housing stock means that often the Council is restricted into placing people into flats. Currently on the housing allocations system you will be allocated 140 points if you are accepted as being statutory homeless but a two bedroomed house at the moment would need, on average, in excess of 250 points to secure, so unless a person is classified as statutory homeless with additional points awarded they are unlikely to secure a house.

2.4 Commission for Inclusion

- 2.4.1 After the health needs of homeless people have been identified in the JSNA, there is a choice about how best to respond. There is no single solution and the most appropriate action will depend on a number of factors but it is clear that multi-agency working will be needed to tackle these problems. Health services are under a duty not only to reduce health inequalities in health outcomes, but also in access to health services. Commissioners need to aim for inclusive commissioning that overcomes these barriers and creates responsive and accessible health services. Commissioners of health and homelessness services need to ensure that services meet the health needs of homeless people and that they are easily accessible and welcoming by taking an integrated approach to addressing health and housing need. Arrangements to achieve this can range from pooling or aligning budgets to informal agreements between services.



- 2.4.2 Integrating health and housing may not always need special commissioning. Much can be achieved by using housing investment to target health inequalities or using health investment to support housing outcomes, for example, health professionals working out of homelessness services. The aim should be to look for opportunities to work together jointly to support services that tackle homeless health and to limit barriers to accessing care and be responsive to local need.

2.5 Joined up Commissioning

- 2.5.1 Whilst integrating health and social care and multi-agency working may not always necessitate special commissioning arrangements, sometimes it may mean commissioning services so they are joined up, eg jointly commissioning services for mental health, substance misuse and alcohol. The recent substance misuse commissioning exercise in Birmingham whereby drug and alcohol services were jointly re-commissioned is an example of this approach to commissioning.
- 2.5.2 In Birmingham it is calculated that there are approximately 10,000 opiate or crack users, 48,000 cannabis users, 15,000 powder cocaine users, 10,000 ecstasy users, 6,000 amyl nitrate users, 6,000 amphetamine users and 4,000 ketamine users. In relation to alcohol there are 117,000 hazardous drinkers (someone drinking above safe limits of 21 units for men and 14 for women), 39,000 harmful drinkers (someone drinking 50 units for men and 35 units for women) and 22,000 dependent drinkers (someone who needs medical intervention to stop drinking). 25% of men and 17% of women in the city are drinking above safe limits. It's fair to say that Birmingham has no greater issue than any other core city but, nevertheless, these are significant numbers.
- 2.5.3 Prior to March 2015 there were 28 separate organisations providing treatment in the city. The new approach aims at recovery outcomes ie. freedom from dependence on drugs or alcohol, sustained employment, sustained suitable accommodation, mental and physical wellbeing, improved relationships with family members, partners and friends, supporting effective and caring parenting, reduction in crime and re-offending and prevention of blood borne viruses.
- 2.5.4 Drug and alcohol services have been re-commissioned with a single lead provider who is also a provider of provision with a set of sub-contracted organisations. It also includes additional commissioning of small third sector organisations to ensure engagement of the diverse communities of Birmingham. All elements of the recovery system are part of the single contract with the new provider - CRI - which commenced on 1st March 2015 with a focus on smoothing the transition and an outreach approach and partnership working. At the time of the evidence gathering for the Inquiry various concerns were raised by organisations working in these areas about the transition arrangements but it was too early in the process to assess the success or otherwise of the new approach which will need to be revisited during 2015 when the new arrangements have been in place for a longer period.
- 2.5.5 The new approach to this commissioning is fundamentally an outreach model so that rather than service users having to go to the main centres the aim is to take the services out into communities and there is ongoing close working with GPs and pharmacies on what is known as 'shared care'.



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This service will be retained and built on and partnership working and working in other locations will be a particular focus in delivering these services in the future. There are particular issues in relation to homelessness and work is ongoing with homeless hostels and with SIFA Fireside to support the delivery of a service at SIFA to make it easier for service users to engage with drug and alcohol services.



3 Statutory homelessness

3.1 Definition

- 3.1.1 Statutory homelessness is different from the wider definition of homelessness referred to in paragraph 1.1.2. It refers to local authority assessments of applicants who seek help with housing due to either imminent loss of accommodation or actual 'rooflessness'. Local authorities have a statutory duty to provide a homeless service and housing advice with 24 hour access.
- 3.1.2 A number of homeless people go to a variety of different agencies across the city to secure accommodation and assistance to get accommodation and don't necessarily approach the council. So the statutory service does not see all homeless households. These households who may be in a similar housing situation to those who apply to the local authority as homeless but who do not formally apply or register with a local authority or other homeless agency are often referred to as 'hidden homeless'.
- 3.1.3 When a person approaches a local authority, the local authority first has to make a decision about whether they have reason to believe, which is a low threshold, that somebody is threatened with homelessness, that they are eligible for assistance and that they do have a priority need. If that is the case, there is a duty to trigger a homeless application, to undertake investigations into that homeless application and then make a decision on that. This decision must be provided to the applicant in writing. Households 'accepted as homeless' means that they have been formally assessed as unintentionally homeless and in priority need and are therefore owed the main housing duty.

3.2 Tests for statutory homelessness

- 3.2.1 In order to be owed the full housing duty a household must pass five tests:
- **Eligibility:** whether someone is eligible in terms of their immigration status to be in this country and therefore to have access to social housing.
 - **Homeless:** whether someone has accommodation to occupy in the UK or elsewhere, whether they can gain entry to it, whether it is reasonable for them to continue to live there eg. it wouldn't be reasonable to expect a victim of domestic violence to continue to remain in that situation if they approach the council for assistance or where the property is in a state of severe disrepair or where there is statutory overcrowding. The homelessness test also covers where someone is likely to become homeless within 28 days.
 - **Priority Need:** automatic priority need applies if an applicant is pregnant or lives with someone who is pregnant, to households with dependent children, to all 16 and 17 year olds, to anyone aged 18-20 who was in local authority care when aged 16 or 17 years for three



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months (referred to as a former relevant child) and to anyone homeless due to an emergency which would include a natural disaster such as a flood or fire. Consideration also needs to be given to whether someone is vulnerable in terms of the homelessness legislation as a result of age, mental illness, either a physical or learning disability or if someone has an institutionalised background such as having been in prison or been in the armed forces which makes them vulnerable. The test is whether the applicant is less able to fend for themselves when homeless in finding and keeping accommodation so that injury or detriment would result, than an 'ordinary homeless person'. Subsequent to the evidence gathering, there has been a very recent case in the Supreme Court which has said that councils assessing the needs of single homeless people should compare them with an 'ordinary person' rather than an 'ordinary homeless person'. This decision will change the vulnerability test as it is currently applied.

- **Intentionality:** whether the person has done something or failed to do something that as a direct consequence has caused them to lose their last settled accommodation. The most common intentional homeless cases would be cases where households have been evicted through rent arrears because they haven't paid the rent rather than because they can't pay or households who have lost their accommodation through anti-social behaviour.
- **Local Connection:** whether someone has a local connection to the local authority. The applicant must basically have lived in the area for 6 out of the last 12 months or 3 out of the last 5 years or have close family residing in the area or work in the city. Consideration must also be given as to whether the applicant has special reasons for needing to live in the city.

3.3 Single Homelessness: SIFA Fireside

- 3.3.1 The term 'single homeless' is generally understood to mean those people who are homeless but do not meet the priority need criteria to be housed by their local authority. They may nevertheless have significant support needs and may live in hostels, sleep rough, sofa surf or live in squats.
- 3.3.2 SIFA Fireside work with this very vulnerable group of people and gave evidence about some of the difficulties faced by this group in getting the assistance they need. Much of the evidence related to the kind of practical advice and support provided at SIFA, for example in providing meals, food parcels, warm clothing, sleeping bags and laundry facilities and the important support provided by faith groups, schools and churches to SIFA in this respect was acknowledged. Every day about 130 homeless people attend at SIFA Fireside's open access drop in, around 12% of whom will be sleeping rough with about a quarter to a third of those sleeping rough being from Central and Eastern Europe. Many of the remainder will be sofa surfing, or living in squats either because they have no recourse to public funds or because their benefits have been stopped or sanctioned.
- 3.3.3 Many of the people attending SIFA have become homeless because of relationship breakdown or domestic violence but many also have other underlying problems such as substance misuse or alcohol or mental health issues, which make it more difficult to get back into settled accommodation. Once people become homeless if they have any kind of health or addiction



problems these are likely to get worse quite rapidly and there are significant barriers to accessing healthcare which have already been referred to, including difficulties registering with a GP practice without a fixed address. SIFA do provide accommodation advice but the need for more resource around longer term resettlement advice, as opposed to just accommodation advice, to support people to have the life skills to manage and maintain a tenancy was highlighted.

- 3.3.4 One of the solutions put forward is to try to co-locate more statutory services where homeless people are already attending, at places such as SIFA or the Health Exchange, rather than expecting homeless people to travel to various different locations to access services. This is already happening to an extent and the example was given of the Homeless Mental Health Team who go into SIFA at least once a week to carry out a mental health triage clinic working alongside SIFA staff, which is a much more proactive way of picking up people who have either dropped out of mental health services or who have previously undiagnosed mental health problems or picking up and treating people in mental health crisis. **(R05)**
- 3.3.5 Mental health support was highlighted as a very important issue for this vulnerable group and in particular the need for flexibility in the way this support is provided was highlighted. The example given was the Improved Access to Psychological Therapies programme which is delivered through a very formal structured programme with a very formal assessment with a lot of required forms to be completed and improvement targets to be measured. This tends to present a lot of barriers for homeless people. SIFA had, at the time of giving evidence, been given funding which enabled them to recruit two part-time psychological wellbeing workers who are able to work in a much more flexible way than would otherwise have been possible.

3.4 Homeless prevention

- 3.4.1 Homeless prevention means providing people with the ways and means to address their housing and other needs to avoid homelessness. The majority of this work tends to be through providing housing aid and advice services which can help those at risk of becoming homeless to retain existing accommodation, for example through debt advice, or by working with landlords to assist people to access private tenancies to prevent homelessness occurring.
- 3.4.2 Unsurprisingly, the demand for services in Birmingham is significant. Over 16,000 households either had their homelessness prevented or made a statutory homeless application to the local authority or one of our funded partners in 2013/14. There was a 40% increase in demand for services since 2011 including a 19% increase from 2012/13-2013/14. Birmingham took 5,500 homeless applications in 2013/14 and out of those homeless households a duty was accepted to 3,100 households. This means that about 60% of those people who make a homeless application actually end up being accepted as homeless.
- 3.4.3 Out of the 2,400 households to whom it was decided that a homeless duty was not owed, 659 received a non-priority decision. For a non-priority household, the local authority has a duty to provide advice and assistance. This duty is discharged through funding Midland Heart to work at



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the Bradford Street Homeless Centre where they see single people over the age of 25, in the 4 Housing Advice Centres and also the Rough Sleeping Outreach Team. In total Midland Heart prevented homelessness for in excess of 3,000 single people last year.

- 3.4.4 In terms of younger people under the age of 21, St Basil's Youth Hub recorded 2,293 homeless preventions in 2013/14 where they prevented young people becoming homeless or secured them accommodation. This would have been either supported accommodation or accommodation through the local authority or through registered providers within the private rented sector. From April 2015 the Youth Hub deals with young people aged 16-25 whereas previously they only dealt with young people up to the age of 21. SIFA Fireside also prevented homelessness for 601 single people last year.
- 3.4.5 In terms of supporting vulnerable people and preventing homelessness, the Supporting People Programme (see paragraph 2.3.4) also plays an important role in supporting people in accommodation who would otherwise have to be placed in bed and breakfast or other forms of temporary accommodation.

3.5 Homeless households in temporary accommodation

- 3.5.1 When a household presents to a local authority as homeless a decision needs to be made about whether the local authority are obliged to help that person to find a home. If there is a legal duty to assist the household local authorities cannot always find them a place to live immediately and may need to place them in temporary accommodation while inquiries are carried out, a decision is made on the homeless application or until settled accommodation can be found.
- 3.5.2 The bulk of households placed in temporary accommodation are in either publicly or privately owned self-contained housing with a smaller proportion accommodated in B&B accommodation. One of the aspects of prioritising homelessness within the Birmingham Health and Wellbeing Strategy has been to bring a renewed focus on improving the way the city deals with temporary accommodation with a view to delivering more suitable temporary accommodation and specifically to reduce the number of individuals, and particularly families, in B&B accommodation.
- 3.5.3 As a result, there has been a reduction in the number of households in B&B accommodation in Birmingham from 180 on 31st March 2014 to 25 households in B&B accommodation in December 2014 when the evidence was taken (See paragraph 2.3.2).



4 Young people and homelessness

4.1 Causes of youth homelessness

4.1.1 The main causes of youth homelessness are parents, relatives and friends no longer willing or able to accommodate young people (69%). The underlying causes contributing to this are overcrowding and previous offending history (28% each), followed by mental health issues (21%). The small numbers of young people who resort to rough sleeping (45 in the last 12 months) tend to be those who do not have access to support networks such as friends and family and find themselves having to stay outside on the streets when they are made homeless. Substance misuse is cited as one amongst several reasons leading to increased tension within a family home, escalating in young people being asked to leave their home; others include issues such as various mental or physical illnesses and young people that have an offending history, (which young people tend to withhold and is therefore under represented).⁸

4.2 Centrally located Young Person's Hub: St Basil's

4.2.1 The Council has particular responsibilities for most 16-17 year olds and 18-21 year old care leavers, or up to 24 if in full-time education who have spent time in care when they were 16 or 17. In recognition of these responsibilities towards vulnerable young people the Council commissioned a Young Person's Hub service which is delivered by St Basil's Housing Association.

4.2.2 St Basil's works with young people aged 16-25 who are homeless or at risk of homelessness across Birmingham, Sandwell, Solihull, Worcestershire, Coventry and surrounding areas. They provide a range of advice and prevention services for young people at risk of homelessness as well as accommodation, engagement and support services to help those who have become homeless to regain the stability they need to rebuild their lives. Where possible they aim to prevent young people from becoming homeless in the first place. They provide services tailored to support young residents to build confidence and access further education, training and employment to help them break the cycle of exclusion and homelessness.

4.2.3 They offer a range of different options, depending on the needs of the young person. These include emergency accommodation options where young people can stay temporarily while a full assessment is carried out. Young people then move on to accommodation they can stay in for up to two years which ranges from fully supported accommodation with staff on site 24/7 to a range of increasingly independent options, depending on the age, vulnerability and needs of the young person. Every young person living with St Basil's is assigned a support worker who holds regular

⁸ St Basil's Youth Hub Service Report April 2012 to March 2013



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one to one meetings with that young person and helps them to move on from the housing crisis which caused them to become homeless and to rebuild their confidence and support networks.

- 4.2.4 St Basil's has been a Psychologically Informed Environment (PIE) since 2011. This means that all staff are trained in psychological skills so they can support young people to develop the practical skills and the emotional and psychological resilience needed to overcome the multiple challenges of being young and homeless and to achieve their potential. Currently the Birmingham and Solihull Mental Health NHS Foundation Trust are partners in St Basil's psychologically informed services. The view expressed by St Basil's was that a similarly targeted approach to providing in-reach access to primary health care is essential in addressing youth homeless health issues in a holistic way. St Basil's would welcome an opportunity to work with primary care services to extend this multi-agency approach to preparing young people for independence and to effectively access mainstream services by providing in-reach access to primary health care.
- 4.2.5 Building skills and finding employment is the most successful route out of homelessness and into independent living. The learning, skills and work service aims to help young people access education, training and employment opportunities and can also help with removing some of the financial barriers to accessing education, training or employment such as travel costs and sourcing clothes for interviews. This includes working intensively with a number of young people who are NEET (Not in Education, Employment or Training) and face multiple barriers to identifying appropriate opportunities which are suited to their skill-set.
- 4.2.6 The success of the work that they do is demonstrated by some of the headline figures highlighted in the 2013/14 Annual Review:
- 4116 young people provided with advice and homeless prevention services via the Youth Hub in Birmingham and the single access points in Solihull, North Worcestershire and Coventry.
 - 1017 vulnerable young people and in some cases their children too, housed in St Basil's supported accommodation.
 - 76% of the young people re-engaged with employment, education and training.
 - 93% of young people established or maintained independent living.

4.3 NHS Young People's GP Charter

- 4.3.1 Young People at St Basil's have developed a Young People's GP Charter which has been presented to Birmingham South Central CCG to encourage its member GP practices to provide services in line with the principles in the Charter.
- 4.3.2 The Charter has seven statements:



- Access – I want to be able to see a GP at a time to suit both of us without needing to take time away from college or training during the day and I want to be able to get to the service by public transport.
- Believe Me – When I go to the GP it is often the last resort. Explain to me how the system works if you are referring me to other services. Don't judge me or make me feel as though I have brought it on myself.
- Publicity – Make sure that information is written in easy to understand language for everyone, explain clearly how we can get the help we need and what will happen when we access services and make sure that confidentiality is explained, including that we can see a GP without a parent or carer.
- Involve young people in monitoring services – I want to be included in patient satisfaction surveys. Have a suggestion box in the surgery so we can have our say and use the Department of Health's quality criteria for young people friendly services.
- Staff – Staff need to make me feel relaxed and supported. They need to see me as a person, not just a set of problems. Staff need to be trained on how to engage with young people.
- Environment – GP surgeries and other NHS buildings should be welcoming. We suggest a water machine, comfy chairs, enough room for buggies and up-to-date information on notice boards.
- Health issues for young people – If I ask for help to improve the quality of my life, refer me to services that can support me with smoking cessation, healthy lifestyles, mental health and emotional support, sexual health and other specialist services. We want to know what to expect before being referred to services.

4.4 Care leavers

- 4.4.1 For all care leavers in Birmingham, there are a number of options in relation to support to find accommodation, dependent on individual circumstances and the needs of individual care leavers. Housing and children's services work together on an established Housing Pathway, within which accommodation is an integral component, through which young care leavers can secure local authority accommodation. There are various alternative options to local authority accommodation, for example, a care leaver may stay with their former foster carer under the 'staying put' arrangement or BCC may seek to secure a suitable adult transition placement for a young person who has complex needs.
- 4.4.2 Care leavers are given priority in the allocations scheme. Once the team are made aware that a young person is leaving care, if their social worker is of the opinion that they need to be living independently the local authority will seek to facilitate their move into local authority or supported



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or private rented accommodation. The local authority work closely with the St Basil's Youth Hub where St Basil's workers and social workers are co-located at the Youth Hub to facilitate dealing with the needs of care leavers in a timely way.

- 4.4.3 The suitability of accommodation is checked by the allocated social worker or personal adviser when undertaking statutory visits to the young person. The quality of the accommodation should also be quality assured by the independent reviewing officer for care leavers aged 16 to 18. There is a housing checklist used by social workers when placing a young person in supported accommodation. In terms of ongoing support, all care leavers are supported until the age of 21 or 24 if in full time education and supporting young people to maintain their accommodation is a key component of this. A number of emergency beds are available to be used where necessary to ensure that unsuitable B&B or other emergency type accommodation is not relied on.
- 4.4.4 In 2013/14 the authority took 193 homeless applications from care leavers. These are not necessarily all young people leaving care at the age of 18. They could be older and have had accommodation where the arrangements have broken down or they could be aged over 21 because the local authority has a duty up to the age of 24 for some young people such as those in further education. Although this is a significant figure, it represents a reduction on the previous year and the figures are showing a steady downward trend over the past few years; 2010/11 343, 2011/12 286, 2012/13 264 and 2013/14 193. The latest figures for 2014/15 up to when the evidence was taken were 105 up to November 2014.
- 4.4.5 In the case of particularly vulnerable young people aged 16-21 or for care leavers St Basil's operate Supported Lodgings schemes where young people lodge with a family in the local community (a Host). This arrangement is sometimes better suited to young people who have no support networks or those that are particularly isolated or vulnerable due to their age or other factors.

4.5 Healthwatch Birmingham

- 4.5.1 A representative from Healthwatch Birmingham spoke to the Inquiry Members about some of the work they have been involved in with homeless young people and highlighted some of the issues raised by young people relating to healthcare services and a healthy lifestyle. These included:
- The importance of supporting families whilst the children are young as a way of preventing homelessness later on.
 - The need for young people to have access to mental health services that are more accessible.
 - Signposting for pre-natal and maternity services.
 - Linking young people into drug and alcohol support services.



- The general need, as also referred to by other witnesses including SIFA Fireside, to take the services out into the community and to where the young people are to venues such as family centres, and churches, mosques and other places of worship.

4.5.2 St Basil's GP Charter which has been developed by young people as a way of setting out to GPs what young people feel they need to help them feel confident and comfortable in accessing GP services (See paragraph 4.3) which looks at all the health issues that young people want to highlight with the NHS was referred to.



5 Homelessness and Rough Sleeping

5.1 The scale of the problem nationally

5.1.1 It is hard to imagine a more extreme form of poverty than sleeping on the streets:

“It’s horrible, it’s bloody horrible sleeping rough. I don’t care how hard people think they are, if you go and sleep rough, I tell you what, it’ll make you scared.”

“When I was sleeping rough I was vulnerable, scared, was spat upon and told I’m a dirty tramp.”

“Sleeping rough was horrible. Waking up with frost over me in the morning.”⁹

5.1.2 In their strategy, ‘Vision to end rough sleeping: No Second Night Out Nationwide’ (2011) the Government called on every local authority area to adopt the strategy and work to end rough sleeping in their area.

5.1.3 Given the shifting populations involved and ‘snapshot’ nature of street counts, any data in relation to rough sleeping tends to be approximate and tends to underestimate the numbers of those affected over a longer time period, but it can give an indication of a trend. However there is evidence nationally of rising numbers of people sleeping in our streets in recent years:

- Snapshots of the number of people sleeping rough on a single night shows a 31% increase from 1,768 in 2010 to 2,309 in 2012
- Over the course of 2012/13, 6,437 people slept rough at some point in London, an increase of 12 % on the previous year’s total of 5,678.
- On average, every day in 2012/13, 12 people started sleeping on streets of London for the first time, an increase from 10 per day in 2011/12.¹⁰

5.1.4 Key points to emerge in relation to England from the fourth annual Homeless Monitor study which provides an independent analysis of the homelessness impacts of recent economic and policy developments showed that:

officially estimated rough sleeper numbers have continued to grow, with the 2013 national total up 37% on its 2010 level. In the last two years however, the annual rate of increase has been more modest at around 5%, though continued

⁹ St Mungo’s No More: Homelessness through the eyes of recent rough sleepers 2013

¹⁰ St Mungo’s No More: Homelessness through the eyes of recent rough sleepers 2013



growth in the more ‘entrenched’ rough sleeping cohorts in London is a matter of particular concern. New restrictions on the Housing Benefit entitlements of European Economic Area migrants from April 2014 may further contribute to rough sleeping amongst Central and Eastern European nationals.¹¹

5.1.5 The only national count of homeless people available is an annual snapshot gathered on one night of the year across the country, where the number of people sleeping rough is counted for the purpose of comparison year on year. The Autumn 2013 count was 2,414 people across England which is 5% up from 2012 and 37% from 2010.¹²

5.2 Factors leading to rough sleeping in Birmingham

5.2.1 Midland Heart presented evidence about some of the reasons for rough sleepers not accessing services by looking at the outcomes of three projects delivered by Midland Heart; Rough Sleepers Outreach Team, Rough Sleeper Personalisation Service and Homeless Hospital Discharge Pilot. Analysis of customers supported by Midland Heart Rough Sleepers Personalisation Service found that:

- 70% of customers who were supported by the service presented complex needs, involving physical and mental health issues and substance misuse.
- 30% of those who were identified as high needs required rapid intervention to manage their health
- 26% of customers were experiencing mental health issues and felt that this was the main contributing factor preventing them from maintaining accommodation.

5.2.2 The Midland Heart evidence also looked at some of the factors leading to homelessness. The main recorded reason for individuals becoming homeless was relationship breakdown. Nearly 60% of the people who attended Midland Heart’s Homeless Service Centre during the period between April 2014 – September 2014 and who needed accommodation stated that they were homeless due to breakdown of a relationship either with their parents or a partner. The most common reasons cited as contributing to the relationship breakdown were offending, income, substance misuse and poor physical and mental health. These findings were supported by evidence presented by West Midlands Police about the reasons why people were sleeping rough. The main reasons they were given were relationship breakdown/family conflict (42%) and lack of social support (38%).

5.2.3 Although in many cases individuals were using substances prior to becoming homeless, people were found to experience a significant increase in their substance use once they were no longer in stable accommodation. The Midland Heart evidence showed that some customers used substances

¹¹ The homelessness Monitor: England 2015 (Crisis)

¹² Department for Communities and Local Government (2014) Rough sleeping statistics England Autumn 2013 Official Statistics



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as a coping mechanism to help them to deal with the traumatic experience of becoming homeless and this pattern is supported by evidence from West Midlands Police who found that from the feedback collected through Operation 'Engage', substance misuse was not cited at all as a cause of sleeping rough. Many of the rough sleepers disclosed that their alcohol intake increased in the winter months as it helps them to feel warm. However this warmth is superficial and can lead to people putting themselves at an increased risk of hypothermia. Midland Heart's Homeless Welfare Services were accessed by 89 clients who were sleeping rough during a nine month period. Alcohol dependency was an issue for 42% of clients whilst 39% had drug related issues.¹³

- 5.2.4 There is other local data which highlights significant causes of homelessness and rough sleeping. 72% of clients at SIFA Fireside were deemed to have complex needs with three or more issues contributing to their circumstances, which included having learning or physical disabilities, mental health issues or a criminal record. Those accessing Midland Heart Welfare Services were also dealing with physical (19%) or learning disabilities (13%). Some were also previous offenders or were at risk of offending (35%).
- 5.2.5 In summary, there are a variety of complex reasons why people may start sleeping rough including relationship breakdown/family conflict, lack of social support, learning or physical disabilities, domestic violence, mental health issues or having a criminal record.

5.3 Numbers of Rough Sleepers in Birmingham

- 5.3.1 The West Midlands Police provided evidence focused on the work undertaken in Birmingham West and Central (BWC) Local Policing Unit (LPU) which is the command unit responsible for policing Birmingham city centre. The evidence was drawn from work carried out under the operational name 'Engage' which was initially an 8 week programme in 2013 which was extended to 6 months in 2014 and from activity reported from the Moseley area of the city focusing on the partnership between SIFA Fireside and the local police team in that area which is contributing to tackling homelessness in that part of the city. The police activity in the city centre focuses on the 'street population' which refers to people who have a 'street lifestyle' such as street drinking or begging. Many people who have a street lifestyle are also rough sleepers but a minority are not.
- 5.3.2 It is difficult to provide absolute figures for the number of people sleeping rough. One reason is that many rough sleepers hide themselves away in places where they are difficult to find in order to protect themselves. This is especially true for women. 44% of current rough sleepers surveyed by Crisis reported that they had not had any contact with a rough sleepers' team in the past month.¹⁴
- 5.3.3 The official estimated number of rough sleepers in Birmingham local authority has increased with 14 in the autumn 2013 count compared to 8 and 7 in the 2012 and 2011 counts respectively.

¹³ Midland Heart Homeless Services Centre: Accommodation Access Team Welfare Service reports Q2,Q3&Q4 (2012/13)

¹⁴ The Homelessness Monitor: England 2013 (Crisis)



Birmingham was officially recognised as an 'Ending Rough Sleeping Champion' in 2010/11 and still compares favourably to other city counts such as Manchester (24 in 2013) and Coventry (26 in 2013). However the police evidence rightly points out that it should be noted that this figure is a snapshot taken on one night and falls well short of the numbers evidenced by local agency reporting:

- SIFA Fireside gave housing advice to 249 rough sleepers and others of no fixed abode and found accommodation for 309 homeless or vulnerably housed clients in 12 months.¹⁵ In one month, 25 sleeping bags were given out to rough sleepers by SIFA and the drop-in centre saw an average of 139 clients each day.¹⁶
- Street Link is a service that enables the public to alert local authorities about rough sleepers in their area. Their data records 187 referrals made for Nechells and Ladywood wards combined in 16 months. Five of the people referred were involved in 'street activity' such as begging or drinking.¹⁷
- Midland Heart Housing Association's Homelessness Prevention Services data shows that in nine months over 220 of the new clients who were referred to them were currently sleeping rough (10% of their total new referrals).¹⁸ Additionally 89 homeless people accessed their Welfare Service in nine months.¹⁹
- St Basil's Youth Hub reports that 45 of the young people (aged 16-21) referred to them in 12 months were already sleeping rough (1% of all referrals)²⁰.

5.4 Outreach: West Midlands Rough Sleeper Project, Midland Heart

5.4.1 Midland Heart operate a West Midlands Rough Sleepers Outreach Team which is often the first point of contact for people sleeping rough. The project works across the local authorities in the West Midlands to identify people who have consistently refused previous offers of services which is helpful in engaging with a transient population. It runs out of Midland Heart's Homeless Centre in Birmingham and offers a range of advice and health support to rough sleepers and other homeless people in the city. The project aims to support an identified group of around 25 long-term rough sleepers in the area and give them an alternative to the usual offer of a direct access hostel, which many had previously refused.

¹⁵ SIFA Fireside Impact Report 2011-2012

¹⁶ Data for Feb 2014 contained in e-mail dated 17/03/14 from Enterprise Manager SIFA Fireside

¹⁷ <http://www.streetlink.org.uk/> between Dec 2012 & Mar 2014

¹⁸ Midland Heart Homelessness Prevention Services Performance Monitoring reports for Q1, Q2 & Q3 2012/13 & 2013/14

¹⁹ Midland Heart Homelessness Prevention Services Performance Monitoring reports for Q1, Q2 & Q4 (2012/13)

²⁰ St Basil's Youth Hub Service Report April 2012 to March



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- 5.4.2 At the time of giving evidence, there were 27 clients using the project, of whom all but two were men. Most (24) were White British and the average age was 46 years. Over half of clients had alcohol issues (18) or mental health issues (17), 11 had drug issues and 17 clients had two or more of these issues. Many clients had also been in prison or had contact with the police, 17 were still sleeping rough, 4 were in hostels or supported accommodation and 2 clients were housed.
- 5.4.3 Referrals to the project come from local authorities, from other services like drug or alcohol treatment or from Street Link, a helpline for members of the public to alert services to rough sleepers in their area. Clients are allocated to a project worker who works with them to move them off the street. This involves building a trusting relationship and getting to know clients, before starting to talk to them about what would help them to move into accommodation. Project workers have considerable freedom to support clients as needed and offer a high degree of support to help individual rough sleepers address their issues and move into secure accommodation. The project also allocates a personal budget for each client to help them move away from sleeping rough.
- 5.4.4 Staff, who have the skills and knowledge of services to meaningfully advise and support people, carry out an initial assessment with individuals to establish their risk and needs. This would cover needs connected to substance use, housing, mental health, sexual health and domestic violence. Staff are then able to take customers through the treatment options available and support them to access GP services, counselling etc. If external agency support is required, staff can arrange joint outreach with partner agencies as appropriate. Several of the project staff are peer support workers who have experienced homelessness themselves and who were recruited as a way of helping clients to engage more effectively.
- 5.4.5 The project had only been running for a few months with most clients at the time the evidence was given but staff did describe positive outcomes for some clients including accessing appropriate healthcare, moving into residential care, securing a council tenancy and re-building relationships with family members.

5.5 Other unmet needs of rough sleepers

- 5.5.1 The evidence suggests that people who sleep rough are in an especially disadvantaged position. People sleeping rough are more likely than the general population to suffer from mental and physical ill health. The rate of tuberculosis among rough sleepers and hostel residents is 200 times that of the known rate among the general population and people who sleep rough are 35 times more likely to commit suicide than the general population. They are likely to present a high level of health needs and at the same time are not accessing health services for a number of reasons which exacerbates their vulnerability and level of exclusion.
- 5.5.2 Health needs are not the only unmet needs which were highlighted when Inquiry members spoke to a group of rough sleepers. Members were told that frequently rough sleepers are not claiming benefits to which they would be entitled because of some of the difficulties they face in claiming or



in maintaining benefit claims. Claims now need to be made online and this presents a barrier for people in circumstances with no access to a computer where they can process a claim. There are computer terminals available in the library but these are not always available and although there are computers in Jobcentres, access to these computers need to be booked in advance. Members were told that people may have to wait a week to get access and then it takes 7-14 days to process the claim. This obviously causes huge difficulties for homeless people who may be living a chaotic lifestyle where their main concern is where their next meal is coming from and where they are going to sleep tonight so that making and keeping an appointment to access a computer to make a benefit claim may come fairly low on their list of priorities. This links to a slightly different but related issue for homeless people being released from prison which is set out in the evidence in paragraph 6.3.3 and R08 about the need to work better with prisons to improve the connection between prison healthcare and other services and the services in the community when prisoners are released from prison. This was also highlighted by the group of rough sleepers who gave evidence to the Inquiry who spoke about the difficulties of linking back into community services and in particular about the difficulties in making benefit claims when a homeless person has been released from prison. It was suggested that it would be relatively easy to address this before a prisoner is released from prison if someone with a laptop could go into the prison before release and set up the claim online before the homeless person is released from prison. **(R06)**

- 5.5.3 This is part of a wider issue which needs to be addressed which was also raised during the discussion with members which is the lack of access to somewhere in the city centre that homeless people can go for advice and support. The homeless offices are some way from the city centre and they do not all open five days a week. Significant numbers of homeless people turn up at the reception desk in the Council House and then have to be sent to whichever office is open on that day and they have to make an appointment if one is available. Often they do not have the bus fare to get there and if they do manage to get there and are turned away, they do not have the bus fare to get back to the place where they live. There needs to be a location in the city centre where homeless people can go for advice and support with accommodation, benefits and referrals to healthcare services. Many of the services are already there for homeless people but they need to be working together and engaging with service users and building relationships with service users and a central point of contact in the city centre would be a helpful start to this process. There needs to be a location in the city centre, such as for example the Homeless Health Exchange which is based in the William Booth Centre, but it could be somewhere else in the city centre, where homeless people can go to get advice and support on accommodation, claiming benefits and health services. **(R01)**
- 5.5.4 As part of the discussion, there was also a feeling expressed that currently there is no direct channel of communication for people sleeping rough in the city to raise problems or issues encountered by them. The city council need to explore the best way to provide a means of communication, for example this could potentially involve advice surgeries in the city centre or



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other suitable means, to enable people sleeping rough who have issues that they wish to raise to be heard. **(R08)**



6 Joint working

6.1 West Midlands Police

- 6.1.1 Much of the evidence provided by West Midlands Police to the Inquiry focused on the work of the command unit responsible for policing Birmingham city centre based on feedback from Operation 'Engage'. The work carried out under the operational name 'Engage' was initially an 8 week programme in 2013 which was extended to six months in 2014 and is based on police activity driven through the local community concerns in relation to begging and homelessness. Much of this evidence has contributed to and been incorporated into section 5 on homelessness and rough sleeping.
- 6.1.2 Concern about begging is a main source of complaints to the police from the business community and has been identified as the top anti-social behaviour issue for the city centre. However the police data tends not to support the hypothesis that people beg because they are homeless or have no settled accommodation. The data shows that whilst force wide begging offences are concentrated in the city centre police unit and that this proportion has increased significantly between 2012 and 2013, the majority of people who were arrested for begging were not in fact homeless: over the three years 2011 to 2013 between 70 and 90 per cent of beggars did have a home address.²¹ In contrast, Arrest Referral Workers' surveys conducted for Operation Engage suggested that 41% of beggars in the city centre were also sleeping rough. However, anecdotal evidence from the Council's Safer Communities Team supports the arrest data findings and suggests that most of the high risk aggressive beggars do have access to accommodation and that some have settled accommodation.
- 6.1.3 The police evidence said that substance misuse and addiction, primarily to drugs, is the main driver for people begging in the city centre. However, whilst it is true that many rough sleepers are addicted to drugs and alcohol, they do not consider this to be a significant factor in causing their homelessness. Rough sleepers and homeless people cite a variety of complex issues as causing their circumstances, primarily family breakdown and lack of social support, which suggests that substance misuse is a consequence rather than a cause of becoming homeless.
- 6.1.4 The work has highlighted the complex nature of the issues which cause homelessness and rough sleeping but there have also been a number of positive outcomes from the referrals made under Operation 'Engage' which illustrate the complex issues faced by homeless people and the difference that can be made to their lives by effective joint working.

²¹ West Midlands Police Drug Intervention Programme tests analysis



Good Practice Case Study

Male G is a long term rough sleeper in the city centre. He funded his heroin addiction through begging around the city centre. G was one of the most prolific beggars in the city centre. Among other issues, G needed assistance with the following; accommodation, registering with a GP surgery in order to obtain methadone prescriptions and obtaining his benefits. Sorting out these basic requirements is especially complex given the 'chaotic' lifestyles of some of those referred. Initially, G was extremely sceptical of the help offered, however with some persuasion by officers, he was taken in person to his first Swanswell's appointment.

Since his original referral in June this year, G has engaged well and attended regular appointments with both Swanswell and then also Midland Heart (who have assisted him with accommodation). As a result of Operation Engage, G has been registered with a local GP surgery away from the city centre and is now on a daily 80ml methadone prescription. Together with these regular prescriptions, G has also received assistance in relation to his ESA benefits, and subsequently G no longer has any need to continue to beg and is currently in the process of being transferred to shared care as he has stabilised well on his methadone prescription.

6.2 West Midlands Fire Service

- 6.2.1 The Inquiry heard evidence about the work that happens within the Fire Service on community risk reduction. The Fire Service has a number of specially trained Vulnerable People Officers who work to build relationships with the most vulnerable people, many of whom may be living in squats in the city centre and in places such as Paradise Forum and at high risk, and can open doors for a range of other partner agencies such as Midlands Heart, SIFA Fireside and others, by signposting them to services that are available through other agencies and targeting resources where they are most needed to keep people safe. The West Midlands Fire Service visit squats primarily to provide fire safety information in the first instance and they provide wind-up torches to discourage the use of candles which is an obvious fire risk and they also fit smoke alarms. At the same time they are also talking to and getting to know the homeless people they are helping and will leave leaflets signposting them to other services. They no longer close squats down unless the building is deemed to be dangerous as the prevailing view is that the interaction and engagement and chance to build trust with the individuals concerned would be lost if the squat was closed and they were forced to move to another derelict building.
- 6.2.2 The opportunity to build on the knowledge gleaned and relationships built by the work of the Fire Service in facilitating and enabling other agencies to take a more joined up approach to identifying



the location of where people are living in squats and working together to find a more permanent outcome and to make sure that their health and other needs are met is an important opportunity that needs to be used to maximum advantage. Clearly much excellent work is already being done in this area. Members were told that there is already at least one multi-agency working group in existence which works in the city centre that includes a range of agencies including Drugline, the West Midlands Police, the Salvation Army, SIFA Fireside, Midlands Heart and others. There is an opportunity to build on the work of this group and to find out whether there may be other groups already doing similar work and to develop this further to ensure that all opportunities for joint working are maximised wherever possible to strengthen multi agency working further and to ensure better outcomes for homeless people. A review needs to be carried out of what groups are already operating in this area and whether they are working together effectively, for example there may be more opportunities to include public health in this work to strengthen partnership working to ensure that more health needs are met. **(R03)**

- 6.2.3 Members also asked questions about the situation where it becomes known that redevelopment or regeneration of an area where there may be people sleeping rough is being planned. There was general support for the idea that it would be useful to review the existing city centre protocol to ensure that the agencies involved in the StreetLink multi-agency working group in the city centre are aware in advance of major regeneration work starting. This would provide an opportunity to work with rough sleepers in an area in advance of any redevelopment starting. **(R03)**

6.3 HM Prison Birmingham

No fixed abode (NFA) is the formal term used to identify homeless prisoners. In 2012 the Ministry of Justice found that 15 per cent of people in prison were homeless prior to custody, which represents nearly 13,000 people. This is possibly an underestimate as in 2002, a report by the Social Exclusion Unit found that 32 per cent of all prisoners were 'not living in permanent accommodation prior to imprisonment' (p21). A third of people leaving prison say they have nowhere to go (Centre for Social Justice, 2010). Including those on remand, this could represent up to 50,000 people annually (Ministry of Justice, 2013a, 2013b). The large portion of people in prison with no permanent accommodation prior to and post imprisonment, begs the question: where do homeless people in the criminal justice system go when they are not detained in custody?²²

²² The Howard League for Penal reform 'No Fixed Abode'



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- 6.3.1 When homeless people enter Birmingham prison they have access to a range of healthcare facilities including mental health services, substance misuse services and primary care services including GPs, general nurses, dental care, chiropody, optician, physiotherapy, smoking cessation and sexual health clinics. All prisoners receive an initial health screening which covers both physical and mental health issues. If any further intervention is required then the appropriate referrals are made within the service to ensure that people gain access to the services they require. Homeless people are considered to be high risk for TB and are routinely screened on reception into the prison.
- 6.3.2 The written evidence submitted to the Inquiry by the Head of Healthcare at HMP Birmingham reinforced some of the issues already raised by other witnesses in relation to homeless people who may have lost contact with services entering prison with untreated mental health issues. This often links, not just with physical and mental health issues, but often with offending behaviour and with the high prevalence of substance misuse amongst homeless people which is often related to coping strategies for underlying mental health issues or underlying distressing life events such as sexual abuse, domestic violence and relationship breakdown which can leave them very isolated.
- 6.3.3 Some of the Inquiry members were taken to some sites near the city centre which are often frequented by rough sleepers and also met with and listened to a small group of rough sleepers who agreed to meet with the Inquiry members in the Council House. The evidence provided by the prison further reinforced an issue which was raised by the group of rough sleepers who spoke to members of the Inquiry about the need for more joined up working and improved pathways between the prison service and the general community in order to be able to provide better support for homeless people on release from prison. When people are homeless one of the difficulties on release from prison is linking people back to appropriate healthcare services and appropriate accommodation that will be able to meet their needs and provide appropriate support especially for people with drugs and/or alcohol problems when released from prison. A 'Forum' or some other means of linking homeless prisoners back into services and support in the community, needs to be developed between HMP Birmingham and the local authority with a view to supporting prisoners into housing and other services in the community both before and after release and to link prisoners into appropriate healthcare services, in particular where prisoners are known to have drug or alcohol problems. **(R06)**
- 6.3.4 The provision of more appropriate accommodation on release from prison is a key area in terms of stabilising people who are homeless and in trying to reintegrate people back into a lifestyle that provides them with motivation to change and work towards their goals in life. Members were told that Birmingham has signed up to the West Midlands Resettlement Protocol whereby referrals come through the Pathways Team which should start to help to address this issue but clearly there is more work to be done regarding the provision of accommodation for prisoners being released. **(R06)**



- 6.3.5 One of the particular issues highlighted in the evidence from the prison was the vulnerability of homeless women to being exploited on release from prison by drug dealers who may end up forced into prostitution and a never ending cycle of ongoing debt. Women who are released from prison who may become homeless are a vulnerable group highlighted by both the evidence from HM Prison Birmingham and by the Director of Public Health. There is some excellent work that is already happening to help women on release from prison and the work being done by Anawim Women's Centre was cited in terms of good practice. **(R06)**

Good Practice The work done by The Anawim Women's Centre in Balsall Health with women released from prison who may become homeless was highlighted. The centre undertakes prison in-reach to the three main prisons which accommodate women from the Birmingham area. These are HMP Foston Hall, HMP Drake Hall and HMP Eastwood Park. They visit each prison every three weeks and during the visits they support women leading up to their release, helping them to prepare for life in the community and to ensure that on release they have a network of support ready for them in the community and are re-connected with family members. They also deliver a community sentence programme as an alternative to going to prison. Anawim places emphasis not only on ensuring that all clients are supported towards finding accommodation that meets their needs, but also on supporting clients so that they are able to sustain their accommodation in the longer term. One source of support is referral to outside agencies who attend the centre. A member of staff from the Sparkbrook Neighbourhood Office and SIFA Resettlement attend each week offering appointments and follow-up work. As part of this work Anawim have a partnership agreement with Midland Heart called the Re-Unite programme whereby Midland Heart have undertaken to offer up to 40 suitable properties a year on a priority letting scheme to women on release from prison so that they can be re-united with their children with support from Anawim.



7 Healthcare needs amongst homeless

7.1 Homelessness and physical health

- 7.1.1 As previously stated in this report, being homeless can have a huge impact on a person's health and homeless people face inequalities in accessing health services. In addition people who are homeless or living in poor quality temporary accommodation can often suffer worse health than those living in settled accommodation due to their physical surroundings. Poor health, whether mental or physical or both, can also be a contributing factor to a person becoming homeless in the first place.
- 7.1.2 The 2014 Homeless Link Needs Audit found that 73% of homeless people reported a physical health problem. In total, 41% of those surveyed reported a long term problem, compared with 28% of the general population who report a long term physical health condition.²³
- 7.1.3 Some of the most common conditions which occur in homeless patients presenting in primary care were described in the evidence from the Homeless Health Exchange (see paragraph 8.3). Homeless people experience significantly higher rates of physical health problems such as respiratory and circulatory problems especially chronic obstructive pulmonary disease, bronchitis, pneumonia and lung infections, skin problems and musculoskeletal problems than the general population. Physical health problems in homeless people are two to three times greater than the general population. The resulting healthcare needs are often far more complex than the average patient accessing primary care due to the need to address multiple chronic illnesses and diseases which may have gone untreated for a number of years.
- 7.1.4 These are in addition to infectious diseases such as tuberculosis (TB), sexually transmitted infections, blood borne viruses such as hepatitis C and HIV, vascular problems such as deep vein thrombosis and ulcers, cardiovascular disease, bad feet, minor illness, dental problems and all the normal chronic diseases.
- 7.1.5 The Director of Public Health referred to the fact that there is a particular niche issue around tuberculosis and homelessness. The rate of tuberculosis among rough sleepers and hostel residents is 200 times that of the known rate among the general population. The evidence shows that over 90% of TB patients complete their treatment but out of the remaining 5 or 6% who don't complete their treatment many of those are homeless. Treatment completion is important because if they don't complete their treatment they risk getting 'multiple drug resistance' (MDR) and once they are MDR positive, they will basically die with TB. There is no treatment and they risk passing on MDR resistant TB to other people. This is just one example on a very practical level of why tackling homelessness is important.

²³ Homeless Link (2014) The unhealthy state of homelessness: health audit results 2014



7.2 Homelessness and substance and alcohol misuse

- 7.2.1 Alcohol is often a contributing factor to becoming homeless. However problems can also develop after becoming homeless. It is not uncommon for alcohol and drug addiction to develop as a means of coping with the difficulties associated with homelessness.
- 7.2.2 The effects of drug and alcohol use have an extremely detrimental effect on the physical health of homeless people. It causes early alcoholic liver disease and is often also associated with Hepatitis C, both of which often result in severe liver disease and early death. Homeless people with alcohol dependency are 28 times more likely to have an emergency admission to hospital than the general public.²⁴
- 7.2.3 However it also affects the brain and causes brain damage and results in early onset dementia. The Homeless Health Exchange encourages engagement with services, provides proactive, multidisciplinary care, provide regular physical health checks (blood tests etc), prescribe high doses of vitamins and thiamine, attend to other factors such as smoking, provide regular support from alcohol nurses and can organise admission for detox or rehab.
- 7.2.4 Drugs are also a common problem and injecting drugs carries associated risks including hepatitis C, HIV, abscesses, DVT, chronic leg ulcers and endocarditis. Death from overdose is more common when people have lost their tolerance by being in prison or after coming out of rehabilitation but it can be prevented by the use of naloxone which is the drug that reverses the effects of opiates.
- 7.2.5 Legal highs are an increasing problem. In spite of changes in the law to try to ban them the manufacturers are constantly one step ahead. They usually contain mephedrone or synthetic cannabinoids, amphetamines or cocaine and appear to be causing a risk of drug induced psychosis similar to that caused by super strong cannabis. The government has recently announced that it intends to bring in new legislation under the Psychoactive Substances Bill which will introduce a blanket ban on so-called legal highs and make it an offence to produce, supply, offer to supply, possess, import or export psychoactive substances.

7.3 Homelessness and mental wellbeing

- 7.3.1 Homelessness increases the risk of mental health problems - research from the Queens Nursing Institute was quoted in evidence which shows that for 33% of homeless cases, the first episode of mental ill health occurs whilst homeless - but having a mental health problem makes you much more likely to become homeless in the first place. In other words poor mental health is both a cause and a consequence of homelessness and the connection between the two is complicated. There are also complex associations with issues such as childhood trauma, drug and alcohol misuse, domestic abuse, violence, neglect and relationship breakdown.

²⁴ Data from Central London CCG 2011



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7.3.2 Mental ill health is far more prevalent amongst the homeless population than amongst the general population.

- Homeless Link's Health Needs Audit found that 80% of those surveyed had some sort of mental health problem, with 45% having a mental health diagnosis compared to 25% among the general population.²⁵
- West Midlands Police evidence was that 76% of the individuals who were in custody for begging offences during the eight weeks of Operation Engage declared that they had a mental health issue. This is similar to levels amongst the prison population where 70% have two or more mental health issues.
- SIFA Fireside Drop-in Centre's 'snapshot study' found that 48% of their respondents said that they had a mental health issue.²⁶

7.3.3 The prevalence of common mental health problems like depression is over twice as high amongst the homeless and the prevalence of psychosis is up to 15 times higher among the homeless population compared to the general population. This is even worse if you are a street homeless person, who are probably up to 100 times more likely to have or to have had a serious mental illness such as a psychotic disorder or schizophrenia than the general population. One third of people with schizophrenia experience homelessness in their lifetime. Overall research shows that as the stability of housing increases then rates of serious mental illness decreases.

7.3.4 In relation to Birmingham, the evidence presented to the members by Birmingham and Solihull Mental Health NHS Foundation Trust said that within their own homeless mental health service, they had noted a 39% increase in patient numbers over the last two years, with a 29% increase of service users with a serious and enduring mental health diagnosis. Overall the mental health team have seen an increase in psychotic disorders and those with dual diagnosis and a reduction in common mental health problems.

7.3.5 Personality disorder rates are also high. Members were told that two thirds of homeless people could be considered to have a personality disorder which can result in self destructive behaviour which can make it quite difficult and challenging to help a person who sometimes may not want to be helped. The evidence from the Homeless Health Exchange was that there are long waiting lists and that it is very difficult to get people into personality disorder services. In addition people who have personality disorders often engage well with services and often don't attend appointments or comply with treatment.

7.3.6 In relation to homelessness and mental wellbeing, Members visited the hostel at the William Booth Centre, which is run by the Salvation Army and receives funding from Supporting People, during which mental health was highlighted as a major issue. Since December 2014, all clients are referred to the centre through the BCC Gateway Service and are only allowed to live on the

²⁵ Homeless Link (2014) The unhealthy state of homelessness: health audit results 2014

²⁶ SIFA Fireside Complex Needs Snapshot Studies – survey conducted in the drop-in centre



premises for a maximum of three months. Members were told that in the last year, 94% of clients were found accommodation at the end of their three month stay and 87% have maintained their tenancy. Their evidence highlighted a particular issue they have encountered relating to their ability to access emergency or out of hours specialist mental health homeless services which can cause difficulties in obtaining a mental health assessment for homeless service users.

7.4 People with a dual diagnosis

- 7.4.1 Serious mental illness is often accompanied by alcohol and/or by substance misuse problems with the result that dual diagnosis is common amongst homeless people ie people who have a mental health problem and an addiction. Most studies suggest that around 10-20% of the homeless population would fulfil the criteria for dual diagnosis and they are nearly 5 times more likely to die than the equivalent age group in the general population.
- 7.4.2 There is a particular lack of support for people with a dual diagnosis of mental health and substance misuse. Many mental health services exclude those who are currently using drugs or alcohol. However, often people need to deal with their mental health problems in order to tackle their drug or alcohol use. If someone is drinking a large amount of alcohol it is difficult to know what is alcohol related and what is mental health related. If someone has mental ill health then they are very much less likely to be in a position to be able to stop drinking.
- 7.4.3 There is another group of patients with a different type of dual diagnosis, who have an alcohol addiction and who also suffer from dementia, for whom there is very limited access to services at the moment. This is because dementia services won't take people under a certain age and the younger people's dementia services won't take people that are drinking. An example of good practice in relation to commissioning services is the recently re-commissioned public health substance misuse services where the ring-fence on drug budget and alcohol budget has disappeared and drug and alcohol services have been re-commissioned. Should we be looking at commissioning specialist dual teams to deal with people with a dual diagnosis of mental health and substance misuse issues? **(R04)**

7.5 Difficulty accessing dental services

- 7.5.1 People who are homeless have difficulty accessing dental services, even though they often have poorer dental health than the general population and therefore have a high treatment need. When appointments are made they have poor attendance rates. This poor access was highlighted in the Birmingham Homeless Health Needs Audit where only 60% of respondents were registered with a dentist, with the over 25 age group less likely to have registered with a dentist.
- 7.5.2 This is also supported by the evidence provided by Birmingham Community Healthcare NHS Trust which provided evidence about some of the reasons for poor access to dental services by this group. Poor access to care can be a result of a lack of perceived need for dental care and



knowledge of how to access dental services, possible negative attitudes of some dental staff and high levels of client dental anxiety. Neglect of their general health and personal hygiene, in addition to heavy smoking and drinking, makes homeless people high risk for many diseases including cancer.

- 7.5.3 There is a need to provide dental services specifically aimed at this group that are easy to access in a non-threatening environment. Delivering a drop-in dental service allows contact with this hard to reach group.

7.6 Dental Drop-in Service for Homeless in Birmingham

- 7.6.1 A dedicated dental drop-in service for people who are homeless in Birmingham opened in September 2012. It provides a dedicated service where homeless people can just drop-in, in a convenient city centre location, integrated with other health and social services and providing a combination of fixed site and outreach services.
- 7.6.2 Birmingham Community Healthcare Trust Special Care Dentistry Team provide this NHS dental service at Attwood Green Health Centre. This provides an NHS dental service on Thursday afternoon between 1.15 and 4pm on a drop-in basis, on a first come first served basis. They provide check-ups, X-rays, fillings, scale and polish, extractions, dentures and emergency treatment for toothache or swelling. They are highly experienced in providing care for people with complex health problems, mental health problems, learning and other disabilities and social impairment/exclusion including alcohol and substance misuse and homelessness.
- 7.6.3 Outreach services are also required to provide preventative advice, screening for oral cancer and information on accessing dental services for more comprehensive care and so highlighting the importance of good oral health to a client group who are at high risk of oral disease.



8 Medical care for the homeless: Primary care

8.1 Access to Primary Care Services

- 8.1.1 GPs are the primary point of access to health services. One of the striking issues highlighted in the Homeless Health Needs Audit is the fact that only 75% of those responding were registered with a GP. People who are homeless frequently struggle to access health services and are 40 times more likely not to be registered with a GP and are 4 times more likely to use an A&E department than the general population. The evidence given by Birmingham and Solihull Mental Health NHS Foundation Trust was that less than a third of the mental health service patients they deal with are accessing other homeless healthcare services and there is an increasing trend in patients that are not registered with any GP at the time of assessment.
- 8.1.2 There are many barriers which prevent homeless people from being able to access primary care services. Priorities are understandably different for people who are trying to survive without a permanent home or on the streets. They may often 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 and GP surgeries don't necessarily make it easy for people to register without a fixed address. Some do, but there is huge variation. If GP surgeries ask a homeless person for a utility bill or proof of their name which they cannot provide the result is often that they cannot register. Members were told that the Homeless Health Exchange Primary Care Service register people care of the surgery and sometimes use organisations such as SIFA Fireside, one of the day centres or the Homeless Service Centre in order to get homeless people registered with a GP. More work is needed to ensure that every homeless person can register with a GP. **(R02)**
- 8.1.3 However making it easier for homeless people to be able to register with a GP is only the start of what needs to be done. Even if homeless people do manage to become registered with a GP, they don't necessarily keep appointments which leads to problems with health services and statutory services in general. If they do not turn up for appointments they will often be discharged as not engaging. This is part of a wider issue in relation to engagement of homeless people with services whereby they may frequently be banned from using or discharged from services for not complying with rules or for behaviour which is deemed to be unacceptable. Services generally need to be as flexible and tolerant as possible when dealing with homeless people and awareness training for front line staff dealing with homeless people can help staff to better understand how to deal with some of the behaviours which may be encountered by services engaging with homeless people.



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- 8.1.4 The relationship that a person builds with their GP is important and once someone has registered with a GP they should be able to remain on that list and stay with that GP with whom they have built a relationship even if they move out of that area, especially if they are vulnerable because they become homeless. This would enable that GP to ensure that other services are contacted and alerted and brought in to support the homeless person, even if they have moved away from the area and the GP may not be able to visit personally. It would provide valuable continuity to provide greater protection for this vulnerable group. **(R02)**
- 8.1.5 A much better solution to providing services for homeless people would seem to be to take services to where the people are, along the lines of what happens at SIFA Fireside, rather than placing services where different providers are at various locations across the city. SIFA see around 130 people every day at their open access drop in where various services can work alongside SIFA staff. For example, the Homeless Mental Health Team work alongside SIFA staff at the SIFA premises once a week to do a formal mental health triage clinic. This tends to be a more successful way of picking up people who have dropped out of services or in the case of mental health services, provides an opportunity to spot people with undiagnosed mental health issues or to spot people in mental health crisis. **(R05)**
- 8.1.6 Developing and improving access to primary care services for homeless people in this way and facilitating registration of homeless people with GP services are both important steps towards making access to primary care services easier and more accessible for homeless people. Improving access to primary care services is also the first step in ensuring that health problems get treated at an earlier stage to avoid homeless people presenting at primary health services at a late stage with multiple and entrenched problems. This will also help in avoiding the delay which causes problems to become more serious until they become critical and are therefore likely to require more intensive and more expensive treatment leading to a disproportionate reliance on emergency and acute services and avoidable emergency admissions to hospital.

Good Practice Case Study – Inclusion Healthcare Social Enterprise CIC, Leicester

Inclusion Healthcare is a specialist GP practice for homeless people in Leicester. It is run as a social enterprise based at a city centre venue, close to public transport. It has around 1000 patients registered with a turnover of 50-70% per year. Translation services are available for those patients who do not have English as a first language.

The clinical team is led by a GP and consists of a consultant nurse, three female and one male part time GPs, two practice nurses, a primary care plus (PCP) nurse, specialist alcohol worker and a healthcare worker. Patients with poor mental health have access to a dual trained GP and psychiatrist and the practice has an Improving Access to Psychological Therapies (IAPT) therapist who works with clients who have a range of complex problems related to anxiety and depression.

The practice operates flexibly and offers longer appointments for patients with complex needs. When a patient does not attend the practice contacts other agencies to ensure that the patient is safe.



All patients with a long term condition have a named GP and the practice carries out annual reviews for long term conditions such as diabetes or heart failure. GPs also offer smoking cessation advice, NHS Health Checks to all patients aged 40-75 years old and chlamydia screening to patients aged 18-25.

Due to the complex nature of the physical and psychological problems of homeless patients referral rates to hospital and 'do not attend' (DNA) rates were high. To reduce the DNA rate the practice put in place a system where a healthcare assistant attends with the patient, to act as an advocate if necessary and the healthcare assistant reminds the patient about the appointment; accompanies them and, if requested, will be with them in the consultation room.

The practice is commissioned to provide an enhanced level of service provision above what is normally required under the core GP contract and has a process in place to follow up patients discharged from hospital. The PCP nurse works as the interface between primary and secondary care and other agencies such as social care. She provides a link for patients and ensures a safe admission and discharge for the patient which helps to reduce inappropriate attendance at the hospital's emergency and urgent care departments.

The two GPs who work at the practice also go into the local prison three times a week during the day and also provide out of hours care for substance misuse patients. They also carry out two sessions of substance misuse in the community drug treatment team. Some patients go between prison and the practice's care so the practice provides an integrated system which includes developing yearly care plans.

8.2 Primary Care Services for the homeless in Birmingham

8.2.1 There are excellent examples of specialist primary care provision in the city which illustrate some common themes in providing appropriate primary care to homeless people. A flexible approach needs to be taken to working and engaging with people who are homeless because of the multiple and complex health needs which need to be dealt with. This would include making patients feel welcome, taking a non-judgmental approach, offering a variety of appointments with a mix of drop-in and scheduled appointments. Longer than average appointments are needed to allow time to investigate and respond to a range of complex and multiple health needs. Providing services in a range of settings where homeless people are, such as homeless centres and offering a range of assertive outreach support which actively tries to engage rough sleepers. Also because patients often find that they can't comply with the multiple appointments needed to treat each of the problems at once, a better approach is often to triage conditions and address health needs through a structured health programme over time.



8.3 The Homeless Health Exchange Primary Care Service

- 8.3.1 The Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT) are commissioned by the Joint Commissioning Team to provide a primary care and a mental health service to the homeless people of Birmingham. The Homeless Health Exchange Primary Care Service is a GP surgery for the homeless based at William Booth Centre in the city centre which provides a specialist GP service for homeless adults over the age of 18. Patients are fully registered and the surgery is open Monday to Friday between 9 and 5. They are staffed by three part time GPs, two practice/community nurses, three alcohol nurses, one CPN, two counsellors/psychotherapists and two administrators/receptionists.
- 8.3.2 The Community Mental Health Team does have 24 hour 7 days a week provision of mental health services for homeless people available through their universal crisis provision. The evidence from BSMHFT was that unfortunately they are not currently commissioned to provide an emergency or out of hours specialist homeless primary care service for the city. This means that the default position for homeless service users would be to attend a walk in centre or A&E. **(RO7)**
- 8.3.3 The practice is specifically for homeless people and differs from a standard GP practice in a number of ways. The criteria for access to the service would be someone who is of no fixed abode, sofa surfing, living in temporary accommodation or a hostel. The service has open access which means that service users can self-refer and drop in appointments are available.
- 8.3.4 A normal GP practice would have a relatively stable population of approximately 1800 patients per GP with an equal male and female patient mix but with females and children attending more often than males. By contrast, the Exchange has about 850 patients but with a high turnover of about 50% per year and the male to female ratio is about 90% male to 10% female with no children registered and very few patients over the age of 60 years of age.
- 8.3.5 The services offered include GP appointments and consultation, generic primary care nursing provided by practice nurses, specialist prescribing for minor illnesses and chronic disease, community nursing delivered on an outreach basis. A number of specialist services are also offered including blood borne virus and sexual health screening, women's health services, chronic disease management, wound management, smoking cessation and supply and training in the use of Naloxone for high risk drug users. There are specialist alcohol nurses who provide harm reduction advice, management and interventions for dependant drinkers and those with chronic physical health disease related to their alcohol misuse, and they also undertake preparation work with service users to support an inpatient detoxification programme in consultation with substance misuse providers. They also do outreach work, for example, at SIFA Fireside.
- 8.3.6 There is also provision of a primary care community psychiatric nurse and two counsellors who provide psychological therapies. Service users also have access to podiatry by way of a weekly screening clinic and limited dental care by means of specialist support once a month with onward referral to community dental services as required.



8.3.7 The evidence presented to the committee on behalf of the Exchange was that many of the homeless people they see are likely to have been in care as a child or had a disturbed childhood. A high proportion have some form of mental illness or addiction or have been in the armed forces. A very high proportion have spent some time in prison, often multiple times and an increasing proportion have migrated to this country from Eastern Central Europe or arrived as asylum seekers. This often results in patients presenting in crisis with multiple, severe problems, high levels of morbidity and a lack of engagement with medical care. Many of the patients seen and treated at the Exchange would otherwise be in secondary care.

8.4 The Homelessness Community Mental Health Service

8.4.1 This service is based at the Matthew Centre in Nechells and provides a city wide service between 9 and 5 Monday to Friday. Out of hours access to services is via the trusts' wider home treatment services. The criteria for access mirrors the criteria for access to the primary care service except that this service is for adults over the age of 18.

8.4.2 The service offers community psychiatric support, medication and psychiatric nursing care to service users requiring clinical management by a consultant psychiatrist. The service provides physical health monitoring for service users in receipt of psychiatric medication, assessment and management of complex psychological and social needs, psycho-social interventions and relapse prevention and care planning.

8.4.3 Referral to the service is via the trusts single point of access telephone triage service and from other trust services including those working within A&E departments. The service also liaises and takes referrals directly from other statutory services such as prisons, probation, addiction and forensic services.

8.5 The Homeless Service Centre

8.5.1 Midland Heart deliver a walk in service for individuals who are homeless or at risk of homelessness. A number of initiatives within the Homeless Service Centre address health needs:

8.5.2 Prescribing clinic for homeless customers – Whilst assessing customers housing needs it became apparent that some people could not access accommodation due to their substance use. To address this a prescribing clinic was arranged and GP and substance misuse agency staff are available on site to assess, provide advice as well as carry out drug screening and to prescribe medication.

8.5.3 Regular surgeries for customers not in accommodation who need specialist services such as chiropody and a hot shower and laundry facilities are also provided.



Homeless Health

- 8.5.4 By accessing these health services within a less traditional setting people can get information about support available to them in an informal way and agencies can build trusting relationships with customers.



9 Medical Care for the homeless: Secondary care

9.1 Inappropriate admission to hospital

9.1.1 Homeless people are much more likely than the general population to attend A&E and are often less likely to stay around in the hospital once they have had their medical checks to make sure any appropriate care plan follow up support is provided. Members heard of an example of one homeless person who attended 4 different A&E departments in 4 different cities within 24 hours.

9.1.2 The evidence from Midland Heart estimated that homeless people attend A&E six times more often than people in stable accommodation; are admitted to hospital four times more often and stay in hospital three times longer. This can obviously lead to a disproportionate use of emergency and acute health services and paints a troubling picture of society's most vulnerable individuals stuck in a damaging cycle of homelessness, poor health and hospital admission.

9.1.3 A number of issues for homeless people accessing hospital treatment were identified during the Homeless Hospital Discharge Pilot:

- It was found that in the majority of cases, homeless individuals were discharged from hospital without a discharge summary, care plan or risk assessment. This created delays in assessing housing and support needs.
- Previously, front line medical staff had to spend time trying to arrange accommodation for homeless patients to enable discharge which impacted on time that would have been spent providing medical care.
- A review of hospital data showed that 'no fixed abode' (NFA) coding was used inconsistently resulting in variations in data and there was no way to capture the extent of homelessness according to the definition by Shelter, 2013.

9.2 Reasons for hospital admission

9.2.1 Data from the Homeless Hospital Discharge Pilot which worked with 70 customers, illustrated a number of findings from the pilot.

- Heavy alcohol use was thought to be a contributing factor to some of the primary reasons leading to admission.
- 80% of patients within the pilot had a recorded mental health issue.



Homeless Health

- Financial problems including issues such as debts and no income were recorded in 62% of the patients in the pilot. Those on low income were not recorded as having financial problems unless they stated difficulties with budgeting or managing debts.

9.2.2 Unsafe hospital discharge of homeless people is a regular occurrence. A report on hospital discharge across the country found that more than 70% of homeless people are discharged from hospital back to the streets.²⁷ The types of issues which happen around unsafe or inappropriate discharge of homeless people from hospital would include early discharge before the patients' needs have been met, discharge without addressing housing needs ie discharge with inappropriate or no housing, discharge with no support or discharge having been given some doses of methadone in hospital but then facing a long wait to enter into a detoxification programme because there are no places available, failure to communicate effectively with relevant agencies around discharge and discharge without clothing or transport.

9.2.3 Members were told in the evidence from SIFA Fireside of very occasional instances where a homeless person has been discharged from hospital to the drop-in at SIFA in pyjamas and with nowhere to go. The SIFA evidence also flagged up a lack of active discharge planning from the start. Quite often it seems, it is not flagged up on admission that somebody is homeless and the issue is not recognised until the person is ready to be discharged.

9.3 Homeless Hospital Discharge Pathways

9.3.1 Funding was secured from the Department of Health to deliver two hospital discharge projects based at University Hospitals NHS Foundation Trust with Midland Heart and at Sandwell and West Birmingham NHS Hospitals Trust and the Heart of England Foundation Trust with Trident Reach. The service provided a 'Navigator' located in each of the hospitals who worked with the hospital discharge teams to identify and assess homeless patients and to look at how individuals who were likely to be discharged as 'no fixed abode' could be supported back into the community with accommodation and into ongoing care support. This work was further supported by having a brokerage service in the community with access to flexible funding to purchase ad-hoc services such as housing support and/or accommodation where appropriate to ensure that services which were being delivered from a clinical setting in the hospital continued out in the community. The clinical element was provided by way of a part-time GP and two nurses.

9.3.2 The project aims to prevent the 'revolving door' scenario of homeless people being treated, discharged and then returning to hospital with worsening health problems because they have nowhere to go and no proper support. This supports more effective discharge to get people home and prevents unplanned admissions by keeping people in hostels or supported housing. The team work together to assess patients, establish their needs and deliver a package of housing, healthcare and support which continues into the community after the person has left hospital. This

²⁷ Homeless Link and St Mungo's 2012



includes nurses carrying out regular support home visits in the community after discharge, as well as making sure people are registered with a GP and dentist and accessing the health and other services they need. This involves working with specialist hospital consultants, housing providers and other agencies such as social services, alcohol advice services and specialist mental health services.

- 9.3.3 The pilot ended in July 2014 but was extended for a further twelve months from November 2014 at the Sandwell and West Birmingham Hospitals Trust and at the Heart of England Hospitals Trust with Trident Reach. In its first three months the extended scheme, now known as the Homeless Patient Pathway at Birmingham City Hospital helped 131 people, aged from 18 to 74 find housing and become re-integrated back into the local community, reducing the average length of stay in hospital by 3.2 days per person. 80% of people helped have not been re-admitted to hospital, 10% have since gained employment and 10% are doing voluntary work. Various funding options are being explored with a view to embedding the pilot as a mainstream service in the future.



10 Conclusion

10.1 Health and homelessness

- 10.1.1 There is an intrinsic link between health and homelessness. Homeless people face poorer health than the general population with many suffering long term physical and mental health problems which can be difficult to manage for people who are living in hostels or on the street. They struggle to access the healthcare that most people take for granted. This failure to improve health at an early stage places a significant financial burden on the health system in terms of avoidable emergency admissions to hospital and reliance on long term care.
- 10.1.2 Some services are very effective in addressing the health needs of homeless people and there are some excellent examples of innovative and flexible approaches to addressing the health needs of the homeless, with inclusive commissioning and effective joint working. There is no easy answer but it is clear that local authorities and homelessness services need to listen to what homeless people have to say in order to work together better to provide more flexible and person centred services which are designed to meet the health needs of homeless people.



Appendix: Contributors

The Committee would like to thank all those who have taken the time to contribute to this inquiry.

Contributor	Organisation
Bernadette Byrne	Head of Addictions & Homeless Services, Birmingham & Solihull Mental Health Foundation Trust
Cath Gilliver	Chief Executive, SIFA Fireside
Cllr John Cotton	Cabinet Member for Neighbourhood Management and Homes (formerly Cabinet Member for Health and Wellbeing)
Dean Hatton	Chief Inspector, West Midlands Police
Derek Tobin	Head of Healthcare, HMP Birmingham
Dr Adrian Phillips	Director of Public Health
Dr Kenneth Wilson	Consultant in Special Care Dentistry, Birmingham Community Healthcare NHS Trust
Dr Sarah Marwick	GP for the Homeless
Gail Read	Community Risk Reduction Officer, West Midlands Fire Service
Garry Murphy	Service Manager, Salvation Army William Booth Centre
Ian Sturmey	Firefighter, West Midlands Fire Service
Jacqueline Latty	Young People and Families Engagement Officer, Healthwatch Birmingham
Jean Templeton	Chief Executive, St Basil's
Jim Crawshaw	Integrated Service Head Homeless & Pre-Tenancy Services, BCC
Jo Davis	Acting Service Manager for Homeless and Addictions, Birmingham & Solihull Mental Health Foundation Trust
John Denley	Consultant in Public Health
John Hardy	Policy & Development Officer, Housing Strategy Policy & Commissioning, BCC
Max Vaughan	Commissioning Manager – Substance Misuse, BCC
Paulina Korgol	Operations Manager, Midland Heart
Sam Henry	Youth Engagement Coordinator, St Basils
Vanessa Devlin	Associate Director of Operations, Birmingham & Solihull Mental Health Foundation Trust

Member Visits
Organisation
Health Exchange
Salvation Army William Booth Centre
St Basil's Youth Hub

Report of:	Cabinet Member for Health and Social Care
To:	Health, Wellbeing and the Environment Overview and Scrutiny Committee
Date:	21st February 2017

Progress Report on Implementation: Homeless Health

Review Information

Date approved at City Council:	7 July 2015
Member who led the original review:	Councillor Susan Barnett
Lead Officer for the review:	Rose Kiely
Date progress last tracked:	20 th October 2015

1. In approving this Review the City Council asked me, as the appropriate Cabinet Member for Health and Social Care, to report on progress towards these recommendations to this Overview and Scrutiny Committee.
2. Details of progress with the remaining recommendations are shown in Appendix 2.
3. Members are therefore asked to consider progress against the recommendations and give their view as to how progress is categorized for each.

Appendices

1	Scrutiny Office guidance on the tracking process
2	Recommendations you are tracking today
3	Recommendations tracked previously and concluded

For more information about this report, please contact

Contact Officer:	John Hardy
Title:	Policy and Development Officer
Telephone:	0121 675 8661
E-Mail:	john.hardy@birmingham.gov.uk

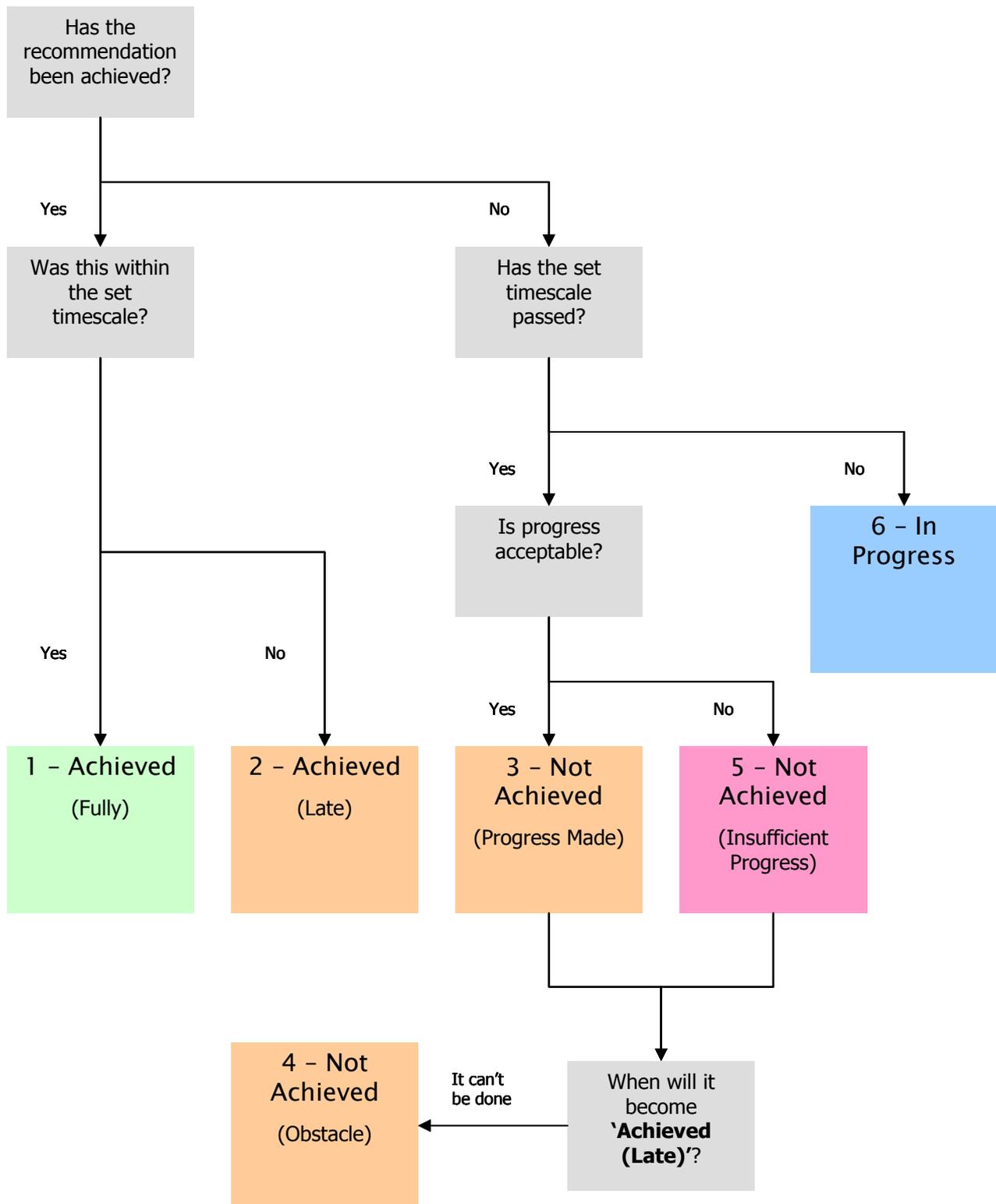
Appendix 1: The Tracking Process

In making its assessment, the Committee may wish to consider:

- What progress/ key actions have been made against each recommendation?
- Are these actions pertinent to the measures required in the recommendation?
- Have the actions been undertaken within the time scale allocated?
- Are there any matters in the recommendation where progress is outstanding?
- Is the Committee satisfied that sufficient progress has been made and that the recommendation has been achieved?

Category	Criteria
1: Achieved (Fully)	The evidence provided shows that the recommendation has been fully implemented within the timescale specified.
2: Achieved (Late)	The evidence provided shows that the recommendation has been fully implemented but not within the timescale specified.
3: Not Achieved (Progress Made)	The evidence provided shows that the recommendation has not been fully achieved, but there has been significant progress made towards full achievement. An anticipated date by which the recommendation is expected to become achieved must be advised.
4: Not Achieved (Obstacle)	The evidence provided shows that the recommendation has not been fully achieved, but all possible action has been taken. Outstanding actions are prevented by obstacles beyond the control of the Council (such as passage of enabling legislation).
5: Not Achieved (Insufficient Progress)	The evidence provided shows that the recommendation has not been fully achieved and there has been insufficient progress made towards full achievement. An anticipated date by which the recommendation is expected to become achieved must be advised.
6: In Progress	It is not appropriate to monitor achievement of the recommendation at this time because the timescale specified has not yet expired.

The Tracking Process



Appendix 2: Progress with Recommendations

No.	Recommendation	Responsibility	Original Date For Completion	Cabinet Member's Assessment
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	1
Evidence of Progress (and Anticipated Completion Date if 'Not Achieved')				
<p>The Homeless Welfare Service commenced on 1st May and is a joint contract delivered by Shelter and SIFA from SIFA's Digbeth premises. The contract runs until 30 April 2018.</p> <p>The Housing Options Service moved to one Housing Options Centre on 7 July 2016</p>				
R02	That the three Birmingham Clinical Commissioning Groups should explore: <ol style="list-style-type: none"> 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 of that area. 	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	1
Evidence of Progress (and Anticipated Completion Date if 'Not Achieved')				
<p>In addition to the Health Exchange contract patients can register at any practice of their choice in the city and have access to the city's WIC and A&E services.</p> <p>See attached information from SWB CCG.</p>				

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	2
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Evidence of Progress (and Anticipated Completion Date if 'Not Achieved')

Multi-agency working in response to tackling rough sleeping has grown. Partnership working now exists across BCC, Police, BIDs, commissioned services, Fire Service, BSMHFT, CCGs, Changing Futures, Big Issue, CGL, voluntary agencies, Crisis, Shelter, CSP.

A new partnership network has been established with voluntary agencies and charities including Reach Out Network, Socks and Chocs, As- Suffa, Sifa, Midland Heart, Up for Giving, Red Bag Company, Help the Homeless Society, Homeless Heroes Outreach, We Are Happy, Helping Homeless in Birmingham, Health Exchange .

Further work is being undertaken to maximize the use of all of the services that are in place and to ensure that there is a clear constellation map of all the services available and how they work together and can be accessed.

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: <ol style="list-style-type: none"> 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	2
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Evidence of Progress (and Anticipated Completion Date if 'Not Achieved')

Providers of addiction and mental health services in the City have developed and signed up to a new joint policy which sets out how organisations will work together to treat and support people with co-existing mental health and substance misuse issues. The policy was developed during 2016 and agreed by providers in January 2017. Implementation is to be completed by 31st March 2017.

The aims and objectives of the work are to:

- Promote and encourage joint working and assessment between organisations involved
- Reduce the risk of referrals being delayed or diverted
- Utilise the expertise of each organisation to ensure the appropriate treatment package
- Map out and match community resources

The changes will

- Reduce waiting times
- Reduce the risk of over-prescribing

- Reduce the number of Serious Incidents
- Improve the experience of accessing treatment and support for this client group
-

A project plan sets out the work required to implement the policy and is being monitored by the Mental Health Collaborative Group which forms a part of the City-wide governance structure for mental health. The Group includes representation from all key commissioning organisations.

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	1
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Evidence of Progress (and Anticipated Completion Date if 'Not Achieved')

The concept of the Welfare Service was to make available the range of service needed to support an individual in one key location. As well as access to food, bathing and clothing facilities the Welfare Service has established a range of health clinics such as

- Mental Health (access to Community Mental Health Outreach team)
- Substance Misuse (both drug and alcohol provided by CGL)
- Sexual Health clinics (provided by Umbrella/UHB)
- Chiropody
- Optician
- Dentist
- Regular access to nurse
- Support and encouragement to register with GP services
- Smoking cessation service (provided by nurse)
- Cooking and healthy eating courses

There has only been a 26% take up of these services from those known to be rough sleeping and work is being done to analyse the reasons for this. In addition an element of the successful rough sleepers bid was to introduce a multi-disciplinary team that would provide a peripatetic universal service offer of access to accommodation, health and well being check, mental health assessment and substance misuse screening. The use of mobile units to undertake these assessments as close to where an individual is located whilst at the same time offering the required level of privacy is also being explored.

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: <ol style="list-style-type: none"> 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 accommodation for homeless women in contact with the criminal justice system. 	Cabinet Member for Health and Social Care Cabinet Member for Neighbourhood Management and Homes	31 March 2016	3
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	<p>4. Supporting prisoners to link into the benefit system before and after release from prison.</p> <p>5. Providing/sharing information about services available in the community to facilitate improved pathways between prison and the general community.</p>			
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Evidence of Progress (and Anticipated Completion Date if 'Not Achieved')

The rough sleeper bid seeks to establish a Prison Community navigator to work alongside and co-ordinate the services that are already available in prison settings such as mental health and health provision, benefits advice and housing options.

The navigator will then ensure that the ongoing delivery of these services is continued in the community upon release.

As part of the supported housing review, detailed further discussions will be taking place with the Prison Service, National Probation Service and the Community Rehabilitation Company to understand the pathways for ex-offenders and the required levels of support that are beyond the requirements for effective offender management.

Birmingham City Council attends the Multi-Agency Integrated Offender Management Board to ensure that the housing issues are considered as part of the agenda as well as the Birmingham Offender Accommodation Forum with National Probation Service, Community Rehabilitation Company and Providers.

R07	<p>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.</p>	<p>Cabinet Member for Health and Social Care</p> <p>Birmingham and Solihull Mental Health NHS Foundation Trust</p> <p>Cabinet Member for Neighbourhood Management and Homes</p>	<p>31 December 2015</p>	<p>2</p>
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Evidence of Progress (and Anticipated Completion Date if 'Not Achieved')

The Homeless Primary Care Service Model provided by Birmingham & Solihull Mental Health Foundation Trust – in hours provision

The Homeless Primary Care Service adopts an assertive engagement approach in its work with individuals which is commissioned on behalf of Sandwell & West Birmingham, Birmingham Cross City and South and Central CCGs. The 'assertive outreach' model of working originates from within the mental health field. It is an approach that is employed when the relationship between services and an individual is complex and chaotic. The flexibility of this approach enables the service to be provided to those who may not otherwise access it. The overall aim in working within this approach is to develop trusting relationships with individuals in a needs-focused way, employing flexibility and creativity, so enabling the delivery of a care package that is specific to client need. The service aims to stay in contact with individuals, making repeated assertive attempts to make contact with people if they miss appointments. The service also provides an outreach element to hostels.

Key Services Outcomes

- Increase in the number of homeless or vulnerably housed people appropriately accessing primary care services and holding permanent registration with a General Practitioner.
- Reduction in the number of inappropriate attendances at Accident & Emergency Department by homeless

and vulnerably housed people.

- Increase in the number of homeless or vulnerably housed people accessing specialised support for drug & substance misuse.
- Improved access to primary and secondary mental health care services (including access to psychological therapy) for homeless and vulnerably housed people.
- Prevention of homelessness through appropriate, targeted health support.

Location(s) of Service Delivery

The service is currently located at the William Booth Centre, which is located centrally to the main core of hostel beds in the City.

The Homeless Primary Care Service
William Booth Centre
William Booth Lane (Off Constitution Hill)
Birmingham
B4 6HJ

Days/Hours of Operation

The Homeless Primary Care Service is available between the hours of 9.00am-5.00pm, Monday - Friday (excluding Bank Holidays)

In addition to the service provided at the Health Exchange patients can register at any practice of their choice in the city and have access to the city's Walk In facilities and A&E services.

Also see attached information from SWB CCG.

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	
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Evidence of Progress (and Anticipated Completion Date if 'Not Achieved')

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Appendix ③: Concluded Recommendations

These recommendations have been tracked previously and concluded.

They are presented here for information only.

concluded

No.	Recommendation	Responsibility	Date Concluded by Overview and Scrutiny Committee	Tracking Assessment
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	October 2015	1

All you need to know about...

Patient registrations GMS / PMS / APMS contracts

- Access to primary care services is free to everyone in the UK – whether they are permanent residents or visitors from overseas
- Patients **do not** need to provide proof of ID to register with a practice. It's helpful if they can provide a medical card or confirm their NHS number but if they can't submission of a GMS1 Form is acceptable
- Practices can only refuse a registration if the patient:
 - Is already registered under a Zero Tolerance Scheme
 - Lives outside the practice boundary and it's not clinically appropriate or practical for them to be registered at the practice
 - Has previously been removed from the practice list due to relationship breakdowns with the practice
 - Other exceptional circumstances may apply – if unsure contact Time2Talk
- No patient should be refused on the grounds of race, gender, social class, age, religion, sexual orientation, appearance, disability or medical condition
- If a practice does refuse a patient then the patient must be informed in writing, confirming the reason for refusal, within 14 days and the practice should keep a log of all refused registrations

We often get queries from member practices around the Do's and Don'ts.

Most of this will be familiar to you.

To help support you, we're pulling together a series of factsheets that will give you everything you need to know.

Don't forget our Time2Talk team is happy to help with any queries you have, call them on 0121 612 4110.

See appendix one for more information

Patient registration Supporting information

New patient registration

Patients who wish to register with a GP practice can do so by either:

- a) Providing their medical card that will have details of their name, address, and NHS number; or if the patient does not have a medical card
- b) Submitting the GMS1 form (forms may vary slightly and some practices use their own version).

The GMS regulations state *“an application for inclusion in the contractor’s list of patients shall be made by delivering to the practice premises a medical card or an application signed (in either case) by the applicant or a person authorised by the applicant to sign on his behalf”*. **GMS Regulations 2004 No. 291 Schedule 6 Part 2 Regulation 15**

NB: Although it is useful if patients are able to produce a NHS medical card or provide their NHS number to register with a GP or get NHS treatment, it should not prevent them from registering.

Temporary resident registration

A patient may be regarded as a temporary resident if they are away from their normal place of residency and intend to stay in the area for more than 24 hours, but not more than three months. A practice may accept the patient onto its list as a ‘temporary resident’ where:

- a) The patient is away from their normal place of residence and is not being provided with essential services (or the equivalent) under any other arrangement in the locality where they are temporarily residing; or
- b) The patient is moving from place to place and is not currently resident in any place.
GMS Regulations 2004 No. 291 Schedule 6 Part 2 Regulation 16

GP choice scheme – out of area registration

From 5 January 2015, all GP Practices in England are free to register new patients who live outside their practice boundary area without the obligation to provide home visits.

However, before registering a patient under this scheme a practice should:

- a) Consider each application on a case by case basis to ascertain whether it is clinically appropriate and practical for the patient to be registered in this way
- b) Ensure that the patient is aware of their registration status and the impact this may have should there be a requirement to refer them to other specialist services / community services closer to their home
- c) Ensure that the patient is aware of what they should do if they require urgent primary medical care when they are at home and it is not reasonable to expect them to attend the practice.

Overseas visitors

Overseas visitors have no formal obligation to prove their identity or immigration status to register with a practice. However, asylum seekers may be able to show an Immigration Service issued 'Application Registration Card' (ARC) or official documents that confirm their status.

A practice may register an overseas visitor as a temporary or permanent resident, but this does not necessarily entitle them to receive free NHS hospital treatment. It's the relevant hospital's duty, not the GP's, to establish entitlement for free NHS hospital treatment and so this should not be a barrier to registering overseas visitors.

Homeless patients / No Fixed Abode

If a patient is not able to provide a home address because they are homeless or have no fixed abode this should not prevent the patient from registering with the practice. It's acceptable to use the practice address as the patient's address in these circumstances.

NB: The practice may need to establish ways of keeping in touch, suitable to the patient's needs.

Requesting ID / proof of address

When registering patients GP practices may ask to see proof of the patient's identity, for example photo identification such as a passport or driving licence and proof of address such as a recent utility or council tax bill, but there is no legal obligation to do this.

If a patient is unable to produce any proof of identity they should not be refused registration.

When can a practice refuse a patient?

Practices can only refuse a patient registration if it has reasonable grounds for doing so, which do not relate to the applicant's race, gender, social class, age, religion, sexual orientation, appearance, disability or medical condition.

GMS Regulations 2004 No. 291 Schedule 6 Part 2 Regulation 17

There are limited reasons, where a practice is able to refuse a registration, including:

- a) The patient resides outside of the practice boundary and it is not clinically appropriate or practical for them to be registered, without provision of home visits (GP Choice – Out of Area Registration)
- b) If the patient is registered with the zero tolerance scheme
- c) If the patient has previously been removed from the practice register at the doctor's discretion due to an irrevocable breakdown in the relationship between the patient and the practice.

Refusal process

Where a practice does have reasonable grounds to refuse a patient's request for registration it must notify the patient within 14 days of its decision in writing and provide the reason for the refusal. The practice must also keep a record of all refusals and make available for the commissioner on request.

Appendix 3

Progress Report on the Homeless Prevention - Welfare Service

Background

The contract for the Homeless Prevention – Welfare service was awarded to Shelter who deliver the service in partnership with SIFA Fireside. SIFA Fireside are sub-contracted by Shelter to deliver the Health and Welfare element of the service while Shelter focus on housing advice. The service is delivered from SIFA Fireside's premises in Digbeth and began on 1st May 2016. It is expected to run up until 30th April 2018.

Overview of Service

The purpose of the service is to provide an access point for single homeless and street sleepers to move towards independence, through the provision of housing advice, health services and support.

Homeless Prevention

The service is expected to deliver housing advice from a location that is independent of Birmingham City Council. The support offered includes;

- Advice and assistance in accessing temporary accommodation
- Help in completing necessary forms such as housing applications, benefit forms etc.
- Help accessing privately rented accommodation including the rent deposit scheme
- Assistance in bidding for properties using Birmingham Home Choice.
- Advice regarding accessing properties with Registered Social Landlords
- Advice regarding accessing local authority accommodation including supply and demand information.
- Advice regarding accessing supported accommodation and/or floating support.
- Assistance obtaining immigration advice in relation to entitlement, right to work and accommodation.

Health & Welfare

Welfare facilities are provided, such as bathing and clothing along with easy access to a range of health services who hold regular clinics on site. These include;

- Mental Health (access to Community Mental Health Outreach team)
- Substance Misuse (both drug and alcohol provided by CGL)
- Sexual Health clinics (provided by Umbrella/UHB)
- Chiropody
- Optician
- Dentist
- Regular access to nurse

- Support and encouragement to register with GP services
- Smoking cessation service (provided by nurse)
- Cooking and healthy eating courses

The service is currently working with Public Health England to strengthen the offer around effective testing and screening for TB and to enable better access to treatment services. This will include training staff to spot the signs of TB and be able to better identify those most at risk.

Outcomes to date

Performance is reported on a quarterly basis and to date Commissioners have received performance reports for the first 3 quarters of this financial year (16/17). As the contract started on 1st May 2016 the first quarter only comprises two months data instead of three.

Below is a summary of performance to date linked to expected outcomes. The data represented is a cumulative total taken from Q1 to Q3 (16/17) and reflects Year to Date totals.

1. General Findings

To date it has been reported that 1812 people have accessed the service for either housing and/or welfare support. Of this number 96% were classed as single homeless, 86% of whom were male. ***To date only 26% have reported to be sleeping rough. Recording of data in this area is lower expected. Therefore, Commissioners have asked the service to review the pathway and recording of information with the Rough Sleepers Team and to re-submit this figure in Q4 (16/17).***

2. Assistance to remain at Home

1479 (81%) have accessed support to assist them to remain in their own home. Interventions delivered include activities such as;

- Referral to mortgage arrears/rescue services
- Negotiation or legal advocacy to ensure that some can remain in the private or social rented sector
- Crisis Intervention

However, the bulk of reporting (82%) falls under the non-specific title of 'other' support and Commissioners will review this reporting to attain a clearer picture of what activity is being delivered and captured.

3. Assistance to obtain alternative Accommodation

1118 (62%) have accessed support to assist them to obtain alternative accommodation. Interventions delivered in this area have included referrals to;

- Any form of hostel or House in multi occupation (HMO) with or without support (81%)
- Supported accommodation (including supported lodging schemes)(8%)
- Other (non-specified services) (10%)

- Private rented sector accommodation with/without landlord incentive scheme (1%)

4. Improvement in physical and mental health

A range of health and lifestyle services are available on site. To date the following activity has been reported;

- Service Users not already registered with a GP practice are actively encouraged to and to date the service has supported 503 people to register with a GP.
- 139 people have accessed help with substance misuse issues
- 290 have received advice on mental health issues and 32 (11%) have gone on to engage further with mental health services
- 377 have accessed sexual health services with 126 (33%) going on to follow appointments
- 42 people have been screened for TB, hepatitis and other blood borne viruses 6 (14%) of whom have gone on to engage in treatment. Commissioners expect these figures to increase following input from Public Health England.
- Cooking courses are delivered by volunteers and are reported to be well attended. However, we are waiting on exact numbers as there have been technical issues with capturing this information.
- Smoking cessation services have been delayed following decommissioning of the original service however this will be delivered by the nurse who regularly attends SIFA and will be reported on from Q4 16/17.
- 608 people have gone on to receive support around debt or hardship following access to the health and welfare services
- 24 people received support around domestic violence
- 506 people were helped into employment opportunities.

Overall activity levels have seen a steady increase since Q1 16/17. Work is in had at present to advertise and promote more effectively the health and welfare services and the housing advice provision to service users. It is expected that activity levels will increase further.