**Liverpool
Public Health
Observatory**

Homelessness in Liverpool City Region

A Health Needs Assessment

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PROVIDING INTELLIGENCE FOR THE PUBLIC HEALTH

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Glossary

CCGs: Clinical Commissioning Groups are organisations responsible for implementing the commissioning roles as set out in the Health and Social Care Act 2012. They are groups of GP practices that are responsible for commissioning most health and social care services for patients.

Health Inequalities: the differences in the health status or in the distribution of health determinants between different population groups are called health inequalities.

Health Needs Assessment: HNAs provide evidence of the health needs of a specific population and usually include some or all of the following features 1. Collection of relevant local and national statistics, 2.Surveys/data collection relating to the topic area, 3.Literature reviews.

Hospital Episode Statistics: HES processes over 125 million admitted patient, outpatient and accident and emergency records each year. They are collected during a patient's time at hospital and submitted to allow hospitals to be paid for the care they deliver.

Liverpool City Region: LCR is an economic and political area of the North West of England, centred on Liverpool which consists of Halton, Knowsley, Sefton, St Helens, and Wirral. There are approximately 1.5 million people resident in the Liverpool City Region.

MDT: A Multi-disciplinary Team is a group of health care workers and social care professionals who are experts in different areas with different professional backgrounds united as a team for the purpose of planning and implementing treatment programs.

NFA: No fixed abode

QOF standards: The Quality and Outcomes Framework is a voluntary incentive scheme for GP practices in the UK, rewarding them for how well they care for their patients.

Supporting People: A government programme providing housing related support services for vulnerable adults, including homeless people. The **primary client group** 'single homeless with support needs' or 'homeless families with support needs' are those individuals whose predominant issue is homelessness. For others, this may be the **secondary client group** by which they are defined. For these clients, their primary classification relates to a more predominant issue, such as being an offender or having a drug problem. There may be variations between local authorities and between individual support workers as to how these issues are recorded.

Liverpool Public Health Observatory (LPHO) was founded in 1990. It provides public health research and intelligence for the Liverpool City Region local authorities: Halton, Knowsley, Liverpool, St. Helens, Sefton and Wirral.

LPHO is situated within the University of Liverpool's Division of Public Health and Policy.

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Introduction

Liverpool Public Health Observatory was commissioned by the Merseyside Directors of Public Health to deliver this Health Needs Assessment of homelessness in Liverpool City Region. This followed concerns that the recent economic downturn and changes to welfare provision were negatively impacting on housing security across the region.

The health needs assessment covers the six local authorities that make up Liverpool City Region - Halton, Knowsley, Liverpool, Sefton, St Helens, and Wirral

The project aims and objectives are set out in Box 1.

Scope: For the purposes of the project, homelessness was defined as "those who do not have a settled housing solution", which broadly encompasses the following groups:

- Those who are statutorily homeless and in priority need
- Non-priority homeless people living in hostels and bed and breakfast accommodation
- Rough sleepers
- Hidden homeless people: sofa surfers, some of those in shared, concealed and overcrowded households, and failed asylum seekers and economic migrants who are homeless.

> **Box 1**
> **Aims and objectives of homelessness HNA**
> **Aims**
> - To determine the health needs of the local homeless population within Liverpool City Region
> - To investigate the extent to which current service provision is addressing the health needs of the local homeless population
> - To make a set of evidence-based recommendations for local commissioners on the provision of health services for the local homeless population
>
> **Objectives**
> - To identify the extent of homelessness in Liverpool City Region
> - To assess health needs
> - To identify current health service provision
> - To identify current health service use
> - To identify priority health, care and well-being issues, barriers to accessing services and barriers to delivering services and user perspectives of service provision and gaps
> - To present information on the above at an individual local authority level

The Housing Act 1977, Housing Act 1996 and the Homelessness Act 2002 placed statutory duties on each local housing authority to provide free advice and assistance to households within its area who are homeless or threatened with homelessness. To be considered statutorily homeless, a person has to be eligible for public funds, have a connection to the local area, be unintentionally homeless, and in priority need. The local authority is then required to secure accommodation for them. Priority need groups include households with dependent children, people vulnerable due to e.g. mental illness or domestic violence and those aged 20 or under previously in care (see DfCLG 2013a for full details).

Rising trends: After a period of decline, nationally, there has been a recent increase in both statutory and non-statutory homelessness. There was a rise of 6% in overall homeless figures between 2012 to 2013, with the numbers in temporary accommodation rising by 10% (Shelter online, 2013c).

Levels of rough sleeping have risen sharply recently, with the national 'snapshot' count showing a 37% increase between autumn 2010 to autumn 2013 (DfCLG, 2014). 'Hidden homelessness' in the form of overcrowded, concealed and shared households has also increased recently. Whitechapel is the leading homelessness charity for Liverpool City Region, based in Liverpool, providing assistance to a spectrum of homeless clients including some homeless families, although the majority will be single homeless, rough sleeping or vulnerably housed. Whitechapel noted that a record number of 2,286 Merseysiders used its services in 2012/13 — a 27% increase from the previous year (Whitechapel Centre, 2013).

It should be noted that throughout the report, where comparisons between local and national data are made, national data may be skewed due to the specific circumstances and levels of homelessness in London.

Effects of the economic downturn and welfare reform: The risk of homelessness has increased due to the economic downturn which began in 2007 and changes to welfare provision. The economic downturn has led to cuts in the funding of public services, a shortage of affordable housing and rising private rents. Welfare reform has included cuts in housing benefit (the 'bedroom tax'), the introduction of an overall benefit cap, and changes to the Jobseeker's Allowance and Employment Support Allowance regime. The latter has already shown signs of impacting negatively on homeless people with chaotic lifestyles (Fitzpatrick et al, 2012, 2013). Many people are struggling with the tougher sanctions and increased conditionality that have been introduced.

The continued reduction in front-line services available to homeless people, which with 'Supporting People'[1] ring-fence abolition, is likely to lead to further increases in rough sleeping (Fitzpatrick et al, 2013). In the near future, there are concerns about the impact of the national roll out of Universal Credit and the move away from direct payment of rent to landlords. In addition, the introduction of 'flexible tenancies' will gradually weaken the housing sector's safety net function, and the increased emphasis on local connection in social housing eligibility will risk excluding some marginalised groups such as those fleeing domestic violence or some single homeless people.

Health and Social Care Act 2012: Under the Health and Social Care Act 2012, reducing health inequalities is now a requirement. CCGs have a duty to provide services for all patients in their locality, whether registered or not, including services for the homeless. The Act presents new opportunities for CCGs to provide services for the homeless, for Health and Wellbeing Boards to make links between housing and homelessness, and to use work around homelessness to assist in meeting new public health outcomes targets (Homeless Link, 2012a; NICE, 2014). With Public Health now having a new home within the Local Authority, this also presents new opportunities for potential influence and joint working.

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[1] 'Supporting People' is a government programme providing housing related support services for vulnerable adults, including homeless people. Until recently, it had a ring-fenced fund.

Regional summary and individual local authority summaries

Liverpool City Region Summary

The extent of homelessness

1.1 Statutory homelessness, in priority need

In 2012/13, 1,626 people in Liverpool City Region applied for assistance under the Housing and Homelessness Acts. Of these, 714 (44%) were accepted as being statutorily homeless and in priority need (compared to 47% in England).

From 2004-05, statutory homeless rates in Liverpool City Region declined until 2010-11, after which they flattened out at 1.1 per 1,000 households up to 2012/13. This is in contrast to the national picture, where rates have risen recently and are now more than twice as high as in Liverpool City Region. Figure (i) shows actual numbers.

In Liverpool City Region during 2012-13, the most common reason for homelessness was parents, relatives or friends not being able or willing to accommodate the applicant, which accounted for more than a quarter of cases (27.6%). In 1 in 5 cases (19.5%), the reason for homelessness was the breakdown of a relationship with a partner, with three-quarters (73.3%) of these involving violence. This was higher than nationally, where the proportion was 69% involving violence.

The proportion of homeless acceptances due to mortgage arrears (4.8%), leaving prison (1.5%) and leaving HM Forces (0.8%) were twice as high in Liverpool City Region compared to nationally (national levels were 2.2%, 0.8% and 0.4% respectively).

Figure (i). Homelessness in Liverpool City Region, 2010/11 to 2012/13

	non-priority homeless	statutory homeless in priority need
2010/11	170	686
2011/12	312	711
2012/13	287	714

Sources: www.gov.uk & Homeless Link, 2013. Based on decisions made on applications for assistance under the Housing and Homelessness Acts

1.2 Non-priority homelessness

In 2012/13, 18% (287) of all housing assistance applications in Liverpool City Region were eligible, homeless, but not in priority need (i.e. mainly single homeless). This is a large rise compared to 2010-11, when 12% (170) of applications were homeless but not in priority need (Figure (i) shows actual numbers).

Between 2011-12 and 2012-13, the numbers of 'Supporting People' clients (primary group) who were sleeping rough increased by 78% (from 83 to 148). There was a corresponding rise of 85.7% in rough sleeping counts and estimates between autumn 2010 and autumn 2013 (from 14 to 26). This was a much steeper increase than nationally (36.5% increase) and in the North West (52% increase).
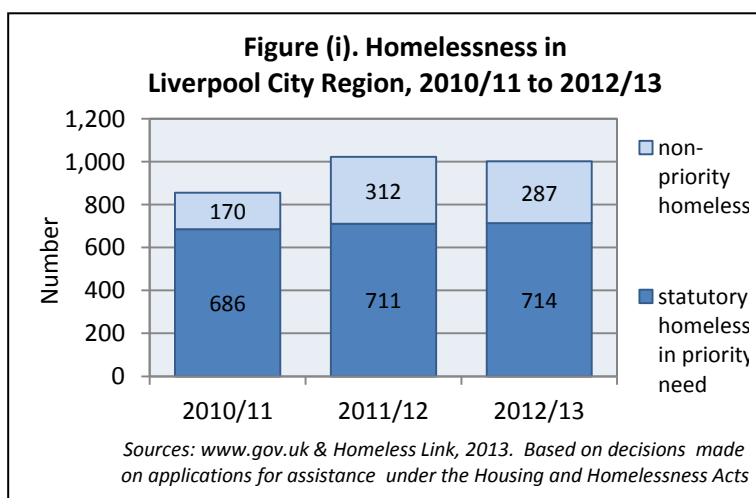
2. Health needs

Supporting People clients
There were 2,948 single homeless people moving on from Supporting People services in Liverpool City Region in 2012/13 (primary client group). Of these:

- 944 (32%) had physical health needs and 87% had these needs met
- 817 (28%) had mental health needs and 78% had these needs met
- 1,089 (37%) had substance misuse issues and 53% had these needs met

There were 546 homeless families moving on from Supporting People services in 2012/13. Of these:
- 110 (20%) had physical health needs and 89% had these needs met
- 109 (20%) had mental health needs and 85% had these needs met
- 26 (5%) had substance misuse issues and 62% had these needs met

Structured drug and alcohol treatment
Of all alcohol and drug clients in Liverpool City Region commencing structured treatment during a 9 month period (1/4/13 to 31/12/13), there were 353 alcohol clients in treatment who were homeless (134 Urgent 'no fixed abode' [NFA]) and 507 drug clients (144 Urgent NFA). Of all alcohol and drug clients, 1 in 7 are homeless (11% of alcohol clients and 17% of drug clients – 1 in 7 or 14% in total).

3. Specialist healthcare

Across Liverpool City Region, specialist healthcare for homeless people is provided in Liverpool, St. Helens and Wirral. There is no specialist homeless healthcare in Halton, Knowsley and Sefton.

4. Summary of recommendations
For commissioners and providers of health and social care:
1. Consider the Faculty for Homeless and Inclusion Health Charter of Healthcare Standards.
2. Ensure multi-disciplinary team working, with case management.
3. Implement collaborative commissioning.
4. Ensure each CCG has an identified lead for homelessness.
5. Ensure the availability of intermediate/respite care facilities.
6. Use 'reasonable adjustments' to improve access to healthcare.
7. Collate standard datasets on numbers of homeless people.
8. Establish a full audit of hospital activity for those who are homeless in the region.
9. Continue developing and funding hospital discharge protocols for homeless people.
10. Expand the specialist homeless health services.
11. Address the low level of 'needs met' for homeless people with substance misuse issues.
12. Continue to monitor numbers of homeless people from ethnic minorities.
13. Ensure access to dental care, physiotherapy and podiatry.
14. Ensure access to vaccinations, screening and sexual health services.
15. Ensure that strategies for end of life care consider the needs of homeless people.
16. Include service users in service design and evaluation and use peer education.
17. Provide adequate training and remuneration for those working with homeless people.
18. Continue to fund homelessness prevention initiatives.

Halton Summary

1. The extent of homelessness

1.1 Statutory homelessness, in priority need

In 2012/13, 166 people in Halton applied for assistance under the Housing and Homelessness Acts. Of these, 86 (52%) were accepted as being statutorily homeless and in priority need (compared to 44% in Liverpool City Region).

In the three year period from 2010/11 to 2012/13, the rate of statutory homelessness in Halton increased from 0.76 to 1.72 per 1,000 households (Figure A shows actual numbers).

The rate in 2012/13 was the second highest in Liverpool City Region (Liverpool City Region rate = 1.1 per 1,000 households).

The most common reason for statutory homelessness in Halton was the 'loss of rented or tied accommodation' (25%). The next most common reason was 'violent relationship breakdown with partner', which at 18%, was the second highest in Liverpool City Region.

Figure A. Homelessness in Halton 2010/11 to 2012/13

Sources: www.gov.uk & Homeless Link, 2013. Based on decisions made on applications for assistance under the Housing and Homelessness Acts

1.2 Non-priority homelessness

In 2012/13, 18% (30) of all housing assistance applications in Liverpool City Region were eligible, homeless, but not in priority need (i.e. mainly single homeless). This is the same as the Liverpool City Region rate and lower than the England rate of 20%.

The 2012/13 figures show a large rise in non-priority homeless applications compared to 2010-11, when 4% (3) of all applications were homeless but not in priority need (Figure A shows actual numbers).

2. Health needs

Supporting People clients

There were 280 single homeless people moving on from Supporting People services in 2012/13 (primary client group). Of these:
- 62 (22%) had physical health needs (compared to 32% in Liverpool City Region) and 90% had these needs met (87% Liverpool City Region)
- 56 (20%) had mental health needs (28% Liverpool City Region) and 82% had these needs met (78% Liverpool City Region)

- 99 (35%) had substance misuse issues (37% Liverpool City Region) and 61% had these needs met (53% Liverpool City Region)

There were 115 homeless families moving on from Supporting People services in 2012/13. Of these:
- 20 (17%) had physical health needs (20% Liverpool City Region) and 75% had these needs met (89% Liverpool City Region)
- 34 (30%) had mental health needs (20% Liverpool City Region) and 79% had these needs met (85% Liverpool City Region)

(numbers of families with substance misuse issues were too small to include)

Structured drug and alcohol treatment

Of all alcohol and drug clients from Halton commencing structured treatment during a 9 month period (1/4/13 to 31/12/13), there were 44 alcohol clients who were homeless (6 Urgent NFA) and 62 drug clients (11 Urgent NFA). Halton has the highest proportions of homeless drug and alcohol clients, at more than 1 in 4 of all clients (22% of alcohol clients and 27% of drug clients) – compared to around 1 in 7 across Liverpool City Region.

3. Specialist healthcare

There is no dedicated GP lead or nursing team for the homelessness population in Halton. There are weekly sexual health screening drop-in sessions at the hostel and various health and well-being block sessions.

Hospital Outreach Work: A recent pilot at Whiston Hospital involved the outreach worker ensuring that on discharge, homeless patients can be found accommodation and offered GP and drug and alcohol services if needed. Readmission statistics will be available by May 2014, which will be used to evaluate whether the project is helping to keep homeless people out of hospital.

4. Summary of priority issues identified by stakeholders

- Future planning should ensure that the preventive work continues as it has proved to be cost beneficial and an overall success.

- Commissioners could look at whether community health for homeless people needs to be addressed in the Halton area.

- Stakeholders would benefit from networking events, collaboration across pathway planning and more partnership working. It is important to ensure that the provision of services is not duplicated and that the homeless person is signposted to a full range of available services.
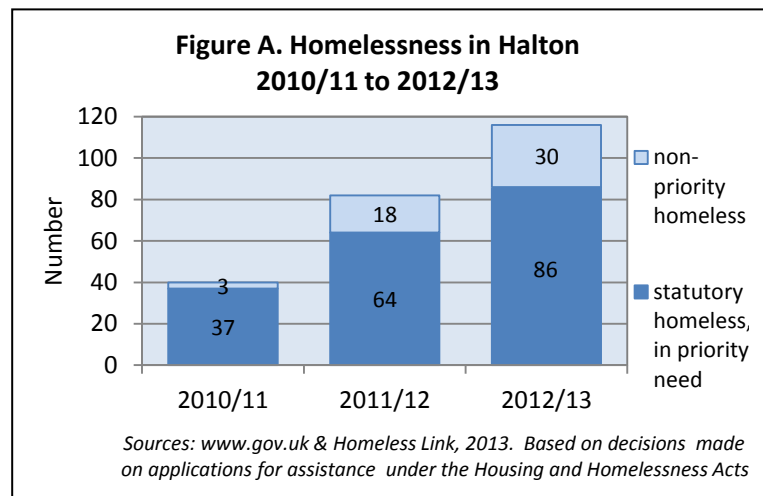
Knowsley Summary

1. The extent of homelessness

1.1 Statutory homelessness, in priority need

In 2012/13, 221 people in Knowsley applied for assistance under the Housing and Homelessness Acts. Of these, 66 (30%) were accepted as being statutorily homeless and in priority need (compared to 44% in Liverpool City Region).

The rate of statutory homelessness in Knowsley has fluctuated recently, at 1.37 per 1,000 households in 2010/11, 0.82 in 2011/12 and 1.03 in 2012/13 (Figure B shows actual numbers) (Liverpool City Region rate = 1.1 per 1,000 households, 2012/13).

The most common reason for statutory homelessness in Knowsley was the 'parents no longer willing or able to accommodate' (22%). The next most common reason was 'violence or harassment other than with partner' (21%). For both of these, levels were the highest in Liverpool City Region.

1.2 Non-priority homelessness

In 2012/13, 16% (36) of all housing assistance applications in Knowsley were eligible, homeless, but not in priority need (i.e. mainly single homeless). This is lower than the Liverpool City Region rate of 18% and the England rate of 20%.

Figure B. Homelessness in Knowsley 2010/11 to 2012/13

Sources: www.gov.uk & Homeless Link, 2013. Based on decisions made on applications for assistance under the Housing and Homelessness Acts

The 2012/13 levels show a large rise in non-priority homeless applications compared to 2010-11, when 4% (7) of applications were homeless but not in priority need (Figure B shows actual numbers).

2. Health needs

Supporting People clients

There were 197 single homeless people moving on from Supporting People services in Knowsley in 2012/13 (primary client group). Of these:
- 35 (18%) had physical health needs (compared to 32% in Liverpool City Region) and 91% had these needs met (87% Liverpool City Region)
- 33 (17%) had mental health needs (28% Liverpool City Region) and 76% had these needs met (78% Liverpool City Region)
- 21 (11%) had substance misuse issues (37% Liverpool City Region) and 67% had these needs met (53% Liverpool City Region)

There were 161 homeless families moving on from Supporting People services in 2012/13. Of these:

- 18 (11%) had physical health needs (20% Liverpool City Region) and 83% had these needs met (89% Liverpool City Region)
- 12 (7%) had mental health needs (20% Liverpool City Region) and 83% had these needs met (85% Liverpool City Region)

(numbers of families with substance misuse issues were too small to include)

Structured drug and alcohol treatment

Of all alcohol and drug clients from Knowsley commencing structured treatment during a 9 month period (1/4/13 to 31/12/13), there were 25 alcohol clients who were homeless (8% of all clients) and 25 drug clients (7% of all clients). Knowsley has the lowest proportions of homeless drug and alcohol clients in Liverpool City Region.

3. Specialist healthcare

The GP Options service caters for a range of vulnerable adults who have problems accessing GPs, e.g. because they are not registered, including homeless people. It currently provides a weekly service to three of the larger supported housing schemes in Knowsley.

Hospital Outreach Work: A recent pilot at Whiston Hospital involved the outreach worker ensuring that on discharge, homeless patients can be found accommodation and offered GP and drug and alcohol services if needed. Readmission statistics will be available by May 2014, which will be used to evaluate whether the project is helping to keep homeless people out of hospital.

4. Summary of priority issues identified by stakeholders

- GP Options is commissioned to provide healthcare at one hostel but other housing providers would welcome their input.
- Stakeholders would benefit from networking events, collaboration across pathway planning and more partnership working.
- Ensure that the successful homeless prevention work in Knowsley continues, as it has proved to be cost beneficial.
- Mental health provision was mentioned as something that was difficult to access. It would be useful for the mental health service pathway to be revisited for homeless people in the Knowsley area.
- Welfare reforms, in particular benefit sanctions, are causing a lot of hardship and putting extra pressure on services.
- The limited number of sexual health sessions at the SHAP supported housing scheme are always over-subscribed, suggesting the need to expand this service, which is successful in reaching 'hard to reach' groups.

Liverpool Summary

1. The extent of homelessness

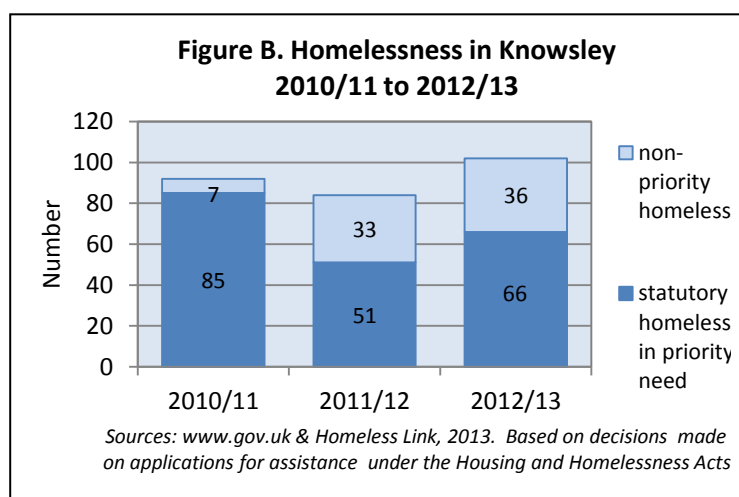### 1.1 Statutory homelessness, in priority need

In 2012/13, 524 people in Liverpool applied for assistance under the Housing and Homelessness Acts. Of these, 187 (36%) were accepted as being statutorily homeless and in priority need (compared to 44% in Liverpool City Region).

In the three year period from 2010/11 to 2012/13, the rate of statutory homelessness in Liverpool fluctuated, from 1.13 to 0.94 per 1,000 households (Figure C shows actual numbers). The rate in 2012/13 was the second lowest in Liverpool City Region (Liverpool City Region rate = 1.1 per 1,000 households, 2012/13). Black and ethnic minority groups are significantly over represented among those recognised as homeless and in priority need, with more than 1 in 4 (28.3%) coming from a BEM group.

The most common reason for statutory homelessness in Liverpool was 'violent relationship breakdown with partner' (28%). Levels were the highest in Liverpool City Region. There were also relatively high levels of homeless acceptances due to leaving asylum support (11.0%, compared to 2.8% nationally) and prison (3.2%, compared to 0.8% nationally) (Jan 2010 to June 2013).

1.2 Non-priority homelessness

In 2012/13, 19% (97) of all housing assistance applications in Liverpool were eligible, homeless, but not in priority need (i.e. mainly single homeless). This is comparable to the Liverpool City Region rate of 18%.

Figure C. Homelessness in Liverpool 2010/11 to 2012/13

Sources: www.gov.uk & Homeless Link, 2013. Based on decisions made on applications for assistance under the Housing and Homelessness Acts

The 2012/13 levels show a fall in non-priority homeless applications compared to 2010-11, when 22% (124) of all applications were homeless but not in priority need in Liverpool (Figure C shows actual numbers).
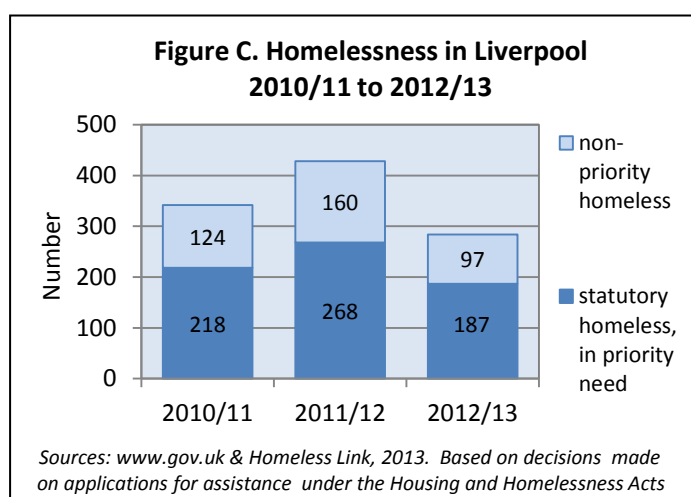
2. Health needs

Supporting People clients

There were 1,249 single homeless people moving on from Supporting People services in Liverpool in 2012/13 (primary client group). Of these:
- 340 (27%) had physical health needs (compared to 32% in Liverpool City Region) and 77% had these needs met (87% Liverpool City Region)
- 318 (25%) had mental health needs (28% Liverpool City Region) and 73% had these needs met (78% Liverpool City Region)
- 489 (39%) had substance misuse issues (37% Liverpool City Region) and 44% had these needs met (53% Liverpool City Region)

There were 89 homeless families moving on from Supporting People services in 2012/13. Of these:

- 23 (26%) had physical health needs (20% Liverpool City Region) and 100% had these needs met (89% Liverpool City Region)
- 23 (26%) had mental health needs (20% Liverpool City Region) and 91% had these needs met (85% Liverpool City Region)
(numbers of families with substance misuse issues were too small to include)

Structured drug and alcohol treatment

Of all alcohol and drug clients from Liverpool commencing structured treatment during a 9 month period (1/4/13 to 31/12/13), there were 91 alcohol clients who were homeless (8% of all clients) and 212 drug clients (16% of all clients).

3. Specialist healthcare

Specialist healthcare for the homeless is provided by the Brownlow Group Practice, with 2 specialist GPs, 2 homeless outreach nurses; and a Hepatitis nurse (who also deals with the general practice population). For those who are registered, there is a walk-in service available 8am-4pm. The Homeless Access Clinic (HAC) is run 1 afternoon per week for people who do not have to be registered. Liverpool also has a specialist mental health homeless nurse and an alcohol nurse.

Hospital Outreach Work: The specialist hospital outreach scheme at the Royal Liverpool Hospital ensures that on discharge, homeless patients can be found accommodation and offered GP and drug and alcohol services if needed. Readmission statistics will be available by May 2014, which will be used to evaluate whether the project is helping to keep homeless people out of hospital.

4. Summary of priority issues identified by stakeholders

- Commissioners should ensure that services are in delivered in appropriate ways to maximise uptake among the homeless population. Current good examples include the Outreach care provided through Brownlow Group Practice and hospital outreach workers from RLBUHT. Consideration should also be given to independent sector providers.
- Homeless people need to be able to access the same services as other vulnerable groups, for example by the commissioning of nurses to work on site in hostels.
- There is a need to improve assessment procedures and provide more immediate and flexible appointments, in mental health and also for drugs and alcohol interventions.
- Young people are presenting at an even younger age and staying longer than before at hostels, with more complex problems. Local services are closing due to lack of funding which over time will exacerbate this problem.
- Re-organisation, redesign and re-commissioning of services, involving increased collaboration, could help remove duplication of provision, and keep the funding cuts away from front line staff.
- 'End of Life Care for homeless people' should be included in the Strategic Plans for all Clinical Commissioning Groups.

Sefton Summary

1. The extent of homelessness

1.1 Statutory homelessness, in priority need

In 2012/13, 178 people in Sefton applied for assistance under the Housing and Homelessness Acts. Of these, 59 (33%) were accepted as being statutorily homeless and in priority need (compared to 44% in Liverpool City Region).

In the three year period from 2010/11 to 2012/13, the rate of statutory homelessness in Sefton increased from 0.38 to 0.50 per 1,000 households (Figure D shows actual numbers). The rate in 2012/13 was the lowest in Liverpool City Region (Liverpool City Region rate = 1.1 per 1,000 households, 2012/13).

The most common reason for statutory homelessness in Sefton was 'other relatives/friends no longer willing to accommodate' (25%). Levels for this reason were the highest in Liverpool City Region. There were also relatively high levels of homeless acceptances due to leaving care (2.2%, compared to 1.4% nationally) and leaving prison (2.2%, compared to 0.8% nationally) (Jan 2010 to June 2013).

1.2 Non-priority homelessness

In 2012/13, 49% (88) of all housing assistance applications in Sefton were eligible, homeless, but not in priority need (i.e. mainly single homeless). This is the highest level in Liverpool City Region (Regional rate = 18%).

Figure D. Homelessness in Sefton 2010/11 to 2012/13

Sources: www.gov.uk & Homeless Link, 2013. Based on decisions made on applications for assistance under the Housing and Homelessness Acts

The 2012/13 levels show a large rise in non-priority homeless applications compared to 2010-11, when 16% (17) of all applications were homeless but not in priority need in Sefton (Figure D shows actual numbers).

2. Health needs

Supporting People clients

There were 222 single homeless people moving on from Supporting People services in Sefton in 2012/13 (primary client group). Of these:
- 149 (67%) had physical health needs (compared to 32% in Liverpool City Region) and 95% had these needs met (87% Liverpool City Region)
- 60 (27%) had mental health needs (28% Liverpool City Region) and 87% had these needs met (78% Liverpool City Region)

- 86 (39%) had substance misuse issues (37% Liverpool City Region) and 52% had these needs met (53% Liverpool City Region)

There were 57 homeless families moving on from Supporting People services in 2012/13. Of these:
- 9 (16%) had physical health needs (20% Liverpool City Region) and 89% had these needs met (89% Liverpool City Region)
- 4 (7%) had mental health needs (20% Liverpool City Region) and 75% had these needs met (85% Liverpool City Region)

(numbers of families with substance misuse issues were too small to include)

Structured drug and alcohol treatment

Of all alcohol and drug clients from Sefton commencing structured treatment during a 9 month period (1/4/13 to 31/12/13), there were 39 alcohol clients who were homeless (8% of all clients) and 67 drug clients (17% of all clients).

3. Specialist healthcare

There is no dedicated GP lead or nursing care for the homeless population in Sefton. The following healthcare is available to clients in supported accommodation: Healthcare Assessments; Hep B and Hep C Testing, vaccination and treatment; HIV testing; Wound care (injection sites); Prescribing Services; Complementary Therapies.

4. Summary of priority issues identified by stakeholders

- Improved provision of preventive services would in the long term reduce the need for funding into crisis management work.
- Leads from Public Health, CCGs and Housing should further develop existing collaborative working. Integrated commissioning of services would ensure successful joint working continues.
- Much of the available housing is privately owned and there are few emergency or short term beds for homeless people
- Relationship building across statutory, voluntary and other organisations will help to increase personalised care and enhance appropriate care pathways.
- Services are facing cuts, whilst dealing with individuals with more complex needs leading to bigger workloads for less staff. The Council is undertaking a commissioning exercise that will include all "homeless and housing related support services". The recommendations within the Council's Homeless Strategy will inform the commissioning exercise.
- The adult mental health service provide a good service, but young homeless people do not have timely access to the services to meet their mental health needs, meaning voluntary organisations are under increasing pressure to provide in-house care themselves. Commissioners need to work with voluntary organisations to develop direct pathways from voluntary organisations to service providers such as IAPT (the Increasing Access to Psychological Therapies programme).

St. Helens Summary

1. The extent of homelessness

1.1 Statutory homelessness, in priority need

In 2012/13, 232 people in St. Helens applied for assistance under the Housing and Homelessness Acts. Of these, 151 (65%) were accepted as being statutorily homeless and in priority need (compared to 44% in Liverpool City Region).

In the three year period from 2010/11 to 2012/13, the rate of statutory homelessness in St. Helens decreased from 2.99 to 1.99 per 1,000 households (Figure E shows actual numbers). Despite this fall, the rate in 2012/13 was still the highest in Liverpool City Region (Liverpool City Region rate = 1.1 per 1,000 households, 2012/13).

The most common reason for statutory homelessness in St. Helens was 'loss of rented or tied accommodation' (29%). Levels for this reason were the highest in Liverpool City Region.

1.2 Non-priority homelessness

In 2012/13, only 4% (10) of all housing assistance applications in St. Helens were eligible, homeless, but not in priority need (i.e. mainly single homeless). This is the lowest level in Liverpool City Region (Regional rate = 18%).
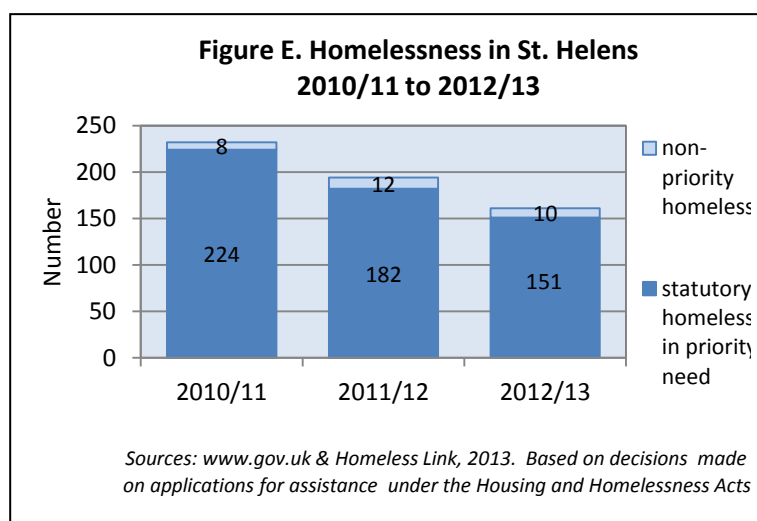
Levels have been relatively stable since 2010-11, when 3% (8) of all non-priority applications were homeless but not in priority need in St. Helens (Figure E shows actual numbers).

Figure E. Homelessness in St. Helens 2010/11 to 2012/13

Sources: www.gov.uk & Homeless Link, 2013. Based on decisions made on applications for assistance under the Housing and Homelessness Acts

2. Health needs

Supporting People clients

There were 568 single homeless people moving on from Supporting People services in St. Helens in 2012/13 (primary client group). Of these:

- 167 (29%) had physical health needs (compared to 32% in Liverpool City Region) and 87% had these needs met (87% Liverpool City Region)
- 175 (31%) had mental health needs (28% Liverpool City Region) and 80% had these needs met (78% Liverpool City Region)
- 191 (34%) had substance misuse issues (37% Liverpool City Region) and 53% had these needs met (53% Liverpool City Region)

There were 68 homeless families moving on from Supporting People services in 2012/13. Of these:

- 30 (44%) had physical health needs (20% Liverpool City Region) and 90% had these needs met (89% Liverpool City Region)
- 24 (35%) had mental health needs (20% Liverpool City Region) and 88% had these needs met (85% Liverpool City Region)

(numbers of families with substance misuse issues were too small to include)

Structured drug and alcohol treatment

Of all alcohol and drug clients from St. Helens commencing structured treatment during a 9 month period (1/4/13 to 31/12/13), there were 47 alcohol clients who were homeless (17% of all clients). Around 1 in 4 of all drug clients were homeless (n=38, 23% of all clients). St. Helens had the second highest proportions of homeless drug and alcohol clients in Liverpool City Region.

3. Specialist healthcare

There is a specialist homelessness nursing service in St. Helens. Bridgewater Health for Homeless Team consists of one specialist homelessness nurse, a support worker and an administrator. Their work includes visiting hostels once a week. A large proportion of time is undertaken on preventive work, including hospital visits. They also make twice weekly visits to Hope House, a Day Centre that provides an important link to health services for homeless people.

Hospital Outreach Work: A recent pilot at Whiston Hospital involved the outreach worker ensuring that on discharge, homeless patients can be found accommodation and offered GP and drug and alcohol services if needed. Readmission statistics will be available by May 2014, which will be used to evaluate whether the project is helping to keep homeless people out of hospital.

4. Summary of priority issues identified by stakeholders

- The specialist homelessness nursing service is said to be over-stretched. A review of the capacity of this service needs to be undertaken.
- A regular forum to discuss working, case management and collaboration across sectors would be useful in continuing to promote collaboration across sectors.
- There is a need for improved access to mental health care.
- The service provided by the drug and alcohol service is seen by some as not accessible/flexible enough to meet the needs of the population. It is also extremely difficult to share information across the sector. Agencies need to work collaboratively to seek creative solutions and to identify opportunities for appropriate data sharing
- Hostel staff and housing association staff are finding it increasingly difficult to work with people when their benefits are sanctioned, which can often undo the work of homelessness services.
- The focus group felt that some clients including those discharged from hospital are too ill to be cared for in a hostel. Some felt that other options, such as a specialist hostel providing intermediate care or extra staff with health care training in existing hostels, should be considered.

Wirral Summary

1. The extent of homelessness

1.1 Statutory homelessness, in priority need

In 2012/13, 305 people in Wirral applied for assistance under the Housing and Homelessness Acts. Of these, 165 (54%) were accepted as being statutorily homeless and in priority need (compared to 44% in Liverpool City Region).

In the three year period from 2010/11 to 2012/13, the rate of statutory homelessness in Wirral increased from 0.57 to 1.21 per 1,000 households (Figure F shows actual numbers). (Liverpool City Region rate = 1.1 per 1,000 households, 2012/13).

The most common reason for statutory homelessness in Wirral was 'loss of rented or tied accommodation' (18%). The proportion of homeless acceptances due to people leaving HM Forces was especially high on Wirral, at 3.4% (n=13) (Jan 2010 to June 2013. National rate = 0.4%).

1.2 Non-priority homelessness

In 2012/13, 9% (26) of all housing assistance applications in Wirral were eligible, homeless, but not in priority need (i.e. mainly single homeless). This is the second lowest level in Liverpool City Region (Regional rate = 18%).

Figure F. Homelessness in Wirral 2010/11 to 2012/13

Sources: www.gov.uk & Homeless Link, 2013. Based on decisions made on applications for assistance under the Housing and Homelessness Acts
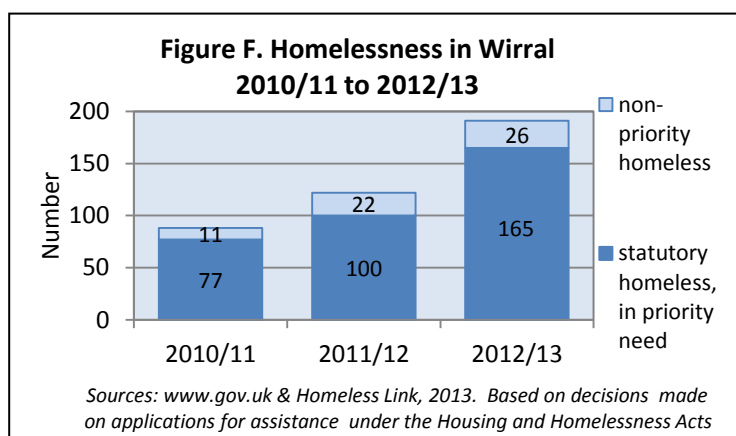
The 2012/13 levels show a rise in non-priority homeless applications compared to 2010-11, when 6% (11) of applications were homeless but not in priority need (Figure F shows actual numbers).

2. Health needs

Supporting People clients

There were 432 single homeless people moving on from Supporting People services in Wirral in 2012/13 (primary client group). Of these:
- 191 (29%) had physical health needs (compared to 32% in Liverpool City Region) and 95% had these needs met (87% Liverpool City Region)
- 175 (41%) had mental health needs (28% Liverpool City Region) and 82% had these needs met (78% Liverpool City Region)
- 203 (47%) had substance misuse issues (37% Liverpool City Region) and 71% had these needs met (53% Liverpool City Region)

There were 56 homeless families moving on from Supporting People services in 2012/13. Of these:

- 10 (18%) had physical health needs (20% Liverpool City Region) and 100% had these needs met (89% Liverpool City Region)
- 12 (21%) had mental health needs (20% Liverpool City Region) and 92% had these needs met (85% Liverpool City Region)

(numbers of families with substance misuse issues were too small to include)

Structured drug and alcohol treatment

Of all alcohol and drug clients from Wirral commencing structured treatment during a 9 month period (1/4/13 to 31/12/13), there were 105 alcohol clients who were homeless (13% of all clients) and 95 drug clients (19% of all clients).

3. Specialist healthcare

There is no specialist GP provision for the homeless on Wirral, but there are seven dedicated homeless health workers with various roles:
- A Homeless Nurse Practitioner, with regular clinics in all local hostel and homeless services.
- A Homeless Mental Health Nurse Practitioner similarly holds regular clinics.
- A Homeless Drug and a Homeless Alcohol Worker.
- Two Town Centre Outreach Workers commissioned to engage with rough sleepers and street drinkers.
- A Hospital Discharge Worker attached to Arrowe Park and Clatterbridge Hospitals.

Other initiatives include a controlled drinking pilot to tackle problematic street drinking. There are also two key strategic groups that are presently working to improve community healthcare services for the homeless: the Frequent Attenders Group (Arrowe Park Hospital) and the Critical Needs Group (Community).

4. Summary of priority issues identified by stakeholders

- Commissioners should review existing funding arrangements and where possible, explore opportunities for collaborative working to deliver innovative initiatives.
- Consideration should be given to a review of the existing governance/membership arrangements of multi-agency groups which support the local homeless population.
- Health commissioners should consider whether current community nursing care provision is sufficiently meeting patient demand.
- Hostels require greater support from other appropriate services to address the complex needs of residents.
- Action should be taken to ensure that homeless people have equal access to appropriate End of Life care, including hospice provision.
- Whilst acknowledging the financial constraints now and in the future, a longer term vision with a focus on prevention is required.

Main Report

1. Homelessness in Liverpool City Region

1.1 Demographic profile of homelessness

Age

Homelessness incidence is greater for younger adults, with nearly 7.6% of 16-24 year olds reporting recent experiences of homelessness (i.e. in the last 5 years), compared to around 2% for other age groups (Fitzpatrick et al, 2013, taken from the 2012 Poverty and Social Exclusion Survey).

Statutory homeless
Figure 1 shows the age profile of those who are statutorily homeless in Liverpool City Region (recorded as the age of the applicant). Just over half are aged between 25-44 and 1 in 4 are aged under 25.

Figure 1
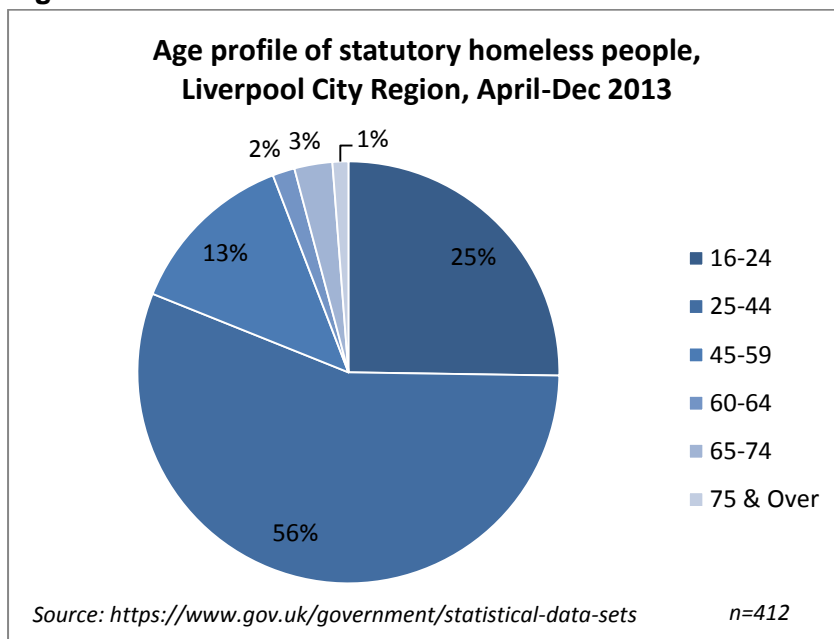
Single Homeless
Single homeless 'Supporting People' clients in Liverpool City Region appear to be relatively young, with over a third (36%) aged under 24 in 2012/13 (Figure 2). This data is for a slightly earlier time period than the data in Figure 1 and covers the Supporting People primary client group.

Figure 2

**Age profile of single homeless people,
Liverpool City Region, 2012/13**

- 16-24
- 25-45
- 46-59
- 60-64
- 65-74
- 75 and Over

1% 1% 0.2%
15%
36%
47%

source: Homeless Link, 2013 (Supporting People data)   *n=3237*
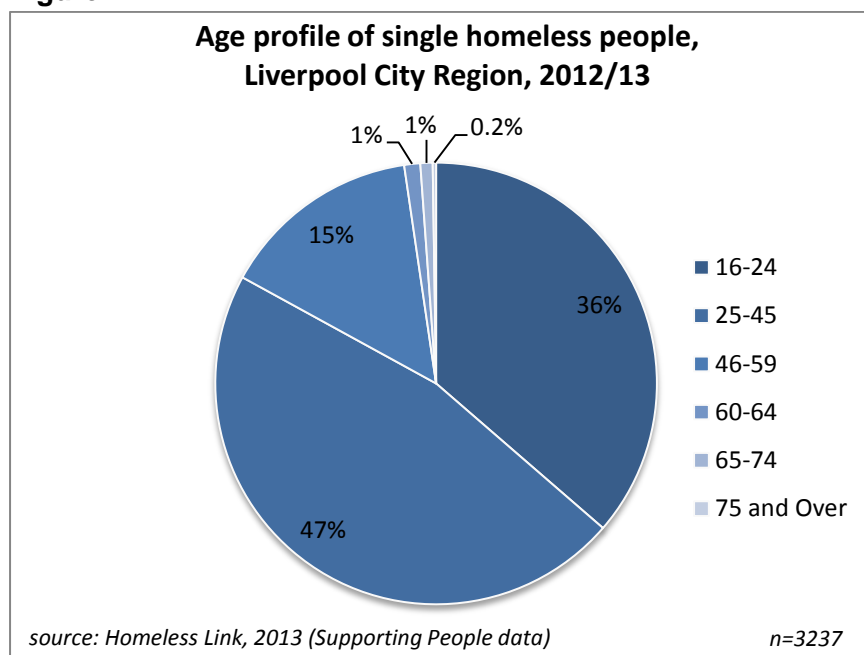
As detailed in the Merseyside Needs Analysis, in the previous financial year, the proportion aged under 24 was higher at 44% (Homeless Link Merseyside, 2013). Although there are significantly more 16-24 year olds in the region than other age groups, overall the numbers have decreased from 1,327 in 2011/12 to 1,177 in 2012/13. While the overall number of young people has decreased from 2011/12 to 2012/13, there have been increases in the number of people in all of the other age groups. The Merseyside Needs Analysis noted that this data is broadly comparable with national data over the last three years.

Gender

In the single homeless population, the vast majority are men, making up three quarters (74%) of clients of homelessness services in England (Homeless Watch/Homeless Link, (2013). The triggers and experiences of women's homelessness tend to be of a distinct nature (Crisis online).

Locally, there is limited data on the gender of homeless people, except for statutorily homeless households, where the majority were female (Table 1).

Table 1
Statutorily homeless households by household type & gender of household recorded during the quarter Apr - Jun 2013, Liverpool City Region

Couple with dependent children	Lone parent household with dependent children		One person household		All other household groups	Total
	Male Applicant	Female Applicant	Male Applicant	Female Applicant		
22.1%	3.1%	50.9%	10.6%	7.1%	6.3%	**100%**

Source: https://www.gov.uk/government/statistical-data-sets

Ethnic group

People from ethnic minority backgrounds are around three times more likely to become homeless than their White counterparts (ODPM, 2005a). The Office of the Deputy Prime Minister (ODPM) report noted that amongst the ethnic minority populations, those of Black African and Black Caribbean origins are twice as likely to be accepted as homeless as those of Indian, Pakistani and Bangladeshi origins.

In Liverpool in 2012/13, more than 1 in 4 (28.3%) of those recognised as homeless and in priority need were from black and ethnic minority groups (BME). This was more than double the number expected when taking into account the ethnic mix of the general population in Liverpool (11.1% BME). Table 2 shows the ethnic mix of the 62 BME homeless people across Liverpool City Region.

Table 2
Ethnic group of those accepted as being homeless and in priority need, 2012/13

	Total	White	Black or Black British	Asian or Asian British	Mixed	Other ethnic origin	Ethnic group not stated	Tot BME	%BME
Halton	86	84	0	0	2	0	0	2	2.3
Knowsley	66	63	0	0	2	0	1	2	3.0
Liverpool	187	127	21	15	7	10	5	53	28.3
Sefton	59	57	1	1	0	0	0	2	3.4
St. Helens	151	143	1	0	0	0	7	1	0.7
Wirral	165	162	1	1	0	0	1	2	1.2
Liverpool City Region	714	636	24	17	11	10	14	62	8.7
North West	3,973	3,071	302	280	83	100	113	765	19.3
England	53,540	34,570	8,150	4,170	1,730	2,230	2,700	16,280	30.4

Source: https://www.gov.uk/government/statistical-data-sets

1.2 Statutory homelessness, priority need

In Liverpool City Region in 2012/13, 1,626 decisions were made on applications for assistance under the Housing and Homelessness Acts[2]. Of these, 714 (44%) were accepted as being statutorily homeless and in priority need. To be considered statutorily homeless, a person has to be eligible for public funds, have a connection to the local area, be unintentionally homeless, and in priority need. The local authority is then required to secure accommodation for them. Priority need groups include households with dependent children, people vulnerable due to e.g. mental illness or domestic violence and those aged 20 or under previously in care (see DfCLG 2013a).

Table 3, taken from the Merseyside Needs Analysis (Homeless Link Merseyside, 2013), shows numbers in each local authority.

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[2] Housing Act 1996, and Homelessness Act 2002

The rate of homelessness in Liverpool City Region, at 1.1 per 1,000 households, was half the national rate (2012/13). Within Liverpool City Region, rates varied from only 0.50 in Sefton, to 1.99 in St. Helens, which was still below the national rate (Table 3 and Figure 3).

Table 3 also shows numbers of those considered to be intentionally homeless and in priority need. In these cases, the local authority has a duty to provide accommodation for a short period and a duty to provide advice and assistance to enable them to find their own accommodation.

Table 3
Homelessness decisions in Liverpool City Region local authorities, 2012-13

	Total decisions	Accepted as unintentionally homeless and in priority need			Eligible, homeless, in priority need, but intentionally	Eligible, homeless but not in priority need	% not in priority need	Eligible but not homeless
		number	%	Rate per 1,000 house holds*				
Halton	166	86	52%	1.72	21	30	18%	29
Knowsley	221	66	30%	1.03	19	36	16%	100
Liverpool	524	187	36%	0.94	16	97	19%	224
Sefton	178	59	33%	0.50	7	88	49%	24
St. Helens	232	151	65%	1.99	23	10	4%	48
Wirral	305	165	54%	1.21	36	26	9%	78
L'pool City Region	1,626	714	44%	1.1	122	287	18%	503
England	113,260	53,540	47%	2.4	8,420	19,790	17%	31,510

Sources: Homeless Link Merseyside (2013) Merseyside Needs Analysis, August 2013.
*https://www.gov.uk/government/statistical-data-sets

Those people who are not homeless have made a claim to be homeless and have been assessed as not homeless.

Non Priority need cases are discussed in Section 1.2.

Prevention

The 2002 Homelessness Act brought in new requirements for local authorities to assess and prevent homelessness in their local areas, and marked the start of a renewed Government focus on homelessness prevention. This was reviewed in 2005 with a Select Committee of ODPM (Office of Deputy Prime Minister) which called for the eradication of homelessness (ODPM, 2005b). A report was produced – 'Sustainable Communities: settled homes; changing lives' (CLG, 2005). From this developed the target to halve the number of households in temporary accommodation by December 2010. A task force was set up to achieve this with its main emphasis on preventing homelessness. The target was achieved and the ethos of prevention became embedded in local authority practices so that homeless figures are still low compared to previously.

Homelessness prevention involves providing people with the ways and means to address their housing and other needs to avoid homelessness. This is done by either assisting them to obtain alternative accommodation or enabling them to remain in their existing home, for example through mediation, conciliation, use of a homeless prevention fund, debt advice, resolution of benefit problems, sanctuary schemes for domestic violence, crisis intervention and mortgage arrears interventions (DfCLG 2013b).

Homelessness relief occurs when an authority has been unable to prevent homelessness but helps someone to secure accommodation, even though the authority is under no statutory obligation to do so. Examples of accommodation that someone might be helped to obtain would include any form of hostel, private rented accommodation, accommodation with friends or relatives, supported lodgings, social housing or low cost home ownership schemes (DfCLG 2013b).

Since 2008, local authorities have been required to provide data on the numbers of households for whom casework and positive action took place in order to prevent or relieve homelessness, either by the authority themselves or by a partner organisation (DfCLG 2013b). With a rate of 6.21 per thousand households, levels of prevention and relief in Liverpool City Region were lower than the national average of 8.20 in 2012/13. Within Liverpool City Region, Knowsley (12.09) and Halton (8.62) had levels higher than the national average. Levels in Sefton were lowest, at 2.65 per thousand households (Table 4).

Table 4
Reported cases of homelessness prevention and relief, 2012/13

	Rate per 1,000 households
Halton	8.62
Knowsley	12.09
Liverpool	6.51
Sefton	2.65
St. Helens	6.75
Wirral	4.90
Liverpool City Region	6.21
England	8.20

Data source: Dept. for Communities & Local Govt. Table 792

Further details on prevention and relief can be found in the technical supplement to this report, and in the Merseyside Needs Analysis, which noted that Halton and Knowsley may have some good practice in this area. For example, Halton prevent many young people (80%) from becoming homeless by enabling them to return home through mediation (Homeless Link Merseyside, 2013).

Trends

Statutory homelessness rates declined between 2004-05 and 2009-10, nationally and in Liverpool City Region and the North West. This was mainly due to government prevention initiatives described in the previous paragraphs.

In Liverpool City Region, rates continued to decline until 2010-11, after which they flattened out at 1.1 per 1,000 households in 2012/13. This is in contrast to the national picture, where rates have risen recently and are now more than twice as high as in Liverpool City Region.

Within Liverpool City Region, rates have fluctuated widely since 2008, as shown in Figure 3. Between 2011/12 and 2012/13, rates increased in Halton, Knowsley, Sefton and Wirral, but they are still much lower than the very high rates found between 2004-05 to 2008-09. Further details on actual numbers can be found in in the technical supplement report.

Figure 3

Trends in homelessness rates across Liverpool City Region, 2008-09 to 2012-13

Source: https://www.gov.uk/government/statistical-data-sets
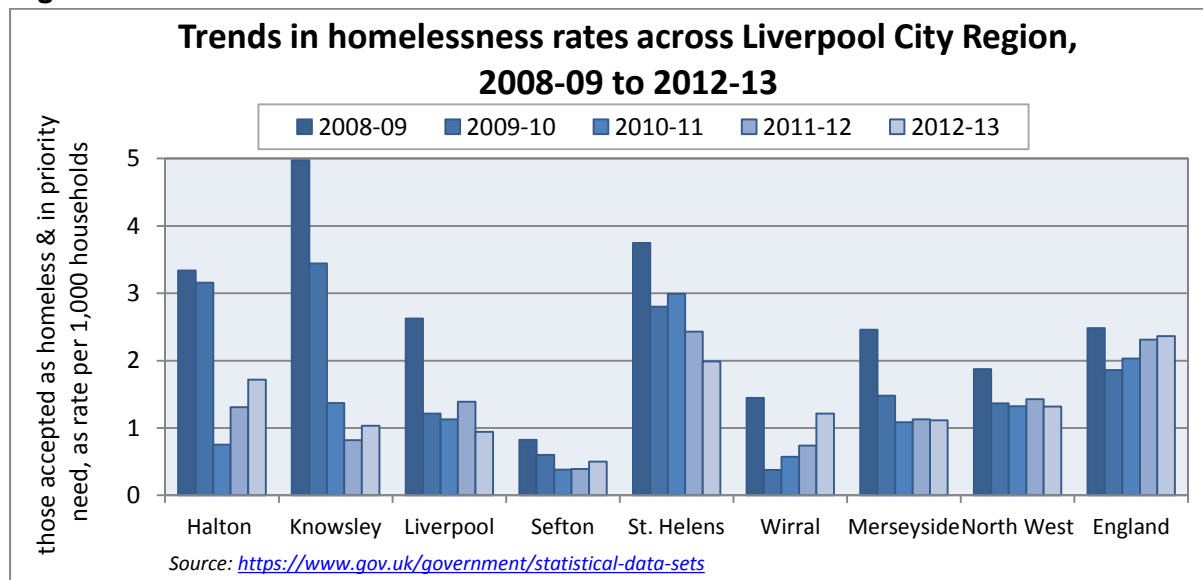
Figure 4 shows that although there have been fluctuations in the numbers of people presenting as homeless over the last five years, there has been very little change in the proportion who are accepted as homeless, at around 44% in Liverpool City Region. Nationally, the proportion of acceptances has similarly been stable, at around 47% over the last 5 years.

Figure 4

Decisions made on homelessness applications and % accepted as homeless, Liverpool City Region, 2008/09 to 2012/13

source: DfCLG https://www.gov.uk/government/statistical-data-sets/live-tables-on-homelessness#discontinued-tables
Note - the number of total decisions are counted, rather than number of applications, because different local authorities have different ways of counting applications for assistance.

Reasons for homelessness

The causes of homelessness are complex and involve personal circumstances and structural factors which may be outside the control of an individual. Homelessness can result from a combination of inter-related factors, often involving family breakdown, poverty, alcohol/ drug abuse and poor mental and physical health. There is evidence which suggests that more homeless people have a low level of educational attainment, compared to the general population (Shelton et al. 2009). There is also evidence of an increased incidence of involvement in crime in the homeless population and an increased level of parental/caregiver abuse or neglect, particularly in young people that are homeless (Shelton et al. 2009). The pie diagram in Figure 5 shows some of the triggers to homelessness, produced by the National Alliance to End Homelessness (online, 2014).

Figure 5
Triggers to homelessness

Taken from: National Alliance to End Homelessness (online, 2014)
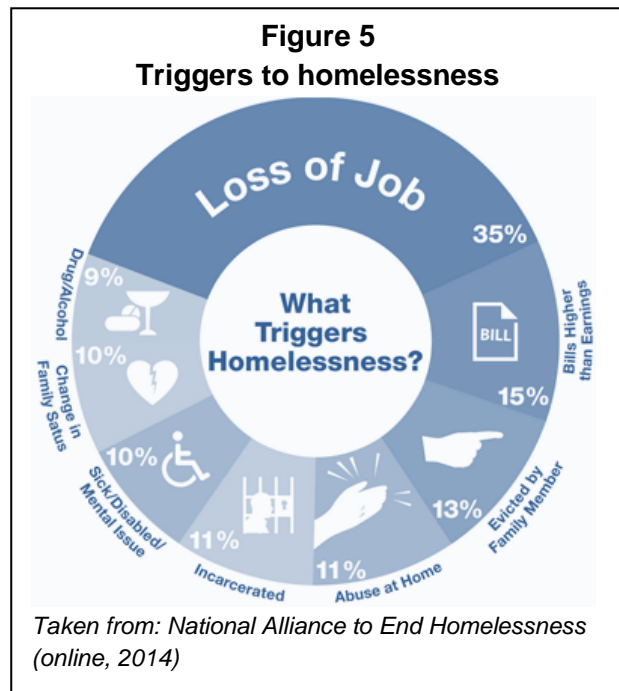
A useful diagram on the pathways into homelessness is reproduced in Figure 6.

Figure 6
Commonly reported pathways into homelessness (Crane 1996)

Taken from: Fordham & Bennett (2008)
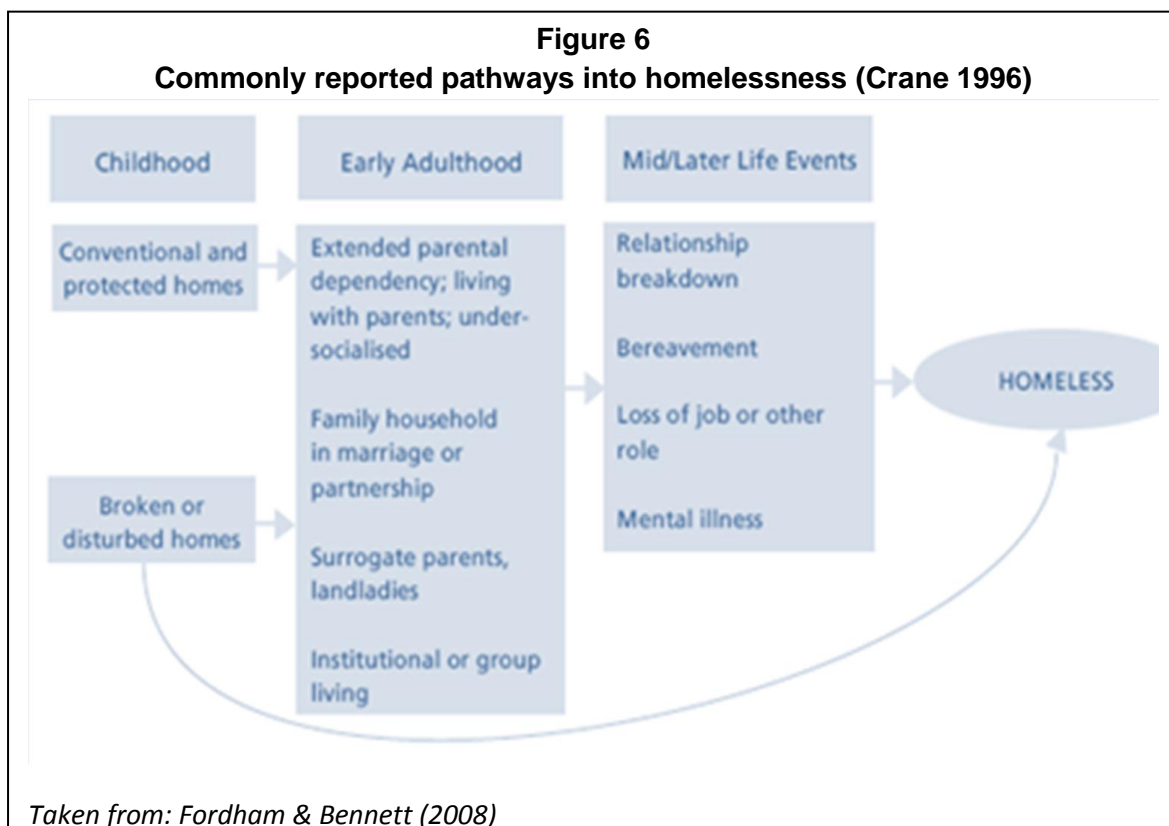
Care leavers, military veterans, ex-offenders, asylum seekers and victims of domestic violence are amongst those who are particularly vulnerable. These groups of people have an

increased risk of becoming homeless and have lower levels of social support once they become homeless. For example, in 2002, it was reported that between 25%-33% of people sleeping rough have been in local authority care (Griffiths 2002). It is es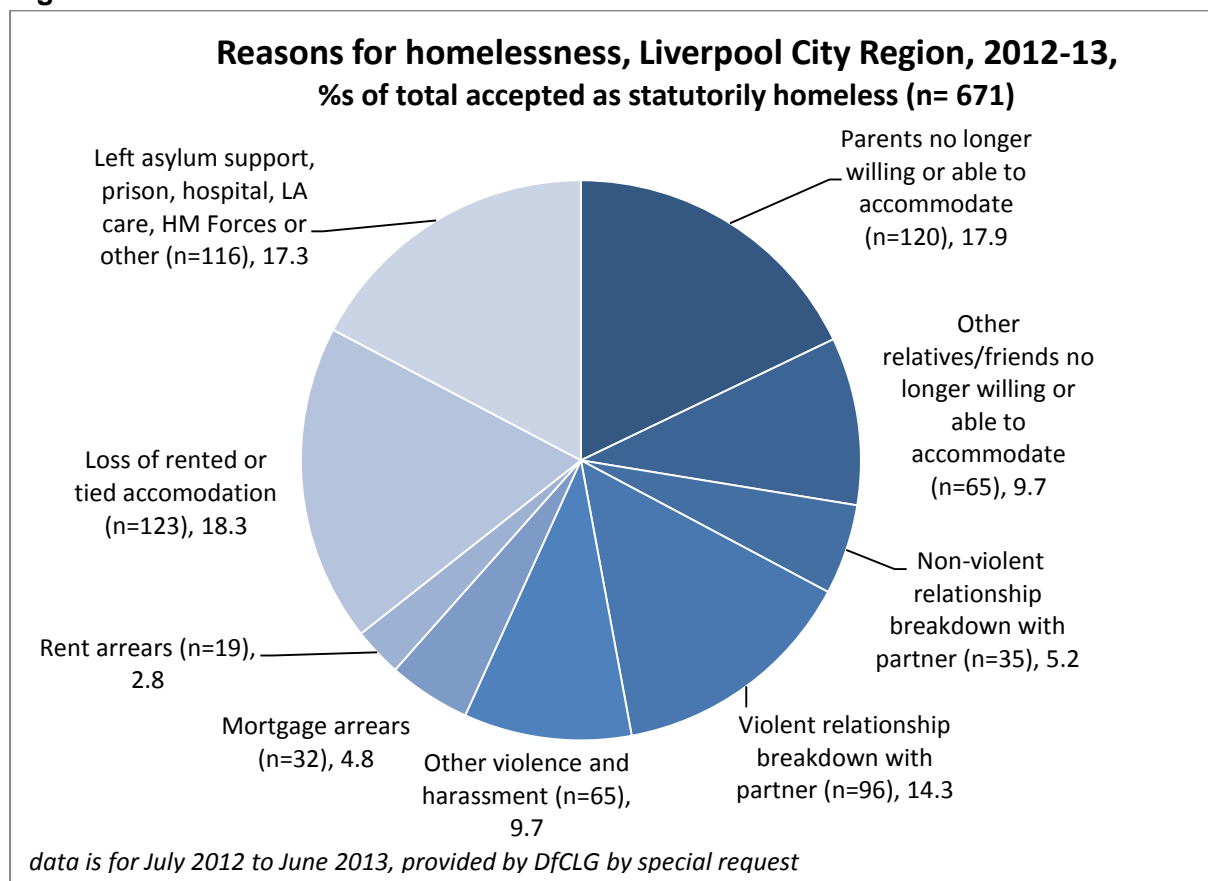timated that between 5 to 12% of single homeless people are military veterans, having been in the armed forces at some time (Royal British Legion, 2011, National Audit Office, 2007).

Reasons for statutory homeless for those in priority need in Liverpool City Region

In Liverpool City Region during 2012-13, the most common reason for homelessness amongst those in priority need was parents, relatives or friends not being able or willing to accommodate the applicant, which accounted for more than a quarter of cases (27.6%) (see the key in Figure 7 for actual numbers).

Figure 7

Reasons for homelessness, Liverpool City Region, 2012-13, %s of total accepted as statutorily homeless (n= 671)

- Left asylum support, prison, hospital, LA care, HM Forces or other (n=116), 17.3
- Loss of rented or tied accomodation (n=123), 18.3
- Rent arrears (n=19), 2.8
- Mortgage arrears (n=32), 4.8
- Other violence and harassment (n=65), 9.7
- Violent relationship breakdown with partner (n=96), 14.3
- Non-violent relationship breakdown with partner (n=35), 5.2
- Other relatives/friends no longer willing or able to accommodate (n=65), 9.7
- Parents no longer willing or able to accommodate (n=120), 17.9

data is for July 2012 to June 2013, provided by DfCLG by special request

In 1 in 5 cases (19.5%), the reason for homelessness was the breakdown of a relationship with a partner, with three-quarters (73.3%) of these involving violence. This was higher than nationally, where the proportion was 69% involving violence.

The loss of rented or tied accommodation accounted for 18.3% of all homeless acceptances in Liverpool City Region (29.3% nationally). This was especially high in St. Helens (29.3%) and in Halton (24.6%) (Jan 2010 to June 2013[3]).

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[3] For individual local authorities, data was combined over a number of years, due to small numbers

The proportion of homeless acceptances due to mortgage arrears is twice as high in Liverpool City Region compared to nationally (4.8% compared to 2.2%). Proportions of people homeless due to rent arrears (2.8%) are similar to national figures.

1 in 10 (11.0%) of all priority need homeless acceptances in Liverpool were people required to leave asylum support accommodation, in the period Jan 2010 to June 2013. This compares to only 2.8% nationally. The high figure in Liverpool is due to the fact that this is the location of one of the few asylum dispersal centres in the country.

During the same period, the proportion of homeless acceptances due to leaving prison was nearly twice as high in Liverpool City Region compared to nationally (1.5% compared to 0.8%). It was especially high in Liverpool (3.2%) and Sefton (2.2%), which may be expected, due to the locations of prisons in Liverpool City Region.

Acceptances due to leaving care were half the national rate (0.7% compared to 1.4% nationally). They were however high in Sefton, at 2.2% of all priority homeless acceptances (Jan 2010 to June 2013).

The proportion of homeless acceptances due to people leaving HM Forces in Liverpool City Region, although small at 0.8% (n=20), was twice the national rate of 0.4%. It was especially high on Wirral, at 3.4% (n=13) (Jan 2010 to June 2013).

Further details on actual numbers can be found in in the technical supplement.

Households in temporary accommodation

Nationally, between 2012 and 2013, the number of households in temporary accommodation rose by 10%, after having fallen between 2004 to 2011. A snapshot in Liverpool City Region in December 2013 revealed there were 108 homeless households in temporary accommodation. The snapshot data showed little change from March 2013, when there were 109 households. However, within each local authority, there have been large fluctuations in numbers (more details in the technical supplement report).

The December 2013 snapshot showed that the proportion of homeless households placed in accommodation with 'shared facilities'[4] was more than four times as high in Liverpool City Region (71.3% of the 109 households) compared to 15.2% nationally. There was little change since the March snapshot, when the figure was 70% in Liverpool City Region. A large proportion of these were in hostel-type accommodation, with the remainder in bed and breakfasts (B&Bs). As many as 17.6% were being housed in bed and breakfast accommodation (B&Bs) (6.9% nationally). Table 5 gives details for each local authority.

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[4] *i.e. bed and breakfast or hostels – although some of these now consist of self-contained units*

Table 5

Types of temporary accommodation found for those accepted as homeless, <u>snapshot</u> as at 31st December 2013.

Number of households (and % of all those in temporary accommodation)

	Bed and breakfast (including shared annexe)		Hostels (including women's refuges)		LA/HA stock/other		Total in temporary accommodation	
	number	%	number	%	number	%	number	%
Halton	0	0.0	3	50.0	3	50.0	6	100
Knowsley	3	33.3	5	55.6	1	11.1	9	100
Liverpool	0	0.0	48	100.0	0	0.0	48	100
Sefton	2	28.6	1	14.3	4	57.1	7	100
St. Helens	0	0.0	1	7.7	12	92.3	13	100
Wirral	14	56.0	0	0.0	11	44.0	25	100
Liverpool City Region	**19**	**17.6**	**58**	**53.7**	**31**	**28.7**	**108**	**100**
England	**3,920**	**6.9**	**4,710**	**8.3**	**48,300**	**84.8**	**56,930**	**100**

Data source: Dept. for Communities & Local Govt. Table 784
https://www.gov.uk/government/statistical-data-sets/live-tables-on-homelessness

Supporting People data shows that there were 546 homeless families (primary client group) with support needs receiving housing related support in 2012/13. There were an additional 184 homeless families (secondary client group), for whom homelessness was not the predominant issue.

1.3 Non-priority need homelessness

If an individual is not considered to be in priority need, then they will not have a statutory entitlement to housing. They will have no legal rights to even emergency accommodation even when roofless (Fitzpatrick et al, 2012), but the local authority does have a duty to provide advice and assistance – usually to enable them to find their own accommodation. Such groups include the following:

- Non-priority homeless people living in hostels and bed and breakfast accommodation
- Rough sleepers
- Hidden homeless people: sofa surfers, some of those in shared, concealed and overcrowded households, and failed asylum seekers and economic migrants who are homeless.

The latest 'Homeless Monitor' report noted that data on the incidence of single homelessness are hard to source. 'Non-priority' cases logged by local authorities provide one possible benchmark (Fitzpatrick et al, 2013). However, this is likely to be an underestimate, as some local authorities may not record every applicant. Most non-priority

homeless people will be single, but there will also be some couples, parents with non-dependent children and non-dependent sibling groups.

The reasons for homelessness amongst the single homeless and other non-statutory homeless groups are likely to be similar to those outlined in Section 1.2 for statutory homelessness (e.g. parents/others no longer willing to accommodate) – but there is no nationally collected data on reasons for non-statutory homelessness.

By its very nature it is extremely difficult to accurately estimate the true levels of hidden homelessness, and failed asylum seekers and economic migrants who are homeless. Those who are 'hidden homeless' may be living in bed and breakfasts, squats, in unsatisfactory or overcrowded accommodation, or staying with friends or families sleeping on floors or settees, with no official right to do so. (NHS Devon, 2011).

In the form of overcrowded, concealed and shared households, there has been a long-term broadly rising trend in such levels of 'hidden homelessness', according to the latest Homelessness Monitor report (Fitzpatrick et al 2013).

Numbers in Liverpool City Region

Table 3 in the previous section shows that in 2012-13, 18% (287) of all housing assistance application decisions in Liverpool City Region were eligible, homeless, but not in priority need. This is lower than the England figure of 20%.

Within Liverpool City Region, proportions of non-priority homeless applicants range from only 4% (10) in St. Helens, to nearly half (49%, 88) of all housing assistance applications in Sefton, 2012-13 (see Table 3 in previous section). It is possible that these may be under-estimates, as some local authorities may not record every applicant.

The 2012-13 figures show a large rise in non-priority homeless applications compared to 2010-11, when there were 170 people homeless but not in priority need in Liverpool City Region (12% of all applications). Within Liverpool City Region, there were increases in each local authority except Liverpool – especially in Sefton, where numbers rose from 17 (16% of all applications) to 88 (49% - around half of all applications) from 2010-11 to 2012-13. Full details can be found in the Merseyside Needs Analysis (Homeless Link Merseyside, 2013).

The Merseyside Needs Analysis included interviews with Housing Options managers. They reported further large increases in presentations to the Housing Options service for housing assistance, of which it is predicted that around 20% will be single homeless people (Homeless Link Merseyside, 2013).

As mentioned in Section 1, it would appear that the Single Homeless clients in Liverpool City Region are relatively young (see Figure 2 in previous section).

Supporting People: Supporting People data shows that there are far more single homeless people than indicated by statutory homelessness figures. There were 2,948 single homeless people using short term 'Supporting People' supported accommodation in Liverpool City Region in 2012/13 – a rise from 2,546 in 2011/12. Numbers in each local authority are shown in Table 6.

This data relates to the primary client group 'single homeless with support needs'. Each of these people will have needs, some of which will be health-related. There were a further 523 individuals in 2012/13 where single homelessness was the secondary client group by which they were defined. For these clients, their primary classification relates to a more predominant issue, such as being an offender or having a drug problem. There may be variations between local authorities and between individual support workers as to how these issues are recorded.

Table 6
Single homeless people moving on from short term supported accommodation, 2012/13

	Number of clients
Halton	280
Knowsley	197
Liverpool	1,249
Sefton	222
St. Helens	568
Wirral	432
Liverpool City Region	**2,948**

- Data relates to the primary client group 'single homeless with support needs'
- Source: Supporting People Outcomes Framework data, supplied by St. Helens Borough Council, Housing Dept.

Rough sleepers

The extent of rough sleeping is difficult to determine. The annual local authority counts are likely to be an underestimate, but can give some indication of the trends over time. Between 2003 and 2010, there had been a sustained large reduction in levels of recorded rough sleeping. However, levels have been rising sharply recently, with the national 'snapshot' count showing a 37% increase between autumn 2010 to autumn 2013 (DfCLG, 2014).

Table 4 shows that in Liverpool City Region, the autumn 2013 total of rough sleeping counts and estimates was 26. This is up by 85.7% from the count of 14 in 2010. Nationally and in the North West, levels also increased, but not by as much - by 36.5% nationally and by 52% in the North West, over the same time period.

Within Liverpool City Region from 2010 to 2013, rough sleeping increased in Halton, Sefton and Wirral. In 2013 in Sefton (9) and Wirral (7), there were more rough sleepers than in Liverpool (6), which is perhaps surprising. In 2013, numbers in Halton and Liverpool were actual counts whilst the other local authorities in Liverpool City Region provided estimates.

Table 4
Street counts and estimates of rough sleeping,
snapshot data, autumn 2010, 2011, 2012 and 2013

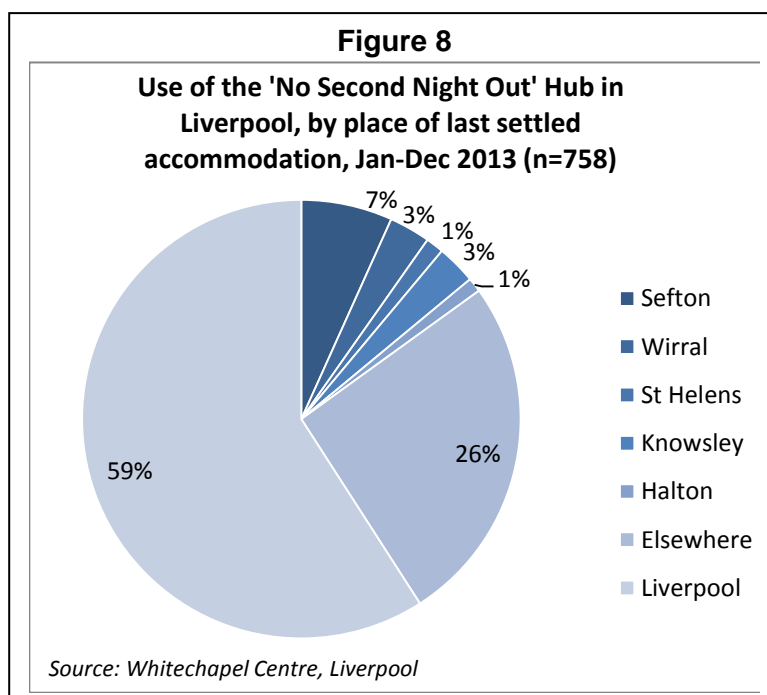|	2010	2011	2012	2013
Halton	*0	*0	0	2
Knowsley	*1	*1	*3	1*
Liverpool	*3	9	6	6
Sefton	*4	*6	*7	*9
St. Helens	*2	2	*2	*1
Wirral	*4	*5	*7	7*
Liverpool City Region	14	23	25	26
North West	100	149	147	152
ENGLAND	1,768	2,181	**2,309	2,414

Notes:
* = estimate
** 24% were in London
A count is a single night snapshot of the number of rough sleepers in a local authority area. Counts are independently verified by Homeless Link.
An estimate is the number of people thought to be sleeping rough in a local authority area on any one night in a chosen week.

No Second Night Out: Whitechapel is the leading homelessness charity for Liverpool City Region, based in Liverpool. Their 'No Second Night Out' (NO2NO) Hub aims to ensure that no individual spends more than one night sleeping rough. Between 2012 and 2013, there was an 18.6% increase in individuals presenting for assessment for support. Of the 1,271 individuals assessed in 2013, 758 had either slept rough the night before or would be sleeping rough that night. The remainder would make other arrangements, such as sleeping on friends' sofas.

During 2013, a total of 758 people used the NO2NO Hub in Liverpool. The majority of clients were from Liverpool (59%, n=448). Figure 8 shows how many clients from other areas accessed the Hub. There are formal arrangements with Sefton and Knowsley to use the Liverpool Hub. Halton and St. Helens have

Figure 8

Use of the 'No Second Night Out' Hub in Liverpool, by place of last settled accommodation, Jan-Dec 2013 (n=758)

7% 3% 1% 3% 1%
59%
26%

- Sefton
- Wirral
- St Helens
- Knowsley
- Halton
- Elsewhere
- Liverpool

Source: Whitechapel Centre, Liverpool

their own arrangements. There were 26% (196) clients accessing the Hub from outside Liverpool City Region.

Wirral run their own emergency provision for rough sleepers. A total of 944 people used this service between March 2013 to Feb. 2014 – nearly three times the target figure of 360. Of the 944, 83% were male and 17% female. There were 13% aged 16-25 and 12% aged 50+. Numbers in Wirral seem high when compared to Liverpool (Figure 8). Further investigation is needed to ensure that any comparisons use the same definitions etc.

Supporting People data: The Merseyside Needs Analysis presented Supporting People data on those receiving housing related support (Homeless Link Merseyside, 2013). They reported that between 2011-12 and 2012-13, the numbers of clients who were sleeping rough increased by 78% (from 83 to 148) (primary client group 'rough sleeper). Clients with general/complex needs also increased, by 67% over the same time period (from 283 to 473) (primary client group).

2. Health needs

Single homeless

The health needs of single homeless people are the most severe and widely documented (DfCLG, 2013c). This group are likely to have complex health needs, including inter-related mental health problems, drug misuse problems, and alcohol dependence. They are also at risk of injury, pneumonia, tuberculosis, dental problems and hypothermia (Gavine, 2013).

Rough sleeping has been described as the most visible and damaging manifestation of homelessness (DfCLG, 2013c). People who sleep rough are likely to have complex health needs, including mental health problems, drug misuse problems, and alcohol dependence. They are also at risk of injury, pneumonia, tuberculosis, dental problems and hypothermia (Gavine, 2013). Rough sleepers have often suffered family breakdowns and other traumatic experiences (Gavine 2013, ref 3).

The rough sleeper population has been generally characterised as:
- 90% male
- 75% aged over 25
- between 25%-33% have been in local authority care
- average age at death of 42 years*
- 35 times more likely to kill themselves than the general population
- four times more likely to die from unnatural causes, such as accidents, assaults, murder, drugs or alcohol poisoning
- 50% alcohol reliant
- around 70% misusing drugs
- 30-50% with mental health problems
- 5% from black and minority ethnic groups

(Griffiths 2002)

average age at death of a sample of homeless people who die whilst they are on the streets or while resident in homeless accommodation – it does not take into account those people who become settled in a home (Department of Health 2010).

Homeless families

Families in temporary homeless accommodation suffer from increased health risks. The report by Shelter (2004) examining the impact of temporary accommodation on the health of homeless families reported that of the 194 families with dependent children that they surveyed, there were increases in reports of depression, increased GP visits/hospital visits and a decrease in self-esteem. There was increased vulnerability to bronchitis and tuberculosis and existing asthma was exacerbated. 58% of families reported that their health had suffered since moving into temporary accommodation with more than 50% reporting depression, rising to up to 64% for those living in workless households. Shelter (2004) also reported that support for existing medical and social problems was not being accessed by families in temporary accommodation; for example, two thirds of people with mental health problems were not accessing support and three quarters of families with children under 4 years old were not accessing Sure Start schemes. One concern voiced by

many families was their inability to plan for their children's future whilst living in temporary accommodation, particularly in terms of their education.

Although some B&Bs are well managed, many are overcrowded, have poor facilities and pose a risk to health and safety (BMA, 2003). Children in B&Bs face greater risks of infection and accidents, with poor housing conditions increasing the risk of severe ill-health or disability by up to 25% during childhood and early adulthood (Shelter, 2006). Access to health care is also a problem. Effects can be long-term, with two-fifths of homeless children still having mental health and development problems one year after being rehoused (Shelter 2006).

Table 5 over the page, taken from a study in Salford, summarises the main health needs associated with single homeless people and homeless families.

Table 5
Homelessness: Broad demographics and health needs by housing status

Homeless Status	Accommodation Type	Accommodation Issue	Demographics	Health Needs
Statutory Homeless	Temporary	• Households accepted by Local Authority	• Predominately lone female led families • Asylum Seekers	• Routine/ general health • Mental Health
Non Statutory Homeless	Insecure	• Squatters • Sofa Surfers • Temporary guests • Facing eviction	• Young people. Often single	• Routine/general health • Mental Health • Communicable disease (esp HIV, Hep A,B & C) • Substance misuse • Poor sexual health
	Unacceptable housing	• Overcrowding • Sub standard accommodation • Personal Safety and wellbeing at risk	• Illegal migrants	• Routine/general health • Mental Health • Violence
	Involuntary long term sharing	• Long term sharing against will	• Illegal migrants	• Routine/general health • Mental Health • Violence
	Houseless	• Hostels • Shelters • Bed & Breakfast	• Single men and women	• Routine/general health • Mental health • Accidents (burns, scalds & infection) • Behavioural disturbances
	Roofless	• Rough sleepers	• Predominately single males	• Substance misuse • Mental health • Suicides & self harm • Violence • Accidents • Communicable diseases • Musculo Skeletal disease • Dental/oral diseases • Neurological diseases • Gastrointestinal diseases

Source: Taken from 'Health and Homelessness in Salford: A rapid review of health needs' (Musgrave, 2011).

National and local data on the health needs of homeless people is presented in sections 2.1 to 2.8 below. The two main sources of local data are the Homeless Link Health Needs Audit for Liverpool, and Supporting People data for Liverpool City Region:

- *Health Needs Audit:* Liverpool is the only Liverpool City Region local authority to have undertaken the Homeless Link audit. This was carried out in July and August 2013 (Homeless Link, 2013). Surveys were conducted with clients from a range of homelessness agencies in Liverpool, with 455 completed questionnaires. The largest group of respondents were from hostels (45%) and 2nd stage supported accommodation (30%), with the remainder sleeping rough (11%), on sofas (3%) or in the Sit Up Shelter (4%) ('other' and 'not known' 8%).

- *Supporting People Data:* Clients using Supporting People accommodation services are asked, during the assessment process, whether they need support to better manage their physical health, mental health, or substance misuse issues. When they leave, a check is made by the support worker on whether their needs were met whilst they were with the service. The support worker will answer 'yes' or 'no' to the question *'is the client managing their (physical) health better?'* (DfCLG and Centre for Housing Research, 2007). So for example, ensuring GP attendance or registration would be a physical health need met. The view of need is client-led. Data was extracted for all clients regarded as homeless (primary client group) for each local authority in Liverpool City Region.

- Local data on treatment for substance misuse is also presented.

2.1 Physical health

Audit and related literature

The national Homeless Link audit found that 8 in 10 (82%) single homeless people have one or more physical health conditions (Homeless Link, 2010). The top four reported physical health needs related to joints/muscular pain; chest pain/breathing; dental; and eyesight (Table 6). The table shows that levels of poor physical health are significantly higher than in the general population for these conditions.

The Liverpool Homeless Link audit found that the prevalence of physical health problems was higher for each condition when compared to the results of the national homelessness audit. In Liverpool, 2 in 5 homeless people experience joint aches or problems with bones and muscles, and 1 in 3 suffer from chest pain or breathing problems.

(Note: Liverpool is the only Liverpool City Region local authority to have undertaken the Homeless Link audit).

Families: The effect of homelessness on children can be long-lasting. Shelter noted that poor housing conditions increase the risk of severe ill-health or disability by up to 25% during childhood and early adulthood (Shelter, 2006).

Table 6
Physical health needs of people who are homeless, compared to the general population

	National (and Liverpool)	General population
Joints/muscular pain	38% (41%)	10%
Chest pain/breathing problem	32% (34%)	5%
Dental problems	29% (32%)	N/A
Eye complaints	25% (29%)	1%

Sources: Homeless Link 2010, national audit (n=727); and Homeless Link 2013, Liverpool Audit (n=455) (Liverpool is the only Liverpool City Region local authority to have undertaken the Homeless Link audit).

Supporting People data

The health needs of single homeless clients using Supporting People accommodation services are likely to be less severe than those in the Homeless Link Audit, which included rough sleepers and sofa surfers. Of the 2,948 Supporting People single homeless clients (primary client group) in 2012/13, 1 in 3 (32%) were reported to have physical health needs. Highest levels were found in Sefton, at two-thirds (67%) of all clients. Lowest levels were found in Knowsley (18%) (Table 7).

Of the 546 homeless families (primary client group), 1 in 5 (20%) were reported to have physical health needs (Table 8). Within Liverpool City Region, there were high levels of need reported in St. Helens (44% of all families) and Liverpool (26%). Levels were low in Knowsley, at only 1 in 10 (11%).

Needs met: Across Liverpool City Region, 87% of single homeless clients and 89% of homeless families had their physical health needs met whilst in supported accommodation.

Table 7
Single homeless people moving on from Supporting People services:
Numbers with health needs and proportions with health needs met, 2012/13
Primary client group 'single homeless'

	Total Clients	Physical Health		Mental Health		Substance Misuse	
		Number with Need (% of total)	% with Need Met	Number with Need (% of total)	% with Need Met	Number with Need (% of total)	% with Need Met
Halton	280	62 (22%)	90%	56 (20%)	82%	99 (35%)	61%
Knowsley	197	35 (18%)	91%	33 (17%)	76%	21 (11%)	67%
Liverpool	1249	340 (27%)	77%	318 (25%)	73%	489 (39%)	44%
Sefton	222	149 (67%)	95%	60 (27%)	87%	86 (39%)	52%
St. Helens	568	167 (29%)	87%	175 (31%)	80%	191 (34%)	53%
Wirral	432	191 (29%)	95%	175 (41%)	82%	203 (47%)	71%
Liverpool City Region	**2,948**	**944 (32%)**	**87%**	**817 (28%)**	**78%**	**1,089 (37%)**	**53%**

Source: Supporting People Outcomes Framework data, obtained from St. Andrews University by St. Helens Borough Council Housing Dept.

Table 8
Homeless families moving on from Supporting People services:
Numbers with health needs and proportions with health needs met, 2012/13
Primary client group 'homeless families with support needs'

	Total number of families	Physical Health		Mental Health		Substance Misuse	
		Number with Need (% of total)	% with Need Met	Number with Need (% of total)	% with Need Met	Number with Need (% of total)	% with Need Met
Halton	115	20 (17%)	75%	34 (30%)	79%		
Knowsley	161	18 (11%)	83%	12 (7%)	83%		
Liverpool	89	23 (26%)	100%	23 (26%)	91%	Numbers too small to include	
Sefton	57	9 (16%)	89%	4 (7%)	75%		
St. Helens	68	30 (44%)	90%	24 (35%)	88%		
Wirral	56	10 (18%)	100%	12 (21%)	92%		
Liverpool City Region	**546**	**110 (20%)**	**89%**	**109 (20%)**	**85%**	**26 (5%)**	**62%**

Source: Supporting People Outcomes Framework data, obtained from St. Andrews University by St. Helens Borough Council, Housing Dept.

Reasons needs not met:

Accommodation providers are asked to record why the physical health, mental health, and substance misuse needs of homeless people had not been met against a list of reasons (Box 2).

Across Liverpool City Region as a whole, two reasons predominate -

- o Client unwilling to engage with support
- o Client ceased to receive support before outcome was achieved

In more than 80% of cases these were cited as the main factors for physical health, mental health, and substance misuse needs not being met.

It is unclear why this is. Some possible reasons include:

- ▪ Clients abandoning accommodation before it is possible to achieve an outcome. The single homeless client group is known to be quite mobile
- ▪ Clients may have multiple and competing support needs. There may not have been time to address all of these needs. Such clients are also more likely to be unwilling to engage
- ▪ Accommodation providers ticking this reason as an easy option.

> **Box 2**
>
> **Needs met**
> The support worker will answer 'yes' or 'no' to the question *'is the client managing their (physical) health better?'*
>
> **Reasons needs not met**
> Supporting People providers are asked to select from the following list:
>
> *Factors to do with the client:*
> - o Client unable to engage with support
> - o Client unwilling to engage with support
> - o Client ceased to receive support before outcome was achieved
>
> *Service unable to meet support need:*
> - o Difficulties with support planning
>
> *Factors in the external environment:*
> - o Problems in accessing local primary health care services
> - o Long waiting lists for primary health care services
> - o Client awaiting assessment
> - o Treatment ongoing
> - o Other
>
> *Supporting People Outcomes Framework, DfCLG and Centre for Housing Research, 2007*

2.2 Mental health

Audit and related literature

There is strong evidence that those who experience repeat homelessness have severe and enduring mental health problems (Maguire et al, 2009). Problems are inter-related, with nearly half of those with a mental health problem self-medicating by using drugs or alcohol (Homeless Link 2010). The prevalence of personality disorders in the homeless population is thought to be between 60% to 70% (DH, 2010, Maguire et al, 2009). Psychological disorders such as personality disorders are often ways of coping with traumatic experiences in childhood and may lead to homelessness (Maguire et al, 2009). Maguire et al report on evidence that psychological interventions can improve the life chances of homeless people.

Homeless Link found that 7 in 10 single homeless people have one or more mental health condition - 2.5 times the rate of the general population (Homeless Link 2010). Around 1 in 3 homeless people in Liverpool felt stressed, anxious or mildly depressed, higher than found in the national homeless audit, as shown in Table 9 (Homeless Link 2013, Homeless Link, 2010).

Table 9
Most commonly reported mental health needs amongst homeless people

	Liverpool (2013, n=455)	National (2010, n=727)
Often feel stressed	71%	50%
Experience mild depression	63%	37%
Often feel anxious	65%	41%
Have had suicidal thoughts	25%	19%
Have self-harmed	16%	14%

Source: Homeless Link 2013 and Homeless Link 2010

The Homeless Mental Health Nurse Practitioner in Wirral is reported to be currently working at approximately 50% over specified caseload and is picking up lots of complex cases which fall between services. In addition to the usual dual diagnosis cases, ADHD and in particular, Acquired Brain Injury cases are also prevalent. Initial findings from a study in Wirral suggest that homelessness can be a consequence of Attention Deficit Hyperactivity Disorder (ADHD), with an estimated prevalence of ADHD in the young homeless population of 22%. They found that young homeless adults are **at least** 11 times more likely to be diagnosed with ADHD (Parry, 2014).

Families: Children who have been in temporary accommodation for more than a year are over three times more likely to demonstrate mental health problems such as anxiety and depression than non-homeless children (Shelter, 2006). Previously, the Joseph Rowntree Foundation (1994) has reported that mental health problems are 8 times more likely amongst the hostel and B&B population than the general population and 11 times more likely amongst people sleeping rough than the general population.

Supporting People data

Of the 2,948 Supporting People single homeless clients (primary client group) in 2012/13 in Liverpool City Region, more than 1 in 4 (28%) had mental health needs. Reported levels were highest in Wirral, at 41% of all clients and lowest in Knowsley, at 17%.

Of the 546 homeless families (primary client group) in Supporting People accommodation in 2012/13, 1 in 5 (20%) had mental health needs. This level of mental health need was the same as for physical health need. Within Liverpool City Region, as with physical health needs, levels were again highest amongst families in St. Helens (35% of families). Lowest levels of mental health need were found in families in Knowsley and Sefton.

Needs met: Compared to homeless families, fewer single homeless people had their mental health needs met whilst in supported accommodation – 85% of homeless families and 78% of single homeless clients had their mental health needs met.

2.3 Substance misuse

Audit and related literature

Drug use

There are strong links between substance misuse and homelessness, with drug users seven times more likely to be homeless than the general population (Homeless Link, 2012b).

Nationally, up to half of the drug treatment population are insecurely or unsuitably housed (NTA, 2007). Homelessness also acts as a barrier for many people who could otherwise benefit from accessing drug treatment. A study by Shelter, which interviewed people living within homelessness services, found that primary care practitioners were often reluctant to refer those suffering from substance misuse to psychiatric services (Byrne, 2008; MHN NHS Confederation, 2011).

It has been reported that 75% of injecting drug users have experienced homelessness. Sharing of needles is more common amongst those who are homeless and homeless people are also less able to maintain hygienic injection practices – factors which make them more vulnerable to associated infections (NHS Devon, 2008, – not possible to trace original source). It has been reported that 90% of Hepatitis C infections are related to intravenous drug use (DH, 2002). It has been suggested that screening for drug use based in hostels and day centres would encourage uptake of support (NHS Devon, 2011).

Of the 455 homeless clients in the Liverpool audit, 40% stated that they used drugs, which is fewer than the 52% reported in the national audit.

Only 6 clients (1.3%) in the Liverpool audit said they currently injected drugs and only 2 said they shared injecting equipment. This is fewer than the national homelessness audit figure of 4% who said they injected drugs. These are likely to be underestimates, as clients may not be willing to disclose this information.

Alcohol use

There are high levels of alcohol use amongst the homeless population. A study of 266 homeless hostel dwellers in Glasgow found that 78% were drinking hazardously (Gilchrist and Morrison, 2004). Such levels of alcohol use will lead to high levels of alcohol related harm, from injuries caused by falls or accidents, violent attack and longer term harms such as liver damage or coronary heart disease (NHS Devon, 2011). In the Glasgow study, the prevalence of cognitive impairment was 82% and 21% had alcohol related brain damage. A combination of high alcohol intake and malnutrition can increase the likelihood of certain types of brain damage (NHS Devon, 2011).

There are a comparatively small but persistent group of rough sleepers who maintain high levels of alcohol use and have endured long and sustained periods of rough sleeping (NHS Devon, 2011). They often spend the majority of the day intoxicated. Relationship breakdown is often the trigger to a pattern of rough sleeping and drinking. Alcohol use becomes the central organising principle for this group of people, with any physical ailments having a low priority (NHS Devon, 2011).

Two thirds of the 455 homeless clients in the Liverpool Audit were drinkers (64%), with 1 in 4 (24%) reporting that they usually drink more than 3 times a week, the frequency recognised as being harmful. This was more than the 1 in 5 in the national audit.

Supporting People data

Substance misuse was more prevalent than physical or mental health issues amongst single homeless clients (primary client group) in Liverpool City Region, at 37% of all clients. Levels were particularly high in Wirral, at 47% and low in Knowsley, with only 1 in 10 (11%) reported as having substance misuse issues.

Only 5% of homeless families in Liverpool City Region had needs related to substance misuse

Needs met: The Merseyside Needs Analysis (Homeless Link Merseyside, 2013) noted that the proportion of single homeless people whose needs are being met with regard to substance misuse is consistently low and has fallen throughout the last three years.

Of the 1,089 single homeless people with substance misuse issues, only around half (53%) had their need met whilst in supported accommodation. Within Liverpool City Region, proportions were lowest in Liverpool, with only 44% having their needs met and highest in Wirral, where 71% had needs met.

In the Merseyside Needs Analysis, it was noted that during the interviews with housing options managers, substance misuse and particularly misuse of alcohol was one of the main support needs discussed. It was felt that the number of people with alcohol as their main support need was increasing, that there was generally a lack of support available for those with alcohol needs and that alcohol could often cause clients to behave inappropriately which frequently ends in clients being evicted from hostels (Homeless Link Merseyside, 2013). This would suggest that there is a need to consider how the beds/housing provision are commissioned for people with substance misuse challenges. Do housing providers have a role to play or should what is being commissioned in these circumstances look different?

Although numbers were small, only two thirds (62%) of the 26 homeless families with needs relating to substance misuse had their needs met whilst in supported accommodation – fewer than those with physical or mental health needs.

Drug and alcohol treatment service data

Structured treatment programmes

The National Drug Treatment Monitoring System (NDTMS) collects information on drug and alcohol treatment. The NDTMS database records those in structured treatment for drug and alcohol use, i.e. high threshold tier 3 and 4 services as defined by the Models of Care (NTA, 2002). These services are provided by specialist drug and alcohol teams. The database records accommodation need at the start of each treatment episode.

NDTMS records the accommodation status of clients, including whether they are of 'no fixed abode' (NFA), or have a housing problem, defined as follows:

- o *Urgent/ NFA:* Clients recorded as NFA are regarded as having an *urgent housing problem,* and either live on the streets, use night hostels (on a night-by-night basis), or sleep on a different friend's floor each night.

- o *Housing problem:* Clients recorded as having a *housing problem* are those who stay with friends/family as a short term guest; in a night winter shelter; in a Direct Access short stay hostel; a short term B&B or other hotel; or who are squatters.

For the purposes of this needs assessment, such clients are regarded as homeless. Although there are limitations with the data (detailed after Table 10 below), it does provide a useful proxy indicator of the overall scale of clients with accommodation problems.

Table 10 shows numbers of alcohol and drug clients commencing treatment during a 9 month period (1/4/13 to 31/12/13). Across Liverpool City Region, there were 353 alcohol clients in treatment who were homeless (134 Urgent NFA) and 507 drug clients (144 Urgent NFA). Of all alcohol and drug clients, 1 in 7 are homeless (11% of alcohol clients and 17% of drug clients – 1 in 7 or 14% in total).

Table 10 illustrates that within Liverpool City Region, Halton has the highest proportions of homeless drug and alcohol clients, at more than 1 in 4 of all clients (22% of alcohol clients and 27% of drug clients). Wirral has the highest proportions with urgent housing need. St. Helens has the highest level of drug clients classed with a housing problem (25%).

Table 10
Structured drug and alcohol treatment: Clients commencing new treatment journey, by accommodation need, as recorded at start of latest treatment episode. Numbers and percentages, 1/4/13 to 31/12/13

Primary alcohol client

Accommodation Need		Halton		Knowsley		Liverpool		Sefton		St Helens		Wirral		Liverpool City Region Total	
		(n)	(%)	(n)	(%)	(n)	(%)	(n)	(%)	(n)	(%)	(n)	(%)	(n)	(%)
Homeless	Urgent housing problem	6	3%	**	**	27	2%	7	1%	5	2%	87	11%	**134**	**4%**
	Housing problem	38	19%	25	8%	64	6%	32	7%	42	15%	18	2%	**219**	**7%**
No housing problem		153	77%	264	89%	976	88%	444	90%	230	83%	678	85%	**2745**	**87%**
Young people (under 18)		0	0%	0	0%	20	2%	**	**	0	0%	**	**	**25**	**1%**
Question not answered (or response code 0)		**	**	5	2%	19	2%	6	1%	0	0%	9	1%	**40**	**1%**
Total alcohol clients		**198**	**100%**	**296**	**100%**	**1,106**	**100%**	**492**	**100%**	**277**	**100%**	**794**	**100%***	**3163**	**100%**

Primary drug client

Accommodation Need		Halton		Knowsley		Liverpool		Sefton		St Helens		Wirral		Liverpool City Region Total	
		(n)	(%)	(n)	(%)	(n)	(%)	(n)		(n)	(%)	(n)	(%)	(n)	(%)
Homeless	Urgent housing problem	11	5%	**	**	70	5%	20	5%	**	**	35	7%	**144**	**5%**
	Housing problem	51	22%	25	7%	142	11%	47	12%	38	23%	60	12%	**363**	**12%**
No housing problem		172	74%	350	92%	1,097	84%	312	82%	122	74%	421	82%	**2474**	**83%**
Young people (under 18)		n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**	**n/a**
Question not answered (or response code 0)		n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**	**n/a**
Total drug clients		**234**	**100%***	**379**	**100%**	**1,309**	**100%**	**379**	**100%***	**164**	**100%***	**516**	**100%***	**2981**	**100%**

*Source: data supplied by Public Health England, taken from the NDTMS database, which records those in structured treatment for drug and alcohol use, i.e. high threshold tier 3 and 4 services as defined by the Models of Care (NTA, 2002). For the purposes of this needs assessment, clients with a housing problem are regarded as homeless. *discrepancies due to rounding with fewer decimal places. **supressed value, less than 5*

Data limitations
When interpreting the NDTMS data, the following limitations should be considered:

- accommodation status is not updated, so for some individuals, their accommodation problems may have been resolved, but they will still be registered as homeless on NDTMS. This is why those currently in treatment that commenced before the study period were not included, due to the possibility that their accommodation status may have changed. In future, it may be possible to use data gathered in the TOPS (Treatment Outcomes Profile) quarterly outcomes reports, which would give information on a client's accommodation status throughout their journey (rather than just at journey commencement). However, each partnership area will need to meet an 80% threshold for TOPS completions in order to achieve a meaningful output which is visible on NDTMS.

- the dataset only covers structured treatment, and so is only analysing part of the treatment system. Although there is limited data on non-structured treatment, non-structured treatment services may no longer report to NDTMS in some partnership areas (see next paragraph). Most of the recovery and aftercare services are not included in the NDTMS dataset.

Non structured treatment programmes

Non structured treatment programmes for drugs and alcohol include brief interventions and advice[5] provided by professionals such as GPs, probation and housing workers (tier 1 and 2 services, http://www.drugscope.org.uk/resources/databases/typesoftreatment)

The Centre for Public Health at Liverpool John Moores University (LJMU) collect both Drug and Alcohol data for non-structured (tier 1 and 2) services from the ATMS (Alcohol Treatment Monitoring System), NSTMS (Non-Structured Treatment Monitoring System) and the SES-IAD (Syringe Exchange Service – Inter Agency Database).

Coverage of the data is limited due to poor completion rates in some parts of Liverpool City Region. Some areas report that they do not provide non-structured interventions. LJMU Centre for Public Health are working with areas at the moment to improve coverage.

Table 11 shows the numbers of individuals with substance misuse problems who received non-structured interventions over a 9 month period, 1/4/13 to 31/12/13. In Liverpool City Region, there were a total of 8,068 clients receiving interventions, of whom at least 18% (1,425) were homeless (as defined on the page preceding Table 10). As 22% of returns were not completed, it is likely that numbers of homeless clients are even greater.

Within Liverpool City Region, proportions were highest in Liverpool, where more than 1 in 4 of all clients were homeless (28%). The data for Liverpool comes from a variety of agencies providing services to clients with drug & alcohol treatment needs, including those working

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[5] *Brief interventions:*- usually delivered by a competent practitioner in about five minutes, brief interventions normally include information about the nature and effects of alcohol/drugs and their potential for harm, goal settings, e.g. start dates, targets for reducing alcohol/drug consumption, and arrangements for follow-up monitoring. Extended brief interventions comprise a series of structured interviews (between three and twelve) in general or non-alcohol/drug specialist settings (DH 2006).

with the homeless such as the Basement Project, the Whitechapel Centre, and Community Voice, which might explain the high numbers.

Alcohol

Table 11a shows data for alcohol clients only. Data was only available for 3 local authorities – Liverpool, Sefton and Wirral. For Sefton, data was incomplete, with very low numbers and for Wirral, in 76% of returns, housing status was not recorded.

In Liverpool, 1 in 5 (19%) of the 2,838 clients seen for alcohol misuse in the 9 month period were homeless.

Drugs

Around half of the 4,088 clients in Liverpool City Region attending for drug use interventions had problems with steroid use (2,004 clients), of whom only 38 were recorded as homeless (Table 11b). None of these had an urgent housing problem.

Excluding those with steroid use problems, more than 1 in 3 (38%) of the 2,084 clients in Liverpool City Region receiving non structured interventions for drug use were homeless (Table 11c). Compared to homeless alcohol clients, those receiving interventions for drug misuse were more likely to have an urgent housing problem. The majority of homeless drug clients had urgent housing problems (496) with a further 291 having less severe housing problems (e.g. living in a hostel, sofa surfing – see definition on previous page).

The majority of 'all other drug' clients were from Liverpool (1,536), where almost half (47% n= 724) were homeless.

Table 11. All Clients 1/4/13 to 31/12/13- Accommodation Status

Local Authority	Homeless Urgent housing problem		Housing problem		No housing problem		Not Completed		Total	
	no.	%	no.	%	no.	%	no.	%	no.	%
Halton	-	-	-	-	90	20%	356	80%	446	100%
Knowsley	-	-	*	*	11	23%	36	77%	47	100%
Liverpool	744	16%	530	12%	2,948	64%	371	8%	4,593	100%
Sefton	5	4%	5	4%	120	92%	*	*	130	100%
St. Helens	21	4%	16	3%	406	70%	138	24%	581	100%
Wirral	33	1. 5%	71	3%	1,259	55%	908	40%	2,271	100%
Total:	**803**	**10%**	**622**	**8%**	**4,834**	**60%**	**1,809**	**22%**	**8,068**	**100%**

Table 11a. Primary Alcohol Only

Local Authority	Homeless Urgent housing problem		Housing problem		No housing problem		Not Completed		Total	
	no.	%	no.	%	no.	%	no.	%	no.	%
Liverpool	286	10%	254	9%	2,050	72%	248	9%	2,838	100%
Sefton	-	-	*	*	14	-	-	-	14	-
Wirral	16	1.4%	32	3%	224	20%	841	76%	1,113	100%
Total:	**302**	**8%**	**286**	**7%**	**2,288**	**58%**	**1,089**	**27%**	**3,965**	**100%**

Table 11b. Primary Steroids Only

Local Authority	Homeless Urgent housing problem		Housing problem		No housing problem		Not Completed		Total	
	no.	%	no.	%	no.	%	no.	%	no.	%
Halton	-	-	-	-	77	20%	306	80%	383	100%
Knowsley	-	-	-	-	8	22%	29	78%	37	100%
Liverpool	-	-	10	5%	184	84%	25	11%	219	100%
Sefton	-	-	-	-	46	100%	-	-	46	100%
St. Helens	*	*	*	*	302	74%	106	26%	408	100%
Wirral	*	*	28	3%	836	92%	47	5%	911	100%
Total:	**0**	**0**	**38**	**2%**	**1,453**	**73%**	**513**	**26%**	**2,004**	**100%**

Table 11c. All Other Drugs

Local Authority	Homeless Urgent housing problem		Housing problem		No housing problem		Not Completed		Total	
	no.	%	no.	%	no.	%	no.	%	no.	%
Halton	-	-	-	-	13	21%	50	79%	63	100%
Knowsley	-	-	*	*	*	*	7	100%	7	100%
Liverpool	458	30%	266	17%	714	46%	98	6%	1,536	100%
Sefton	5	8%	*	*	60	92%	*	*	65	100%
St. Helens	18	11%	14	8%	104	62%	32	19%	168	100%
Wirral	15	6%	11	4%	199	81%	20	8%	245	100%
Total:	**496**	**24%**	**291**	**14%**	**1,090**	**52%**	**207**	**10%**	**2,084**	**100%**

Source: Centre for Public Health, Liverpool John Moores University

2.4 Smoking and diet

Smoking:

Smoking disproportionally affects homeless people as they are both more likely to smoke and less likely to quit than wealthier groups (Healton and Nelson 2004). The Liverpool Audit found that 77% of homeless clients were smokers, which was the same as the national figure and much higher than the 21% amongst the general population (Homeless Link 2010, Homeless Link 2013). Research from other countries show similar results (Lee et al 2005). It is estimated that homeless people on average smoke approximately 18.3 cigarettes per day (Okuyemi et al 2006) and rates are also reported to be high in people who have mental health problems. Since 26% of homeless people have mental illness, this subgroup may be particularly at risk. Also, with poor general health and exposure to the cold weather, the detrimental short term effects of smoking such as chest infections, bronchitis, breathing problems and coughs are likely to be further exacerbated.

Diet:

Malnutrition is a common problem amongst homeless people, particularly serious amongst children and the elderly. Homeless people are more likely than the general population to drink excessively and this drinking has a greater impact on the body such as the kidneys or liver, when the person has malnutrition. Because the choices of food that homeless people are offered are usually pre-packaged items such as canned meals or fast food, people who are homeless are likely to be eating more sodium and less likely to have the recommended levels of calcium and fibre.

The Queens Nursing Institute (2012) reported on current evidence for food nutrition and homelessness. They discuss how previous research has focused on diet, nutrition and healthy eating amongst low income households but not amongst homeless people. They discuss research evidence that suggests single people and families who live in low income households have been found to have a reduced intake of vitamins and minerals and have been found to eat more high fat, processed foods or fast food/snack food. They are also less likely to eat food recommended for healthy living e.g. low fat milk, and plenty of fruit, vegetables and wholemeal products.

The report examines the barriers to meeting a healthy diet from the perspective of single homeless people and families. Some of these barriers include: having limited money to buy food, sharing food preparation areas and cooking facilities or having no fixed abode in which to prepare meals, limited food storage spaces and relying on hostels meals, meeting children's food needs first (meaning parents become poorly nourished), eating for fullness rather than nutritional value and the general lack of knowledge about healthy eating.

In the Liverpool Homeless Link Audit, 28% of clients reported not eating any of the recommended '5 a day'. Nationally, the picture was worse, at 1 in 3 of all respondents (Homeless Link, 2010 and Homeless Link, 2013).

2.5 Vaccinations, screening and communicable disease

Children living in temporary accommodation are more likely to miss out on their immunisations (Shelter 2006). Homeless adults may not be able to access routine screening, vaccinations and sexual health services appropriate to their age and sex, especially if they are not registered with a GP.

A template is needed of what vaccinations and screening should be available for different individuals, such as children, women of a certain age, men over 65, diabetics etc. This could be devised in collaboration with Public Health England. Then the agencies involved in the care of homeless people can ensure that their clients are able to access these as appropriate. In routine assessment of individual's and family's needs, their health care needs and eligibility for screening or vaccinations can be formally considered and advice given.

Communicable disease:

TB: The World Health Organisation in their 'Bulletin of TB in vulnerable groups' (WHO online) report that homeless people are at increased risk of TB, have higher default rates and worse treatment outcomes (including mortality) than the general public. In many industrialised countries, TB rates among the homeless can be up to 20 times higher than the general population. Homeless people will require additional targeted screening for communicable diseases such as Hepatitis C, TB and HIV. There are high levels of such disease amongst homeless people. In 1997, TB rates amongst the homeless were 25 times the national average, at nearly 1 in 50. After an increase in the incidence of TB between 1990 to 2005, rates stabilised in the UK over the next seven years (Pedrazzoli et al, 2013). The majority of TB cases in urban homeless populations are attributable to ongoing transmission in shelters (Kong et al. 2002). Poor compliance results in low effectiveness drug therapy (Figueroa-Munoz & Ramon-Pardo 2008), high default rates, poor treatment outcomes, high mortality often related to poor nutritional status and concomitant illness including HIV. Hospitalisation rates are higher and for longer periods, resulting in higher health-care expenditure. A competent referral system is critical to coordinate efforts and ensure treatment success. Providing housing and social services may reduce hospital utilisation and improve treatment completion. Supervised housing appears effective in increasing treatment compliance resulting in substantial cost savings (Figueroa-Munoz & Ramon-Pardo 2008).

HIV: The average time from HIV infection to AIDS is usually about 10 years and a person can live for several years after the AIDS diagnosis (Straub 2007). In the US, it is estimated that 3.4% of the homeless population are HIV positive compared to 0.4% of the general population (Centre for Disease Control and Prevention, 2008). In 2013 it was reported that homeless people also often have problems with other communicable and infectious diseases as well as HIV, TB and Hepatitis C, including hepatitis A, hepatitis B, diphtheria and foot and skin infections. In a meta-analysis of 43 studies (4 UK based) involving 53,736 homeless people by Beijer et al (2012), it was reported that in the UK the prevalence of TB is 34 times higher in the homeless population than the general population and for hepatitis C the prevalence was 50 times higher for homeless people than people in the general population.

Hepatitis C: Hepatitis C is a virus that infects and damages the liver, causing no noticeable symptoms, or vague symptoms such as flu-like symptoms, tiredness and depression. In England, Hepatitis C is most commonly passed on from one person to another by sharing illegal drug injecting equipment, although it can be passed through unprotected sex with an infected person. In 9 out of 10 cases it is passed by sharing drug injecting equipment. One in four people will fight off the virus within the first 6 months of catching it and become virus free, this is dependent on risk factors and the general health of the person. In three out of four people acute hepatitis C develops into chronic hepatitis C and depending on risk factors, more likely in the homeless population, 10-40% of people will develop liver cirrhosis and 20% of these will develop liver failure and another 1 in 20 will develop liver cancer, both of these diseases can be fatal (population data taken from NHS Choices website). The prevalence of Hepatitis C is 3.9%-36.3% of homeless people. In the USA, Beijer et al (2012) report homeless people being four times more likely than the general population to have the disease, whilst in the UK they report homeless people being 50 times more likely than the general population to have the disease.

In the Liverpool single homeless audit, around 1 in 3 clients had received vaccinations for Hepatitis A, Hepatitis B and flu. Between one-third and a half of all clients had been screened for communicable disease (Hepatitis C, TB and HIV) (Homeless Link, 2013).

2.6 GP and dental care

People who are homeless find it more difficult to access primary care, preventive health services and continuing treatment regimes. As problems are left to become more serious, they are more likely to attend A&E or become hospital inpatients, using hospital services at a rate four to eight times greater than the general population (Homeless Link online).

Providing homeless people with access to GP services has been described as an essential step towards their reintegration into mainstream society (Crisis, 2002). The Crisis study estimated that homeless people were forty times more likely not to be registered with a GP than the general population (Crisis, 2002). Mahoney et al. (2008) reported how in primary care it is difficult to access services, or to register with a doctor without an address and therefore the delivery of normal care may be lacking for homeless people. Hostels can be listed as private addresses but professionals may be wary of the background of homeless people and therefore they may be discriminated against. HIV or hepatitis C status along with issues of substance abuse can all cause health professionals to treat homeless people as different from the general population (Tarzian, Neal and O'Neil, 2005). On the other hand, homeless people may be distrusting of professionals and fearful that abstinence of drugs or alcohol may be a condition of treatment (Moller, 2005).

Audit data

In the Liverpool homelessness audit, only 2.4% (11) of homeless clients were not registered at all (Homeless Link, 2013). This compares favourably to the national picture, where 15% of

clients were not registered at all, with some having been refused access due to 'unsuitable behaviour' or lack of ID (Homeless Link, 2010).

Dental care: In the Liverpool homelessness audit, although 1 in 3 homeless clients had dental and teeth problems, access to dental care for homeless people in Liverpool was not as good as access to GPs, with 39% [177] not registered at all. However, since 2006 when the new dental contract came into place, there has been no need to register with a dental practice. An individual can call for an appointment or have an emergency slot at any practice if they have availability. Liverpool have linked Brownlow Group GP practice with Ropewalks dental practice to ensure that any homeless population who need dental treatment can have one place that they can attend which is central to the city centre.

Checklist for GP data request:

CCGs and some individual GP practices were approached regarding the kinds of data they could access relating to homelessness. The codes relating to homelessness are:-

> 13D – housing lack + all child codes
> 13FW – living in temporary housing
> 13F9 – living in hostel
> 13FL – living rough
> 13FA – living in B&B accommodation

Practices need to ensure that all known hostel addresses are included in the homeless code.

These codes stay with the patient, even if the circumstances of the patient change, meaning that the usefulness of any data extracted is debatable. We would have a set of data showing the profile of people who have <u>ever</u> been homeless. It is recommended that further discussions take place on how this data can be improved, using fields that are updated. At present, there is no code to say a patient is no longer homeless. Once this issue has been resolved, the following checklist of GP data for local teams to request can be used:

Data for CCGs to request from each practice:

- o age/sex/ethnicity of patients who are homeless
- o how many had a consultation in the last 12 months? (not counting repeat visits)
- o frequency of attendance in the last 12 months (include comparison to the rest of the practice population)
- o reason for GP consultation.

Data to request from each CCG

- o how many homeless patients have long term conditions such as mental health problems, alcohol or drug misuse and communicable disease? (provide a list of conditions to search).
- o how many have died in the last 12 months, by age group

2.7 Hospital attendance and admission

Due to their complex health problems and lack of access to preventive care and continuing treatment regimes, homeless people will use local health services more often. The costs to the NHS of acute service-use by homeless people are proportionately four times higher than in the general population. Costs of inpatient care are eight times higher (DH, 2010). Single homeless people are five times more likely to use Accident & Emergency Services than the general public and 3.2 times more likely to have hospital admissions (with three times the duration of stay) (DH, 2010, Aspinall 2014).

In the Liverpool homeless audit, during the last 6 months:

- 26% homeless clients had used an ambulance
- 11.5% (52) had been to A&E on 3 or more occasions
- 28% (127) had been admitted to hospital (4 times the rate of 7% for the general population)
- average length of hospital stay was 6.2 days (2.1 days in the general population)

(Homeless Link, 2013 and Homeless Link 2010)

The national homelessness audit found that only just over a quarter (27%) of clients admitted to hospital had help with their housing before they were discharged (Homeless Link, 2010). Homeless Link point out that this would suggest that discharge protocols are not being implemented. According to the Department of Health good practice guidance on hospital discharge (DH, 2003), all acute hospitals should have admission and discharge policies ensuring that homeless people are identified on admission and linked into services on discharge.

The Pathways scheme, introduced in London, involves partnership working between a GP and a hospital nurse for homeless patients in secondary care. This specialist support service, involving regular multiagency meetings to coordinate care, resulted in a 30% reduction of bed days in the first full year. It has led to homeless patients feeling more cared for (Hewett et al, 2012 and http://www.pathway.org.uk/).

Also in London, councils are working with St Mungo's and Homeless Healthcare CIC to create the first London-wide Homeless Hospital Discharge Network to help London's homeless people who need nursing help after leaving hospital (St. Mungo's, 2013). Initially, 24 beds will be provided, located in existing St Mungo's homeless hostels, but specifically designed for homeless people leaving hospital who need follow on nursing aftercare. A team of nurses will work alongside health and housing support staff and peer support workers to best help the person move on as their treatment comes to a close. This could be days or around six to eight weeks, depending on the physical and mental health needs of the person.

Hospital attendances and admissions in Liverpool City Region

A recent Inclusion Health report discussed the issues around identifying key vulnerable groups in data collections, including homeless populations (Aspinall, 2014). The report noted that given the high use of secondary services, the greater likelihood of being admitted as

emergency admissions, and significantly longer length of stays, the capture of the homeless population in hospital service use datasets is a priority area. However the recording of homelessness in Hospital Episode Statistics (HES) Datasets is poor and inconsistent. The 'no fixed abode' (NFA) coding is widely regarded as unsatisfactory as it can miss some homeless people who may give the address of their hostel or other temporary accommodation. It may count people who are not homeless but want to conceal their true address.

For the purposes of the needs assessment, it was decided to make a request for data to assess its usefulness and help to identify where any improvements in data collection would need to be made. Cheshire and Merseyside Commissioning Support Unit (CSU) were approached to provide data on hospital admission and A&E attendances for patients recorded as of 'no fixed abode' for each of the 6 Clinical Commissioning Groups (CCGs) in Liverpool City Region. The data requested was as follows:
* A&E attendances by age and broad diagnosis categories
* Non-elective admissions by age and board diagnosis categories
* Number of 'frequent flyers'
* Any cost data that could be attributed to people identified as NFA

The data obtained showed a large variation between the CCGs in the area, suggesting inconsistencies in data recording are significant. It was felt the figures were unlikely to reflect the true situation and as a result the project steering group made the decision to omit the hospital and A&E data from this report.

Data recommendation

- Clinical Commissioning Groups should establish a full audit of hospital activity for those who are homeless in the region
- In hospitals within each CCG, ensure consistency in defining and recording of 'NFA'
- Future data requests should ensure the following:
    - data is collected by each separate CCG
    - age and broad diagnosis categories are included
    - 'frequent attenders' data includes number of attendances grouped 1-5, 6-10, 11-15 etc.

Hospital discharge

Hospital Outreach Work

There is a specialist hospital outreach worker for the homeless based at the Royal Liverpool Hospital. A recent pilot has seen this service extended to employ more staff to provide outreach cover for evenings and weekends at the Royal, and to cover Whiston Hospital. The outreach worker will make contacts with GPs, voluntary organisations, housing providers and other relevant agencies. They then work with homeless people in hospital so that on discharge, they can be found accommodation and offered GP and drug and alcohol services if needed. This provides much needed assistance to those who are not statutorily homeless. There are ring-fenced beds available for short term use (7 days) if needed, at hostels in

Liverpool (2 beds) and until recently in Halton (2 beds). The pilot has now ended and no further funding is available to cover the extra outreach staff.

By the end of January 2014, 60 homeless people discharged from hospital had been supported under the pilot scheme which ran from 24 Oct 2013 through to 30 April 2014. Readmission statistics will be available by May 2014, which will be used to evaluate whether the project is helping to keep homeless people out of hospital. The London Pathway scheme, mentioned on the previous page, resulted in a 30% drop in bed days occupied by homeless patients in its first full year, equivalent to a reduction of 1000 bed days for the hospital. Allowing for the costs of the intervention, this quality improvement was regarded as being highly cost effective (Hewett et al, 2012 and Bax et al, online).

On the Wirral, a Hospital Discharge Worker is attached to Arrowe Park and Clatterbridge Hospitals with a remit to work with any patients who may be homeless, either prior to or as a result of their hospital stay. The post aims to ensure that all patients who are discharged from these hospitals have secure accommodation to go to. This post has also received national recognition as a model of good practice.

Hospital Discharge Protocols

From the above the benefits of a planned hospital discharge for homeless people will be evident. The local authorities in Liverpool City Region are all considering or have developed hospital discharge protocols for the homeless. It is vital that this work continues and that it is funded appropriately. Hospitals need to ensure that the housing status of hospital patients is checked on admission to hospital so that discharge is planned accordingly. The Faculty for Homeless and Inclusion Health standards include a suggested question to ask – *'do you have somewhere safe to stay when you leave hospital'* as well as the importance of staff training (Hewett ed, 2013)

For future consideration, the possibility of introducing a hospital discharge network for Liverpool City Region could be discussed, based on the London model described on p.34 above (St. Mungo's, 2013). This would provide a co-ordinated approach to providing hospital aftercare for homeless people. The network would involve all agencies working together in an integrated housing, personal care and health and wellbeing model.

2.8 End of Life Care

As mentioned at the start of Section 2, homeless people have complex health needs leading to premature mortality. The average age of death is 47 years old and is even lower for homeless women at 43, compared to 77 for the general population (74 for men and 80 for women). It is important to note that this is *not* life expectancy; it is the average age of death of those who die on the streets or while resident in homeless accommodation including hostels (Thomas 2012). At the ages of 16-24, homeless people are at least twice as likely to die as their housed contemporaries; for 25-34 year olds the ratio increases to four to five times, and at ages 35-44, to five to six times. Even though the ratio falls back as the population reaches middle age, homeless 45-54 year olds are still three to four times more

likely to die than the general population, and 55-64 year olds one and a half to nearly three times. Hewett (2010) reported results from the Leicester Homeless Primary Health Care Service (2007/8) that the average age at death is 40.2 years and that homeless patients (including hostel dwellers) admitted to hospital in Glasgow with a drug related problem are 7 times more likely to die in the subsequent 5 years than housed patients with the same drug problem.

In Liverpool, there are expected to be up to 20 deaths per year amongst the homeless population (Hutchinson H, 2014), with numbers in other local authorities in Liverpool City Region likely to be very small.

Barriers to end of life care

In Section 4.1, the barriers homeless people face in accessing primary care are discussed. These include the reluctance of some health professionals to become involved with homeless people and also the distrust homeless people themselves may have of health professionals (Tarzian, Neal and O'Neil, 2005; Moller, 2005).

Preferences of homeless people at the end of life

There is little understanding of the preferences of homeless people and more research needs to examine this area. One study found that homeless people often access palliative care services very late into their illness and most die in secondary care (Ahmed et al. 2004). An interview study of homeless people in the USA found that they wanted someone to be with them when they died, even if it was just a stranger (Song et al. 2007) and what they were most concerned about was dying alone or being undiscovered (Tarzian, Neal and O'Neil 2005). In Canada, there was a successful scheme where there was a half-way house shelter, staffed 24 hours a day to provide a safe convalescent environment when recovering from a hospital admission and homeless people found the service helpful and much preferable than staying in hospital (Podymow, Turnbull and Coyle 2006). This is something that could improve the care homeless people receive in the UK.

Recommendations to improvement end of life care for the homeless

It is unrealistic to expect homeless people to present regularly to primary care or palliative services for assessment or symptom control. Numbers of deaths amongst homeless people in Liverpool City Region are not high enough to commission a bespoke service, but improvements in the current service could be made by;

•   Training staff in hostels to recognise when a person's symptoms change and the end of life seems nearer and linking them into health professionals who can then take action.

•   Ensuring equitable access to end of life care services such as the STARS Care scheme which provides personal and social care in the last 12 weeks of life. Liverpool CCG is specifically including this in their tender documentation for the new service to start in April 2015.

•   Encouraging residents in homeless services to discuss their symptoms, their health worries and concerns thus allowing staff to build relationships and become more aware of these issues.

•   Exploring with homeless people how they can reconnect with family members at the end of life to address their concern about dying alone.

•   Promoting links between local palliative service providers and local hostels and homeless shelters, allowing health professionals to visit homeless people more regularly.

3. Specialist healthcare provision for homeless people in Liverpool City Region

Halton

There is no dedicated GP lead or nursing team for the homelessness population in Halton. At the YMCA hostel, there are weekly evening drop-in sessions for sexual health screening. There are also occasional blocks of weekly drop-in sessions for those who want to quit smoking and recently there was a 12 week well-being project which ran a course for one afternoon per week, with 8 participants. Referrals will be made to mental health and drug and alcohol treatment services as required. Clients are encouraged to register with a dentist and GP.

Knowsley

GP options is a health service commissioned through the CCG to enable people to access GP provision who may find it difficult to register with a permanent surgery. It currently provides a weekly service to three of the larger supported housing schemes which has been well received by people living in these supported services. Other supported accommodation services, if they feel there is a need for their service users, can contact options directly to arrange similar provision.

There have been some changes to how the mental health teams have been structured within Knowsley. This may have led to providers to access services on behalf of their service users. There is no specific pathway for people who are at risk of homelessness.

There are a range of clinics and provision for sexual health providing services in the main townships of Knowsley which are well advertised and provide services throughout the day into early evening. If service providers feel there is a particular need for bespoke provision within individual schemes then this evidence will need to be submitted to Public health as the commissioners of sexual health services.

Liverpool

Specialist healthcare for the homeless is provided by the Brownlow Group Practice, on three sites (Student Housing, Ropewalks and Brownlow). There are 2 GPs in the practice with a special interest in the homeless (other GPs will also see homeless patients); 2 homeless outreach nurses; and a Hepatitis nurse (who also deals with the general practice population). For those who are registered, there is a walk-in service available at any site, 8am-4pm. The Homeless Access Clinic (HAC) is run 1 afternoon per week for people who do not have to be registered. Liverpool also has a specialist mental health homeless nurse and an alcohol nurse.

Liverpool CCG reported that there were 1,281 homeless patients across Liverpool, as at 20/2/14. These patients were identified using homeless patient codes (see Section 2 for discussion of codes).

Brownlow data: The Brownlow Group Practice had 516 homeless patients registered as at 24/1/14. The number of homeless patients who had a consultation in the previous 12 months (including those not fully registered/left/died) was 839.

There were 18 homeless patients who died during 2013. Figure 9 shows the age & sex of the 516 currently registered homeless patients. Two thirds (345) were male. There are more males within each age group, except amongst those aged 10-19, where although numbers were small, 58% were females. The age profile is relatively old when compared with the age profile of single homeless people for the whole region, shown in Figure 2 (Section 1). This may be because Figure 2 is based on Supporting People data, whose client group are likely to be younger than those seeking medical help at Brownlow practice.

**Figure 9.
Brownlow Group Practice, Jan. 2014. Age & sex of currently registered homeless patients**

source: Brownlow Group Practic
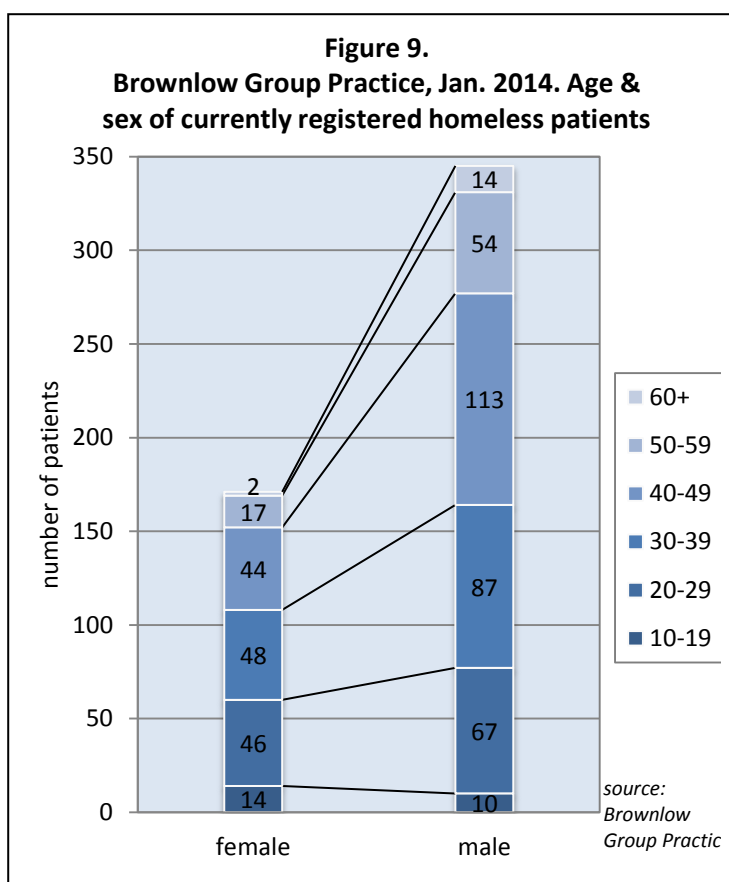
Sefton

There is no dedicated GP lead or nursing care for the homeless population in Sefton. The following healthcare is available to clients in supported accommodation: Healthcare Assessments; Hep B and Hep C Testing, vaccination and treatment; HIV testing; Wound care (injection sites); Prescribing Services; Complementary Therapies.

The following projects provide some health care/advice:

- Bosco House - 1 specific post for health related issues e.g. registering with GP/dentist, supervision medications, drug testing.
- DISC - 1 specific post of Recovery Worker, promoting abstinence and recovery. Complementary therapies
- Lifeline – Syringe Exchange, safer injecting and harm reduction advice.

St. Helens

Specialist homeless healthcare:

There is a specialist homelessness nursing service in St. Helens. Bridgewater Health for Homeless Team consists of one specialist homelessness nurse, a support worker and an administrator. Their work includes visiting hostels once a week. Preventive work is also undertaken, such as dealing with referrals from the local authority housing service, for

example intervening to support people whose tenancies may be in danger of breaking down due to physical or mental health problems.

In 2013. There were 136 individuals referred to the team, with a total of 364 face-to-face consultations (including repeat visits) and a further 176 individuals receiving telephone advice. From April 2014, additional information will be recorded on any physical and mental health conditions the client might have and whether these needs were met. Related information on housing needs and whether these needs were met would also be useful.

GP activity:

The Cornerstone practice in St. Helens previously received funding to provide medical services to homeless patients as a separate service. Once the funding stopped, the practice continued to see most of the clients as regular patients. There is no designated GP for the homeless at present. Although the usefulness of the 'homelessness' codes is limited (see under next main heading), there were 26 homeless patients currently registered (as at February 2014), of whom 20 had appointments with a GP in the previous 12 months.

The Hope Centre:

Hope House is a Day Centre dedicated to supporting those who are homeless and at risk of homelessness through basic needs provision, including a Breakfast Club and Personal Care service and advice, advocacy and support. The Centre provides a frontline link between healthcare services and those who are homeless in St Helens. The team provides support to homeless people to register with a GP if they are not already registered and refer on to the Bridgewater Health for Homeless Team who visit the Centre twice weekly to support service users with their health issues Last year the Centre supported service users to contact their GP to make appointments on 67 occasions. The team are also able to refer into emergency dental care if service users have an immediate problem. Basic drug and alcohol substance misuse screening followed by signposting and referral (with consent) is provided at the Centre, as is signposting and referral into mental health provision.

Wirral

There is no specialist GP provision for the homeless on Wirral, but there are seven dedicated homeless health workers with various roles:

A Homeless Nurse Practitioner holds regular clinics in all local hostel and homeless services. The clinics are designed to address physical health needs and interventions include health assessments, BBV screening and vaccination, flu vaccination where appropriate, wound care (injection sites) and signposting to other services.

A Homeless Mental Health Nurse Practitioner similarly holds regular clinics and, as mentioned in Section 2.2, is reported to be currently working at approximately 50% over specified caseload, picking up a lot of complex cases.

A Homeless Drug and a Homeless Alcohol Worker provide dedicated, specialist practitioner support to hostel/homeless clients and provide an interface with services for those individuals who wish to access substance misuse treatment.

Two Town Centre Outreach Workers are commissioned to engage with rough sleepers and street drinkers, with a view to referring them to specialist treatment. In addition, they also provide a range of other interventions from crisis management, advocacy, referrals/support into accommodation, distribution of winter clothing, etc.

A Hospital Discharge Worker is attached to Arrowe Park and Clatterbridge Hospitals with a remit to work with any patients who may be homeless, either prior to or as a result of their hospital stay. The post aims to ensure that all patients who are discharged from these hospitals have secure accommodation to go to. This post has also received national recognition as a model of good practice.

Local investment has been made at a local homeless charitable organisation, to install appropriate clinical rooms for healthcare staff to work from. In addition, a controlled drinking pilot is currently running across two town centre sites, which aims to tackle entrenched, problematic street drinking. As well as providing a supportive environment for health workers to work intensively with street drinkers towards stabilisation, treatment and abstinence, the pilot is expected to deliver other benefits for the town centre, such as reductions in crime and disorder and an improvement in public perception.

There are also two key strategic groups that are presently working to improve community healthcare services for the homeless. The Frequent Attenders Group (Arrowe Park Hospital) aims to monitor and reduce inappropriate patient use of Acute Services. A proportion of patients who are monitored are homeless/hostel residents. The Critical Needs Group (Community) is a practitioner-led, multi-agency response to support the most complex cases, deemed as being in 'critical need'. As the two strategic groups work with many of the same individuals, there is extensive collaboration to ensure that homeless individuals have timely access to appropriate community healthcare services.

Specialist Hospital Outreach Workers

The Hospital Outreach Work scheme based at the Royal Liverpool Hospital and Whiston Hospital has been described in Section 2.

4. Priority issues identified by stakeholders

Focus Group Summary for Liverpool City Region

This section of the report presents findings from a series of focus groups conducted to explore the views of professionals and service users on the health needs of and gaps in the services for homeless people in their local authority, the effects of the recent welfare cuts and reform to services and any evidence of increased demand for services due to recent cuts/reforms. It also provided professionals the opportunity to discuss any other pertinent issues they feel are important in their local authority.

The six focus groups had a total number of 175 participants invited with 91 participants attending, with the majority being health, social care, voluntary sector and housing professionals and 5 representing the homeless population as ex-service users. All invited participants were sent a questionnaire sheet in which they could add further comments (see the technical report for a copy of the questionnaire).

The key messages were that;
- Homelessness preventive services need to continue
- Better joint working and networking needs to be facilitated
- The homeless population is a vulnerable client group and as such should be able to access the same services as other vulnerable groups e.g.: they should be offered:
    - access to nurses working on site in hostels and/or more respite care from hospitals
    - flexible arrangements, using the principle of reasonable adjustments where necessary, such as flexible appointment times. .
- Consideration should be given to a common data collection method for health organisations to record homeless people as identifying who is homeless and subsequently identifying their health needs and outcomes of interventions.

Collaborating the views of the focus group participants and the questionnaire results revealed five overarching themes;

1. There are now increasing numbers of young people presenting at homelessness services such as hostels, Housing Options Services and shelters. This was seen by stakeholders as being related to the effects of welfare reforms, especially benefits sanctions, and the growing problems of alcohol misuse amongst young people. Young people can have difficulty in meeting the criteria for access to services, although on an individual basis, they are in need of support.

2. Health concerns of stakeholders are particularly related to homeless single people. It was felt that on the whole the health needs of homeless families are being met. Stakeholders reported that homeless families usually have a good package of support and a relationship with social services. Wider determinants of health are important, so the decreased supply in suitable housing will be likely to further exacerbate their health problems.

3. It is common across Liverpool City Region for hostel staff to be trained and funded to provide housing related support to enable people to live independently. Some providers report that this borders on 'care' being provided by unskilled staff in an inappropriate environment for health and wellbeing. Subsequently, staff and service users are not receiving appropriate support and care for their level of need. Particular examples include; (a) loss of benefits and related high support and advocacy needs, (b) nursing care needs as homeless people are being looked after by hostel staff not trained health professionals and (c) End of Life Care needs being occasionally met in the hostel by untrained staff, (d) mental health and drug and alcohol issues not being adequately addressed by specialist agencies leading to an exacerbation of behavioural problems in hostels, relapse and a loss of accommodation.

4. Health services tailored to meet the needs of the homeless population either do not exist or are at best limited, across Liverpool City Region as a whole. All stakeholders from housing organisations through to health professionals (primary, secondary, and specialist) and all tiers of professionals working with homeless people report that they need more of the health services they already receive and need many more services in addition to meet the gaps in provision.

5. Joint commissioning, strategic lead, increased collaborative and partnership working and improved, not necessarily increased provision, was seen as vital in ensuring services operate to meet the increasingly complex needs of homeless people at a time when welfare reform is increasing demand on services. Homelessness prevention services should be a public health priority area.

Halton

Halton Stakeholder Focus Group Participants

A wide range of organisations were invited to the Halton focus group. These included the YMCA, Your Housing, Public Health, Housing Options, SHAP, Community Integrated Care, Halton And District Womens Aid Association, Crime Reduction Intitatives, primary care, Haven hospice and the local authority and participants were from a variety of professional backgrounds including councillors, principle managers, service manager positions, nursing, health care assistants, recovery workers, and service users and carers. All the invited participants, whether they attended or not, were asked to complete a free text questionnaire.

From the 35 people who were invited to the focus group, 18 people attended on the day and contributed to the discussion and 2 people returned the questionnaire later.

The results are only a reflection of the experiences of the participants who engaged with the focus group and/or questionnaire. Once the final themes and subsequent suggestions had been developed, direct comments on whether this was a true reflection of the focus group discussion were sought from members of the group. Views from the stakeholders were then finalised.

Summary of issues and suggestions for Halton

- From a housing perspective, there is a lot of good work that is ongoing in terms of prevention and avoiding homelessness in the first instance. The mortgage rescue scheme and the work of the youth officer was commended by stakeholders. **Future planning should ensure that the preventive work continues as it has proved to be cost beneficial and an overall success.**
- There is no provision for community health for homeless people in Halton. Some form of community health care in hostels, accessible by housing associations or drop in clinics for homeless people would be likely to increase the health of homeless people. There may be a gap in this cohort where outreach health checks are missing, along with screening and preventive work. **Commissioners could look at whether this needs to be addressed in the Halton area.**
- It was identified that stakeholders would benefit from networking events, collaboration across pathway planning and more partnership working. All services are stretched and front line staff are aiming to provide the same level of service whilst developing solutions to decreases in funding. Increased collaboration and partnership working will **ensure that the provision of services is not duplicated and that the homeless person is signposted to a full range of available services**.

Knowsley

Knowsley stakeholder focus group participants

A wide range of organisations were invited to the Knowsley focus group. These included Alt Bank Hostel, Whitechapel, Action for Children, SHAP, Yates Court, CRI, Ross House, 5BP, social services, public health and housing providers, and participants were from a variety of professional backgrounds including service managers, GPs, medical directors, nurses, epidemiologists and recovery workers. All the invited participants, whether they attended or not, were asked to complete a free text questionnaire.

From the 27 people who were invited to the focus group, 11 people attended on the day and contributed to the discussion and 7 people returned the questionnaires later.

The results are only a reflection of the experiences of the participants who engaged with the focus group and/or questionnaire. Once the final themes and subsequent suggestions had been developed, direct comments on whether this was a true reflection of the focus group discussion were sought from members of the group. Views from the stakeholders were then finalised.

Summary of issues and suggestions for Knowsley

1. The health provision for homeless people in Knowsley is provided by Options. Options is commissioned to work with one hostel but other housing providers would welcome their input as they feel there is not enough health provision for homeless people currently. Options provides health and social care services to clients within the homeless establishments, including health checks, GP appointments, sexual health screening, health promotion and access to dentist and optician services, as

well as signposting clients to other services including education, transport, and Mental Health. **Commissioners could look at whether this needs to be addressed in the Knowsley locality.**

2. It was identified that stakeholders would benefit from networking events, collaboration across pathway planning and more partnership working. All services are stretched and front line staff are aiming to provide the same level of service whilst developing solutions to decreases in funding. Increased collaboration and partnership working will **ensure that the homeless person is signposted to a full range of available services.**

3. The homeless prevention work in Knowsley was seen as a success and usually people at risk of homelessness are helped to find alternative accommodation. **The Knowsley area benefits from this type of prevention work.**

4. Mental health provision was mentioned as something that was difficult to access, dependent on whether the person had a clinical diagnosis and whether they were under 5 Boroughs or Merseycare NHS Trusts. Seeking help can be dependent on whether access to services is timely and appropriate. **It would be useful for the mental health service pathway to be revisited for homeless people in the Knowsley area.**

5. The effect of the welfare reforms was highlighted, in particular benefit sanctions, which are causing a lot of hardship. As a result, homeless services are increasingly having to help clients out e.g. with food, food vouchers and telephone access, at considerable expense.

6. The Youth Offending Service health screening programme was mentioned as a possible example of good practice that could be applied to homelessness services.

7. The limited number of sexual health sessions at the SHAP supported housing scheme are always over-subscribed, suggesting the need to expand this service, which is successful in reaching 'hard to reach' groups.

Liverpool

Liverpool Stakeholder Focus Group Participants

A wide range of organisations were invited to the Liverpool focus group. These included the YMCA , Local Authority Housing, CCG, Whitechapel, Brownlow Hill Practice, SHAP, Drug and alcohol team, Liverpool DIP, Outreach workers from RLBUHT, The Basement project, Merseycare, LCAS and participants were from a variety of professional backgrounds including service manager positions, nursing, mental health, outreach workers, GPs, psychiatrists, strategic directors, ex-service users, managing directors of voluntary organisations and team leaders of front line staff. All the invited participants, whether they attended or not, were asked to complete a free text questionnaire.

From the 20 people who were invited to the focus group, 12 people attended on the day (Male=7, Female=5) and contributed to the discussion and 5 people returned the questionnaires.

The results are only a reflection of the experiences of the participants who engaged with the focus group and/or questionnaire. Once the final themes and subsequent suggestions had been developed, direct comments on whether this was a true reflection of the focus group

discussion were sought from members of the group. Views from the stakeholders were then finalised.

Summary of issues and suggestions for Liverpool

1. The enhanced services provided at a primary care (Brownlow Practice outreach work) and secondary care level (hospital outreach workers in RLBUHT) are described by other professionals as excellent and if they are funded in the future, can continue to provide much needed support to the homeless population and other voluntary organisations. In this sense, Liverpool is a trailblazer in terms of homeless population health care. Reducing the out of hours service when this population present regularly with health needs during these times, seems counterintuitive. **Commissioners need to ensure that services are in the right place at the right time and commission more from the independent sector.**

2. District nurses could be commissioned to work alongside hostels and in other relevant places to better meet the needs of the homeless population. Other vulnerable groups (e.g. care home residents) have nurses working on site. District nurses providing specialist case management for homeless clients may also allow other primary care homelessness workers to better meet their remit of providing care. **The homeless population is a vulnerable client group and as such should be able to access the same services as other vulnerable groups such as nurses working on site in hostels.**

3. Mental health assessment and interventions are not timely for this population as appointments are often a long period of time away, or not accessible enough to this group (fixed appointment times). Psychological interventions are also lacking for similar reasons. Psychological and/or psychiatric assessment is extremely limited for this group, particularly in hospital and out of hours. The capacity assessment is flawed and takes no account of the key worker involved with the client. **There is a need to improve assessment procedures and provide more immediate and flexible appointments, in mental health and also for drugs and alcohol interventions.**

4. Young people are presenting younger than before at hostels, with more complex problems (largely alcohol dependence and substance misuse) and their length of stay in hostels is almost double the previous 12 months (Whitechapel). Many are citing the increased demand on services from young people directly linked to the recent welfare reforms. Alcohol services do not currently meet the needs of the homeless population in terms of assertive outreach services and furthermore are not tailored towards providing '**spot purchasing' detoxification programmes, shown locally to be effective.** Local services are closing due to lack of funding which over time will exacerbate this problem.

5. Budget restrictions across the sector are leading to only the most acute and complex homeless clients being engaged with and preventive services are the most likely to be cut. More clients are seen by the complex needs panel than ever before. Services are distinguishing between statutory obligations and 'the meaningful extras' and therefore a **re-organisation, redesign and re-commissioning of services, involving increased collaboration, could help remove duplication of provision, and keep the funding cuts away from front line staff. Any re-design should take**

into account the views of the experts who work with homeless people and also those of service users.

6. End of life care is one area where homeless people receive an inequitable health care service. Other vulnerable groups such as older people would receive 'care in the community' if they wished to. Problems around administration of medication, lack of bereavement services and no current training or support for hostel staff exacerbate this lack of care. Liverpool CCG is working towards recommendations. These **include providing End of Life Care for homeless people in the Strategic Plans for all CCGs, providing a key worker for the homeless person once they are identified as at the end of their life, and identifying and developing key end of life champions per hostel or specialist accommodation**.

Sefton

Sefton stakeholder focus group participants

A wide range of organisations were invited to the Sefton focus group. These included Forum Housing Association, Light for Life, Salvation Army, DISC, Bosco society, South Sefton Neighbourhood centre, CCG leads, Housing Options, Public Health, Merseycare, Lifeline, One Vision Housing, 408 for Young People, and Chart, and participants were from a variety of professional backgrounds including leads for commissioning, registrars in public health, nursing, service managers, recovery workers, safeguarding and health lead and support workers. All the invited participants, whether they attended or not, were asked to complete a free text questionnaire.

From the 32 people who were invited to the focus group, 17 people attended on the day and contributed to the discussion and 2 people returned the questionnaires later.

The results are only a reflection of the experiences of the participants who engaged with the focus group and/or questionnaire. Once the final themes and subsequent suggestions had been developed, direct comments on whether this was a true reflection of the focus group discussion were sought from members of the group. Views from the stakeholders were then finalised.

Summary of issues and suggestions for Sefton

1. Homeless prevention services are limited in Sefton, but are vitally important in the current economic climate to ensure that as many people as possible are supported to live in housing and not become homeless. If homelessness can be prevented by agencies working together to ensure recent welfare reforms do not increase homelessness then there will in turn be less crisis work to be conducted by services that are largely under resourced and understaffed. Crisis work, and working with homeless people with complex mental health needs and drug and alcohol misuse takes up a large proportion of health and housing professionals time and resources. **An improved provision for preventive services would in the long term reduce the need for funding into crisis management work**.

2. Stakeholders reported that there were good working relationships between services and a shared vision to improve the health and housing services for homeless people.

However, a more formal collaborative working arrangement would be beneficial to the organisations as well as increase the services which can be signposted to homeless people. Similarly, a revised confidentiality agreement across sectors would facilitate this collaborative working. Knowing what services exist is important when professionals are trying to coordinate services. **Leads from Public Health, CCGs and Housing should develop this further and integrated commissioning of services would ensure successful working continued.**

3. In the Sefton area much of the available housing is privately owned and emergency or short term beds for homeless people are few. The demand for housing far exceeds the provision. Housing someone creates an opportunity to access many services; they can register with a GP, have health appointment letters sent out, with an address in place, benefits can be accessed and engagement is much easier from a professional perspective. People can be supported to independent living. **The Local Plan should address the housing need of this vulnerable group.**

4. Barriers to effective partnership working were reported to be largely from the statutory sectors who may require certain criteria to be met, before they can engage with an individual. The group felt very strongly that personalised individualistic care was the way to meet the health and social care needs of homeless people and it was noted that the majority of housing and voluntary organisations do provide care and support based on the persons need, rather than criteria that they may meet. Relationship building across statutory, voluntary and other organisations may increase the personalised care homeless people receive, as **relationships across sectors and between professionals can sometimes expedite pathways of care appropriately**.

5. Recent cuts to funding have affected all services and organisations, with a majority losing front line staff. This loss of capacity is at a time when there is increased demand due to welfare reforms. Services unfortunately have to reduce the quality of their services, particularly outreach work, meaning there is less engagement with vulnerable groups, including homeless people. Services are dealing with individuals with more complex needs leading to bigger workloads for less staff. Hostel services are also under increasing pressure from a decrease in donations and funding cuts. Food banks are increasingly used at crisis points. However, the Council is undertaking a commissioning exercise that will include all "homeless and housing related support services". **The recommendations within the Council's Homeless Strategy will inform the commissioning exercise.**

6. The adult mental health service provide a good service, receiving complex referrals and relationships across organisations referring to adult mental health are good. Young homeless people do not have timely access to the services to meet their mental health needs, meaning voluntary organisations are under increasing pressure to provide in-house care themselves. **Commissioners need to work with voluntary organisations to develop direct pathways from voluntary organisations to service providers**, ensuring young people do not wait until their problems and health issues become unmanageable for themselves and their families and complex for the professionals providing them with support. Services such as IAPT (Increased Accessed to Psychological Therapies) have spare capacity that homeless agencies could refer young people to.

St. Helens

St Helens Stakeholder Focus Group Participants

A wide range of organisations were invited to the St Helens focus group. These included Public Health, the Salvation Army, the Local Authority, the YMCA, Pennington Lodge, Whiston hospital, SHAP, Ravenhead Foyer, Bridgewater Centre, the Hope Centre, Helena Partnerships, Your Housing Group, Great Places, Housing Options, local GPs and the CCG, and Addaction.

All the invited participants, whether they attended or not, were asked to complete a free text questionnaire. From the 30 people invited, 14 people attended on the day to contribute to the discussion (Male= 4, Female=10) and in total 7 returned the questionnaire.

The results are only a reflection of the experiences of the participants who engaged with the focus group and/or questionnaire. Once the final themes and subsequent suggestions had been developed, direct comments on whether this was a true reflection of the focus group discussion were sought from members of the group. Views from the stakeholders were then finalised.

Summary of issues and suggestions for St Helens

1. The primary care provision for the homeless population (one specialist nurse plus support worker) is said to be understaffed and under-resourced but is seen as providing important patient centred and holistic care, prevention work and a critical liaison between health providers and homeless services. District nurses and Macmillan nurses also visit hostels. GP access and engagement is good with Hope House forming an important link to health services often for the more chaotic. **A review of this service needs to be undertaken, particularly to address capacity.**

2. The collaborative working in St Helens and positive relationships between the statutory and voluntary sector allows for the best use of limited resources to cater for most of the homeless population. Stakeholders could benefit from networking events, collaboration across pathway planning and more partnership working. Increased collaboration and partnership working may ensure that the provision of services is not duplicated and that the homeless person is signposted to a full range of available services. **A regular forum to discuss working, case management and collaboration across sectors would be useful in continuing to promote collaboration across sectors.**

3. A significant number of clients are presenting to hostels, housing associations and health care professionals with mental health needs. **Some participants reported a need for improved access to mental health care. Commissioners could look at whether these mental health needs should be addressed in the St Helens area.**

4. The service provided by the drug and alcohol service is seen by some as not accessible/flexible enough to meet the needs of the population. It is also extremely difficult to share information across the sector. **It is the responsibility of the housing and healthcare agencies to work together to identify opportunities for appropriate data sharing to deliver improved care and to keep people free from harm. All organisations should work collaboratively to seek creative solutions and for commissioners to identify gaps in service provision.**

5. Hostel staff and housing association staff are finding it increasingly difficult to work with people when their benefits are sanctioned. Food bank vouchers can cover some shortfall for a limited period (3 visits per year), but other necessities such as transport to health appointments and utility expenses are not covered by discretionary funds. Sanctions can undo the work of homelessness services and it is also likely sanctioned clients will be chaotic by nature suggesting a greater level of support may be needed. **Relationships should be built with Job Centre Plus so that their staff understand the barriers experienced by homeless people. Where resources permit, alternative models of service delivery could be considered for those clients**.

6. The focus group felt that some clients including those discharged from hospital are too ill to be cared for in a hostel. Some felt that other options, such as a specialist hostel providing **intermediate care** or extra staff with health care training in existing hostels, should be considered. **Consideration needs to be given to the scale and evidence for this view so that potential options for change can be considered. Joint working with the CCG and housing providers should ensure that the needs of people requiring intermediate care when discharged from hospital are being met.**

Wirral

Wirral Stakeholder Focus Group Participants

A wide range of organisations were invited to the Wirral focus group. These included the council housing schemes, the mental health team, the substance misuse team, the YMCA, primary care representation, public health, families and wellbeing services, advocacy in Wirral and council officials and professionals from a range of backgrounds such as nursing, clinical services managers, chief executives, volunteers, service managers, head of service development, drug workers, intelligence analysts and community development workers. All the invited participants, whether they attended or not, were asked to complete a free text questionnaire.

From the 30 people who were invited to the focus group, 19 people attended on the day (Male=10, Female=9) and contributed to the discussion and 5 people returned the questionnaires.

The results are only a reflection of the experiences of the participants who engaged with the focus group and/or questionnaire. Once the final themes and subsequent suggestions had been developed, direct comments on whether this was a true reflection of the focus group discussion were sought from members of the group. Views from stakeholders were then finalised.

Summary of Issues and Suggestions for Wirral

1. In Wirral, significant investment has been made in recent years, to improve the delivery of healthcare services to the homeless population. Many professionals from across the sectors are passionate about their role in improving the health of homeless people. While local provision includes a number of dedicated homeless

professionals/resources, the system has been configured to encourage homeless people to use mainstream health services. Despite this investment, there are concerns that some of the current initiatives are subject to time-limited funding and are therefore vulnerable to discontinuation in the future. Further, that any withdrawal of funding would significantly impact upon the health of homeless people in Wirral. **Commissioners should review existing funding arrangements and where possible, explore opportunities for collaborative working to deliver innovative initiatives that respond effectively to the health needs of the local homeless population.**

2. There is already considerable collaborative working between services but this could be improved. Attendance at the Critical Needs Group, a multi-agency group to specifically address the health and housing needs of the homeless, was cited as an example. A commitment from all partners to ensure greater and more regular attendance at such groups would not only increase a sense of shared responsibility but could also improve outcomes for homeless people. **Consideration should be given to a review of the existing governance/membership arrangements of multi-agency groups which support the local homeless population. This review should aim to ensure that such groups are placed on a secure strategic footing and that membership includes key decision-makers from relevant service areas.**

3. Considerable resources have been committed to the provision of dedicated community nursing care for homeless people in Wirral. Although described as 'excellent at the point of access', the demand placed upon this resource has grown, particularly for the Mental Health Nurse Practioner. Increased waiting times for a clinical appointment has contributed to missed windows of opportunity, whereby homeless people eventually present in crisis at Acute Services. Subsequent treatment then tends to deal with the patient's crisis but not the underlying causes, thereby perpetuating a 'revolving door' between hospital and community services. **Health commissioners should consider whether current community nursing care provision is sufficiently meeting patient demand. In addition, acute and community services should ensure better planning for continuity of care, including mental health assessment, with an overarching aim to reduce avoidable and costly hospital admissions.**

4. Hostel funding provides support to promote independent living but this support element is often consumed with the crisis management of this client group and the growing complexity of their multiple, concurrent health and social care needs. **Hostels require greater support from other appropriate services to address the complex needs of residents, in relation to their physical and mental health, substance misuse and criminality, etc. This would leave hostel staff free to support residents to leave hostel provision and achieve independent living, which in turn, would also contribute to the individual's wider recovery.**

5. The End of Life Care Strategy is developing in Wirral but gaps in provision have been identified. Hostel staff reported that there have been occasions when patients in receipt of palliative care in hospital have eventually been discharged back to the hostel. This has usually arisen because of the patients' unsuitability for discharge to a

hospice, leaving hostel staff to provide nursing care to those residents on the End of Life Care pathway. Aside from not being appropriately qualified/trained to deliver such care, these functions are significantly over and above that which is reflected in the level of funding for these services. **Health commissioners should review these cases as a matter of urgency as part of the development of the End of Life Care Strategy. Action should be taken to ensure there is appropriate access to hospice provision, irrespective of the individual's accommodation status, mental health or substance misuse problems.**

6. In the present financial climate where there are significant budget pressures, there are concerns that prevention work and enhanced services (anything not a statutory requirement) could be the services cut first. Perversely, need for these services is increasing, caused by high levels of unemployment, 'bedroom tax' and the impact of benefit sanctions. Further reductions to funding for homeless services may result in access to such facilities being restricted to only those in crisis, resulting in the deterioration of circumstances amongst the majority of homeless people that do not meet such a threshold. **Whilst acknowledging the financial constraints now and in the future, a longer term vision is required, as this may cost less than short term solutions in terms of breaking the cycle of homelessness as its associated health, social care and societal costs.**

Reflection on stakeholder focus groups across Liverpool City Region.

During most of the focus groups, contacts were made between organisations who felt that working together would be beneficial for the service and the homeless people and contact details were exchanged. Occasionally, one organisation was not aware of another organisation providing a service in their area. Contact was also made by organisations and services to commissioners who wanted to improve the pathway working between services. These are examples of how the focus groups themselves have had a positive impact on collaboration across sectors in the local areas and how increased partnership working has already started.

An excellent example of this is in St Helens and how there is work now being conducted by the commissioning leads, housing and hostel providers and the drug and alcohol service around waiting list issues and sharing of information.

5.Evidence of good practice and cost effectiveness

The Faculty for Homeless and Inclusion Health, Charter of Healthcare Standards

The Faculty for Homeless and Inclusion Health has published a charter of healthcare standards for healthcare professionals which they should expect to meet when coming into contact with individuals who are homeless (Hewett ed, 2013).

Many of the Faculty standards mirror the recommendations that emerged from the local focus group consultations in this Liverpool City Region HNA, for example for drop-in and flexible appointment health services, multi-disciplinary team working involving case management, and for intermediate care provision.

For commissioners, standards include:

MDT: Primary Care Led Multidisciplinary Team providing service linkage and case management including hospital in-reach and hostel/street outreach. MDT case management requires a named patient advocate to assess needs and ensure access to a package of care by linking health, housing, social care and voluntary sector provided services.

Intermediate/Respite Health and Social Care: to a) avert unnecessary accident and emergency attendance and secondary care admission; b) prevent inappropriate hospital discharge and emergency re-admission; c) organise onward care and resettlement.

Outcomes measurement: Outcomes for excluded populations need to be an integral part of the NHS, Public Health Outcomes Framework (PHOF) and Adult Social Care Outcomes Framework (ASCOF).

Data: standard datasets concerning numbers of homeless people should be collated and inform commissioning to address health inequalities in the community and in primary and secondary care. Once reliable data is available, the Faculty suggested that measures of success could include reductions in un-scheduled hospital re-admission within 30 days, and unplanned A&E re-attendance within 7 days. Once 'housing status' is recorded, this should be regularly reviewed.

Access/registration: enhanced/easy access to health care for homeless people. All primary care providers should be routinely tested for their willingness to register patients who are homeless and refusal of access should be robustly contested. Specialist services are not the only solution, enhanced access and outreach services from mainstream providers are also important (including community health care, specialist primary care, mainstream primary care, dental care, mental health care and secondary care).

Ease of access requires walk-in provision to be available – in-reach to hostels and outreach to rough sleepers.

Collaborative commissioning will be required, between NHS England (primary care), CCGs (community care) and local authorities/Public Health England (public health services).

Horizontal, patient-centred integration to be requested by commissioners: i.e. care planning and continuity across community settings and service provider boundaries, so that people

can continue to receive continuity of care even if they lose the address that originally gave access to that care.

Vertical integration to be requested by commissioners: i.e. care planning, multiagency working and continuity of care into secondary care and back into the community. A clear expectation of compassion, communication and continuity of care between secondary, primary and community care.

Support and training should be available for health and related workers in understanding and working with homeless people with complex needs.

In summary, the Faculty states that it aims to support services to demonstrate:
- A service which is welcoming, holistic and inclusive
- Easy access to care, including outreach (at hostels etc.) and at other easily accessible places such as primary care and drop-in centres, with self-referral permitted
- Multi-agency working, joined up care across health, social care and voluntary sector with updated directories of partner agencies
- Service user involvement in service design and evaluation
- A systematic approach to highlighting the plight of vulnerable people in contact with the service
- Promotion of permanent GP registration
- A considered response to Public Health challenges involving its service users
- A mechanism for monitoring and responding to frequent attendance at A&E
- Monitoring of outcomes for service users
- A process aimed at recovery and movement towards mainstream services

(Hewett ed, 2013).

For primary care, standards include:

Ensure registration at first consultation – either full or temporary – so all patients can be logged.

QOF (Quality and Outcomes Framework) standards/Key Performance Indicators (KPI's) should include the following:

- Pro-active management of selected patients with high needs by weekly multi-agency meetings including local street outreach, statutory and non-statutory services
- hospital in reach ward rounds/visits for homeless patients where necessary in the local Acute and Mental Health Trusts
- regular outreach clinics in local hostels and drop-in centres
- collaboration, with multi-agency review and care plans for all registered patients admitted to hospital twice or more in any 6 months period and when necessary those with Combined Homeless Information Network (CHAIN) or other rough sleeping record in the same period
- all patients offered drop-in clinics with presenting problem addressed first, but offered health screening and access to treatment to include, physical health assessment, screening for dental/oral problems, BBV (Blood Borne Viruses), smoking, drug and

alcohol problems, TB (Tuberculosis) screening, screening for mental health problems, diet and exercise
- regular review of locally negotiated approach to ensure easy access, including drop-in clinics and outreach clinics at hostels and drop-in centres to include primary care based mental health treatment
- QOF or KPI funding thresholds should reflect the challenges of working with excluded groups

(see Hewett, 2013 for more standards and further details)

For community services, standards include:

Mental health: Where there are significant numbers of homeless or other excluded people specialist services may be necessary; in other areas enhanced access to mainstream services may be enough. In both situations, services should be provided to Faculty standards. A willingness to work around relatively high rates of non-attendance at appointments will help to ensure that patients are not further excluded.

Services for homeless people should accept self or non-health agency referral.

Mental health services should be ready to work with people with drug and or alcohol problems in addition to mental health issues.

Access to care enhanced by outreach, for example to hostels and drop-ins and on the streets.

A flexible approach centred on patient choice to overcome geographical barriers to accessing care, e.g. for those who have temporarily moved out of the geographic boundaries of a service.

Enhanced and flexible, easy access to psychological therapies, with open access by self-referral and outreach sessions available.

Some long term rough-sleepers have significant mental health problems and may benefit considerably from treatment. New tools and guidance have recently been published (p.27, Hewett ed, 2013).

Dental care: the commissioners for healthcare for excluded groups must identify an individual to champion access to dental care (e.g. head of dental services). Particular standards for access to physiotherapy and podiatry services are also outlined (p.34, Hewett ed, 2013).

For secondary care, standards include:

In general and psychiatric inpatient units, discharge planning should begin on admission and involve as wide a network of health and social care as required. All hospitals should have fully operational protocols for discharge planning for excluded groups, based on Homeless Link Guidance (Homeless Link, 2012c). All admitted patients should be asked "do you have somewhere safe to stay when you leave hospital" and staff should be trained and supported

to help people who say "no". For hospitals with significant numbers of patients who are homeless, the Pathway approach is recommended (more details on p.38, Hewett ed, 2013).

There should be **intermediate care discharge accommodation** available, so that those who no longer need psychiatric support can continue to recover within a therapeutic setting.

(Hewett ed, 2013).

Department of Health

In 2010, the Department of Health presented the results of analysis aimed at better understanding the health needs and relative healthcare costs of people who are homeless (DH, 2010).

The report noted that homeless people face extra barriers to accessing healthcare and have health needs often different to those of the general population. Barriers to accessing mainstream health services include:
- Requirements for proof of address
- Difficulties in booking and keeping appointments, due to chaotic lifestyles
- More immediate needs for food and shelter may surpass health needs, so that help is not sought until health needs become critical.

Other barriers include conditions such as requiring abstinence before the commencement of alcohol or drug treatment interventions, and reluctance to attend group sessions for mental health therapies.

Some of these barriers can be overcome by the provision of specialist homelessness primary care provision. Four different models of provision, appropriate for differing sizes of homeless populations, have been outlined by the Department of Health in their analysis of healthcare for single homeless people (DH, 2010).

RCGP and Inclusion Health

The Royal College of General Practitioners and Inclusion Health have produced an evidence-based commissioning guide for Clinical Commissioning Groups and Health & Wellbeing Boards on improving access to health care for Gypsies and Travellers, homeless people and sex workers. For homelessness, the report recommends the following actions:
- Continue outreach and in-reach (e.g. in hostels) by health professionals.
- Ensure a dedicated hospital pathway, cutting across medical specialities
- Create access to 'one-stop shops', combining basic facilities such as washing and food with access to a range of health services
- Use peer education to promote recovery
- Ensure professionals are trained to work effectively with homeless clients they may come across
- Provide intermediate care for an appropriate step-down in order to maximise recovery

http://www.rcgp.org.uk/news/2013/december/~/media/Files/Policy/A-Z-policy/RCGP-Social-Inclusion-Commissioning-Guide.ashx

Inclusion Health

Inclusion Health have produced a report that discusses how the health care needs of the most vulnerable groups in society, including homeless people, are not being met because of gaps in health information and data gaps. The conclusions of the report are as follows:

- o it is impossible to obtain a comprehensive picture of the vulnerable groups' health
- o the health needs of some of the most vulnerable people in society continue to be invisible to health commissioners and the wider health system planners
- o the health needs of the vulnerable groups sometimes place heavy and unpredictable demands on the health service, which may result in multiple avoidable visits to hospital
- o the data gaps prevent effective monitoring of health care use and seriously undermine local efforts by NHS and local government to understand and prioritise the local needs of the vulnerable groups.

The range of existing data sources are described and suggestions are made on how better information can be collected in order to inform commissioning.
https://www.gov.uk/government/publications/effective-health-care-for-vulnerable-groups-prevented-by-data-gaps

The Institute of Health Equity

The Institute of Health Equity are in the process of compiling an evidence review of 'What Works' in implementing the Marmot recommendations on reducing health inequalities in local authorities. The review includes addressing homelessness. An early draft notes the scarcity of evidence of interventions in this area, but identifies the following as 'what works':

- For rough sleepers and single homeless: - the No Second Night Out scheme (see Section 1.3 above) and the Housing First initiative (http://tinyurl.com/p3z77yv)
- For youth homelessness: - preventive services offering family support and advice services targeting vulnerable young people, offering help with housing options, money management and healthcare.
- For households: - identification of vulnerable tenants and the use of 'preventing evictions' protocols.

(Institute of Health Equity, 2014)

NICE

NICE have recently published a briefing on 'Improving access to health and social care services for people who do not routinely use them' (NICE, 2014). They note that people who do not routinely access standard health and social care services are at increased risk of poor

health, which can accumulate through life and lead to increased demand on services and increased health and social care costs. Improving access to services for the local population can help local authorities work towards achieving the two overarching outcomes in the Public Health Outcomes Framework:

- increasing life expectancy
- reducing differences in life expectancy and healthy life expectancy between communities by improving those of people in more disadvantaged communities

The briefing acts as a link to recent NICE reports, such as 'raising awareness of tuberculosis among hard-to-reach groups' in NICE's 'Tuberculosis' pathway.

NICE, 2014, http://publications.nice.org.uk/improving-access-to-health-and-social-care-services-for-people-who-do-not-routinely-use-them-lgb14/introduction

Cost effectiveness of tackling homelessness

Homeless people use public services in inefficient and costly ways. Preventing homelessness and ensuring speedy transitions to accommodation will, in the long term, help reduce other public service costs related to homelessness. A body of research evidence has slowly been building which supports the case for spending money to prevent homelessness (NatCen 2010). There has long been an economic case for tackling homelessness as there are many wide ranging and far reaching consequences to society in not addressing the problem, not least in terms of economic cost effectiveness. Preventing homelessness is cost effective for a number of reasons, and evidence suggests it is:

- Value for money
- Achieves outcomes for the local community
- There are many risks to society, communities, individuals and the economy if funding to preventing homelessness is reduced

The costs of homelessness to society include the obvious social, psychological and physical toll on people. When people are deprived of the taken-for-granted support citizens in the UK have such as accessing public services, health care, maintaining employment and community and family support, they can be left in a position where they are vulnerable to crime, drugs and alcohol problems, poor health and premature death. Services that are dedicated to helping homeless people often do a lot of work which minimises the loneliness and isolation felt by homeless people by contributing to promoting positive mental and physical health, improving people's quality of life and mitigating the wider community-felt effects of homelessness by supporting people to turn their life around. In addition, the financial costs of homelessness include:

- An increase in health and substance misuse problems
- An increase in unplanned admissions to hospital and A&E admissions
- An increase in contact with the Police, and more criminal justice system work
- Unemployment and economic inactivity
- An increase in failed tenancies and associated work

61% of homelessness prevention services involve the household being assisted to obtain alternative accommodation when faced with the threat of homelessness. In the remaining 39% of cases, the household was assisted to remain in the existing home (NatCen 2010).

Spending money to tackle homelessness would include:

- Support of the ongoing provision of hostels and temporary accommodation
- Support to encourage and facilitate independent living
- Physical and mental health care service work and substance misuse services

Evidence to support the cost effectiveness of tackling homelessness

1. National Audit Office (2005) report estimates we spend £1 billion to deal with homelessness and similarly, the Supporting People financial benefits report by CLG (2009) reported that the net financial benefits is £3.4 billion per annum compared to the £1.61 billion per annum we spend on homelessness prevention.

2. Supporting People report we spend £107 million per annum on 13,000 units of temporary accommodation whilst Supporting People services provide a benefit of £97 million per annum (DfCLG, 2009).

3. The National Audit Office (2005) estimates that ending bed & breakfast accommodation for families alone would result in a saving of £40-50 million.

4. The New Economics Foundation indicated that per annum a homeless person costs the UK taxpayer £26,000 which includes accommodation, benefits and caring for children (quoted in National Audit Office, 2005 – original reference not available). The New Policy Institute carrying out work for Crisis reported that the cost of preventing a typical case of homelessness could be as little as £1700 (Crisis, 2008).

5. Homeless Link (online2) compared Department for Work and Pensions data for homelessness services data to examine the cost of sanctions for homeless people and the impact the sanctions have. They found 31% of homeless people were sanctioned compared to 3% of typical claimants and that sanctions significantly increased existing problems putting a majority of clients into increased debt, increased food poverty and led to an increase in survival crime. One third of services who responded to the survey reported homeless people were sanctioned when they have existing mental health problems, learning disabilities or substance misuse problems.

6. Conclusion and recommendations

Conclusion

Across the Region, homelessness is on the increase amongst those considered to be in priority need (mainly families) and also those in non-priority need (mainly single homeless). The effects of the recession and welfare reforms have impacted negatively on homeless people, especially those with chaotic lifestyles.

Those who are homeless face extra barriers to accessing healthcare and have health needs often different to those of the general population. There is a need for standard datasets, with agreed definitions, on numbers of homeless people in the community and in primary and secondary care to inform commissioning. Data collection should be aimed at identifying housing status, health needs and outcomes of interventions. Throughout the report, there are discussions and recommendations on various data issues, including those relating to data from general practice, hospitals, drug and alcohol services and Supporting People.

In view of the large scale of resource use involved in hospital admissions and emergency healthcare outlined above, it has been recognised that more effective and cost-effective ways of securing healthcare for the homeless population could be identified by reviewing current delivery models and considering alternatives (DH, 2010). The recommendations from this health needs assessment set out what can be done locally.

Recommendations

The following set of recommendations result from a consideration of the findings of the health needs assessment, including the data gathered, the stakeholder focus groups held in each local authority, and evidence in the literature.

Recommendations for commissioners

1. Consider the charter of healthcare standards for healthcare professionals, published by the Faculty for Homeless and Inclusion Health (Hewett ed, 2013. See p.54 above).

2. *MDTs:* Implement multi-disciplinary team working, led by primary care, with case management, linking health, housing, social care and voluntary providers. Create a better understanding of service delivery processes and an understanding of each other's roles in order to improve services.

3. *Collaboration*: Implement collaborative commissioning, involving NHS England (primary care), Clinical Commissioning Groups (community care) and local authorities/Public Health England (public health services). This will result in better organised services, even if provision has not increased.

4. *Homelessness lead*: Ensure each CCG has an identified lead for homelessness.

5. *Intermediate/ respite care:* Ensure the availability of such facilities, which will help prevent inappropriate hospital use and assist in resettlement.

6. *Access:* The homeless population is a vulnerable client group and as such should be able to access the same services as other vulnerable groups:
   6.1. Monitor access to healthcare for homeless people, including testing the willingness of primary care providers to register homeless patients.
   6.2. Ensure providers offer flexible arrangements, using the principle of reasonable adjustments where necessary, such as flexible appointment times, walk-in provision, self-referral and out-reach and in-reach (for example for psychological therapies or drug and alcohol treatment).
   6.3. Improve access to 'one-stop shops', combining basic facilities such as washing and food, with access to a range of health services, such as at Hope House in St. Helens.
   6.4. Consider the particular needs of young people, who can have difficulty in meeting the criteria for access to services, although on an individual basis, they are in need of support.

7. *Data:* Collate standard datasets, with agreed definitions, on numbers of homeless people in the community and in primary and secondary care to inform commissioning. Datasets should identify who is homeless and subsequently identify health needs and outcomes of interventions.

8. *Hospital audit:* Once reliable data is available, establish a full audit of hospital activity for those who are homeless in the region

9. *Discharge protocols:* Ensure that work on developing hospital discharge protocols for the homeless continues and that it is funded appropriately.

10. *Specialist homeless health services:* Continue to provide and consider expanding specialist general and mental health services where these exist. Consider introducing specialist health services in those areas that have none, or where numbers are too small, ensure enhanced access to mainstream services.

11. *Substance misuse*: Address the fact that for homeless people with needs relating to substance misuse in the Region, the proportion whose needs are met is low and has fallen in the last three years.

12. *Ethnic group*: Continue to monitor the relatively high numbers of homeless people from ethnic minorities, particularly in Liverpool, and consider how their needs can be met.

13. *Dental care, physiotherapy and podiatry:* Identify individuals to champion access for homeless people to dental care, physiotherapy and podiatry (e.g. head of dental services). Consider the possibility of extending this to identify champions of homelessness in health services generally.

14. *Vaccinations, screening and sexual health:* Work with Public Health England to draw up guidelines, so that in routine assessment of individual's and family's needs, their health care needs and eligibility for screening or vaccinations can be formally considered and they can be signposted for advice or treatment as appropriate.

15. *End of life care:* Ensure that strategies for end of life care include a consideration of the needs of homeless people.

16. *Service user involvement:*
    16.1. Ensure service user involvement in service design and evaluation
    16.2. Use peer education to promote recovery

17. *Training:* Provide adequate training and remuneration for those working with homeless people, to match the level of need of the homeless people they are working with.

18. *Prevention:* Use joint commissioning to continue to fund prevention initiatives, as these have been successful and cost effective:
    18.1. For youth homelessness: - continue to fund preventive services offering family support and advice services targeting vulnerable young people, offering help with housing options, money management and healthcare.
    18.2. For households: - continue the identification of vulnerable tenants and the use of 'preventing evictions' protocols.

Recommendations are aimed at the commissioners of services relating to homelessness. Detailed standards for the providers of community services and primary and secondary healthcare are outlined in Section 5 above. An outline of the specific priorities and recommendations identified by stakeholders from each local authority are presented in Section 4 and in the summaries at the start of the report.

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