Herefordshire Council

Meeting:	**Health and wellbeing board**
Meeting date:	**Tuesday 5 March 2019**
Title of report:	**Homeless Link Health Needs Audit**
Report by:	**Consultant in public health and housing strategy officer**

Classification

Open

Decision type

This is not an executive decision

Wards affected

(All Wards);

Purpose and summary

The purpose of this report is to:

i. Inform the board of the results of Herefordshire's Homeless Link Health Needs Audit.
ii. Approve the recommendations arising from the audit.

The Homeless Health Needs Audit is an audit toolkit developed by the Department of Health and pilot areas, updated by Public Health England. It provides a framework for gathering and using this information to assess local need and improve healthcare services, using the direct experiences of people who are homeless.

The audit was identified as an action under Herefordshire's Homelessness Prevention Strategy 2016-2020, Objective 3: Help improve the health and wellbeing of homeless people and those who are at risk of homelessness.

The audit was undertaken for the first time in Herefordshire between December 2016 and February 2018. 102 audits were completed through face-to-face interview by Home Group, Supported Housing for Young People Project (SHYPP) and Herefordshire Council's Outreach Service.

Further information on the subject of this report is available from
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The vast majority of respondents were white British males. The average age was 34.5 years. Participants were sleeping in a hostel or supported accommodation (42%), in emergency accommodation (23%), rough on the streets or in a park (15%) or on someone's sofa/floor (14%). Backgrounds in institutions, including prison, local authority care and mental health admissions were common.

Overall the data showed that participants' physical and mental health, on all dimensions, was extremely poor compared to that of the population as a whole. Key health and service use findings were:

- 56% of respondents reported a physical health problem. Common physical health problems included joint/bone/muscle problems, dental problems, eyesight/eye problems and asthma.
- Overall 76% of respondents reported a mental health problem/behaviour condition. Just under half of those with a mental health problem felt that they were not receiving treatment that they would benefit from, this included respondents with severe mental health conditions and common mental health conditions.
- Drugs and alcohol use was common but not universal: 43% of respondents did not use drugs, 15% used cannabis only and 42% used Class A, prescription or other non-cannabis drugs. A quarter of respondents identified themselves as having a drug problem or being in recovery.
- Use of acute care services was common and frequent. Mental health problems and self-harm/attempted suicide contributed to approximately 40% of A&E, ambulance and hospital admissions. Violence and accidents were the main reason for approximately 30% of use of these acute services. Over three-quarters of respondents were registered with a GP and 29% with a dentist.
- Uptake of preventative health interventions was low in this population, for example <10% of respondents had the flu vaccine last year.

The report recommends a strategic commitment to improving the health of homeless population, evidenced through health and wellbeing board (HWBB) sign-up to the Charter for Health for Homelessness. The Charter commits the HWBB to identifying need, providing leadership and commissioning for inclusion. Furthermore, the audit report recommends the HWBB partners work together to improve access to mental health, primary and secondary health care and preventative services.

Recommendation(s)

That:

(a) The health and wellbeing board sign up to the 'Charter for Homeless Health' and implement its commitments, including identifying need, providing leadership and commissioning for inclusion;

(b) The health and wellbeing board members review within their organisations access to services, including mental health services, primary and secondary health care and preventative services for homeless people with the aim to improve health and reduce first-line use of A&E and ambulance services;

(c) The health and wellbeing board seeks assurance from lead agencies (including Herefordshire Council, Herefordshire Clinical Commissioning Group, Wye Valley NHS Trust and 2gether NHS Trust) on the actions they are taking to address this inequality

and considers these in a future session together with local consideration/adoption of the national memorandum of understanding on health and housing "Improving health and care through the home: A National Memorandum of Understanding"; and

(d) The Homeless Health Needs Audit be undertaken again in 3 years' time (2022; completing the audit cycle) and reported to the HWBB .

Alternative options

1. The board could decide not to agree some or all of the recommendations.

2. The board could decide not to sign-up to the Charter for Homeless Health. It is a statutory responsibility to produce a Joint Strategic Needs Assessment (JSNA) to improve the health and wellbeing of the local community and to reduce inequalities. Furthermore, without taking a leadership role or working with partners to ensure commissioning meets the needs of this vulnerable population it will be difficult for the HWBB to demonstrate they understand the link between homelessness and health and wellbeing and are working to address it, in line with Ministry of Housing, Communities and Local Government (MHCLG) Rough Sleeping Strategy, August 2018.

3. The board could decide not to work together to improve access to services for the homeless population. This would result in continued high demand and use of emergency and acute services by this population at high cost to both the individuals and the system.

4. The board could decide not to complete the audit cycle. This would result in a lack of up-to-date data on this population and mean any improvements could not be measured.

Key considerations

5. Homeless Link's Homeless Health Needs Audit was first developed in partnership with the Department of Health. It was updated in 2015, with funding from Public Health England.

6. The audit aims to:

    - Increase the evidence available about the health needs of people who are homeless and the wider determinants of their health.
    - Bring statutory and voluntary services together to develop responses to local priorities and address gaps in services.
    - Give people experiencing homelessness a stronger voice in local commissioning processes.
    - Help commissioners understand the effectiveness of their services.

7. That rough sleepers and single homeless people with complex needs experience considerable health inequalities is evidenced by the greatly reduced average life expectancy compared with general population. Men sleeping on the streets have an average life expectancy of 47 years whilst for women it is even lower at 43 years. These figures compare to 79.5 and 83.1 years average life expectancy for males and females in the general population respectively.[1] The Health Needs Audit provides a way to better understand the physical and mental health and wellbeing of Herefordshire's rough sleeping and single

[1] Public Health Matters, The inequalities of homelessness – how can we stop homeless people dying young? Public Health England, February 2018.

homeless people with complex needs, as well as access to and use of health related services.

8. The Audit consists of 42 questions including background information, physical and mental health, drug and alcohol use, access to services and staying healthy. The audit tool is given in appendix 2.

9. 102 health needs audits were completed in Herefordshire between December 2016 and February 2018, which is a considerable achievement given the comprehensive nature of the audit and the resulting time needed for questions and answer completion. Audits were undertaken through face-to-face interview by Home Group, Supported Housing for Young People Project (SHYPP) and Herefordshire Council's Outreach Service.

10. This is the first time that the Homeless Health Needs Audit has been undertaken in Herefordshire. The audit was used to capture the health needs of people who were/are sleeping rough, sofa surfing, otherwise chaotically housed or living in specialist supported accommodation and the collected data provides a significant evidence base of their physical and mental health needs. Completing the audit cycle by repeating the audit in three years' time will enable an analysis of whether or not the health outcomes for single homeless people in Herefordshire have improved during this time.

11. The following summarises some of the key findings from the report:

Background information:

i. The majority of respondents were male (82%), white British (92%) and the average age was 34.5 years. Participants were sleeping in a hostel or supported accommodation (n=43; 42%), in emergency accommodation (n=23, 23%), rough on the streets or in a park (n=15, 15%) or on someone's sofa/floor (n=14, 14%). Six percent of respondents did not have recourse to public funds.

ii. Backgrounds in institutions, including prison, local authority care and mental health admissions were common. The majority of respondents identified the cause of their most recent homelessness to be related to loss of their individual personal support networks: parents/carers or other relatives/friends being unable or unwilling to accommodate or breakdown of a relationship (non-violent). Mental or physical health problems were reported as a reason by 13% of respondents, drug and alcohol problems by 12% and domestic abuse or violence for nearly 10%.

Health needs:

iii. **Physical health:** The most common physical health problems identified were joint/bone/muscle problems (26%), dental problems (19%), eyesight/eye problems (16%) and asthma (16%).

iv. **Mental health**: Results of the Herefordshire audits show that participants experience high levels of stress, anxiety and other signs of poor mental health. Overall 76% of respondents reported a mental health problem/behaviour condition. Dual diagnosis (severe mental health issue and substance misuse) was reported by 18% (18 people, 78% of whom were told in the last 12 months); 14% reported psychosis (of whom 71% were told in the last 12 months). Just under half of those with a mental health problem felt that they were not receiving treatment that they would benefit from, this included respondents with severe mental health conditions and common mental health conditions.

v. **Drugs and alcohol**: 43% of respondents did not use drugs, 15% used cannabis only and 42% used Class A, prescription or other non-cannabis drugs. 25 people identified themselves as having a drug problem or being in recovery, of which 32% felt they would benefit from more treatment. Approximately half of respondents drank frequently (from almost every day to once or twice a week). Those that drink, drink on average 10.7 units on a typical day.

vi. **Access to services:** 78% of respondents were registered with a GP and 29% with a dentist. Use of acute care services was common, and frequent. Mental health problems and self-harm/attempted suicide contribute to approximately 40% of A&E, ambulance and hospital admissions. Violence and accidents were the main reason for approximately 30% of use of these acute services.

vii. **Staying healthy:** Basic nutrition in this population was identified as a problem with only 19% of respondents reporting an average of 3+ meals per day (81% had one or two meals a day). Uptake of preventative health interventions was low in this population, for example <10% of respondents had the flu vaccine last year.

12. Recommendations from the audit:

a. St Mungo's Charter for Homeless Health has been established as a means to galvanise change, and reduce some of the worst health inequalities in society, through health and wellbeing boards. The Charter itself is short and contains only the following commitments:

i. Identify need: We will include the health needs of people who are homeless in our Joint Strategic Needs Assessment. This will include people who are sleeping rough, people living in supported accommodation and people who are hidden homeless. We will work with homelessness services and homeless people to achieve this.

ii. Provide leadership: We will provide leadership on addressing homeless health. Our Director of Public Health has a key leadership role to play in tackling health inequalities and will lead in promoting integrated responses and identifying opportunities for cross boundary working.

iii. Commission for inclusion: We will work with the council and clinical commissioning group to ensure that local health services meet the needs of people who are homeless, and that they are welcoming and easily accessible.

b. Through endorsing sign up and commitment to the Charter, the HWBB will demonstrate its commitment to reduce this severe health inequality.

c. The JSNA currently does include top level data on homelessness. The findings of the audit report will be published on the Facts and Figures website, and as such contribute to the evidence base of the JSNA.

d. The audit highlighted the need for improving access to services, specifically mental health services, primary and secondary healthcare and preventative services for homeless people. Given the high level and high cost usage of acute and emergency health care services, there is an incentive both for the health and care system as well as for the best outcome for the individual.

National and local homelessness health policy

13. The Ministry of Housing, Communities and Local Government (MHCLG) Rough Sleeping Strategy, August 2018, identified the need for local recognition of the link between health and homelessness. Through acknowledgment of the findings of the Homelessness Health Audit, and approval of the recommendations, the HWBB will demonstrate such recognition in Herefordshire.

14. The Homelessness Act 2002 requires every council to carry out a review of homelessness in their district every five years and to publish a Homelessness Strategy based on the findings of the review. Rough sleeping is the most visible and damaging manifestation of homelessness. Herefordshire's first strategic objective in its Homelessness Prevention Strategy is to minimise rough sleeping and increase tenancy sustainment opportunities for rough sleepers and people with complex needs. As set out in the council's Homelessness Review document, homelessness places substantial costs on the NHS.

15. The Ministry of Housing, Communities and Local Government (MHCLG) Homelessness Code of Guidance for local authorities, February 2018 states that housing authorities should ensure that their homelessness strategy is co-ordinated with the Health and Wellbeing Strategy, and that their review of homelessness informs and is informed by the Joint Strategic Needs Assessment. The availability of data from the Homeless Link Health Needs Audit, and its inclusion in the JSNA, will support this.

Community impact

16. As stated in the JSNA 2018, Herefordshire Council's and Herefordshire Clinical Commissioning Group's focus is on prevention, early intervention and demand management in order to deliver better outcomes, whilst also managing the challenges of scarce public resources. This requires an understanding of the full range of socio-economic and lifestyle factors that affect the health and wellbeing of Herefordshire's people and communities, and an appreciation of the links between the wider determinants of health, the factors that contribute to multiple deprivation, and vulnerability. Nationally, rough sleepers and single homeless people have some of the poorest outcomes, and some of the costliest health needs in the population. However, prior to the completion of the audit very little reliable Herefordshire recent and specific information has been available.

17. Homeless people are recognised as a priority in the Herefordshire Health and Wellbeing Strategy: Priority 6, Special Consideration, includes reducing health inequalities and homeless people. Furthermore, the strategy recognises the importance of working together across the system to improve health and wellbeing.

18. As part of the government's national rough sleeping strategy, the MHCLG has announced its requirement that all councils update their homeless prevention strategies and rebadge them as homeless and rough sleeping strategies by winter 2019. Councils will be required to publish their strategies online, submit them to the MHCLG and to report progress on delivering the associated annual action plans. The data from the homeless health needs audit will support the achievement of this new duty.

19. Ten percent of audit participants reported previously being in local authority care and thus the data indicate that previously looked after children are over-represented in the homeless population. The recommendations set out, including high level leadership and identifying need, will positively impact on reducing the likelihood of homelessness for looked after children in the future.

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Equality duty

20. Under section 149 of the Equality Act 2010, the 'general duty' on public authorities is set out as follows: A public authority must, in the exercise of its functions, have due regard to the need to –

    a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;

    b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;

    c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

21. The public sector equality duty (specific duty) requires us to consider how we can positively contribute to the advancement of equality and good relations, and demonstrate that we are paying 'due regard' in our decision making in the design of policies and in the delivery of services. Our providers will be made aware of their contractual requirements in regards to equality legislation.

22. This decision will benefit those with a protected characteristic through the provision of a service to support their continued integration. For example a Syrian refugee who has a physical disability would have the protected characteristics of race and disability, they would be supported to access appropriate benefits or employment, understand how to manage their tenancy and what their rights as tenants are.

23. Homelessness is both a symptom and a cause of significant health inequalities across individuals with all protected characteristic. By better understanding and addressing these needs commissioners are better placed to reduce inequalities.

24. Single homeless people experience significant health inequalities being more likely than the general population to experience multiple physical and mental health problems. However, for various reasons they may miss out on the health care they need. Where health problems go untreated until they become critical, this can result in expensive, and often avoidable, treatment.

Resource implications

25. The recommendations have no direct financial implications. HWBB partners should work together, allocating resources as appropriate, to reduce health inequalities in the homeless population.

Legal implications

26. There are no specific legal implications in the report. The Homelessness Reduction Act 2017 came into force on 3 April 2018. It places new legal duties on councils so that everyone who is homeless or at risk of homelessness will have access to meaningful help, irrespective of whether they are judged to be in priority need as long as they are eligible for assistance. Homelessness Act 2002 requires councils to review homelessness and its causes in their area and to develop a strategy for tackling homelessness.

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27. The Health and Social Care Act 2012 amends the Local Government and Public Involvement in Health Act 2007 to introduce duties and powers for health and wellbeing boards in relation to joint Strategic Needs Assessments.

Risk management

28. There is a reputational risk if it fails to consider the results of the Homeless Health Needs Audit.

29. There is a risk if partners do not work together to implement effective multiagency interventions to tackle the inequalities highlighted in this report.

Consultees

None

Appendices

Appendix 1: Homeless Health Needs Audit Report

Appendix 2: Homeless Health Needs Audit toolkit printable questionnaire

Background papers

None identified.

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