

Joint Strategic Needs Assessment 2017

Executive summary

Homelessness is the result of multiple disadvantages and can describe a range of circumstances from vulnerable housing to rough sleeping. The homeless population suffers worse health outcomes than the housed population: the average age of death of a rough sleeper is 47, compared to 77 for the general population, and a homeless person is more likely to attend and be admitted to hospital. Healthcare costs are high, with secondary healthcare for a homeless person costing more than three times more than the average.

Homelessness, both statutory and rough sleeping, is increasing nationally. This is in part due to a shortage of suitable and social housing and increasing rent costs. In Tower Hamlets, contrary to the national trend, statutory homelessness has reduced in recent years due to efforts to prevent people losing existing tenancies. However, rough sleeping has increased by more than a third over the past four years. This is of particular significance as hostel spaces are reducing.

Healthcare data on the homeless population is limited, as housing status is not routinely recorded in healthcare settings. Although it is possible to see how many patients are managed by homeless services, it is not possible to follow these people through different care settings, or to measure health outcomes for them consistently. It is unclear how many people using healthcare services are not known to be homeless. The implementation of the Homelessness (Reduction) Bill 2017 will require healthcare providers to refer homeless patients to the local authority's housing department. It will therefore require healthcare services to routinely record housing status.

Recommendations

1. Enable consistent flagging of homelessness as a status in GP and hospital records
To accurately assess the health needs of the homeless population, there needs to be consistent identification of housing status in all healthcare settings. The Homelessness (Reduction) Act 2017 will require healthcare providers to refer homeless patients to the local authority housing department, and this may represent an opportunity to better record housing status in general.
2. Plan for implementation of referral element of Homelessness (Reduction) Act 2017
3. Develop homeless health outcome measures
It may be worth developing specific health outcomes to be measured for the homeless population across healthcare settings to aid in evaluating interventions. Although it is possible to assess the usage of an individual service, it is not currently possible to assess how those same patients interact with other services.
4. Continue specialist provision of primary care and integrated approach through in-hospital service
Despite the difficulty in assessing the impact of specific services, the available evidence suggests that the specialist services provided in the borough have a positive impact. Both Health E1 and Pathway receive positive feedback from their service users, and they are in line with recommendations from the Faculty of Inclusion and Homeless Health.
5. Enable people to register with mainstream general practices when this is suitable
Qualitative feedback suggests that some patients of Health E1 feel they have been excluded from mainstream general practice. Moving from Health E1 to a mainstream GP, at a suitable point, may be part of progressing into stable housing, and would reduce the practice population of Health E1.
6. Ensure training of frontline staff in engaging with the homeless population
Many homeless people have had negative experiences in healthcare settings, often feeling presumptions are made about them, leading to distrust in clinical services. This remains a barrier to engagement.
7. Further work on use of specialist services such as dentistry
Qualitative feedback suggests a reliance on ad hoc, charitable services for accessing dentistry. It has not been possible to assess the use of NHS dentists by the homeless population, and this is vital to ensure the

service is available to those who need it.

1 What is homelessness / what are the issues?

Defining Homelessness

Homelessness is often the consequence of multiple disadvantages. It describes a range of circumstances from living on the streets to residing in insecure housing. This factsheet aims to include as many experiences of homelessness as possible.

Statutory homelessness

If an individual or household is accepted by the local authority as meeting the criteria set out in the Housing Act 1996, they will be deemed statutorily homeless. Statutory homelessness may apply to people who have no access to housing of any type, or who have access to housing which is unsuitable for their needs. If the applicant is also deemed to be in priority need, the local authority has a duty to provide them with accommodation. If they are not in priority need, the local authority should provide them with housing advice¹.

Priority need

A household or person is likely to be considered in priority need if²:

- Children live with them
- They are pregnant
- They are aged 16-17 and do not qualify for housing from social services
- They are a care-leaver aged 18-21
- They are homeless through disaster such as flood or fire
- They are a vulnerable adult

Threatened homelessness

Threatened homelessness applies to those who are at risk of losing their access to housing within 28 days. They are entitled to the same services as somebody who is statutorily homeless. Under the Homelessness (Reduction Act) 2017 the at-risk period will be extended to 56 days.

Hidden homelessness

The hidden homeless are those who do not have access to suitable housing, but may be staying with friends or family or living in squats, and are not known to services. This group may also include recent migrants, and those without recourse to public funds.

Rough sleeping

Rough sleepers are those who sleep or live on the street. This is the most extreme manifestation of homelessness.

Homelessness and health

Most research on homelessness and health relates to street homelessness and hostel dwellers. There is less evidence available on the effects of being vulnerably housed, although the link between poor quality housing and ill-health is well established. By definition, there is little on the hidden homeless population.

Vulnerabilities to homelessness include personal circumstances, such as relationship breakdown, loss of income, illness and bereavement, and structural risk factors, such as the housing shortage and welfare reform³.

Health outcomes for the homeless population are poor. The average age of death⁴ of a homeless person is 47, compared to 77 in the general population⁵. People from the homeless population most commonly die from physical

¹ Housing Act 1996

² Shelter 2017. Help from the council when homeless: Are you in priority need?

³ St Mungo's. 2016. Nowhere safe to stay: the dangers of sleeping rough

⁴ This is not the same as life expectancy

⁵ Crisis 2011. National estimate, definition of homeless includes rough sleepers, and people in hostels or temporary housing.

medical conditions, such as liver disease, respiratory disease, and the consequence of chronic drug and alcohol use, rather than the direct effects of homelessness such as exposure⁶.

A homeless person is more likely to suffer from physical and mental illness than a housed person, more likely to attend emergency departments for healthcare, and more likely to be admitted to hospital⁷. It is estimated that the annual cost of secondary health care for the homeless population is £2100 per person, compared to £525 for the general population⁸.

Measuring homelessness

There are limitations on quantifying the homeless population and identifying health outcomes or the results of interventions. Many homeless people will not be known to statutory services, and therefore will not be on official registers.

2 What is the policy context?

Legislation

Many pieces of legislation will affect the homeless population. The following are acts which directly pertain to homelessness prevention or reduction.

Housing (Homeless Persons) Act 1977

The first piece of legislation to define homelessness, and to make it a requirement of the housing authority to house homeless households that are vulnerable or have dependent children.

Housing Act 1996

Made it a duty for local authorities to provide accommodation for a broader group of eligible people, in priority need, and who are not deemed to be 'intentionally homeless'.

Homelessness Act 2002

The first piece of legislation requiring local authorities to implement strategies to prevent homelessness.

Homelessness (Reduction) Act 2017

This Bill achieved Royal Assent in April 2017. It makes it a requirement that a housing authority should provide help for any homeless individual or household, regardless of whether they would have been deemed to be in priority need under previous legislation. It also requires statutory bodies, including healthcare providers, to notify the housing authority of all cases of homelessness. It extends the period of 'threatened homelessness' from 28 to 56 days. It introduces further conditions relating to people who are deemed to be intentionally homeless.

National policy and strategy

Making Every Contact Count

Making Every Contact Count is the government's strategy for reducing homelessness through joint working and preventative measures. It sets out ten recommendations to local authorities⁹:

1. Adopt a corporate commitment to prevent homelessness which has buy in across all local authority services
2. Actively work in partnership with voluntary sector and other local partners to address support, education, employment and training needs
3. Offer a Housing Options prevention service, including written advice, to all clients
4. Adopt a *No Second Night Out* model or an effective local alternative
5. Have housing pathways agreed or in development with each key partner and client group that includes

⁶ O'Connell JJ. Premature Mortality in Homeless Populations: A review of the literature. Nashville Health Care for the Homeless Council. 2005

⁷ More than a statistic - Groundswell

⁸ Deloitte Centre for Health Solutions. Healthcare for the homeless: homelessness is bad for your health. 2012

⁹ Department for Communities and Local Government. 2012. Making every contact count: a joint approach to preventing homelessness.

appropriate accommodation and support

6. Develop a suitable private rented sector offer for all client groups, including advice and support to both clients and landlords
7. Actively engage in preventing mortgage repossessions including through the Mortgage Rescue Scheme
8. Have a homelessness strategy which sets out a proactive approach to preventing homelessness and is reviewed annually so that it is responsive to emerging needs
9. Not place any young person aged 16 or 17 in Bed and Breakfast accommodation
10. Not place any families in Bed and Breakfast accommodation unless in an emergency and then for no longer than 6 weeks

No Second Night Out¹⁰

No Second Night Out operates across London, and Tower Hamlets commissions outreach workers as part of this project. Rough sleepers are rapidly referred and given emergency accommodation to prevent a second night of sleeping rough.

Five Year Forward View¹¹

Although there is no direct reference to homelessness, the NHS Five Year Forward View promotes preventative work, engaging the community in health provision decisions, and forging stronger ties with the voluntary sector. These are all areas relevant to working with the homeless population; a population which is isolated and often reliant on voluntary sector programmes.

Local strategy

Tower Hamlets Homeless Statement 2013-2017

The borough's statement on homelessness prioritises work in the following areas: children, young people and families; supporting vulnerable people; access to housing; employment and economic well-being; excellent public services.

Other local strategies and needs assessments which have an impact on the homeless population include:

- Tower Hamlets Mental Health Strategy
- Tower Hamlets Substance Misuse Strategy
- Tower Hamlets Alcohol Joint Strategic Needs Assessment

3. What is the local Picture?

Housing

There are now over 124,000 households in Tower Hamlets¹². The borough has seen the fastest rate of housing growth in the country: the number of homes increased by 29% between 2004 and 2014¹³. However, building has not kept up with demand; there remains a shortage of suitable housing.

34.8% of households in Tower Hamlets are overcrowded, defined as having one or more rooms too few for the number of occupants¹⁴. 7078 of the 19,000 households on the housing waiting list are currently overcrowded¹⁵. More than 2100 households are living in temporary accommodation¹⁶.

Statutory homelessness – single people

Statutory homelessness has been increasing in London and England over the past seven years.

¹⁰ No Second Night Out 2017. www.nosecondnightout.co.uk

¹¹ NHS Five Year Forward View 2014

¹² Department for Communities and Local Government. 2017. Table 784: Local authorities' actions under the homeless provisions of the 1985 and 1996 Housing Acts (financial year) 2016-2017

¹³ Mayor of London. 2016. Housing in London 2015: The evidence base for the Mayor's Housing Strategy

¹⁴ Census 2011

¹⁵ London Borough of Tower Hamlets. 2016. Housing Evidence Base

¹⁶ Department for Communities and Local Government. 2017. Table 784: Local authorities' actions under the homeless provisions of the 1985 and 1996 Housing Acts (financial year) 2016-2017

Contrary to national and regional trends, the rate of statutory homelessness in Tower Hamlets has generally been reducing over the past seven years (figure 1). 504 households were deemed to be homeless and in priority need in 2016/17. This is the equivalent of 3.6 per 1000 households, compared to 7.8 in 2009/10¹⁷.

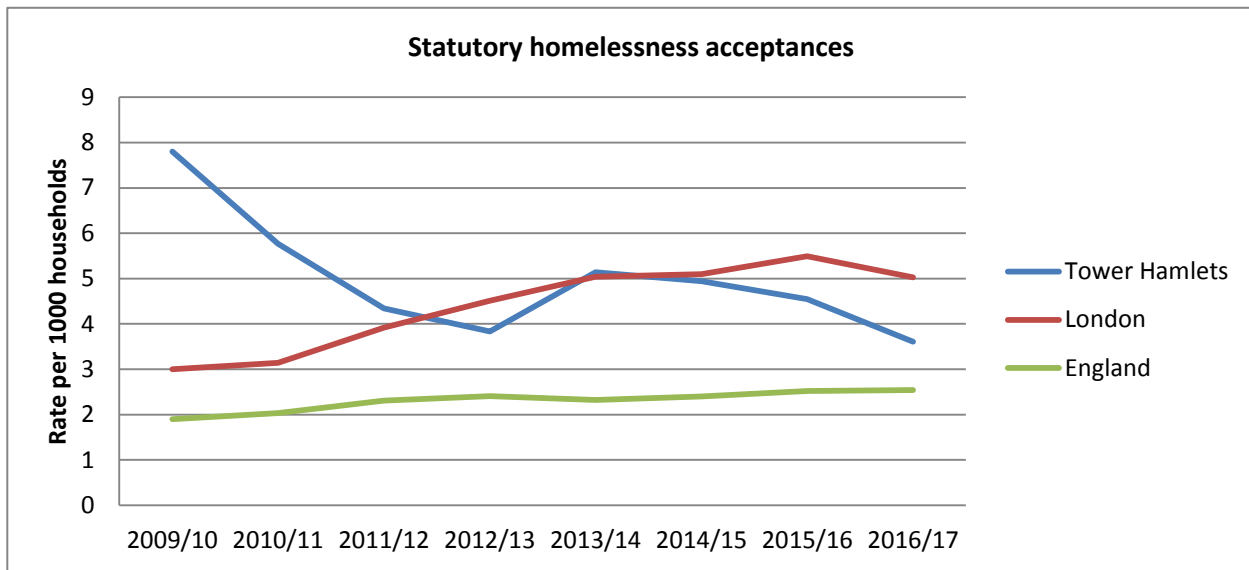


Figure 1 Statutory homelessness acceptances in Tower Hamlets, London, and England, 2009/10 - 2016/17

The reduction in statutory homelessness acceptances in Tower Hamlets is likely due to a reduction in official approaches made to the council. The housing options service offers a larger range of solutions to avoid losing a tenancy than other local authorities.

The causes of statutory homelessness have changed over the past five years. Research suggests that this is due to a reduction in the proportion of housing which is social housing, and the introduction of the housing benefit cap. In the same period house prices have risen and stricter mortgage regulation has been implemented. These conditions have led to a greater proportion of the population living in private rented accommodation, which has increased in price and therefore become less accessible¹⁸.

In 2016/17 the most common causes of statutory homelessness were the ending of a short-hold tenancy and ejection from a family home. The proportion of statutory homelessness caused by the ending of a short-hold tenancy has increased from 25% to 41% over five years¹⁹.

¹⁷ Department for Communities and Local Government. 2017. Table 784: Local authorities' actions under the homeless provisions of the 1985 and 1996 Housing Acts (financial year) 2016-2017

¹⁸ Wilson W, Barton C. 2017. House of Commons briefing paper: Statutory Homelessness in England

¹⁹ Tower Hamlets Housing Options Service, Reasons for statutory homelessness 2012-2017

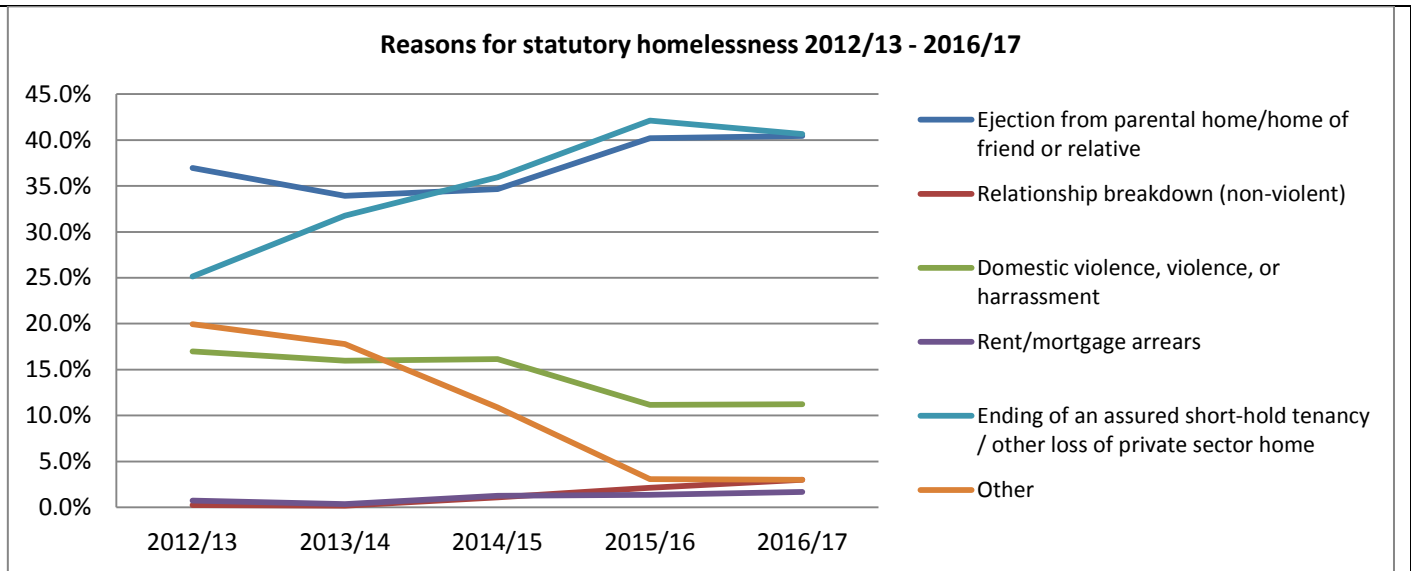


Figure 2 Reasons for statutory homelessness (singles) in Tower Hamlets as a percentage of the total, 2012/13-2016/17

Street Homelessness

There is uncertainty in estimating the number of people living or sleeping on the streets. This is a mobile population with a high turnover that by its nature is unlikely to be recorded on routine registers. Methods for quantifying rough sleeping vary from source to source and provide different results.

Department for Communities and Local Government

The Department for Communities and Local Government collates data from each local authority on rough sleeping. Tower Hamlets has conducted annual street counts, although this has not been required since 2009; the majority of results from other local authorities are now estimates based on data from local service providers. The government street count is unlikely to reflect the true nature of rough sleeping, as it counts only once per year, and excludes anybody not witnessed to be asleep.

In Tower Hamlets, the number of people sleeping witnessed to be sleeping on the street was recorded as 11 in the 2016 count. This figure has fluctuated over the past five years, but has remained between four and 12 people. The picture across London as a whole shows a growing number of people are sleeping rough; there were 964 rough sleepers in 2016 compared to 446 in 2010, doubling over the course of five years²⁰.

Combined Homelessness and Information Network (CHAIN)

CHAIN conducts more frequent and inclusive street counts. Between April 2016 and March 2017 CHAIN saw 445 unique cases of people sleeping rough in the borough, an increase of 13% on the previous year²¹. In London there were 8104 unique rough-sleepers in the same time period, an increase of 1% from the previous year, and of 7% from 2014/15²². The number of rough sleepers in Tower Hamlets has increased at a greater rate than across London as a whole in recent years.

The causes of this increase are likely the same as those for the national increase in statutory homelessness, coupled with a reduction in services available for those most vulnerable, such as sheltered housing spaces²³.

In Tower Hamlets 186 people (42%) were defined as either 'returner' or 'stock', having also been witnessed sleeping rough in previous years.

²⁰ Department for Communities and Local Government 2017. Homelessness statistics, Tower Hamlets 2016

²¹ CHAIN 2017. Annual report 2016/17: Tower Hamlets

²² CHAIN 2017. Annual reports 2014/15 – 2016/17: Greater London

²³ St Mungo's. 2016. Nowhere safe to stay: the dangers of sleeping rough

259 people were new rough sleepers. Of the 190 people whose last settled base was recorded, 47.4% had been living in long-term accommodation immediately prior to first being seen rough sleeping. 11.6% had been in temporary accommodation or hostels, 11.6% had newly arrived in the UK, and 3.7% had been released from an institution (hospital or prison).

Of all the rough sleepers (new or previously known), 45% had experienced time in prison, 10% had been in the armed forces, and 9% had been in care.

The majority of rough sleepers are male (83%), similar to the proportion in London as a whole. However, the number of women sleeping rough has been increasing, and more than doubled between 2015/16 to 2016/17.

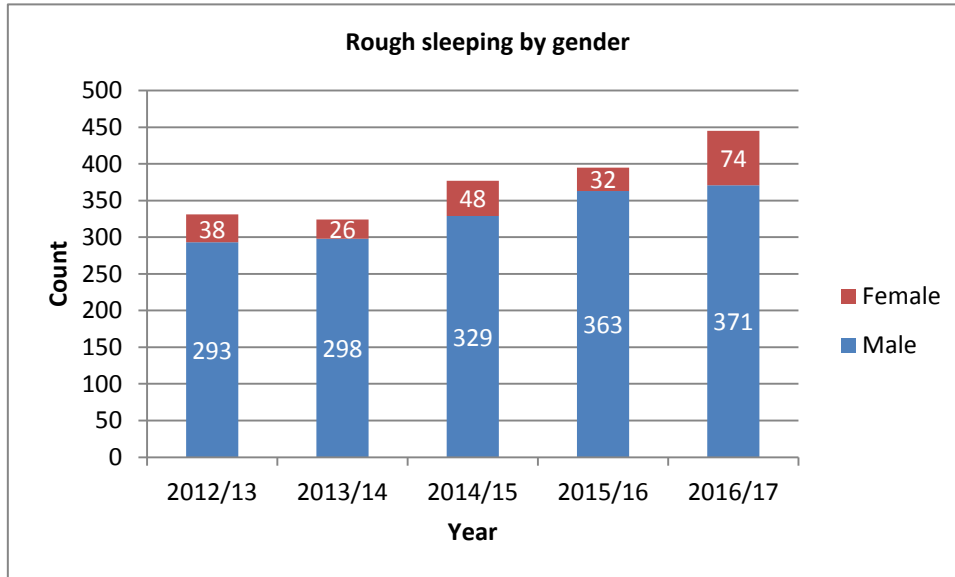
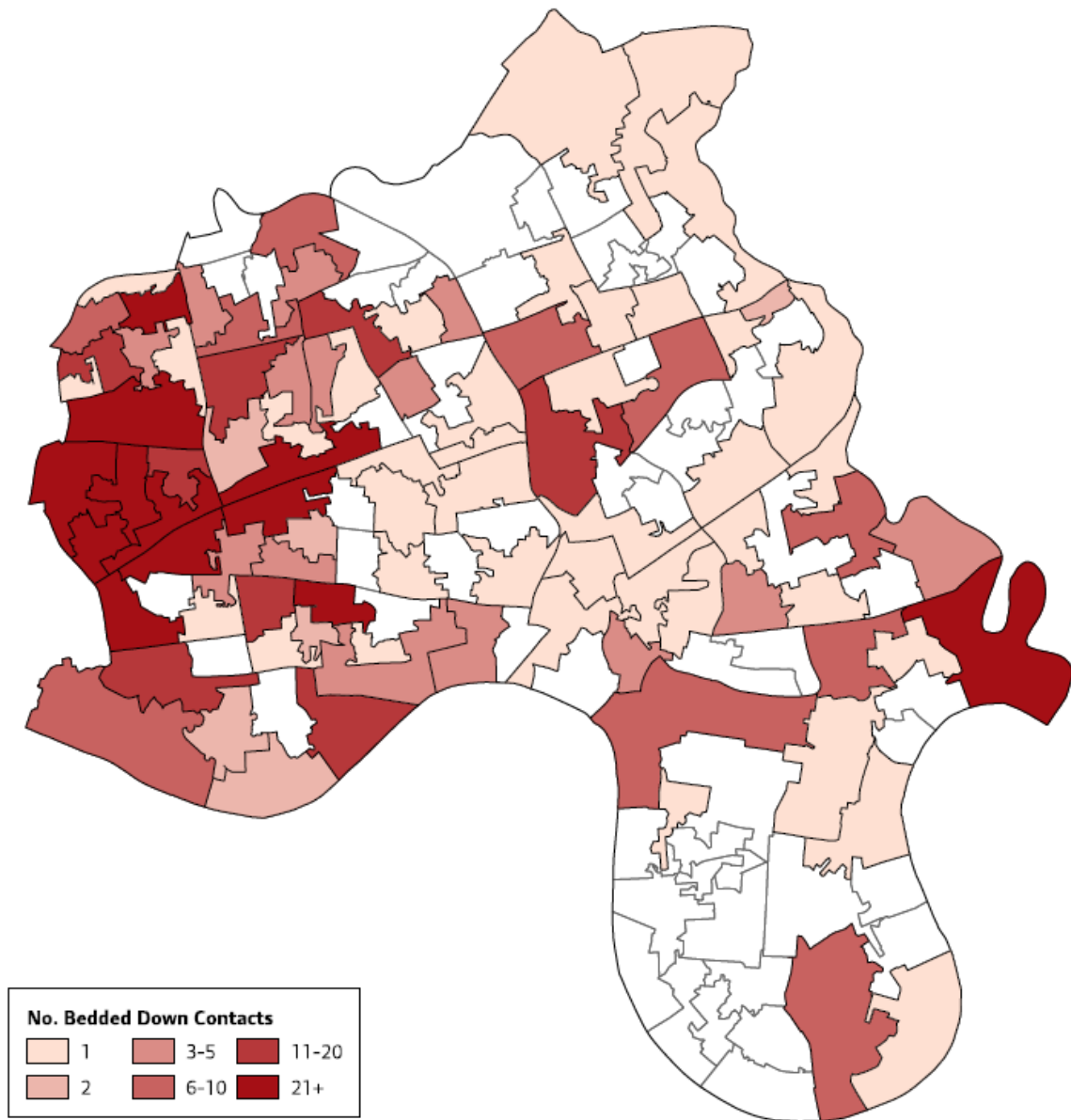


Figure 3 Rough sleeping by gender, Tower Hamlets 2012/13 - 2016/17, CHAIN data

More than half (58%) are UK citizens. A further 24% are from the European Economic Area, representing a reduction in both numbers and proportion of the total from the preceding year.

Rough sleeping does not occur consistently across the borough; there are areas where far more people are seen to be 'bedded down'. Most of the areas are in the West of the borough: Spitalfields and Banglatown, Whitechapel, Weavers, Bethnal Green South. This corresponds with the location of homelessness services such as Health E1 and many of the hostels, and the night-time economy. There is also a pocket of rough sleeping in the East which corresponds with a similar increased prevalence outside the borough boundary in Newham.



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Figure 4 CHAIN Tower Hamlets 2016/17 Bedded down street contacts by area (NB number of incidents of people witnessed bedded down, not number of rough sleepers)

Demographics

The ethnic breakdown of the homeless population does not mirror the borough as a whole. The Asian or Asian British population makes up a large proportion of the statutorily homeless population, but a minority of rough sleepers.

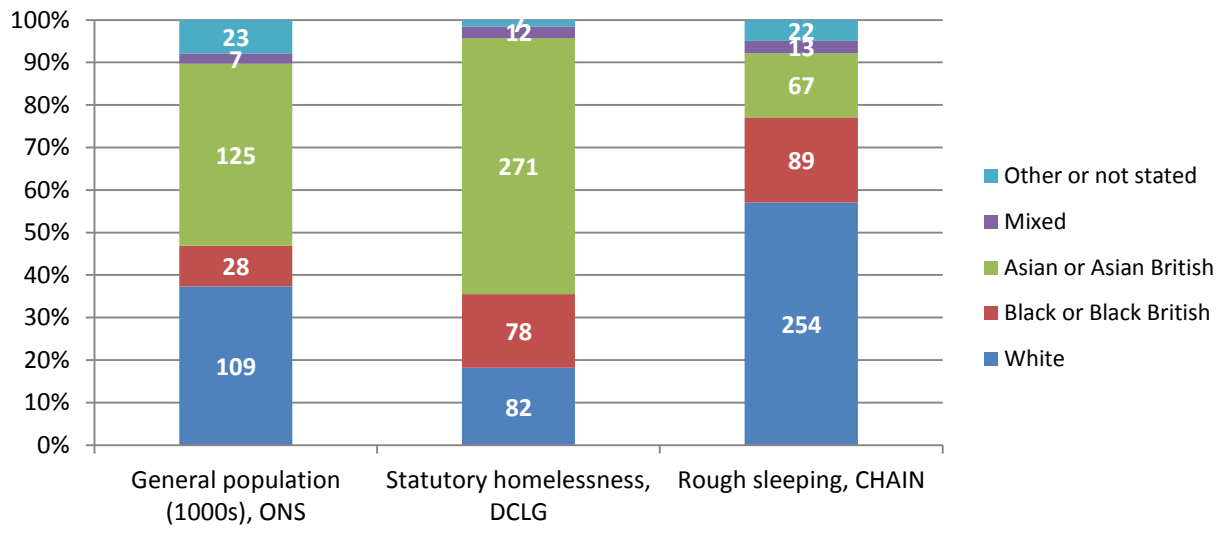


Figure 5 Ethnic breakdown of Tower Hamlets general population, statutory homelessness, and rough sleeping 2016/17

Although not broken down into directly comparable age groups, it is clear that the majority of both rough sleepers and those who are statutorily homeless are aged between 25 and 45. A greater proportion of the statutorily homeless are aged under 25.

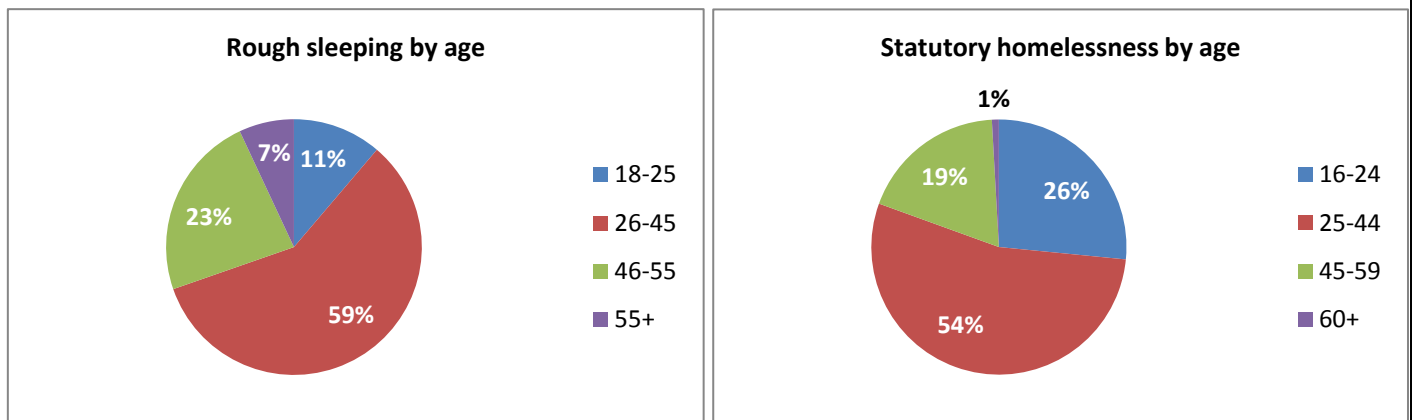


Figure 6 Age of rough sleepers (CHAIN 2016/17) and statutory homelessness (housing options service Q1 2017)

4. What are the effective interventions?

There is limited evidence on effective interventions to prevent or reduce homelessness. Models of best practice in healthcare have been proposed based on needs assessments of the homeless population, for example of integrated specialist care. However, these have not been evaluated on a large scale.

Commissioning guidance

The Faculty of Homeless and Inclusion Health sets out to define standards for effective health services for homeless people²⁴. In *Standards for Commissioners and Service Providers* it proposes an integrated care model, with a specialist service for the homeless population coordinating communication between other providers of health and social care.

²⁴ Faculty of Homeless and Inclusion Health. Standards for Commissioners and Service Providers 2011

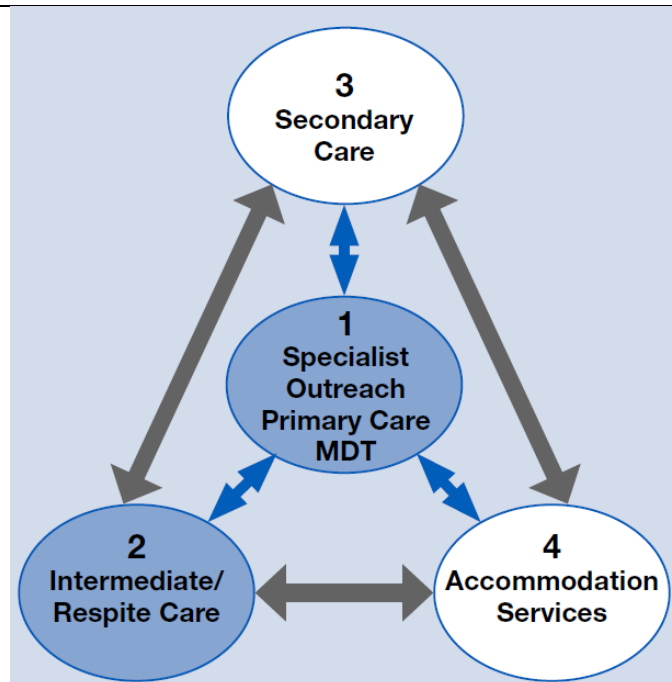


Figure 7 Faculty of Inclusion Health, integrated care model

The London Homeless Health Programme, part of the Healthy London Partnership, suggests ten key commitments for clinical commissioning groups which would improve healthcare services for the homeless population²⁵:

1. People experiencing homelessness receive high quality healthcare
2. People with a lived experience of homelessness are pro-actively included in patient and public engagement activities, and supported to join the future healthcare workforce
3. Healthcare 'reaches out' to people experiencing homelessness through inclusive and flexible service delivery models
4. Data recording and sharing is improved to facilitate outcome-based commissioning for the homeless population of London
5. Multi-agency partnership working is strengthened to deliver better health outcomes for people experiencing homelessness
6. People experiencing homelessness are never denied access to primary care
7. Mental health care pathways, including crisis care, offer timely assessment, treatment, and continuity of care for people experiencing homelessness
8. Wherever possible people experiencing homelessness are never discharged from hospital to the street or to unsuitable accommodation
9. Homeless health advice and signposting is available within all urgent and emergency care pathways and settings
10. People experiencing homelessness receive high quality, timely, and co-ordinated end of life care

Housing First

Housing First is a model in which homeless people are independently housed without any pre-conditions. The model originated in the USA and assumes that adequate housing is a prerequisite for good health, and that housing is a human right. The model has been successfully implemented internationally, and a version in England is being piloted in several regions including in London.

The principles of Housing First England are²⁶:

²⁵ Healthy London Partnership 2016. Healthcare and people who are homeless: commissioning guidance for London.

²⁶ Homeless Link. 2016. Housing First in England: the principles.

1. People have a right to a home
2. Flexible support is provided for as long as it is needed
3. Housing and support are separated
4. Individuals have choice and control
5. An active engagement approach is used
6. The service is based on people's strengths, goals, and aspirations
7. A harm reduction approach is used

Where Housing First has been evaluated internationally, it has been shown to have a positive impact in terms of long-term stable housing. One American study showed that 88% of tenants remained stably housed at five years, compared to 30-50% who had to demonstrate they were 'housing-ready' prior to being moved into independent housing. In another evaluation it was shown to be either cost-neutral or cost-saving in terms of healthcare service use²⁷.

5. What is being done locally to address this issue?

The Tower Hamlets Homelessness Statement 2013-2017 lays out four central themes for tackling homelessness in the borough:

- Homeless prevention and tackling the causes of homelessness
- Access to affordable housing options
- Children, families, and young people
- Vulnerable adults

Specialist healthcare for the homeless population is provided through the specialist general practice Health E1, and the in-hospital service Pathway.

Primary care: Health E1

Health E1 is the specialist general practice for homeless people in Tower Hamlets. The practice offers 20 minute appointments, a walk-in service, mental health nurses on site, a blood-borne virus testing service, and substance misuse workers from drugs and alcohol service RESET.

Health E1 caters for a complex population, who typically experience a greater burden of ill-health from a younger age. The prevalence of certain conditions is far higher in this population, and is demonstrated by some key Quality Outcomes Framework (QOF) indicators.

The prevalence of severe mental illness, such as schizophrenia and bipolar disorder, is 13 times higher than in the rest of the borough, and the prevalence of Chronic Obstructive Pulmonary Disease (COPD), is four times greater²⁸.

²⁷ Centre for Social Justice. 2017. Housing First.

²⁸ Public Health England Fingertips, National General Practice Profiles, QOF 2015/16

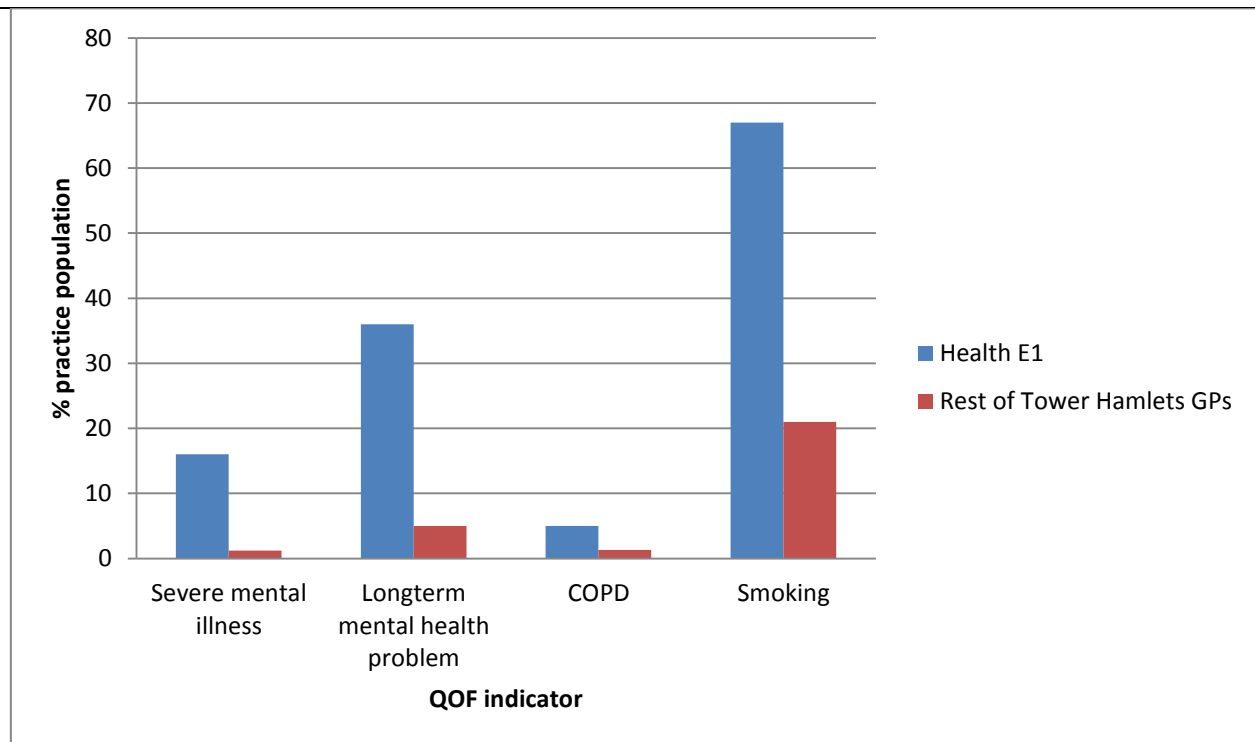


Figure 8 Key QOF indicators for Health E1 and the rest of GPs in Tower Hamlets (averaged), 2015/16

Patients from Health E1 are four times more likely to attend A&E than patients from other practices. In 2016, the rate of attendances to A&E was 28.8/1000 practice population for Health E1, and 7.1 in the remaining Tower Hamlets practices²⁹.

In 2015/16, 562 Health E1 patients received 1868 episodes of care in an A&E, of whom 478 attended a Barts NHS Trust A&E. Of these, 139 patients were registered with long-term conditions³⁰.

Secondary care: Pathway Service

The CCG commissions the in-hospital Pathway service, which operates at the Royal London Hospital. It provides care to inpatients who are homeless or at risk of becoming homeless, with a view to improving their outcomes after discharge. The stated outcomes in the service specification are:

Desired outcomes

- Improved health for homeless patients
- Improved self-efficacy in handling money, relationships and accommodation
- Reduced rough sleeping (as an outcome to which the service contributes through coordination with the work of other agencies)

Patient experience outcomes

- Trusting relationship formed with supportive team
- Improved self-efficacy in handling money and accommodation
- Joined up, integrated care

Efficiency outcomes

- Reduced average duration of stay (when assessed annually across whole patient group)
- Reduced admissions and emergency attendances

Positive recovery outcomes for individuals

- Increased ability to manage mental health
- Increased physical health and self-care skills
- Encourage social networks and peer support
- Increase in the ability to find work, training and access education

²⁹ Public Health England Fingertips, National General Practice Profiles, QOF 2015/16

³⁰ Health E1 data, incomplete dataset representing 781 patients registered at Health E1

- Improvement in the ability to develop and maintain relationships / contact with family
- Reduction in addictive behaviour
- Increase in self-esteem, trust and hope.

In 2016/17 Pathway were notified of 306 inpatients, of whom 296 were unique cases. The average length of admission was 11.8 days, with an average of 10 days spent under Pathway management. 40% of the admissions were related to drugs, alcohol, or a combination³¹.

Of the 629 patients managed by Pathway between November 2015 and July 2017, just 7% were registered at Health E1, 27% were registered at other Tower Hamlets general practices, and 54% were registered in another part of Greater London. The small number registered at Health E1 is significant, and is possibly because Health E1 has been successful in helping patients avoid hospital attendance³². It is worth noting that this data was manually extracted, as the databases used by the two NHS trusts (East London Foundation Trust and Barts Health Trust) are not compatible.

RESET

RESET is the drugs and alcohol service commissioned by London Borough of Tower Hamlets. The full service operates at Mile End Hospital, with two substance misuse workers based at Health E1.

During 2015/16 RESET at Health E1 saw 293 people for drug and alcohol misuse, of whom the vast majority (95%) presented with opiate dependency. 19% of all of those in treatment had a dual diagnosis of substance misuse and a mental health condition³³.

Hostels

There are currently seven hostels providing accommodation to the homeless, supplying a total of 516 beds. Of these there are a number of specialist hostel spaces: 35 on an abstinence programme; 50 'wet' provision for entrenched alcohol users; and 33 beds for stabilised drinkers and the ageing homeless. The hostels service is undergoing a restructure, resulting in a net loss of 150 beds. It is planned that this will be mitigated by a more robust 'moving on' process whereby residents will be successfully placed into long-term housing sooner.

Other commissioned services

Groundswell

Groundswell provide a peer advocacy programme, in which people with a lived experience of homelessness help people who are currently homeless navigate healthcare services. In Tower Hamlets they take self-referrals, or referrals from homeless or healthcare services, and can accompany patients to physical healthcare appointments, including in dentistry and optometry services.

In 2016/17 Groundswell engaged with 39 people on a one-to-one basis, and a further 82 in in-reach sessions in hostels and day centres. They offer a range of support, with assistance in making, keeping, and attending healthcare appointments being the most used³⁴.

³¹ Pathway, service data 2017

³² Pathway, service data 2017

³³ Adult provider activity report, RESET, Health E1. May 2016

³⁴ Groundswell HPPA monitoring form, 2016/17

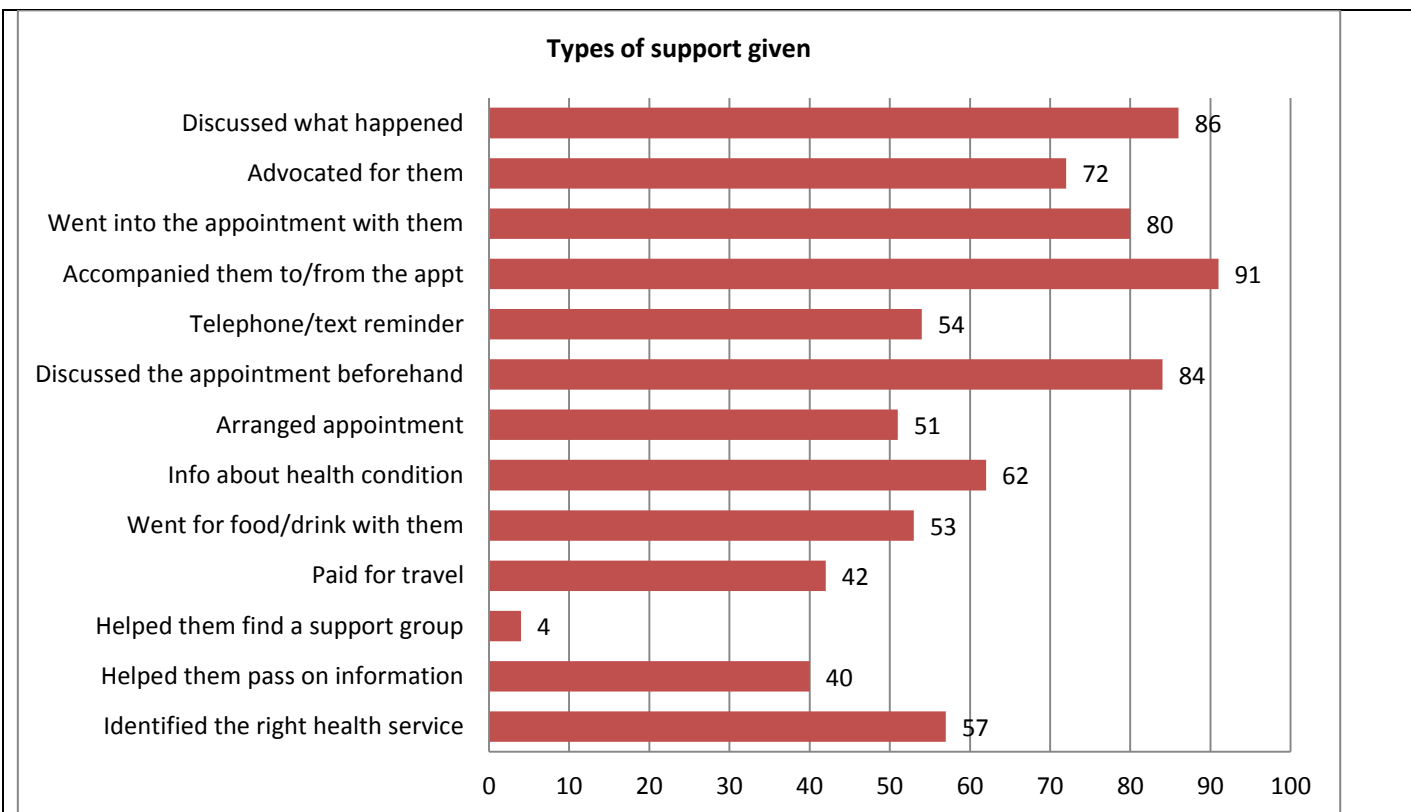


Figure 9 Types of support given by Groundswell, 2016/17

The estimated cost savings in the 180 days following a Groundswell peer advocacy intervention are £1.97 for every £1 spent³⁵.

Routes to Roots

Routes to Roots reconnects homeless people to areas where they have a local connection, either to other local authorities where they have access to more support, or to their home countries. In 2016/17 32 people were helped to return to their home areas. 84% of those reconnections were to destinations outside the UK³⁶.

Outreach workers

Tower Hamlets employs nine outreach workers who rapidly refer new rough sleepers to the No Second Night Out service, where they will be guaranteed a bed for the night. In 2016/17 125 rough sleepers were referred to the No Second Night Out service³⁷. They also take referrals for those at risk of rough sleeping, as part of the No First Night Out pilot.

6. What evidence is there that we are making a difference?

Two Public Health Outcome Framework indicators directly pertain to homelessness³⁸:

- 1.15i eligible homeless people not in priority need
This is the number of households who have presented themselves to the local authority as homeless but have not met the criteria for being in priority need, and therefore are not owed a duty of housing from the council. This group is overwhelming single adults. The rate has remained stable at 0.2 per 1000 households for the past five years, equating to between 15 and 25 individuals every year.
- 1.15ii households in temporary accommodation
This is the number of households deemed homeless which have been placed in temporary accommodation. The rate has been reducing for the past five years, despite increasing in London as a whole.

³⁵ Groundswell HPPA monitoring form 2016/17.

³⁶ CHAIN 2017. Annual report 2016/17: Tower Hamlets

³⁷ CHAIN 2017. Annual report 2016/17: Tower Hamlets

³⁸ PHE Fingertips. Public Health Outcomes Framework indicator 1.15, Tower Hamlets

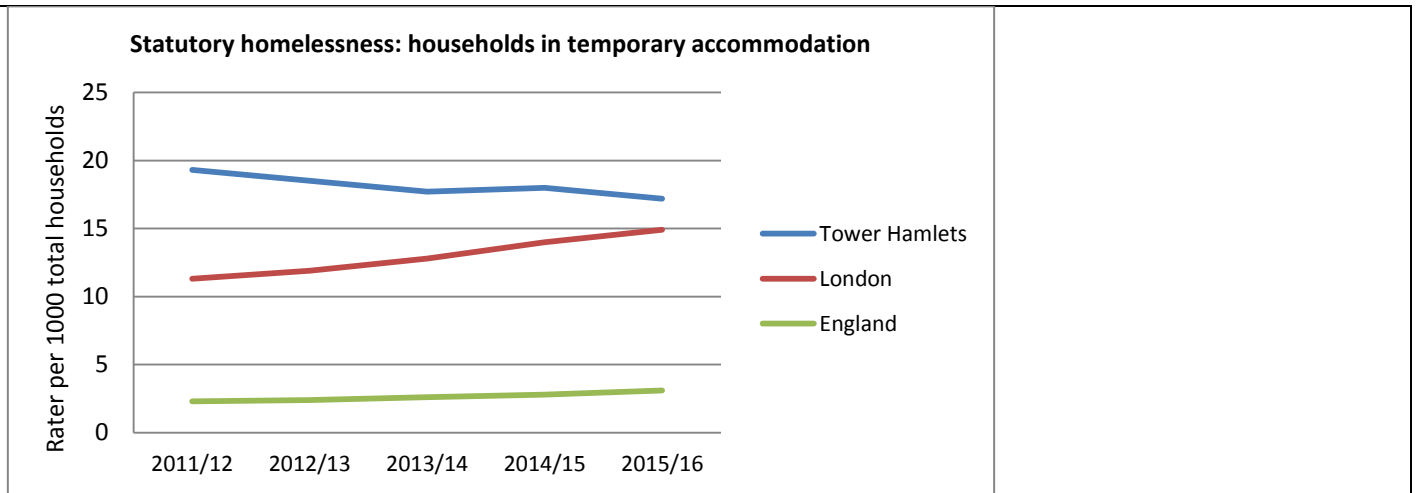


Figure 10 Public Health Outcomes Framework indicator 1.15 households in temporary accommodation

Public Health England (PHE) publishes other measures quantifying homelessness as a social determinant of health. These have been described in section 3.

- Statutory homelessness, rate per 1000 households,
- Homelessness applications, rate per 1000 households

Other PHE measures are relevant to the homeless population, including the prevalence of some communicable diseases, and alcohol-related hospital admissions. However, as these can only be measured for the borough as a whole, there is a limit to what conclusions can usefully be drawn about the homeless population.

Housing status is not routinely recorded in healthcare settings, so monitoring the health outcomes of the homeless population consistently across services is difficult. As it is not possible to extract healthcare data on homeless people, either in a hospital setting or in mainstream general practice, it has not been possible to analyse in depth the burden of individual diseases on this population. It is unclear how many people using healthcare services are not known to be homeless.

From the data available, it appears that a patient registered at Health E1 is four times more likely to attend A&E than a patient registered elsewhere. However, Health E1 patients make up a small minority of those seen by the Pathway service. Further data on service usage, where available, is outlined in detail in section 5.

Feedback received in focus groups (section 8) suggests that, despite this population having negative experiences of health and healthcare, services in Tower Hamlets have a significant positive impact on quality of life, and are valued by those who have a lived experience of homeless.

Pathway Service

Pathway conducted a randomised control trial of this in-hospital intervention at the Royal London Hospital and the Royal Sussex County Hospital in Brighton. It found that, although the intervention did not significantly reduce length of stay or likelihood of re-admission, it significantly increased quality of life scores in the group which received the intervention, demonstrated by an increase in EQ-5D-5L score from 0.43 to 0.56³⁹. The intervention was shown to reduce discharge to rough sleeping to a greater extent than standard hospital care: of the intervention group 39.8% were rough sleeping on admission and 3.8% at discharge, compared to 47.1% on admission in the control group and 14.7% at discharge⁴⁰.

³⁹ Euro-QoL, 5 dimensions, 5 levels quality of life survey.

⁴⁰ Hewett N, Buchman P, Musairi J, et al. 2016. Randomised controlled trial of GP-led in-hospital management of homeless people ('Pathway'). *Clinical Medicine*. Vol 16, 3:223-9

In local Pathway service data, significant changes in housing status between notification of admission and discharge are recorded. There was a reduction in the number of rough sleepers and those who could not return to their previous home, and an increase in numbers in hostel places or housing (figure 7)⁴¹.

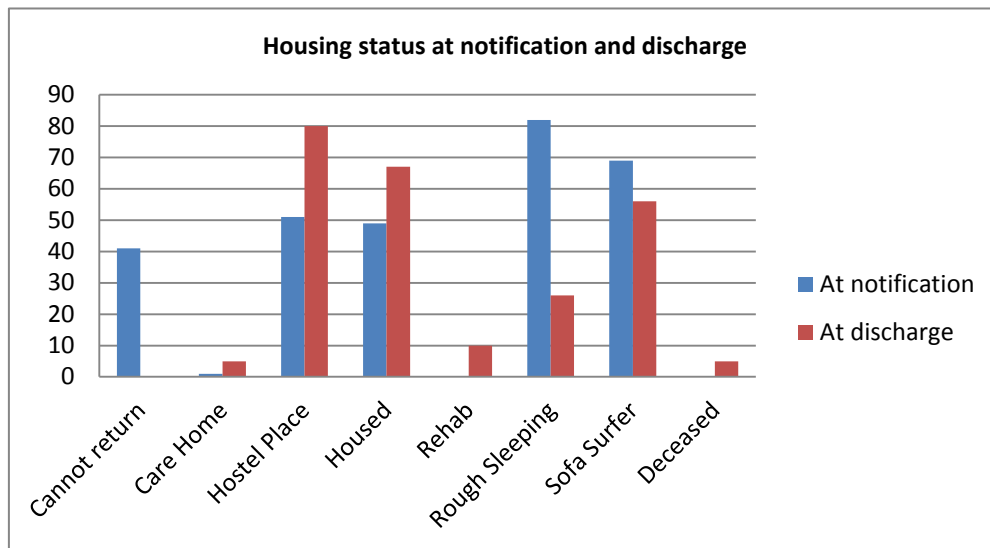


Figure 11 Status of Pathway patients at notification of admission and at discharge, 2016/17

7. What is the perspective of the public on the support available to them?

Focus Groups

With support from the London Homeless Health Project, Groundswell were commissioned to conduct focus groups with adults with a lived experience of homelessness in Tower Hamlets. A full report is in appendix 1.

Five sessions with a total of 34 participants were conducted in July 2017, at a range of hostels and day centres in Tower Hamlets:

- Hopetown, a low to complex needs hostel for women
- Booth House, a high to medium needs hostel for men
- The Dellow Centre, a high to medium needs hostel for men and women
- Edward Gibbons House, a 'wet' substance misuse and complex needs hostel for men
- Praxis community centre, a community centre for vulnerable migrants and refugees

The focus groups highlighted the unmet needs of the homeless population. Health and housing are inextricably linked, and many participants felt that one is impossible without the other. Although health is valued, health needs are commonly overshadowed by the more immediate priorities of day-to-day survival.

It is clear that barriers to accessing healthcare remain. Lack of documentation, language barriers, poor understanding of services, and limited opening hours and appointment times were all given as reasons for not engaging with services. Most participants had had negative experiences of healthcare services in the past and there is significant distrust in healthcare providers. Many participants felt that presumptions are made about them, and that they receive worse care as a result of being homeless.

Consistency in care was highly valued amongst participants; services which provided a single point of access, or a single person in charge of care were the most popular. Flexibility was also considered to be vital, with people wanting to address health problems at the point they arose rather than waiting for an appointment at a later date.

Of the support made specifically available to them, participants reported good experiences of Health E1 and Pathway, and singled out individual members of staff from both services as having had a positive impact on care.

⁴¹ Pathway Service data, 2016/17

GP Patient Survey

The Department of Health conducts annual GP patient surveys. Respondents from Health E1 generally report higher than average satisfaction with the service they receive:

Indicator	Health E1	Other Tower Hamlets practices
Reporting good overall experience of making an appointment	83.5%	64.9%
Would recommend their practice	75.9%	71.7%
Satisfied with telephone access	84.1%	66.9%
Satisfied with opening hours	81.1%	73.9%

8. What more do we need to know?

Housing status is not routinely recorded in healthcare settings, so monitoring the health outcomes of the homeless population consistently across services is difficult. Although it is possible to see how many patients are managed by individual services, it is not always possible to follow these people through different care settings, or to measure health outcomes for them consistently. It is unclear how many people using healthcare services are not known to be homeless.

As it is not possible to extract healthcare data on homeless people, it has not been possible to analyse the burden of individual diseases on this population. For planning future healthcare services it would be useful to be able to segment healthcare data based on housing status, in order to analyse specific health outcomes for this population. This would also allow for analysis of crossover in service usage.

9. Conclusion and recommendations

Conclusion

Homelessness is a growing problem at local, regional, and national levels. The homeless population has worse health outcomes and more complex health needs than the general population.

Preventative measures in Tower Hamlets have succeeded in reducing statutory homelessness, in defiance of the national trend. However, rough sleeping increased by 13% between 2015/16 and 2016/17, and it is this population which experiences the worst health outcomes.

There is limited evidence on effective healthcare interventions for homelessness. Although evidence suggests factors which predict homelessness risk, solutions for its prevention have rarely been evaluated on a large scale. Current best practice guidance suggests healthcare interventions based on needs assessments, for example an integrated care model which coordinates care across different settings.

Data sources for this population are not sufficiently interlinked to give an accurate picture of health and healthcare service use. However, the homeless population in Tower Hamlets, defined by those registered at Health E1, suffer a greater burden of serious mental illness and of respiratory disease than the rest of the population. The majority of substance misuse is opiate dependency, and a fifth of people suffering from substance misuse also have a diagnosis of a mental health condition.

Services in the borough receive positive feedback from service users. However, incomplete data makes it difficult to draw conclusions about how they are used. Health E1 data suggests that their patients attend A&E four times more frequently than those from other practices. Pathway data shows that only a small minority of the patients they see are registered at Health E1. This may suggest that Health E1 patients attend A&E but are not commonly admitted into hospital, or that Health E1 is successful in reducing hospital admissions. Better data-sharing in this area is needed to fully understand this.

Recommendations

1. Enable consistent flagging of homelessness as a status in GP and hospital records

To accurately assess the health needs of the homeless population, there needs to be consistent identification of housing status in all healthcare settings. The Homelessness (Reduction) Act 2017 will require healthcare providers to refer homeless patients to the local authority housing department, and this may represent an opportunity to better record housing status in general.

2. Plan for implementation of referral element of Homelessness (Reduction) Act 2017

3. Develop homeless health outcome measures

It may be worth developing specific health outcomes to be measured for the homeless population across healthcare settings to aid in evaluating interventions. Although it is possible to assess the usage of an individual service, it is not currently possible to assess how those same patients interact with other services.

4. Continue specialist provision of primary care and integrated approach through in-hospital service
Despite the difficulty in assessing the impact of specific services, the available evidence suggests that the specialist services provided in the borough have a positive impact. Both Health E1 and Pathway receive positive feedback from their service users, and they are in line with recommendations from the Faculty of Inclusion and Homeless Health.

5. Enable people to register with mainstream general practices when this is suitable
Qualitative feedback suggests that some patients of Health E1 feel they have been excluded from mainstream general practice. Moving from Health E1 to a mainstream GP, at a suitable point, may be part of progressing into stable housing, and would reduce the practice population of Health E1.

6. Ensure training of frontline staff in engaging with the homeless population
Many homeless people have had negative experiences in healthcare settings, often feeling presumptions are made about them, leading to distrust in clinical services. This remains a barrier to engagement.

7. Further work on use of specialist services such as dentistry
Qualitative feedback suggests a reliance on ad hoc, charitable services for accessing dentistry. It has not been possible to assess the use of NHS dentists by the homeless population, and this is vital to ensure the service is available to those who need it.

10. Key stakeholders/links to further information

Further information is available from:

[Combined Homelessness and Information Network](#)

[Department for Communities and Local Government](#)

[London Homeless Health Project, Health London Partnership](#)

[Groundswell](#)

11. Communication strategy/plan

This JSNA was requested by the CCG in order to inform commissioning intentions for healthcare services for the homeless population in Tower Hamlets.

This is a publicly accessible document.

12. Crosscutting links with other JSNA topics

- Tower Hamlets Mental Health Strategy
- Tower Hamlets Substance Misuse Strategy
- Tower Hamlets Alcohol Joint Strategic Needs Assessments

Factsheet info

Author	Dr Hannah Emmett	Contact details	hannah.emmett@towerhamlets.gov.uk	Date updated	Sept 2017	Next update due	
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Factsheet signoff

Date signed off by Senior JSNA leads	Signed off by (Public Health Lead (name))		Date signed off by Strategic Group:	Sign off by Strategic Group (name):	
	Signed off by (LBTH Lead if different to above(name)):				

13. Appendix 1: Focus groups with adults with lived experience of homelessness

With support from the London Homeless Health Project, Groundswell were commissioned to conduct focus groups with adults with a lived experience of homelessness.

Methodology

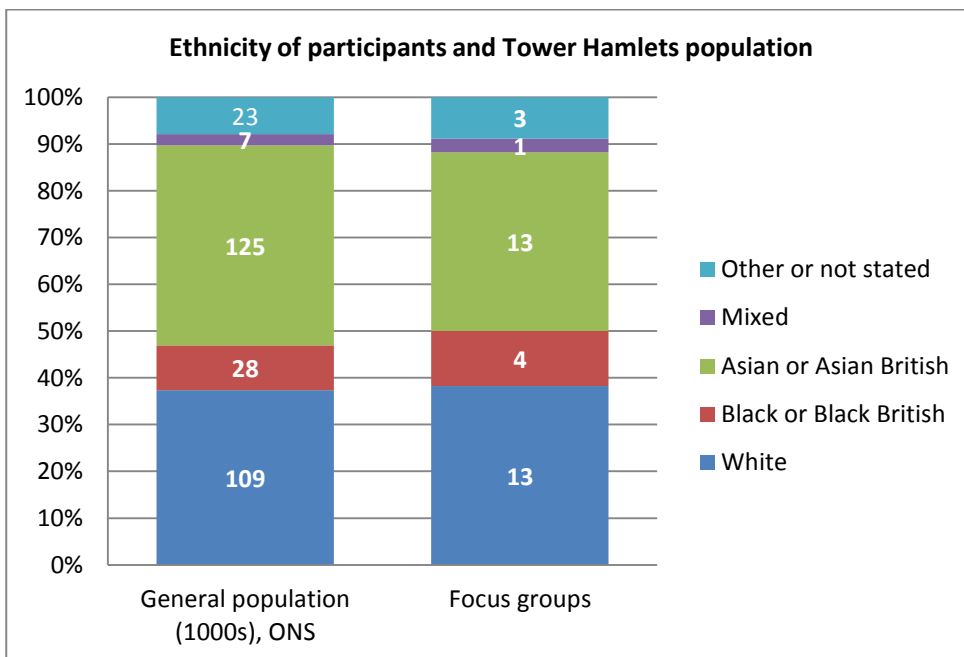
A peer-led research method was used, with people with lived experience of homelessness being central to the design and delivery of the focus groups. Five sessions of five to eight participants each were conducted in July 2017, at a range of hostels and day centres in Tower Hamlets, each with different target clientele:

- Hopetown, a low to complex needs hostel for women
- Booth House, a high to medium needs hostel for men
- The Dellow Centre, a high to medium needs hostel for men and women
- Edward Gibbons House, 'wet' substance misuse and complex needs hostel for men
- Praxis community centre, a community centre for vulnerable migrants and refugees

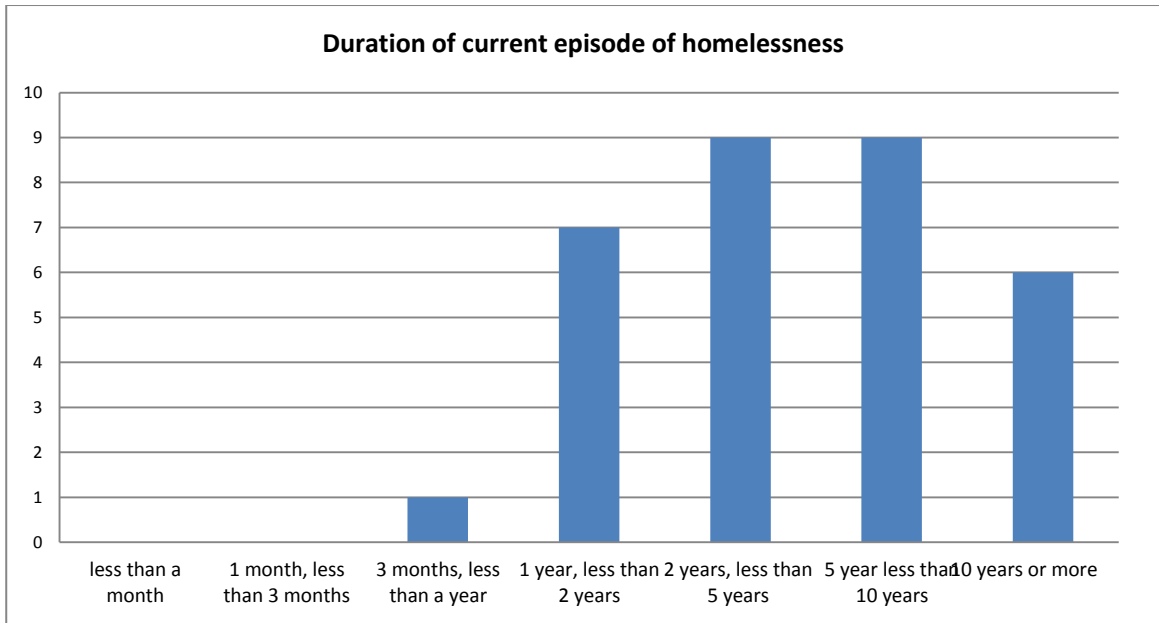
The focus groups were transcribed and analysed thematically.

Participants

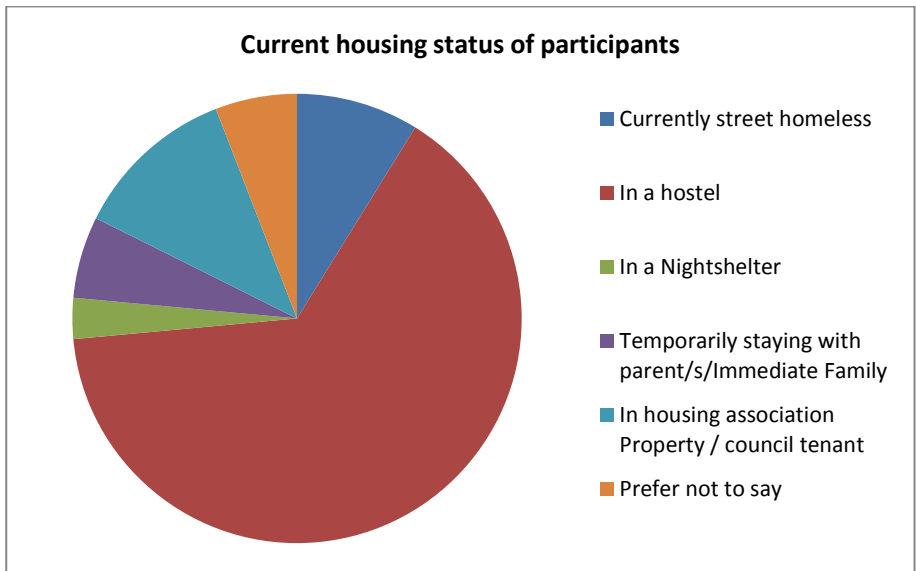
There were 34 participants; 74% men and 25% women, with an average age of 43 (age range 22 to 62). The ethnic backgrounds represented are close in proportion to the general population of Tower Hamlets.



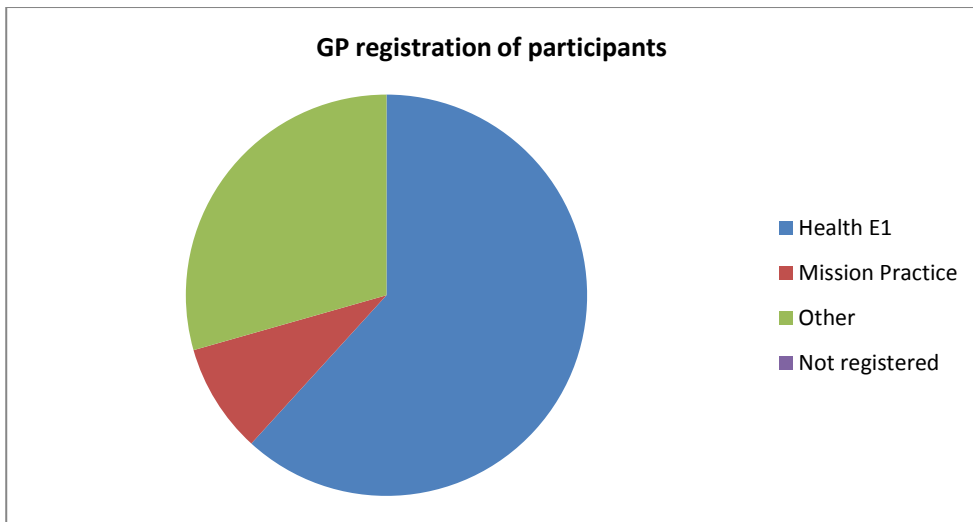
The vast majority of participants had been homeless for more than a year, with more than two fifths having been homeless for more than five years.



The majority (64%) of participants were living in hostels at the time of the focus groups, with the next largest groups living in social housing (12%) and rough sleeping (9%).



All of the participants were registered at GP surgeries, with several citing this as a prerequisite for living in a hostel. The majority were registered with Health E1 in Whitechapel, with a few (9%) registered at the Mission Practice, linked to Edward Gibbons House. The remainder were registered at different practices around and outside of Tower Hamlets.



Discussion

The discussions were structured around a set of questions and prompts. Key themes that emerged from the focus groups are discussed below:

- Attitude to health, healthcare, and housing
- Primary care
- Hospital care
- Mental health
- Dentistry and other services
- Access to care: facilitators and barriers
- Data sharing and continuity
- Decision making and having a voice

Attitudes to health, healthcare, and housing

Across all groups, participants valued their health, and viewed it as key to managing other areas of their life. Several felt they were excluded from employment through ill-health.

“[Health] means a stable life ... one of the first things you need is your health to move forwards.”

Housing is a pre-requisite for good health. Many felt it is impossible to focus on health and wellbeing whilst worrying about having a home, and that ill-health is inevitable for people experiencing homelessness. Despite health being valued, health needs are often overshadowed by the more immediate concerns of day-to-day survival: eating, finding somewhere to sleep, or managing substance dependency.

“Before that you need a house, you need to be accommodated, otherwise you can lose your health ... You can’t wake up on the streets and go to work. You can’t wake up on the streets and do something positive. It’s hard for you to brush your teeth, or have a shower, or eat ...”

Many participants made a significant effort to care for themselves, before seeking clinical advice. Often this stemmed from a distrust of the medical profession. Many had experienced what they perceived to be dismissive encounters or ineffective treatments in the past, and evidently found it difficult to contemplate returning to formal healthcare settings.

“My health is a priority to me. I am recently exploring the route of just not trying to interact with the NHS and just trying to do things myself. Because I feel I am extremely unsuccessful in trying to navigate what is available from the public sector.”

“I go to my doctor and they’re like ‘your time is up ... do you not see I have other patients?’ so you are like ok, fine, I won’t come to you anymore.”

Health and access to housing are inextricably linked, and several participants felt that healthcare services should do more to help service users to access housing.

Primary care

All of the participants were registered with a GP surgery; this is a requirement for accepting a hostel space. The majority (21 of 34) were registered with Health E1. Of the remaining participants, three were registered with the Mission Practice, a surgery with links to one of the hostels. Ten were registered at other practices. Of the seven people who identified which other practice they were registered with, only one was outside of Tower Hamlets.

Although Health E1 generally got very positive feedback, it was clear that many participants had been directed there by hostel staff and by other GP surgeries, and had not had the opportunity to register at a mainstream practice despite wanting to. This demonstrates that both staff and patients are not fully aware of their rights regarding GP registration, and that there remain ongoing difficulties with registering without identification.

“Because you have a licence agreement, not a tenancy agreement, you can’t take it to a normal high street GP and be like ‘hey, I am a normal person, can I join a normal GP?’ You have to go to Health E1 because you can’t prove you are normal enough to join a regular one.”

“Some people don’t have nothing, no paperwork, nothing. So Health E1 accepts that. If you don’t have no paperwork, or you are illegal or don’t have no status, they still do accept that.”

Health E1 was highly valued by participants for its flexible service, which offers shorter waiting times and longer appointments, and its hub-like structure, where several services are available at the same site. Individual members of staff were singled out as having provided a high standard of care.

“We have got a homeless GP which is Health E1. They have got drop in services, they also do scripting of methadone there. So they do quite a variety. They have got mental health nurses there, so I believe that is a real life-saver for local homeless people ... It is important because if you are homeless you can’t be running about everywhere. You don’t have the means to travel or commute here and there. So it’s just good that you can go to one practice and have everything dealt with.”

“I want to say something about Health E1. They do lots of hard work in there ... I have been going there for seven years, and they are specialist. And that is why I don’t want to change. Because I have got my own flat but I am still with them. And I get a lot of things that I would not get from other GPs. So I am saying they are doing good things in Health E1.”

The majority of participants were happy to access primary care as a first port of call, with very few suggesting they would attend A&E first. However, some had difficulties in getting appointments. Services which provided same and next day appointments consistently were preferred, as these allowed participants to be seen at the point at which the issue had been identified. Those who did prefer to attend A&E were typically recent migrants or refugees, who were unsure of how NHS services worked.

Hospital care

Most participants had been admitted to hospital, often via an emergency route. Negative experiences were widespread. It was in talking about inpatient care that complaints about staff being presumptuous, judgmental or lacking empathy were most common. Several people felt that they received worse care because of their homeless status; with some implying they might try to hide the fact that they were homeless in order to avoid this.

On being asked whether hospital staff should ask about housing status:

"They leave us on the streets, you know. And sometimes what I think is if you tell them you are homeless, they don't give you the right service, they look down on you."

"If you go to the hospital, at some point they are going to look at your address. I just don't say I live in a hostel. As soon as they find out they live in a hostel the way the consultants treat them dramatically changes."

As in primary care, there was significant distrust in medical professionals in a hospital setting, both in their clinical skills and in their judgement of homeless people. Several reported feeling that clinicians did not believe the symptoms they described.

"I was getting pins and needles in my face and yet I am going to the doctors in hospital they are saying there is nothing wrong with you. What are these people, is it the longer you get trained, the thicker you become? Because that this is how it appears to be me to be honest."

"A doctor ... is just going to be thinking 'you scumbag, you have probably done this to yourself' ... Or he is probably thinking you are just here to get yourself warm."

Participants were asked specifically about their experience of the in-hospital Pathway service. Knowledge of the service varied; all participants from one group had heard of it, whereas in another none had. This may be because people had received different care, or because individuals had not drawn a distinction between Pathway and other care they experienced in hospital. Of the people who had experience of Pathway, feedback was positive. Some credited the service as preventing their discharge to the street, and others were grateful of receiving specialist care.

"When I last got discharged from hospital they called me up a couple of days later to see how I was doing and ask me to come in."

"I think they are really good actually. I don't think they get as much credit as what they should. They'd go out of their way some of them ... The last time when I was homeless before I came in here. She was like 'they are not allowed to discharge you without an address, this is what you do...' She was really nice she was. She come and like see me after her work and everything."

Despite the Pathway service, several participants had been discharged from hospital with nowhere to go.

"First of all they said to me 'have you got accommodation?' I said 'if you look on the computer I am homeless'. 'OK I tell you what you can stay', half past seven I was told that ... 8 o'clock they turned round and said you have got to get out. And the nurse couldn't even look me in the eye when she was saying it."

Mental health and substance misuse

This is a population with a high burden of mental ill-health, alcohol and substance misuse, or both. A recurrent theme was managing substance dependency across different care settings. Many had had negative experiences regarding methadone prescriptions; inpatient prescription regimes differ to those in the community and transitioning between the two can be difficult. Some mentioned this as a reason to avoid being admitted to hospital, or as a situation that might lead them to relapse.

“[We can’t] get our full dose [of methadone]. In there they want to give you half in the morning and half at night. And then like during the day you are sick all day. So what do you want to do? You want to go outside when you know in the area to use. Or you are going to get someone to bring you something.”

Experiences of drug and alcohol services varied. As with other types of care, the services which were based at existing healthcare sites (e.g. Health E1) were most popular.

A key topic was the difficulty of returning to hostels after a period of abstinence as, by their nature, these places service users in surroundings not conducive to recovery; they will be living amongst others with substance dependency and in areas where drug dealing is common.

Dentistry and other services

Participants were asked to discuss their experiences of accessing other healthcare services such as dentistry, podiatry, and optometry.

Although many reported problems with their teeth, most participants had had positive experiences of accessing a dentist, either as an NHS patient or through the Christmas dental service run by Crisis. Nobody specifically mentioned difficulty in registering with a dentist, although some mentioned the inflexibility of appointment times.

Access to care: facilitators and barriers

It is clear that the homeless population faces significant barriers to accessing healthcare. Much of this is to do with having typically more complex presentations of ill-health, and having a lifestyle which is not compatible with an inflexible clinical system. A common topic was the difficulty in accessing a same-day GP appointment: many reported that phoning or attending at a certain time in the morning was not feasible for them. It is important to be able to access services whilst healthcare is a priority.

“The GP I have to call early and they did give appointment same today. But still like you have to call early in the morning and long waiting.”

A lack of housing, money, and a safe place to store belongings makes the simple act of attending hospital and healthcare appointments difficult. For this reason sites which offer several services in one place were greatly valued. Mobile and in-reach services were popular, with several participants calling for more of these services and lamenting the closures of ones they had accessed in the past.

A lack of documentation, including identification and proof of address, remains a barrier to accessing primary care anywhere other than Health E1. For refugees and new migrants, language and poor understanding of NHS services were a significant barrier to accessing healthcare.

Having one person act as a first port of call for both health and social care issues was important to many participants. Many had positive feedback on individual keyworkers, and the peer advocacy programme.

Service continuity and data sharing

Continuity of care was a recurrent theme. For participants who were still seeing GPs outside of Tower Hamlets, and for one who stated he had remained with Health E1 despite being in stable housing, it was beneficial to see staff who already knew their case histories. This is of particular importance to those who had had traumatic experiences, and who did not wish to relive these every time they saw a new healthcare professional.

“The majority of people prefer to see the same doctor what they have always seen, where they know your file. They have seen you loads of times so it’s easy for them to deal with you because they dealt with you last time. So they know the problem. But when you go to a new one, you have got to explain kind of everything all over again. “

Some felt that the commissioning model meant that their care providers changed too frequently, and prevented them from receiving consistent care.

“This is also the problem with the funding model. You get contracts for two or three years. Then it gets put out to tender again, then another company. Or charities are now proper fully fledged businesses. And you know there is no consistency, it’s just this two, three year contract. And then like the Inspire Consortium for mental health. It’s not working, no one understands what’s going on.”

Most saw the benefits of personal data being shared between services if it meant they did not have to repeat themselves, but did not want it to be shared without good reason.

“For me if it’s like relevant people, who are working on my case, I am fine with it. But there are some people who don’t know boundaries, and just share your information with someone who is in a different department. For me as long as it is relevant, yeah.”

“If it’s just to benefit off-loading your work load then I don’t feel that is right.”

Decision making and having a voice

Participants often felt that presumptions were made about them from the start of interactions with healthcare services, and so were treated differently to the general population. When asked to consider whether they were offered choices in treatment, some felt that they were only presented with one option, and that if this was refused they would be denied other services.

“Because every time you go to doctor you always hear them words: ‘it’s for your own good’. It really winds me up mate. It’s like well, I am happy the way I am. Just because you are not happy with the way that I am...”

Others trusted that they were being offered the right treatment.

“I really do it because I think they are the professionals and they are looking out for me. So that is the reason why. Even though sometimes I don’t feel like I do [want to accept the treatment offered].”

The routes for giving feedback to healthcare providers are limited, and many felt that when they had tried to complain about aspects of their care they had been ignored.

“I have never found it effective to complain. You never feel like they’re like ‘oh we are sorry, we will have more training for our staff now’, or ‘we will give more training to that person’, nothing like that. So it’s just been a waste of my energy and I increase my stress and my daily workload for no reason.”

Formal routes of giving feedback (e.g. complaint forms) are not always easily accessible. Having simpler means of asking about treatment options, or giving feedback on a service, is vital if patients are to have a voice in this setting.

Conclusion

The focus groups highlighted the unmet needs of the homeless population. Health and housing are inextricably linked, and many participants felt that one is impossible without the other. Although health is valued, health needs are overshadowed by the more immediate priorities of day-to-day survival.

Most participants had had negative experiences of healthcare services in the past, the most damaging examples of which led to people avoiding healthcare and NHS services in the future. Specialist services which provided

greater flexibility in appointments were popular, with many individual members of staff in both Health E1 and Pathway being singled out as having had a positive impact on care.

It is clear that barriers to accessing healthcare remain. Lack of documentation, language barriers, poor understanding of services, and limited opening hours and appointment times limit the homeless population's access to services. Although Health E1 was a highly valued service, several participants felt they had been wrongly excluded from mainstream general practices. The Crisis at Christmas dental service was popular, but this highlighted that access to a mainstream dentist for the rest of the year was limited.

There is significant distrust in healthcare providers, with many participants feeling that presumptions are made about them, and that they receive worse care as a result of being homeless.