Homeless Community
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This needs assessment was prepared in July 2015 by the Public Health Action Support Team on behalf of Suffolk County Council.
Summary

Homeless community introduction

Amongst many other factors, ill health can be both a cause and consequence of homelessness. This paper reviews the topic in some depth and provides a context for understanding the services which are and could be provided.

Homeless community key points

- Homelessness can affect anyone, as a consequence of any number of factors, for example social exclusion, the loss of a job, unexpected serious illness or accident. The health of homeless people is at particular risk.
- The average age of death for homeless people is 47 years for men and 43 years for women, compared to 77 years in the general population, but those living on the streets have the highest rates of premature death.
- A study found that 30 people each year died by suicide whilst homeless.
- Homelessness is very isolating, can be physically dangerous and puts people at high risk of mental illness and of health behaviours which may provide short term relief but are hazardous in the longer term.
- An analysis was carried out of the referrals to the Suffolk Coordination Service over a 14 month period, and potential indicators of homelessness were identified. Prevention or early intervention should be considered.
- Eastern Europeans were among those needing winter night shelter in Ipswich.
- Homeless people are known to display physical ill-health, mental ill health and drug or alcohol misuse (tri-morbidity). Specialist level care may not be appropriate but given the presence of multiple morbidities, the indication may be for a more focused service than can be provided in general practice.
- The incidence of tuberculosis (TB) is increasing amongst homeless people. The National Institute for Health and Care Excellence (NICE) is due to release updated guidance on finding cases, treatment and application to marginalised and vulnerable adults, in October 2015. The provision of shelter to the homeless is strongly recommended as a preventive against contracting TB.
- NICE recommends that Directors of Public Health should provide commissioners of TB prevention and control programmes with local needs assessment information on an annual basis, and ensure that TB is part of the JSNA (NICE Guidance PH37).
• There are many voluntary organisations working in this sector and the views of some of those, and service users, are included as Appendix A.

Homelessness recommendations

1. The Health Outreach Project support General Practices who register homeless people but currently relatively few practices are involved. NHS England and the Clinical Commissioning Groups (CCGs) should encourage other General practices to offer registration to homeless people.

2. The CCGs should consider a training and education remit for The Health Outreach Project, for staff from mainstream services.

3. The CCGs should support the Health Outreach Project to improve their monitoring and reporting of activity and outcomes so that the full scope of their work is recognised this needs assessment lacked the data necessary to support clear recommendations that would lead to service improvement.

4. The public sector should facilitate data sharing agreements with partners to improve understanding of the state of health of the local homeless population.

5. Homelessness can be reduced by the health and care system being alert to the known risk factors such as having a learning disability, being a care leaver, needing to use emergency accommodation and/or having a criminal record. Multiagency work is recommended to find ways to influence those at greatest risk of becoming homeless.

6. After October 2015 Public Health should review the local adherence to the new Tuberculosis NICE guidance and highlight areas for action with the relevant agencies.

7. The CCGs, The Health Outreach Project and GPs with significant numbers of people who are homeless on their lists, should co-operate to decrease ‘do not attend’ (DNA) rates, and maximise preventive measures to encourage Accident and Emergency avoidance.

8. Acute Trusts need to ensure that discharge planning for the homeless is appropriate and if required involve local voluntary services as well as health and social care.

9. Prevention or early intervention of homelessness should be considered to reduce the number of individuals requiring supported housing from Suffolk Co-ordination Service (SCS).

What is homelessness and why is it important for Suffolk?

One definition of homelessness is: “not having a home, because you are living on the streets, or because your home is unsuitable or you don't have any rights to stay where you live” (Shelter 2015). Service providers use more specific terms.
“Homelessness” includes a wide range of situations. Rough sleepers can be in the open air or buildings – doorways, stairwells, or tents - not intended for habitation (DCLG 2014). Those without their own current housing who squat or stay with family or friends (termed “sofa surfers”), or in temporary accommodation such as hostels, bed and breakfast, or women’s refuges are also without a fixed home. The Department for Communities and Local Government (DCLG) statistics are based on those for whom local authorities have a statutory duty, a small proportion of those who are homeless. These households may not be without a roof over their head, but this may be a strong possibility owing to imminent eviction, domestic violence or for other reasons.

Excluded from this are people not deemed eligible for assistance, those who became intentionally homeless and not falling within a specified priority need group. Priority need groups include households with a dependent child, a pregnant woman or people who are vulnerable for example by reason of mental illness or physical disability. Also included are young people aged 16 to 17, or 18 to 20 and previously in care, or people vulnerable as a result of time spent in care, in custody, in HM Forces or as a result of having to flee their home because of violence or the threat of violence.

For the purposes of this needs assessment homelessness includes:

- statutory and non-statutory homelessness, families with children, single people and couples without children
- those who are homeless (rough sleepers, ‘sofa surfers’ and those with no recourse to public funds)
- those who are temporarily housed in hostels, bed and breakfast accommodation or other short term provision
- those at risk of becoming homeless with no legal right to continue to occupy their property or for whom the risk of doing so, for example from domestic violence, means it is no longer reasonable for them to continue to live there.

The vast majority of single homeless people who are not entitled to housing, as well as those who do not apply for homelessness assistance, end up surviving ‘out of sight’. The local authority, on request, must make an assessment of their housing needs and provide advice and assistance to help them find accommodation for themselves.
Many homeless people stay in hostels. There are just over 38,500 bed spaces in hostels for single homeless people in England. They may opt for squats or bed-and-breakfast accommodation, or occupy floors or sofas of friends and family. These are described as ‘concealed’ homeless people.

Categorisation by the type of accommodation is not a helpful measure since many homeless people circulate between somewhere ‘concealed’, a prison stay, hostel, “sofa surfing”, or rough sleeping. This is a transient population.

Homelessness is a risk for the whole population. People who seem secure and well provided for may suddenly find themselves homeless. This can occur in a situation of job loss or where income is suddenly and drastically reduced, or in the case of marital breakdown, serious illness or disability. It also includes those who arrived in the UK as job-seeking migrants whose plans have not been fulfilled. Homelessness is a difficult cycle to break and people with experience of this may continue to live precarious and high-risk life styles, their stability compromised by issues of mental health, physical or learning disability, addictive behaviours or domestic violence, and they may again become homeless.

A particular group which, anecdotally, is increasing in numbers, is those with no recourse to public funds (NRPF). This relates to a person’s immigration status. The Immigration and Asylum Act 1999, Section 115, states that “a person will have no recourse to public funds if they are subject to immigration control” and as a result of this have no entitlement to certain welfare benefits, local authority housing or homelessness assistance. The frequency with which people enter this category is increasing owing to the number of asylum seekers who have leave to remain on condition of NRPF, whose leave to enter or remain in the UK is subject to a maintenance undertaking, or who require but do not have any leave to enter or remain. This is dealt with more fully in the Health Needs Assessment on Asylum Seekers and Refugees.

Homelessness is a particular risk in the winter. The crisis winter shelter provision is researched and provided through voluntary community sector in Ipswich in partnership with local and county authorities. However a number of Eastern European migrant workers sought shelter last winter. It is possible, though unverified, that they had come from accommodation available only with seasonal employment. These numbers may increase and should be accounted for.
Homelessness can affect people in any of the topic groups included in the Groups at Risk of Disadvantage, but especially in the Gypsy/Roma/traveller, asylum seekers/refugees, Eastern Europeans, and Rural Deprivation groups.

**Homelessness as a health determinant**

Homelessness is a major health risk factor in itself. Particular health risks for homeless people were identified in “*Our Health and Wellbeing today*” (DH 2010). These include tuberculosis (TB) which has been steadily increasing since the 1980s with 8,423 new cases in 2009, an increase of 5.7% compared with 2008. There may be 142,000 people aged 15–59 years chronically infected with hepatitis C in England only about half of whom are aware of their condition. Hepatitis C is almost always spread via blood-to-blood transmission and more than 90% of known cases in which there is information on risk factors are associated with injecting drug use. HIV rates remain relatively high, with 2,760 new diagnoses in 2009, and undiagnosed HIV is still a problem – around 26% of the estimated 86,500 people living with HIV at the end of 2009 were unaware of their infection. This means they are unable to benefit from effective treatment and risk unwittingly passing HIV on to others.

The number of homeless people is small compared to the overall population but the health effects are large and often intractable. There is also evidence that the number of homeless people is growing (DCLG 2015a, OCA 2010). Being without a home involves material hardship, social marginalisation and restrained relationships (Hodgetts et al 2007). Poverty, relative deprivation and social exclusion have a major impact on health and premature death, but those living on the streets have the highest rates of premature death (Wilkinson R and Marmot M 2003).

Marmot (2010) proposed to tackle this by “proportionate universalism”1. Public Health England included the concept in the Public Health Outcomes Framework, here stated as, to “improve the health of the poorest fastest”. The Faculty of Homelessness and Inclusion Health, ([www.pathway.org.uk](http://www.pathway.org.uk)), published *Standards for Commissioners and Service Providers* (FHIH 2013) “to re-affirm the fundamental rights of all people to be treated with dignity, compassion and respect”, seeking to reduce “extremely high healthcare costs coupled with appalling outcomes”. Using robust methodologies and data for England, 2001-

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1In seeking to minimise social inequalities and “to reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. We call this “proportionate universalism.”
09, it has been shown that the average age of death for homeless people is 47 years for men and 43 years for women, compared to 77 years in the general population (Crisis 2011). A national clinical survey based on a four year (1996-2000) sample of people in England and Wales who died by suicide showed that a total of 131 individuals who died by suicide were reported to have been homeless at the time of death, 3% of all suicides by psychiatric patients, more than 30 suicides per year. Social and clinical risk factors for suicide were common, including drug and alcohol misuse, and recent suicidal ideas and behaviour (Bickley et al 2006).

Although homelessness can occur as a function of poor health (perhaps relating to job loss), chronic – or “entrenched” - homelessness is itself a risk factor for physical ill-health, mental ill health and drug or alcohol misuse. These are often associated with advanced illness at presentation, in the context of a person lacking social support who often feels ambivalent both about accessing care and their own self-worth. This often has its roots in histories of complex trauma, including high levels of child neglect and abuse, that impact on developmental trajectories and mental health (FHIH 2013 p7).

Aspinell (2014) identified that the particular characteristics of sleeping rough, rotating in and out of emergency hostel accommodation, having more than one indicator of vulnerability, being very young (aged 16 – 20) or a migrant rough sleeper, is to be at risk of violence, severe illness and premature death. More generally, there is a raised risk of poor mental health, including depression and other affective disorders, anxiety states, personality disorder, and schizophrenia, which together with drug and alcohol misuse, and physical illness contributes to the “tri-morbidity” commonly found in homeless people (FHIH 2014). Up to 60% of people in the hostel population in England may suffer from personality disorder. A study of consultations at a specialist homelessness practice over ten years, showed that diagnoses of heroin dependence had fallen from 37% to 28% but alcohol dependence had increased from 20% to 29% (Aspinell, 2014).

A study of homeless people in London (Bilton, 2008) found that 43% of their hostel residents had a physical illness. Respiratory problems (pneumonia, influenza, asthma, and tuberculosis, frequently latent), upper gastrointestinal disease, physical trauma (injury, foot trauma), blood-borne viruses, and skin problems (especially eczema) occurred more frequently than in the general population. Assault (17.5%) and fractures (28.6%) were reported in consultations at a special practice for the homeless and many homeless have a lifetime experience of some form of trauma.
Aspinall also observed that significant numbers of Eastern European migrants were amongst the rough sleeping population of a number of cities, possibly homeless during the winter season of low availability of work, where accommodation was “tied” to the period of employment. This group also had high alcohol support needs, their position compounded by having minimal recourse to public funds².

**Homelessness: costs and service usage**

Socially excluded groups are often invisible in national data sets, both in records of housing and homelessness and in health status and access to health services. Hospital records may record “no fixed abode” but a homeless person may use an address of a friend or a homeless charity to receive correspondence or attain registration with a GP (or to prevent identification of their real status), so cannot be identified as homeless.

The Autumn 2014 total rough sleeping counts and estimates in England (DCLG 2015)³, collected between 1 October and 30 November 2014, was 2,744, an increase of 330 (14%) on the Autumn 2013 when the total was 2,414. However the number of rough sleepers in London had increased by 37%, compared to far fewer, an increase of 7% in the rest of England.

The high costs and service usage were demonstrated by research for the Department of Health Office of the Chief Analyst (OCA 2010) which showed that single homeless people attended accident and emergency departments five times more than the local average and hospital admissions were 3.2 times the local average. The total national cost of hospital usage by this client group was conservatively estimated to be £85m (in 2010), four times the level of the general population and inpatient costs (the bulk of the usage for this client group) was eight times higher than for the housed population in the same age group. In fact this is likely to be a considerable underestimate, as many homeless people will give a hostel or “care of” address and are not identified in this type of analysis.

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² The 2004 A-8 accession states: Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia and Slovenia, plus the 2007 accession states, Bulgaria and Romania.

³ “Rough sleeping counts and estimates are single night snapshots of the number of people sleeping rough in local authority areas. Local authorities decide whether to carry out a count or an estimate based upon their assessment of whether the local rough sleeping problem justifies counting.”
What is the local picture?
There is no available total number of homeless households in Suffolk. Those in priority need for whom there is a Local Authority Statutory duty are recorded, but these are only a proportion of the total. “The vast majority of single homeless people are not considered statutorily homeless” (IHAG 2014), and of these there is no record.

Figure 1 shows the trend in homelessness where the local authorities have accepted a duty of care. It is based on numbers rather than rates related to the population, so larger authorities will have higher numbers. The increase in recording by St Edmundsbury may be an artefact, but the service manager is “confident that those who present here as homeless or threatened with homeless are dealt with appropriately under the legislation and the figures we report are an accurate record of the numbers that we have a duty to accommodate”.

Figure 1: Number of households accepted as being homeless and in priority need, 2007/08 – 2013/14, Local Authorities, Suffolk

Source: DCLG Table 784. Local authorities’ action under the homelessness provisions of the Housing Acts.  

Figure 2 presents the data on households accepted as eligible for Housing Related Support, in Suffolk and compared with England, as a rate per 1,000 households. There is no discernible trend.
This needs assessment was prepared in July 2015 by the Public Health Action Support Team on behalf of Suffolk County Council.

Figure 2: Households accepted as eligible for Housing Related Support, rate per 1,000 households, Districts in Suffolk, and England 2012 - 2014

The Hostel Accommodation Recording Project (HARP)\(^\text{5}\) showed that between January 2011 and December 2012, there were 1,060 individuals a year applying to hostels for the homeless in Ipswich. In 2012 the 365 single person hostel bed spaces in Ipswich were approached for housing by 1,108 individuals (IHAG 2014).

Table 1 shows the DCLG record of an annual count of rough sleepers. Local authorities may carry out a count or an estimate based upon their assessment of whether the local rough sleeping problem justifies counting.

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\(^{5}\) HARP recorded every individual applying to the single person hostels in Ipswich, delivered on behalf of the Ipswich Hostel Liaison Group by Ipswich Housing Action Group
Table 1: Street counts and estimates of rough sleeping in Suffolk, Autumn 2014

<table>
<thead>
<tr>
<th>District</th>
<th>People</th>
</tr>
</thead>
<tbody>
<tr>
<td>Babergh</td>
<td>0</td>
</tr>
<tr>
<td>St Edmundsbury</td>
<td>3</td>
</tr>
<tr>
<td>Suffolk Coastal</td>
<td>2</td>
</tr>
<tr>
<td>Ipswich</td>
<td>8</td>
</tr>
<tr>
<td>Forest Heath</td>
<td>2</td>
</tr>
<tr>
<td>Mid Suffolk</td>
<td>0</td>
</tr>
<tr>
<td>Waveney</td>
<td>3</td>
</tr>
</tbody>
</table>


However, in a one year period (01/02/2014 to 31/01/2015), 85 clients applied for accommodation to Suffolk Coordination Service (SCS) as ‘rough sleepers’ in Ipswich alone. These are self-defined and it is possible that some presented themselves as such in their hope of increasing their chance of being housed.

The most complete dataset on statutorily accepted homeless people in Suffolk currently is held by SCS. The service links individual applicants for housing with available resource. Approximately 80% of those accepted and assessed by local authorities as having priority need would be referred to SCS, the remainder would be housed through other routes, but others can also refer to SCS. The comprehensive referral form allows analysis of the characteristics of the anonymised referrals. In the fourteen month period April 2014 – May 2015 there were 3,557 acceptances of which 75% were male.

Figure 3 shows the trend of homeless applications since the SCS began (14 months). The ratio of male to female has increased owing to a greater increase in the number of male referrals. It is possible that the increase in the number of applicants over time is due to the establishment of a new service in the Suffolk Co-ordination Service. There is no discernible seasonal trend.

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Figure 3: Applicants to SCS for accommodation by gender April 2014 – May 2015

![Graph showing applicants by gender over time]

Source: SCS

Figure 4 shows the area from which the applicant presented for referral to SCS, rather than where he was before he became homeless. Figure 2 shows the homelessness rate per 1,000 households. Figure 4 shows the actual number of referrals.

Figure 4: Applicants to SCS, by area referred, by gender, April 2014 – May 2015

![Graph showing applications by area and gender]

Source: SCS

Figure 5 shows the main reasons for referral to SCS, being relationship breakdown, family

*includes 81 discharges from prisons

Source: SCS
disputes and eviction. Leaving prison is also significant, and is a more predictable event. Analysis of these reasons by age group is show in Appendix A.

**Figure 5: Main reason for referral, by gender, April 2014 – May 2015**

![Bar chart showing main reasons for referral by gender.](image)

Source: SCS

Applicants to the SCS for housing related support were asked to give their medical needs. Of the 1,278 who responded to this question, the conditions most frequently mentioned were depression (285), anxiety (144) and asthma (111). It is possible that these were related to the problem of homelessness being experienced. Other frequently cited health problems were ADHD (77), back problems (57), mental health (57), and epilepsy (42). Fewer, but significant in people applying for housing were people with Asperger’s, autism, stroke, psychosis, cerebral palsy and cancer. A complete table is in Appendix A.

Drug users were asked what substances they used. The most frequent, in order of magnitude were Cannabis (457), Heroin (214), Methadone (131), Cocaine (107), and Crack (88). A further 124 applicants listed other substances used.

The referral form requested information about having a criminal record (1,831), learning disability (437), or being a previous occupant of emergency accommodation (836).
The great majority of applicants were white British (2,983), with nine white Irish and 244 White Other. All other ethnic groups were very small. Of the 967 young people applying for housing aged between 15 and 19 years, 183 were care leavers.

The answers to the questions were not entirely surprising, but give a clear indication in terms of prevention of homelessness, the interventions that would have the greatest effect on health.

A number of the questions refer to relationships; these are difficult to control. Other factors such as having a learning disability, being a care leaver, needing to use emergency accommodation and having a criminal record indicate that more developmental programmes are needed before the homeless reach the SCS. Male gender and drug misuse are also risk factors.

It is important to remember that these findings relate to a group of people who had already been found eligible for Housing Related Support. They are among the most vulnerable, but are only a proportion of the total homeless population in Suffolk, most of whom will not have such eligibility.

**What is the evidence base for interventions? What is best practice?**

There is little evidence of best practice in prevention and management of homelessness from routine information sources. One forum for development of evidence based interventions for the homeless in the UK is the Faculty of Homelessness and Inclusion Health.

The National Institute for Health and Care Excellence (NICE 2013) published guidelines for Local Authorities on best practice management of tuberculosis (TB), a major risk factor of which is homelessness. A recommendation is “providing shelter for homeless people with tuberculosis: just one way local government can help tackle TB”, and for a whole systems approach. The risk of spread of infection is greatest in the areas of greatest concentration of at-risk groups, such as London and the West Midlands. However it is associated with new arrivals from countries of high TB prevalence and the guidance should be adhered to in Suffolk. New national arrangements mean that people wishing to seek asylum must be tested in their home country and be clear of the disease before applying for asylum in the UK (PHE 2013, UKBA 2012).
NICE PH37 gives guidance on identifying and managing tuberculosis among hard-to-reach groups. Under this guidance, Directors of Public Health should provide TB prevention and control programme commissioners with local needs assessment information on an annual basis, and ensure that TB is part of the JSNA in areas of high need (NICE 2012). The guidance also recommends use of a mobile digital x-ray unit which in London screens almost 10,000 high risk people every year.

NICE is in process of producing an “Update of CG117 Tuberculosis” which deals with clinical diagnosis and management of tuberculosis, and measures for its prevention and control, incorporating PH37 “Tuberculosis - Hard to reach Groups”. On publication which is anticipated in October 2015, this should be reviewed for evidence on the most efficient way of providing TB screening in Ipswich.

NHS Health Checks are a nationally approved screening programme to help prevent the onset of heart disease, stroke, and type 2 diabetes and kidney disease and is being offered to people between the ages of 40 and 74. Its effectiveness is still being evaluated but it has been found to be a useful screening tool for homeless people. We were told that homeless people do not present for healthcare until their condition is advanced and more difficult to treat. These people may not be registered with a general practitioner so an NHS health check is appropriate until registration can be completed. NICE notes that where delivery and uptake are sub-optimal and the lifestyle advice offered does not meet the person's needs, then there is a risk of the programme being ineffective (NICE 2014). However participation by those at greatest risk, including the homeless, is especially encouraged and at The Health Outreach it has been found to be a valuable tool in identifying latent or active disease as well as instituting preventive measures.

What is the pattern of services in Suffolk at present?
Providing care services to people who are homeless can be difficult. We were told they “often need help with: using services, behavioural issues, attending appointments, having to wait, having to attend, having to organise, taking treatments and tablets. They need help controlling their “chaos” (a Suffolk GP).

The service to marginalised and vulnerable adults delivered in Suffolk, The Health Outreach Project works at all stages of the prevention, treatment and care pathway providing treatment, information and advice on health related issues and facilitating access to GPs and other mainstream health and social services.
Services are provided to people who are either:

- Homeless
- Refugee and asylum seekers
- Gypsies and Travellers
- Other Black Minority and Ethnic (BME) individuals
- Migrant workers
- Ex-offenders

These groups are heterogeneous and will have individuals with multiple health inequalities such as people with learning disability, mental health problems, sensory loss, physical disability, a few in older age and many with co-morbidities.

The Health Outreach also has a geographic spread across Suffolk (excluding Waveney), a main static base located in Ipswich and visiting arrangements with the mobile clinic to a number of the market towns in Suffolk, as well as regular support provided in the 20% most deprived lower super output areas in the County, and other places as needed. The service also works with people on the street on a regular basis.

People with learning disability (currently about 5% of the caseload), have been identified;  
- as a target group for NHS health checks and seeing a very poor level of access to primary and secondary care  
- as a group turning up to crisis services (food banks, soup kitchens, night shelters) with very complex needs and often significant safeguarding issues

The Health Outreach provides initial contact treatment and advice widely in Suffolk. The team consists of general nurses, mental health nurses, a blood-borne virus nurse specialist, social workers, a GP, a physician’s assistant, support workers and administrative staff who visit a number of venues for the homeless (the Chapman Centre, The Salvation Army, Cavendish Lodge and others), encouraging links with health services. Please see Appendix A for a map showing coverage by this service.

Clients initially present with a wide range of problems such as head wounds, infection, and a crisis with a service, a personal relationship or other concern, pain, depression, foot problems. All patients have their presenting problem addressed first, but are offered health screening and access to treatment including 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.
TB screening is offered at Ipswich Hospital, but this does not work well for homeless people because of the distance and the problems of their chaotic lifestyles which result in high rates of non-attendance (DNA). The National Institute for Health and Care Excellence is due to publish revised guidance in October 2015, and when available this should be reviewed for cost effective measures of offering screening for TB amongst marginalised and vulnerable groups.

The Health Outreach partners with NHS treatment services at many levels. Initially links are made with the GP surgeries. People who are homeless can require additional time and effort, particularly if people have a history of homelessness or rough sleeping, and some GPs are unwilling to engage with this, expressing concern that if they take one or two, others will follow and they will not be able to cope. There are six practices which will take these homeless patients, three work comprehensively with them.

Recording and enumerating is a serious challenge when working with homeless clients. A frequently used GP surgery told us that if a new patient is homeless, rather than “No Fixed Abode”, they are normally registered with an address as the Chapman Centre, in this way letters by post can be sent to them. Some will give friends’ or family addresses that they can access.

A coding for No Fixed Abode will not identify the majority of the homeless in primary or secondary care.

A Health Outreach support worker attends the primary care practice if necessary to help with registration. But they cannot provide ongoing personal care: the objective is to enable the individual to access mainstream services.

We were told that homeless people normally require many more GP appointments than other patients, some weekly. They often require weekly prescriptions. Some have been violent, so will need to be looked after by the violent patient scheme. Accurate data collection is almost impossible. The Health Outreach has devised a patient record card to be completed with each new client attending their service. The Health Outreach Project manager acknowledges that written records are something they need to improve on. Each patient now is entered on SystmOne unless this has already been completed.
Secondary care is most often accessed by the homeless via Accident and Emergency (A & E), attending only when a problem has become an emergency. Patients are not recorded as NFA (No Fixed Abode) at the hospital, as most give a past address or the day care centre, so they cannot be identified through routine data searches. None of the hospitals serving homeless patients can provide this information.

The Health Outreach has made the following estimates:

- Approximately 3,500 patients have been seen over two years.
- Many clients have co-morbidities, each at a lower level than to attract specialist attention but with a cumulative effect of serious disadvantage, both to themselves and to NHS staff who must treat them. Specialist level care may not be appropriate but the indication may be for a more focused service than can be provided in general practice.
- Most attend The Health Outreach with no record of NHS engagement but 90% are registered with a GP by the end of the care episode.
- Each Health Outreach episode is targeted to be completed in 6 weeks however the range can be from one week to 7 years.
- “We do know that the interventions we are delivering are evidence based and have raised the average age of death from 40 to 49 in ten years but we know we still have a long way to go” (Manager, The Health Outreach)
- There are few set clinics. This is a “low threshold open access service”: when people arrive, they are seen. Any who did not fit the target groups would be unlikely to attend here but if any not meeting the acceptance criteria did seek to attend, they would be re-directed. Many of the specific groups and clinics are not generally advertised but are focussed to the target populations.

The Health Outreach refers to a number of agencies as well as into the NHS care pathway. Clients can be referred, and assisted in making the links. They routinely work with:

- 7 foodbanks
- 200 housing providers, housing associations, private rented landlords
- 6 Local Authorities and Norfolk, Essex, and Cambridgeshire County Councils.
- 120 GP practices
- Several hundred health visitors.
- Children’s centres
- Job centres
• Benefits advice
• Welfare services
• Home Office
• Acute hospitals: Ipswich, West Suffolk, Norfolk and Norwich, Colchester General, and Papworth.
• Mental Health – crisis, and Integrated Drug and Alcohol services.
• Members of the Ipswich Locality Homelessness Partnership (ILHP)
• The Chapman Centre and the ILHP’s Assertive Street Outreach Service
• Police and probation who also refer into The Health Outreach Project.
• Roma adults often come with a number of children, so safeguarding is an issue and they refer into social work teams.
• The MASH (Multi agency Safeguarding Hub) centrally organised for Suffolk
• The Ropes Trust providing small grants to help the people of Ipswich. For The Health Outreach it provides for clients’ travelling, fridges for medication and housing deposits.

Most clients are supported and referred onwards. Little prescribing is done by The Health Outreach.

There are 10,000 – 15,000 interventions to 1,500 clients in one year. Interventions might mean organising supported housing, providing food parcels, dental prevention services, immunisations (flu vaccines) and going out to rural areas. They see drug users, do health checks, provide wound care, and support harm reduction (needle exchange), giving education on overdose training so clients will be able to help a peer in that situation. Homeless people tend to have more blood clots (pulmonary embolism and deep vein thrombosis) and infection (skin infection and pneumonias), also poor condition through self-neglect. A GP told us he would like The Health Outreach to accompany the homeless people to NHS appointments as the DNA rate is very high, and costly. He would also like GPs to partner with Turning Point, the mental health services and to work with The Health Outreach on some joint management of patients.

Information on homeless clients is shared on SystemOne which supports quality of care for The Health Outreach clients. It could be used to better support The Health Outreach’s need for recording their output.
Admission to secondary care is traumatic and difficult for homeless people. Early self-discharge is known, or patients might be discharged with little notice and nowhere to go. It is not uncommon for homeless people to be discharged by ambulance to the Chapman Centre (see Client interviews). Some patients will have their discharge delayed until they have registered with a GP practice, which can be valid, as continuity of treatment and care needs to be safely provided in the community, which would only be possible if the patient was registered with a practice.

**Comparator services in East Anglia**

Homeless services are provided in other towns but the need is marked in Ipswich as it is a dispersal centre for asylum seekers and has cheaper property which attracts people with less disposable income including migrant workers.

Cambridge provides a GP surgery specifically for the homeless. The distinction between this and The Health Outreach is that The Health Outreach goes to where the need is. Suffolk covers a large area, and services are truly inventive in being provided in such a wide range of venues. Many of the care group seen in Suffolk also have limited literacy and technological skills, for whom the Cambridge approach would be less suitable.

A service similar to The Health Outreach, although much more restricted in its geographical reach, exists in Norwich. City Reach offers clinic services and outreach services, facilitating attendance at hospital appointments, and offering shower facilities at their premises. It has a wider number of target groups – including sex workers and people leaving prison, and a Freephone telephone number for people to call them. Like The Health Outreach it is a five day service and GPs provide out of hours at the weekends, but it offers a number of links with other statutory and voluntary services.

**Surveys of service user opinion**

Conversations were held with clients at the soup kitchen, the Chapman Centre, Christchurch House and with providers at a winter planning session and the women’s refuge (The Lighthouse). Some notes are included in the Appendix A.

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7 [http://www.mhcambridgeaccess.co.uk/the-practice/about-the-practice/](http://www.mhcambridgeaccess.co.uk/the-practice/about-the-practice/)

Key points were:

- The precariousness of the lifestyle as the night before we attended the soup kitchen, one of the clients had died, making everyone unsettled and easily upset.
- That the clients, whatever their current living arrangements, would rather live a more secure life, though the revolving style of life through different sheltering arrangements suggested that settling was quite difficult. It was not the provision of a roof but enabling clients to value and retain it.
- The soup kitchen provided hot food but as important, companionship. Some of the exchanges were angry, but there was human interaction.
- The requirement to conform to regulations in order to keep a place in the hostel was a matter of contention.
- The ever-present personal danger. This was evidenced by the anger and disturbance expressed that evening as one of their group had died the night before. A young woman present who by the age of 24 had given birth to 7 children who were all now in care, was living a precarious lifestyle. All the group spoken to carried fear of attack from one’s fellows.
- We had two conversations with men who had been rehoused; one to a one-bedroom flat and was lonely; and one to sheltered accommodation who had settled well.
- One man complained that after a 999 phone call and treatment in A&E he was returned to the streets after a few hours with no support. Others joined in with similar stories.
- Use of the Chapman Centre as an address for mail and to register with the GP was a benefit, but this may be the cause of ambulances returning people to the centre after hospital admission.
- Homeless people had well developed skills in keeping warm and dry, a basic requirement for health protection and promotion.
- The difficulties of getting help were emphasised. Being homeless somehow “allows others (nurses, paramedics) to feel able to abuse and ignore you”.
- Young people in a hostel, all of whom have had an independent life, were now being retrained, and all wanted to move on but were all nervous about it. A home is fundamental to security.
- Ill health and homelessness are closely linked, with high levels of mental ill health openly displayed.
- There were two emergency beds at Cavendish Lodge. These were unpopular amongst the group. If one was taken and two friends were looking for somewhere for
the night and only one could be admitted, the two would prefer the streets together for safety.

- People were in and out of prison on short sentences. Currently there was a couple rough sleeping in a tent by the swimming pool and one who was in the door way of the Methodist church.

- There were normally about 12 people who were roofless, circling between sofa surfing then into temporary accommodation then back to prison and on to more temporary accommodation.

- Discharge from hospital was also raised in different forums. The Chapman Centre said they received a call each week from Ipswich hospital asking if they could send someone “home” to the Chapman Centre. But about once in six weeks the hospital would simply put a patient in an ambulance and send him to the Chapman Centre. It was agreed that a better discharge arrangement was needed.

What additional information is needed?

- The Health Outreach manager acknowledges that written records are something they need to improve on. The impression is that the service provides a very useful support to other NHS services whilst delivering a good quality service to the most vulnerable people. This is evidenced by effective working relationships with other professionals, and the network of partners who use The Health Outreach for patients and clients who otherwise would fall through a gap in services.

- The Health Outreach needs a stronger brand since clients do not always realise that the services they receive at the Chapman Centre, at Cavendish Lodge, or other centres, are The Health Outreach staff.

- A consistent multidisciplinary team (MDT) approach might help to pull services together such as A&E, Ambulance Service paramedics, additional GPs, and members of the Ipswich Locality Homelessness Partnership (ILHP), The Chapman Centre and the ILHP’s Assertive Street Outreach Service. There was evidence of one MDT initiated by a GP surgery and attended by The Health Outreach, but this is not in effect uniformly across the system.

- Additional research is needed on homeless families.

- NICE is in process of producing an Update of CG117 Tuberculosis (incorporating PH37), anticipated publication date October 2015. On publication this should be reviewed for evidence on the most efficient way of providing TB screening in Ipswich.
What can be concluded?

There is a significant group of homeless people mainly in Ipswich but also in other centres in Suffolk. They cannot be categorised in terms like rough sleepers or sofa surfers as they move from prison, to a hostel, to the streets, a different hostel, a tent, someone’s floor and back to prison or a spell in hospital.

Through negative life events it is possible for anyone to become homeless and homelessness is both a cause and may be an effect of ill health. Single men only obtain statutory help with homelessness if they have additional needs.

- The analysis showed many had traumatic backgrounds, addicted to drugs and alcohol, time in prison, and time in care as children. Many gave relationship breakdown as the cause of their homelessness.
- Common health needs were head wounds from falling or aggression, depression and anxiety, increased suicide risk, personality disorder, foot problems, diabetes, blood clots and alcohol-related conditions.
- Even when someone is housed, he may return to the streets through lack of cooperation on regulations, not managing the budget, or relationship breakdown.
- Winter and very cold weather are a particular risk to people without permanent accommodation. They should be accommodated during the day and night when temperatures drop. Additional migrant populations may also need accommodation.
- Record keeping was difficult owing to lack of coding for the homeless, and the temporary situations in which health care was sometimes carried out.
- To an extent homeless people do defy organisation but they have their own way of managing life and have a loyalty to the group.
- The Health Outreach Project played a major role in support of the homeless, as evidenced by staff in other parts of the NHS who were dependent on the organisation to sort out GP registration, immunisations, cold weather interventions, and drug advice and support, referrals for TB screening and hepatitis screening.
- Other parts of the service would like them to do more to support the reduction of DNA rates; The Health Outreach would like to do more in capacity building with mainstream services by training primary and secondary care staff how to manage homeless people better, and by training more staff for the Outreach Team, a specialist role which requires special training.
- Life expectancy among The Health Outreach clients rise from 40 – 49 years in ten years of operation.
References

Bickley H et al. (2006). Suicide in the homeless within 12 months of contact with mental health services: a national clinical survey in the UK. *Social psychiatry and psychiatric epidemiology*. 41 (9), 686-691.


Healthwatch Suffolk. Engagement Report


Appendix A: Surveys of service user opinion and additional information about homelessness

A number of groups relating to homelessness were visited to obtain a spread of views of local people. These comprised:

- Visitors to the soup kitchen in Ipswich town which hosts The Health Outreach team every Wednesday and Sunday evening,
- Attendees at the Chapman Centre, a voluntary sector walk in day advice and support centre providing showers, meals, support, advice and hosting The Health Outreach team for a daily surgery,
- Christchurch House hostel for young people aged 16 – 25
- The Winter Planning meeting organised by Ipswich Locality Homelessness Partnership (ILHP) and attended by a number of providers of services to homeless people.

Soup Kitchen
There was an air of disturbance as one of the regular attenders had died the previous night. This obviously created a sense of upset and was what most people wanted to talk about. Some were expressing anger. Although it was a very cold evening there was a large number, maybe 40 people.

- A young woman in a hostel spoke of her anger that she would be required to undertake a detox programme or “be thrown out”. It was one of the conditions of her place in the hostel.
- Another young woman age 24 had had a large number of children, all in care, and The Health Outreach had arranged for her to have a long acting contraceptive, a great saving to service budgets and to the young woman.
- Two men just wanted conversations. Each lived in a one bedroom flat. There is an association between loss of relationships and homelessness, and either might be the causal factor. Each came to the soup kitchen, on a very cold, dark night, as it was lonely at home. Although there is distrust among those who are most vulnerable (apparently if two friends go for an emergency bed at the hostel for a night, and only one can get a place, both will sleep on the street as they feel safer than alone in the hostel), there is also a need for companionship.
Chapman Centre
Here five people joined the conversation.

- V living in a bedsit for the last 15 months following 28 days at Cavendish Lodge
- W from the street moved to Cavendish Lodge for 28 days and then to a room provided by a Housing Association
- X had lived on the streets then to a shared accommodation bedsit and a council house in January 2015
- Y had been in bed and breakfast accommodation for six months and then had obtained a council flat where she has been for 2 years.
- Z was homeless following eviction from private rented accommodation. He was at Cavendish lodge for a short time and then was offered a room in sheltered accommodation where he is very happy.

Most were pleased with the outcome of their search for a home especially the female, Y who had a bed and breakfast arrangement for six months and now has a home. One man was depressed by his bedsit, a one room flat. Because he was now “adequately housed” there was no prospect of improvement and that was hard for him. He found it lonely.

Impact of rough sleeping on health
Those with experience of sleeping rough knew the great importance of keeping warm and dry. They could get showers and wash clothes at the Chapman Centre and so keep clean but it was a struggle to survive and depression and feeling “down” was often mentioned. Personal danger and survival was also a very real issue – “if I go to sleep in the tent, will someone come and kick it over? Will it still be there in the morning?” Care of self and belongings was the most important concern, and to this fear and anxiety was attributed being underweight and stress. Companionship – having a mate – was key, a relationship of trust. If one of the two emergency direct access beds at the Cavendish Lodge was offered, but there was no space for a mate, the two would rather sleep on the street for safety. Use of drugs and alcohol was common.

Healthcare services
One mentioned a problem with discharge from hospital which following a 999 call and visit to A & E, left him to return to his life on the streets within a few hours. Discharge from hospital was discussed in other meetings as well. Some of the homeless people use the Chapman Centre address to receive mail, or as a home address for registration with a GP. On discharge from hospital, some have been taken by ambulance to the Chapman Centre and
left there although there are no beds and indeed the service closes at 2pm although it runs specific sessions on two days from 3pm – 5pm.

They had experienced discrimination, from doctors surgeries which would not offer registration if the address was the Chapman Centre. There were a few practices that would accept those without a permanent home and they were very good but very busy. It was not always possible to get an immediately necessary appointment. Also there were experiences of rejection by paramedics if they were called – referring to the homeless person as “just a junkie”.

Most healthcare was provided by The Health Outreach and there was a community dental nurse. The Health Outreach was very much appreciated although there was some confusion about the source of the clinical staffing provided at the Chapman Centre. Clients did not always realise this was provided by The Health Outreach. This is where they would come for a head wound, a foot problem (cases of trench foot have been known), more serious conditions (heart or leg) or other conditions. Many times they would not report until the condition had become serious.

**Christchurch House Hostel for 16 – 24 years olds**

Approximately 8 young people were in evidence at the 29 bed hostel for 16 – 24 year old people.

Four young people, two men and two young women, all in their very early twenties were interviewed separately.

All were registered with a local GP, although one was where he used to live, not near the hostel. None was worried about physical health but most admitted to a poor level of mental health from having emotional problems from anxiety and depression to personality disorder and psychosis. They had not experienced any discrimination in primary care though they had not always found the service they wanted. For example, a young man had missed his GP appointment and needed another as he was keen to see a consultant psychiatrist. He felt he should be getting more help. A young woman who had an ectopic pregnancy had discharged herself from the hospital when she overheard staff talking about her in a derogatory manner.
None had visited the dentist though one young man wanted to get his teeth “sorted out”. The men were at either end of the scale in length of stay, one having been there for three weeks, one for three years. One woman had been there for one year and the other for 2 ½ months. Reasons for admission to the hostel (sometimes more than one reason per client) were loss of job leading to inability to pay rent (2) or children taken into care so loss of council accommodation (1) and two were from a progression of other hostels (or women’s refuge) and rough sleeping.

They were comfortable with their current accommodation though all wanted to move on. The hostel does have a system of progression to independence but a young woman who was very anxious to get her own place was not moving to the more independent wing of the hostel as that was classed as a Band C (more independent) from which it is harder to get a place from the council. But from a Band A – her current place – she was more likely to get housed independently. It was very difficult to obtain small units of social accommodation. The spare room subsidy made these the most sought after units.

The young people did express concerns about their current accommodation. The young man who had been there longest found it difficult when friends moved on, or if he had stuff taken from his room; the young woman keen to get her own place found it hard that she could never be alone, also that the kitchen was locked at 10.30pm, coupled with the fact that it was shared and never clean enough for her. She found these limitations quite frustrating. However the other young woman was concerned about her mental health if she moved on to living alone having been in the hostel. She is a smoker and would not think of giving it up. Information from hostel staff and other voluntary providers

The manager knew those who were rough sleeping at that time: 4 – 6 in the town centre and sometimes someone in a tent.

There were two emergency beds at Cavendish Lodge and eight 28 day Hostel beds People were in and out of prison on short sentences. Currently there was a couple in a tent by the swimming pool and one who is in door way of Methodist church in Blackhorse Lane Normally about 12 “do the rounds”, people who were roofless. They tend to sofa surf then into temporary accommodation then back to prison and back again.

Discharge from hospital was raised in different forums. The drop in centre said they received a call each week from Ipswich asking if the hospital could send someone home to them. But
about once in six weeks the hospital would simply put a patient in an ambulance and send him to the Chapman Centre. It was agreed that a better discharge arrangement was needed. It is possible that it happens as GPs register patients with the Chapman Centre as their home address so they can receive mail there and also to get onto the GP list.

**The Lighthouse**

Lighthouse Women's Refuge Ipswich is one of three refuges in Ipswich Bury St Edmunds and Lowestoft. The Lighthouse has 15 bedrooms of which 11 are family rooms and four for single women. Average length of stay is 3 – 9 months, but if they are waiting for rehousing it will often be longer. If they are moving to another refuge or have family or friends elsewhere they might need to wait for housing. The women move frequently for fear of being located. They provided for 67 women in 2014/15.

They provide accommodation and are also a women’s centre to support women experiencing domestic violence, offering the Freedom programme, building emotional resilience. There is an outreach service which is county wide Anglia Care Trust. The proportion of women is one third is local, two thirds from outside Suffolk. When they first arrive they go through a needs assessment and part of it would ask if they have medication, and whether they have it with them. If they are on long term medication whether they need to see a GP quickly.

The Lighthouse Works with two local surgeries. They have been in the area for 15 years and have good relationships with health services. If a woman came and needed to register quickly, they would help her register with one of the surgeries.

Generally it is safe for a woman to leave the house to see the GP as much as they are safe in the house. Some women may feel very anxious about going out.

If a woman required an inpatient stay and there are children it is difficult. If she is not local and does not have family locally then they have to get social services to arrange childcare. Social Services were supportive and if the children had been receiving support elsewhere then notes were sent on quite quickly. Their common health problems are mainly mental health issues, depression and anxiety and stress related illness.
As everybody is living in quite close quarters they always catch any infection that is contagious. They have family rooms where they live quite closely and use common bathrooms and kitchens. Often the women have different attitudes to cleanliness and hygiene and attitudes to child care.

The Health Outreach used to provide a visit to do flu vaccinations, talk about nits and how to protect against contagious diseases. The women used to find it quite useful. But residents usually have many issues to deal with and are in a state of crisis when they first arrive so that attending courses or clinics can be difficult. Uptake varies greatly depending on the dynamics of the house at the time. We were told that attendance could be quite low, possibly The Health Outreach taking the view that it was not a good use of time and resource.
This needs assessment was prepared in July 2015 by the Public Health Action Support Team on behalf of Suffolk County Council.

Figure B1: Map of geographic service focus of The Health Outreach

Source: www.openstreetmap.org.uk and The Health Outreach Project. Each yellow spot indicates a frequent venue.

The following is information obtained through analysis of the Suffolk Co-ordination Service application forms from clients (See “What is the local picture?”). It indicates some additional factors about those facing, or experiencing homelessness. Figure B2 illustrates responses on whether applicants had a medical condition. To this question, nearly 500 (14%) did not respond, and 100 (3%) replied “Don’t know”. Of the remainder, 1,780 (50%) did not claim a medical condition, and 1,176 (33%) did.
This needs assessment was prepared in July 2015 by the Public Health Action Support Team on behalf of Suffolk County Council.

Figure B2: Do you have a medical condition? By age, April 2014 – May 2015

Source: SCS

Figure B3: Main reason for referral by age group, April 2014 – May 2015

Source: SCS

Table A1 shows the main medical problems that were reported. Of 3,557 applications in a period of fourteen months, 2279 gave no reply or declined to answer. Of the 1,278 who responded, the conditions above were the most frequently mentioned.
This needs assessment was prepared in July 2015 by the Public Health Action Support Team on behalf of Suffolk County Council.

### Table A1 Main medical problems cited by applicants to SCS, April 2014 – May 2015

<table>
<thead>
<tr>
<th>Condition</th>
<th>Count</th>
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<tbody>
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<td>Depression</td>
<td>285</td>
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<tr>
<td>Heart problem</td>
<td>40</td>
</tr>
<tr>
<td>Bowel problem</td>
<td>16</td>
</tr>
<tr>
<td>Seizures</td>
<td>9</td>
</tr>
<tr>
<td>Anxiety</td>
<td>144</td>
</tr>
<tr>
<td>Arthritis</td>
<td>27</td>
</tr>
<tr>
<td>High blood pressure</td>
<td>16</td>
</tr>
<tr>
<td>Hepatitis</td>
<td>8</td>
</tr>
<tr>
<td>Asthma</td>
<td>111</td>
</tr>
<tr>
<td>Leg problems</td>
<td>25</td>
</tr>
<tr>
<td>Autism</td>
<td>14</td>
</tr>
<tr>
<td>Bi-polar</td>
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<tr>
<td>ADHD</td>
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<tr>
<td>Hep C</td>
<td>22</td>
</tr>
<tr>
<td>Liver problem</td>
<td>14</td>
</tr>
<tr>
<td>Cerebral palsy</td>
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</tr>
<tr>
<td>Back problem</td>
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<tr>
<td>Hearing problem</td>
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<tr>
<td>Eczema</td>
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<tr>
<td>Cancer</td>
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<tr>
<td>Mental health</td>
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</tbody>
</table>

Source: SCS

Figure B4 considers some factors which may offer the opportunity of prevention against homelessness if clients in these groups can be identified with a significant risk earlier in the process.

**Figure B4: Characteristics of people found to be statutorily homeless, SCS, April 2014 – May 2015**

![Bar chart showing frequency of various factors](image)

Source: SCS