MANCHESTER JOINT STRATEGIC NEEDS ASSESSMENT
ADULTS AND OLDER PEOPLE

CHAPTER: Key Groups

TOPIC: Working age adults experiencing chronic homelessness

WHY IS THIS TOPIC IMPORTANT?

Tackling homelessness and the impact it has on the health and wellbeing of the population is a key priority in Manchester. People experiencing chronic homelessness, or who have been rough sleeping for some time, have been shown to have poorer physical and mental health than the general population, are more likely to be dependent on alcohol and/or drugs, and can find it more difficult to access healthcare services. Physical disability, poor physical or mental health, and alcohol/drug misuse can also contribute to an individual becoming homeless.

The focus of this chapter is on working age adults experiencing chronic homelessness including those who are sleeping rough. This population has very poor health compared to the general population and tackling homelessness experienced by this population, alongside action to improve health and wellbeing and reduce health inequalities, is therefore a priority for organisations in Manchester.

In England, homelessness is legally defined – a person is considered homeless if they have no home in the United Kingdom or anywhere else in the world available to occupy.[1] Homelessness can include:

- rooflessness (e.g. sleeping rough, in a night shelter)
- houselessness (e.g. in temporary accommodation such as an institution, hostel, or bed and breakfast)
- living in insecure housing (e.g. in insecure tenancies, threatened with eviction, experiencing domestic violence, 'sofa surfing')
- living in inadequate housing (e.g. in temporary/unconventional structures, unfit housing or in extreme overcrowding)[2]

Local authorities have a number of legal duties in relation to homelessness:

- A duty to find accommodation for households assessed as being homeless, unintentionally homeless, eligible, and in 'priority need' (Housing Act 1996). Often referred to as 'statutory homelessness', 'priority need' includes pregnant women and those with dependent children, young people under 18, young people leaving care, and people who are otherwise vulnerable (e.g. because of old age, mental illness, disability, leaving care/prison/the armed forces, or being at risk of violence).

[1] Shelter, 2017. *Legal Definition of Homelessness*. Available at: http://england.shelter.org.uk/get_advice/homelessness/homelessness_-_an_introduction/legal_definition_of_homelessness.
[2] European Federation of National Organisations Working with the Homeless (FEANTSA), 2005. European Typology of Homelessness and housing exclusion. Available at http://www.feantsa.org/download/en-16822651433655843804.pdf

- A duty to review homelessness, and publish a strategy to tackle and prevent homelessness in their area, considering all households at risk of homelessness, not just those who may be owed a statutory duty (Homelessness Act 2002). [3]
- Duties to work with households at risk of homelessness to prevent or relieve this, regardless of whether they are considered 'priority need' (Homelessness Reduction Act 2017).[4]

The Homelessness Reduction Act 2017 also introduces a new duty on public bodies (to be defined in January 2018) to refer households who are at risk of losing their home, or without a home, to the local authority of the household's choice. Public bodies are likely to include health services that are most likely to come into contact with households at risk.

National data – homelessness trends

National data from official and administrative statistics shows that there has been a substantial expansion in all forms of recorded homelessness since 2009/10, although the rate of increase has significantly slowed, in the most recent financial year (2016/17).[5]

Table 1: Summary of Homelessness Statistics in England

Homelessness Statistic	2009/10	2016/17	% change 2009/10-2016/17
Rough sleeping (snapshot)	1,768	4,134	134%
Statutory homelessness applications	89,120	115,550	30%
- Of which, statutory homelessness acceptances	40,020	59,100	48%
Homelessness prevention and relief positive interventions	165,200	215,217	30%
Total homelessness local authority actions reported to DCLG (excl. rough sleeping)	254,320	330,767	30%

Source: Department for Communities and Local Government (DCLG)

Between 2009/10 and 2016/17, there was a 30% increase in applications to local authorities for statutory homelessness i.e. the number of households approaching local authorities for assistance to find settled housing. The number of households found to be owed the statutory duty has increased by 48%.

Official data on non-statutory/single and couple homelessness is less readily available. The official national count of 'rough sleepers' for 2016 (a snapshot) shows a 134% increase in the estimated number of individuals sleeping rough in England each year since 2010 (an estimated 4,134 individuals).[6] This will be a significant underestimate of all people who sleep rough during

[3] Shelter, 2017. *The Act in Action - An Assessment of Homelessness Reviews and Strategies.* Available at: http://england.shelter.org.uk/professional_resources/policy_and_research/policy_library/policy_library_folder/the_act_in_action_-_an_assessment_of_homelessness_reviews_and_strategies.
[4] HM Government (2017) Homelessness Reduction Act 2017 Available at: http://www.legislation.gov.uk/ukpga/2017/13/contents/enacted
[5] Crisis, 2017. *The homelessness monitor: England 2017* Available at: https://www.crisis.org.uk/media/236823/homelessness_monitor_england_2017.pdf
[6] DCLG, 2017. *Official Statistics Rough sleeping in England: autumn 2016.* Available at: https://www.gov.uk/government/statistics/rough-sleeping-in-england-autumn-2016.

a year, for example the London 'snap shot' in 2016 was 3,170 people, but outreach teams contacted 8,108 individuals during 2016/17.[7]

Not all of those who become homeless will go on to sleep rough, or they may only sleep rough for one night:

- There are many 'hidden' households i.e. people who are sleep on sofas of friends and family ('sofa surfers') or who share accommodation with others on an informal basis. The number of adults in concealed household units was estimated to be 3.34 million in 2016 - an increase of a third since 2008.[8]
- Data collected from outreach services in London in 2016/17 indicated that 63% of the people seen rough sleeping had not been seen rough sleeping in London prior to April 2016.[9]

However, for many others rough sleeping is experienced on a longer-term basis (after a year on the street this is more likely), some with intermittent periods of time in accommodation, and they may be described as 'entrenched'. The latter population has similar needs to those described for people experiencing severe and multiple deprivation (SMD).

Severe and multiple disadvantage is shorthand for the problems faced by adults in the homelessness, substance misuse and criminal justice systems in England, with 'poverty an almost universal, and mental ill health a common, complicating factor'. Research suggests that there are an estimated 58,000 people in in England with at least these three needs and around 250,000 people are affected by two of the three needs. The average local authority area might expect to need to work with around 385 people with disadvantages in all three domains or 1,470 people with disadvantages in two of the three areas. The largest group affected by SMD is white men aged between 25 and 44.

The evidence indicates that severe and multiple disadvantage appears to result from a combination of structural, systemic, family and personal factors, leading to great difficulty in achieving positive outcomes with this group.

With higher levels of rough sleeping in London, it could be expected that there is a greater number of people with multiple and complex needs, but this is not necessarily the case: areas identified as having the largest SMD populations are primarily in the North and Midlands.

Causes of homelessness

The causes of homelessness are typically described as structural and/or individual (see table below) and can be interrelated and reinforced by one another.

Table 2: Causes of homelessness

Structural factors	Individual factors
• Poverty • Inequality • Housing supply and affordability • Unemployment or insecure employment • Access to social security	• Debt • Poor physical and/or mental health • Experience of violence, abuse, neglect, harassment or hate crime • Alcohol and/or drug misuse • Bereavement or relationship breakdown • Leaving an institutional environment e.g. prison, care, armed forces • Being a refugee[10]

The most important driver of homelessness in all its forms is poverty. In particular, 'childhood poverty very often predates, and is a powerful predictor of, (adult) homelessness'.[11]

Impact of homelessness on health and wellbeing

Physical and mental health can be affected both by poor quality, inadequate and insecure accommodation, and by homelessness. This chapter looks at on the effects of homelessness on health and wellbeing, with a particular focus on chronic homelessness experienced by working age adults. Children and families and young people have different experiences. Although this chapter focuses on homelessness it should be noted that people experiencing homelessness often also live in unsuitable accommodation, even when the council is trying to assist them, which can add to their health issues.

Poor health and wellbeing can be both a cause and a consequence of homelessness. People without a home experience poorer physical and mental health than the general population, are more likely to be dependent on alcohol and/or drugs, and can find it more difficult to access healthcare services. Physical disability, poor physical or mental health, and alcohol/drug misuse can also contribute to an individual becoming homeless. Data collated from health needs audits of homeless people carried out across England indicate that of the approximately 2,600 people responding to health needs surveys:

- 73% reported physical health problems, with 41% reporting these as long-term problems (12 months or more). The most common long-term physical health problems reported were joint and muscular problems (22% of respondents), chest and breathing problems (15%), dental problems (15%), eye problems (14%) and stomach problems (10%).
- 80% reported mental health issues, with 43% reporting these as diagnosed mental health problems. The most common diagnosed mental health problem was depression (36% of respondents). 12% of those surveyed reported having a 'dual diagnosis' (a diagnosed mental health problem alongside alcohol and/or drug dependence), and almost half of respondents reported using alcohol or drugs to cope with their mental health issues.
- 39% reported taking drugs or recovering from a drug problem, 27% reported recovering from an alcohol problem, and 35% reported drinking alcohol 3 or more times per week (with 16% reporting drinking every day) [12]

People who are rough sleeping (including those who move between hostels and sofa surfing and/or are otherwise chronically insecurely housed) face additional risks to their life chances:

[7] GLA (2017) *Rough sleeping in London (CHAIN reports) 2016/17* Available at: https://files.datapress.com/london/dataset/chain-reports/2017-06-30T09:03:07.84/Greater%20London%20full%202016-17.pdf

[8] Crisis, The Homeless Monitor: England 2017, March 2017, Executive Summary p xi.

[9] GLA (2017) *Rough sleeping in London (CHAIN reports) 2015/16* Available at: https://files.datapress.com/london/dataset/chain-reports/2017-06-30T09:03:07.84/Greater%20London%20full%202016-17.pdf

[10] Public Health England, 2016. *Homelessness: Applying All Our Health* Available at: https://www.gov.uk/government/publications/homelessness-applying-all-our-health/homelessness-applying-all-our-health#facts-about-homelessness.

[11] Bramley, G., & Fitzpatrick, S. (2017). Homelessness in the UK: Who is most at risk? Housing Studies, 1-21

[12] Homeless Link, 2014. *The unhealthy state of homelessness - Health audit report 2014*. Available at: http://www.homeless.org.uk/sites/default/files/site-attachments/The%20unhealthy%20state%20of%20homelessness%20FINAL.pdf.

- Death by unnatural causes has been found to be four times more common than average amongst rough sleepers, and suicide 35 times more likely
- The prevalence of infectious diseases, such as tuberculosis, HIV and hepatitis C, is significantly higher than in the general populations.[13]

Access to health care for this population is different to that of the general population: one third of rough sleepers are not registered with a GP; attendance at accident and emergency is at least eight times higher than the housed population.[14]

Once people experience more acute forms of housing need, such as prolonged periods of homelessness or sleeping rough, the rate at which health problems occur increases rapidly.[15] It has been estimated that the average age of death for someone who is rough sleeping could be as low as 47 for a man and 43 for a women.[16]

Homelessness can also increase the risk of being a victim of crime and antisocial behaviour. A recent survey of people's experiences of sleeping rough in England and Wales found that:

- 77% of survey respondents reported anti-social behaviour and/or crime against them in the past 12 months
- 30% rough sleepers reported being deliberately hit or kicked or experiencing another form of violence in the past 12 months (women proportionally more)
- Almost half (45%) of current or recent rough sleepers surveyed said they had been intimidated or threatened with violence or force. 31% had had things thrown at them and in 7% of cases rough sleepers had been urinated on
- Over half of respondents (56%) reported being verbally abused or harassed - the most common form of anti-social behaviour experienced
- More than half (51%) of recent and current rough sleepers surveyed reported having personal belongings stolen. Deliberate damage or having personal items vandalised was experienced by 20%
- Over half (53%) of the latest incidences of abuse and violence rough sleepers had experienced were unreported to the police. The main reason for this was due to the expectation that nothing would be done by the police.[17]

Costs of homelessness

A 2010 study of the use of health care by single homeless people found that single homeless people were 2.3 times more likely than the general population to have had an inpatient admission and that the cost associated with those admissions was 1.5 times higher than the

[13] NICE (2013) *Infectious diseases among homeless populations.* Available at https://arms.evidence.nhs.uk/resources/hub/970755/attachment
[14] LGA (2017) *The impact of homelessness on health: a guide for local authorities*. Available at https://www.local.gov.uk/impact-health-homelessness-guide-local-authorities
[15] Public Health England, 2015. *Preventing homelessness to improve health and wellbeing.* Available at: https://www.gov.uk/government/publications/preventing-homelessness-to-improve-health-and-wellbeing.
[16] Crisis/University of Sheffield, 2012. *Homelessness Kills.* Available at: http://www.crisis.org.uk/data/files/publications/Homelessness%20kills%20-%20Executive%20Summary.pdf.
[17] Crisis, 2016. *"It's no life at all" Rough sleepers' experiences of violence and abuse on the streets of England and Wales*. Available at: http://www.crisis.org.uk/publications-search.php?fullitem=516.

general population. The estimated net cost associated with the use of health care by single homeless people (i.e. the cost over and above the costs for the same number of the general population) was £64 million per year, although this may be conservative given the health issues experienced by this population.[18] Since this time, rough sleeping has doubled, as have NHS costs, and the figures cited above are almost certainly an under-estimate of the current costs of homelessness.

Research carried out by Crisis in 2015, drawing on large studies on homelessness across Britain, suggests that tackling homelessness early could save the government between £3,000 and £18,000 for every person helped.[19]

THE MANCHESTER PICTURE

Levels of homelessness in Manchester

Manchester City Council records information about individuals and families approaching its homeless service, including data on presentations (for all types of assistance) and statutory homelessness, the use and provision of temporary accommodation and successful homelessness prevention and relief interventions. The table below shows trends in the total number of approaches to the service over the past 5 years (2012/13 to 2016/17).

Table 3: Approaches to the Manchester City Council homeless service (2012/13-2016/17)

	2012/13	2013/14	2014/15	2015/16	2016/17
Families	1,968	1,802	1,741	1,559	2,031
Singles	3,977	3,785	3,742	3,543	3,694
Not recorded	-	48	126	88	36
Total	5,945	5,635	5,609	5,190	5,761

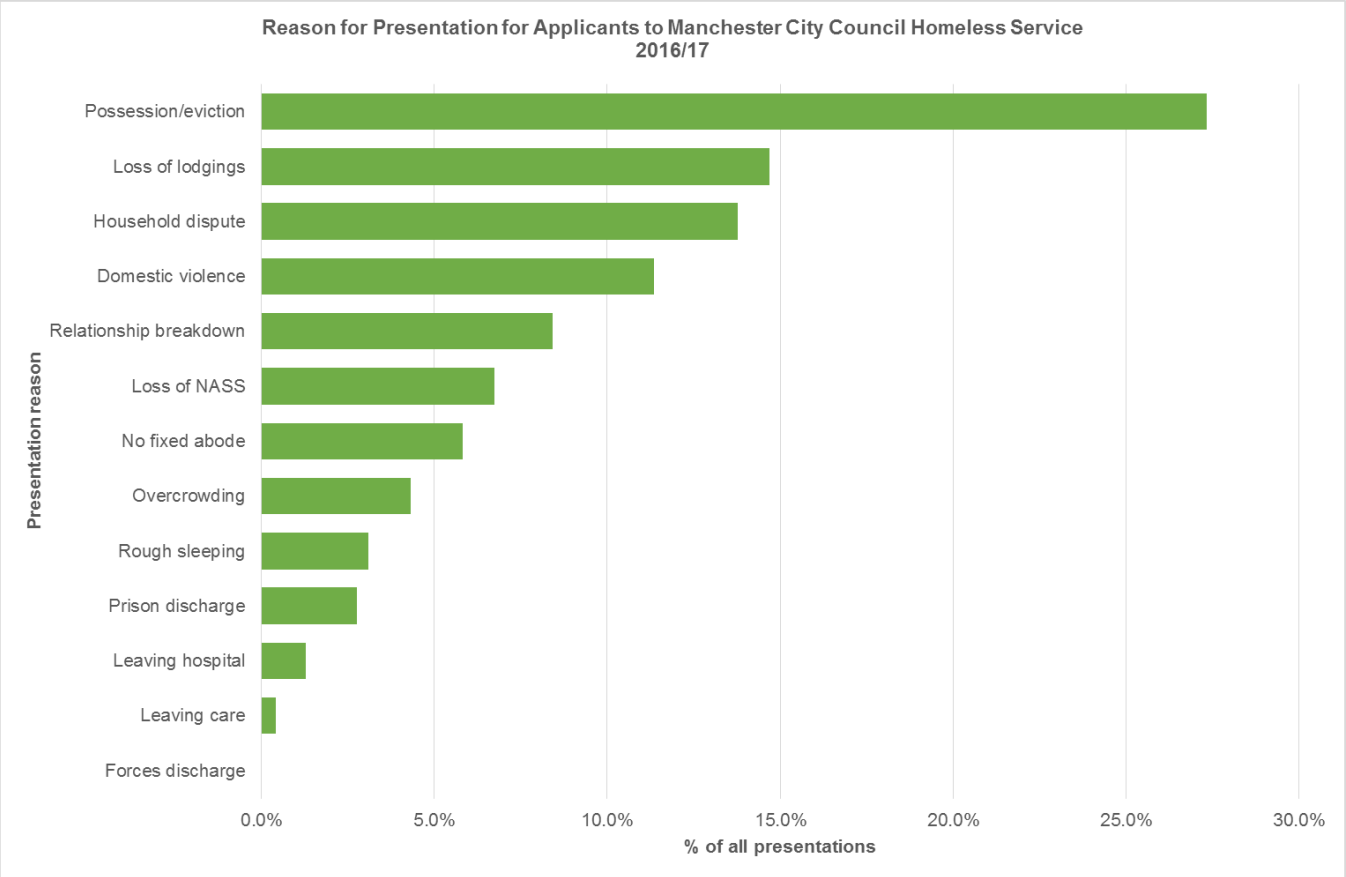
The figures show that in 2016/17 there were 5,761 approaches to the service - an 11% increase in approaches compared with 2015/16. The majority of approaches (64%) were made by single people with around 35% made by families. The number of family applicants increased by 30%, although there was only a slight rise in the number of approaches by single people. The number of families approaching the service was higher than at any point in last five years.

A monthly snapshot of approaches to the homeless service by gender and ethnicity for April 2016 showed that 56% of people approaching the service were male and 44% were women. The majority of those presenting (48%) were of White ethnic origin, followed by Black / African / Caribbean / Black British (24%) and Asian/Asian British (10%). People of a Black / African / Caribbean / Black British background were more likely to have approached the homeless service compared with the population as a whole but the reverse is true for people of an

[18] Department of Health, 2010. *Healthcare for Single Homeless People*. Available at: http://www.qni.org.uk/docs/healthcare%20for%20single%20homeless%20people%20NHS.pdf
[19] Crisis, 2015. *At what cost? An estimation of the financial costs of single homelessness in the UK.* Available at: http://www.crisis.org.uk/data/files/publications/CostsofHomelessness_Finalweb.pdf.

Asian/Asian British background. Information is not available on the age of those presenting. These patterns are relatively consistent across most months.

The graph below shows the main reasons for presenting to Manchester City Council as homeless in 2016/17 (all households).



Source: Manchester City Council

The graph shows that, in 2016/17, the main reasons for households approaching Manchester City Council for assistance with their housing were possession/eviction (27% of presentations), loss of lodgings (15%), household dispute (14%) and domestic violence (11%).

As can be expected with an increase in statutory homelessness, the number of households in temporary accommodation has also increased. Use of temporary accommodation for people who have lost their home has increased by 319% since 2010, from 273 to 1,145 by March 2017. Nationally the use of temporary accommodation has also increased, by 60% since 2010.

Households are placed in B&Bs for emergency accommodation if suitable temporary accommodation is not immediately available. Periods of stay in this accommodation are short, typically less than a week. As of October 2017, the Council had placed 117 single people in B&Bs. It is estimated that there are a further 450 single people across the city who are meeting their housing needs through the use of B&Bs. The charity Just Life works with a number of people in these circumstances, and report that they often have complex needs and that the accommodation is often poor quality and precarious.

Some temporary accommodation is outside of Manchester. As at October 2017, 40 single households were living in temporary homes elsewhere in Greater Manchester.

In addition to temporary accommodation, there are 571 units of supported housing in Manchester, of which the vast majority are for single, working age, adults, many of whom are at risk of homelessness or have experienced homelessness, including people who have been sleeping rough. 714 people went into housing related support (HRS) accommodation during 2016/17 - an average of 179 people each quarter. The number of people going into supported housing decreased by 27.1% since the first quarter of 2015/16, and the numbers leaving HRS accommodation has also decreased (by 18.4%).

Limited access to settled housing is presenting a barrier to people moving on when they are ready, and for people who would benefit from accessing supported housing. There is currently (October 2017) a waiting list of around 300 people with the average length of time for someone to move to settled housing being 7.5 months. Around 25% of people leaving housing related support accommodation were rehoused with friends or family, with a further 19% being rehoused in social housing with support.

The latest official count of people sleeping rough in Manchester (based on a snapshot on a single night in November 2016) indicated a significant increase in the number of such individuals in the city, from 24 in 2013 to 78 in 2016 - an overall increase of 192% (although the increase compared with the 2015 figure of 70 has plateaued at 11%). Nationally, the increase over this same period is 48%.[20] The latest monthly head count for December 2016 showed a figure of 88 rough sleepers in the city.

Housing status of adults engaged in public health commissioned drug and alcohol treatment services

The lack of a safe, stable home environment can be both a cause and consequence of drug and alcohol misuse and can also have an impact on whether people are able to sustain their recovery from such problems. Data on the self-reported housing status of adults is collected when they start in public health commissioned structured drug and alcohol treatment services. Data is also collected on the proportion of clients who have successfully completed treatment with no housing problem reported. This is an indicator of the success of drug and alcohol treatment services in engaging with local housing and homelessness agencies.

Table 4: Self-reported housing status of adults starting drug and alcohol treatment services

	Drug Treatment		Alcohol Treatment	
	Manchester	England	Manchester	England
Urgent problem (NFA)	13%	10%	3%	3%
Housing problem	12%	13%	8%	8%
No housing problem	68%	73%	81%	87%
Other	1%	2%	0%	0%
Not stated/Missing	6%	1%	8%	1%
No. of new presentations	1,130	78,633	672	52,553

Source: Public Health England drugs and alcohol commissioning support packs 2018-19: key data

[20] Department for Communities and Local Government (2017). Official Statistics Rough sleeping in England: autumn 2016 Available at: https://www.gov.uk/government/statistics/rough-sleeping-in-england-autumn-2016.

Over the period 1 April 2016 to 31 March 2017, there were a total of 2,784 adults in drug treatment services in Manchester, of which 1,130 started treatment during this period. Around 13% of these reported an urgent housing problem and a further 12% reported some other housing problem. Over the same period, 672 clients started alcohol treatment services in the city, of whom 3% reported an urgent housing problem and a further 8% reported some other housing problem. The proportion of new presentations to drug treatment services in Manchester with an urgent housing problem (13%) is higher than the national average (10%). The figure for new presentations to alcohol treatment services in Manchester reporting an urgent housing problem is the same as the national average (3%).

In 2016/17, 95% of adults successfully completing drug treatment in Manchester and 85% of those successfully completing alcohol treatment no longer reported a housing need. This compares with 84% of clients exiting drug treatment services and 85% of those exiting alcohol treatment services across England as a whole.

Homeless Health Needs Audit

In 2016, a Homeless Health Needs Audit (HHNA) for Manchester[21] was carried out, using a toolkit and guidance developed for national use by Homeless Link.[22] The Audit was conducted between January and March 2016 and aimed to gather quantitative and qualitative data about people experiencing homelessness who were registered as patients with Urban Village Medical Practice, as well as from a sample of organisations providing support or accommodation to people without a home in Manchester. The target population for the survey was adults aged 16 and over experiencing a range of homeless situations, including rough sleepers, people living in temporary accommodation (e.g. hostels and B&Bs) and 'sofa-surfers' (e.g. people living temporarily with friends or relatives). Homeless families were excluded from the survey.

The survey provides a good overview of the health issues of people experiencing homelessness although the limitations of the sample means that it does not provide a complete picture. Also, differences in the wording of some survey questions mean that that it is not always possible to compare the findings of the Manchester Homeless Health Needs Audit with national data.

A total of 238 surveys were completed during the audit period:

- 82% of respondents were male and 18% were female.
- 81% of those responding to the survey stated that they were UK citizens, 11% said they were from the European Economic Area (EEA).
- 79% of respondents gave their ethnic origin as White, 8% as Black / African / Caribbean / Black British, 6% as Mixed/Multiple ethnic groups, and 3% as Asian/Asian British.

Analysis of ethnic origin indicates that few refugees were included in the survey. Newly granted asylum refugees make up part of the homeless population and more work is needed to understand where this section of the homeless population are accessing health care. This is being explored in the JSNA chapter on new migrant communities (in development).

[21] Manchester Homeless Health Needs Audit, 2016 (Unpublished)

[22] Homeless Link, 2017. *Homeless Health Needs Audit.* Available at: http://www.homeless.org.uk/our-work/resources/homeless-health-needs-audit

Key findings from the audit were:

Physical health

83% of those responding to the survey reported having at least one physical health condition; 36% reported having more than one physical health condition. Respondents were asked only to report the health conditions which had been identified by a doctor or other health professional. The main health problems reported by respondents (at any time i.e. in the last 12 months or more than 12 months ago) were aching joints/bone or muscle problems (40%) and dental/teeth problems (35%).

Other health problems included:

- Problems with feet (27%);
- Problems with eyes (25%);
- Asthma (25%);
- Skin/wound infection or problems (24%);
- Fainting/blackouts (22%);
- Circulation problems/blood clots (20%).

In terms of infectious diseases (including blood-borne viruses), levels were generally lower:

- Hepatitis C (14%)
- HIV (2%)
- Tuberculosis (2% - with the majority of these more than 12 months ago)

The survey did not ask any questions about incidence of accidental injuries or injuries as a result of violence of any kind.

Mental health

73% of respondents to the survey reported having a mental health condition. Respondents were asked only to report the mental health conditions which had been identified by a doctor or other health professional. The main mental health conditions reported were depression (64% overall, including 45% in the last 12 months) and anxiety disorder/phobia (51% overall, including 35% in the last 12 months). 25% of respondents reported having co-existing mental health and substance misuse (alcohol and/or drug) problems (referred to in the survey as ‘dual diagnoses) and 19% reported having psychosis (including schizophrenia or bipolar disorder).

The survey did not ask any questions about incidence of self-harm or attempted suicide.

Substance `misuse (alcohol and drugs)

71% of respondents to the Homeless Health Needs Audit reported using drugs in the last 12 months and 70% reported using alcohol in the last 12 months.

For reported drug use, the most commonly used substances in the last 12 months were:

- Cannabis/weed (47%)
- Crack (33%)
- Heroin (30%)
- New psychoactive substances (26%)
- Cocaine (24%)

Of the 160 respondents who reported alcohol use, 47%said they drank at least 3-4 days per week, with 71% of that group reporting drinking ‘almost every day’.

General health and wellbeing

Survey participants were asked questions about their general health and wellbeing. 87% of those responding to the survey reported smoking tobacco (e.g. cigarettes/roll-ups/pipe), with 48% stating a desire to stop smoking. 50% of survey respondents reported having been offered smoking cessation support. In addition, 39% of respondents reported having one or fewer meals per day and 62% reported having one or fewer portions of fruit and vegetables per day.

Access to health and care services

The Health Needs Audit asked participants about their experiences of accessing healthcare and support services. Of those individuals responding to the survey, 79% reported being registered with a GP and 39% with a dentist. 8% reported that they had been refused registration with a GP and 4% with a dentist.

In terms of treatment for *physical health* problems, 37% of respondents reported receiving treatment that met their needs, with an additional 24% saying that their treatment/support met their needs but that they would like more support. Just over a quarter of respondents (27%) said they were NOT receiving treatment/support but they thought that it would help them. The main reasons for not being able to access treatment/support when needed were waiting lists, difficulty getting an appointment and distance/difficulty getting to the service

In terms of treatment for *mental health* problems, 27% of respondents reported receiving treatment that met their needs with a further 27% saying that their treatment/support met their needs but that they would like more support. Over a third of respondents (35%) said that they were NOT receiving treatment/support but they thought that it would help them. The main reasons for not being able to access treatment/support when needed were waiting lists, or being refused treatment/support because of alcohol or drug use.

In terms of reported service use in the last 12 months, of those responding to the question:

- 78% had used a GP or homeless healthcare service
- 57% had used an Accident and Emergency (A&E) department
- 42% had used the ambulance service
- 41% had been admitted to hospital

In terms of *repeat service use* (over 3 times in the last 12 months):

- 42% used a GP or homeless healthcare service
- 13% used an Accident and Emergency (A&E) department
- 10% used the ambulance service
- 7% had repeat hospital admissions

Other data

The Homeless Health Needs Audit also gathered data on the background of individuals completing the survey, and illustrates the complexity of lifestyles and risk factors among the population. Of the 238 individuals surveyed:

- 57% had spent time in prison
- 28% had been admitted to hospital because of a mental health issue
- 25% had spent time in a secure unit or young offender institution
- 25% had been a victim of domestic violence
- 23% had spent time in local authority care
- 7% had spent time in the armed forces

Survey participants were also asked about the reasons for them becoming homeless. The most commonly reported reasons were:

- Non-violent relationship breakdown with partner
- Parent(s)/care-giver(s) no longer able to accommodate
- Alcohol or drug problems

Homeless Feedback on Services

Feedback on the state of homelessness service provision in Manchester, together with ideas about what improvements could be made, was collected from homeless people and non-homeless members of the public in 2015. Questions focused on what respondents thought the people of Manchester could do to reduce homelessness, what messages they would give to the leaders of Manchester City Council, what other agencies could do to reduce homelessness and what people considered to be the three most important factors in tackling homelessness.

A total of 119 respondents provided some feedback - 81 homeless people and 38 non-homeless members of the public. The collated responses identified the following key themes:

- Accessibility of housing
- More and better temporary accommodation
- Coordinated action
- Volunteering
- Changing public perceptions

A further consultation exercise took place between December 2015 and January 2016. Nine meetings were held in a variety of locations with around 100 people participating. Around half of these were people who were homeless or recently homeless. This consultation laid the groundwork for the Manchester Homelessness Charter (see next section) and also provided the information that led to the formation of the first eight Street Support Action Groups.

Accessibility of housing

A key issue cited by respondents was the need to build more social housing and ensure that it is accessible for people without a home, especially those who require single-bed accommodation and those who struggle with rent or have Benefit sanctions, and to shorten or improve the Manchester Move application system.

> *"Need to re-house people quicker and forget past issues so they can have a better future. Life on the streets can be life and death"*

“Help more people who can't claim housing benefit”

“Help people with a deposit for private housing”

Other less consistently cited issues were linked to the perceived shortage of social housing, including immigration, the impact of benefit sanctions and the unwillingness of some private landlords to accept homeless people or those claiming housing benefit.

Incidences of benefit sanctions in Manchester have decreased over recent years and other welfare-related issues have become focal, notably the impact of the roll out of Universal Credit, for which there is plenty of anecdotal evidence of a detrimental impact on health and being a contributory factor of homelessness.

More and better temporary accommodation

Another prevalent theme was the perceived lack of temporary accommodation, including night shelters, hostels and B&Bs, and housing-related support or supported housing. Linked to this shortage were other issues, such as the lack of knowledge about help or shelter for young people, the lack of social activities in the absence of day centre capacity and indications that some homeless people prefer the streets to the available hostels and B&Bs. A significant minority of respondents called for vacant properties to be opened as shelters for homeless people, with some suggesting homeless people could earn money and skills contributing to renovation work.

“It's really hard as there's nothing to do when places like the Booth Centre are closed and there's nowhere to go”

“Provide more day centres and night shelters. Homeless people need somewhere to go to find food and advice and look for jobs”

“Make better use of empty buildings in the city to make homes and create jobs”

Coordinated action

The need for more coordination and collaborative working between councils and across the public, voluntary and private sector was a key theme from respondents. Many highlighted that services and funding should not be limited by LA boundaries and that coordinating individual services and support would give a more coherent and consistent support structure for homeless people. Linked to this was the stated need for more accessible services and information about what support is available. Safety and the need for protective action by the police and other services was also highlighted.

"When you're homeless you're homeless in Greater Manchester, not just Manchester. Councils all need to be working off the same page"

"Services need to make themselves better known among homeless people"

"Agencies should cooperate to come up with a new project for homeless people and make them feel like part of the community"

"Coordinate early help agencies like GPs and schools to help with mental health, substance abuse, harmful behaviour"

"[It needs a] joint effort with council to offer support groups and make donating items easier. Raise awareness of the causes of homelessness and how to spot a person at risk and intervene effectively"

Volunteering

A further theme was a call for greater use of, and opportunities for, volunteering and the need to develop better and more innovative ways of the public providing financial and material support. Linked to this, a significant minority of respondents explicitly mentioned alternative ways of giving, such as an alternative donation fund or more ways to donate clothes and food.

"Get involved. People who have got out of homelessness have one person they can point to and say that person made a difference to me"

"Encourage volunteering to reduce homelessness, and educate citizens on the causes and how to tackle it"

"Find ways to offer more support for people in vulnerable positions in terms of mental health. Talk to communities and businesses to increase support, and form more collaborative organisation"

Changing public perceptions

Respondents also highlighted the need to change public perceptions and awareness of homelessness and related issues, including the causes of homelessness, and for services to engage with homeless people to establish their specific individual needs. The public perception changes mentioned included protecting homeless people against violence and abuse, helping to alleviate the stigma surrounding homeless people and educating the public so that they can intervene effectively and early where there is a risk of someone they know becoming homeless.

"Be aware of our plight - more understanding and compassion, less judgement. Raise awareness and financial support, and recognise that anyone can end up on the street"

"Homeless people are made unsafe by the way in which people view them. Homeless people are the most vulnerable. We've been hit and kicked by drunken men on the way home. People die like that."

"Listen to people and recognise the signs that lead to homelessness - risks of family breakdown, alcoholism, risk taking behaviour can be helped and managed with greater effect"

"Work with people in a more caring way. Work out issues and find an easier way for people to cooperate with services"

"Improve [public] awareness of homeless services so people can be directed to them"

Other themes

Respondents also urged more employment and training opportunities for people without a home in order to give them the skills and experience necessary to find paid work and move off the streets. Feedback from people without a home also focused on desired changes to the delivery of services more broadly, including mental health support and the use of peer support to help homeless people and those who move into social housing.

"Organise employment kick-starter schemes and easily accessible jobs for homeless people"

"Provide support to people in properties. Hold their hand through the early journey, take small steps. Use people who have been through it before themselves"

"Improve mental health services. This is the number one issue"

"Find ways to offer more support for people in vulnerable positions in terms of mental health. Talk to communities and businesses to increase support, and form more collaborative organisations"

Homelessness Strategy Review

Manchester's Homelessness Strategy has recently been reviewed and a number of key issues have been identified, including:

- Increases in the number of rough sleepers in the city, resulting in a review of current responses
- Increases in the complexity of those presenting as homeless (particularly single homeless people), more people presenting as homeless as a result of being given leave to remain, and a large increase in numbers of people being given notice in the private rented sector
- Increased investment in services for homeless people, in particular, rough sleeper services (including winter provision) and homelessness prevention (supported by a national government programme of investment, and local city centre review work)
- Difficulties accessing affordable housing, including social housing and the private rented sector, leading to blockages in the flow of individuals from temporary and supported accommodation into independent living
- Welfare reform and access to employment opportunities
- Poor physical and mental health in the homeless population (particularly rough sleepers) compared to the general population, including high levels of complex needs and difficulties accessing general and specialist healthcare services.

These will inform the development of refreshed multi-agency action plans.

WHAT WOULD WE LIKE TO ACHIEVE?

Ill-health is a cause and consequence of homelessness: preventing ill-health amongst at risk populations, mitigating the impact of homelessness on health, and improving health as a means to enable people to progress towards a settled home, will contribute a number of ambitions for Manchester. These ambitions are described in a number of strategies and plans, including:

- Our Manchester community strategy (in particular the aspiration for a 'progressive and equitable city')
- Joint Health and Wellbeing Strategy 2016-2026 and A Healthier Manchester locality plan
- MHCC's vision and commissioning strategy (MHCC is a partnership between the Council and NHS Manchester Clinical Commissioning Group)
- Manchester's Homelessness Strategy and Charter, and health care standards

Our Manchester sets out a vision for a city that is:

- Thriving – with great jobs and the businesses to create them
- Full of talent – both home-grown and from round the world
- Fair – so everyone has an equal chance to contribute and to benefit

- A great place to live – with a good quality of life: a clean, green, safe city
- Connected –with world-class transport, and high quality broadband.

The strategy notes that the increased visibility of homelessness in the recent past, with more people sleeping on the streets in the city centre, was an issue raised during the public consultation. It goes on to highlight the fact that street homelessness is a particularly complex problem and people who are living rough can be particularly vulnerable and marginalised. Agencies are working together with the voluntary sector and businesses to ensure that those people who need and want it can access the shelter and services they need.

The **Joint Health and Wellbeing Strategy 2016-2026** is the overarching framework for reducing health inequalities and improving health outcomes in the city. The priority areas are:

- Getting the youngest people in our communities off to the best start
- Improving people's mental health and wellbeing
- Bringing people into employment and ensuring good work for all
- Enabling people to keep well and live independently as they grow older
- Turning round the lives of troubled families as part of the Confident and Achieving Manchester programme
- One health and care system – right care, right place, right time
- Self-care

Addressing the physical and mental health needs of homeless people in Manchester can contribute to improved outcomes across these priority areas.

Manchester's Locality Plan, **A Healthier Manchester** supports the Health and Wellbeing Strategy by identifying the most effective and sustainable way to improve the health and social care of Manchester people. Its priorities are to:

- Prevent people becoming ill and support them to live healthier lives by addressing the causes of ill health, spotting illness earlier, providing support earlier and managing illness better
- Improve services and the way we work together by transforming physical and mental healthcare services and commissioning
- Support staff and carers, provide modern and accessible buildings, and use technology to keep people well

Adults with complex needs are identified as a key cohort for consideration within health and social care integration and transformation activity.

Manchester Health and Care Commissioning's vision and aims

Manchester Health and Care Commissioning's (MHCC) vision:

- We are determined to make Manchester a city where everyone can live a healthier life
- We will support you and your loved ones, investing in what you tell us is important to you
- We will make sure you receive the right care in the right place and at the right time, delivered by kind, caring people that you can trust
- We will make the most of our money by reducing waste and funding the things we know will work
- We will forge strong partnerships with people and organisations, in the city and across the region, and put health and wellbeing at the heart of the plans for developing Manchester's future as a thriving city

MHCC's aims are to:

- Improve the health and wellbeing of people in Manchester
- Strengthen the social determinants of health and promote healthy lifestyles
- Ensure services are safe, equitable and of a high standard with less variation
- Enable people and communities to be active partners in their health and wellbeing
- Achieve a sustainable health and care system

Manchester's current **Homelessness Strategy** (2013/18) outlines the current partnership approach to addressing and reducing homelessness by:

- Preventing homelessness
- Improving housing
- Targeting support for groups at increased risk of homelessness
- Improving the health and wellbeing of homeless people
- Improving access to education, training and employment

Improving health and wellbeing focusses on:

- Planning for housing and support needs prior to discharge from hospital
- Recognising and responding to the health needs of homeless people within the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy
- Providing an integrated service response for homeless people with complex needs (e.g. co-existing mental health and alcohol/drug misuse)
- Removing the barriers that prevent homeless people accessing primary healthcare services
- Increasing awareness of health issues and services among accommodation and support providers and staff
- Ensuring health and social care transformation programmes address homeless peoples' health, including complex needs

An increased focus on reducing homelessness in Manchester has resulted in the development of a Manchester Homelessness Charter and Manchester Homelessness Partnership.

The **Manchester Homelessness Charter** describes a shared vision for ending homelessness in the city by bringing together people without a home/with lived experience of homelessness, support organisations and local businesses under the umbrella of the Manchester Homelessness Partnership in order to identify the key challenges and develop partnership responses. The Charter has been endorsed by Manchester's Health and Wellbeing Board and provides a set of guiding principles concerning the rights of homeless people and responsibilities of those providing support. It states that everyone working with people who are homeless or at risk of homelessness has a responsibility to provide a consistent approach across services and to work in meaningful partnership with other agencies to help end homelessness and that everyone who is homeless:

- Should have a right to a safe, secure home, along with the level of support that they need to create a good quality of life
- Has a right to feel safe from abuse, violence, discrimination, theft and degrading treatment; and expect the full protection of the law
- Has a right to respect. They should be treated with dignity and should receive good quality service, like any citizen
- Should be afforded equal access to information, services, and Manchester's institutions regardless of their accommodation status, age, gender, sexual orientation, nationality, ethnicity, religion or disability
- Has a right to play a part in determining their own solutions, in partnership with people from statutory, voluntary and faith-based organisations, businesses and institutions; and a right to play his or her role in society
- Should seek to articulate their needs, to engage with relevant services and to work with them in order to try to meet those needs; and accept support being made available to them when sufficient choice and opportunity is on offer.

The **Manchester Homeless Healthcare Standards,** endorsed by the Health and Wellbeing Board in February 2016, were developed to support statutory and voluntary agencies. They are:

- Health must form a significant element of any assessment of needs and remain a priority
- All homeless people must be registered with a GP
- All homeless people should be supported to engage with primary and secondary health care services
- Homeless people should be supported to be self-caring in relation to their health care
- Appropriate access to out of hours and emergency care

The Standards are supported by training for partner agencies to raise awareness about health issues for homeless people, and the responses currently available.

Public Health Outcomes Framework (PHOF)

The PHOF measures progress against public health outcomes across a range of domains, including specific indicators for statutory homelessness, namely eligible homeless people not in a priority need (indicator 1.15i) and households in temporary accommodation (indicator 1.5ii).

Evidence suggests there is also a relationship between homelessness experienced by working age adults and a range of other PHOF indicators as set out in the table below (indicator number given in brackets).[23]

Wider determinants of health: school readiness (1.02)	• adults in contact with secondary mental health services who live in stable and appropriate accommodation (1.06) • domestic abuse (1.11) • first time offenders and re-offending levels (1.13)
Health improvement	• smoking prevalence in adults (2.14) • successful completion of alcohol and drug treatment (2.15i-iii) • cancer screening coverage (2.20i-ii) • NHS health checks (2.22iii-v) • average Warwick-Edinburgh Mental Well-being Scale score (2.23v)
Health protection	• population vaccination coverage – Flu (at risk individuals) (3.03xv) • people presenting with HIV at late stage of infection (3.04) • incidence of, and treatment completion for TB (3.05i-ii)
Healthcare and premature mortality	• mortality rate from causes considered preventable (persons) (4.03) • mortality from communicable diseases (4.08) • emergency readmissions within 30 days discharge from hospital (4.11) • excess winter deaths (4.15)

Evidence Base for Effective Interventions

There is a wide evidence base demonstrating effective interventions to address health and wellbeing issues among people experiencing homelessness. Some of the key sources of evidence are listed below.

The Unhealthy State of Homelessness (Homeless Link, 2014) makes recommendations for action in the following areas:

- homeless people's access to healthcare services
- co-ordination of service provision for homeless people
- national policy for addressing the health inequalities experienced by homeless people

[23] Public Health England, 2016. *Homelessness: Applying All Our Health* [ONLINE] Available at: https://www.gov.uk/government/publications/homelessness-applying-all-our-health/homelessness-applying-all-our-health#facts-about-homelessness.

- quality of healthcare services provided to homeless people

Preventing homelessness to improve health and wellbeing (Public Health England, 2015) includes an evidence review into interventions that are effective in responding to health and wellbeing needs in households at risk of homelessness, with recommendations for policy and practice relating to the following areas:

- stronger leadership and joint strategic working
- access to advice and early intervention
- improving data collection and evaluation

Homelessness: Applying All Our Health (Public Health England, 2015) provides guidance for healthcare professionals responding to homelessness as part of the All Our Health programme (which provides a framework and call to action to healthcare professionals working with patients and the population to prevent illness, protect health, and promote wellbeing). The guidance outlines core principles for healthcare workers working with people who are homeless or at risk of homelessness, and suggests a range of interventions at population, community, service, and individual levels.

Improving access to health care for Gypsies and Travellers, homeless people and sex workers (Royal College of General Practitioners, 2013) provides evidence-based commissioning guidance for Clinical Commissioning Groups and Health and Wellbeing Boards on improving access to healthcare for vulnerable groups, including homeless people.[24] The guidance identifies a number of key principles for improving access to healthcare for socially excluded groups:

- Removing material and psychological barriers to services
- Improving joint working between professionals and voluntary sector organisations and other potential providers
- Asking the right questions and building up the data and evidence base
- Establishing proportionate and appropriate services where there is unmet need
- If users are not coming to the service, take the service to them

WHAT DO WE NEED TO DO TO ACHIEVE THIS?

The Manchester Homeless Partnership and the review of Manchester's Homelessness Strategy in 2018 presents an opportunity to further develop partnership activity to prevent homelessness arising as a consequence of ill-health, to mitigate the impact of homelessness on health and wellbeing and to protect and improve the health and wellbeing of people experiencing homelessness in Manchester, taking into account current evidence of need and effective interventions.

Based on the findings and recommendations from local and national homeless health needs audits, and the current guidance on improving the health and wellbeing needs of homeless people, the following objectives and action areas should be considered for inclusion in revised

[24] Royal College of General Practitioners, 2013. *Improving access to health care for Gypsies and Travellers, homeless people and sex workers.* Available at: http://www.rcgp.org.uk/policy/rcgp-policy-areas/health-inequalities.aspx

homeless strategy action plans and other partnership work currently underway to develop integrated health and social care responses to complex needs.

Access to housing, support and healthcare services

- Pathways and protocols for accessing appropriate accommodation and support prior to discharge from hospital and other institutions (e.g. prison, detox/rehab)
- All services in contact with people experiencing homelessness carry out holistic assessments of health and wellbeing needs (including physical and mental health and lifestyle issues) and support registration and engagement with mainstream healthcare services
- Regular audits of access to physical and mental healthcare services among people experiencing homelessness, in partnership with citizen and patient representative groups e.g. Healthwatch
- Develop and maintain pathways between housing and homelessness services and mental health services
- Continue to commission specialist healthcare provision for people experiencing homelessness
- Ensure that all health and care services routinely enquire and record information about patients'/service users' housing situation and identify potential homelessness as part of holistic health assessments (it is likely that the Homelessness Reduction Act 2017 will require services to refer patients to local authority housing options teams from 2018/19)
- Ensure that people with complex needs and long term conditions experiencing homelessness are able to access appropriate social care support

Leadership and strategic partnership working

- Recognise the homelessness and health relationship in the JSNA, Health and Wellbeing Strategy and Homelessness Strategy and Review
- Work closely with the Manchester Homeless Partnership
- Develop an 'every contact counts' approach for health and social care services identifying housing issues/homelessness, and housing and homelessness services identifying health and wellbeing issues
- Consider options for governance, accountability and monitoring implementation of the Manchester Homeless Healthcare Standards
- Involve individuals with experience of homelessness in the development of strategies, plans and services
- Recognise that improving homeless people's health and wellbeing is a key driver for reducing health inequalities and reflect this in healthcare planning, including healthcare actions to contribute to homeless prevention and reduction
- Ensure that strategic assessments of crime and disorder recognise the relationship between homelessness, health and offending

Prevention and early intervention

- Identify opportunities across partners for targeting homelessness prevention and healthcare interventions for key groups and settings e.g. primary and secondary healthcare, temporary and hostel accommodation
- Provide access and referral routes to financial advice to prevent people falling into debt, which is one of the biggest issues in causing homelessness
- Engagement with schools, early years and early help settings to raise awareness and identify children and families at risk of homelessness
- Provide information and training to increase awareness of homeless health issues and enable frontline health professionals to identify housing and homelessness risk and refer to appropriate services

Integrated service responses to complex needs

- Homeless health to be a central consideration in plans for new service models for integrated health and social care provision, particularly in relation to complex needs care models
- Provision of alcohol and drug and mental health information, early intervention and treatment services that are able to respond to the range of issues experienced by homeless people (e.g. co-existing mental health and substance misuse, new psychoactive substances)
- Improved communication and integrated case working across services, particularly in relation to individuals with complex needs e.g. co-existing physical health/mental health/substance misuse needs
- Consideration of the accommodation support needs of homeless people with long term conditions or needing palliative or end of life care
- Integrate a health service into the homelessness prevention pathway for 16-25 year olds provided by Centrepoint in order to make a more significant and joined-up impact on the health of young people experiencing homelessness in Manchester.

Data collection and evaluation

- Recording and sharing of data on housing status (for those accessing healthcare services) and physical and mental health (for those accessing housing/homelessness services), and outcomes of interventions to address these
- Development of effective metrics to evidence impact of homelessness prevention activity on wider partnership outcomes, and cost effectiveness/return on investment for services

Other issues

- Further research to understand the health and social care needs of particular groups within the homeless population e.g. migrants, women, to ensure that health and care services are responsive to specific needs of those groups

WHAT ARE WE CURRENTLY DOING?

Previous sections of this chapter describe the framework for action provided by the range of different strategies that exist in Manchester. This section describes some of the work that has been done to address the issues identified earlier on in this document, particularly by homeless people themselves (see the Lived Experience section).

Manchester Homelessness Partnership

In May 2016, a number of Action Groups were set up under the umbrella of the Manchester Homelessness Partnership in order to tackle some of the key challenges that people experiencing homelessness regularly face, such as access to mental health support, emergency accommodation and employment. Each Action Group includes people who have experienced homelessness, as well as those who have relevant skills or professional expertise.

The work of the Action Groups to date includes helping to improve the quality of night shelter accommodation through the development of co-produced minimum standards. There has been an increase in the provision of temporary accommodation. Another action group is working to tackle issues related to people being placed in B&B accommodation and left without support for long periods of time. Early intervention and prevention has been addressed by the Prevention Action Group. The Homelessness Reduction Act legislation will have an enormous impact on this once it is implemented in 2018.

The Big Change Fund has been set up as part of the work of Manchester Homelessness Partnership and has raised over £120,000 - £80,000 of which has been distributed to people who are rough sleeping or in danger of rough sleeping. The need to find alternative ways of donating clothes and food has been addressed by streamlining donating through Street Support and also by the Indoor Evening Provision Action Group. There are also many ongoing meetings and pieces of work aimed at educating businesses, students and the public about what is most needed, including via CityCo, Street Support, Big Change and other partners in the Manchester Homelessness Partnership.

The need to change public perceptions and awareness of homelessness and related issues, including the causes of homelessness, is being continually addressed an ongoing basis, as well as through high-profile arts events such as Manchester Street Poem, part of the Manchester International festival. This installation was co-produced by people with experience of homelessness, homelessness charities and artists and was seen by 3,500 people over a nine day period.

The development of more employment and training opportunities for people without a home is being addressed by the Employment Action Group and also the Business Support Group, as well as by the ongoing work of various charities. The Mental Health Action Group has attracted a huge number of people with lived experience of homelessness and mental health issues, and has done some excellent work.

The need for more accessible services together with information about what support is available is enshrined in the Homelessness Charter and has been addressed comprehensively, not least through the service provided by streetsupport.net in Manchester.

Manchester City Centre Review

A review was recently carried out in Manchester City Centre to create a better understanding of the complexities, demands and pressure points for services delivering in the city centre. The review focussed on the issues affecting the way the city centre looks and feels to users of the city centre including residents, businesses, visitors and front-line staff providing public services. Homelessness and rough sleeping were highlighted as priority issues for the city centre and were the most frequently mentioned areas of concern.

Solutions have been developed and co-produced by the Manchester Homelessness Partnership and are in the process of being delivered, including:

- More help to prevent people becoming homeless e.g. debt advice
- The development of an emergency hub to provide accommodation and support to prevent homelessness (the Longford Centre)
- An improved outreach and support offer to rough sleepers
- Better access to move-on accommodation and support for people to resolve their homelessness
- Developing a 24-hour, seven day week, offer for those who need it and addressing the current gap in evening provision

SERVICES

Primary care

Urban Village Medical Practice (UVMP) is a GP practice based on the outskirts of the city centre. The practice provides primary healthcare to over 10,000 registered general patients, a specialist primary healthcare service for homeless patients plus a hospital in-reach service to homeless patients at Manchester Royal Infirmary (MRI).

The practice provides the following healthcare support and interventions for homeless people:

- Proactive engagement with homeless people including outreach and hostel drop-ins by clinical and non-clinical staff to enable registration and engagement with the practice or other health advice
- Flexible and accessible range of services including GP, nurse, tissue viability service, alcohol services, drug assessment and treatment, mental health services and dentist
- A hospital in reach service by clinical and non-clinical team members offering assessment of medical and social needs and discharge planning for homeless patients that are admitted
- Case management of homeless patients that are frequent attendees at MRI A&E to address health and social needs in order to reduce the impact on secondary care
- Additional support for all homeless patients in relation to benefits, outpatient appointments and housing options

The service also works strategically to promote homeless health. It has developed the Manchester Homeless Healthcare Standards and delivered training for all agencies in the city to support this.

Other primary care services

Revive Dental Care works in partnership with Urban Village Medical Practice, the Booth Centre and others in Manchester. Revive has also worked with Groundswell, a London-based peer advocacy charity who recently published Healthy Mouths to raise awareness of, and improve, oral health amongst people who are described as 'hard to reach'.

Vision Care for Homeless People provides a service at the Cornerstone Day Centre.

With services in Openshaw, Audenshaw and Oldham, it is understood (from Just Life and UVMP) that Pharmaco has developed its services to respond to the needs of people experiencing homelessness, specifically people who are living in unsupported temporary accommodation who often have multiple and complex needs and chaotic lifestyles.

Mental health services

Greater Manchester Mental Health NHS Foundation Trust provides a range of mental health, social care and wellbeing services for people of working age both in hospital and in the community. Services focus on individual recovery and also include employment support, help with alcohol and drug misuse and support with housing. The Trust provides crisis intervention services, and mental health liaison teams within Accident and Emergency departments.

The Manchester Engagement Team (MET) Service is a partnership between the Greater Manchester Mental Health NHS Foundation Trust and Manchester Mind, a voluntary sector organisation and registered charity. The Service is delivered as a dedicated strand of Manchester's Community Mental Health Service and works specifically with people who have been involved with mental health services and who, for various reasons may find it difficult to engage. MET also provides Housing and Welfare Rights Advice, which is an essential part of the service for several reasons as MET service users present with many issues which can cause or be compounded by low income, inadequate housing or homelessness and debt.

In addition, the Manchester Engagement Team (Homeless Pathway) works with homeless people who have dropped out of Trust services. Some of the service users may have had an undiagnosed Serious Mental Illness (SMI) compounded by past trauma issues, poor coping mechanisms and personality disorder. Clients are often difficult to reach and mistrustful of anyone representing authority. The team work with service users who have severe and enduring mental health issues, visiting day Centre's and outpatient clinics to improve the service user's quality of life.

Allied health services

There is a monthly podiatry service available at the Urban Village Medical Practice.

Public health services

Sexual and reproductive health services are available in Manchester at the Urban Village Medical Practice. Smoking cessation and diet and nutrition services are also on offer to people experiencing homelessness at the Urban Village Medical Practice.

Manchester Integrated Alcohol and Drug Service (MIDAS) operates citywide from a number of community-based venues, providing alcohol and drug early intervention and treatment services for adults using a variety of substances (including new psychoactive substances). Services delivered include needle exchanges, alcohol and drug awareness and early intervention training for agencies, self-help materials, brief interventions, targeted outreach and in-reach for vulnerable and high-risk groups, structured treatment programmes for alcohol and drug dependency, and recovery and reintegration support (e.g. relapse prevention, access to accommodation and education/employment/training, and peer support and mutual aid).

Secondary care

There is a Greater Manchester Homeless Hospital Discharge Protocol in place. This is currently under review by the University of Salford. Feedback during the mapping exercise suggests that this is not always (and increasingly so) being followed by hospitals, and people experiencing homelessness can be released without accommodation.

The Urban Village Medical Practice is also commissioned by MHCC to deliver a hospital discharge service, known as MPath. This is a hospital in reach service at Manchester Royal Infirmary and North Manchester General Hospital, with commitment to extend to Wythenshawe Hospital, the service actively case manages homeless people admitted to hospital, assessing needs and working innovatively to address them, and providing an effective discharge plan. Case management is also provided for homeless frequent attenders to the A&E department.

Other services

In Manchester the Urban Village Medical Practice identified St Ann's Hospice as providing medical respite and palliative care for people experiencing homelessness. This provision was not identified by any other locality.

Inspiring Change Manchester (ICM): Developed by service users and partners from across the voluntary and public sectors in the city and funded by the Big Lottery Fund, ICM aims to deliver a programme of services for people with multiple and complex needs who are disengaged from services, focusing on providing the right range of services at the right time to address the barriers to those individuals leading fulfilling lives. ICM supports adults with multiple needs as defined as having two or more presenting needs from the following: homelessness, reoffending, substance misuse, mental ill-health. Mental health support is a key component of the service offer. Self Help Services (a user-led mental health charity) provide a mental health pathway on the programme.

Centrepoint: Centrepoint in Manchester provides the Homelessness Prevention Pathway for young people between 16 and 25 years of age, including housing options, move-on tenancies and housing related support in the community. Given the prevalence and increase of substance misuse issues and mental health conditions experienced by young homeless people, Centrepoint is exploring opportunities for replicating its dual diagnosis and psychotherapy programmes in Manchester via a mixed funding approach, including fundraised income from the private sector. This needs to be combined with commissioned services for the offer to make a significant and joint up impact. This development will diversify the homelessness prevention offer to young people in Manchester, add to existing capacity within the city and help to integrate a health service into the homelessness prevention pathway.

OPPORTUNITIES FOR ACTION

The main opportunities for action are:

The **development of a new homelessness strategy in 2018**, of which protecting and improving health and wellbeing, and reducing health inequalities will be core. The process of strategy development will be led by the Manchester Homelessness Partnership, with input from the recently formed Manchester Health and Homelessness task and finish group (members of the Partnership are also on this group).

Health and social care integration. The Manchester Locality Plan - *A Healthier Manchester* – describes how integration will improve health outcomes in Manchester, while also moving towards long-term financial and clinical sustainability. There will be a single commissioning system; a single local care organisation; and a single Manchester Hospital service.

The local care organisation is a partnership that will bring hospital, community healthcare services (including mental health), the council and the voluntary sector together and is part of the transformational approach to improve outcomes for people of this city. There has been an initial focus on developing models of care for integrated adult social care and community/district nursing; the next stage will be to broaden this focus to develop integrated care models for wider cohorts of individuals at high and rising risk of poor health outcomes, one of which is adults with complex lives (defined as a combination of risk factors such as: mental health issues, social isolation, homelessness, being out of work, involvement with criminal justice system, alcohol/drug dependency or misuse)**.**

Greater Manchester Health and Social Care Partnership and the Greater Manchester Combined Authority have acknowledged the homelessness and health relationship and are working together to establish plans. The Greater Manchester Health and Social Care Partnership has made an initial commitment for change, most of which (e.g. hospital discharge, and GP registration) MHCC is already delivering on (see Manchester's Homeless Health Care Standards). Going forward, there is an opportunity to inform further change and influence Greater Manchester resources to contribute to improved health and wellbeing for this population e.g. through the Social Impact Bond for entrenched rough sleepers.

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OTHER RELATED JSNA TOPICS

- Adults with Complex Lives

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It is hoped that you have found this topic paper useful. If you have any comments, suggestions or have found the contents particularly helpful in your work, it would be great to hear from you.

Responses can be sent to jsna@manchester.gov.uk