# Tower Hamlets Health Scrutiny Sub-Committee

# Health & Social Care Provision for Homeless Residents

## Scrutiny Review

TOWER HAMLETS

March 2018

## Chair's Foreword

I am pleased to present this report which explores the provision of health and social care services for homeless people in Tower Hamlets. Homeless people experience some of the worse health in society. Many homeless people suffer from a combination of complex physical health, mental health and substance misuse issues. Yet, despite this, homeless people often struggle to access the appropriate health and social care services they need. This is illustrated by the fact that the average life expectancy of a rough sleeper in Tower Hamlets is 44, compared to 77 for the general population. Rough sleepers are the most visible representation of homelessness however it can present itself in many forms including those in temporary accommodation, people fleeing domestic violence, and more hidden homelessness such as sofa surfers. The council must address this and ensure that all homeless people are able to access the health and social care services they need.

It is clear to me that in addition to providing much needed provision to some of our most vulnerable residents, improving the health of homeless people also provides the opportunity to reduce demand on the NHS and make savings during a time of public sector funding cuts. Too often homeless people access health services when their symptoms have become so critical that they are likely to require more intensive and more expensive treatment, leading to a disproportionate reliance on emergency and acute services and avoidable emergency admissions to hospitals. Further work is required to provide more preventative care and services need be more proactive in identifying the health needs of homeless people to allow an early diagnosis before they present at primary care and A&E with multiple and entrenched problems.

Although there are a lot of things services in Tower Hamlets do well to support the health and social care needs of homeless people, there is always room for improvement. There are currently too many homeless people encountering issues registering at a GP surgery and access to this key pathway must improve. Many homeless people have had negative experiences of health and social care services and feel that presumptions made about them leads to them receiving poorer care. Further work is needed to support frontline workers to effectively engage with homeless people and gain their trust. There are also key gaps in understanding the relationship between domestic violence and homelessness, meeting the needs of a cohort of homeless people with more extreme behaviour, and integrating the provision of health and social care.

This report therefore makes a number of practical recommendations for the council and its partners for improving the services available for homeless people. The recommendations focus on providing training to frontline workers to support them to engage with homeless people and gain their trust, exploring commissioning options for the more challenging and harder to reach homeless residents, performing research to better understand the relationship between homelessness and domestic violence, and establishing a partnership

forum to support information sharing across the key agencies involved in providing health and social care services to homeless people.

I would like to thank all of the council officers, health partners and a wide range of organisations from across the borough who gave their time and effort to contribute to this Review. I am also grateful to my Health Scrutiny Sub-Committee colleagues for their support, advice and insights.

**Councillor Clare Harrisson**
**Chair of the Health Scrutiny Sub-Committee**

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## 1. Recommendations

| | |
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| **Training** | |
| R1 | That the CCG provides training to staff in GP surgeries and for other health professionals to support them to deal with some of the behaviours which may be encountered when engaging with homeless people. |
| R2 | That LBTH Adult Social Care and the CCG explore the possibility of providing all frontline workers and auxiliary staff (i.e. staff in ideas stores, parks service) with training and awareness raising sessions to help them identify and signpost the hidden homeless, and how to ask the appropriate questions without offending them. Information on provision for homeless people should be made available at all public facing council services. |
| **Commissioning** | |
| R3 | That the council explores the possibility of commissioning specialist provision to accommodate individuals with challenging behaviour (older people, substance misuse issues) who can no longer remain in mainstream provision for their safety or the safety of others. Many of these individuals are beyond the point where traditional treatment programmes are appropriate. |
| R4 | That the council and CCG review how palliative care is provided to people living in hostels and temporary accommodation. |
| R5 | That the CCG explore the possibility of commissioning a peripatetic team consisting of a paramedic and advanced care practitioner in mental health to provide a visiting service to very difficult to manage and violent patients. |
| **Service Improvement** | |
| R6 | That a person's housing issues are identified and addressed as part of the social prescribing programme in the borough. |
| R7 | That Barts Health Trust reviews its discharge planning process to ensure that staff routinely ask all patients on admission if they have somewhere safe to be discharged to. Where a housing issue is identified a referral should be made as soon as possible to the Pathway Homeless team so that appropriate support is put in place before discharge. Where patients who are homeless or in insecure accommodation had a package of care in place prior to the admission ward staff should notify social services on admission so they are aware and again on discharge so that the care can be restarted. |
| R8 | That the council and the CCG review the way services share information and consider if the introduction of GDPR and the review of |

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| | systems that follows will allow for more information to be shared between services to support the way homeless residents access and engage with services. |
| R9 | That the Housing Options service works with organisations involved in this Review, and with individuals who present at Housing Options, to find out what they consider to be a safe offer of temporary accommodation and provide insight into what they value and how they would feel better supported upon approach. |
| **Domestic Violence and Violence Against Women and Girls** | |
| R10 | That the council performs further research on the impact homelessness has on the health needs of women who are rough sleeping, in Temporary Accommodation, or hostels. |
| R11 | That the council performs further research into the relationship between homelessness and VAWG with a view to updating the VAWG strategy to include a stronger consideration of violence against homeless women. |
| **Partnership Working** | |
| R12 | That LBTH Adult Social Care explores the possibility of establishing a partnership forum (including commissioners, providers, third sector) to discuss the health and social care issues, provision, and cases of homeless residents in LBTH. |
| R13 | That Healthwatch Tower Hamlets reach out to the organisations involved in this Review and establish a link to share the information they collect on homeless people's experiences of using health and social care services in the borough. |
| R14 | That Healthwatch Tower Hamlets work with Groundswell to disseminate 'My Right to Healthcare' cards across the borough and ensure they are available in all GP surgeries. |

## 2. Introduction

2.1. The Tower Hamlets Health Scrutiny Sub-Committee identified the effectiveness of health and social care provision for homeless residents as the subject for a Scrutiny Review. Homelessness is a complex and growing problem which reaches right across the health, public health and social care agendas. It has been a historic problem in Tower Hamlets and the borough has the 9th highest number of homeless people in the United Kingdom[1]. It continues to be a pressing issue due to reforms to the welfare system, the austerity measures of the current government, and the ongoing national housing crisis, which is creating affordability pressures in the owner-occupier and rental sectors.

2.2. Chronic homelessness is an associated marker for tri-morbidity; meaning homeless residents are vulnerable to a combination of physical ill-health, mental ill-health, and substance misuse. Homeless households experience significantly poorer health outcomes than the general population and their health issues are more complex and exacerbated. The average age of death for a homeless person is 30 years below the national average[2]. There are also serious challenges around hospital discharge as evidence indicates that more than 70% of homeless people are discharged from hospital back onto the street, without their housing or underlying health problems being addressed.[3]

2.3. Homeless households may experience difficulty accessing health and social care services and they have a disproportionately high reliance on unplanned health care services and A&E. For them, their health may be a secondary priority, meaning they have a high level of missed outpatient appointments and they do not access early stage or preventative treatment. Subsequently, their health problems only get addressed when they become acute[4]. Additionally they experience challenges in accessing primary care as they encounter difficulty registering with a GP. This is often due to their inability to prove permanent residence within a catchment area or provide the appropriate documentation required to register with a GP. This leads to a heavy dependence on acute health services which has significant cost and demand pressures on the NHS. National evidence indicates that the number of A&E visits and hospital admissions is four times higher for homeless people than for the general public[5], and the Department of Health estimates that the annual cost of hospital treatment alone for homeless people is at least £85 million a year. This

[1] Shelter, Health Scrutiny Presentation, 2018
[2] 'Homelessness Kills: An analysis of the mortality of homeless people in early twenty first century England' (Crisis, 2012)
[3] 'Improving Hospital Discharge and Admission for people who are homeless', (Homeless Link and St Mungos, 2012)
[4] Royal College of General Practitioners statement referenced in: Rough Treatment for Rough Sleepers, an investigation into the way that medical treatment for homeless people could improve, Brighter Futures Academy research paper, No. 6/11, September 2011
[5] Homeless Link Report "The unhealthy state of homelessness: Health audit results" 2014

means costs of more than £2,100 per person compared to the £525 per person cost among the general population[6].

2.4. The Sub-Committee wanted to review the quality of provision for homeless residents in order to develop a clear understanding of the health and social care issues they experience in terms of outcomes and service provision, with a view to informing the future commissioning and provision of health and social care services for this group of people. The Scrutiny Review is underpinned by four key questions:

- What are the main barriers in providing effective health and social care for homeless residents in Tower Hamlets?
- How do health outcomes for homeless residents in Tower Hamlets differ from the wider population?
- What is the response to addressing the health and social care issues for these groups from local health and social care commissioners and providers?
- What more can health and social care providers do to address inequality in access and outcomes for homeless residents?

## Review Approach

2.5. The review was chaired by Councillor Clare Harrisson, Chair of the Health Scrutiny Sub-Committee and supported by Daniel Kerr, Strategy, Policy and Performance Officer; LBTH.

2.6. To inform the Sub-Committee's work two evidence gathering meetings were undertaken in February 2018. These included:

- **Wednesday 7th February 2018**

  The first evidence gathering session set out the context to the review, and invited commissioners and providers from the London Borough of Tower Hamlets and the NHS to inform the Sub-Committee of the current service provision available to homeless residents. Public Health presented a summary of the findings from the LBTH Homelessness Joint Strategic Needs Assessment (JSNA) which formed the context for the review. Colleagues from Tower Hamlets Clinical Commissioning Group (CCG), East London Foundation Trust (ELFT), and Barts Health Trust delivered a joint presentation on the health services and

[6] McCormick B (2010) Healthcare for single homeless people, Office of the Chief Analyst, Department of Health

access points available to homeless residents. They provided particular consideration to the role of Health E1 and the Pathways Homeless team at the Royal London Hospital. The LBTH Commissioning team and Adult Social Care service then delivered a joint presentation which detailed the social care services available for homeless residents in the borough. They were supported in their presentation by colleagues from Providence Row Housing Association, Edward Gibbons House and Lookahead, who each provide hostel services for LBTH. Finally, the LBTH Drug and Alcohol Action Team (DAAT) provided information on substance misuse issues for homeless residents and how the council is responding to them.

- **Thursday 15th February 2018**

  The second evidence gathering session invited homeless residents and their advocates to share with the Sub-Committee their experiences of accessing and utilising health and social care services in the borough. The meeting began with a presentation from Shelter who provided an overview of the key health and social care issues for homeless residents at both a national and local level, and suggested how approaches to providing services for homeless residents could be improved. This was followed by a presentation from Groundswell Homeless Health Peer Advocacy service, Providence Row Housing Association and St Mungo's who detailed the barriers their clients face in accessing and using health and social care services and made suggestions on how provision could be improved to better meet their needs.

- **Monday 5th March 2018**

  At the Health Scrutiny Sub-Committee meeting on the 5th March 2018 members of the Sub-Committee discussed the findings from the two evidence gathering meetings and developed recommendations.

**Health Scrutiny Sub-Committee Members**

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| Councillor Clare Harrisson | Health Scrutiny Sub-Committee (Chair) |
| Councillor Rachael Saunders | Health Scrutiny Sub-Committee Member (Vice Chair) |
| Councillor Khales Uddin Ahmed | Health Scrutiny Sub-Committee Member |
| Councillor Peter Golds | Health Scrutiny Sub-Committee Member |
| Councillor Muhammad Ansar Mustaquim | Health Scrutiny Sub-Committee Member |
| Councillor Abdul Asad | Health Scrutiny Sub-Committee Member |
| David Burbidge | Health Scrutiny Co-Opted Member (Healthwatch) |

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| Tim Oliver | Health Scrutiny Co-Opted Member (Healthwatch) |

The panel received evidence from a range of officers and partners including;

**London Borough of Tower Hamlets**

| | |
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| Denise Radley | Corporate Director of Health, Adults and Community Services |
| Somen Banerjee | Director of Public Health |
| David Jones | Interim Divisional Director Adult Social Care |
| Karen Sugars | Acting Divisional Director, Integrated Commissioning |
| Aneta Wojcik | Commissioning Manager |
| Stephanie Diffey | Interim Service Manager, Adult Social Care |
| Rachael Sadegh | Substance Misuse Service Manager |
| Kath Dane | Street Population Coordinator – Rough Sleeping Lead |
| Rafiqul Hoque | Head of Housing Options |
| Lade Ogunseitan | Housing Options |
| Seema Chote | Team Manager, Statutory & Advocacy Team, Housing Options |
| John Harkin | Client Support -Assistant Lettings Manager, Housing Options |

**NHS**

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|---|---|
| Jenny Cook | Deputy Director for Primary and Urgent Care, Tower Hamlets CCG |
| Chima Olugh | Primary Care Commissioning Manager, Tower Hamlets CCG |
| Edwin Ndlovu | Tower Hamlets Borough Director, East London Foundation Trust |
| Michael McGhee | East London Foundation Trust |
| Paulette Lawrence | East London Foundation Trust |
| Peter Buchman | Clinical Lead Pathway Homeless Team at Royal London Hospital |
| Dan Gibbs | Director of Operations<br>Royal London and Mile End Hospitals, Barts Health Trust |
| Alfred Overy | Barts Health Trust |
| Chris Banks | Chief Executive, Tower Hamlets GP Care Group |

**Third Sector**

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|---|---|
| Mary Kneafsey | Assistant Director Client Services, Providence Row Housing Association |

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|---|---|
| Simon Harold | Manager, Edward Gibbons House |
| Katie Davies | Look Ahead, Service Manager |
| Kellie Murphy | St Mungo's<br>Regional Director South and East London and South England |
| Laura Shovlin | TH SORT Service Manager |
| Vicky Steen | TH SORT Team Coordinator |
| Sam Byers | Resilience Worker, Shelter |
| John Driscoll | Peer Advocate Caseworker, Groundswell |
| Martin Murphy | Project Manager, Groundswell |
| Micky Walsh | Crisis |

## 3. Defining Homelessness

3.1. Legally, someone is homeless if they do not have a right to occupy accommodation or if the accommodation is of such poor quality that they cannot reasonably be expected to stay there. However, the Health Scrutiny Sub-Committee acknowledges that Homelessness presents itself in many forms and is about much more than suitable accommodation:

> *"Homelessness is about more than rooflessness. A home is not just a physical space; it also has a legal and social dimension. A home provides roots, identity, a sense of belonging and a place of emotional wellbeing. Homelessness is about the loss of all of these. It is an isolating and destructive experience and homeless people are some of the most vulnerable and socially excluded in our society".*[7]

3.2. Most research on homelessness and health relates to street homelessness and hostel dwellers as it is this cohort who present with the most complex needs. The Sub-Committee recognises that the health and social care needs of homeless residents varies significantly depending on circumstances and therefore aims to include as many experiences of homelessness as possible in the Scrutiny Review, including:

**Statutory Homelessness**

If an individual or household is accepted by the local authority as meeting the criteria set out in the Housing Act 1996, they will be deemed statutorily homeless. Statutory homelessness may apply to people who have no access to housing of any type, or who have access to housing which is unsuitable for their needs. If the applicant is also deemed to be in priority need, the local authority has a duty to

[7] Crisis

provide them with accommodation. If they are not in priority need, the local authority should provide them with housing advice[8].

**Priority Need**

A household or person is likely to be considered in priority need if[9]:

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

**Threatened Homelessness**

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

**Hidden Homelessness**

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

**Rough Sleeping**

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

## 4. National Context

4.1. Homelessness was first defined in legislation in the Housing (Homeless Persons) Act 1977, which made it a requirement of the housing authority to house homeless households that are vulnerable or have dependent children. This was developed in the Housing Act 1996 which placed a duty on local authorities to provide accommodation for a broader group of eligible people, in priority need, and who are not deemed to be 'intentionally homeless.' Following on from this, the Homelessness Act 2002 was the first piece of legislation which

[8] Housing Act 1996

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

mandated local authorities to implement strategies to prevent homelessness. The recent introduction of the Homelessness (Reduction) Act 2017 requires that a housing authority should provide help for any homeless individual or household, regardless of whether they would have been deemed to be in priority need under previous legislation. It also requires statutory bodies, including healthcare providers, to notify the housing authority of all cases of homelessness (the 'duty to refer'). It extends the period of 'threatened homelessness' from 28 to 56 days and introduces further conditions relating to people who are deemed to be intentionally homeless.

4.2. The 'duty to refer' is expected to come into force from October 2018. This provides an opportunity to strengthen the relationship between health services and local authorities' housing teams and develop a cooperative way of working that improves homelessness prevention.

4.3. The London Homeless Health Programme (LHHP) was developed in response to the large and growing issues associated with homelessness and rough sleeping. The programme is part of the Healthy London Partnership, which is collaboration between all 32 London CCGs, and NHS England London region. As part of the LLHP, extensive consultation was undertaken with more than 100 NHS and non-NHS organisations across London, including all CCGs and many service providers, to develop ten key commitments for CCGs which suggest best practice and would improve healthcare services for the homeless population[10]:

- People who experience homelessness receive high quality healthcare.
- People with a lived experience of homelessness are pro-actively included in patient and public engagement activities, and supported to join the future healthcare workforce.
- Healthcare 'reaches out' to people experiencing homelessness through inclusive and flexible service delivery models.
- Data recording and sharing is improved to facilitate outcome-based commissioning for the homeless population of London.
- Multi-agency partnership working is strengthened to deliver better health outcomes for people experiencing homelessness.
- People experiencing homelessness are never denied access to primary care.
- Mental health care pathways, including crisis care, offer timely assessment, treatment, and continuity of care for people experiencing homelessness.
- Wherever possible people experiencing homelessness are never discharged from hospital to the street or to unsuitable accommodation.

[10] Healthy London Partnership 2016. Healthcare and people who are homeless: commissioning guidance for London

- Homeless health advice and signposting is available within all urgent and emergency care pathways and settings.
- People experiencing homelessness receive high quality, timely, and co-ordinated end of life care.

4.4. The NHS Five Year Forward View promotes preventative work, engaging the community in health provision decisions, and forging stronger ties with the voluntary sector. These are all key components to working with the homeless population; a population which is isolated and often reliant on voluntary sector programmes.

4.5. 'No Second Night Out' was introduced by the London Mayor in 2011 and aims to ensure rough sleepers are rapidly referred and given emergency accommodation to prevent a second night of sleeping rough. Following on from this, Making Every Contact Count was launched, which is the government's strategy for reducing homelessness through joint working and preventative measures.

4.6. The Ministry of Housing, Communities, & Local Government (MHCLG) collates information on rough sleepers based on a single night snapshot that is taken annually in England using street counts and intelligence driven estimates. Local authorities' counts and estimates show that 4,751 people slept rough in England on a snapshot night between 1st October and 30th November 2017[11]. This is up 617 (15%) from the autumn 2016 total of 4,134. Of these, there were 1,137 rough sleepers in London, which accounts for 24% of the total England figure. This is an increase of 18% from the 2016 figure of 964.

4.7. Of the 4,751 rough sleepers counted in autumn 2017, 653 (14%) were women, 760 (16%) were EU nationals from outside the UK, 193 (4%) were from outside the EU and 402 (8%) did not disclose their nationality. The majority of rough sleepers were above the age of 25 with 366 (8%) aged 18-25. There were 3 people, or less than 0.1% of the England total, who were under 18 years old.

4.8. The Combined Homelessness and Information Network (CHAIN) is a multi-agency database recording information about people seen rough sleeping by outreach teams in London. It is not comparable to data captured by the MHCLG as it fundamentally differs in its method of collecting data. It is a count of all individuals who were seen sleeping rough on the streets of London on at least one night during the year between 1 April 2016 and 31 March 2017. It is much more comprehensive and inclusive than street count data, which represents a snapshot of people seen rough sleeping on a single night.

4.9. CHAIN data found that a total of 8,108 people were seen rough sleeping in London during 2016/17, which is virtually unchanged from the total of 8,096 people seen in 2015/16. Of these people, 5,094 were

[11] Ministry of Housing, Communities and Local Government. Rough Sleeping Statistics Autumn 2017

new rough sleepers, who had never been seen rough sleeping in London prior to April 2016. Amongst the new rough sleepers, 3,666 (72%) were seen rough sleeping on just a single occasion during the year.[12]

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

## 5. Local Context

5.1. The average life expectancy of a rough sleeper in Tower Hamlets is 44, compared to 77 for the general population. The major contributing factors to this disparity include liver disease, respiratory disease, and the impacts of substance misuse. The homeless population in Tower Hamlets, defined by those registered at Health E1, also suffer a burden of serious mental illness that is thirteen times higher than Tower Hamlets average. A&E visits for homeless people are four times higher than the Tower Hamlets average.

5.2. CHAIN data shows that the number of rough sleepers in Tower Hamlets has increased at a greater rate than across London in recent years. The causes of this increase are likely to be the same as those for the national increase in statutory homelessness.

5.3. Between April 2016 and March 2017 CHAIN saw 445 unique cases of people sleeping rough in the borough, an increase of 13% on the previous year[13]. Of the 445 rough sleepers identified in Tower Hamlets by the CHAIN methodology, 186 people (42%) were identified as sleeping rough in previous years. In addition to this, 259 people were identified as new rough sleepers. Of the 190 people whose last settled base was recorded, 47.4% had been living in long-term accommodation immediately prior to first being seen rough sleeping. 11.6% had been in temporary accommodation or hostels, 11.6% had newly arrived in the UK, and 3.7% had been released from an institution (hospital or prison). Of all the rough sleepers (new or previously known), 45% had experienced time in prison, 10% had been in the armed forces, and 9% had been in care.

5.4. The majority of rough sleepers are male (83%), which is similar to the proportion in London as a whole. However, the number of women sleeping rough has been increasing, and more than doubled from 8% in 2015/16 to 17% 2016/17.

[12] St Mungo's. Chain Annual Report, 2016-17.

[13] CHAIN 2017. Annual report 2016/17: Tower Hamlets

5.5. More than half (58%) of rough sleepers are UK citizens. A further 24% are from the European Economic Area, representing a reduction in both numbers and proportion of the total EEA rough sleepers from the preceding year. The ethnic breakdown of the homeless population does not mirror the borough as a whole. The Asian or Asian British population makes up a large proportion of the statutorily homeless population, but a minority of rough sleepers. 60% of the statutory homeless population are Asian/Asian British, 18% are White, and 18% are Black/Black British. In comparison, rough sleepers in the borough are 57% White, 15% Asian/Asian British, and 20% Black/Black British.

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

5.7. Although not broken down into directly comparable age groups, it is clear that the majority of both rough sleepers (82%) and those who are statutorily homeless (73%) are aged between 25 and 59. A greater proportion of the statutorily homeless are aged under-25.

5.8. Of 8,065 acute bed days lost to Delayed Transfers of Care at RLH in 2017, 1459 (18.09%) were attributable to homelessness and housing issues. It was the 2nd most common of the 10 delay categories and accounted for almost as many bed days lost as delays awaiting residential homes, nursing homes and care packages combined (total 1490). Of 711 patients who were counted as Delayed Transfers of Care in the year, 148 (20.82%) were affected by homelessness or housing issues. The average amount of days any patient spent on the DToC list was 11.26. For homelessness and housing delays, it was slightly lower at 9.93.

## 6. Health and social care provision available for homes residents in LBTH

### Heath E1

6.1. Health E1 is the specialist General Practice surgery for homeless people in Tower Hamlets. East London Foundation Trust assumed responsibility for managing Health E1 in 2013. It aims to improve homeless residents' wellbeing, provide timely and appropriate intervention and accommodate their transient and chaotic lifestyles. A CQC inspection of the practice in 2016 rated the service as 'Good' overall.

6.2. The practice is open between 8:00am-6:30pm, and offers walk in clinics every morning. Patients can also book up to one month in advance with a named clinician. The practice also provides specialist in-house support and offers mental health nurse appointments, substance misuse clinics, a blood-borne virus testing service, and appointments with a Consultant Psychiatrist and a Psychologist. As there may not be a further opportunity to treat the patient the practice aims to test and treat as much as they can in one visit.

6.3. The practice currently has 1264 patients registered. Currently 53% of patients registered have a substance misuse issue, and 20% are receiving anti-psychotic medication. The occurrence of certain conditions is far higher in this population as is demonstrated by the Quality Outcomes Framework (QOF) indicators. The prevalence of severe mental illness, such as schizophrenia and bipolar disorder, is 13 times higher than in the rest of the borough, and the prevalence of Chronic Obstructive Pulmonary Disease (COPD), is four times greater[14].

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

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

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

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

[14] Public Health England Fingertips, National General Practice Profiles, QOF 2015/16

## Royal London Hospital Pathway Homeless Team

6.6. The CCG commissions the in-hospital Pathway Homeless team at the Royal London Hospital. It provides care to inpatients who are homeless or at risk of becoming homeless, with a view to improving their outcomes after discharge. They aim to facilitate timely, safe and well-co-ordinated hospital discharge as well as discharge to accommodation wherever possible. The service aims to prevent the 'revolving door' scenario of homeless people being treated, discharged and then returning to hospital with worsening health problems because they have nowhere to go and no suitable support in place.

6.7. The Pathway Homeless Service operates an integrated model that combines a range of specialities and includes; a GP from Health E1, nurses, a social worker and a care navigator with a lived experience of homelessness. The integration between secondary care and primary care is improved as clinical leads work in both sectors, which allows vulnerable adults to receive continuity of care.

6.8. The service aims to ensure there is a joined up approach to treating a homeless resident who presents at the hospital by co-ordinating different services around the individual. For example, if somebody is in a hostel and has alcohol related dementia it can be challenging to get this person diagnosed as it is difficult to perform an assessment. If they present in hospital this is an opportunity to get a psych team to assess them, receive occupational therapist input and consult social services, which is very difficult to achieve in a community setting.

6.9. The Pathway Homeless team facilitates weekly multidisciplinary meeting between primary care, secondary care, housing, social care and the voluntary sector. This has helped to shape relationships between the different agencies and made the process for discharging and finding suitable accommodation for patients much more effective.

6.10. In 2016/17 the Pathway Homeless team was notified of 306 inpatients, of which 296 were unique cases. The average length of admission was 11.8 days, with an average of 10 days spent under Pathway management. Just under half (40%) of the admissions were related to drugs, alcohol, or a combination.[15]

6.11. The Pathway Homeless Service conducted a randomised control trial of this in-hospital intervention at the Royal London Hospital and the Royal Sussex County Hospital in Brighton. It found that, although the intervention did not significantly reduce length of stay or likelihood of re-admission, it significantly increased quality of life scores in the group which received the intervention, demonstrated by an increase in EQ-5D-5L score from 0.43 to 0.56[16]. The intervention was shown to reduce

[15] LBTH Homelessness JSNA, 2017

[16] Euro-Qol, 5 dimensions, 5 levels quality of life survey.

discharge to rough sleeping to a greater extent than standard hospital care: of the intervention group 39.8% were rough sleeping on admission and 3.8% at discharge, compared to 47.1% on admission in the control group and 14.7% at discharge[17].

**Groundswell Homeless Health Peer Advocacy Service (HHPA)**

6.12. Groundswell delivers it's HHPA in several London boroughs and has been operating in Tower Hamlets for two years. It provides a peer advocacy programme, in which people with a lived experience of homelessness support people who are currently homeless to navigate healthcare services. In Tower Hamlets they take self-referrals or referrals from homeless or healthcare services. They can accompany patients to physical healthcare appointments, including in dentistry and optometry services.

6.13. In 2016/17 Groundswell engaged with 39 people on a one-to-one basis and a further 82 via in-reach sessions in hostels and day centres in Tower Hamlets. They offer a range of support, with assistance in making, keeping, and attending healthcare appointments being the most used. The estimated return on investment in the 180 days following a Groundswell peer advocacy intervention is £1.97 for every £1 spent[18].

6.14. An evaluation of the effectiveness of Groundswell's HHPA found that it reduced unplanned admissions and increased attendance at scheduled appointments; reducing Did Not Attend (DNA) rates to that of the general population. It also decreased reliance on secondary care by 42%. It increased knowledge, confidence, and motivation to manage health and engage with healthcare. It increased independent healthcare related behaviours.

*"It's made me more confident in myself and I'm dealing with thing now that I never would have dealt with. I no one was there with me I wouldn't have dealt with it. So in the long run it's going to help. It really is."*
**(HHPA Client)**

**LBTH Adult Social Care Services**

6.15. The Care Act 2014 replaced much of the preceding social care legislation and underpins the council's approach to providing social care services. It promotes wellbeing for individuals and their families, promotes personal resilience, and places a duty on local authorities to prevent and delay ongoing need for formal care. Furthermore, it formalises the integration agenda as it ensures that care and support

[17] Hewett N, Buchman P, Musairi J, et al. 2016. Randomised controlled trial of GP-led in-hospital management of homeless people ('Pathway'). *Clinical Medicine*. Vol 16, 3:223-9
[18] Groundswell HPPA monitoring form 2016/17.

services work together. Where a local authority becomes aware that an adult may have care and support needs, it must carry out a 'needs assessment'. However, it must be noted that many homeless residents are not treated under the Care Act 2014 as they fail to engage with a Care Act assessment and are not agreeable to the type of support that might be available to them.

6.16. There are a number of prevention and early intervention services available for the homeless population in the borough. The Housing Options service offers assistance, signposting on housing issues and provides temporary accommodation. The council also commissions a community based floating support service and a day service for rough sleepers and homeless people.

6.17. The council also ensures that provision is in place for crisis intervention. The council commissions Tower Hamlets Street Outreach Response Team (TH SORT) to work with rough sleepers with a range of needs; the majority have medium, high or complex needs. Furthermore, temporary accommodation is also available through B&Bs or emergency bed spaces in generic hostels. This allows homeless residents to be brought in from the street very quickly and receive the appropriate assessment.

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

6.19. There are a number of move on accommodation options available for homeless residents to get them back into long term accommodation. The social housing quota helps keep individuals with complex needs housed in the borough. A specialist pathways manager supports every individual who comes through the hostels sector and ensures they leave with a comprehensive support plan. There is an in-house Private Rented Sector scheme in the Housing Options Service. Partnership arrangements with a number of private sector accommodation providers are in place as part of the No First Night out Project. Additionally, there are Pan-London Clearing House properties available for medium support rough sleepers.

**LBTH Drug and Alcohol Action Team (DAAT)**

6.20. The DAAT delivers the partnership 2016-19 Substance Misuse Partnership Strategy. The strategy aims to reduce the harm caused by

drug and alcohol misuse, commission high quality treatment, improve the health and well-being of individuals who misuse substances and reduce the crime and antisocial behaviour associated with substance misuse.

6.21. Nearly two thirds of rough sleepers in the borough had drug and /or alcohol needs in 2016/17[19]. Of all the people starting drug and alcohol treatment (around 2000 per year), 11% had an acute housing risk or problem, meaning they were homeless in the 28 days prior to treatment. After they completed their treatment this reduced to 3%. Furthermore, 8% of new entrants had an acute eviction risk within the 28 days prior to treatment, which reduced to 1% by the time they exited treatment.

6.22. To help prevent substance misuse issues from emerging and encourage behaviour change the DAAT is integrated with Housing Options and share governance processes and key performance targets, and they present at each other's forums. The DAAT is also linked into the Pathways Homeless Service at the Royal London Hospital, Dallow Day Centre and TH SORT. They have dedicated substance misuse outreach teams on the street and in hostels to identify issues and people on the street early and motivate them to engage in treatment.

6.23. The DAAT has a High Impact Drinkers Programme which takes a multi-agency approach to engaging alcohol misusing individuals. This targets a cohort in the borough who are dependent drinkers and are not willing to access support services even after they have been engaged and referred to treatment. This cohort places a high demand on accommodation services, the Police, the Ambulance Service, the Fire Brigade and social care. The programme has trained over 100 frontline professionals and focuses on risk management, engagement and encouraging behavioural change through motivating vulnerable individuals to get help.

6.24. The DAAT commissioned RESET, an integrated drug and alcohol treatment service, in 2016. This service has been designed to make it easier for people to access treatment. RESET has three key strands; outreach and referral, mainstream treatment, and a separate recovery support service which focuses on long term interventions to help people to move on from evictions. The service provides treatment interventions and supports people with broader health care issues. It also supports service users at risk of homelessness, supports homeless service users with GP registration, provides a suite of activities to provide structure to the lives of service users and offers advice and support on financial welfare. RESET have developed very robust pathways with the Royal London Hospital, LBTH hostels, TH

[19] St Mungo's CHAIN data, 2016/17

SORT, Health E1, criminal justice pathways, prostitution forum and social care pathways.

6.25. The DAAT also commission a dedicated service at Health E1 to support homeless service users misusing substances. Furthermore they commission a Primary Care Drug and Alcohol service which is focused on broader health checks to ensure people accessing substance misuse services, including many of the homeless population, have good access to physical and mental health care through mainstream general practice.

## 7. Findings

7.1. The Sub-Committee examined various sources of service user experience and performance information. As detailed above, members of the Sub-Committee met with officers from the NHS, officers from LBTH Adult Social Care services, patient user groups and advocates, providers of hostels and other key partners who are integral to improving the health and social care of the Tower Hamlets homeless population.

7.2. The Sub-Committee would like to note that they are encouraged by the range of specialist health and social care services available for homeless residents in Tower Hamlets. The co-opted Sub-Committee member from Healthwatch Tower Hamlets was particularly pleased to see that there is now significantly more provision in place than when Healthwatch performed a review in 2013.

7.3. In presenting and summarising the findings of this review it is important to stress that the Sub-Committee heard a range of views about the services available for homeless people, some positive and some not so positive. The Sub-Committee was able to access this feedback as hostels, advocates, and support services for homeless people collected and shared their experiences of interacting with health and social care services.

*"Before that you need a house, you need to be accommodated, otherwise you can lose your health … You can't wake up on the streets and go to work. You can't wake up on the streets and do something positive. It's hard for you to brush your teeth, or have a shower, or eat …"*
(Person with lived experience of homelessness, Tower Hamlets JSNA)

*"Because you have a licence agreement, not a tenancy agreement, you can't take it to a normal high street GP and be like 'hey, I am a normal person, can I join a normal GP?' You have to go to Health E1 because you can't prove you are normal enough to join a regular one."*
(Person with lived experience of homelessness, Tower Hamlets JSNA)

*"First of all they said to me 'have you got accommodation?' I said 'if you look on the computer I am homeless'. 'OK I tell you what you can stay', half past seven I was*

*told that … 8 o'clock they turned round and said you have got to get out. And the nurse couldn't even look me in the eye when she was saying it."*
(Person with lived experience of homelessness, Tower Hamlets JSNA)

*"The majority of people prefer to see the same doctor what they have always seen, where they know your file. They have seen you a load of times so it's easy for them to deal with you because they dealt with you last time. So they know the problem. But when you go to a new one, you have got to explain kind of everything all over again. "*
(Person with lived experience of homelessness, Tower Hamlets JSNA)

*"I was in hospital recently. The nurses made me feel like a third class person. I was in a room all by myself, it was horrible. Then they did not give me enough methadone whilst I was withdrawing. I was in a lot of pain. I was ashamed of me, I felt so small and angry by their behaviour so I left."*
(TH SORT Client)

*"The long wait in A&E when you are in pain is too much. They make you feel bad about yourself, from the reception to the ward. All they see if the alcohol and not the person. They keep sending you to different departments, not really listening to you."*
(TH SORT Client)

*"More Health E1's needed so when you go the drop in you don't have to sit around for three hours"*
(TH SORT Client)

*"The language and communication barriers, not understanding what the doctors are saying. People don't have the confidence to even ask to see someone."*
(Groundswell Peer Advocate)

7.4. Health and housing are inextricably linked, and many homeless people feel that one is impossible without the other. Although health is valued, health needs are overshadowed by the more immediate priorities of day-to-day survival.

7.5. Many of the issues described by the homeless population are equally applicable to the general Tower Hamlets population; however they are intensified for homeless people. During the course of the review some key themes came through very strongly, including: a lack of formal documentation for homeless people, limited opening hours and appointment times of GP surgeries, language barriers and heavy substance misuse. Most homeless people had negative experiences of healthcare services in the past and there is significant distrust in healthcare providers. Many participants felt that presumptions are made about them, and that they receive worse care as a result of being homeless.

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

7.7. The Sub-Committee noted that many patient views and experiences have been collected by the different organisations involved in this review. The Sub-Committee questioned whether organisations have submitted these views to Healthwatch Tower Hamlets as they have the authority to carry out an 'Enter & View' visit on services, and act as a formal advocate for residents, so long as they are provided with evidence which highlights where services are underperforming. The organisations stated that they had not previously contacted Healthwatch Tower Hamlets with the experiences they collected however they will ensure that they do so in the future.

**Recommendation:** That Healthwatch Tower Hamlets reach out to the organisations involved in this Review and establish a link to share the information they collect on homeless people's experiences of using health and social care services in the borough.

## Prevalent Health Issues for the LBTH Homeless Population

7.8. As previously stated in this report, being homeless can have a huge impact on a person's health and homeless people face inequalities in accessing health services. In addition people who are homeless or living in poor quality Temporary Accommodation often suffer worse health than those living in settled accommodation due to their physical surroundings. Poor health, whether mental or physical or both, can also be a contributing factor to a person becoming homeless in the first place. St Mungo's informed the Sub-Committee that the following medical issues are the most common for Tower Hamlets homeless people:

- Mortality and unintentional injuries.
- Ulcerations and abscesses due to unsafe injecting practice.
- Infectious diseases; there was recently a TB epidemic within the homeless population in the borough. This was caused by an individual who was contagious but was not accessing healthcare.
- Respiratory illness; COPD is a widespread issue.
- Sexual and reproductive care.
- Pregnancy and miscarrying on the street.
- Musculoskeletal disorders and chronic pain.
- Skin and foot problems.
- Dental problems; there is a significant gap in dental provision. Currently, a mobile dental clinic visits Whitechapel Mission and the Dellow Day Centre. However there are significant challenges in registering to a normal dental clinic.

**Best Practice**

7.9. Feedback from the LBTH Adult Social Care teams suggests that best practice in this area meets the Healthy London Partnership themes and values. The borough still has to improve services to meet all of these points. This means that timely, holistic preventative services are available so that people do not end up being homeless. There needs to be high quality personalised interventions in place for people who are in crisis with complex needs. Furthermore there needs to be provision in place which offers timely recovery focused generic support for vulnerable people in need of support including temporary housing in hostels. Significantly, there must be work across the system to provide person centred care to maximise people's independence. Finally, care must be delivered at the right stage to offer choice and control to residents, and support them to move on into suitable independent long-term supported accommodation. In practice, this means agencies must develop a joined up approach so that they can respond to these issues collectively and be flexible to extend their remit and responsibilities where required. There must be clear leadership and co-ordination so that the roles and responsibilities of the different agencies are clear.

7.10. TH SORT was presented as an example of good practice and a service which is an exemplar of strong multi partnership working to deliver the best outcomes for homeless residents. The service performs both outreach and in-reach and aims to identify and engage people who are sleeping rough and find the best pathway for them into accommodation. Assessments are carried out by the team to identify local connection, needs and risk assessments. It has joint working protocols in place with agencies and services throughout the borough, including Health E1, Pathways and RESET. Significantly it also has an embedded approved Mental Health Professional (AMHP) within the team who is seconded from ELFT. This is important as they are on the street developing relationships with many people who have mental health issues, some of who are diagnosed and some are undiagnosed, and they will need to perform mental health assessments. The majority of their clients have medium, high and complex needs. In 2016/17 TH SORT worked with 640 rough sleepers and 97 residents in hostels through their preventative 'In Reach' work. They supported 338 clients into accommodation in 2016/17.

7.11. The Sub-Committee is keen to highlight the good practice and the learnings which can be taken from TH SORT and implemented across frontline adult social care teams. Specifically this refers to proactively identifying people with health and social care needs and signposting them on to engage with support services. This will help to avoid more costly interventions when a person is in crisis. The Sub-Committee notes the current learning and development programme being developed in adult social care to emphasise a more conversational,

strength based approach to assessment which is person centred. The Sub-Committee encourages this approach which will focus on providing more preventative care, bespoke to the personal circumstances of the individual and embedding the key ideas demonstrated in the good practice of the TH SORT approach.

**Primary Care**

7.12. GPs are the primary access point to health services and the Sub-Committee identified this area as a place where a number of improvements are required to improve outcomes for homeless people. The Sub-Committee would like to note that improving homeless peoples access to primary care will allow them to be treated at the earliest opportunity and will avoid people presenting at primary health services at a late stage with multiple and entrenched problems. This will also help avoid the delay which causes problems to become more serious, leading to a disproportionate reliance on emergency and acute services and avoidable emergency admissions to hospital.

7.13. Of the support made specifically available to them, homeless people reported good experiences of Health E1 and singled out individual members of staff as having a positive impact on care. This is supported by the findings from the Department of Health's GP Patient Survey, which shows high levels of patient satisfaction for Health E1. However, the survey also shows markedly lower levels of satisfaction for the rest of the practices in the borough. Evidence submitted to the Sub-Committee by Groundswell shows homeless residents questioning why other practices in the borough are not as accommodating or as easy to register with as Health E1. Other GP surgeries do not cater for the transient lifestyle of homeless residents. Some homeless people find it difficult to attend appointments, often forgetting or not being contactable due to not having a phone. Furthermore, homeless residents may not have the perseverance to navigate the system and they encounter difficulty in filling in the forms required to register. More work is needed to ensure every homeless person can register with a GP.

7.14. The Sub-Committee questioned the links GP surgeries in the borough have with wider services for homeless people and if a person's housing needs are picked up at GP appointments. Shelter reported that as part of their study considering the impact of housing problems on mental health, 74% of people had not told their GP about their housing concerns[20]. Shelter supported the Sub-Committee's view that a GP appointment provides the right setting to identify a person's housing issues and address them at the earliest opportunity. However, GPs have reported to Shelter that due to the demand placed on primary care, and appointments only lasting for

[20] The impact of housing problems on mental health (Shelter, April 2017)

approximately ten minutes, they have to treat a person's medical need first and do not always have sufficient time to assess their housing needs. Moreover GPs have reported that they don't always know where to refer people due to the increasingly diverse support landscape. The Sub-Committee feel that is important that housing is made a part of everyone's agenda in order address a person's housing needs at the earliest opportunity. The Sub-Committee identified the social prescribing programme in Tower Hamlets as an excellent location to identify peoples housing needs.

7.15. The Homelessness JSNA focus group activity found that although Health E1 generally got very positive feedback, it was clear that many participants had been directed there by hostel staff and by other GP surgeries, and had not had the opportunity to register at a mainstream practice despite wanting to. This demonstrates that both staff and patients are not fully aware of their rights regarding GP registration, and that there remain ongoing difficulties

7.16. The main barrier repeatedly expressed to the Sub-Committee, from a variety of sources, is the issue of GP surgeries requiring residents to provide documentation evidencing their proof of address in order for them to register. Currently, if a person does not have a fixed address or identification it is very challenging to register with a GP surgery. The Sub-Committee was informed by the CCG that this should not be the case, and that all residents can register for a GP without providing proof of a fixed address. This is set out in the Primary Medical Care Policy and Guidance Manual. The CCG reported that it has been identified that a lot of GP surgeries are unaware of the correct registration process to follow and have therefore asked for proof of address as part of a 'safety-first' approach. In response to this the CCG are about to launch a new streamlined registration process which will also include an online offer. Significantly, this will include training and awareness raising for every GP practice in the borough to inform them of the rules around registration.

7.17. However, the Sub-Committee are concerned that ensuring it is easier for homeless residents to register with a GP is only the start of the behaviour and cultural change needed by practices in the borough. Once a homeless person is registered with a GP, they don't always keep appointments which can lead to problems with health services and statutory services in general. If they do not turn up for appointments they will often be discharged as not engaging. This is part of a wider issue in relation to engagement of homeless people with services whereby they may frequently be banned from using or discharged from services for not complying with rules or for behaviour which is deemed to be unacceptable. Services generally need to be as flexible and tolerant as possible when dealing with homeless people to support them to remain registered at a GP. Awareness training for front line staff dealing with homeless people will help staff to better understand how to deal with some of the behaviours which

may be encountered by services engaging with homeless people. The Sub-Committee feel that this is an opportune time to provide this type of training to staff at GP surgeries as they already have plans in place to provide them with training as part of their new streamlined registration process.

7.18. Shelter informed the Sub-Committee that they have advocated on numerous occasions for homeless people who were denied access to registering at a GP surgery due to their lack of documentation. Shelter has the skills and understanding of the rules to do this, however a homeless person left to advocate for themselves is likely to encounter great difficulty. Groundswell stated that they worked in partnership with the London Homeless Health Programme to produce the 'My Right to Healthcare Card' which aims to address this issue and support residents who have nobody to advocate for them. The card sets out the rights for all residents when registering at a GP and spreads the message that being denied access to a GP practice is not acceptable. The Sub-Committee feel that this card can be a key tool to empower homeless residents to advocate for themselves and would like the council to support Groundswell in ensuring it available across the borough.


*'My right to healthcare care card' - front*


*'My right to healthcare care card' - back*

**Recommendation:** That Healthwatch Tower Hamlets work with Groundswell to disseminate 'My Right to Healthcare' cards across the borough and ensure they are available in all GP surgeries.

**Recommendation:** That the CCG provides training to staff in GP surgeries and for other health professionals to support them to deal with some of the behaviours which may be encountered when engaging with homeless people.

**Recommendation:** That a person's housing issues are identified and addressed as part of the social prescribing programme in the borough

**Fragmented support landscape**

7.19. The Sub-Committee recognised that whilst a great deal of work has been delivered to improve health and social care outcomes for homeless residents in the borough, there still needs to be greater co-ordination between agencies. The support landscape needs to be clearer to support residents to navigate the system and receive the care they need. Gaps exist between services which can sometimes disagree about whose responsibility it is to provide care for a person. For an individual with profoundly complex needs, being referred from service to service can be extremely difficult and distressing.

7.20. Shelter informed the Sub-Committee that a significant barrier restricting homeless people from receiving the health and social care services is the fragmented structure of the support landscape, meaning clients are unclear who is responsible for elements of their care. This is supported by findings in the Homelessness JSNA which reported that having one port of call for both health and social care issues is important for homeless people. The JSNA also reports that homeless people have a poor understanding of how social care services and NHS services work. Supporting this point, the CCG informed the Sub-Committee that they have recently conducted patient engagement around the CCG commissioned services. The feedback they received was unanimous in asserting the need for a single integrated service for homeless people. In response to this the CCG are planning to commission a service for single homeless people, homeless families, vulnerably housed people, people in temporary accommodation and individuals at Tower Hamlet hostels. It will also provide in-reach into hostels, and have an overarching leadership and coordinating remit. They are currently developing the specification and timelines for this service. The Sub-Committee was also informed that work is underway to address this issue and develop better integration and alignment between health and social care through the creation of four locality teams in the borough.

7.21. Due to the current structures in place, providing care for a homeless person becomes even more complicated for a person when they are moved outside of the borough. Shelter informed the Sub-Committee that support networks are often broken down when clients are placed out of the borough. Approximately 1/3 of people who are in temporary accommodation are placed outside of their borough, and 9 out of 10 of these are placed there by London authorities. If an individual has been provided with a package of care in one borough, and then their housing circumstances are addressed and they are placed in a different borough, the gap in organising their care in the new borough can be problematic. Representatives from LBTH Adult Social Care informed the Sub-Committee that the Care Act enforces a national eligibility and if an individual moves to a new authority they would have to accept the assessment which they would have to review and if there had been a change in need then they would have to perform a

reassessment. However, it is accepted that local authorities are currently struggling to perform effective reassessments due to the volume of cases and difficulties in undertaking reviews. In response to this the council is looking at how it can strengthen the arrangements in place to raise the standards of practice and monitor the care being delivered outside of the borough.

7.22. Providence Row Housing Association informed the Sub-Committee that they have encountered many difficulties for their clients when they are discharged from hospital. When an individual is in hospital and it is recognised that there is a need for a care package they have had to wait a long time to get a referral to the hospital social worker. By the time they receive the referral, their clients are often ready to be discharged and rather than carry the assessment forward it often feels like the process has to start again in the community setting and clients have lost out on the package of care they were originally assigned in the hospital. The handover between the hospital and the community social work teams needs to be better coordinated. Furthermore it was reported that clients were being discharged without the required incontinence packs. Providence Row stated that they had to purchase these for their clients, and raised concerns about how a homeless person discharged without this support would cope. They also reported that clients are released without their medication provided in dosette boxes. This leads to confusion over what medication should be taken and at what time. The Sub-Committee stated that both of these points were picked up as part of the Scrutiny Review the Sub-Committee performed on the Reablement Service Scrutiny Review undertaken in 2016/17. Actions have been put in place to respond to these issues and Barts Health is aware of these issues, however the learning from the review may take a little time to feed through.

7.23. The LBTH Adult Social Care representative informed the Sub-Committee that the service is performing well in providing care packages for those referred from the Admissions Avoidance and Discharge Team. However, more work needs to be undertaken to improve referrals for homeless people who arrive at local offices (i.e. Albert Jacob House, John Onslow House) where there is a struggle to overcome a backlog of assessments and reviews. Individuals attending a local office to arrange their support are much more likely to see different people at different times and it is important in complex cases to keep continuity.

7.24. The Sub-Committee questioned whether there is a partnership forum in place where agencies across health and social care get together to discuss the health and social care issues, provision, and cases for homeless residents. The Sub-Committee were informed that agencies do hold a Multi-Agency Risk Assessment Conference (MARAC) in circumstances where there is a particularly complex case which involves different agencies. There are also multiple forum meetings held by different agencies, such as the Royal London Hospital

Pathway Homeless team's multidisciplinary team meeting. However, it is clear to the Sub-Committee that there is no formal partnership committee which convenes to take a holistic view of key issues and developments for homeless residents.

**Recommendation:**
That Barts Health Trust reviews its discharge planning process to ensure that staff routinely asks all patients on admission if they have somewhere safe to be discharged to. Where a housing issue is identified a referral should be made as soon as possible to the Pathway Homeless team so that appropriate support is put in place before discharge. Where patients who are homeless or in insecure accommodation had a package of care in place prior to the admission ward staff should notify social services on admission so they are aware and again on discharge so that the care can be restarted.

**Recommendation :** That LBTH Adult Social Care explores the possibility of establishing a partnership forum (including commissioners, providers, third sector) to discuss the health and social care issues, provision, and cases of homeless residents in LBTH.

**Hard to reach homeless groups**

7.25. The Sub-Committee was informed that there is a huge gap in providing sheltered type accommodation and extra care for an aging, chaotic homeless population. These are people who have additional health needs, are still using drugs and alcohol, and can be very difficult to manage. With the best will in the world, and effective joined up working, there is no ideal place for this group to be accommodated. The type of care they need is extra care accommodation with the specialist expertise provided by LBTH hostels, but this facility does not exist.

7.26. The DAAT provided more insight into this group of people and emphasised that this is a cohort for which there is no treatment intervention to offer them. There is an aging cohort of people using substances, particularly those who are dependent on alcohol and have been for 30 or 40 years. There are very limited treatment options to offer them. They are not able to be detoxed repeatedly as it's too dangerous, and they cannot be involved in psychosocial interventions because they are too inebriated to do so.

7.27. The Sub-Committee recognised that the Royal London Hospital Pathway Homeless Service is effective for people who disclose their homeless status but questioned how effective services are in identifying the hidden homeless population in the borough. These are people who have no fixed abode and sofa-surfing. Groundswell stated

that it is difficult to identify these people and often it requires the service to ask the right questions and develop trust, as many homeless people have negative perceptions of health services and feel judged. The first experience an individual has makes a substantial difference in terms of how a homeless person will proceed to engage with a service.

7.28. The homeless JSNA focus group activity revealed several people felt that they received worse care because of their homeless status; with some implying they might try to hide the fact that they were homeless in order to avoid this.

*"They leave us on the streets, you know. And sometimes what I think is if you tell them you are homeless, they don't give you the right service, they look down on you."*
(Person with lived experience of homelessness, Tower Hamlets JSNA on being asked whether hospital staff should ask about housing status)

*"If you go to the hospital, at some point they are going to look at your address. I just don't say I live in a hostel. As soon as they find out they live in a hostel the way the consultants treat them dramatically changes."*
(Person with lived experience of homelessness, Tower Hamlets JSNA on being asked whether hospital staff should ask about housing status)

7.29. Groundswell suggested that in their experiences the best way to obtain information is to develop trust and ensure that this is used to ensure a homeless person accesses the care they need. It is important that all frontline workers are aware of the key signs somebody may be homeless, the correct questions to ask and where to signpost people. It may be a hospital porter, an A&E nurse or somebody in the Housing Options team. More work is needed to explore and develop these relationships. The Sub-Committee observed that whilst the NHS tries to make sure that 'every contact counts' it only really applies to those who are specialist in that area. The Sub-Committee would like services to explore empowering all individuals who have contact with homeless people with the awareness to identify the hidden homeless and provide them with the skills and knowledge to engage with them and signpost them on to the correct pathway. The representative from LBTH Adult Social Care suggested that with the introduction of the locality model professional development could incorporate this type of training.

7.30. Groundswell informed the Sub-Committee that a further barrier which prevents people from revealing their housing status is the requirement to repeatedly provide background information every time you attend a new service. For many homeless people it can feel like a test, and is particularly problematic if somebody suffered past trauma and they have to recount the abuse every time they ask for help. The Homeless JSNA focus group activity found that most saw the benefits of personal data being shared between services if it meant they did not have to repeat themselves, and it is an issue of particular importance to those who had had traumatic experiences.

7.31. The Sub-Committee questioned if there was any provision in place to support the end-of-life care needs of homeless people. Providence Row Housing Association stated that research into this area has uncovered vast inequalities in access to appropriate palliative care, with seriously unwell people often living in hostels that struggle to meet their needs as their health deteriorates. Hostels are not designed to provide end-of-life care. They do not have the resources, and staff do not have the palliative care training or input from in-reach services to deliver high-quality, person-centered care to residents. Providence Row reported that hostels used to be visited by a palliative care worker in the borough however this no longer happens. The Sub-Committee support the view of the London Healthy Homeless Programme that people experiencing homelessness need to receive high quality, timely, and co-ordinated end-of-life care, and feel that more work is required in the borough to explore how services provide this for those whose behaviour or lifestyle would make placement in a traditional hospice setting not possible.

7.32. Providence Row Housing Association stated that as part of the commissioning process for hostels in Tower Hamlets they have introduced smart plan which allows information to be shared between services. This attempts to tackle the issue of people moving between services and having to repeat their information. The Sub-Committee stated as part of a move towards greater integration between health and social care, and as part of the North East London Sustainability and Transformation Plan, there are numerous activities in place to improve the digital performance of health and social care services. The Sub-Committee noted that the introduction of General Data Protection Regulation (GDPR) may provide greater opportunities to passport people's key information with peoples consent between agencies.

**Recommendation:** That LBTH Adult Social Care and the CCG explore the possibility of providing all frontline workers and auxiliary staff (i.e. staff in ideas stores, parks service) with training and awareness raising sessions to help them identify and signpost the hidden homeless, and how to ask the appropriate questions without offending them. Information on provision for homeless people should be made available at all public facing council services.

**Recommendation:** That the council and the CCG review the way services share information and consider if the introduction of GDPR and the review of systems that follows will allow for more information to be shared between services to support the way homeless residents access and engage with services.

**Recommendation:** That the council explores the possibility of commissioning specialist provision to accommodate individuals with challenging behaviour (older people, substance misuse issues) who can no longer remain in mainstream provision for their safety or the safety of others. Many of these individuals are beyond the point where traditional treatment programmes are appropriate.

**Recommendation:** That the council and CCG review how palliative care is provided to people living in hostels and temporary accommodation.

## Mental Capacity

7.33. A number of people who provided evidence to the Sub-Committee stated that the thresholds for mental capacity can sometimes act as a barrier to people receiving the required care. The Mental Capacity Act states that everyone should be treated as able to make their own decisions until it is shown that they are not able to. A person's capacity to make a decision will be established at the time that a decision needs to be made. A lack of capacity could be because of a severe learning disability, dementia, mental health problem, a brain injury, a stroke or unconsciousness due to an anaesthetic or a sudden accident. It is very difficult for those people on the precipice of mental capacity to access the required support.

7.34. There is a gap in provision for people who are judged to have capacity, and are not able to be sectioned because they are not a risk to themselves or others, but who are completely unable to advocate for themselves or navigate the process successfully. The Sub-Committee was provided with a number of case studies where an individual was stuck in a cycle of falling into such a state of ill health that they were sectioned. This individual would then receive treatment in hospital and would be discharged on recovery. The individual would then leave the hospital and lacking the capacity to adequately care for themselves would fall back into the same condition of ill health and would need to be sectioned again to receive treatment. If alcohol is involved, as is often the case, it complicates matters further and it is very difficult to receive a clear steer on the agreed treatment pathway. There have been a number of challenges around mental capacity however; frontline workers find it very difficult to challenge this when they have legislation dictated to them.

## Domestic Violence and Violence against Women and Girls

7.35. The Sub-Committee questioned if there are any specific strands of work ongoing around sexual health, women's health and maternity. The CCG responded that they have commissioned a service identifying vulnerable women and homeless pregnant women are a part of this. They will have long term care needs while pregnant that will need to be supported. St Mungo's reported that pregnancy and miscarriages (on the street) are a significant issue for the homeless population. Moreover the council commission prostitution support service in the borough. They perform outreach and case management to help women exit prostitution. This is focused around healthcare, accommodation, benefits, financial welfare, employment training and education, as well as substance misuse need and particularly sexual health needs. The service was recommissioned in October 2017.

7.36. The Sub-Committee identified domestic violence amongst homeless people as a considerable issue which needs further exploration. There are a high number of women in temporary accommodation, rough sleeping or in a hostel that are pregnant. Statistically women make up a small number of the boroughs homeless population but they do have specialist needs which services must ensure they address. The TH SORT team informed the Sub-Committee that in many cases they are involved with, there are concerns around Adult Social Care's idea of appropriate temporary accommodation, and the accommodation not being sufficiently risk assessed. TH SORT highlighted that professionals they engage with to support their clients are not always able to appropriately recognise domestic violence risks and there is a need for further training and increased reporting. A lot of women will present at Housing Options after fleeing abuse, and with high complex needs, but they will often be referred to refuge. However, Housing Options is unaware they are often not eligible for refuge. There needs to be more work to educate services and residents on what the appropriate and available options are for those fleeing domestic abuse. The Housing Options service stated that if there is a real threat to the individuals they try to protect and safeguard individuals; however they suggested that there is scope to work with organisations who advocate for abused individuals to map what those fleeing abuse want from their temporary accommodation. This will be customer focused to assess what clients want when they attend Housing Options and how to manage the situation. This will allow Housing Options to find out what they value, what they think will keep them safe and improve the service they provide. The Sub-Committee agree with this approach and stated more work is needed to explore the relationship between homelessness and violence against women and girls (VAWG).

**Recommendation:** That the Housing Options service works with organisations involved in this Review, and with individuals who present at Housing Options, to find out what they consider to be a safe offer of temporary accommodation and provide insight into what they value and how they would feel better supported upon approach.

**Recommendation:** That the council performs further research on the impact homelessness has on the health needs of women who are rough sleeping, in Temporary Accommodation, or hostels.

**Recommendation**: That the council performs further research into the relationship between homelessness and VAWG with a view to updating the VAWG strategy to include a stronger consideration of violence against homeless women.

## Substance Misuse

7.37. The effects of drug and alcohol use have an extremely detrimental effect on the physical health of homeless people. It causes early alcoholic liver disease and is often also associated with Hepatitis C, both of which often result in severe liver disease and early death. Drugs are also a common problem and injecting drugs carries associated risks including hepatitis C, HIV, abscesses, DVT, chronic leg ulcers and endocarditis.

7.38. Drug and alcohol use is often a contributing factor to becoming homeless. However, problems can also develop after becoming homeless. It is not uncommon for alcohol and drug addiction to develop as a means of coping with the difficulties associated with homelessness

7.39. A recurrent theme identified in the Homeless JSNA focus group activity, is managing substance dependency across different care settings. Many participants had negative experiences regarding methadone prescriptions as inpatient prescription regimes differ to those in the community and transitioning between the two can be difficult. Some mentioned this as a reason to avoid being admitted to hospital, or as a situation that might lead them to relapse.

*"[We can't] get or full dose [of methadone]. In there they want to give you half in the morning and half at night. And then like during the day you are sick all day. So what do you want to do? You want to go outside when you know in the area to use. Or you are going to get someone to bring you something."*
(Person with lived experience of homelessness, Tower Hamlets JSNA)

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

7.41. Reliance on drugs and alcohol forms a significant barrier to people accessing the services they need. The quote above illustrates the difficulties a person withdrawing form substance abuse in hospital can encounter, and demonstrates why it acts as a deterrent for people entering hospital for treatment. The distress caused from withdrawal is often greater than the need for a person to get their health issues addressed. Similarly, in a case study provided by TH SORT, concerns were raised around Adult Social's Care comprehension of how methadone works and the implications of an individual not receiving it, the need to involve substance misuse services when an individual moves into temporary accommodation, or the continued need for substance misuse treatment.

7.42. TH SORT informed the Sub-Committee that it is extremely difficult to sit in A&E, for an extended period of time; with an individual that has a high dependency on drugs as it's likely they will start withdrawing and they can't be forced to remain there until they receive the care they need. For this person, getting access to their next 'high' is prioritised over receiving treatment for their ill health. They can also be problematic and disruptive for their patients if they are forced to stay in A&E for a long time. Edward Gibbons House also raised this as an issue they have identified for their clients, particularly when they have to wait several hours for scans to take place, and asked if services could incorporate this as part of awareness building for staff.TH SORT emphasised the need to look at different ways of providing treatment for this cohort of patients. The Sub-Committee stated that there has been a service piloted in other parts of the country in which a mobile, advanced healthcare practitioner was tasked with responding to people in unstable conditions in a community setting. The Sub-Committee suggested that this is something which could be explored in Tower Hamlets. A peripatetic team, consisting of a paramedic and advanced care practitioner in mental health, could be commissioned to provide a visiting service to the very difficult to manage and violent patients in order to keep them away from hospital where they can be better treated without upsetting ordinary patients. This team will have the authority to prescribe and admit, and could develop links with agencies such as Shelter, St Mungo's and LBTH Hostels to shortcut the need to attend A&E.

**Recommendation:** That the CCG explore the possibility of commissioning a peripatetic team consisting of a paramedic and advanced care practitioner in mental health to provide a visiting service to very difficult to manage and violent patients.