

# Rapid Health Care Needs Assessment of Homeless People in Leicester

V6

June 2016

**NHS**  
*Leicester City*  
**Clinical Commissioning Group**



This Rapid Health Care Needs Assessment has been undertaken to assist the considerations of the Clinical Commissioning Group regarding its intentions for recommissioning primary health care services for homeless people in Leicester. While there has been some data collection for this needs assessment, a rapid needs assessment does not generate primary data and concentrates on collating information that already exists.

#### Acknowledgements

Dr David Shepherd for analysis of ASSIST and Inclusion Practice data in Appendix A

Jo Ryder for service user engagement input. Appendix C

Specialist APMS Group for information, advice and guidance

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## Summary

- Homelessness is a current and persistent problem for individuals, families and communities. It has worsened since the 2008 recession.
- Homelessness is the lack of decent, secure and safe housing. It includes:
  - People sleeping rough;
  - Single homeless people living in hostels, shelters and temporary supported accommodation;
  - Statutorily homeless households: households seeking housing assistance from local authorities on the grounds of being currently or imminently homeless;
  - Hidden homeless households: people considered homeless but who are not visible on the streets or in official statistics. This includes overcrowded households, squatters, sofa-surfers, and people involuntarily sharing with other households on a long-term basis.
- Estimating total numbers of homeless is difficult but the report provides some indication of relevant numbers.
- Factors linked to homelessness include lack of affordable housing, unemployment, mental and physical illness, low educational attainment and substance misuse. These factors operate at individual and societal levels.
- Homeless people are the most frequently over-represented attenders in A&E. A homeless drug user admitted to hospital is 7 times more likely to die over the next 5 years than a housed drug user with the same medical problem. Without early intervention homeless children and young people are likely to enter such a cycle.
- Since the early 2000s there has been a specialist primary care service for homeless people in Leicester; currently provided by Inclusion Health Care. Mainstream general practices do not regularly treat street homeless people but do deal routinely with those who are insecurely housed or part of the hidden homeless population.
- The different models of care highlighted in research broadly refer to 2 ways of delivering core primary care services to homeless people: the mainstream model with or without supplementary provision and the specialist model. The chosen approach should be the product of consideration of local commissioners, practitioners and stakeholders informed by experience, evidence and evaluation, underpinned by quality and clinical standards.
- All stakeholders consulted support a specialist approach in primary care for homeless people in Leicester.

## The CCG is recommended to:

- Note that equity of healthcare outcomes for homeless people is based on core principles of care including, continuity, multi-disciplinary approach, permanent registration, service user involvement, routine liaison with outreach teams and collaboration with wider services (housing, dentistry, podiatry and mental health).
- Recommission specialist general practice provision for homeless people in Leicester.

## 1. Homelessness

- 1.1 Homelessness can be defined as the lack of decent, secure, safe and affordable housing.
- 1.2 There are at least four groups of homeless people:<sup>1</sup>
  - People sleeping rough;
  - Single homeless people living in hostels, shelters and temporary supported accommodation;
  - Statutorily homeless households: households seeking housing assistance from local authorities on the grounds of being currently or imminently homeless;
  - Hidden homeless households: people considered homeless but who are not visible on the streets or in official statistics. This includes overcrowded households, squatters, sofa-surfers, and people involuntarily sharing with other households on a long-term basis.
- 1.3 Priority groups for statutory support are homeless households with dependent children, pregnant women and vulnerable people. This includes people with mental illness or physical disability; people aged 16 or 17; those aged 18 to 20 who were previously in care; people who had been in custody or in HM Forces and those vulnerable to homelessness because of violence.
- 1.4 The most visible homeless people are those who sleep rough. Broadly defined as people sleeping, about to bed down or actually bedded down in the open air; such as on the streets, in tents, doorways, parks, bus shelters or encampments. It includes people in buildings or other places not designed for habitation, such as stairwells, barns, sheds, car parks, cars, derelict boats, stations, or 'bashes,' makeshift shelters, often made of cardboard boxes.
- 1.5 Homelessness can be caused by structural issues, such as the impact of recession on welfare arrangements and the housing and labour markets.

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<sup>1</sup> See Fitzpatrick, S., et al, 2016, The homelessness monitor: England 2016. Crisis, Herriot-Watt University, University of York, Joseph Rowntree Foundation, University of New South Wales

Some people may be vulnerable to homelessness because of Individual and interpersonal circumstances.

## 2. Homelessness in Leicester, the East Midlands and England

- 2.1 Enumerating homelessness is difficult and sometimes contentious. Official rough sleeper figures are collected by a street count on one night each year by local authorities and charities. There is no agreed estimate of the number of people living in the hostel system. Statutory homeless are people accepted as being homeless by local authorities. Many do not have this formal recognition, but are homeless nonetheless. They may be living informally with friends or relatives, having their cases treated by 'homelessness prevention' and 'homelessness relief' activity or have never declared themselves as homeless to any authority. Hidden homeless people include families which are homeless, at risk of homelessness, people fleeing abusive relationships, and families who are staying in the homes of relatives and friends.
- 2.2 There were 3,569 rough sleepers in England in autumn 2015. This was up 825 (30%) from 2014. Table 1 below shows the national trend has been increasing since at least 2010. The Leicester trend has been more unpredictable with smaller numbers. The 2015 number was slightly higher than that for 2010, but there was no significant difference between the Leicester and national rates of rough sleeping.

**Table 1: Rough Sleeping Counts and Estimates by for Leicester and England autumn 2010 to autumn 2015 (Source: Rough Sleeping Statistics, DCLG)<sup>2</sup>**

Local Authority	2010	2011	2012	2013	2014	2015	Number of Households 2015 ('000s)	2015 Rough Sleeping Rate (per 1,000 households)
Leicester	19	50	11	11	19	22	127.1	0.17
England	1,768	2,181	2,309	2,414	2,744	3,569	22,940	0.16

- 2.3 That there is an upward trajectory in rough sleeping is illustrated by the St Mungo's Broadway which shows that rough sleeping in London has more than doubled since 2009/10<sup>3</sup>, with particular increases in people from Central and Eastern Europe. Even this may not adequately measure the extent of the problem. Swain reports a growing number of people from Roma backgrounds

<sup>2</sup> See Rough Sleeping Statistics Autumn 2015, England. Department for Communities and Local Government at <https://www.gov.uk/government/statistics/rough-sleeping-in-england-autumn-2015>

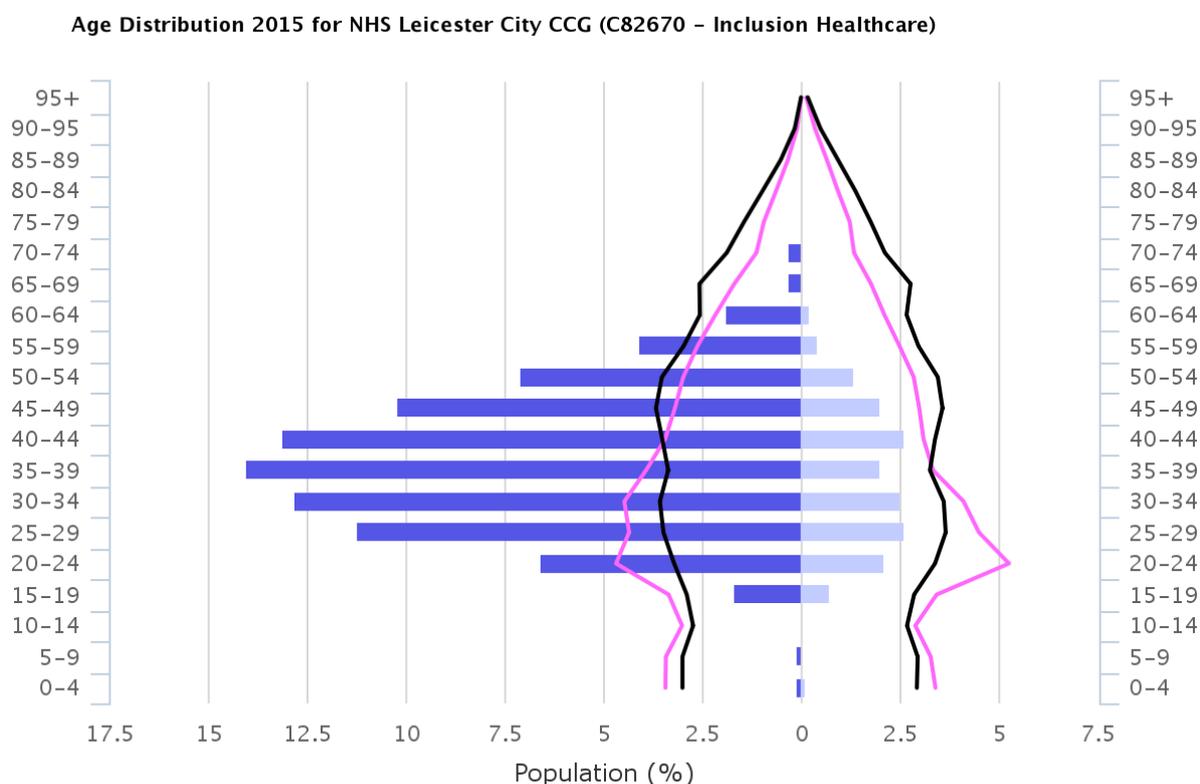
<sup>3</sup> St Mungo's Street to Home monitoring reports at <http://data.london.gov.uk/dataset/chain-reports>

working for very low wages in the informal economy that should be considered non-destitute rough sleepers.<sup>4</sup>

2.4 National General Practice Profile data demonstrate that Inclusion Health Care, the specialist primary care service in Leicester, differs from usual general practice in Leicester and England. There are low rates of children, young people and people aged over 65 years. The Inclusion practice population is mainly male, aged between 20 and 60 years (see Figure 1 below).

2.5 Measured by the Index of Multiple Deprivation 2015, deprivation among the Inclusion registered population is 39.4, higher than the CCG (33.1) or national values (21.8), with far higher rates of unemployment and high rates of income deprivation.

**Figure 1: Age and sex distribution 2015 for Inclusion Healthcare Leicester (pink line CCG %; black line England %)<sup>5</sup>**



2.6 Nationally, statutory homelessness rose from 89,000 in 2009/10 to 113,000 in 2012/13. Appendix G shows that in 2014/15 Leicester had 108 people accepted as being homeless, a rate of 0.86 per 1,000. This rate was significantly lower than that for the East Midlands and England. Since 2010

<sup>4</sup> Swain, J., 2015, Sleeping rough, working rough – with the Roma in London, *ending homelessness in London blog* 28<sup>th</sup> March 2015: <http://jeremyswain.blogspot.co.uk/2015/03/sleeping-rough-working-rough-with-roma.html>

<sup>5</sup> See <http://fingertips.phe.org.uk/profile/general-practice/data#mod,2,pyr,2015,pat,19,par,E38000097,are,C82670,sid1,2000005,ind1,-,sid2,-,ind2,->

the trend has been increasing trend in Leicester and in England, whilst the regional rate has remained stable.

- 2.7 Over the same period households known to be in temporary accommodation in Leicester increased in number and rate from 43 (0.36 per 1,000) to 72 (0.57 per 1,000). The current rate is significantly higher than the East Midlands (0.35 per 1,000), but significantly lower than that for England (2.85 per 1,000).
- 2.8 In Leicester there has not been a year on year increase in households in temporary accommodation. Rather the number and rate doubled between 2010/11 and 2011/12, reducing slightly thereafter before increasing once more in 2014/15.
- 2.9 Some homeless families in Leicester live temporarily at Border House Hostel, which reported 336 children resident in 2015/16. Others are housed in 6 refuges and 4 hostels which support victims of domestic abuse. These generally house single women and women with children.
- 2.10 37% of single homeless people coming into Leicester City Council hostels have experienced at least two previous stays in hostel accommodation. Many entrenched clients experience multiple stays.
- 2.11 There is no accurate local data for the hidden homeless. Fitzpatrick et al<sup>6</sup> estimate that in 2015 there were 4.72 million households contained additional family units (21% of all households in England). This includes couples or lone parent families, unrelated one person units and cases of non-dependent adult children living in the parental household. As a rough calculation of the order of magnitude, the proportion above applied to the number of households in Leicester indicates that around 26,151 households may house hidden homeless people.

### 3. Health needs of homeless people

- 3.1 Homelessness has a detrimental impact on physical and mental health. According to Crisis<sup>7</sup>, it is one of the most damaging experiences that anyone can have.
- 3.2 There is growing understanding<sup>8</sup> that chronic homelessness is an associated marker for tri-morbidity, complex health needs and premature death. Tri-morbidity is the combination of physical ill health with mental illness and drug or alcohol misuse. The complexity is associated with advanced illness at presentation. Tri-morbidity is linked to complex trauma, high levels of child neglect and abuse which impact on development and mental wellbeing.

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<sup>6</sup> Fitzpatrick, S., 2016, The homelessness monitor: England 2016. Herriot Watt University, University of new South Wales, University of York, Joseph Rowntree Foundation, Crisis

<sup>7</sup> See <http://www.crisis.org.uk/pages/health-and-dependancies.html>

<sup>8</sup> O'Connell, J. Premature mortality in homeless populations: A review of the literature in Standards for Commissioners and Service Providers, Faculty of Inclusion Health and others

- 3.3 The mortality rate for homeless people is between 3.8 and 5.6 times higher than that of the general population. Average life expectancy of a rough sleeper is in the region of 42 years.<sup>9</sup>
- 3.4 Compared to the general population, rates of respiratory problems are twice as high for people in hostels and 3 times as high among people sleeping rough.<sup>10</sup> These rates reflect the impact of the weather, poor nutrition and overcrowding. Homeless people seem to be more at risk of pneumococcal pneumonia and tuberculosis.<sup>11</sup>
- 3.5 Rashes, infestations, wounds, ulcers, cuts and grazes are 3 times more common among homeless people as the general population.<sup>12</sup> These are associated with rough sleeping, a lack of general amenities such as toilets and washing facilities. Infestations are difficult to treat because of lack of access to medical care or poor compliance. Foot problems are the cause of up to 20% of medical complaints of single homeless people.<sup>13</sup>
- 3.6 Gastro-intestinal problems are twice as common in homeless people. Problems such as dyspepsia, ulcers, diarrhoea and vomiting are associated with stress, poor diet and poor hygiene.
- 3.7 Mental illness is a cause and a consequence of homelessness. 70% of homeless service users in England have mental health problems. Crisis found the homeless population to have twice the level of common mental health problems compared to the general population. Deliberate self-harm, including suicide, is 7 times higher than that of the general population.<sup>14</sup>
- 3.8 Nationally, unscheduled care costs of homeless people are 8 times that of the housed population. Many studies show that Accident and Emergency (A&E) departments are the first point of contact for many rough sleepers and the homeless population.
- 3.9 Despite the higher rates of illness, Crisis found that homeless people are 40 times less likely to be registered with a GP and 5 times more likely to have problems registering or staying on a GP's list; (5% of the general population experienced difficulties, compared to 26% of homeless people).
- 3.10 The needs of homeless young people are not different to those described above, but are less visible. They have worse outcomes for physical health and safety, enjoyment, personal achievement, schooling and life chances. All homeless children are vulnerable to mental health problems. They have

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<sup>9</sup> Hewett, N., 1998, Primary Health Care for Homeless People: A report for the Secretary of State for Health

<sup>10</sup> Bines, W., 1994, The health of single homeless people. Centre for Housing Policy, University of York

<sup>11</sup> Connelly, J. and Crown, J., (eds), 1994, Homelessness and Ill health. Royal College of Physicians, London

<sup>12</sup> Bines, *ibid*

<sup>13</sup> Connelly and Crown, *ibid*

<sup>14</sup> Grenier, P., 1996, Still dying for a home. An update of Crisis' 1992 paper investigation into links between homelessness, health and mortality. Crisis, London

worse access to health services and are less likely to complete the childhood immunisation programme.

- 3.11 Shared kitchen and bathroom facilities have a detrimental impact on family routines, such as eating together, and regular wash and bed times. Shared toilet facilities can have a detrimental impact on toilet training. Initiating breast feeding in new born children is problematic.<sup>15</sup>

## 4. Homeless health need in Leicester

- 4.1 Appendix A<sup>16</sup> shows that Inclusion Health Care has a predominantly male population aged between 20-59 years (94% is in this age range compared to 64% for HNN South). The practice population is less diverse than that of Leicester, 75% are from White/White British ethnic backgrounds.
- 4.2 There are high levels of psychosocial multi-morbidity and physical illness. Inclusion has a more multi-morbid population than HNN South. A higher than average proportion has long term conditions (LTCs). 52% of Inclusion patients have 2 or more LTCs compared with 27% for HNN South. 82% of the practice population have a long standing health condition, compared with 52% in the CCG. Among Inclusion patients seizure disorder and head injury are prominent, probably reflecting the high rate of alcohol problems.
- 4.3 The National General Practice Profile shows that Inclusion Health Care has a higher proportion of patients with a long standing health condition compared to the CCG and England averages. The prevalences of cancer, diabetes, renal and cardiovascular disease are lower, and the prevalences of mental illness, respiratory disease and epilepsy is higher.
- 4.4 A&E attendance rates for Inclusion patients are higher than other general practices (2015/16 n=1,259). A calculation based on QED data for Inclusion shows that the rate of A&E attendances for Inclusion was approximately 11 times that of Leicester City CCG.<sup>17</sup>

## 5. Evidence of what works

### Health care intervention models

- 5.1 While the burden of homeless health problems is greater than in the general population, access to care is worse. This is because:
- The lifestyles of homeless people make it harder to live healthy lives and access mainstream services;

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<sup>15</sup> Based on telephone interview with specialist Health Visitor

<sup>16</sup> ACG data from Leicester City CCG

<sup>17</sup> 2014/15 CCG A&E total attendance = 34,285; 1/12 = monthly average = 2857; CCG population = 330,000; % attending A&E/ month = 2857 / 330,000 = 0.87%; Inclusion = 825 for 8 months; Therefore 103/month. Inclusion pop = 1091; % attending A&E = 103/1091 = 9.4%

- Poor physical and mental health can be the cause of homelessness, and a barrier to care;
  - Illness causes homelessness. Physical disorders may reduce a person's ability to earn money and thus reduce ability to find and retain accommodation;
  - Homelessness causes and compounds illness. Lack of shelter results in exposure to severe weather and increases the risks of accidents. Lack of privacy increases exposure to infectious diseases in large communal dwellings. Lack of sanitation leads to disorders associated with poor hygiene. Lack of security increases exposure to violent attack and rape. Inadequate diet or malnutrition reduces immunity to disease;
  - Care for homeless people is often characterised by crisis management.
- 5.2 An integrated approach to care is the best way to meet the needs of homeless people.<sup>18</sup> However, the healthcare response is usually fragmented.
- 5.3 Chiddick<sup>19</sup> categorised primary care services for homeless people in England into 5 groups and found that 38% of primary care trusts had no specialist provision, 25% provide just one outreach team and 10% offer temporary registration:
- No specialist provision (n = 48)
  - One outreach team: provided by individual nurses, health visitors and doctors or by teams without dedicated facilities (n = 31)
  - One general practice offering temporary registration (n = 12)
  - One general practice offering permanent registration (n = 43)
  - More than one specialist homeless service (n = 16)
- 5.4 A similar study from the Department of Health found 4 models of homeless healthcare:<sup>20</sup>
- Mainstream practices which provide services for homeless people: A GP from a mainstream practice holds regular sessions for homeless people in a drop-in centre or at the surgery. Patients are not registered and do not get out of hours provision;
  - An outreach team of specialist homelessness nurses provide advocacy and support and episodes of care (e.g. wound management), and are able to refer to other services. No guarantee of patient registration or out of hours care;
  - Full primary care specialist homelessness team: A team of specialist GPs, nurses and other services provide dedicated and specialist care with a hostel/drop-in centre. This service usually registers patients and provides better access to care for people with mental health problems or drug/alcohol dependency;

<sup>18</sup> See <http://www.pathway.org.uk/wp-content/uploads/2013/02/Homeless-Health-Standards.pdf>

<sup>19</sup> Chiddick, L., Health service provision for the homeless in England in Aspinall, P., 2014 Inclusive Practice

<sup>20</sup> Office of the Chief Analyst, 2010, Healthcare for single homeless people. London, Department of Health

- Fully co-ordinated primary and secondary care: A team of specialists spanning primary and secondary care, providing integrated specialist primary care out-reach, intermediate care beds and in-reach services to acute beds. This research suggests that no English PCTs provided a fully integrated care model with a step up and down secondary care unit.
- 5.5 While these are not systematic evaluations, the key emergent theme is that the approach to homeless primary care varies in different localities. However, Aspinall indicates that where specialist services do not exist homeless people are generally not registered and outcomes are likely to be worse.<sup>21</sup>
- 5.6 There are some quality and clinical standards which will improve outcomes for homeless people:<sup>22</sup>
- Continuity: there should be a trusting relationship formed with a familiar clinician;
  - Multi-disciplinary collaborative care is central to effectiveness because many homeless people present with multiple healthcare needs;
  - All patients should be registered at first consultation on a permanent basis;
  - There should be person centred care with service users involved in planning and delivery;
  - Routine liaison with, and provision of, medical support to street outreach teams will improve access to services;
  - Services should collaborate with case tracking, community treatment and public health measures e.g. TB, HIV and Hepatitis C;
  - Recording of housing status with regular review;
  - Promotion and encouragement of accessible provision of dental and podiatry care.

## 6. Services for homeless people in Leicester

- 6.1 The current service model of primary care for homeless people in Leicester is specialist and delivered in both formal ways and opportunistically.
- 6.2 This specialist provision is for the most visible homeless, usually individual rough sleepers, and not families. Families in hostels or refuges are most often temporarily registered with local GPs.
- 6.3 It is not possible accurately to gauge the extent of registration by mainstream general practices. At HNN meetings some GPs reported that they had cases

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<sup>21</sup> Aspinall, P, 2014, Inclusive Practice, Vulnerable Migrants, Gypsies and Travellers, People Who Are Homeless, and Sex Workers: A Review and Synthesis of Interventions/Service Models that Improve Access to Primary Care & Reduce Risk of Avoidable Admission to Hospital, Inclusion Health  
[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/305912/Inclusive\\_Practice.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/305912/Inclusive_Practice.pdf)

<sup>22</sup> See <http://www.pathway.org.uk/wp-content/uploads/2013/02/Homeless-Health-Standards.pdf>

of people who were 'sofa surfing.' In 11 responses to the practice manager survey it was estimated that between 0 and 20-30 hidden homeless people were registered. These were informed estimates not drawn from practice records. Nevertheless there were reports that mainstream primary care routinely deals with patients who are insecurely housed or facing homelessness, but rarely with the 'street' homeless associated with the specialist Inclusion practice.

- 6.4 There has been specialist primary care for the homeless in Leicester since the early 2000s. Until then rough sleepers had been seen at venues such as the Pocklington's Walk night shelter, Y Advice and Support Centre and city hostels. These venues, intended to give general support, were useful for opportunistic health care.
- 6.5 Registering homeless people to a general practice increased understanding of the health needs of homeless people and helped in the development of an effective care model, leading to a shared approach at the Dawn Centre.
- 6.6 The importance of an opportunistic response to homelessness health means that current specialist primary care, while based at Charles Berry House and the Dawn Centre, still retains links with hostels and other providers. For instance, Inclusion Health Care runs clinics at the Y Project.
- 6.7 The complex issues associated with homelessness require expertise from mental health, drug and alcohol services, adult social care, criminal justice, expert homelessness organisations and education.

## 7. Consultation

- 7.1 There were three areas of consultation on the current service and service delivery model:
- 7.2 Patients and service users: There was generally a favourable response to the service. Positive aspects of care include getting an appointment to be seen quickly, and approachable receptionists. Service users felt that it was important for the doctors and nurses to be accessible and aware of the person's medical history. Most said they were happy with the current service and didn't offer any suggestions for improvement saying it was "as good as it can be." Most service users felt that Inclusion Healthcare is supportive.<sup>23</sup>
- 7.3 Wider stakeholders from statutory and voluntary and community sectors,<sup>24</sup> felt that the specialist model is effective in working across traditional boundaries to meet the needs of homeless people. The specialist provider has a non-judgemental approach and helps engage people in looking after their own health. Wider stakeholders felt that the specialist approach was effective in managing co-morbidity in homeless people, addressing complexity of care

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<sup>23</sup> See Appendix C

<sup>24</sup> See Appendix B for a full list of attendees

and offering patient registration. Wider stakeholders felt these issues would be tackled less effectively in mainstream general practice.

- 7.4 Consultation with GPs at Health Needs Neighbourhoods (HNN) Meetings showed that mainstream general practice did have some experience of looking after homeless people. This was not quantified but usually comprised hidden homeless people rather than rough sleepers. Among this group are likely to be families with young children. GPs held the specialist service and staff in high regard. This was mentioned at all city HNN meetings and in individual communications. GPs felt that the specialist practice has the necessary expertise to meet the needs of homeless people and there is no appetite to change from this service.

## 8. Conclusions

- 8.1 Homelessness is a current and persistent problem. It has worsened since the 2008 recession. Homeless people have reduced quality of life, multi-morbidity; the average age of death is about 42 years. Factors linked to homelessness include lack of affordable housing, unemployment, mental and physical illness, low educational attainment and substance misuse. These factors operate at individual and societal levels. Homeless people are the most frequently over-represented attenders in A&E. A homeless drug user admitted to hospital is 7 times more likely to die over the next 5 years than a housed drug user with the same medical problem. Without early intervention homeless children and young people are likely to enter such a cycle.
- 8.2 The different models of care highlighted in research broadly refer to 2 ways of delivering core primary care services to homeless people: the mainstream model with or without supplementary provision and the specialist model. Paragraphs 5.3 and 5.4 describe these approaches, much of which have been reflected in the comments and observations of local stakeholders. The chosen approach should be the product of consideration of local commissioners, practitioners and stakeholders informed by experience, evidence and evaluation, underpinned by quality and clinical standards as considered in paragraph 5.6.
- 8.3 It is broadly recognised by consultees that the best way to gain quality patient outcomes for homeless people in primary care is through a specialist general practice.
- 8.4 It is not possible to enumerate the cases of the hidden homeless accessing healthcare through mainstream general practice in Leicester, though it should be recognised that GPs routinely deal with patients who are, for a range of reasons, insecurely housed or facing the possibility of homelessness.

## 9. Recommendations

The CCG is recommended to:

- 9.1 Note that equity of healthcare outcomes for homeless people is based on core principles of care including, continuity, multi-disciplinary approach, permanent registration, service user involvement, routine liaison with outreach teams and collaboration with wider services (housing, dentistry, podiatry, mental health).
- 9.2 Recommission specialist general practice provision for homeless people in Leicester.

Rod Moore Consultant in Public Health  
Mark Wheatley Public Health Principal  
June 2016

## APPENDIX A

# Specialist APMS Group Leicester City CCG

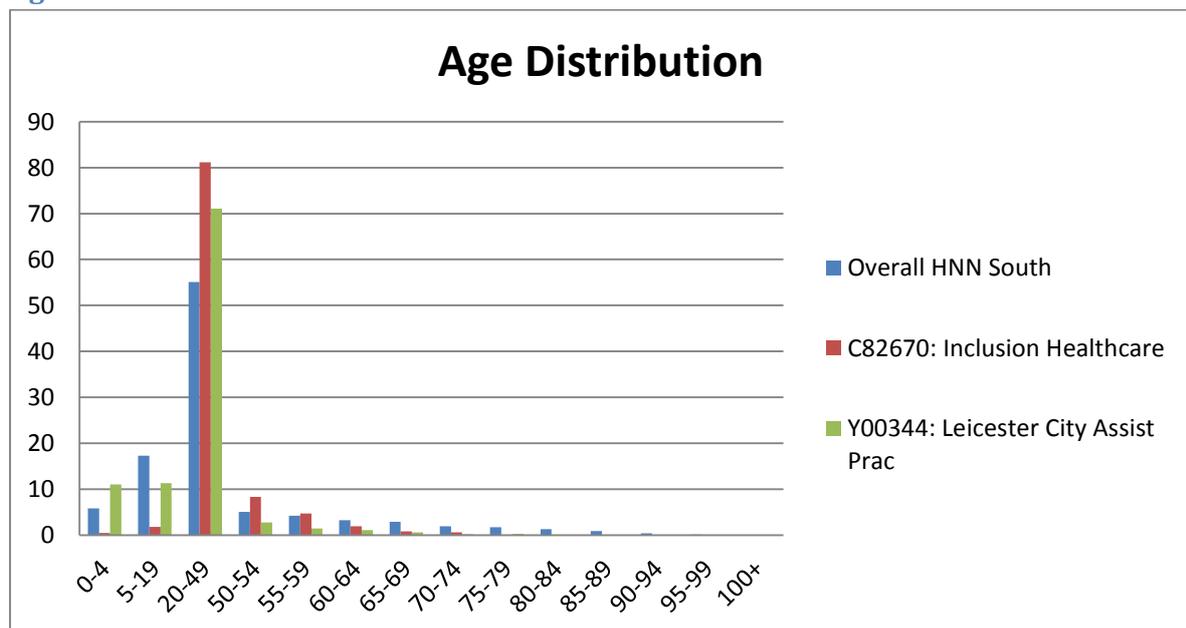
## Needs assessment for current population and health needs of Homeless and Asylum Services

**Method:** data was taken from Gemima 26/4/16 for HNN South which serves as the comparison group for this analysis.

### Registered population

Practice	List
C82670: Inclusion Healthcare	1352
Y00344: Leicester City Assist Prac	1493

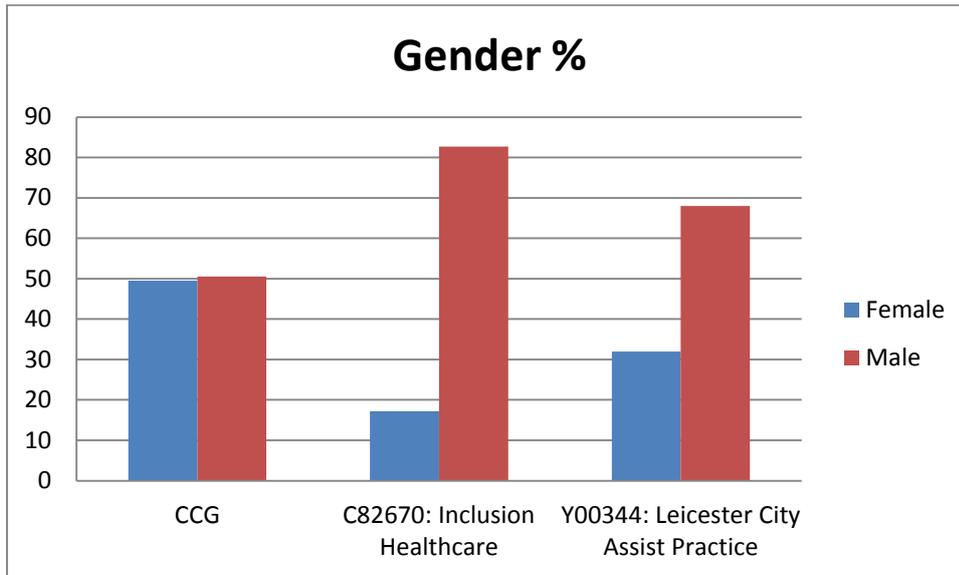
### Age breakdown



Assist has a very young population 93% being under 50 (78% for HNN South)

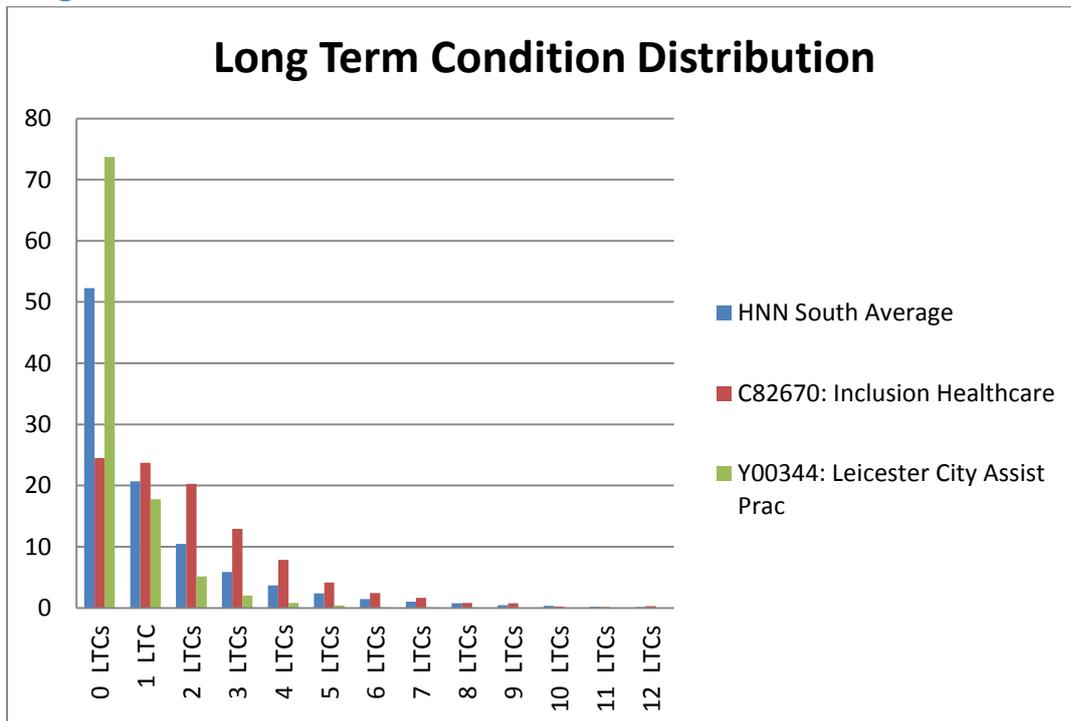
Inclusion too has a young population but heavily concentrated in the 20-59 age group (94% of its population in this age range compared with 64% for HNN South)

## Gender



Both practices have a predominantly male population

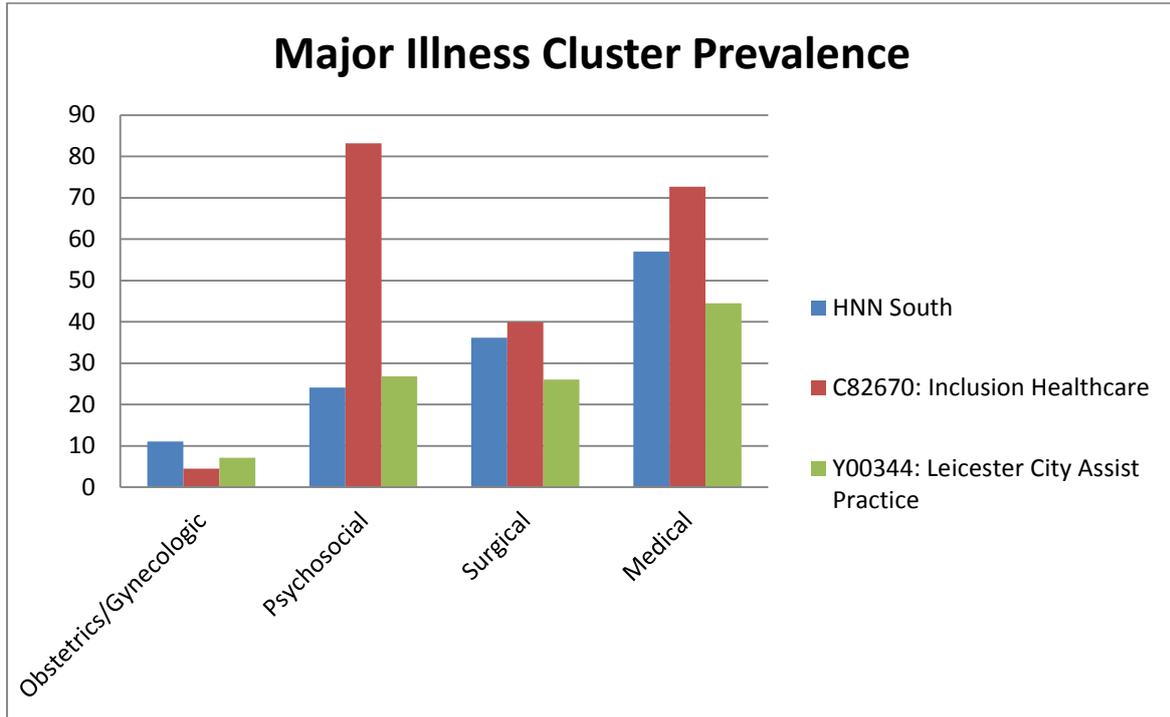
## Long Term Conditions



As expected for a younger population Assist has a higher proportion of patients with no identified Long Term Conditions than HNN South and a lower proportion with multiple long term co-morbidity.

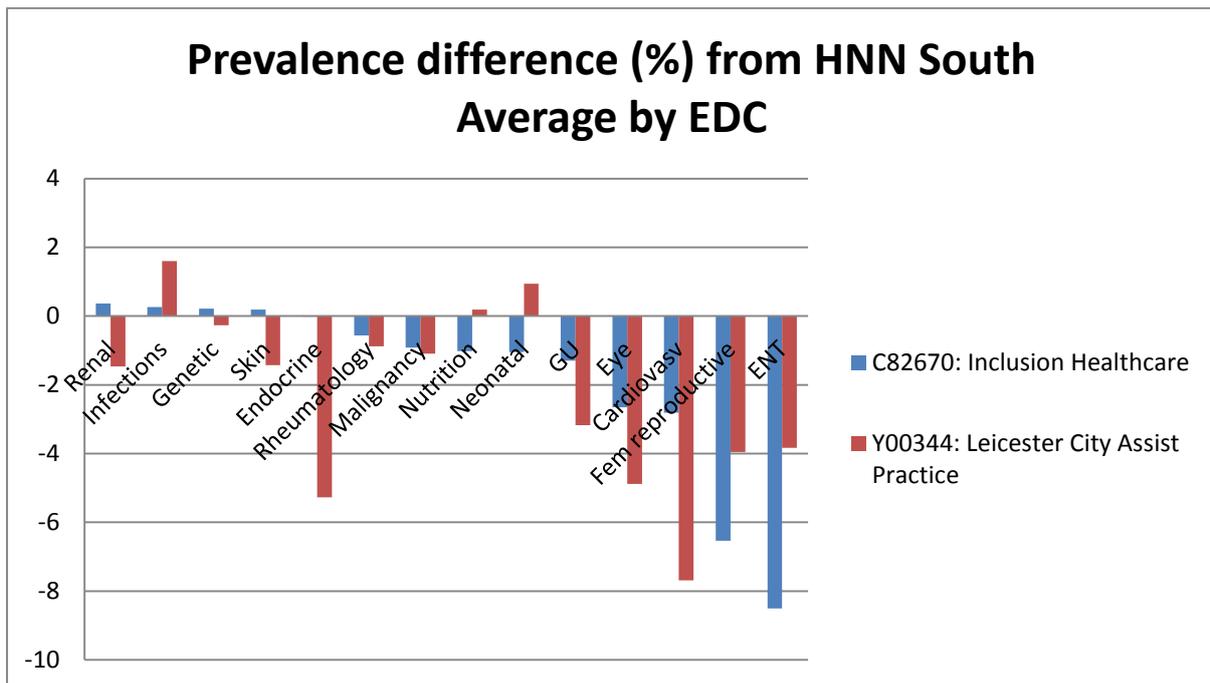
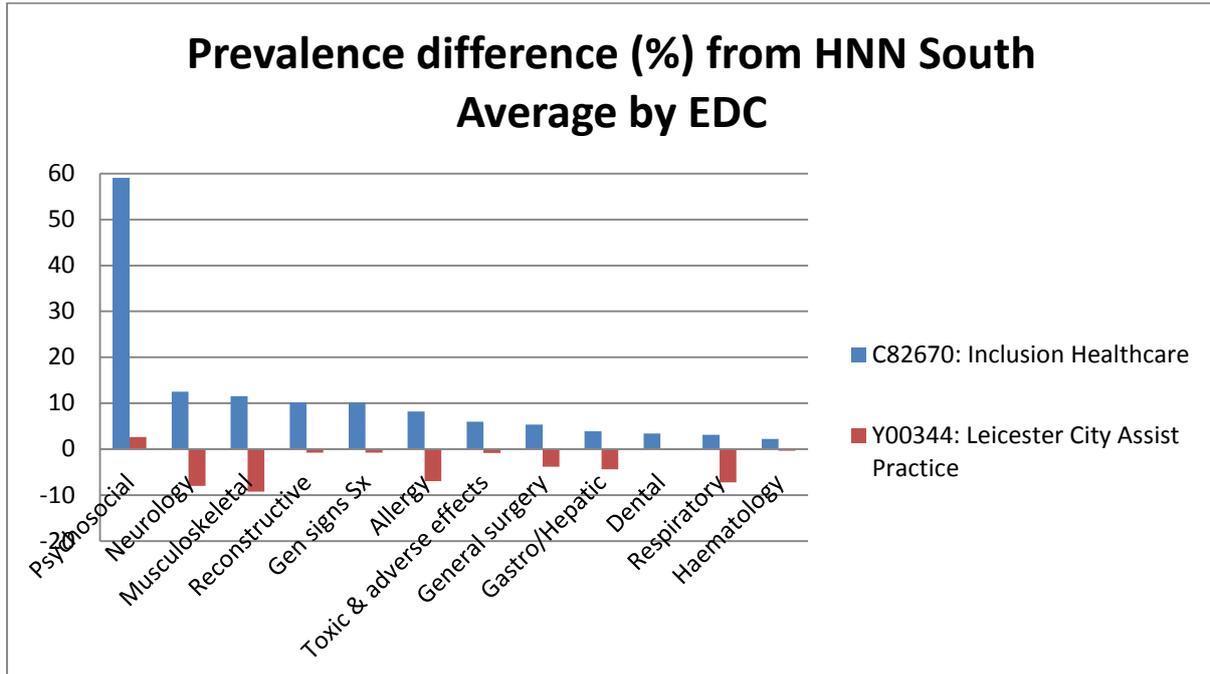
Inclusion clearly has a more multi-morbid population than HNN South, with a higher than average proportion of its population having LTCs. 52% of its patients have 2 or more LTCs, compared with 8.5% for assist and 27% for HNN South overall.

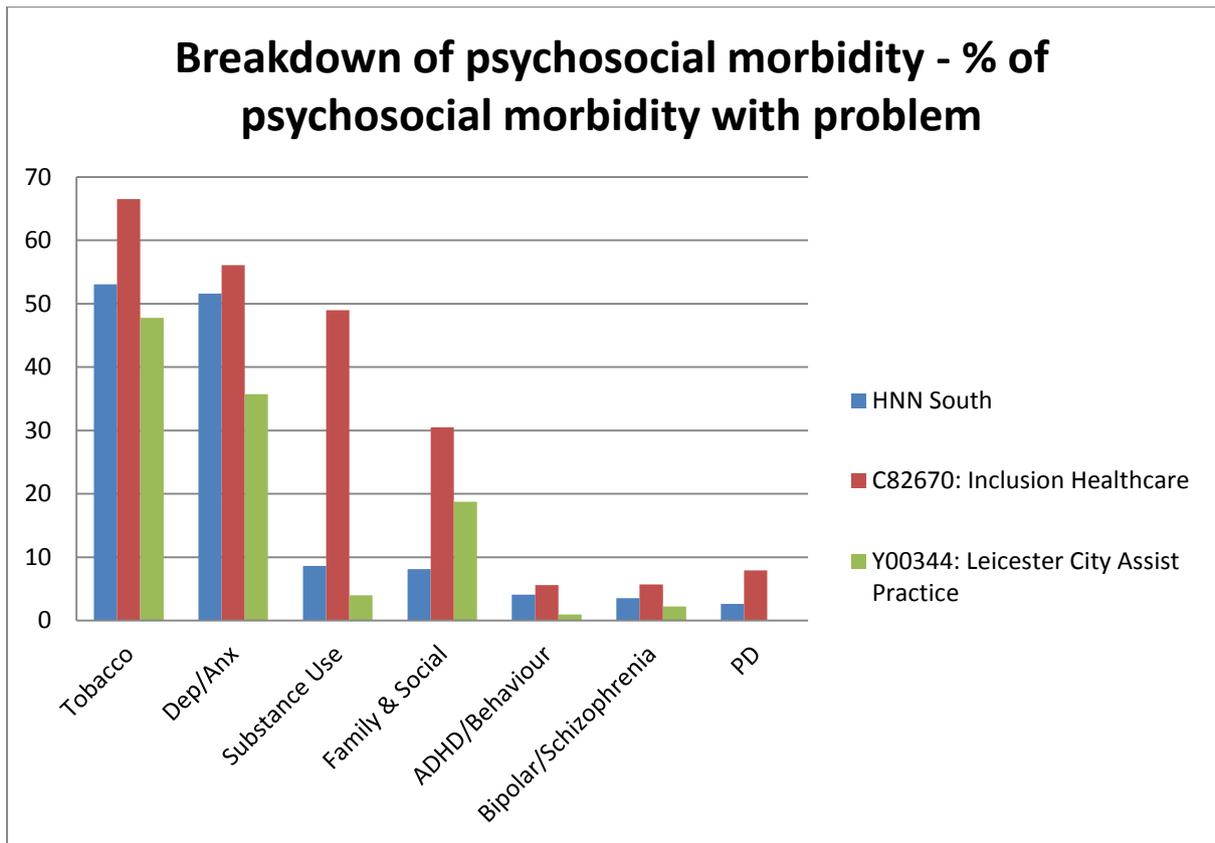
## Major Expanded Diagnostic Clusters (MEDC)



Despite having a young population the prevalence of obstetric and gynaecological illness is low at both practices compared with HNN South reflecting the gender split. However Inclusion has very markedly more recorded psychosocial problems compared with HNN South as well as generally more medical and surgical problems. The lower levels of illness at Assist reflect its young population. The origin of its population is probably reflected in its higher than HNN South prevalence of psychosocial problems (HNN South itself is higher than England average)

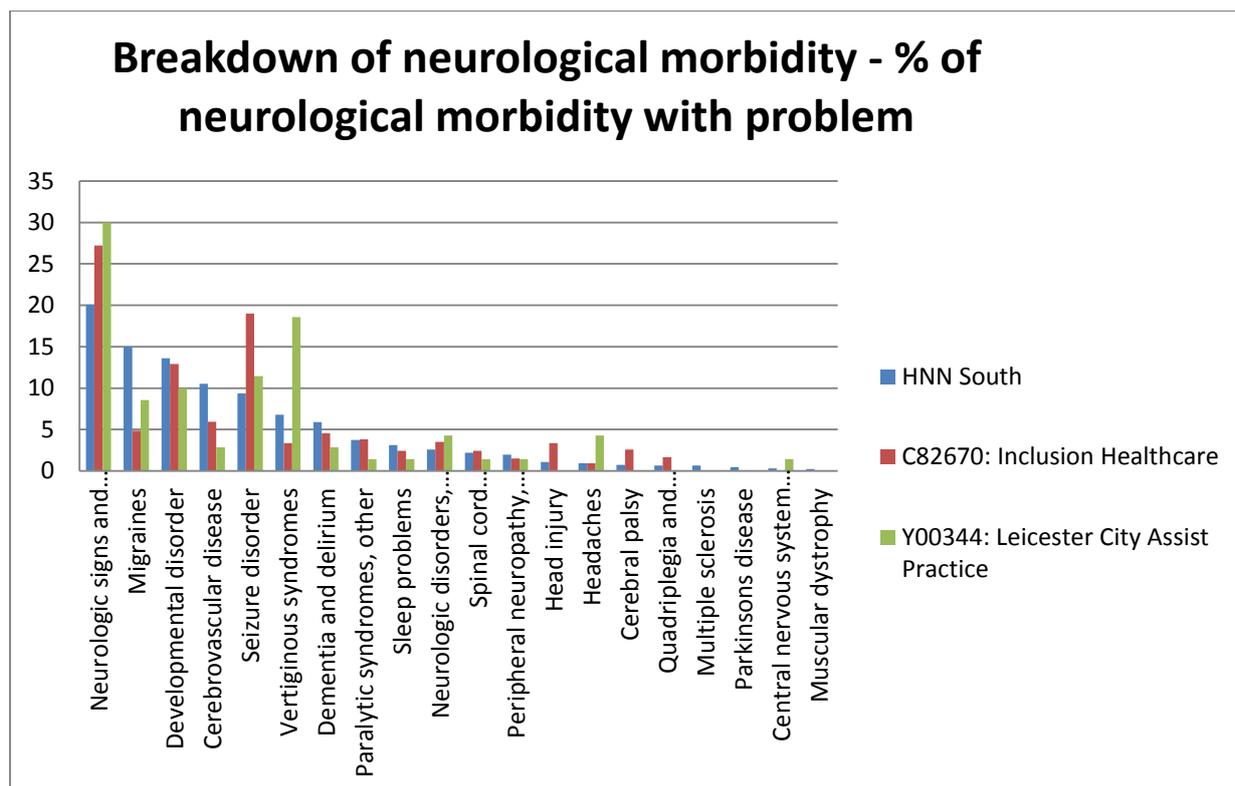
EDC Prevalence Differences from HNN South Average





Of patients with psychosocial morbidity it is notable that Inclusion has a higher proportion across all sub-areas than HNN South, with many of these patients having more than one problem in the psychosocial category.

The increased psychosocial morbidity seen in Assist is confined to tobacco, anxiety and depression and family and social problems, with a lower proportion from major psychiatric illness.



Amongst Inclusion patients seizure disorder and head injury stand out which probably reflects the high rate of alcohol problems in this group.

From Assist the predominance of non-specific neurologic signs, vertiginous syndromes and headache probably reflect high levels of stress in this population.

### Summary

**Inclusion:** a young to middle aged predominantly male population with very high levels of psychosocial multi-morbidity and concomitant physical illness.

**Assist:** a young mainly male population with a disease profile reflecting this with indicators of social distress in psychological and neurological disease profiles.

Please note this analysis has not been able to look at ethnicity, country of origin or communication issues.

DJS April 2016

**APPENDIX B**

**North and East Leicester HNN Meeting Wednesday 27<sup>th</sup> April 2016 - 6.30pm - 8.30pm**

Practice Name	Attendees Name	Initial		Practice Name	Attendees Name	Initial
Ar Razi Medical	Dr AK Vania	AKV		Willowbrook Medical Centre	Dr N Joshi	NJ
Asquith Surgery	Dr G Sharma	GS		The Willows	Dr P Pathak	PP
Downing Drive	Dr A Bentley (Chair)	TB		Senior Strategy & Implementation Manager LC CCG	Clare Sherman	CS
Johnson Medical Practice	Dr B Patel	BP		Head of Governance LC CCG	Jo Grizzell	JG
Humberstone Medical	Dr D Salkin	DS		Locality Pharmacist LC CCG	Mini Satheesh	MS
Sayeed Medical Centre/Rushey Mead (The Practice PLC)	A Balakrishnan	AB		Leicester City Council Public Health	Mark Wheatley	MW
St Elizabeth's Medical Centre	Dr T Cheesman	TC				

**South HNN Meeting Wednesday 27<sup>th</sup> April from 7.00–9.00pm**

Practice name	Attendees name	Initial		Practice name	Attendees name	Initial
Aylestone Health Centre	Dr Minhas Bhavna Maru	HM BM		The Surgery @ Aylestone	Dr Sahdev	RS
Clarendon Park Surgery	Dr Prasad	AP		Victoria Park Health Centre	Dr Browne	LB
De Montfort Surgery	Dr Heaton Paul Houseman	JH PH		Walnut Street Surgery	Dr Panacer	DP
Inclusion Healthcare	Dr Dibdin	ED		CCG : Medicines Optimisation	Kerry Clay	KC
Leicester City Assist Practice	Dr Hiley	AH		CCG : Strategy & Implementation	Hema Jesa Mark Pierce	HJ MP
Pasley Road Health Centre	Dr G Singh	GS		CCG : Nursing & Quality	Wendy Hope	WH
Saffron Health	Dr Shepherd Philippa Guy	DS PG			Sarah Prema	SP
The Hedges Medical Centre	Dr Henwood Carole Jasilek	NH CJ				

**Central Leicester HNN Meeting Thursday 28th April 2016 from 6.30-8.30pm**

<b>Practice name</b>	<b>Attendees Name</b>	<b>Initials</b>	<b>Practice name</b>	<b>Attendees Name</b>	<b>Initials</b>
Al-Waqs Medical Centre	Dr K Choudhry	KC	SSAFA Care CIC	Dr O Uprichard	OU
Belgrave Health Centre	Dr N Lawrence	NL	Shefa Medical Practice	Dr F Docrat	FD
Broadhurst Street Surgery	Dr KS Morjaria	KM	Spinney Hill Medical Centre	Dr P Pancholi	PP
Canon Street Surgery	Dr B Modi	BM	St. Peter's Health Centre	Dr S Mansingh	SM
East Leicester Medical Practice	Dr Farooqui	AF	HNN Pharmacist	Hitesh Parmar	HP
Evington Medical Centre	Paul Houseman Dr C Kumar	PH CK	The Charnwood Practice	Paul Houseman	PH
Highfields Medical Centre	Dr F Patel	FP	CCG: Strategy & Implementation	Mark Pierce	MPi
Highfields Medical Centre	T Masani, Practice Manager	TM	NHS England	Mayur Patel	MPa
The Melbourne Centre	Dr K Hoque	KH	CCG: Senior Strategy & Implementation	Clare Sherman	CS
East Park Medical Centre	Dr S Shah	SS	CCG IM&T Facilitator	Nisha Mistry	NM
St Matthews Health & Community Centre	Dr S D'Souza	SD'S	CCG: Lead Nurse	Wendy Hope	WH

**North and West Leicester HNN Meeting Thursday 28th April 2016 from 7.00-9.00pm**

<b>Practice name</b>	<b>Attendees name</b>	<b>Initial</b>		<b>Practice name</b>	<b>Attendees name</b>	<b>Initial</b>
Dr Arolker & Partners	Dr D Jawahar	DJ		Westcotes Medical Practice & Brandon Street Surgery	Dr G Boora	GB
Beaumont Lodge Medical Practice	Dr Virdee	MB		Public Health	Mark Wheatley	MW
Fosse Medical Centre	Dr H Mukadam	HM		Westcotes Health Centre	Dr KM Taylor	KT
Groby Road Medical Centre	Dr C Rabbitt	CM		Oakmeadow Surgery	Dr P Jones	PJ
The Parks Medical Centre	Dr B Hainsworth	BH		The Practice – Beaumont Leys	Dr G Alagesan	GA
Hockley Farm Medical Practice	Dr A Bayford Cheryl Wright	AB CW		Leicester City CCG Independent Lay Member	Nick Carter	NC
Merridale Medical Centre	Dr R Tew Vicky Kershaw	RT VK		Leicester City CCG	Hannah Hutchinson / Ali Brooks	HH AB
Heatherbrook Surgery	Dr T Kapasi	TK		Medicines Optimisation – Leicester City CCG	Amit Sammi	AS
Fosse Family Practice	Dr U Roy	UR				

**Needs Assessment: Homelessness Wednesday 4<sup>th</sup> May 2016**

<b>Name</b>	<b>Job Title</b>	<b>Organisation</b>
Mark Roberts	Head of Service	LPT
Helen Payne	Frequent Flyer Nurse	LPT
Iain Blakeley	Alcohol Liaison Nurse	UHL
Laura Devlin	Street Drinking Outreach co-ordinator	Leicester City Council
James Atkinson	Service Manager	Turning Point
Clare Davis	GP	Long Lane Surgery
Nigel Hewett	Medical Director	PATHWAY
Anna Hiley	GP Inclusion	Inclusion
Sarah Hancock-Smith	Service Manager	CJDT Probation
Mark Grant	CEO	Action Homeless
Maxine Jenkins	Specialist Health Visitor	LPT
Tirathpal Nante	Development Worker	EQSD/PCEG
Sally Flanagan	City Advocacy Service	LCPT
Martin Mullaley	Advocacy Worker	LCPT
Nicola Wilmot	Service Manager	Leicester City Council
Priya Chavda	Primary Care Contract Support Manager	LC CCG
Lee Keeling	Contracts and Assurance Manager	Leicester City Council
Rebecca Pawley	PA	Inclusion
Anna Maudsley	Housing Director	The Y
Liz Carney	Mentor Co-ordinator	The Bridge
Kate Beaumont	Support Project Manager	The Y

## APPENDIX C

### Homeless service engagement phases 1 and 2

#### Summary of findings

The below bullet points highlight the combined key themes from all qualitative and quantitative data collected from patients during the **first and second** phase of engagement:

##### First survey summary

- 155 people completed the first survey
- The majority of respondents who completed the survey were patients of the service (89%)
- The majority of respondents who completed the survey were male (79%)
- The majority of respondents who completed the survey were British (73%)
- The majority of respondents (58%) stated that they were between 35 and 59 years old.
- Most of the respondents stated they were single (67%).
- Of the 61% who said they had a disability, the main type stated was a mental health condition or illness (67%) 27% said their condition was physical.
- A large proportion of respondents book appointments by visiting surgery
- Patients stated they did not want to wait a long time in surgery for appointment as it could be a time to make 'bad decisions' with people they meet there. Asked for pre-bookable appointments rather than 'sit and wait'
  - Offer reminder service, or offer reminder of when appointment time is near
- A number of patients said they were more concerned with someone being there to listen and help rather than being the same GP
- A small number of respondents asked for appointment reminders as often get side-tracked and needs change on a daily or even hourly basis
- Preferred appointments were Mondays, Tuesdays and Thursdays, 8am-12pm or 12pm-4pm
- Respondents asked for dental services and mental health support
  - Communicate local dental services and access, signposting to mental health locally

Feedback on the option to merge contracts was favourable for the Homeless Service and ASSIST service

##### Second survey summary

- 55 people completed the second survey
- The majority of respondents who completed the survey were patients of the service (49%)
- The majority of respondents who completed the survey were male (86%)
- The majority of respondents who completed the survey were British (70%)
- The majority of respondents (69%) stated that they were between 35 and 59 years old.
- Most of the respondents stated they were single (68%).

- Of the 49% who said they had a disability, the main type stated was a mental health condition or illness (71%) 37% said their condition was physical.
- The preferred location for the homeless service is Charles Berry House (54%)
- Getting an appointment to be seen quickly (50%) and approachable receptionists (40%) are the most important areas for the homeless service
- Knowledge of you as an individual (past history) (43%) and availability (39%) are the most important for doctors and nurses
- 76% would prefer a pre-booked appointment but many said they would like a choice of both.
- 60% of respondents would use an SMS text service to book an appointment
- 77% of respondents would like to use an SMS service for appointment reminders
- Mental health support workers coming to see you where you are, Counselling services (one to one) and alcohol and drugs support were the most important areas for improvement for mental health services at the practice
- Seeing a GP of your choice was the most important choice for respondents overall.
- When asked what patients would do if they couldn't get an appointment, the majority said they would call back later and wait until they could book an appointment (47%)
- Most of the comments asking for improvements in the service said they were happy with the current service and didn't offer any improvements saying it was "as good as it can be".
- Most of the respondents stated that they were happy with their doctor or nurse and offered no improvements saying the service is currently 'good' and explaining that everything was already being done well.
- During the PPG meeting, service users said they were concerned about the impact any dramatic changes to the current service may have on their health and wellbeing.

## Quotes

About Inclusion Healthcare:

*"Quite simply life-saving. It works with an incredibly marginalised, vulnerable, stigmatised (and not easy to work with) population – and it generally does this incredibly well"*

*"Provides a reliable, friendly service with staff that are good with the users"*

*"Prioritising patient's needs – signposting to other agencies"*

General:

*"Anxious patients find it difficult to sit and wait. As a support worker I have 1<sup>st</sup> experience of how difficult it is to get young residents to address health issues and we have to strike when the iron is hot. Sitting and waiting is difficult to get young people with various issues to do."*

*"Mental health nurses should be provided and support with alcohol abuse. This is urgently needed"*

*"Deal with people quickly"*

*"More time with clients, maybe 2 or 3 things to discuss"*

**APPENDIX D**

**Protocol: Schedule and record form for interview with Inclusion Healthcare Homeless Service.**

<b>Date of interview</b>	<b>26<sup>th</sup> April 2016</b>
<b>Background and process:</b> Thinking about the process by which Homeless people register with Inclusion. Chaotic lifestyles;	
<b>Written evidence about basic facts, venues times etc.. annual reports, data, summary of health needs</b>	
<p>1. What's the story of homeless and health care in Leicester? How have services developed over the years?</p>	<p>Healthcare services for homeless people really took shape after a report to the Secretary of State for Health in 1998 written by Nigel Hewett. Up to that point there had not been a defined specialist service as such. There had been some practice, clinician led rather than commissioned, in the Pocklington's Walk night shelter for one day a week.</p> <p>The report, combined with political pressure to improve services for homeless people, helped to secure DH funding for a short period of time. This funding helped in the development of a model for care for homeless people.</p> <p>A pivotal point was registering people seen in the night shelter to a general practice. This built on the opportunistic element of caring for homeless people; Maslow showed the need to make efforts to ensure accessibility to healthcare.</p> <p>The night shelter was inadequate to meet needs (general needs of homeless people), and not the only venue used. So there was the development of the Dawn Centre.</p> <p>Other venues used included the YASC (Y advice and support centre); Office outreach; New walk; Hastings Street; Loughborough Road; Anchor centre; Upper Titchborne Street. These venues, which were intended to give general support to homeless people, were useful resources for health care purposes.</p> <p>Recent closure has led to hostel communities moving into shared accommodation. Homeless people have become more dispersed, giving fewer prospects for opportunistic care. For example, recently case work for a Shared Care Drug Worker (40-50 people) has become too dispersed and less manageable.</p> <p>In general Homeless Healthcare is more reliant on Revolving Door; the local authority service gateway for homeless people (I know about this but needs better definition).</p> <p>Most shared accommodation is housing for 2-3 people, with</p>

	<p>no supervision. Security is sometimes an issue. People may feel vulnerable housed with someone who offers them drugs etc..</p> <p>The change in service provision has happened at a time when the issue of homelessness is worsening. There has been a step change in the problem of street drinking. Service changes mean that there has been a reduction of 200 (?) bed spaces from the closure of hostels (e.g. London Road, Upper Titchborne Street).</p> <p>Local authority definition of homelessness is contentious. It doesn't include sofa surfers or people in shared accommodation. For Inclusion, not having secure accommodation, having no address, no fixed abode, these are all about stability, and the things which may daily living possible. How do you care for people who can't receive appointment letters for example?</p> <p>Another complicating factor is that when services are locality based it means that homeless people move between teams and may have no chance of developing a therapeutic relationship with a clinician or other service provider.</p>
<p>3. Is the CCG the sole commissioner of Inclusion (do NHS England have a role)?</p>	<p>The service is co-commissioned between the CCG and NHS England. The CCG hold the contract.</p> <p>Point of interest Inclusion hold contracts with other organisations. For example Criminal Justice Intervention Team (CJIT), Multi-agency public protection arrangements (MAPPAs), for substance misuse. The service can't register people with an address.</p>
<p>5. What is the process by which homeless people register with Inclusion?</p>	<p>Homeless people go to Charles Berry House, or the Dawn Centre.</p>
<p>2. Do all homeless people in Leicester register with Inclusion?</p>	<p>No, probably not. Older homeless people are more likely to attend their normal general practice. Younger people are more likely to register.</p> <p>Some people are effectively sofa surfing, may live in different areas, and may not want to register with a city centre practice.</p> <p>There is an issue about safe prescribing. Once some homeless people understand that they may not get access to drugs, they may be inclined to seek registration elsewhere. Some homeless people don't want to register with a practice.</p> <p>Inclusion looks after the Zero Tolerance group of patients.</p>

	<p>This is for one session per week for LLR. Patients who are removed from other practices because of violent behaviour. Contract held by Limes in Narborough; now at Westcotes house</p>
Other background	
<p><b>Description of health care service:</b> Thinking about health needs of homeless people what has Inclusion developed above and beyond normal primary care, why it has developed these services and the value of those developments. Issues may include lack of knowledge about the problems faced by homeless people, including effective multiagency working and continuity of care.</p>	
<p>4. Are there any particular issues or special needs in providing effective health care services for homeless people? Advocacy</p>	<p>Some aspects of care are above and beyond what you would expect in primary care. For instance a nurse works with the Outreach Team, often starting in the early hours (4 am). This is important work because it gives homeless people the opportunity to learn who is working with them, establish a trusting relationship. Other people who work with the Outreach Team include Specialist Alcohol Worker.</p> <p>The APMS gives some flexibility. Inclusion is able to get out to people when necessary; using what could be called an assertive outreach approach. Inclusion works with key partners, such as A and E for search for and identify homeless people.</p> <p>The Health Care Assistant (HCA) works beyond the scope of what is normal in general practice. This role supports people who might otherwise miss appointments, accompanying them to hospital appointments. There is a lot of following up, above and beyond chasing of people.</p> <p>When someone is ready to move on the HCA may take people to register with a new GP. The practice will sometimes be the postal address for people who require hospital letters. It has a community fund for patients and partner agencies; helps with, for instance transport, pet care, taxi account. The cost savings from this may be found in the wider health economy.</p> <p>Inclusion also provides training for GPs, in root cause analysis, looking at potential gaps in care, CPD for GPs working in substance misuse, on the substance related death panel. Also give some expertise for domestic violence services across LLR, street drinking, alcohol safety.</p>
<p>6. What are the main health issues faced by homeless people?</p>	<p>Hepatitis C; Substance misuse; mental health problems especially depression, anxiety disorders, psychotic disorder. Co-morbidities, dual diagnosis of substance misuse and</p>

	<p>mental illness. DVT.</p> <p>Release from prison is an issue. The practice often has to chase medical records and scans for people who are released from HMPs such as Peterborough and Lincoln.</p> <p>Other problems: ADHD; Autistic spectrum; Respiratory conditions. Managing homeless diabetics is difficult, for instance where to store needles and insulin.</p>
7. Is your service part of a wider service for homeless or focused solely on their health care needs?	Lots of close working with services, such as the street drinkers, probation etc..
8. How is it organised CBH and Dawn Centre?	<p>People who can choose to be seen at either the Dawn Centre (DC) or Charles Berry House (CBH). There is some pressure on the service to be based at the Dawn Centre, because other homeless services are based there. However, some patients choose not to attend at the Dawn Centre because of feeling vulnerable in contact with other homeless people.</p> <p>DC has the 42 bed night shelter. Inclusion felt that there is no added advantage in being at DC. There was not enough room and the costs of CBH are not so high.</p>
9. What would be the barriers to effective healthcare for homeless people in normal primary care?	The lifestyle of homeless people, the time taken to ensure outcomes; e.g. organising treatments, maintaining records, having basic things like a fridge, an address.
10. What is the service provided?	Host optometry; physiotherapy for musculo-skeletal trauma and pain relief (this may help boost self-efficacy, coming off pain killing drugs); Re-invest into homeless healthcare from social enterprise; Primary care plus role nurse who undertakes patient follow up, advocate on wards with drug services etc.. Review of urgent care use and assertive outreach type model.
11. What services has Inclusion developed above and beyond normal primary care?	The primary care plus features also advocacy role.
12. What has been the value of these services?	Reducing the barriers respect which they don't get in other areas
13. Is it only for homeless people? If not, who else uses it?	Yes
14. How is it staffed?	Figures to be provided

15. How many people go through the service each year?	Figures provided at the meeting
<p><b>Churn and move on:</b> Thinking about the patient journey through Inclusion Healthcare, our assumption is that the Inclusion primary care model offers specialist practice for initial assessment and care of health needs of homeless people. The intention is that there is some churn in the practice for a number of reasons including;</p> <ul style="list-style-type: none"> <li>• Leaving the Leicester area to live somewhere else</li> <li>• Mainstream General Practice</li> </ul>	
16. Can you tell us about the number of people who register and leave in a year?	See figures
17. Does this mean that there is a large churn in patients at Inclusion?	See figures
18. What are the reasons for leaving?	<p>A large number of homeless people are registered and leave in a year. It is a picture of high rate of churn. People who are in prison may not be de-registered. Data from SystmOne show number of people who have several registrations. For some patients there is a degree of stability for a while. But when people are house they usually move practices.</p> <p>It is often the case that people re-register and go through the system again. Generally it is a picture of fragmented care. But there are people who have been on the records for more than 10 years. Some people leave the area but don't let the practice know. This is problematic especially when they don't appear to have any contact with other services; Inclusion retain registration for a while.</p>
19. How does the service fit with other local services for homeless people (the local council, voluntary organisations etc.)?	Close working with the Dawn Centre, local authority and homeless VCS organisations. Work with local secondary care.
<b>Interviewer</b>	Mark Wheatley <b>Present: Dr Hiley; Emily, Wayne; Susanne</b>

## APPENDIX E

### Homelessness: Stakeholder meeting 4<sup>th</sup> May 2016

#### Purpose of today:

By way of context Leicester City Clinical Commissioning Group is looking again at how it provides services for asylum seekers and homeless people in Leicester. Public Health at Leicester City Council is working on a needs assessment for both populations as a first step in identifying a service model and specification for future service provision.

In order to do this we have arranged these meetings with stakeholders to better understand needs, issues and challenges in providing primary health care to the patients that are currently registered with the homeless service and the ASSIST Service.

This meeting is only in relation to the needs assessment. There will be further stakeholder engagement and public consultation, as previously, when the CCG has developed proposals for future service provision.

We have a small number of questions to get through today. If you feel that they are not the right questions to ask and if you don't get the chance to say everything you want we will give you the opportunity to follow up, we are already in contact with some of you and we have your contact details.

<b>In attendance (see Attendee List for Job Titles)</b>	Helen Payne; Iain Blakeley; Laura Devlin; James Atkinson; Clare Davis; Anna Hiley; Mark Roberts; Sarah Hancock-Smith; Mark Grant; Dr Nigel Hewett; Karen Purewal; Dr Clare Mason; Maxine Jenkins; Tahera Khan; Sally Flanagan; Martin Mullaley; Mark Grant; Nicola Wilmot; Lee Keeling; Rebecca Pawley; Anna Maudssley; Kate Beaumont; Liz Carney; Tirathpal Naute
<b>Background information:</b>	Thinking the needs of homeless people and how they impact on health and wellbeing. The way in which homeless people get in contact with you. We are looking for evidence of the main needs, the problems faced by homeless people, age, employment, accommodation type. Why they are homeless? Sofa surfing, squatting, rough sleeping etc., the difference in need between people who are statutory and hidden homeless.
<b>What's the story of homeless people in Leicester? The number of people, where they live</b>	<p>Wider context of homeless people in Leicester is one of high rents. This affects all people, and anyone can become homeless. This is particularly true of a change in economic circumstances. One practitioner reported seeing fewer families with substance misuse problems recently</p> <p>There is a trend of increasing number of rough sleepers from abroad who need access to public services. The number of homeless older beyond retirement age is increasing. Disability and mental illness are problems for homeless people and for getting on the housing list. Specialist help is sometimes difficult to get.</p> <p>Once a person becomes homeless there are issues with access to benefits, and general issues with getting on the housing register. Lack of access to IT is a particular problem, often it means that homeless people are not able to participate, or get the benefits to which they are entitled.</p> <p>There was a feeling that a history of good services in Leicester may be attractive to people who would normally be resident out of area. That there are a rising number</p>

	<p>of people who may have accommodation in other areas.</p> <p>Homeless people are sometimes uncertain about their rights to access health care. They are likely to attend the Emergency Department if they are unwell and cannot access to prompt primary care.</p> <p>Look at the work of York University, this shows that there are multiple factors, co-morbidities, multiple exclusion associated with homelessness. Also consider learning from the recession of the 1970s and how this may apply to the 2009 recession; see the work of Dennis Culhane at Pennsylvania University.  <a href="http://repository.upenn.edu/cgi/viewcontent.cgi?article=1148&amp;context=spp_papers">http://repository.upenn.edu/cgi/viewcontent.cgi?article=1148&amp;context=spp_papers</a></p> <p>The average age of homeless people and people living on the margins is increasing. There is a perfect storm of pushing people to the margins; prisons and NHS can't turn people away. There is a need for health care services to look ahead and anticipate future needs.</p> <p>Increasing number of homeless families who are sofa surfing. An address is important because it gives access to primary and secondary care. GPs often have problems when people have no fixed abode, and this means that homeless people cannot get timely access to care.</p> <p>From a health care and housing perspective homelessness is a proxy marker for deprivation. Homeless people have the risks associated with high levels of deprivation, such as an increasing use of psychoactive substances, don't see themselves as people who would traditionally access services. There needs to be a joint approach to services, linking Homeless health care, the criminal justice system, specialist mental health care, trauma care and looking after people who live at the extremes.</p>
<p><b>In your experience what are the main needs of homeless people? Issues of poverty, trauma, co-morbidities, practicality of not having an address.</b></p>	<p>Some of the main problems are drug taking, mental illness and trauma.</p> <p>Drug taking and alcohol use are linked to worsening mental health. There was a feeling that people misused ambulances and that on occasion ambulances did not attend some homeless people who are known to be difficult. Trauma can affect memory, in a way which affects basic things, such as using a mobile phone. When someone's memory is affected this may have an impact on the stability of someone's life, they may not be able to out on their own, attend appointments.</p> <p>Currently mental health problems are rising in street homeless; estimate that 80% of service users have a mental health problem. There was a sense that mental health services are not able to cope, and that there is a need for joined up thinking to ensure better access to services.</p> <p>Multi morbidity and complexity, complex trauma, mental illness, behaviour management problems, co-morbidity. These issues would be difficult to manage in a mainstream setting. For instance, it is difficult to see how people with complex lives can call a practice at 8 am for an appointment.</p>

	<p>There was a feeling that it was better for homeless people should be supported in an environment which was able to meet multiple morbidities and complexity. People with chaotic lifestyles tend to consult much later, and have self-perceived crisis situations. Neither primary nor secondary care is not geared up to deal with extreme, multiple, problems.</p> <p>Homeless families can only get temporary registration; this stymies proactive care (smears etc.). There are some families who have moved 8 times in a 3 year period.</p> <p>In Sheffield there was a 300% increase in service use by young homeless people (aged 18-25). This was the largest proportional increase. Commensurate with international research it is important to engage and manage homeless people at this age; it will only worsen as this group gets older. However it is difficult to engage with them.</p> <p>In Leicester there is a need for specialist teams to provide mental health for homeless people who don't stay in accommodation long enough to register with a general practice. However, the Homeless Mental Health Service is effective.</p> <p>The local situation has been worsened by the decrease in local floating support; this will make people more vulnerable.</p> <p>Open access works well. Some short lived projects have been effective in mental health care. Mainstream mental health care is difficult for people who are homeless. Lot of workers are willing to help, but there are people who treat patients without respect which can cause damage to their mental health and self-esteem.</p>
<p><b>How do homeless people come into contact with your organisations ?</b></p> <p><b>Housing Options, how people link with networks; rich and poor networks, people who may flourish because of good networks.</b></p>	<p>Is the approach correct? No it is not at all right. People who go to the Bridge are too chaotic for mainstream care. Actually adult social care should be better and health and social care, and VCS should be more joined up.</p> <p>Someone admitted to secondary care from Leicestershire can have their case considered by a formal social service multi-disciplinary team, and this may cover important safeguarding issues. There is a need to consider other factors such as Care Act criteria, advocacy for homeless people and the strategic overview of Better Care Together. There are issues about planned discharge and implementation of protocols which may not work for people in the most chaotic and vulnerable group. There is a lack of continuity of care.</p> <p>In times of recession budgets are cut and barriers of access to services increase. Services could be said to be looking for ways to push people away rather than care for them. There are people, such as the homeless, who fall in the gaps and who have complex needs. The chaos and infighting leads to worsening health and health care response.</p> <p>There needs to be an integrated and joint approach. Homeless people are not compliant, they are easy to ignore and exclude.</p> <p>The Hard Edges research report refers to about 1,500 people in Leicester, some of whom are in prison. There are 365 pts with &gt;10 annual attendances at A and E.</p>

	<p>these are multidisciplinary complex patients, some of whom are homeless.</p> <p>For most homeless people there is no health advocacy no proper use of complaints procedure.</p>
<p><b>Description of health care service:</b> Thinking about health needs of homeless people how well are they met through specialist care, primary and secondary care.</p>	
<p><b>Does your organisation link with Inclusion health care?</b></p>	<p>Everyone who uses Inclusion Homeless Health Care seems to feel that the organisation is supportive and helped homeless people to re-join mainstream services.</p> <p>Without Inclusion access to health care would be more difficult. In some practices Homeless people have experienced locums and lack of continuity of care. Locums may not recognise addresses and have no idea if a person is homeless of staying at a temporary address. Among some homeless people there is a language barrier.</p> <p>Mainstream general practice may offer only a few minutes for a consultation. This restricts illness prevention work. There are often telephone consultations, which require people to contact a surgery at an agreed particular time, there are partial booking systems and many people may not get to see their GP. None of these factors would help in the care of homeless people.</p> <p>A key factor is complexity. Inclusion is an effective problem solving service, which ultimately helps people to move into mainstream services. Potentially there are safety and safeguarding concerns with mainstream services. Where necessary patients are given more time for a consultation. The link with the Dawn Centre is effective; it has even helped with homeless people who need end of life care.</p> <p>Inclusion also has insight into problems such as the shame and guilt of people who are homeless. The service has a non-judgemental helps engage people in looking after their own health.</p> <p>Other issues which are covered by Inclusion which may be missed by mainstream general practice: Substance users who are not homeless but are on the edge of being homeless; care of offenders with high levels of disadvantage; A and E attendance – significantly better where Inclusion is involved: access and trust, flexibility and readiness to care; complexity of need and continuity of care which is accessible.</p>
<p><b>Do you have views about what happens to homeless people? For instance those who are or are not statutory homeless.</b></p>	<p>Some people do register with mainstream general practices. There is some difference between people who are sofa surfing and those who are living in hostels. However, these are chaotic lifestyles, the issues are the same, there appears to be a matter of degree of impact. Middle aged and older men may have more complicated lifestyles than those who are younger or people in homeless families. The latter may have been longer with a particular general practice.</p>

<p><b>Do they register with mainstream general practices and how they come to be with different practices</b></p>	
<p><b>What are the strengths and weaknesses of different service models in looking after homeless health needs?</b></p> <p><b>Specialist Services (separate from but ideally integrated with existing provision)</b></p> <p><b>Enhanced (added on to existing provision)</b></p> <p><b>Mainstream General Practice (Embedded within existing provision)</b></p>	<p>There is a need for a specialist service; otherwise there is a risk of excluding vulnerable groups. However educating other GPs about homeless people is also important, but learning about how to deal with these problems is frustrating in mainstream general practice where 30 patients can be seen at 10 minute intervals.</p> <p>If there was not a specialist practice there would be more attendance by homeless people at A and E and Urgent Care. The specialist practice offers flexibility, more time, joined up working. Sees beyond the problem (i.e. not just drug problem etc.). The service is welcoming, well-resourced and offers a service which is no different to other people.</p> <p>However the trouble with ring fenced specialist services is that there is no change in mainstream practice. This suggests that one way in which the mainstream could be changed if is Inclusion help to train practitioners in normal general practice. The level of knowledge in mainstream practice is poor and it is difficult to envisage individual GPs having the time to support housing applications, and multi-agency working.</p> <p>Should consider how specialist practice is a way of meeting specific Marmot duties.</p>

## Appendix F

### Draft summary of discussions with HNN 27 and 28 April 2016

#### 1. The perception of existing specialist services.

Overall there is little doubt that the specialist services and their staff are held in high regard by the body of GPs in Leicester. This has been mentioned at all the HNN meetings attended and we have also received individual communications to that effect.

#### 2. Practice experience of asylum seekers, homeless and refugees.

Most HNNs had practices within them that encountered both asylum seekers and homeless patients.

It is difficult to quantify the numbers seen. While a practice in North Evington indicated that they had no asylum seekers, others in the same HNN indicated they did have asylum seekers registered. Probably fair to say that all HNNs had some asylum seekers registered. The picture emerging from the HNNs of registration of homeless people is that on the whole it is rarer for practices to register a homeless person and unlikely to be “street” homeless. What practices seem to encounter is less of focus on the “no fixed abode” type of homeless but more on a process of patients becoming homeless – and who are staying with people, sofa surfing and who are generally insecurely housed.

Regarding the asylum seeker population encountered by practices, there was recognition of complex needs, including support for post traumatic stress disorder, physical trauma, advocacy, social rights, lack of knowledge of services available and language barriers. There were also mental health problems, absence of vaccination records or vaccinations, responses to adverse life events, the need for social and psychological support. One practice had an asylum seeker who had lied about his age.

Regarding homeless people there were issues which included cellulitis, drug and alcohol problems, social and psychological support, co-morbidities. The classification of a homeless person is problematic (someone who is staying at a friend’s house, for instance could be homeless). The complexities of care for homeless people was mentioned. Patients are often concerned about drug pushing in hostels, one mentioned that the capacity at a local hostel is a problem and another that some homeless people live in cars. Generally across practices, across HNNs it appeared that GPs dealt with the insecurely housed, young adults leaving/pushed out of home, or patients who have become homeless through other causes. The impression given was that GPs did not see/many of the no fixed abode/street homeless people.

#### 3. Registration issues.

There is possibly some confusion regarding registration of both asylum seekers and homeless people. Many GPs in the south thought that they could not register a patient unless they had some documentary proof of residence, some combination of national requirements – “anti-terrorism” – and a need for proof that the prospective patient is within the catchment area of the practice itself. Most or all GPs in the meetings were aware of the healthcare arrangements for homeless and asylum seekers in the city. Not all, however, had

a protocol of advice that they could give to those seeking help who they were unable (for whatever reason) to register. Clare Sherman from the CCG clarified that “practices can’t refuse to register people who are resident in their catchment area, even though there is a specialist practice to meet the needs of those groups”. There was a feeling amongst some of those who spoke at the central HNN that they are obliged to register asylum seeker patients and that they are therefore not able to signpost to another primary care practice (e.g. ASSIST).

#### **4. Demands on GP Practice.**

Asylum seekers. One GP reported that his practice does register some asylum seekers and the problems encountered are complex. Another indicated that asylum seekers have complex needs which would be difficult to manage in mainstream primary care. The words complex and time-consuming were frequently encountered. One doctor spoke about the complexity of care of people from different ethnic and language backgrounds. And the inadequacies of supporting services, such as IAPT which were described as inadequate in terms of timeliness and sometimes expertise to meet the needs of people who have experienced trauma. One with experience of looking after asylum seekers also recognised the demands of advocacy and letter writing, etc. There were different views about whether asylum seekers needed 2 – 4 weeks to settle and then one HNN at least that the experience of asylum seekers was so complex that they took a long time to recover. The experience of the north west suggested that attendance once registered at practices was high. Sometimes the asylum seekers required 30 – 40 minute appointments. Patients from all over the world, some had experienced bombing, torture and abuse. These require longer appointments. Sometimes the high practice attendance rates is for a limited time only. Overall there was a clear recognition that both groups (and also refugees) require more time and pose challenges to mainstream practices. They require longer appointments, a multi-language clinical practice perspective and staff with experience providing clinical services to these types of groups.

One GP said about how his practice found problems with trust, patients not open and that it takes a few sessions and there were issues such as no clear documentation which did not help. There would often be no or limited communication, language being a particular challenge. There was a feeling that residents, including the homeless and refugees, sometimes preferred local services rather than specialist service and that they would be likely to complain if they had to go out of their area for primary care.

#### **5. Transition to mainstream primary care.**

Areas that need further consideration are - guidelines on the period of time for the specialist service users to make the transition to mainstream practices, and the process for doing this perhaps. With the homeless particularly it was felt it was a bit of a revolving door, linked to the nature of homelessness/insecure housing.

#### **6. Funding cost per patient.**

One GP in the north east HNN observed that if the specialist APMS practices did not exist there was no guaranteeing funding would go to mainstream general practice at the same

rate. And once budgets are broken down they may no longer be protected. Not every asylum seeker particularly, made the same demands upon practices. One observed that his experience of looking after a Syrian asylum seeker who was relatively healthy and ready to work was different to that of an Iraqi asylum seeker who had health problems resulting from traumatic experiences, and is not so settled. Healthcare problems are different for each individual. He felt there is a need for clinical judgement. When looked at only in terms of value for money one could argue in this case that the higher cost per patient is relevant and could be applied to the Iraqi but not necessarily to the Syrian asylum seeker.

## **7. Views on distribution to primary care.**

There were a range of views on whether or not services for asylum seekers and the homeless should be provided by mainstream primary care rather than a specialist primary care services.

In one HNN there appeared to be an appetite for taking on asylum seekers. Some GPs felt they were doing this anyway and in another all practitioners believed that they had the skills to deliver the appropriate care, if there was secondary care support in place and if they had the time and if GPs had time to deal with the complex healthcare problems. GPs have the right skill set and would be willing to assimilate homeless people and asylum seekers if they had the time and money. For some there were caveats connected with this appetite. One practice with experience of registering asylum seekers and others said a small minority have some sort of trauma. There is a special need for quick mental health rapid access. A fast track specialism from IAPT. Felt that the Assist service had something like that. It was said an IAPT service would need to be commissioned. The chair of this particular HNN said that practices should register asylum seekers, but with strong support with mental health issues.

There were voices that had doubts. One GP in the north east HNN said that “patients’ needs will get lost in normal primary care, where access to services may be difficult. Integrating in mainstream primary care will be complicated. Asylum seekers may not know how to use the service. It will be a backward step. A different part of Leicester said that specialist practice gives some flexibility to meet needs of people as they are dispersed. There was a feeling that care would depend on the general practice and that not all practices would want to put in the effort. And others that if there was a move towards mainstream care it would require more GP time and effort. Some concerns were practical, e.g concern over proving asylum seeker status – the Home Office letter.

The chair of central HNN indicated that were the service to be devolved to practices the amount to be paid per patient may not be the current rate.

**APPENDIX G: Statutory Homelessness: Acceptances and households in temporary accommodation (source: Public Health Outcomes Framework)**

Statutory Homeless Per 1,000 total households		2010/11				2011/12				2012/13				2013/14				2014/15			
		Number	Value	Upper	Lower																
Homeless Acceptances	Leicester	56	0.46	0.6	0.35	106	0.88	1.06	0.72	93	0.72	0.88	0.58	91	0.73	0.9	0.59	108	0.86	1.04	0.7
	East Midlands	3,380	1.81	1.87	1.75	3,790	2.03	2.09	1.96	3,590	1.84	1.9	1.78	3,600	1.86	1.92	1.8	3,455	1.78	1.84	1.72
	England	44,160	2.03	2.05	2.01	50,290	2.31	2.33	2.29	53,550	2.37	2.39	2.35	52,270	2.32	2.34	2.3	54,430	2.4	2.42	2.38
Households in temporary accomodation	Leicester	43	0.36	0.48	0.26	87	0.72	0.89	0.58	69	0.53	0.68	0.42	58	0.47	0.6	0.35	72	0.57	0.72	0.45
	East Midlands	680	0.36	0.39	0.34	740	0.4	0.43	0.37	760	0.39	0.42	0.36	690	0.36	0.38	0.32	680	0.35	0.38	0.32
	England	48,240	2.22	2.24	2.2	50,430	2.32	2.34	2.3	55,300	2.44	2.46	2.42	58,440	2.59	2.61	2.57	64,710	2.85	2.87	2.83