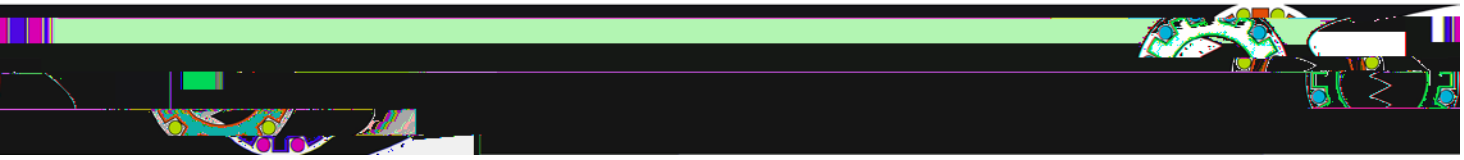
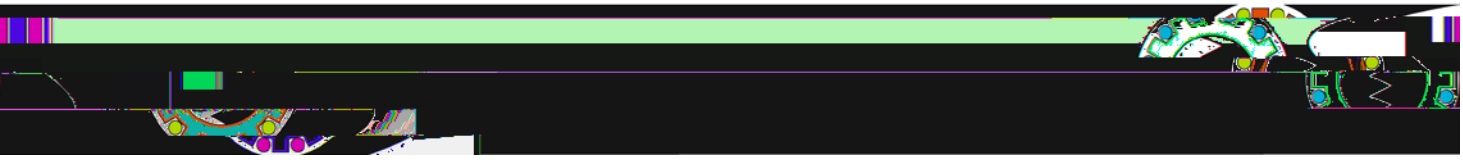
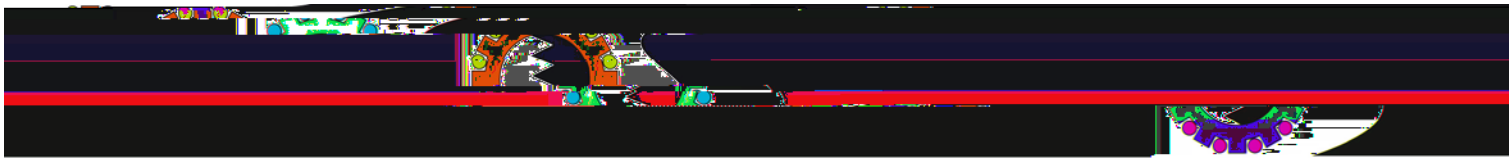




	That potential locations in the city centre be explored to find the most suitable venue which can be made available to be used as a central point where homeless people can go to access information, advice and support on accommodation, benefits (including accessing a computer to start the proc ess of registering to make a claim) and be referred to available health services without needing to make an appointment or travel to one of the customer service centres.	Cabinet Member for Neighbourhood Management and Homes Cabinet Member for Health and Social Careas Chair of the Health and Wellbeing Board	30 September 2015 for final version of Welfare Specification and new service to start 1 April 2016. 31 July 2015 for remodelled Housing Advice Centre Options

That the three Birmingham Clinical
Commissioning Groups should explo mGGel(e)]TJ 1o9.108 Td 15(el(e (H)C 0.004 Tc -0.003 >>BG 0 -1.7.04 129.96



	dual diagnosis of either: 1. mental health and substance misuse or 2. people with alcohol problems who also suffer from dementia, where there is currently a gap in service provision.		
	That wherever possible services for homeless people should be designed to reach out to homeless groups who need them by moving away from a silo culture and exploring options for placing statutory services where homeless people already attend, such as the Homeless Health Exchange or SIFA Fireside, along the lines of the Inclusion Healthcare Social Enterprise Model	Cabinet Member for Health and Social Care Cabinet Member for Neighbourhood Management and Homes	31 October 2015

That a forum or other appropriate mechanism be established between HM Prison Birmingham and Birmingham City Council to facilitate more joined up working with prisons and the probation services to provide improved pathways between prison and the general community with a view to:

1. Linking prison healthcare provision better to wider community healthcare services on release from prison in particular for prisoners with serious mental health, drug and/or alcohol problems;
2. Supporting prisoners into appropriate accommodation before and after discharge from prison;

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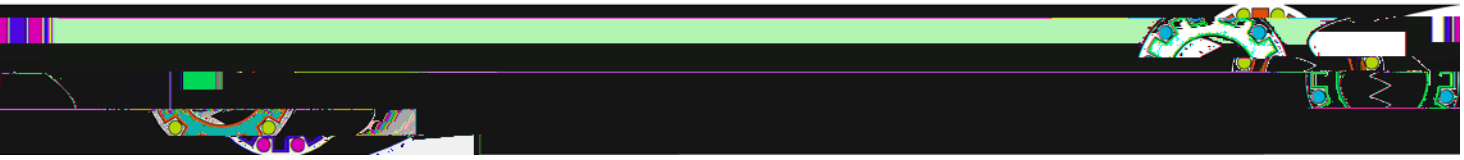
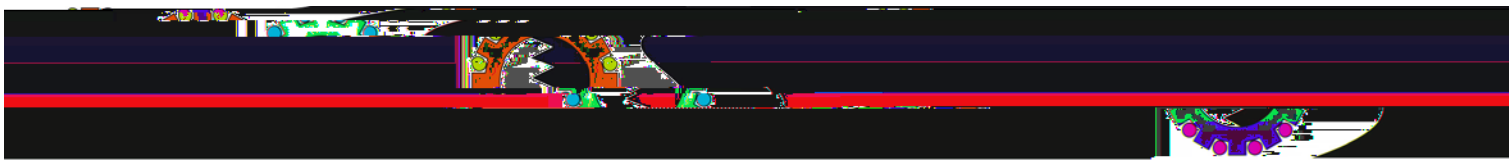
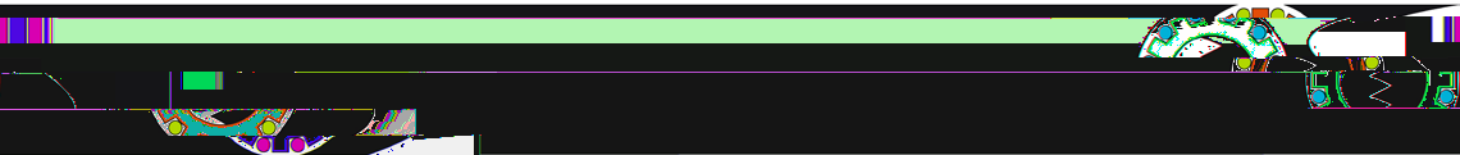




1.1.1 Not having a home damages people's lives and there are thousands of people who don't have the right accommodation to allow them to lead healthy and fulfilling lives. A lack of commitment to ending homelessness just increases the costs to the public purse and postpones the problems associated with homelessness to be dealt with in the future.

1.1.2 The wider definition of homelessness covers a multitude of situations and includes people sleeping rough, single homeless people living in hostels, shelters and temporary supported accommodation as well as statutory homeless households. Statutorily homeless households are households who seek housing assistance from local authorities on the grounds of being currently or imminently without accommodation. The term also includes the 'hidden homeless' households. That is people who may be considered homeless but whose situation is not 'visible' either on the streets or in official statistics. This would accommoda-6(h)T2s people l



Typically this would include those living in insecure accommodation, 'sofa-surfing', squatting and sleeping rough.

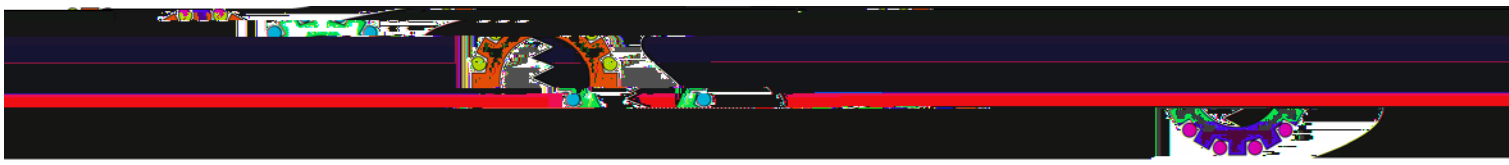
1.2.3 Although evidence was presented about homelessness in the wider sense and much of this has been included in this report, as the evidence gathering progressed it became increasingly clear that the recommendations emerging from the Inquiry were likely to be more narrowly focused. Much of the evidence was around the health and housing needs of a group of single homeless who have slipped through the net and find themselves sleeping rough and about the services that are available to them and their use of and access to those services. Members were mindful that there are other important aspects of homelessness which would merit closer examination and scrutiny which may be covered in a future scrutiny inquiry.

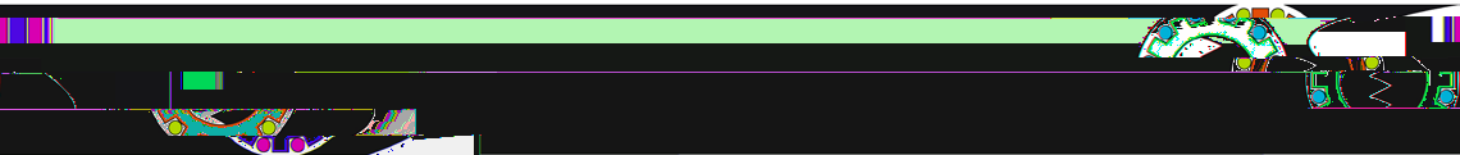
1.3.1 Homelessness and health are inextricably intertwined. Being homeless is physically and mentally difficult and homelessness has significant negative consequences on health with the result that people who are homeless experience some of the worst health problems in our society. They are vulnerable to illness, poor mental health and drug and alcohol problems and are more likely than the general population to have multiple and complex physical and mental health needs.

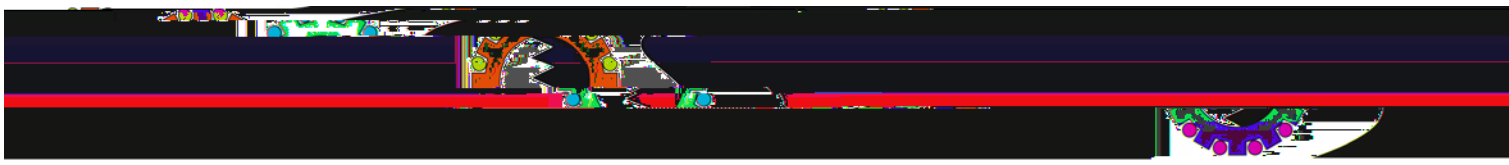
1.3.2 Those who experience homelessness are also more likely to have unhealthy lifestyles which can cause long-term health problems or exacerbate existing issues. Analysis of the latest data found that 77% of homeless people smoke, 35% do not eat at least two meals a day and two-thirds consume more than the recommended amount of alcohol each time they drink. [2]

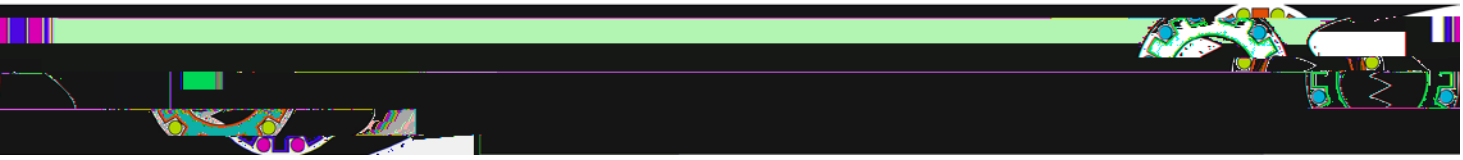
1.4.1 In spite of suffering worse health than the general population, homeless people often struggle to access healthcare services. There are many reasons for this which need to be understood if inequalities in service access are to be addressed.

1.4.2 Some of the barriers include difficulty in accessing primary care such as the inability to register









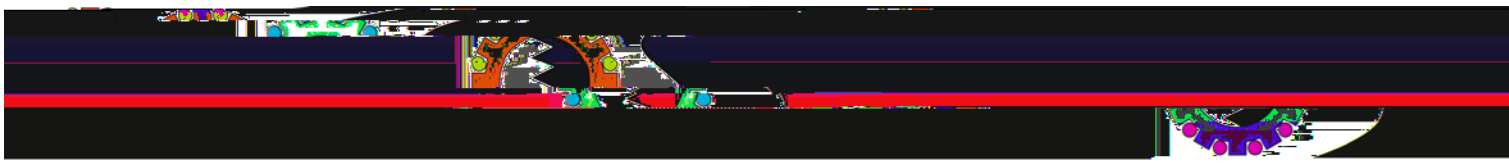
2.2.1 With a view to gathering more accurate data on the health needs of homeless people, a Homeless Health Needs Audit was carried out in Birmingham during 2014. The intention was to review a sample of homeless people and to use their views when designing services. This took the form of a survey distributed to homeless shelters, housing support agencies and related services during 2014 with a view to reviewing the health needs of a random sample of those with priority housing needs or homeless to establish a picture of the current health and mental well-being and of the service provision for this group. A pilot survey ran during May 2014 with a further survey from July to 31 October 2014.

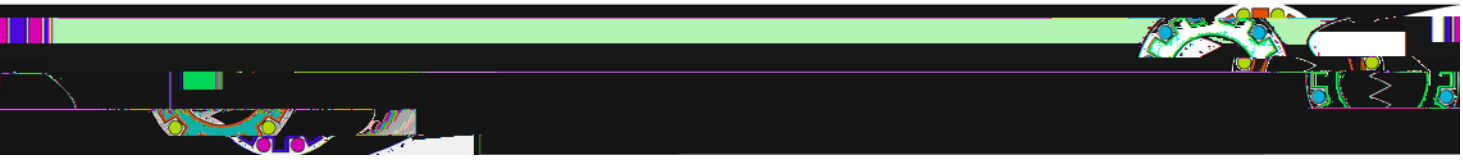
2.2.2 A total of 342 responses were received. Of the responses:

- 77% were aged 25 years or under, the male female split was approximately 60:40 overall but with a majority of females under 25 years.
- 56% were white or other white ethnicity with the under 25 years being 42% white, 18% black and 15% Asian. Of the over 25s 68% were white, 10% black and 3% Asian.
- 18% had a mental health disorder.

2.2.3 General Health - Overall health was OK (34%) or good (34%), their living situation appeared to be stable (40% in hostels, 14% in accommodation) and many did not abuse drugs to cope with their situation (83%). But 16% rated their health as poor.

- Diet and nutrition seemed to fare reasonably well with the majority eating regular meals and having access to fruit and vegetables.
- However only 75% were registered with a GP, 60% were registered with a dentist with the over 25 group less likely to have registered wy 75%e ed H772 0 Td ( )Tj EMC /LBody <</MCID 29 >>B





The aim is to give the JSNA a stronger emphasis on homelessness in order to better shape and direct service provision.

2.3.2 The Cabinet Member stressed his commitment to improving the health and wellbeing of all people affected by homelessness including statutory homeless and including rough sleepers and people living in unsuitable or insecure accommodation such as squats and hostels with a view to reducing health inequalities for all homeless people. Investment in homeless activity has been prioritised for 2015/16 and improved results had already been achieved at the time the evidence was given, in delivering additional temporary accommodation and opening a new homeless temporary accommodation centre in order to reduce the number of households in the city in B&B accommodation. The snapshot evidence at the time (January 2015) was that only 25 households were in B&B accommodation which was an 85% reduction from earlier in the year when there were over 150 households in B&B accommodation in the city. 19 of the 25 households were families and none were single 16 or 17 year olds.

2.3.3 There are various initiatives which are being introduced to tackle homelessness in the city. These include the development of a regional Housing First model for which the City Council is the lead partner. The idea of the Housing First Model is based on the premise that housing is a basic human right and entrenched rough sleepers and people with complex needs will be offered a tenancy directly from the streets with a support package and the initiative is contributing to Public Health England's population healthcare development project for single homeless people. The idea is that if people are given a tenancy then they will be more inclined to work with support agencies to go on and accept any support needed to maintain the tenancy. The package will provide a holistic support package of care for individuals who are entrenched rough sleepers and suffering from complex needs around mental health, community safety, ongoing drug or alcohol treatment and support to deal with behavioural issues. Reference was also made to reviewing the homelessness community mental health service (paragraph 8.4) and primary care services to support the needs of single homeless people, to the Homeless Hospital Discharge pilot (paragraph 9.3) to support single people back into the community when they are discharged from hospital and to the remodelled support provided within the new Public Health Lifestyle Service in which homeless groups are prioritised.

2.3.4 Birmingham's Supporting People programme commissions a wide range of supported housing services for vulnerable customers. These services include hostels for single homeless people, step down schemes and specialist schemes for single people who have experienced homelessness, accommodation schemes for offenders, domestic violence refuges and floating support services to support those who need extra help to continue to live independently or people who have difficulties due to drug or alcohol problems.

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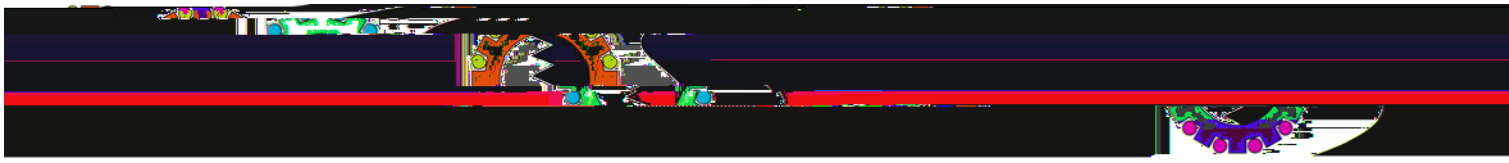
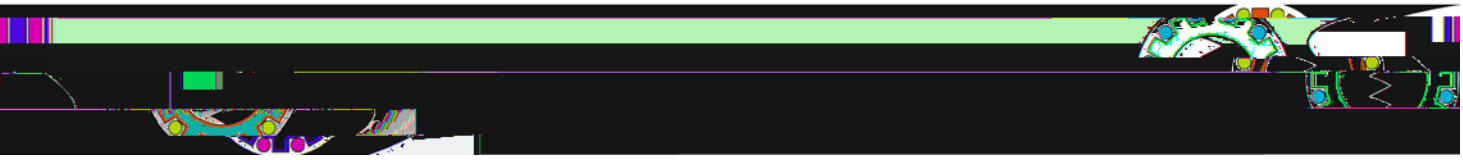


based on a needs and risk assessment the service will seek to match service users to available support services. A bedspace may be allocated in an accommodation based scheme or a floating support worker may be allocated to provide housing related support at the person's current or future address.

2.3.6 The type of housing related support to help to develop and maintain a person's ability to live independently can include helping someone to get their correct benefits, to learn to budget properly for rent and bills, to access a GP or dentist, to get on a training or education course, to maintain a tenancy or to get a permanent home.

2.3.7 It was acknowledged that there are real issues about the depletion of the council housing stock and about how best to try to expand the supply of affordable housing. The Muni cipal Housing Trust is now the biggest house builder in the city in an attempt to increase supply and there is ongoing proactive work with the private rented sector through the Birmingham Social Lettings Agency 'Let to Birmingham' to increase the supply of housing and to provide more options for people.

2.3.8 The Council is committed to increasing the supply of affordable housing



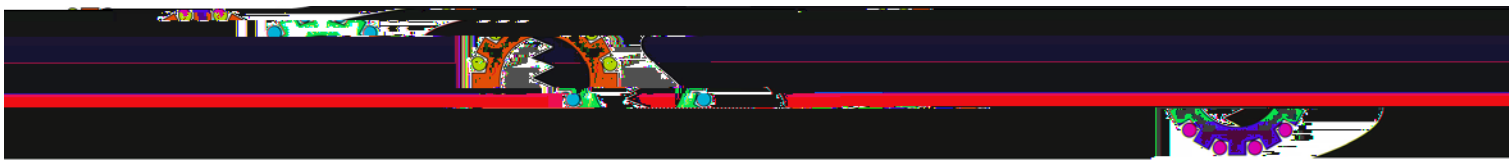
2.4.2 Integrating health and housing may not always need special commissioning. Much can be achieved by using housing investment to target health inequalities or using health investment to support housing outcomes, for example, health professionals working out of homelessness services. The aim should be to look for opportunities to work together jointly to support services that tackle homeless health and to limit barriers to accessing care and be responsive to local need.

2.5.1 Whilst integrating health and social care and multi-agency working may not always necessitate special commissioning arrangements, sometimes it may mean commissioning services so they are joined up, eg jointly commissioning services for mental health, substance misuse and alcohol. The recent substance misuse commissioning exercise in Birmingham whereby drug and alcohol services were jointly re-commissioned is an example of this approach to commissioning.

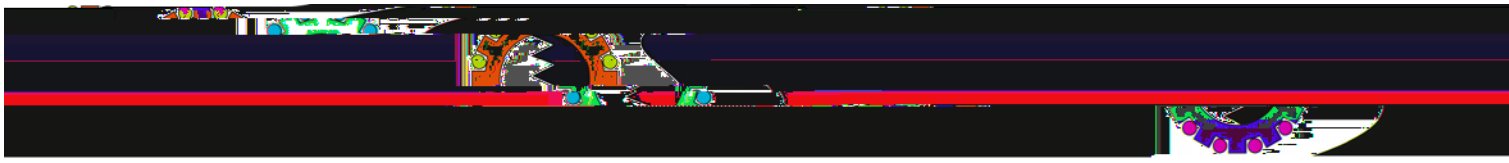
2.5.2 In Birmingham it is calculated that there are approximately 10,000 opiate or crack users, 48,000 cannabis users, 15,000 powder cocaine users, 10,000 ecstasy users, 6,000 amyl nitrate users, 6,000 amphetamine users and 4,000 ketamine users. In relation to alcohol there are 117,000 hazardous drinkers (someone drinking above safe limits of 21 units for men and 14 for women), 39,000 harmful drinkers (someone drinking 50 units for men and 35 units for women) and 22,000 dependent drinkers (someone who needs medical intervention to stop drinking). 25% of men and 17% of women in the city are drinking above safe limits. It's fair to say that Birmingham has no greater issue than any other core city but, nevertheless, these are significant numbers.

2.5.3 Prior to March 2015 there were 28 separate organisations providing treatment in the city. The new approach aims at recovery outcomes ie. freedom from dependence on drugs or alcohol, sustained employment, sustained suitable accommodation, mental and physical wellbeing, improved relationships with family members, partners and friends, supporting effective and caring parenting, reduction in crime and re-offending and prevention of blood borne viruses.

2.5.4 Drug and alcohol services have been re-commissioned with a single lead provider who is also a provider of provision with a set of sub-contracted organisations. It also includes additional commissioning of small third sector organisations to ensure engagement of the diverse communities of Birmingham. All elements of the recovery system are part of the single contract with the new provider - CRI - which commenced on 1st March 2015 with a focus on smoothing the transition and an outreach approach and partnership working. At the time of the evidence gathering for the Inquiry various concerns were raised by organisations working in these areas about the transition arrangements but it was too early in the process to assess the success or otherwise of the new approach which will need to be revisited during 2015 when the new arrangements have been in place for a longer period.



This service will be retained and built on and partnership working and working in other locations will be a particular focus in delivering these services in the future. There are particular issues in relation to homelessness and work is ongoing with homeless hostels and with SIFA Fireside to support the delivery of a service at SIFA to make it easier for service users to engage with drug and alcohol services.



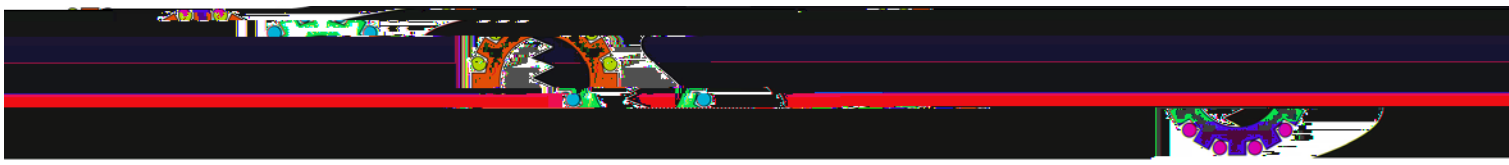
months (referred to as a former relevant child) and to anyone homeless due to an emergency which would include a natural disaster such as a flood or fire. Consideration also needs to be given to whether someone is vulnerable in terms of the homelessness legislation as a result of age, mental illness, either a physical or learning disability or if someone has an institutionalised background such as having been in prison or been in the armed forces which makes them vulnerable. The test is whether the applicant is less able to fend for themselves when homeless in finding and keeping accommodation so that injury or detriment would result, than an 'ordinary homeless person'. Subsequent to the evidence gathering, there has been a very recent case in the Supreme Court which has said that councils assessing the needs of single homeless people should compare them with an 'ordinary person' rather than an 'ordinary homeless person'. This decision will change the vulnerability test as it is currently applied.

- Intentionality : whether the person has done something or failed to do something that as a direct consequence has caused them to lose their last settled accommodation. The most common intentional homeless cases would be cases where households have been evicted through rent arrears because they haven't paid the rent rather than because they can't pay or households who have lost their accommodation through anti-social behaviour.
- Local Connection : whether someone has a local connection to the local authority. The applicant must basically have lived in the area for 6 out of the last 12 months or 3 out of the last 5 years or have close family residing in the area or work in the city. Consideration must also be given as to whether the applicant has special reasons for needing to live in the city.

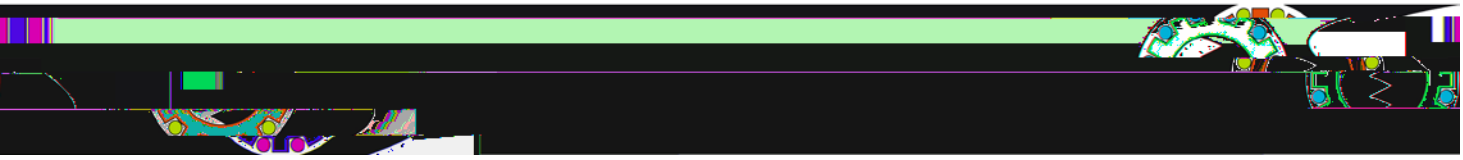
3.3.1 The term 'single homeless' is generally understood to mean those people who are homeless but do not meet the priority need criteria to be housed by their local authority. They may nevertheless have significant support needs and may live in hostels, sleep rough, sofa surf or live in squats.

3.3.2 SIFA Fireside work with this very vulnerable group of people and gave evidence about some of the difficulties faced by this group in getting the assistance they need. Much of the evidence related to the kind of practical advice and support provided at SIFA, for example in providing meals, food parcels, warm clothing, sleeping bags and laundry facilities and the important support provided by faith groups, schools and churches to SIFA in this respect was acknowledged. Every day about 130 homeless people attend at SIFA Fireside's open access drop in, around 12% of whom will be sleeping rough with about a quarter to a third of those sleeping rough being from Central and Eastern Europe. Many of the remainder will be sofa surfing, or living in squats either because they have no recourse to public funds or because their benefits have been stopped or sanctioned.

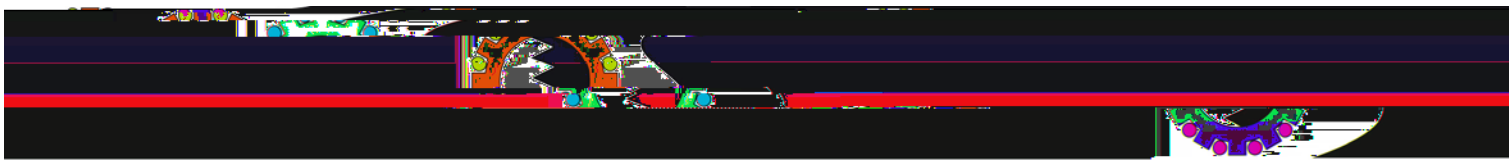
3.3.3 Many of the people attending SIFA have become homeless because of relationship breakdown or domestic violence but many also have other underlying problems such as substance misuse or alcohol or mental health issues, which make it more difficult to get back into settled accommo(,)-a(e)1(r)-2(l)-2(y)-

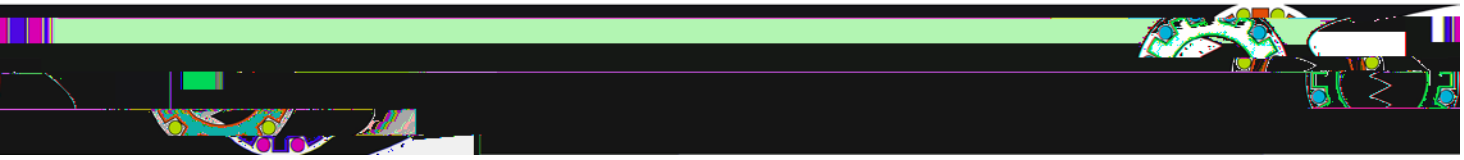


the Bradford Street Homeless Centre where they see



4.1.1 The main causes of youth homelessness are parents, relatives and friends no longer willing or able to accommodate young people (69%). The underlying causes contributing to this are overcrowding and previous offending history (28% each), followed by mental health issues (21%). The small numbers of young people who resort to rough sleeping (45 in the last 12 months) tend to be those who do not have access to support networks such as friends and family and find themselves having to stay outside on the streets when they are made homeless. Substance misuse is cited as one amongst several reasons leading to increased tension within a family home, escalating in young people being asked to leave their home; others include issues such as various





- Access– I want to be able to see a GP at a time to suit both of us without needing to take time away from college or training during the day and I want to be able to get to the service by public transport.
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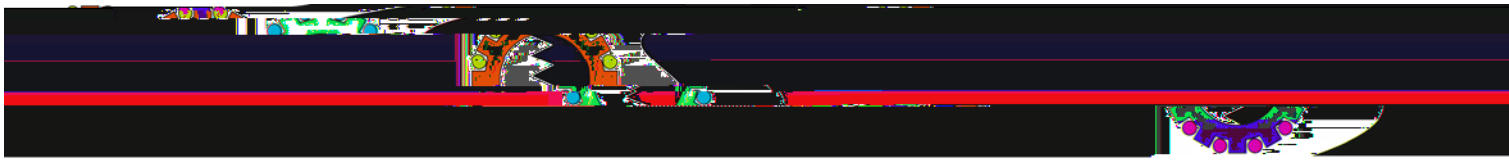
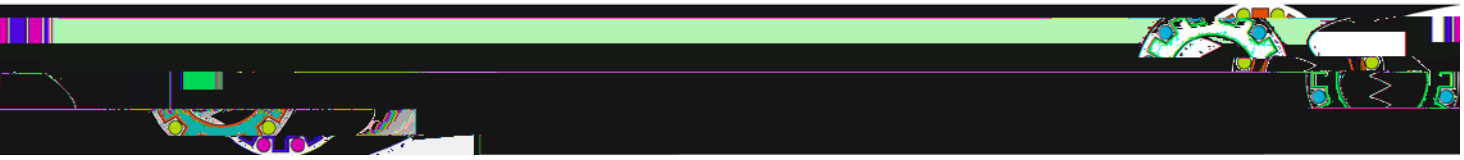


or private rented accommodation. The local authority work closely with the St Basil's Youth Hub where St Basil's workers and social workers are co-located at the Youth Hub to facilitate dealing with the needs of care leavers in a timely way.

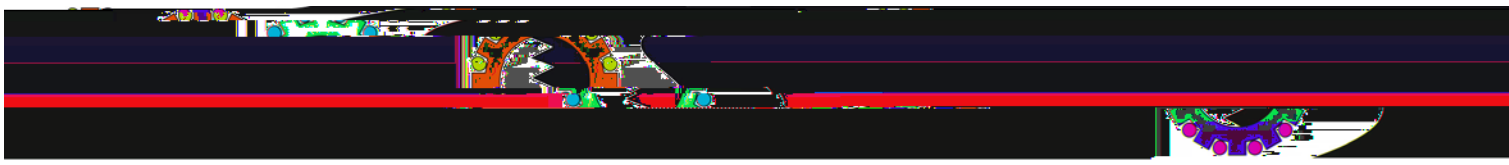
4.4.3 The suitability of accommodation is checked by the allocated social worker or personal adviser when undertaking statutory visits to the young person. The quality of the accommodation should also be quality assured by the independent reviewing officer for care leavers aged 16 to 18. There is a housing checklist used by social workers when placing a young person in supported accommodation. In terms of ongoing support, all care leavers are supported until th e age of 21 or 24 if in full time education and supporting young people to maintain their accommodation is a key component of this. A number of emergency beds are available to be used where necessary to ensure that unsuitable B&B or other emergency type accommodation is not relied on.

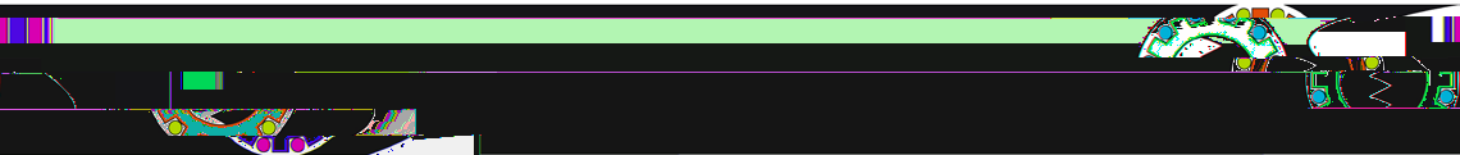
4.4.4 In 2013/14 the authority took 193 homeless applications from care leavers. These are not necessarily all young people leaving care at the age of 18. They could be older and have had accommodation where the arrangements have broken down or they could be aged over 21 because the local authority has a duty up to the age of 24 for some young people such as those in

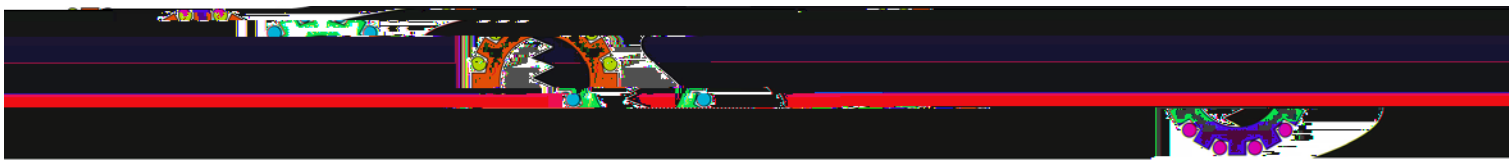


- x The general need, as also referred to by other witnesses including SIFA Fireside, to take the services out into the community and to where the young people are to venues such as family centres, and churches, mosques and other places of worship.

4.5.2 St Basil's GP Charter which has been developed by young people as a way of setting out to GPs what young people feel they need to help them feel confident and comfortable in accessing GP services (See paragraph 4.3) which looks at all the health issues that young people want to highlight with the NHS was referred to.

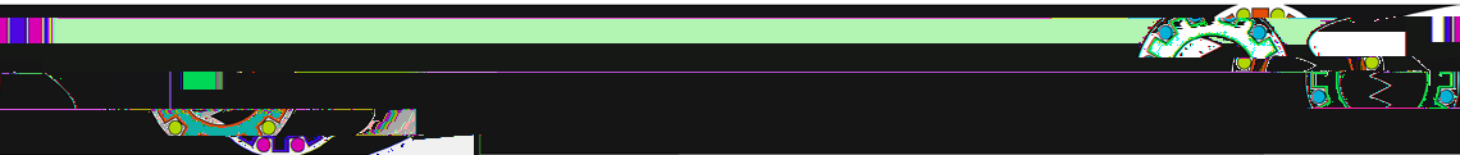






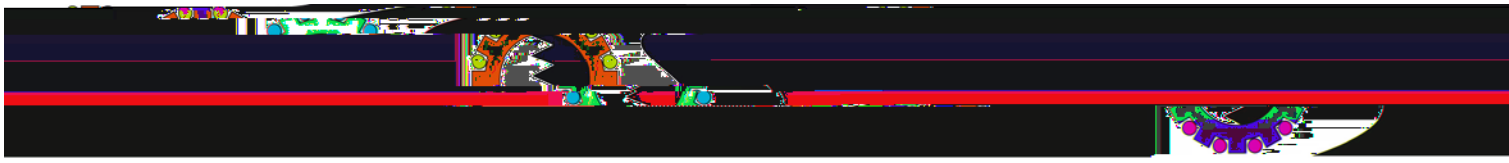
as a coping mechanism to help them to deal with the traumatic experience of becoming homeless and this pattern is supported by evidence from West Midlands Police who found that from the feedback collected through Operation 'Engage', substance misuse was not cited at all as a cause of sleeping rough. Many of the rough sleepers disclosed that their alcohol intake increased in the winter months as it helps them to feel warm. However this warmth is superficial and can lead to people putting themselves at an increased risk of hypothermia. Midland Heart's Homeless Welfare Services were accessed by 89 clients who were sleeping rough during a nine month period. Alcohol dependency was an issue for 42% of clients whilst 39% had drug related issues. [13]

5.2.4 There is other local data which highlights significant causes of homelessness and rough sleeping.



Birmingham was officially recognised as an ‘Ending Rough Sleeping Champion’ in 2010/11 and still compares favourably to other city counts such as Manchester (24 in 2013) and Coventry (26 in 2013). However the police evidence rightly points out that it should be noted that this figure is a snapshot taken on one night and falls well short of the numbers evidenced by local agency reporting:

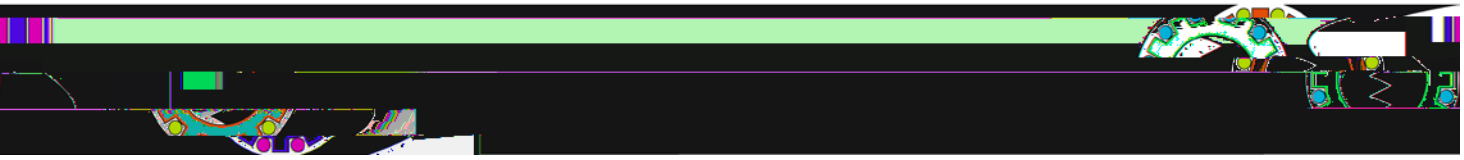
- SIFA Fireside gave housing advice to 249 rough sleepers and others of no fixed abode and found accommodation for 309 homeless or vulnerably housed clients in 12 months.[15] In one month, 25 sleeping bags were given out to rough sleepers by SIFA and the drop-in centre saw an average of 139 clients each day.[16]
- Street Link is a service that enables the public to alert local authorities about rough sleepers in their area. Their data records 187 referrals made for Nechells and Ladywood wards combined in 16 months. Five of the people referred were involved in ‘street activity’ such as begging or drinking.[17]
- Midland Heart Housing Association’s Homelessness Prevention Services data shows that in nine

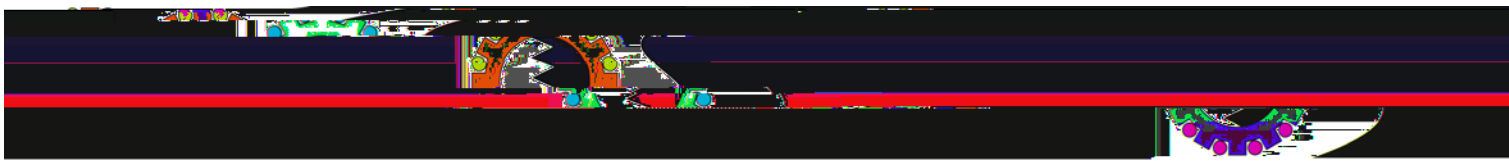


5.4.2 At the time of giving evidence, there were 27 clients using the project, of whom all but two were men. Most (24) were White British and the average age was 46 years. Over half of clients had alcohol issues (18) or mental health issues (17), 11 had drug issues and 17 clients had two or more of these issues. Many clients had also been in prison or had contact with the police, 17 were still sleeping rough, 4 were in hostels or supported accommodation and 2 clients were housed.

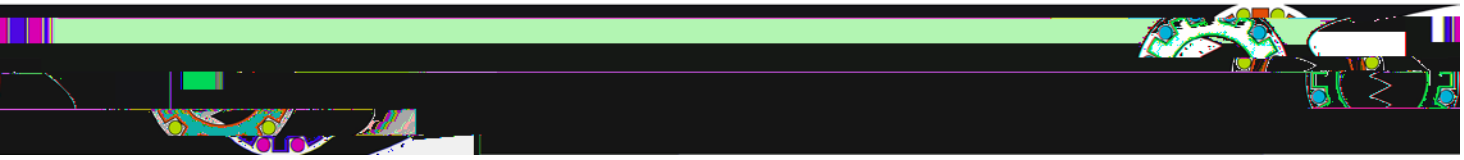
5.4.3 Referrals to the project come from local authorities, from other services like drug or alcohol treatment or from Street Link, a helpline for members of the public to alert services to rough sleepers in their area. Clients are allocated to a project worker who works with them to move them off the street. This involves building a trusting relationship and getting to know clients, before starting to talk to them about what would help them to move into accommodation. Project workers have considerable freedom to support clients as needed and offer a high degree of support to help individual rough sleepers address their issues and move into secure accommodation. The project also allocates a personal budget for each client to help them move away from sleeping rough.

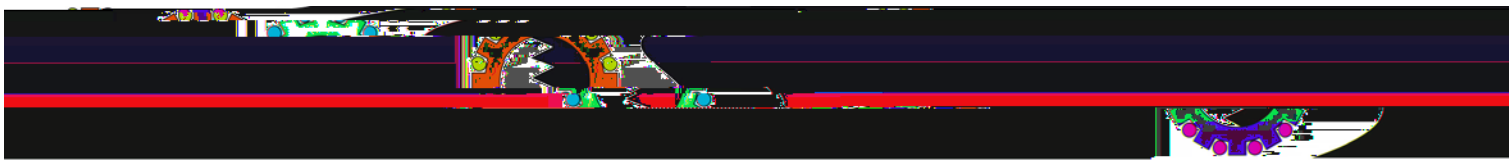
5.4.4 Staff, who have the skills and knowledge of services to meaningfully advise and support people, carry out an initial assessment with individuals to establish their risk and needs. This would cover needs connected to substance use, housing, mental health, sexual health and domestic violence. Staff are then able to take customers through the treatment options available and support them to





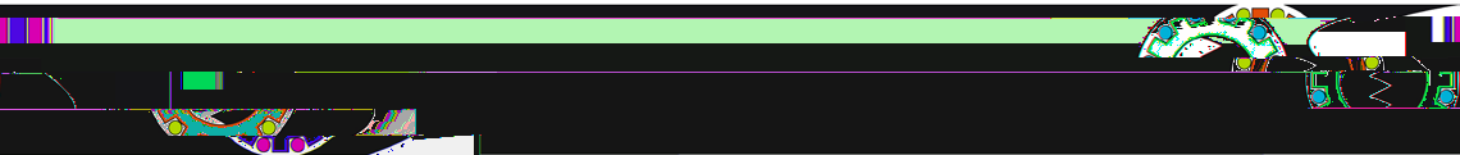
other suitable means, to enable people sleeping rough who have issues that they wish to raise to be heard. (R0 8)

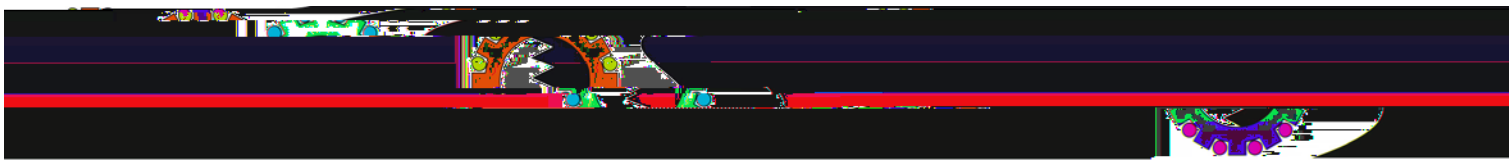




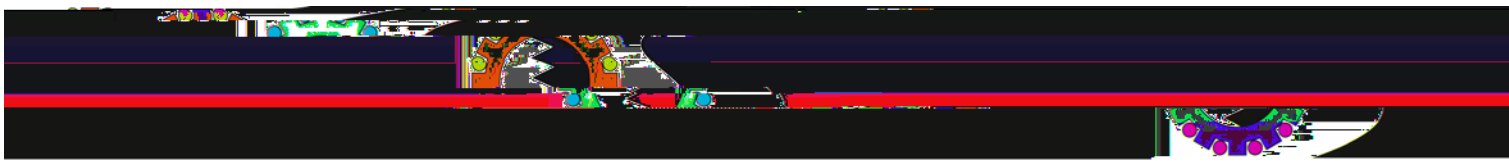
Good Practice Case Study

Male G is a long term rough sleeper in the city centre. He funded his heroin addiction through begging around the city centre. G was one of the most prolific beggars in the city centre. Among other issues, G needed assistance with the following; accommodation, registering with a GP surgery in order to obtain methadone prescriptions and obtaining his benefits. Sorting out these basic requirements is especially complex given the 'chaotic' lifestyles of some of those referred. Initially, G was extremely sceptical of the help offered, however with some persuasion by officers, he was taken in person to his first Swanswell's appointment.





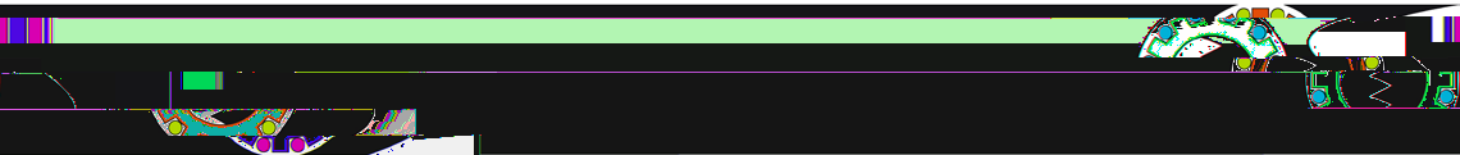
6.3.1 When homeless people enter Birmingham prison they have access to a range of healthcare facilities including mental health services,



7.1.1 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 can 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.

7.1.2 The 2014 Homeless Link Needs Audit found that 73% of homeless people reported a physical health problem. In total, 41% of those surveyed reported a long term problem, compared with 28% of the general population who report a long term physical health condition. [23]

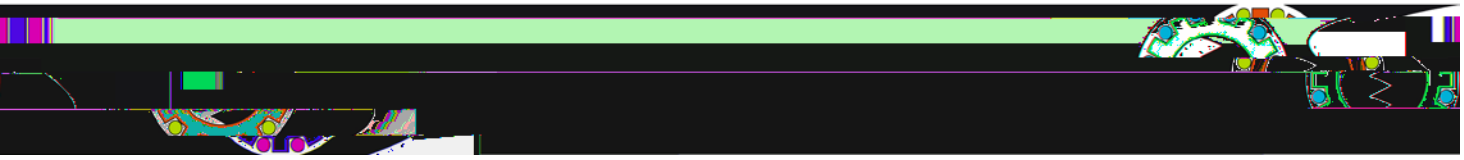
7.1.3 Some of the most common conditions which occur in homeless patients presenting in primary care were described in the evi1(n)1(t)-6(s-1(t)-8(h)-1(e)-1(e)-1(v)-76 0 T f4(i)-2(l)9(o5(mJ 24.5( )1(p)1(h

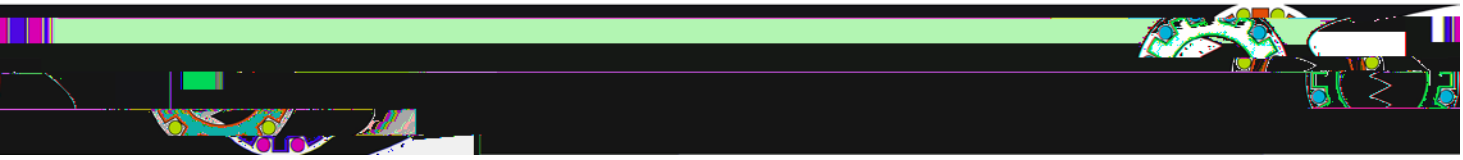


7.2.1 Alcohol is often a contributing factor to becoming homeless. However problems can also develop after becoming homeless. It is not uncommon for alcohol and drug addiction to develop as a means of coping with the difficulties associated with homelessness.

7.2.2 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. Homeless people with alcohol dependency are 28 times more likely to have an emergency admission to hospital than the general public.[24]

7.2.3 However it also affects the brain and causes brain damage and results in early onset dementia. The Homeless Health Exchange encourages engagement with services, provides proactive, multidisciplinary care, provide regular physical health checks (blood tests etc), prescribe high doses of vitamins and thiamine, -6(i)-b(s)-3(e)1(as)S-0.006 Tw4(e)1(me)1(nmu9)9( )-2(n)161(,)-4( )1(-6(i)-

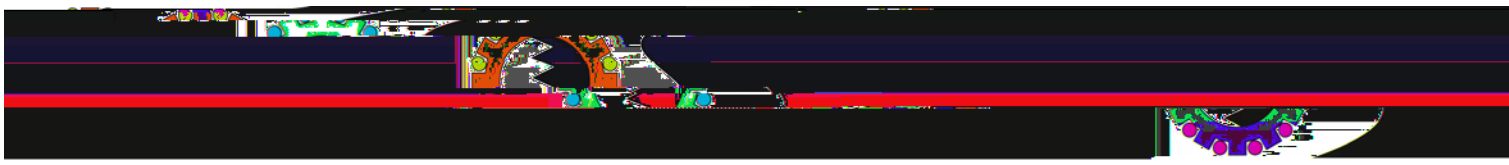




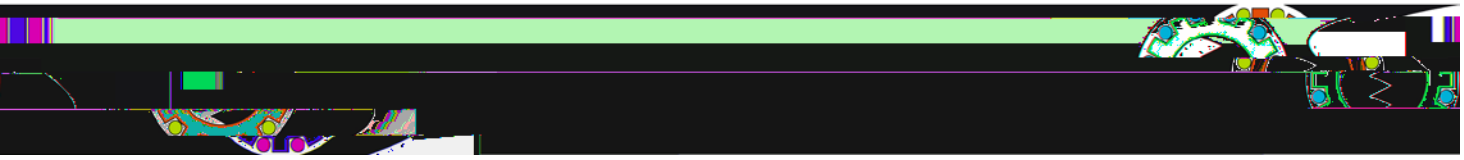
8.1.1 GPs are the primary point of access to health services. One of the striking issues highlighted in the Homeless Health Needs Audit is the fact that only 75% of those responding were registered with a GP. People who are homeless frequently struggle to access health services and are 40 times more likely not to be registered with a GP and are 4 times more likely to use an A&E department than the general population. The evidence given by Birmingham and Solihull Mental Health NHS Foundation Trust was that less than a third of the mental health service patients they deal with are accessing other homeless healthcare services and there is an increasing trend in patients that are not registered with any GP at the time of assessment.

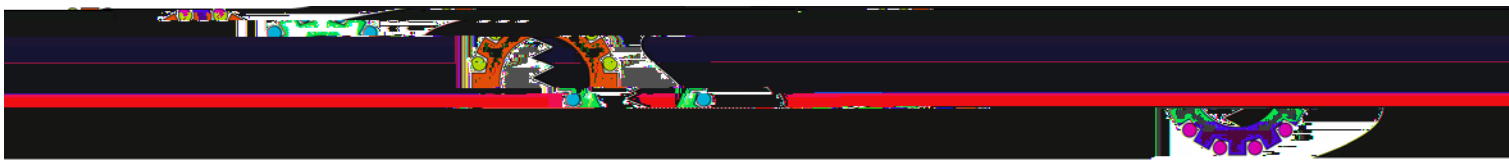
8.1.2 There are many barriers which prevent homeless people from being able to access primary care services. Priorities are understandably different for people who are trying to survive without a permanent home or on the streets. They may often be living a chaotic lifestyle, may not have the perseverance to navigate the system, they may not be good at filling in forms, they may not deal well with complexity or may not have any identification and GP surgeries don't necessarily make it easy for people to register without a fixed address. Some do, but there is huge variation. If GP surgeries ask a homeless person for a utility bill or proof of their name which they cannot provide the result is often that they cannot register. Members were told that the Homeless Health Exchange Primary Care Service register people care of the surgery and sometimes use organisations such as SIFA Fireside, one of the day centres or the Homeless Service Centre in order to get homeless people registered with a GP. More work is needed to ensure that every homeless person can register with a GP. (R02)

8.1.3 However making



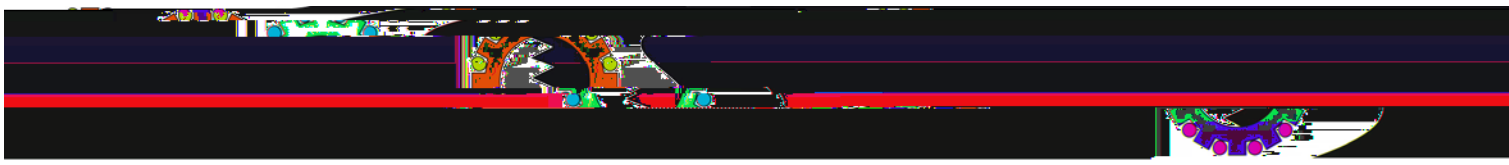
8.1.4 The relationship that a person builds with their GP is important and once someone has registered with a

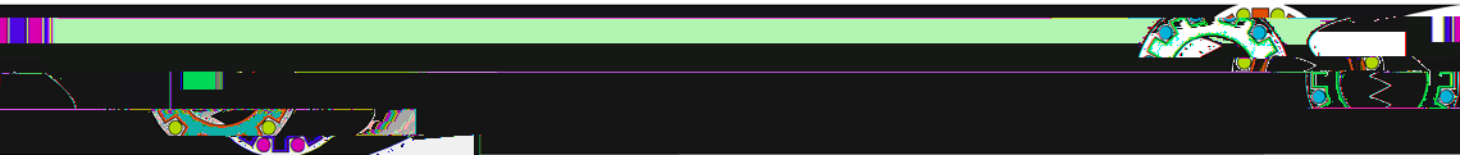




8.3.1 The Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT) are commissioned by the Joint Commissioning Team to provide a primary care and a mental health service to the homeless people of Birmingham. The Homeless Health Exchange Primary Care Service is a GP surgery for the homeless based at William Booth Centre in the city centre which provides a specialist GP service for homeless adults over the age of 18. Patients are fully registered and the surgery is open Monday to Friday between 9 and 5. They are staffed by three part time GPs, two practice/community nurses, three alcohol nurses, one CPN, two counsellors/psychotherapists and two administrators/receptionists.

8.3.2 The Community Mental Health Team does





9.1.1 Homeless people are much more likely than the general population to attend A&E and are often less likely to stay around in the hospital once they have had their medical checks to make sure any appropriate care plan follow up support is provided. Members heard of an example of one homeless person who attended 4 different A&E departments in 4 different cities within 24 hours.

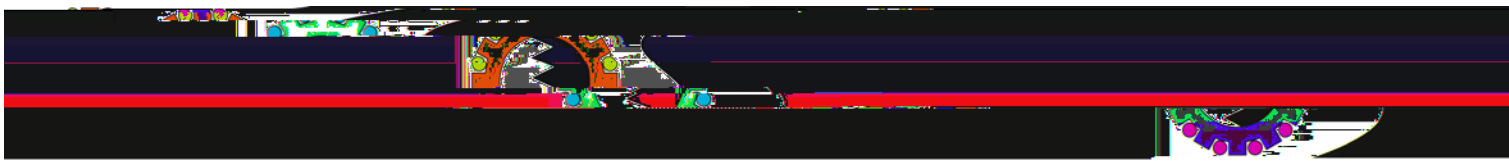
9.1.2 The evidence from Midland Heart estimated that homeless people attend A&E six times more often than people in stable accommodation; are admitted to hospital four times more often and stay in hospital three times longer. This can obviously lead to a disproportionate use of emergency and acute health services and paints a troubling picture of society's most vulnerable individuals stuck in a damaging cycle of homelessness, poor health and hospital admission.

9.1.3 A number of issues for homeless people accessing hospital treatment were identified during the Homeless Hospital Discharge Pilot:

- It was found that in the majority of cases, homeless individuals were discharged from hospital without a discharge summary, care plan or risk assessment. This created delays in assessing housing and support needs.
- Previously, front line medical staff had to spend time trying to arrange accommodation for homeless patients to enable discharge which impacted on time that would have been spent providing medical care.
- A review of hospital data showed that 'no fixed abode' (NFA) coding was used inconsistently resulting in variations in data and there was no way to capture the extent of homelessness according to the definition by Shelter, 2013.

9.2.1 Data from the Homeless Hospital Discharge Pilot which worked with 70 customers, illustrated a number of findings from the pilot.

- Heavy alcohol use was thought to be a contributing factor to some of the primary reasons leading to admission.
- 80% of patients within the pilot had a recorded mental health issue.



- Financial problems including issues such as debts and no income were recorded in 62% of the patients in the pilot. Those on low income were not recorded as having financial problems