# Manchester Homeless Health Needs

## Audit 2016

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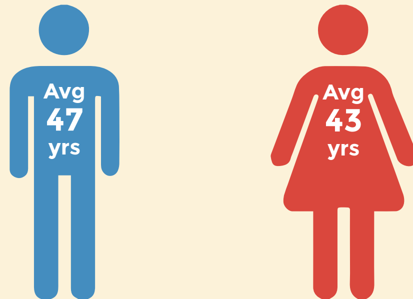
## Homelessness and Health

The experience of homelessness can have seriously detrimental effects on physical and mental health and wellbeing. The average age of death of a homeless man is 47, and for a homeless woman is 43.

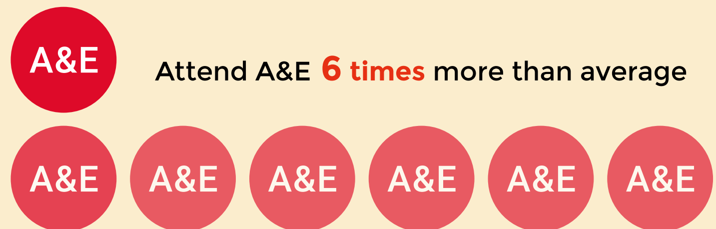



Homelessness is an independent factor for premature mortality and is associated with extremes of deprivation and multiple morbidity. Chronic homelessness is an associated marker for tri-morbidity (the combination of physical ill health with mental health and substance misuse), complex health needs and premature death. Tri-morbidity often has its roots in histories of complex trauma, including high levels of child neglect and abuse, that impact on developmental trajectories and mental health. When homeless people die they do not commonly die as a result of exposure or other direct effects of homelessness, they die of treatable medical problems.

It is widely recognised that homeless people experience specific and multiple health problems that not only contribute to the cause of homelessness but can also exacerbate their homeless situation. The experience of homelessness can make it difficult to access healthcare services. Homeless people are often prevented from registering with a GP as they are unable to provide proof of address or ID. It can be difficult for homeless people to make and keep appointments due to inflexible booking procedures and lack of a phone number or safe address for appointments. The stigma associated with homelessness can lead to perceived and actual discrimination and can deter homeless people from accessing healthcare or can cause them to disengage with healthcare services before their health needs can be met. These factors combined with the chaotic nature of homelessness result in homeless people accessing acute healthcare services disproportionately to the general population.

*Research undertaken by London Pathway evidenced that:*

“Homeless people attend A&E up to **6 times as often** as the general population, are admitted **4 times as often**, and once admitted, tend to stay **3 times as long** in hospital as they are much sicker and as a result, acute services are **4 times** and unscheduled hospital costs are **8 times** those of general patients”



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## Homelessness and Health

**In Manchester there has been a significant increase in the number of reported rough sleepers in the last 5 years.**

This is shown in the annual headcount figures, the headcount provides a snapshot of the number of people found rough sleeping on one night of the year. From 2014 to 2015 Manchester has seen a rise of 62% in the number of rough sleepers recorded which is significantly higher than the 30% increase reported nationally and places Manchester as the 4th highest area for rough sleepers in the country.

Manchester City Council is responsible for receiving and assessing requests for assistance from people who either believe themselves to be at risk of homelessness or are actually homeless. This is a statutory responsibility set out in the Housing Act 1996.

In 2015, Manchester City Council received 2,219 applications for assistance under the Housing Act, a 4% increase from 2014. Manchester has consistently been one of the top ten Local Authorities with the highest number of homelessness applications over the last 5 years. There are approximately 543 temporary accommodation places in supported hostels in Manchester which are generally running at full capacity.

**Several contributory factors have been identified that may account for this increase in Manchester:**

- Impact of welfare reform, such as the bedroom tax and benefit sanctions.
- Increase in European nationals and failed asylum seekers with no recourse to public funds.
- Reduction in local authority funding impacting on single homeless accommodation and funding to support people.
- Difficulties with 'Move On' from supported accommodation to longer-term tenancies.
- A lack of access to 24/7 evening and overnight provision.
- The vibrancy of the night time economy acting as a draw to those accessing on-street donations.
- Significant increase in the number of street groups supporting people with on-street donations.

**It is important to note that there is no data to account for the vast numbers of hidden homeless in Manchester which include those squatting, sofa-surfing or staying in B&Bs**

# Manchester Homeless Health Needs Audit 2016

## UVMP: Urban Village Medical Practice

**Urban Village Medical Practice (UVMP) is a GP practice based at Ancoats Primary Care Centre on the outskirts of the city centre.**

As well as providing primary healthcare to over **10,000** registered general patients they have also provided a primary healthcare service to homeless patients since 1998. Since 2012 the practice has also been commissioned to provide a hospital in reach service to homeless patients.

The service is the only comprehensive healthcare service for homeless people in Manchester and currently provides the following:

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

The practice currently has **849** homeless patients registered at the practice; this total figure has been steadily increasing over the last **3** years. The practice currently registers between **30-40** new patients every month, a total of **361** being registered in the last **12** months. Despite this high churn rate, **80%** of new patients have received a comprehensive health assessment following registration.

During the period April 2015-March 2016, the hospital in reach service at the MRI delivered a **52%** reduction in A&E attendances, and a **59%** reduction in non-elective admissions, a 61% reduction in bed days and a **62%** reduction of repeat admissions within 28 days.

In addition to operational work, Urban Village has also worked to ensure homeless health has become a strategically important issue in the city

**361** new paitents in 12 months

**80%** recieved comprehensive assessment

**52%** reduction in A&E attendances

**62%** reduction of repeat admissions

## The Audit

Over a period of **2 months** Urban Village Medical Practice, with support from other agencies and volunteers, conducted a Homeless Health Needs Audit using the toolkit provided by Homeless Link.

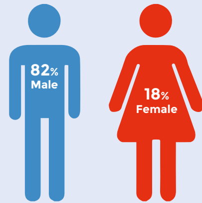
The project involved completing questionnaires with homeless individuals aged 16 or over using the broadest definition of homelessness to include those who are rough sleeping, sofa surfing or in temporary or unstable accommodation such as hostels, shelters and B&Bs.

In total **238 surveys** were completed with homeless people across Manchester. Additionally qualitative research was conducted with professionals working with homeless people were asked about their opinion and experiences about healthcare for homeless people in Manchester.

# Manchester Homeless Health Needs Audit 2016

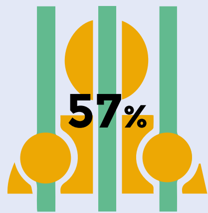
## Demographics

The age range of those included in the survey is from **16 - 78** years of age.




**81%** reported being UK nationals, **11%** were from countries within the European Economic Area (EEA), **1%** were from countries outside the EEA, **4%** refugee or asylum seekers & **3%** had been granted indefinite leave to remain.

**25%** had been a victim of domestic violence.




of respondents had spent time in prison.

### The top 3 reasons cited for becoming homeless were:

- non-violent relationship breakdown with partner

- parents/care givers no longer able or willing to accommodate

- drug or alcohol problems.

## Physical Health

**83%**

of the population reported having at least one physical health condition **10%** higher than the national homeless population.

**36%**

of these reported having more than one physical health condition, **70%** considered themselves to have a longstanding health condition that significantly affected their lives compared to **41%** of the national homeless population.

**37%**

of respondents reported that in the previous twelve months there had been at least on occasion where they needed examination or treatment for a medical condition but they had not received it.

### The top 3 reasons cited for not receiving treatment were:

- waiting list being too long

- couldn't get an appointment

- it was too far to travel.

## Mental Health

**57%** reporting mental health issues said they used drugs or alcohol as a way of coping with their mental health issues.

**64%** report being diagnosed with depression

**28%** had been admitted to hospital due to a mental health problem

**73%** reported a mental health problem

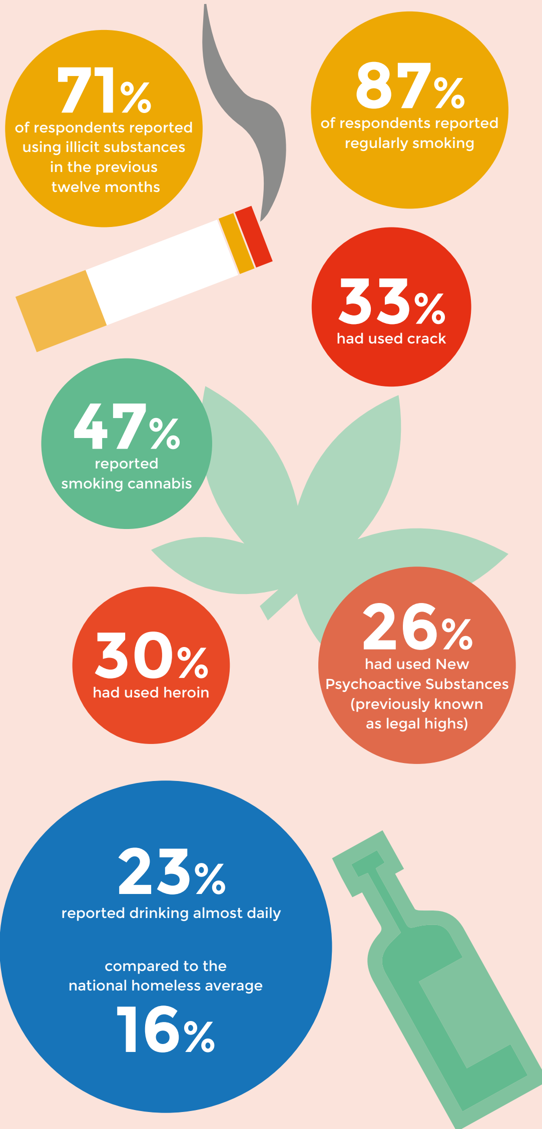
**51%** report being diagnosed with anxiety

**62%** reported needing more help with their mental health

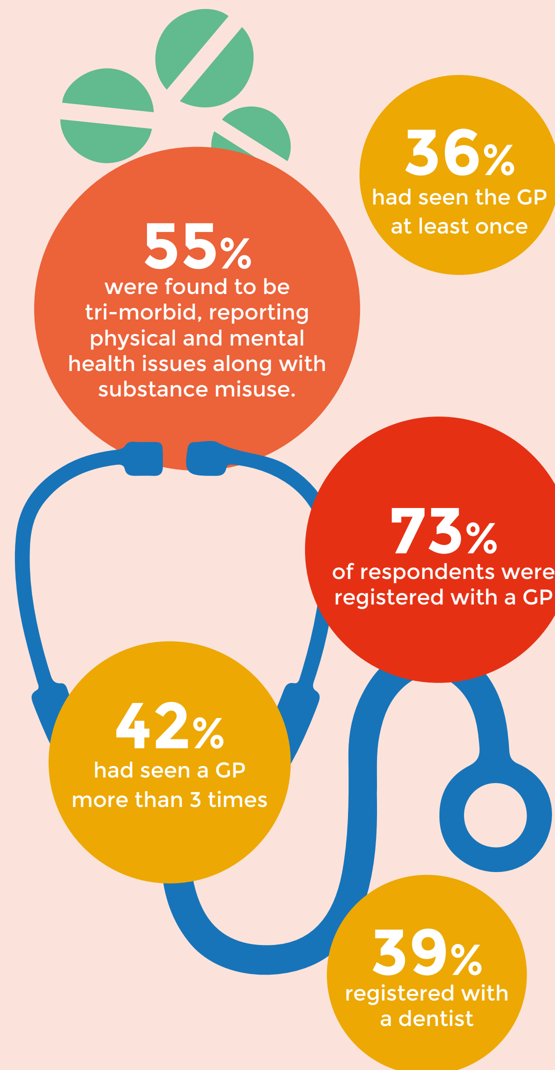
**67%** of people receiving help advised the help they were receiving was in the form of medication and only **35%** from a specialist mental health worker.

# Manchester Homeless Health Needs Audit 2016

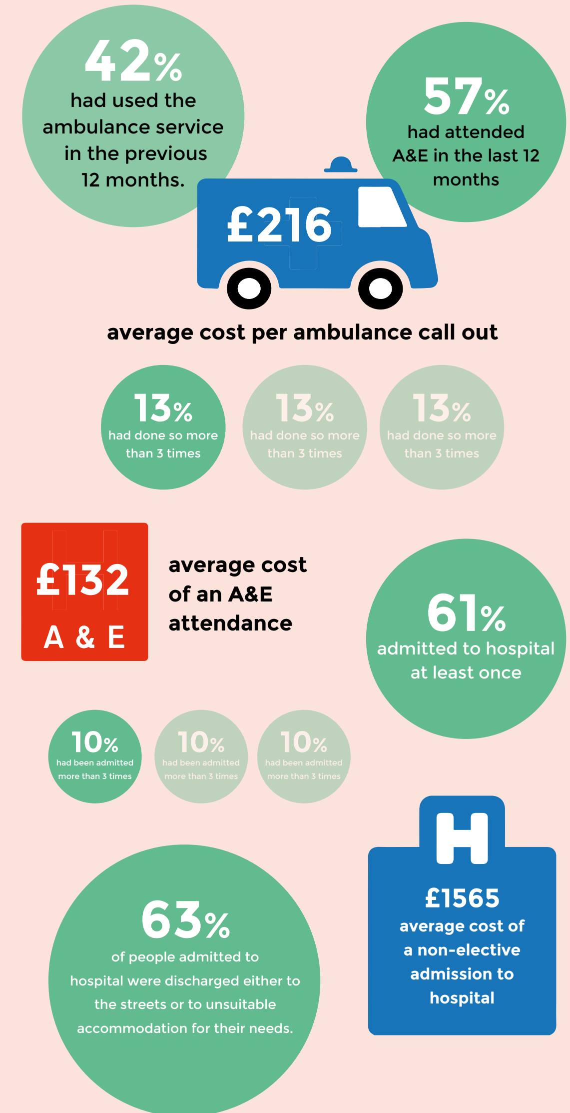
## Drug & Alcohol use




## Tri-morbidity




## Access to services



# Manchester Homeless Health Needs Audit 2016

## Qualitative Research

In order to provide supporting evidence of the issues facing the homeless population of Manchester we opted to gather information from professionals working with this particular client group. Those approached were either employed by or volunteering for services set up to provide support in various different ways for homeless people in Manchester. They were asked to comment on their thoughts about health care currently in Manchester for this population group, what could be improved or what services are lacking and if they have any ideas about what prevents people seeking help or accessing services.

All responders gave permission for their thoughts to be included in this report but shall remain anonymous.

"'Low level mental health issues have been observed by our service to be a huge problem. There is no real service provision for these people and online options for treatments such as CBT are often not appropriate. The complexity of health needs in this population has increased over the years and people often just present at A&E because they become frustrated.'"

"Urban Village is an excellent service due to its flexibility. Other GP's can be more problematic for example if patients can only make appointments by phoning at particular times. This can also be an issue for those that don't have a phone. Clients also often move around frequently so long waiting times for appointments are not helpful."

"'Immigration also has affected the sort of problems that we are seeing. People move here thinking that their health issues will improve but they don't. There are also cultural differences to consider for example Eastern European men often have a different awareness of what is considered to be an alcohol problem. These people are often discharged from hospital to the street as they do not have any entitlement to benefits. We frequently see people issued with bills for health care of prescriptions for medications not considered to be essential that they cannot afford and they therefore never get their treatments.'"

"The main issue I have come across through the audit is that people do not feel supported with their physical or mental health needs especially mental health. More easily accessed counselling & mental health services are needed. Also the problems homeless adults are facing often go way back to childhood so more needs to be done in early years and with teenagers, a more joined up approach of adult & children's services working more closely together to prevent mental health worsening & subsequent substance misuse."

"I would say that more gender specific health services are needed as homeless women are more hidden and services are largely designed around single homeless men or they become that way by default if not designed with women in mind. This could put many off from accessing especially if they have suffered from past trauma. I know that some women do not want to come to our drop in as it can feel intimidating and a previous abusive partner may be there."

# Manchester Homeless Health Needs Audit 2016

## Recommendations

The Manchester homeless health needs audit represents the first comprehensive assessment of Manchester's homeless population. It is well recognised that homeless people represent one of the most marginalised populations and experience significant health inequalities as a result. This audit has confirmed the extremely high level of poor health experienced by homeless people in Manchester and the difficulties they experience in accessing health care.

If services in Manchester are to address these extreme health inequalities the findings of this audit need to be used to inform future commissioning arrangements. It is acknowledged that to address health inequalities effectively in this population, the response needs to be proportionate – i.e. actions must at a scale and intensity proportionate to the degree of need or disadvantage.

### Recommendation 1

**A strategy for integrated commissioning of services.**

There is currently no integrated commissioning response to the homeless population involving the health service, social care and accommodation services.

To achieve improved outcomes for the population health and social care commissioners need to acknowledge that homelessness must feature as a mainstream area in all commissioning strategies, and develop an integrated commissioning framework that supports the effective delivery of this.

The emerging Greater Manchester Health and Social Care Partnership commissioning strategy provides an excellent opportunity to ensure a response to homelessness is firmly embedded within the design and implementation of this to improve the health inequalities experienced by the homeless population of Manchester.

### Recommendation 2

**Integrated Services for substance misuse and mental health**

Extremely high proportions of homeless people experience physical health problems, mental health problems and substance misuse but crucially 60% of individuals experience all three together, more commonly referred to as tri-morbidity, which is associated with very poor outcomes and excess morbidity and mortality.

The audit clearly demonstrated very poor access to services to help them to address these health problems which in turn results in high impact on acute services and the associated high economic burden.

In Manchester the strategy for these areas of healthcare for many years has resulted in the commissioning of separate services for substance misuse and mental health which is an ineffective response for the homeless population. We recommend a strategic review of this area of healthcare with consideration given to integrated models of care and the commissioning support required to test and deliver these. Analysis of the economic benefits of these models should be central to the commissioning strategy.

### Recommendation 3

**Optimal Access To Healthcare**

It is an accepted basic principle of healthcare in the UK that people should be registered with a GP in order to give them access to primary healthcare and optimise access to other areas of the health service. The audit shows that whilst Urban Village Medical Practice is very effective in enabling access to primary care for many homeless people in the city, there is still not optimal access for the whole population, particularly in areas outside the city centre, which continues to impact on acute services and result in poor health outcomes for this population.

As part of the transformation of health and social care, steps should be taken to ensure that access to primary healthcare is equitable for all homeless people across the city, and should include work with all GP practices to offer effective registration for homeless people in line with NHS England guidance. GPs should be encouraged and supported to promote flexible access to appointments and assertive services which aim to not only address health inequalities but also reduce impact on secondary care services. An analysis of the economic benefits of these models of care should be central to the commissioning strategy.

## Recommendation 4

**Adoption of the Homeless Healthcare Standards**

To support homeless people to access appropriate healthcare individuals and agencies supporting homeless people should commit to adopting the Homeless Healthcare Standards developed by Urban Village Medical Practice. Training for which is delivered on a bi-annual basis.

**Standard 1:**
Health must form a significant element of any assessment of needs and remain a priority.

**Standard 2:**
All homeless people must be registered with a GP.

**Standard 3:**
All homeless people should be supported to engage with primary and secondary healthcare services.

**Standard 4:**
Homeless people should be supported to be self-caring in relation to their health care.

**Standard 5:**
Appropriate access to out of hours and emergency care.

## Recommendation 5

**Provision of accommodation appropriate to meet health needs**

The current strategy for commissioning accommodation for homeless people does not take into account the major health problems experienced by homeless people, and the support and environment that is required to improve health outcomes.

For example the audit demonstrates the homeless population experiences high levels of alcohol dependency, this is commonly a chronic health condition, these individuals have associated care needs and health needs, that are not met by current strategies for accommodation and indeed preclude many homeless people from accessing or sustaining accommodation. Consideration and a strategy for “wet houses” or specialist environments may result in better outcomes.

Other examples include:

- Step down accommodation for hospital discharges
- Accommodation with mental health support therapeutic environments
- Accommodation for more complex chaotic individuals

Which could bring about significant improvements in health and reduction in impacts on secondary care services.

## Recommendation 6

**Co-production of service redesign with people with lived experience of homelessness**

The audit demonstrates that homeless people can speak clearly about their experiences of health services. They have very clear ideas of their problems with accessing appropriate healthcare and what good health care should look like. As suggested in the Manchester Homeless Charter any strategic response should have at the heart of it co-production with homeless people ensuring they have a voice to determine the solutions to their own issues.

# Manchester Homeless Health Needs Audit 2016


## Urban Village Medical Practice would like to thank everyone who supported this Health Needs Audit.

Urban Village Medical Practice and the Homeless Service
Manchester Royal Infirmary and the M-path Service
Alex Wood – Public Health
Manchester City Council
Manchester Metropolitan University
University of Manchester
Woodward Court
Victoria House
Brydon Court
Women's Direct Access
Nacro
Manchester Action for Street Health
Inspiring Change Manchester
Booth Centre
Boaz Trust
Lifeshare
Breakfast in Bed Street Life Project
Barnabus
The Salvation Army

Special thanks also to Homeless Link for granting permission for use of their audit template and to all individuals who completed the survey.


Crisis 2010 'Homelessness: A Silent Killer'

Marmot Review 2010 'Fair Society, Healthy Lives' http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review

Homeless Link http://www.homeless.org.uk/facts/homelessness-in-numbers/statutory-homelessness

Woodward Court 84; MCC Shared Housing 156;Women's Direct Access 39; Brydon Court 30 (although have capacity for 3 couples); Project 394 17; Wilson Carlisle 39; Beeches 22; Stopover 10; Newbury House 15;Nacro 24/7 supported projects 24; Salvation Army 40; Victoria House 39 (all self-contained flats so can support couples); Redbank 28. (all figures including sit up accommodation where applicable)

http://neweconomymanchester.com/our-work/research-evaluation-cost-benefit-analysis/cost-benefit-analysis/unit-cost-database

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/477919/2014-15_Reference_costs_publication.pdf

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/477919/2014-15_Reference_costs_publication.pdf

https://charter.streetsupport.net/read-the-charter/

https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/11/pat-reg-sop-pmc-gp.pdf

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