



# **JOINT STRATEGIC NEEDS ASSESSMENT – HOMELESSNESS AND AT RISK OF HOMELESSNESS**

**Version 1, February 2010**

**Table of Contents**

Executive Summary .....	3
Acknowledgements.....	12
1. Introduction .....	14
2. Context.....	16
2.1. History of homelessness .....	16
2.2. Domains of Homelessness.....	17
2.3. Causes of homelessness .....	20
2.4. Health, housing and homelessness.....	22
2.5. Commissioning Homeless Services.....	24
2.6. Views of community service users and staff .....	26
2.7. Data Difficulties .....	28
3. The National Picture.....	30
3.1. Key national policies and strategies.....	30
3.2. Statutory homelessness .....	31
3.3. Single homeless/ Rough sleepers .....	32
3.4. Hidden homeless.....	33
3.5. Effect of the economic recession on homelessness .....	34
4. The Local Picture .....	35
4.1. Introduction .....	35
4.2. Households in priority need – statutory homeless.....	36
4.3. Summary of Supporting People Data .....	40
4.4. Summary of Cambridge City data.....	44
4.5. Summary of Cambridge Access Surgery data .....	48
4.6. Secondary Care Data.....	49
4.7. Chronically Excluded Adults .....	50
4.8. Street Life.....	52
5. Mapping needs of the homeless.....	53
5.1. Introduction .....	53
5.2. Supporting People Outcomes Framework .....	53
5.3. Summary of needs by client group .....	56
6. Mapping services for the homeless .....	67
6.1. Introduction .....	67
6.2. Housing and Support Pathways to services for the homeless.....	68
6.3. Meaningful occupation.....	74
6.4. Health Services .....	76
6.5. Prison Services .....	87
6.6. Commissioning service issues.....	89
6.7. Multi-Agency Risk Assessment .....	90
7. Evidence of effectiveness of interventions for the homeless.....	91
7.1. Introduction .....	91
7.2. Homelessness prevention .....	91
7.3. Tackling rough sleeping.....	95
7.4. Person centred electronic records for the homeless: CHAIN .....	96
7.5. Primary Health care services for homeless people .....	97
7.6. Services for substance misuse and homelessness.....	98
7.7. Meaningful occupation for homeless people.....	99
7.8. User involvement in commissioning.....	99
7.9. Integrated services for homeless people .....	99
8. Recommendations .....	101
APPENDICES.....	106
9. Appendix 1: What exactly is a JSNA? .....	107
10. Appendix 2: Summary of health, homelessness strategies and data limitations ..	109
11. Appendix 3: P1E District Council Statutory Homelessness.....	115

12.	Appendix 4: Supporting people Cambridgeshire client record data.....	120
13.	Appendix 5: Supporting People Cambridgeshire client outcome forms data..	131
14.	Appendix 6: Cambridge City Council Homeless Database .....	136
15.	Appendix 7: Health profile of the Cambridge Access Surgery population .....	147
16.	Appendix 8: Secondary Care Data usage by the homeless population.....	158
17.	Appendix 9: Services for homeless in Cambridgeshire.....	164
18.	Appendix 10: House repossessions data.....	168
19.	Appendix 11: Cambridgeshire City Council Homeless Strategy Consultation	170
20.	Appendix 12: Home-Link the Cambridge Sub- Regional Choice Based Lettings Scheme.....	172
21.	References.....	174

## Executive Summary

### 1. Key Findings Summary

- 1.1 Homelessness describes a wide range of circumstances where people have no secure accommodation. This JSNA categorises homeless people into three overlapping groups:
- **single homeless and rough sleepers (SHRS)** - group of homeless people for whom there may be no statutory duty or simple solution (around 500 are registered with CAS);
  - **statutory homeless** - those defined in law<sup>1</sup> as being in priority need and entitled to housing support from local authorities (around 600 households across Cambridgeshire each year, largely families);
  - **hidden homeless and those at risk of homelessness** – those not recognised by local authorities or services (thought to be much larger than the two other groups together)
- 1.2 There is a great deal of overlap between these groups with people frequently moving in, out and between them. This JSNA has particularly focused on the SHRS population as this group has the poorest outcomes in Cambridgeshire. However, the other two groups also have a constellation of needs and issues.
- 1.3 Homelessness is complex and there is rarely a simple explanation for someone becoming homeless. A number of interlinked personal and social factors can contribute towards people becoming homeless.<sup>2</sup> These may include individual factors, family background and/or an institutional background.
- 1.4 Housing is one of a number of factors that has an important influence on people's health. Homelessness is more than a housing issue and can occur as a result of poor health, unemployment, imprisonment or poverty. Health care, social services and criminal justice systems all impact on homelessness<sup>3</sup>.
- 1.5 Compared to the general population, homeless people experience poorer health outcomes<sup>4</sup>. Physical health, drugs, alcohol, mental health and well-being have been recognised as priority health issues among the homeless. However, homeless people generally experience difficulties with accessing health services; this poor access also impacts on their health status. Health outcomes are generally worst for SHRS but may also be poor in the statutory and hidden homeless. People who are accepted as statutory homeless are at risk of moving into non-statutory homeless groups for a variety of reasons.
- 1.6 Homeless people are much more likely to die young than people who are not homeless. Cambridge Access Surgery (CAS) is a dedicated GP practice largely for single homeless and rough sleepers with around 500 registered patients at any one time. Amongst the patients registered at CAS, 40 are known to have died over the last

---

<sup>1</sup> Her Majesty's Stationary Office, 2002. Homelessness Act 2002.

<sup>2</sup> Department for Communities and Local Government, 2001. Homelessness Strategies; a good practice handbook.

<sup>3</sup> British Columbia. Ministry of Social Development and Economic Security, 2001. Homelessness: causes and effects. Volume 1. The relationship between homelessness and the health, social services and criminal justice systems: a review of the literature.

<sup>4</sup> Department for Communities and Local Government, 2008. No-one left out: Communities ending rough sleeping.

five years, their average age at death was 44 years. The registered patients at CAS are relatively young and range from young adulthood to middle age. Many are at the very lowest point in their lives. Of CAS patients, broadly speaking, ½ have an alcohol problem; 2/3 have a drug problem, ½ have a mental health problem and many people have two or all three of these problems. Taken together, drugs, alcohol and poor mental health play a major part in nearly all deaths among the homeless. Note that this should not be confused with life expectancy. Life expectancy at birth for the general population of Cambridgeshire is 80 for men and 82 for women. This does not mean that life expectancy for the CAS population is half that of the rest of the population in Cambridgeshire but does highlight that, consistent with poor health outcomes and complex health needs, the mortality figures for the CAS population of single homeless and rough sleepers are comparatively very poor.

- 1.7 The housing pathway differs for statutory and non-statutory homeless with the statutory homelessness pathway being undertaken by local authorities and governed by homelessness legislation. For non-statutory homeless there are a range of entry points and the often chaotic lifestyle of this group means that their journey may not follow a clear pathway.
- 1.8 The purpose of the JSNA for Homelessness and those at risk of homelessness is to identify the current and future health and well being needs of people who are identified as homeless or at risk of homelessness in Cambridgeshire, and inequalities and stigma faced by the homeless population. It recommends ways to achieve real improvements in health and well-being outcomes for this group.
- 1.9 Partnership working has been an essential part of this JSNA and key to understanding the needs of the local homeless population. The JSNA has been developed through joint working between the NHS, the County Council, the City and District Councils in Cambridgeshire, and voluntary sector agencies.
- 1.10 Early intervention and proactive prevention of both homelessness and the poor outcomes associated with homelessness are key to improving the health and wellbeing of the homeless and those at risk of homelessness.
- 1.11 Having more integrated, person-centred services would enable more comprehensive joint care planning, information sharing and monitoring of outcomes with a common record of individual homeless pathways. This could avoid duplication, therefore saving money while improving outcomes.
- 1.12 Engagement of the homeless population in planning their own care is essential, and using the insight, information and interaction from the care planning process should inform commissioning and provision of services.
- 1.13 Joint commissioning provides an opportunity to ensure services are integrated, needs-led, evidence based and person-centred, focusing on prevention and early intervention and will make a real difference to outcomes for SHRS and for chronically excluded adults.

### **JSNA Community Views - the homeless**

- 1.14 Generally there appears to be limited involvement of the homeless population in developing and evaluating local services. Homeless people often present with multiple and complex needs. Further work is needed to identify the individual outcomes that the homeless population want and it should be recognised that these outcomes may not be homogenous, just as the population described within this JSNA is not.

- 1.15 An example of service user involvement was in the development of the Cambridge City Homeless Strategy where current and former users of homelessness services and frontline staff were invited to a series of consultation events. The comments made at these events were incorporated into the strategy where appropriate which allowed the homeless population direct input into shaping the future of homeless provision in Cambridge City. Key issues were the need for on-going support, especially around transition periods (see recommendation 5.4), better communication and easier access to a range of accommodation, training and information.
- 1.16 Other examples of obtaining views of the homeless population include:
- Public consultation on the alcohol service specification for Cambridgeshire, engaging with Winter Comfort to consult with the homeless regarding this service as well as frontline homeless service staff.
  - A patient and stakeholder survey undertaken by CAS in 2007 which reported high levels of satisfaction with the service and that if the service was not available just under half of respondents would attend A&E or not access health care at all.
- 1.17 There needs to be more work done in engaging the views of this population to ensure services are responsive to their needs. 'Working together for change: using person-centred information for commissioning'<sup>5</sup> places service users at the heart of the commissioning process. It is an approach for engaging service users, carers and frontline staff, managers and commissioners in systematically collating and reviewing insights from care plan reviews and determining priorities for change. It is hoped that this model can be used with the homeless population.

## **Introduction**

- 1.18 Homelessness and being at risk of homelessness are complex issues which can have wider implications for an individual's health, employment prospects and education. Making the transition out of homelessness can be an intensely difficult process, involving much more than the provision of housing.
- 1.19 These complexities are also reflected in the commissioning of services for the homeless which involves different funding streams and a variety of commissioning and provider organisations.

## **2. Key Facts: the population**

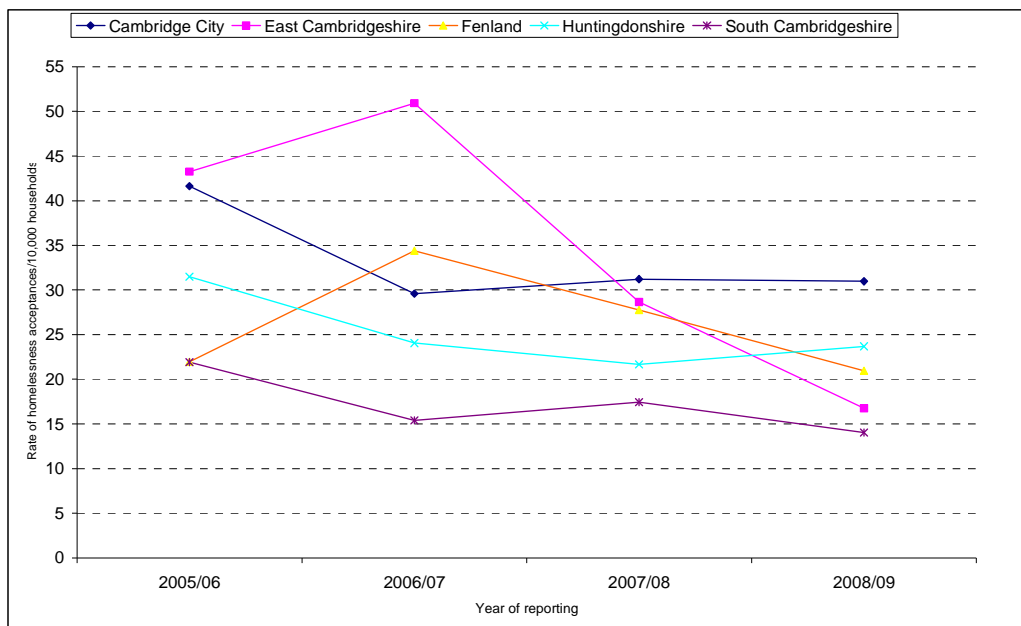
- 2.1 In Cambridgeshire, data on homelessness are collected by numerous service providers. However, most of these operate stand-alone information systems and there is no robust way of uniquely identifying service users and so there are likely to be instances of double-counting. There are a number of factors concerning the current information base on the homeless population of Cambridgeshire which has made it difficult to clearly describe the homeless population, such as:
- The transient nature of the homeless population with high geographic mobility and turnover. Each individual is likely to go through rapid chronological changes with respect to street homelessness/ different temporary accommodations and also health indicators.
  - There are seemingly insurmountable problems in correlating information from different agencies due to categories used, double counting and the impossibility of identifying individuals across services.

---

<sup>5</sup> Department of Health, 2009. Working together for change: using person-centred information for commissioning

- There is large geographical variation of services, particularly for SHRS, between town and rural areas with an overwhelming concentration in Cambridge City and, generally speaking, where there are no services there are no data. Therefore we have limited information for much of Cambridgeshire.
- 2.2 The registered population of Cambridge Access Surgery is around 500 people. The majority of people accessing the service are single homeless/rough sleepers with a higher proportion of males. A substantial proportion have mental health, substance misuse (drugs and/or alcohol) and 'dual diagnosis'. with a mean age of death being 44 years.
  - 2.3 The voluntary and statutory agencies in Cambridge have identified 27 clients they believe to be chronically excluded<sup>6</sup>. These are individuals with very complex needs, who have usually experienced rough sleeping, and may currently be sleeping rough.
  - 2.4 Around 500 people are known to the police in Cambridgeshire as engaging in undesirable 'Street life' activity which can be defined as anti-social behaviours perpetrated by individuals or groups on the streets or in parks and open spaces. It is estimated that 40-50 of these individuals are engaged in street-life activity at any one time; most have been or are homeless or at risk of homelessness. These individuals usually carry the hallmarks of chronically excluded adults.
  - 2.5 The overall trend in the number of households accepted as homeless both in Cambridgeshire (Figure 1) and nationally is downwards, largely due to local authority prevention strategies. However, there is some concern that the number of applications may increase due to the recession.

**Figure 1: Rate of homelessness acceptances per 10,000 households by District, 2005/06 – 2008/09<sup>7</sup>**



- 2.6 Supporting People and other agencies tend to view the homeless population as different (but not mutually exclusive) client groups such as single homeless, rough

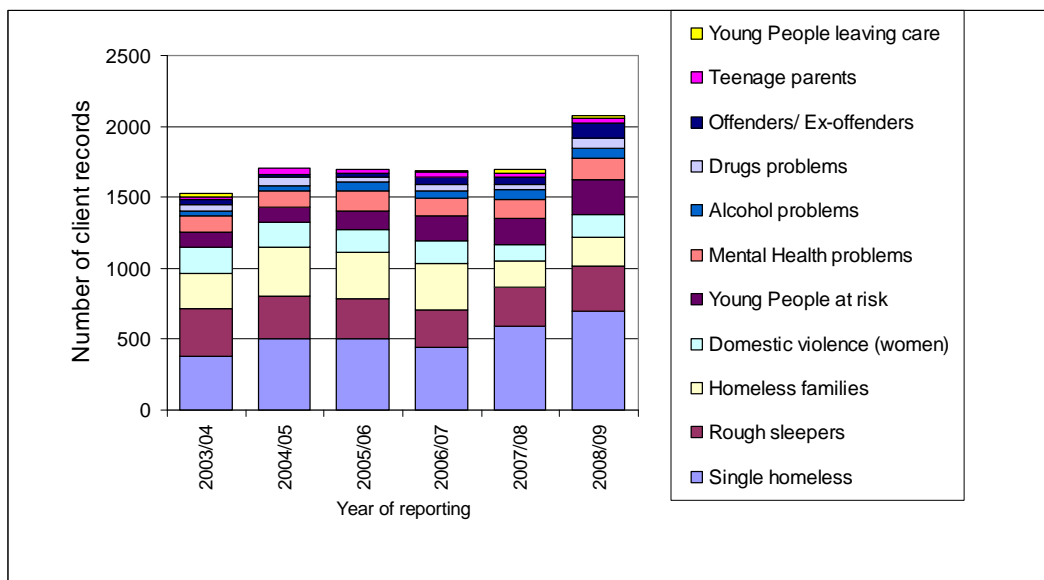
<sup>6</sup> New Directions Team Assessment, August 2009

<sup>7</sup> Source: P1E. Household estimates: Research Group, Cambridgeshire County Council

sleepers, older people, ex-offenders, homeless families, young people (at risk, leaving care or teenage parents), people with disabilities, travellers, migrants, refugees and asylum seekers and also people with drug, alcohol, mental health and domestic violence problems. These categories are not mutually exclusive and one person may fit into or move between different client groups at any one time. Their rather arbitrary nature makes it very hard to get a clear picture of individuals and the complexity of their needs.

- 2.7 The largest client group accessing Supporting People funded services is single homeless and rough sleepers with 49% of clients being recorded as such in 2008/09 (Figure 2). Data from Supporting People and Cambridge City Council show that the majority of people presenting to services for the homeless are white British males aged between 26 and 49.

**Figure 2: Number of clients accessing SP funded services by year of reporting and primary client group (presentations to services)<sup>8</sup>**



### 3. Existing Needs and Inequalities

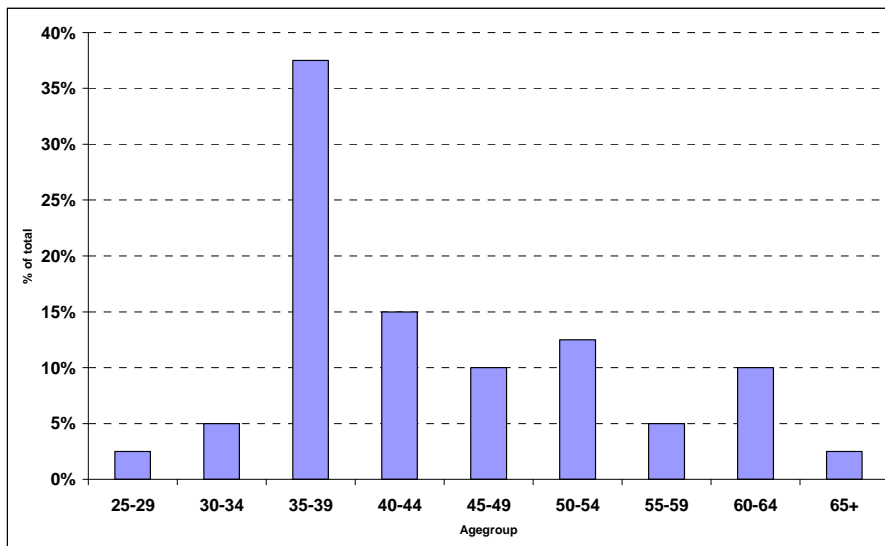
#### Single Homeless and Rough Sleepers (SHRS)

- 3.1 The SHRS have very poor outcomes as illustrated by the age distribution of recorded deaths occurring amongst the population registered with CAS (Figure 3). This partially reflects a small number of chronically excluded adults, with chaotic lifestyles, behavioural, substance misuse and control issues, and poor mental and physical health. They are often difficult to engage with services but represent significant costs to the tax payer as prolific offenders, having frequent hospital admissions and A&E visits, and intensive users of community and housing support services. Although this group represents relatively small numbers, it is essential that services are developed to help reduce the poor outcomes for this population.

<sup>8</sup> Source: Supporting People



**Figure 3: Age distribution of recorded deaths occurring among CAS registered population 2004-2006<sup>9</sup>**



- 3.2 National data suggests that SHRS have 7 to 8 times the rate of hospital admissions as the rest of the population. Age standardised rates for those registered at CAS or those with either No Fixed Abode, a hostel or the default address of CAS as their home address all support this.
- 3.3 Single homeless and rough sleepers too often end up on a downward spiral of deteriorating mental and physical health with behavioural and control issues fuelled by alcohol and/or drugs on a background of socio-economic deprivation, dysfunctional relationships and inadequate support. Lack of past experience of a stable, emotionally secure existence reduces the chances of emerging from this downward spiral of homelessness. Homelessness further exacerbates the poor outcomes of the already disadvantaged because of the loss of daily living skills together with the pervasive culture of drug and alcohol use and associated crime and anti-social behaviour which are strong forces preventing successful re-housing. Many SHRS feel that they have been repeatedly failed by services and find engaging with services difficult. There are many dedicated staff doing their utmost to support the SHRS, who are constrained by a system that is not designed to meet the complex multi-factorial needs of their clients.
- 3.4 A substantial proportion of all homelessness services are based in Cambridge City however of newly homeless people in Cambridge City only 1 in 3 have a local connection with Cambridge City, while 2 in 5 have a local connection with other districts in Cambridgeshire. The size and character of Cambridge City make it an attractive place for homeless people and services have largely been developed there to meet their needs which in turn may attract individuals from both within and beyond Cambridgeshire.
- 3.5 At present, services for homelessness are commissioned independently and often covering different geographic and demographic domains with some services being commissioned by more than one agency within the same areas. There are concerns that the fragmented commissioning of services does not work well for the homeless and an integrated approach to providing services should be more robust.

<sup>9</sup> Source: ONS Public Health Mortality File

- 3.6 This JSNA describes the wide range of current services for the homeless throughout the county. These include housing, health and drug and alcohol treatment, housing support and broader services directed towards rehabilitation such as training and employment. These services are delivered by statutory and non-statutory organisations, ranging from small local charities to national or county-wide organisations.
- 3.7 For many the main route out of SHRS is through being accepted as statutory homeless, but provision of accommodation alone is seldom adequate and many SHRS will require ongoing long term support to maintain tenancies and some will never find the personal resources to enable rehabilitation into society.
- 3.8 The most common needs recorded for SHRS accessing Supporting People services are stated as support to maximise income, support to maintain accommodation and avoid eviction, support to access external groups and services and support to better manage substance misuse. The main reported reasons for these needs not being met are in relation to the client being unwilling or unable to engage or ceasing support before the outcome has been achieved.

### **Statutory Homeless**

- 3.9 In 2008/09, 40% of homelessness acceptances were as a result of parents/relatives/friends being no longer willing or able to provide housing and 74% of households accepted as homeless had a dependent child.
- 3.10 Of clients referred to Supporting People, 22% were statutory homeless. This differs by client group with 72% of homeless families receiving SP services being statutorily homeless compared to only 2% of rough sleepers.
- 3.11 All Cambridgeshire local authority Homelessness Strategies have a focus on homelessness prevention and provision of appropriate accommodation, particularly reviewing the use of temporary accommodation. User involvement, partnership working and provision of support and services are also common themes. Some strategies also have a focus on specific client groups.

### **Hidden homeless and those at risk of homelessness**

- 3.12 The characteristics of the hidden homeless population are largely unknown as those hidden homeless people who do not access services may never appear in the data collection systems and so the picture of the homeless population painted by existing data often misses this group as well as those at risk of homelessness. The hidden homeless are thought to be a transient population made up of some SHRS, 'sofa surfers', those living in hostels. There may be a large group who are in insecure accommodation, who may be at risk of either a crisis or relationship breakdown or loss of a temporary or unskilled job
- 3.13 Some of these may continue to live their lives mainly on the street associating with the homeless and others like themselves who are at risk of slipping back into homelessness; this group sometimes referred to as engaging in antisocial 'street-life' activities may cause local residents and therefore police considerable concern. There may also be a significant number of young people still living with families who want to move out to live independently but cannot do so for economic or other reasons putting stress on family relationships.

3.14 Former members of the Armed Forces have previously been identified as a distinct group among rough sleepers but recent research tends to suggest that the proportion of ex-Service personnel among the homeless and rough sleeping population has fallen; up to 25% of rough sleepers had been in the Armed Forces at some stage in 1997 compared to 7% in London in 2007-08. Better accommodation advice for those leaving the British Armed Forces and closer working between Government and the charitable sector including on the provision of supported housing ventures are thought to have contributed to this improvement. Learning from the success in helping former members of the Armed Forces at risk of rough sleeping can be used to help other groups in the future.<sup>10</sup>

### **Effect of the Recession**

3.15 Moving into the second decade of this century, there will be increasing pressure on public spending which will have an impact on health and social care budgets. Economic recession leads to increased unemployment, repossessions, homelessness and more young people with little hope of achieving a stable future and consequently increased health needs. The effects of recession may include social problems and rising crime. The 'inverse care law' first described by Julian Tudor Hart in 1971<sup>11</sup> states that 'the availability of good medical care tends to vary inversely with the need for it in the population served.' There may be opportunities for jointly commissioning more integrated services for better outcomes potentially at lower cost for some of the most excluded and deprived sections of our society.<sup>12</sup>

## **4. Relevant LAA Indicators**

- NI 1 – % of people who believe people from different backgrounds get on well together
- NI 4 – % of people who feel they can influence decisions in their locality
- NI 5 – overall/general satisfaction with the local area
- NI 17 – perceptions of antisocial behaviour
- NI 20 – assault with less serious injury
- NI 21 – dealing with local concerns about antisocial behaviour and crime
- NI 141 – number of vulnerable people achieving independent living

## **5. Recommendations**

The following recommendations have emerged from this partnership working venture. The consistency in the needs identified by key stakeholders inspires confidence that these recommendations are founded in the experience of working with homelessness. It is recognised that there are significant constraints in the public sector at present. However a number of these recommendations are about using resources better across agencies, in a way which engages service users. A full set of recommendations are available within the full JSNA document.

---

<sup>10</sup> Department for Communities and Local Government, 2008. No-one left out: Communities ending rough sleeping.

<sup>11</sup> Hart JT. The Inverse Care Law. *Lancet* 1971;i:405-12.

<sup>12</sup> A four point manifesto for tackling multiple needs and exclusions. Making Every Adult Matter, September 2009.

- 5.1 Develop a multi-agency group to strengthen joint commissioning to address the needs of chronically excluded adults, single homeless and rough sleepers in Cambridgeshire with a focus on improving outcomes and the complex interrelations between health, housing and social care. Where possible more integrated multi-agency services should be commissioned including funded posts for liaison and co-ordination between services. This group could also consider development of a MARAC (multi-agency risk assessment conference) approach for chronically excluded adults.
- 5.2 Develop methods to encourage service user engagement in the commissioning process. Service users' experience and perceived needs should be embedded in the care planning process. Information and insights from individual care plans should be used to inform service development and commissioning to ensure direct input of homeless people and front-line service providers piloting the use of the 'Working together for change: using person-centred information for commissioning' model.
- 5.3 Develop integrated information systems, data collection tools and ways of unifying individual client records so they can be used and accessed across services and care personalised across pathways to allow more holistic and person-centred identification of needs, commissioning of services and monitoring of outcomes. Establish a process for the sharing and disseminating of knowledge and experience on service provision for the homeless.
- 5.4 Develop services enabling prevention of homelessness and early intervention for the newly homeless to improve individual lives and to reduce overall homelessness. Support is particularly required at transition points such as leaving care, prison release and A&E/hospital discharge. In addition services should be co-ordinated, accessible and responsive to the needs of the homeless population.
- 5.5 Develop a strategy to address the health needs of the homeless population in Cambridgeshire as part of a joint commissioning strategy with action plans to support implementation and supporting the existing district homelessness strategies and action plans.
- 5.6 Recognise that the issues identified in this JSNA are ongoing and that there needs to be ownership and multi-agency partnership for action planning to implement the recommendations.

## Acknowledgements

Thanks to the following members of the Homelessness JSNA working group for their input to the JSNA.

Trevor Baker	Research Manager, Cambridgeshire County Council
Susan Beecroft	Sub-regional housing strategy co-ordinator, Cambridgeshire Horizons
Susan Carter	Housing Advice and Options Manager, South Cambridgeshire District Council
Jon Collen	Huntingdonshire District Council
Diane Doherty	Single Homeless and Rough Sleepers Coordinator, Cambridge City Council
Jill Eastment	PH Information Analyst, NHS Cambridgeshire
Andrew Fowles	Commissioning Service Improvement Manager, NHS Cambridgeshire
Sarah Gove	Fenland District Council
David Greening	Cambridge City Council
Fay Haffenden	Consultant in Public Health, NHS Cambridgeshire
Susan Hinawski	East Cambs District Council
Christine Hugh-Jones	GP, Cambridge Access Surgery / Cambs Community Services
Polly Jackson	Cambridgeshire County Council
Elske Janssen	Supporting People Strategy Officer, Cambridgeshire County Council
Joseph Keegan	Cambridgeshire County Council
Jonathan Lamb	Practice Manager, Cambridge Access Surgery / Cambs Community Services
Maggie Lawrence	Cambridge and Peterborough Foundation Trust
Susan Lammin	Huntingdonshire District Council
Tina Le	Cambridgeshire Drug & Alcohol Action Team
Jeremiah Ngondi	Public Health Specialist Trainee NHS Cambridgeshire
Paul Pescud	Addaction
Christine Robertson	Team Manager, North East Intake and Treatment Team Cambridge and Peterborough Foundation Trust
Jessica Stokes	Screening, Children and Health Inequalities Manager, NHS Cambridgeshire
Anna Whitton	Service Manager, Addaction
Robert Young	Homelessness information and monitoring officer, Cambridge City Council

In addition the following members of the Health and Social Care Homeless Group

Adrian Boyle	A&E Consultant, Cambridge University Hospital NHS Foundation Trust
Stephen Cheetham	Supporting People, Cambridgeshire County Council
Vickie Crompton	DAAT Cambridgeshire County Council
Mags Daly	Assertive Outreach Team, Cambridge and Peterborough Foundation Trust
John Ellis	Mental Health Commissioning lead, NHS Cambridgeshire
Rachel Everitt	Street Outreach Team, Cambridge City Council
Joan Harding	Mental Health Commissioning (Social Care), Cambridgeshire County Council
Brian Holman	Manager, Cambridge Cyrenians
Christopher O'Loughlin	Consultant Psychiatrist, Cambridgeshire and Peterborough Mental Health Trust
Mick Simpson	Cambridge and Peterborough Foundation Trust
Tim Theaker	Cambridgeshire Community Services
Wynn Turley	Bridge Project, Cambridge and Peterborough Foundation Trust
Claire Warner	Commissioning Service Improvement Manager for Mental Health, NHS Cambridgeshire

The people and issues described in this report have been represented by dedicated individuals and organisations who work with and care passionately about the needs of those who are homeless or at risk of homelessness and do their utmost, despite limited resources and organisational constraints to improve the outcomes for this population.

Particular thanks go to the following:

Dr Hugh-Jones, Jonathan Lamb and CAS clinical staff for providing essential input into understanding the complex nature of the work of Cambridge Access Surgery and the needs of clients, primarily the single homeless and rough sleeper population.

Diane Docherty, Cambridge City SHRS Coordinator for providing valuable input and insight into the issues and potential solutions.

Jon Collen (P1E and district analyses of statutory homelessness), Robert Young (Cambridge City database) and Elske Janssen (Supporting People) for developing the data analysis and reporting in association with Dr Jeremiah Ngondi.

Dr Jeremiah Ngondi produced significant analyses of policy, and reviewed the evidence of effectiveness and conducted an original analysis of the CAS patients in collaboration with CAS and many of the analyses within the JSNA.

Analysts and managers in other organisations (DAAT, CCC Research Group, MHT, Voluntary Services) also contributed directly to the chapters on services for the homeless, together with the public health team,

Jill Eastment and Jessica Stokes project managed the JSNA and have produced and edited the final report for comment from the group.

Dr Fay Haffenden provided overall leadership, particularly in the scope and direction that the JSNA should take and the focus on the subsequent recommendations.

## 1. Introduction

The concept of Joint Strategic Needs Assessment (JSNA) was introduced in the Government's *Commissioning Framework for Health and Well-being*,<sup>1</sup> which was published in March 2007. JSNAs 'describe the future health, care and well-being needs of local populations and the strategic direction of service delivery to help meet those needs.' The key elements of the JSNA process are involving all important stakeholders from health and social care, identifying those needs and service requirements that are most relevant and important to its population and making use of existing information, identifying information gaps and including the views of service users, patients and the population (for further information about the JSNA process see Appendix 1).

The Homelessness and People at Risk of Homelessness JSNA aims to identify the current and future health, care and wellbeing needs of people identified as homeless or at risk of homelessness in Cambridgeshire. It identifies the health inequalities faced by the homeless population and recommends achievable improvements in health and well-being outcomes for this group.

The approach taken towards this JSNA was one of partnership working and multi-disciplinary discussion involving NHS Cambridgeshire, Cambridgeshire County Council (Research Group and Supporting People), the five District and City Councils in Cambridgeshire, Voluntary Sector agencies, Cambridge Access Surgery (Primary Care), Addenbrooke's A&E, Drug & Alcohol Services, Mental Health Services, and Cambridgeshire Sub Regional Housing. A working group including representatives from these organisations (see Acknowledgements) has met on a regular basis to inform the content and direction of this JSNA. Members of the working group were tasked with providing information/data specific to their area or service and task groups to tackle specific aspects of the JSNA were set-up on an ad-hoc basis.

The aim was to provide a 'model JSNA', that is to match an analysis of service provision to the constellation of needs expressed by users and identified by front-line service providers and then, from this exercise, to move forward to identify gaps in existing services, suggest appropriate target outcomes and thus inform future commissioning. It is self-evident that such a process is easier with a well-defined set of needs and a small number of service providers with clear user-involvement protocols. It is generally recognised that there have been difficulties applying a model JSNA process to a subject as large, complex and ill-defined as 'homelessness'

It has emerged that there are a variety of problems relating to data collection regarding the homeless. If services are to be improved for homeless people and those at risk of homelessness in Cambridgeshire, and indeed nationally, ways of standardising data collection and understanding individual 'homeless lifecycles' must be found. There is currently a lack of joint cross-service tools for this and one clear outcome of this work has been to identify a need for development of such tools. This recommendation, in turn, presupposes a degree of structural integration of services which does not currently exist on a broad scale.

The JSNA document provides a contextual background to the current issues around homelessness. The available data is used to describe the national and local pictures which is followed by a discussion of the specific needs of the homeless population, the mapping of existing services in Cambridgeshire and a review of the evidence for

interventions for homelessness. Recommendations were collected from as many different agencies and individuals as possible and represent the collective view of the organisations involved. Full reports and analyses submitted from different agencies are included in the Appendices and referred to in the main body of the JSNA. In general, the multi-agency and partnership work involved in this JSNA has been exemplary and complex issues have been discussed and explored in meetings that the final report may not have been able to fully capture.

The JSNA on *Homelessness and People at Risk of Homelessness* has been endorsed by the Cambridgeshire Health and Social Care Homeless Group.



## 2. Context

### CHAPTER SUMMARY

- Homelessness is a political issue. The current recession has led to increasing numbers of households being at risk of homelessness.
- Homelessness is commonly used to describe a wide range of circumstances where people have no secure home. The JSNA recognises three overlapping groups of homeless people: statutory homeless; single homeless and rough sleepers; and the hidden homeless.
- Homelessness is a complex issue. There is rarely a simple explanation for someone becoming homeless and a number of interlinked personal and social factors can contribute towards this.
- Homelessness is more than a housing issue and can occur as a result of poor health, unemployment or poverty. Health care, social services and criminal justice systems all impact on homelessness.
- Compared to the general population, homeless people experience poorer health outcomes and generally experience difficulties with accessing health services. Physical health, drugs, alcohol, mental health and well-being are priority health issues. Health outcomes are generally worse for SHRS but also apply to the statutory and hidden homeless.
- Local authorities are required to carry out a review of homelessness in their area and to publish a Homelessness Strategy at least every five years. All Cambridgeshire local authority strategies have a focus on homelessness prevention and provision of appropriate accommodation. User involvement, partnership working and provision of support and services are also common themes.
- The commissioning of services for the homeless population is complex, involving different funding streams and a variety of commissioning and provider organisations. Generally there appears to be limited involvement of the homeless population in the commissioning process.
- In Cambridgeshire, data on homeless is collected by numerous service providers, most of which operate stand-alone information systems. There is no robust way of uniquely identifying service users and so are likely to be instances of double-counting.

### *2.1. History of homelessness*

Homelessness has arguably never been higher on the political agenda in the UK. In 1998 there were about 1,850 people sleeping rough on the streets of England on any one night, the most visible and unacceptable form of homelessness. Further headline figures continued to shock with over 100,000 homeless households living in temporary accommodation by the end of 2004 and a peak of over 135,000 households accepted as homeless by councils in 2003/04. This led to a range of national targets placed on local authorities aimed at reducing rough sleeping and the number of households placed in temporary housing as a result of homelessness. The current recession has pushed homelessness even further towards the front of the political stage with rising unemployment and the credit crunch adding new dimensions such as increased home repossessions, leading to even higher numbers of households being faced with the threat of homelessness.

Homelessness can be a result of many different factors and in turn can have wider social and economic implications for those affected. Homelessness not only affects a small but significant minority, but wider household issues such as employment prospects, health and education may seriously be affected by homelessness.

Social exclusion can also lead to homelessness particularly when linked to other complex interrelated factors such as mental illness, drug and alcohol addiction, poor health and a history of trauma. Social Exclusion is a complex and multi-dimensional process. It involves the lack or denial of resources, rights, goods and services, and the inability to participate in the normal relationships and activities available to the majority of people in society, whether in economic, social, cultural or political arenas. It affects both the quality of life of individuals and the equity and cohesion of society as a whole. Where this is the case, making the transition out of homelessness can be an intensely difficult process, involving much more than the provision of housing. However, as housing is a key focus of security and social integration, without it, a cycle of exclusion and homelessness remains.

Cambridgeshire, in line with the rest of England, witnessed a steady increase from the early 1990s through to a peak in 2003/04 in the number of households accepted as homeless by the Cambridgeshire District and City councils. The introduction of homelessness prevention measures by the councils and a more proactive approach to providing alternative housing options, has led to a reduction in households faced with homelessness. However, as the economy and state of the property market has a significant effect on homelessness the concern is that homelessness may increase over the coming year as a result of the economic downturn.

In 1991, the Cambridge Homeless Partnership was founded to address the multiple disadvantages faced by a steady pool of some 2,000 men, women and children per year who were homeless, or on the brink of becoming homeless in Cambridge - a City which had some of the highest rents in the country. Over the last decade, there has been a concerted effort to tackle homelessness and there is evidence to suggest that homelessness, especially among rough sleepers, has been on the decline. For instance, between 1998 and 2002, there was a 37% decline in the number of people sleeping rough in Cambridge.<sup>2</sup> Despite the gains made in the last decade, homelessness continues to be a complex problem in Cambridgeshire.

## ***2.2. Domains of Homelessness***

Homelessness is commonly used to describe a wide range of circumstances where people have no secure home.

For the purposes of this JSNA it is necessary to make clear that we are describing and discussing different and distinct groups who may have very different health and social care needs. The JSNA has split homeless people into three groups: the statutory homeless; single homeless and rough sleepers; and the hidden homeless. Each domain is explained below.

### **2.2.1. Statutory homeless**

Legislation provides a safety net for the most vulnerable households in society so that, in the event of their homelessness, a local authority will provide advice and possible assistance so that they are not left without a roof over their head. The relevant legislation is contained within the Housing Act 1996, as amended by the Homelessness

Act 2002 and is supported by a plethora of case law that has set legal precedents over time.

This legislation provides a framework of tests that must be completed and satisfied by the local authority before it provides a household with what is termed a '**full housing duty**'. A household owed a full housing duty is considered to be statutory homeless, and local authorities monitor and report on the instances of homelessness in their area through quarterly returns to central government (called P1E returns).

The first test that a local authority considers when assessing a person's homelessness is whether they have accommodation available to them. This test considers whether the accommodation is available and reasonable for them to occupy. This test does not only apply to accommodation that may be available in this country, so if the person has access to suitable accommodation in another country then it may be considered that this is reasonable to return to that accommodation.

A further test within the legislative framework considers whether the homeless person or household has a defined '**priority need**'. The purpose of the legislation is to ensure that households considered as vulnerable and most likely to be in need of support, are considered as having a priority need for housing. The legislation defines households as having a priority need as those that:

- have dependent children; or
- contain a pregnant woman; or
- have become homeless because of a fire, flood or other emergency; or
- are 16 or 17 years old; or
- are aged 18 to 20 and used to be in care; or
- are assessed as being vulnerable because they would be more at risk than the average person if they were actually homeless.
- People who are homeless and vulnerable because they have experienced violence.

#### **2.2.2. Single homeless, rough sleepers and other groups to whom there is not a 'full housing duty'**

In addition to those households and individuals in priority need there is a group of homeless households and individuals to whom there is not a 'full housing duty' For these people local authorities have a duty to provide advice and help to enable them to find housing of their own. Housing will, however, not be directly provided by the local authority under any homelessness duty. Many of those to whom this applies fall into the category of **single homeless and rough sleepers, the hidden homeless, migrant workers or those with no access to public funds**. The definition of where a person may not be in priority need is described in detail below.

Current legislation sets out the local authority's legal duties to homeless individuals and households. The following applicants may not be owed a housing duty:

- People who are ineligible under immigration rules – e.g. in general terms these will be people who are subject to immigration control or are not habitually resident in the UK;
- People who are not homeless or threatened with homelessness within the next 28 days – although Local Authorities do have a duty to try to work with people as soon as they think they may be homeless in order to try to prevent them losing their home;

- People who are not in priority need: this includes anyone who does not fall into the priority need categories detailed above;
- People who have become homeless intentionally – e.g. they have done something (or failed to do something) that has resulted in them becoming homeless or being threatened with homelessness.
- People who do not have a local connection with an area may be owed a full housing duty but are likely to be referred back to an area where they do have a local connection, as long as it is safe and reasonable for them to return. The local authority in that area would then provide housing under that duty.
- The test of whether a household has a priority need for housing under the homelessness legislation means that local authorities will generally not have a duty to house people without children who are aged over 18 and have no significant illness or disability, or people who have become homeless or as a result of their own actions.

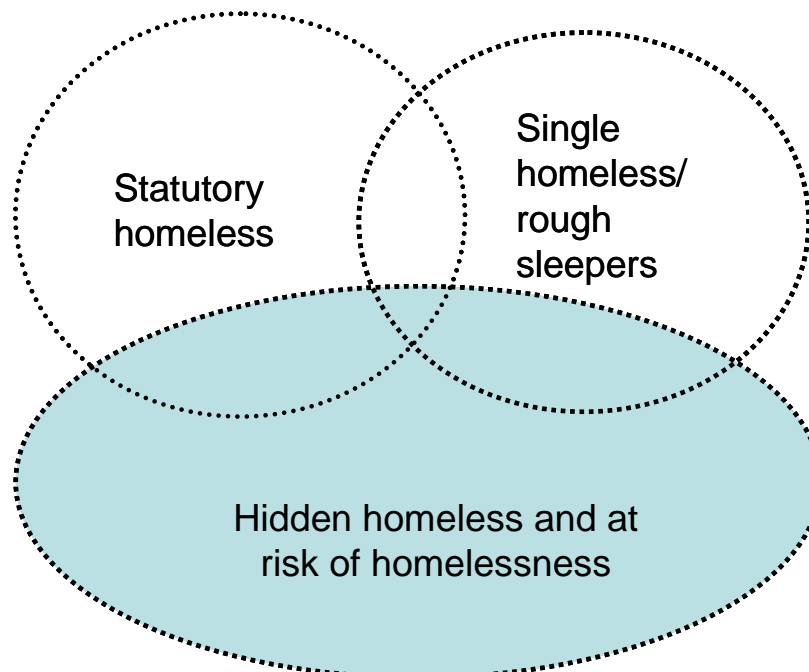
### 2.2.3. Hidden Homeless

The 'Hidden Homeless' are by definition those homeless people not known to local authorities or services. They are in the blind-spot of this report and more generally of homelessness research and policy. They include situations such as sleeping on friends' floors and sofas, living in squatted properties or general poor quality and inadequate housing. Hidden homeless people may not understand or investigate their rights or opportunities fully because they have little contact with advice services or only experience homelessness briefly or intermittently.

### 2.2.4. Overlapping domains

Although homeless people can be defined in terms of their statutory need, it must be recognised that there is a great deal of overlap between the domains with people frequently moving in, out and between the domains we describe. This is illustrated in figure 2.1 and explained in box 2.1 below.

**Figure 2.1:** Three domains of homelessness identified by the JSNA



**Box 2.1:** Reasons why individuals may be in more than one homeless domain or move between domains

- Single homeless people may at times be deemed to have a statutory right to permanent accommodation, but at other times be deemed not to be in priority need or to be intentionally homeless
- Statutory homeless people may choose to make their own housing arrangements or accept an offer of a hostel place instead of pursuing a statutory homelessness application
- Single homeless people and rough sleepers may fail to make statutory homeless applications because their lives are too chaotic or because they decide that a permanent tenancy may not be suitable for them
- Some single homeless people and rough sleepers choose not to engage with any services – at this point when services lose track of them, they become hidden homeless.

### **2.3. Causes of homelessness**

**Homelessness is a complex issue and there is rarely a simple explanation for someone becoming homeless.** A number of **interlinked personal and social factors** can contribute towards people becoming homeless (Box 2.2). These factors can broadly include one or more of the following:

1. **Individual factors:** including drug and alcohol misuse; lack of qualifications and settled employment; lack of social support; debts, especially mortgage or rent arrears; poor physical and mental health; relationship breakdown; and getting involved in crime at an early age
2. **Family background:** including family breakdown and disputes; sexual and physical abuse in childhood or adolescence; having parents with drug or alcohol problems; and previous experience of family homelessness
3. **An institutional background:** including having been in care; the armed forces; or in prison.

**Box 2.2:** Summary of risk factors and precipitating factors for homelessness**Risk factors for homelessness**

- disputes between young people and their parents or step-parents;
- experience of physical or sexual abuse;
- time in local authority care;
- learning disabilities;
- lack of qualifications and basic literacy skills;
- exclusion from school or persistent truancy;
- young parenthood;
- unemployment;
- alcohol and drug abuse;
- mental health problems;
- a combination of mental health, drug and alcohol problems;
- contact with the criminal justice system;
- previous service in the Armed Forces;
- marital or relationship breakdown;
- experience of violence from inside or outside the home, including domestic violence, racial and other harassment;
- previous experience of homelessness;
- lack of a social support network;
- failure to furnish or maintain a home: a warning sign that the tenancy may be failing;
- debts, especially rent or mortgage arrears;
- problems with neighbours: this can be a symptom of other problems, often linked to mental health and alcohol difficulties, as well as being a cause of eviction.

**Crisis points which can precipitate homelessness:**

- leaving the parental home after arguments;
- leaving care without adequate support;
- leaving prison;
- discharge from the Armed Forces;
- marital or relationship breakdown;
- a financial crisis of mounting debts;
- eviction from a rented or owned home;
- a sharp deterioration in mental health or an increase in alcohol abuse.

Source: Communities and Local Government<sup>3</sup>

**RECOMMENDATIONS**

Refine work on homelessness by:

- Recognising principle overlapping domains with differential access to housing and complexity of needs
  - Statutory Homeless: including families, older people, young people.
  - Rough sleepers /Single homeless: including prison and institution leavers
  - Hidden Homeless and those at risk of homelessness
- Recognising different reasons for becoming homeless and remaining homeless.
- Recognising the mobility and transience of the homeless population.

## ***2.4. Health, housing and homelessness***

### **2.4.1. Link between health, housing and homelessness**

Housing is one of a number of factors that has an important influence on people's health. The association between housing conditions and physical and mental ill health has long been recognised and there are a broad range of specific elements relating to housing that can affect health outcomes. 'Housing and public health', a review of reviews of interventions for improving health identifies a number of aspects of poor housing that can adversely affect health including overcrowding and housing tenure.<sup>4</sup>

Overcrowding is a factor that can adversely affect health, although in common with other housing-related components, it can interrelate with other factors so that it is difficult to measure its precise effect. Houses in multiple occupation (HMOs) are defined as a dwelling or converted residential building that is occupied by more than one household.<sup>5</sup> There is evidence to suggest that those living in houses of multiple occupations are four times as likely to suffer injury and twice as likely to die in a fire as those in single dwellings. Home ownership, on the other hand, may provide a degree of security and control. Home ownership can also have a negative relationship on health. People who experienced difficulties in meeting mortgage repayments also suffered increased insecurity and poorer mental health and are risk of being homeless.

Homelessness is one of the most extreme forms of social exclusion. It is more than a housing issue: homelessness can occur as a result of poor health, unemployment or poverty for example. Evidence from literature suggests that there is a strong relationship between homelessness and the health care, social services and criminal justice systems. Box 2.3 summarises conclusions of a review of literature on the relationship between homelessness, health, social services, and criminal justice.

Compared to the general population, homeless people generally experience poorer health outcomes and are particularly disadvantaged in accessing mainstream health services. Physical ill-health among the homeless is complicated further by the high levels of mental ill-health, and drug and alcohol misuse. In particular, rough sleepers experience extremely poor health.

Homelessness is complex with the need for housing being a common issue among the homeless client groups. However, in most instances, homeless people are initially assigned to live in temporary accommodation (usually bed and breakfast or hostels) while in other cases, homeless people may be settled in poor quality housing. Poor quality housing has far reaching negative implications on the health and wellbeing of the occupants. While quantifiable evidence of the health benefits associated with improved housing are difficult to show, the importance of decent homes is linked to improved communities, reducing crime, improving employment opportunities and educational achievement.<sup>6</sup>

**Box 2.3:** Summary of evidence on the relationship between homelessness, health, social services, and criminal justice (Adapted from Homelessness – cause & effect<sup>7</sup>).

- People who do not have safe, secure, affordable shelter have more health problems than the general population, experience social problems that may be exacerbated by their lack of shelter, and are more likely to become involved in criminal activity than the general public.
- Homelessness result in greater use of some services by the homeless, particularly hospital emergency services, shelters and correctional institutions, in terms of frequency and length of use.
- Some specific sub-groups of the homeless, such as those with mental illness, are even more likely to be involved with the health care, social services and criminal justice systems.
- Homeless people cause higher costs to the health care system. They use the most costly elements of the health care system more than housed people do.
- Studies indicate that better access to supportive housing is cost effective and far less expensive than other alternatives such as hospital beds, shelters and prisons.
- Homelessness exacerbates issues associated with poverty. Homeless people experience problems and use services more than low-income individuals who are housed.
- Evidence suggests that combining affordable housing with appropriate services including help in finding work is effective in helping homeless people get off the streets and rebuild their lives.

#### 2.4.2. Overview of health policies and strategies for the homeless

The health of the homeless has been an area of focus over the last decade. The key national and local policy and strategy documents with reference to the health of the homeless are summarised in Appendix 2. A number of national health policies have consistently highlighted the inequalities in health among the homeless compared to the general population and the need for tailoring health services to cater for the homeless has been well recognised. More recently, HM Government has unveiled a strategy focusing on reducing rough sleeping and providing integrated services for this chaotic homeless population.<sup>8</sup> However, at present, there are concerns that a coherent national strategy to tackle health for the homeless is lacking and there have been calls for the National Health Service (NHS) to take the lead on health among the homeless.<sup>9</sup>

#### **RECOMMENDATIONS**

- Develop a health strategy to address the health needs of the homeless population in Cambridgeshire as part of a joint commissioning strategy with action plans to support implementation and supporting the existing district homelessness strategies and action plans.

#### 2.4.3. Overview of housing policies and strategies for the homeless

The Homelessness Act 2002 requires local authorities to carry out a review of homelessness in their area and to formulate and publish a Homelessness Strategy at least every five years.<sup>10</sup> The review process should include a review of homelessness, the reasons behind it, as well as the current and future resources required to tackle it.

The Cambridgeshire local authorities recognise that the introduction of this duty has helped focus the partnership and cross border approach to tackling homelessness. Previously a great deal of good practice and partnership working took place but this



has since moved to a more formal level as a result of the production of formal Homelessness Strategies.

The main objectives of the Homelessness Strategies produced by each local authority in Cambridgeshire are highlighted in Appendix 2. Each authority has published its second Homelessness Strategy most of these being published in 2008/09. Huntingdonshire District Council took a different approach and reviewed its strategy and action plan in 2006 in light of the changes in homelessness prevention and housing options work at that time. This is now being reviewed again in 2009 to take account of the findings of this JSNA and the Supporting People Needs Assessment that is also due to report this year. Cambridge City Council has developed a specific strategy for single homeless and rough sleepers in recognition of this type of homelessness and the issues of this particular client group within the City.

All strategies focus on homelessness prevention and provision of appropriate accommodation, particularly reviewing the use of temporary accommodation. User involvement, partnership working and provision of support and services are also common themes. Some strategies also have a focus on specific client groups such as young people, vulnerable adults and Gypsies and Travellers in East Cambridgeshire and a number of specific priority needs groups identified in Fenland.

As with many public sector service areas local authorities recognise that much more can be achieved by working collaboratively on cross-boundary issues. Central government has grouped local authorities into sub regions based on housing and employment market areas. The Cambridge sub region includes the five District and City Councils in Cambridgeshire (not including Peterborough) as well as two of the District Councils in Suffolk (Forest Heath and St Edmundsbury). These authorities work together on many sub regional issues, including homelessness, and have agreed a Sub-regional Homelessness Action Plan (CSRHAP) bringing together common themes from their own Strategies that they can work on in partnership. Appendix 2 summarises the key tasks and milestones to be achieved by the CSRHAP in 2009.

### ***2.5. Commissioning Homeless Services***

Commissioning is the process of ensuring that health and care services provided effectively meet the needs of the population. It is a complex process with responsibilities ranging from assessing population needs, prioritising health outcomes, procuring products and services, and managing service providers.

At the end of 2007, the Department of Health introduced the concept of 'world class commissioning' with the intention of transforming the way health and care services are commissioned. World class commissioning aims to deliver a more strategic and long-term approach to commissioning services, with a clear focus on delivering improved health outcomes. In order to become a world-class commissioning organisation commissioners should work towards a series of competencies, which include working collaboratively with community partners and meaningful engagement with the public and patients to shape services and improve health.

When commissioning new services or redesigning existing ones, it is important that commissioners consider the homeless population and in particular how the service will be accessed by them and particular needs that this group may have in relation to the service. The commissioning of services for the homeless population is complex, involving different funding streams and a variety of commissioning and provider organisations (see below). These organisations should be working together to

commission services that are responsive to the needs of the homeless population with a focus on improving health outcomes.

- **NHS Cambridgeshire**

NHS Cambridgeshire is responsible for commissioning health and some adult social care services for the population who are registered with GP Practices within Cambridgeshire. This includes primary care and community services as well as secondary care services at Hospital Trusts. NHS Cambridgeshire also undertakes joint commissioning with Local Authority partners.

- **Cambridgeshire Community Services (CCS)**

Cambridgeshire Community Services provides a range of community based health and social care services for children and adults living predominantly in Cambridgeshire and, to a lesser extent, across the East of England. The Cambridge Access Surgery service is provided by CCS and offers a dedicated primary care service for people in Cambridge who are homeless or at risk of homelessness.

- **Cambridge and Peterborough NHS Foundation Trust (CPFT)**

Cambridge and Peterborough NHS Foundation Trust are a partnership organisation providing mental health and specialist learning disability services across Cambridgeshire and Peterborough.

- **Supporting People (SP)**

Supporting People is a national programme funded by Central Government, which commissions housing related support services. These include homeless hostels, supported accommodation for a wide range of client groups, women's refuges, sheltered housing for the elderly and floating support for people in their own home. As many of these services are aimed at supporting people to access housing, and particularly maintain housing once someone has a home, they by definition have a major role to play in preventing homelessness or helping someone who is homeless make the transition back into settled housing. SP services are non-statutory, the funding is separate from that for health and social care and comes from the Department of Communities and Local Government. From April 2009 in Cambridgeshire in common with authorities in England, Supporting People funding has become part of the Area Based Grant used to deliver Cambridgeshire's Local Area Agreement. SP has close links to health and social care which are also represented on its partnership boards.

SP services are generally open to anyone aged 16 years and over with a housing related support need, such as rent arrears or poor life skills that keep them from setting up or maintaining their own tenancy. Individual services will, however, have their own eligibility criteria, such as services for young people being restricted by age or women's refuges only accepting female clients.

- **Local Authorities**

In most of England, there are two levels: a county council and County Councils cover large areas and provide most public services, including schools, social services, and public transportation. In Cambridgeshire, Cambridgeshire County Council (CCC) provides this function.

Each county is divided into several districts. District councils cover smaller areas and provide more local services, including council housing (if still a stock holding authority), gyms and leisure facilities, local planning, recycling and trash collection. There are five district councils in Cambridgeshire responsible for housing services:

- Cambridge City Council
- East Cambridgeshire District Council
- Fenland District Council
- Huntingdonshire District Council
- South Cambridgeshire District Council

Of these councils, only Cambridge City and South Cambridgeshire councils are stock holding, providing the majority of social rented housing in their areas. The others have transferred their stock and so housing associations are the social rented landlords in their areas.

- **Third Sector**

The third sector relates to non-government organisations such as voluntary and community organisations and charities.

### **RECOMMENDATIONS**

- There should be direct input of homeless people and front-line service providers in the commissioning process.
- Strengthen joint-commissioning of multi-agency services in order to address the complex interrelations between health, housing and social care amongst the different categories of homeless.
- Provide for closer integration of services so that they meet the needs of the homeless by commissioning more integrated multi-agency services where possible including funded posts for liaison and co-ordination between services.
- Commission clear patient pathways and co-ordinated interventions in a minimum of different locations through multi-disciplinary working between NHS and third sector services for SHRS which are most crucial to improving outcomes of the homeless. The principle services identified for this are:
  - Primary care
  - Secondary care , particularly Emergency Departments
  - Mental Health Services including Learning Disability Services
  - Drug misuse services
  - Alcohol misuse services
  - Supporting People
- Develop a process for the sharing and disseminating of knowledge and experience service provision for the homeless.

## ***2.6. Views of community service users and staff***

One of the omissions of this JSNA has been the involvement of service users and generally there appears to be limited involvement of the homeless population in developing and evaluating local services. People with direct experience of homelessness should be involved in the commissioning process, including planning, delivery and evaluation of services in order to ensure services are responsive to the needs of the homeless population. Involving service users in this way can also help them to develop a sense of self-worth, confidence, responsibility and new skills<sup>11</sup>

An example of local service user involvement was in the development of the **Cambridge City Council Homeless Strategy consultation** where current and former users of homelessness services and front line staff were invited to a series of events to air their views (see Appendix 11). Comments were then incorporated into the strategy where appropriate. The main themes of the consultation were:

- Temporary accommodation
- Homelessness prevention
- Access to longer term housing options and sustaining settled lifestyle
- Tackling social exclusion

Involving service users and frontline staff in this way helped to ensure that the strategy reflected the needs of the very individuals that the strategy hoped to assist. Key issues identified were the need for on-going support, especially around transition periods, better communication and easier access to a range of accommodation, training and information.

**Cambridge Access Surgery** carried out a patient and stakeholder survey in August/September 2007 which was completed by 97 patients (65% response rate). This showed a high level of patient satisfaction with 84% of respondents being either satisfied or very satisfied with the CAS service. 14% of patients stated that prior to CAS they did not access health care or health care advice. When asked what they would do in the event of services ceasing to be available:

- 21% would not access health care at all
- 26% would attend A&E
- 49% would attend other GP surgeries but had experienced prior difficulties such as being unable to maintain the relationship or registration being declined

Feedback from the stakeholder questionnaire (50 questionnaires completed, response rate 77%) was also positive in providing a multi-agency link between health and other statutory and non-statutory services. Liaison with A&E and being more responsive to needs of the young were identified as areas for improvement.

NHS Cambridgeshire conducted a GP Patient Survey in May 2009, but of the 230 questionnaires sent out to CAS patients, only 21 were returned. This is due to the difficulty in contacting patients, many of whom are of no fixed abode, are rough sleeping, or have moved on from their temporary accommodation in to a hostel. The results of this survey, less than 10%, are considered too small a sample to be considered representative.

NHS Cambridgeshire and Cambridgeshire County Council have jointly employed a Service User Engagement Worker for mental health, who is facilitating the public consultation of the alcohol service specification for Cambridgeshire. The homeless are being engaged in this process through Winter Comfort and also through consultation with CRI street outreach team and the Cambridge Access Surgery.

Currently there is no consistent tool that services can use to collect the views of service users to help shape and inform services. Service user involvement appears to be patchy and sporadic rather than an integral part of the commissioning process. The Department of Health have recently launched the concept of '*Working together for change: using person-centred information for commissioning*<sup>12</sup>', which places service users at the heart of the commissioning process by using person-centred information for commissioning. It is an approach to engaging with people using services to review their experiences and determine their priorities for change. This model could be used to engage with the homeless population of Cambridgeshire.

### **RECOMMENDATIONS**

- Develop methods of ensuring that service users' experience and perceived needs are embedded in the care planning process. Information from individual care plans should be used to inform service development and commissioning.
- Develop ways of identifying broader outcomes which span services and which can be meaningfully identified or measured in practice and meet the needs of homeless people.

### ***2.7. Data Difficulties***

In Cambridgeshire, data on homeless are collected by numerous service providers. Data are collected by District Councils, Supporting People and Substance Misuse Services and submitted to centralised national databases. However, most of the service providers operate stand-alone database/information systems. There is no link between the service-based databases from different service providers and there is no robust way of uniquely identifying service users. In addition, homeless people are likely to present to different services and will often exhibit 'revolving door' phenomenon.

Where people do not access any services and remain as 'hidden' homeless so they will never appear in any of the data collection systems. Although the data available reveals the extent of homelessness in the county these data collection issues can lead to an inaccurate picture. What is unclear is to what extent homelessness is under or over represented by the data currently available.

Specific issues include:

- Information is collected each time a person comes in contact with the service (Supporting People and Cambridge City database). This means that information cannot be readily produced on the number of clients, only the on the number of contacts with services. Nor can people be tracked over time or through the multiple services.
- As described above, there is currently no robust way of identifying people across services. In addition, the comprehensiveness of both the Supporting People information and that held on the Cambridge City homelessness database, key data sources for this JSNA, entirely depend on which services are contributing data. The extent of the overlap or completeness is not known.
- Supporting People categorise clients according to 'primary client group' but these are not mutually exclusive categories. For instance, one person might fit into 'single homeless', 'rough sleepers' 'offenders' 'people with mental health problems' and 'people with drug problems'. This method fails to give due weight to the multiplicity of problems which beset the majority of homeless

individuals. People with 'alcohol problems' are only 2-3% of clients in the Supporting People data using the primary client group approach which is unlikely to be a true representation.

- Data are on people who present to services and exclude hidden homeless people (such as sofa surfers, squatters, people living in houses with multiple occupancy). The assessment is only made once, at the point when the client first makes contact with a service – it is therefore a judgment on the state of that individual before the service begins to work with her/him. Each assessment is made by an individual member of staff and because some of the pieces of information collected are subjective, opinions may vary between different services and members of staff.

### **RECOMMENDATIONS**

- Develop tools for data collection which can be used across services to allow more holistic and person-centred identification of needs, commissioning of services and monitoring of outcomes.
- Develop ways of unifying individual client records so they can be accessed across services.

### 3. The National Picture

#### CHAPTER SUMMARY

- Homelessness is a government priority. Policies and strategies set out national targets and action plans for tackling homelessness and rough sleeping.
- Trends in government statistics show a dramatic decline in the number of households accepted as homeless and households in temporary accommodation.
- Nationally, the number of people counted as sleeping rough by local authorities has been on the decline.
- Hidden homeless remains a potentially big problem. The existing data on the homeless largely does not keep track of the hidden homeless.
- There are concerns the current economic downturn is having a profound effect on the housing market and may reverse some of the gains in tackling homelessness achieved in the past.

#### ***3.1. Key national policies and strategies***

Table 3.1 summarises key National policies and strategies on homelessness. Homelessness was a key target of New Labour's endeavours to address 'social exclusion'. Homeless legislation and policy in the UK has gone through a period of intense change over the last ten years. New legislation has been introduced through the Housing Act 1996 as amended by the Homelessness Act 2002, in England and Wales, and Homelessness Act 2003, in Scotland. In a partnership of social services and the voluntary sector, localised strategic measures to provide accommodation, housing and support have been developed and put in place as part of the statutory obligations local authorities have towards people experiencing homelessness (Randall & Brown, 2002).<sup>13</sup> The focus has shifted from providing accommodation and emergency care to one emphasising resettlement (Seal, 2005).

**Table 3.1 Table: Key National policies and strategies on homelessness**

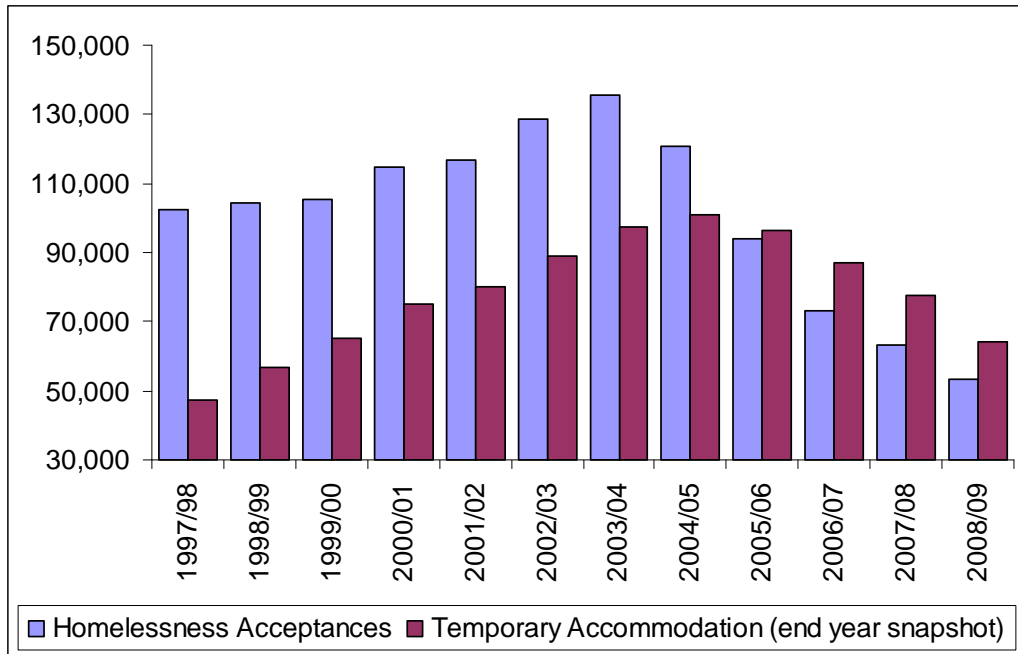
Year	Title	Summary
1998	SEU report (Cm 4008)	This report set targets to reduce rough sleeping in England to as near zero as possible, and by at least two thirds, by 2002.
1998	Coming in from the cold: the Government's strategy on rough sleeping	The strategy outlined six key principles to tackling rough sleeping: 1) tackle the root causes of rough sleeping; 2) pursue approaches which help people off the streets, and reject those which sustain a street lifestyle; 3) focus on those most in need.; 4) never give up on the most vulnerable; 5) help rough sleepers to become active members of the community; 6) be realistic about what we can offer those who are capable of helping themselves.
2003	More Than a Roof: a report into tackling homelessness,	This policy paper signalled local authorities to develop a more interventionist approach to tackling homelessness. The policy advocated a number of practical initiatives on homelessness prevention, including: 1) greater stress on the provision of advice on housing, employment and welfare benefits; 2) development of services such as family mediation and support in dealing with domestic violence; and 3) access to detoxification services, and employment training.
2005	Sustainable Communities: settled homes; changing live. A strategy for tackling homelessness	This strategy aimed to halve the number of households living in insecure temporary accommodation by 2010 by: 1) preventing homelessness; 2) providing support for vulnerable people; 3) tackling the wider causes and symptoms of homelessness; 4) helping more people move away from rough sleeping; and 5) providing more settled homes.
2008	No one left out: communities ending rough sleeping	This is a national strategy that sets out a 15 point action plan for ending rough sleeping by 2012. The report calls for a consistent community led approach building on solutions that are known to work and making these available across the country. Report also emphasises on a joined-up and comprehensive approach across government agencies.

### ***3.2. Statutory homelessness***

Communities and Local Government's (CLG) primary source of data on statutorily homeless households is the quarterly **P1E** return titled *Local Authority activity under homelessness provisions of the 1996 Housing Act*. Figure 3.1 shows the trends in homelessness acceptance reported to CLG through the P1E returns. Since 2004, there has been a dramatic decline in the number of households accepted as homeless and households in temporary accommodation. This is as a result of the shift to preventative homelessness services within the local authorities, so that households are able to avoid homelessness altogether. The knock-on result of this is that fewer households then have to be placed into temporary accommodation by local authorities.



**Figure 3.1:** Number of households accepted as homeless and number of households living in temporary accommodation.



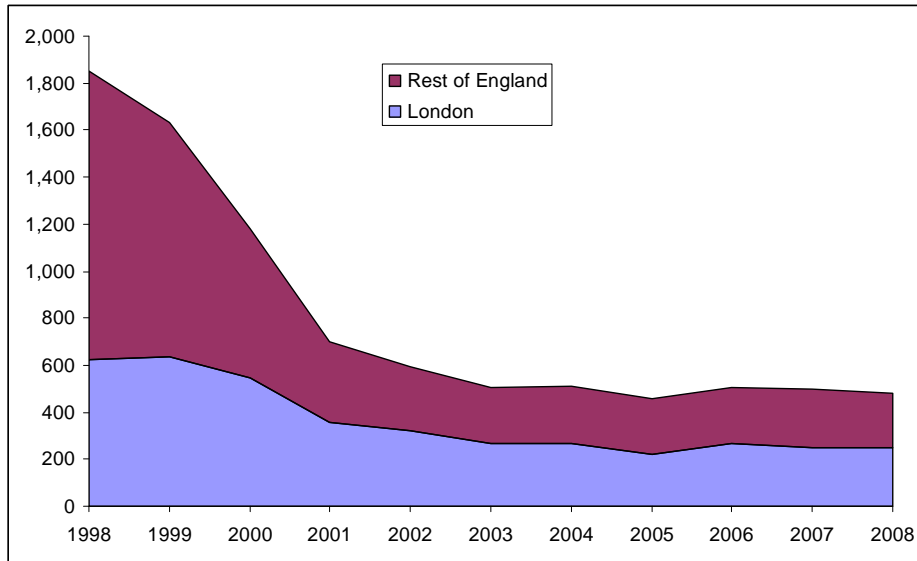
Source: Communities and Local Government (CLG)

### 3.3. *Single homeless/Rough sleepers*

The most visible form of homelessness is people sleeping on the streets. Generally, the characteristics of rough sleepers include:

- 75% who are over 25
- 90% who are male
- between one quarter and one third who have at some time been in local authority care
- 50% who are alcohol reliant
- 20% who are drug users
- 30-50% who have a serious mental health problem
- under 5% from ethnic minorities

Nationally in England, the number of people sleeping rough is measured through local authority street counts which provide a useful snapshot of the number of people sleeping rough on a single night. An annual estimate of the numbers sleeping out in England on any single night is published in September each year. Figure 3.2 shows the rough sleeper counts from 1998 to 2008. The number of rough sleepers declined dramatically until 2003 after which the numbers have stayed more or less constant at around 500 a year. Over half of the rough sleepers are counted in London.

**Figure 3.2:** Rough sleeper counts for in England from 1998 - 2008

Source: Communities and Local Government (CLG)

Former members of the Armed Forces have previously been identified as a distinct group among rough sleepers but recent research tends to suggest that the proportion of ex-Service personnel among the homeless and rough sleeping population has fallen; up to 25% of rough sleepers had been in the Armed Forces at some stage in 1997 compared to 7% in London in 2007-08. Better accommodation advice for those leaving the British Armed Forces and closer working between Government and the charitable sector including on the provision of supported housing ventures are thought to have contributed to this improvement. Learning from the success in helping former members of the Armed Forces at risk of rough sleeping can be used to help other groups in the future.<sup>13</sup>

### ***3.4. Hidden homeless***

Whilst many people tend to think of homeless people as rough sleepers, there are many others who, while not sleeping on the streets, can be seen as homeless as they do not have a decent place that can be considered a home. People who are squatting or sleeping on friends' floors because they have no where else to stay and those staying in substandard, overcrowded or insecure temporary accommodation, including Hostels and housing projects and Bed and Breakfast hotels (B&Bs), can also be seen as homeless. These groups of people tends to be less visible to homeless services and are therefore referred to as 'hidden homelessness'.

In 2003, Crisis estimated there were around 380,000 Hidden Homeless people in England and projected that this number would nearly double to 620,000 by the year 2010.<sup>14</sup> Crisis estimated that around a quarter are staying either in hostels, bed and breakfast accommodation or facing imminent threat of eviction on the grounds of debt. The remaining three quarters form what are known as concealed households, residing with friends or family, without any explicit right to do so and in accommodation which is in some way unsatisfactory.

<sup>13</sup> Department for Communities and Local Government, 2008. No-one left out: Communities ending rough sleeping.

The existing data on homeless people largely does not keep track of the hidden homeless. Presently, the focus of government routine statistics is on statutory homelessness and rough sleepers. This requires a person to have applied to their local authority to be classified as homeless or present to homeless services. Given that around half of single people who are accepted as statutorily homeless are still refused housing on priority grounds, many choose not to approach local authorities for help. Other homeless people are simply unaware of their entitlements or are too vulnerable to either make a homeless application or present to homeless services.

The experiences of hidden homeless living with families and friends have been a subject of research by Crisis<sup>15</sup> which revealed that:

- Homeless people who stay with a relative or friend tend to be younger than the general homeless population. Most who stayed with friends and relatives were single, and one-quarter were employed.
- Although the problems experienced varied by area, they were similar to those of homeless people in general, namely alcohol and drug problems, learning difficulties and time spent in prison or care.
- Specific problems associated with staying with family and friends were found, however, such as limited privacy and having to sleep on a sofa or the floor.
- Restrictions were placed on their behaviour and lifestyle, including when they went to bed, came and left, and used washing and cooking facilities.
- Many homeless people who stayed with family and friends used homeless services, but those recently made homeless or in rural areas had more help from colleges, social services and *Connexions* officers.

Squatters are, in every sense, a 'hidden homeless' population. Largely, monitoring systems, surveys and statistical datasets fail to identify squatters; many agencies are unaware of squatters or perceive squatting to be a rare homeless situation; very few squatters are counted in the official homelessness statistics either because they are not accepted as statutorily homeless or because they do not present as homeless to the local authority; their homeless situation is not literally visible in the way that rough sleeping is; and many squatters make concerted efforts to remain invisible to avoid eviction.<sup>16</sup>

### ***3.5. Effect of the economic recession on homelessness***

Nationally, the current economic recession is expected to have a negative impact. The level of homelessness is associated to the economic situation and the state of the housing market. If historic trends hold true and homelessness increases during periods of recession and increasing unemployment, we may begin to see a reversal of the recent downward homelessness trend. In June 2009, the Financial Services Authority (FSA) reported that compared to 2008 in the first quarter of 2009, home possessions and mortgage arrears increased by 62% and 33%, respectively.<sup>17</sup> A recent national survey on the impact of the economic slowdown on local authorities underscored that inflationary pressure, loss of income and additional demands on services were of major concern. The survey reported that by November 2008, a quarter of the local authorities were experiencing increased demand for services for the homeless.<sup>18</sup> Concerns over diminishing funding and increased demands for services have also been raised in a survey of voluntary sector agencies with a third reporting that they had been 'significantly' affected by the credit crunch.<sup>19</sup>

## 4. The Local Picture

### CHAPTER SUMMARY

- The main data sources on the homeless population of Cambridgeshire are data from local authorities (P1E returns), data from Supporting People and Cambridge City and data from the Cambridge Access Surgery.
- The overall trend in number of households accepted as homeless in Cambridgeshire is downward. This is largely as a result of local authority prevention strategies. Anecdotal data from the fourth quarter of 2008/09 shows that homelessness applications were on the increase in Cambridgeshire.
- Data collected from service providers by Supporting People and Cambridge City show that the biggest group of homeless people accessing services are the single homeless and rough sleepers. A higher proportion of clients are male, there are relatively few older clients and the majority of service users are White British.
- The registered population of Cambridge Access Surgery is around 500 people. The majority of people accessing the service are single homeless/rough sleepers with a higher proportion of males. A substantial proportion have mental health, substance misuse (drugs and/or alcohol) and 'dual diagnosis'.
- The voluntary and statutory agencies in Cambridge have identified 27 clients they believe to be chronically excluded. These are individuals with very complex needs, who have usually experienced rough sleeping, and may currently be sleeping rough.

### 4.1. Introduction

In order to discover the extent of homelessness in Cambridgeshire, four main data sources have been used:

District Council P1E returns	Quarterly returns to central government on 'homeless acceptances' (i.e. people who are considered statutorily homeless)
Supporting People data	Client records for all people accessing the services provided by Supporting People
Cambridge City database	Information collected by Cambridge City Council on people who have presented to accommodation and support services for single homeless people
Access Surgery	Health profile of people registered at Cambridge Access Surgery, a substantial proportion of whom are single homeless/rough sleepers who lead chaotic lifestyles

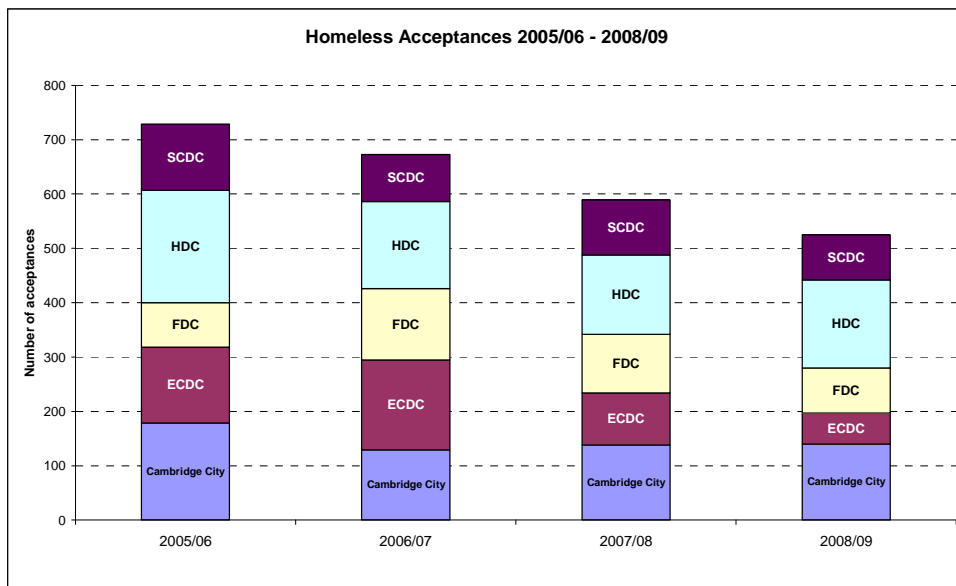
This section gives an overview of the data and summarises the key information that has been provided. Appendices 3 to 7 present these data in detail.

#### 4.2. Households in priority need – statutory homeless

Each local authority records data on the instances of homelessness it becomes aware of in its own area. Data are collated and submitted to central government on a quarterly basis (P1E returns).

The overall trend in the number of homeless acceptances in Cambridgeshire is downward – there is a 28% decrease from 729 households accepted in 2005/06 to 525 households accepted in 2008/09 (Figure 4.1). This has been as a result of the prevention services put in place by local authorities to help households stay in their current accommodation, or where this is not possible, helping them find alternative housing so that they do not become homeless.

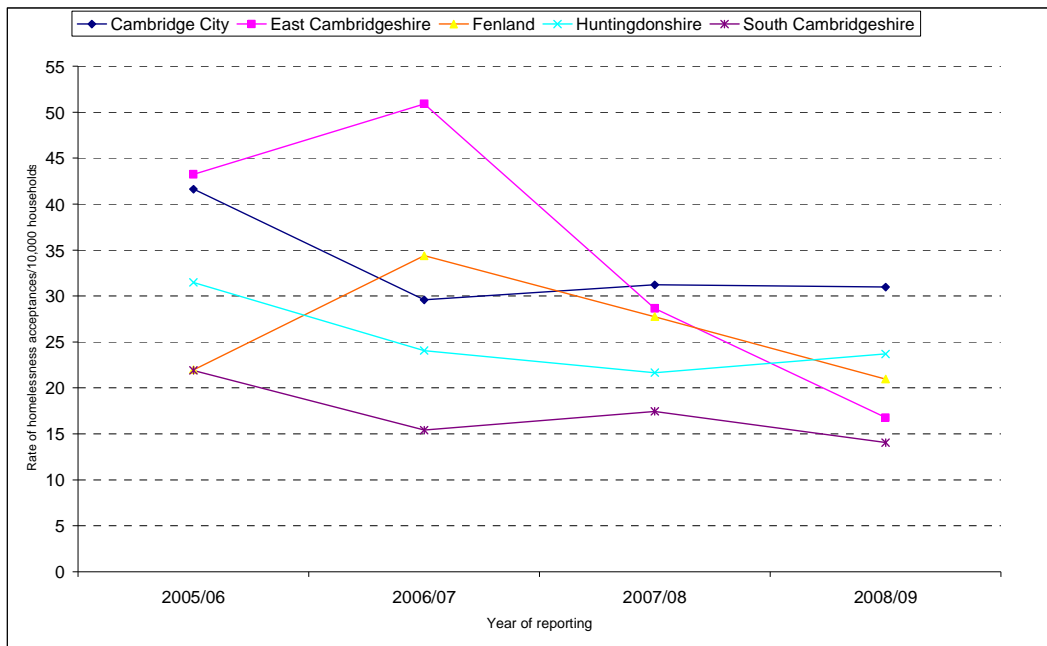
**Figure 4.1:** The number of homeless 'Acceptances' by District 2005/06 – 2008/09



Source: P1E data collated by District Councils SCDC – South Cambridgeshire District Council; HDC – Huntingdonshire District Council; FDC – Fenland District Council; ECDC – East Cambridgeshire District Council; Cambridge City Council.

Figure 4.2 shows homeless acceptances as a rate per 10,000 households for 2005/06 to 2008/09. The overall trend is downward in most districts, particularly in East Cambridgeshire and Fenland. Cambridge City, Huntingdonshire and South Cambridgeshire appear to have been relatively stable since 2006/07. There is variation across the County with Cambridge City having the highest rate in 2008/09 and South Cambridgeshire the lowest.

**Figure 4.2:** Rate of homelessness acceptances per 10,000 households by District, 2005/06 – 2008/09



Source: P1E. Household estimates: Research Group, Cambridgeshire County Council

The P1E collates other information such as the reason for homelessness, information about the households size and type, the priority need the household may have, as defined in legislation, and the outcome of the local authorities investigations into whether it accepts a full housing duty to help that household.

### Reasons for homelessness

- 40% of acceptances in 2008/09 were as a result of parents, other relatives or friends no longer being willing or able to provide housing. A similar picture is seen nationally. 174 households (32%) because parents were unable or unwilling to accommodate and 43 households (8%) because friends or other relatives were unable or unwilling.
- In 2008/09 7% (40 households) of all households accepted as homeless were as a result of a non-violent relationship breakdown.
- However, 12% (67 households) was as a result of a violent relationship breakdown.
- The second largest cause of homelessness in 2008/09 was due to households losing their private rented tenancies and being unable to find alternative housing. This was the situation with 90 households (17% of all acceptances).

### Household types accepted as homeless

- Households with children have a defined 'priority need' for housing if threatened with homelessness. It is therefore not surprising that of the 542 households accepted as homeless in 2008/09 by the Cambridgeshire authorities, 74% (402 households) had a dependant child. Lone female parent households represented 46% (253 households) of these were lone female parents and 25%

(133 households) were couples with children. The remaining 3% were lone male parent households.

- 10% of households (52) were lone females, a proportion of whom may have also been pregnant with their first child, and 9% (49 households) were lone males.

### **Reason for priority need of households**

The following statistics are based on what each local authority has recorded as the households primary priority need.

- 60% (328 households) accepted as homeless in 2008/09 had a priority need because they contained a dependant child.
- 17% (92) had a pregnant woman expecting her first child.
- Mental illness was recorded as the single largest vulnerability with 8% of households (42) having this recorded as an issue.

### **Age ranges of households accepted as homeless**

- In 2008/09 237 of the 525 household heads (45%) were aged from 16 to 24 years of age. 262 household heads (50%) were aged from 25 to 44 years.
- The most challenging age group to assist with housing tends to be 16 and 17 year olds. In 2008/09, 25 16 to 17 year olds were accepted as homeless almost 5% of all acceptances.
- Homelessness amongst older households does occur and 16 household heads (3%) were aged 60 years or over.

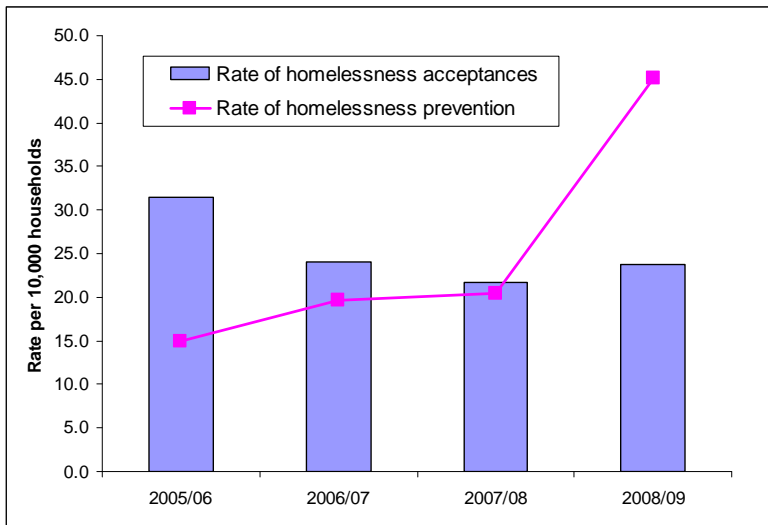
### **Homelessness prevention**

In 2008/09 the P1E returns included for the first time the number of cases where households were helped to avoid homelessness through advice, assistance or action taken by the local authority.

The new data collection section was included during the first quarter of the year and so is not complete data where some local authorities did not have systems in place to monitor this information from April 2008. However, from the instances that were recorded, there were 695 cases across Cambridgeshire where households were helped to avoid homelessness. Changes to the Housing Benefit Local Housing Allowance scheme in the coming year may, however, significantly reduce the number of households that local authorities help into private sector tenancies, where they are reliant on Housing Benefit to help them pay the rent. If this is the case and there are no other alternatives for these households, then becoming homeless may be their only option, with the local authorities then considering what help they may provide under the safety net of the homelessness legislation.

Figure 4.3 shows homelessness acceptances and homelessness prevention as a rate per 10,000 households for one district, Huntingdonshire, where the data are considered to be more complete. Whereas the rate of acceptances in Huntingdon was stable to 2008/09, an increase in the rate of homelessness prevention is apparent. The data suggest that there would have been a sharp increase in homelessness if it had not been for local authority efforts resulting in a doubling of prevention figures between 2007/08 to 2008/09.

**Figure 4.3:** Huntingdonshire – rate of homelessness acceptances and rate of homelessness prevention per 10,000 households



Source: P1E. Household estimates: Research Group, Cambridgeshire County Council

### Effects of the economic recession

Locally, anecdotal data from the P1E returns for the fourth quarter in 2008/09 for Cambridgeshire suggest that homelessness applications were on the increase. One local authority in the county, Huntingdonshire, saw an actual increase in the number of households accepted as homeless as the recession began to grip in the second half of 2008/09. The other local authorities report that they fear this may happen in their own areas and will monitor this throughout 2009. Additionally, data from Cambridgeshire, Norfolk and Suffolk Courts suggest that compared to 2007, mortgage and landlord possession orders made in 2008 increased by 38% and 10% respectively (Appendix 10).



### 4.3 Summary of Supporting People Data

The Supporting People programme funds housing related support services for vulnerable people, including the homeless or those at risk of homelessness. These services support people to access appropriate accommodation or maintain their current accommodation. The programme funds services for a range of client groups, including hostel based services for single homeless people and homeless families, street outreach for rough sleepers and supported accommodation for young people at risk, people with mental health problems, ex-offenders and people with drug and alcohol problems.

#### *Data limitations*

Supporting People providers are required to complete and submit a client record form for each person entering their services. This form collects information on primary and secondary client group, age, ethnicity, gender, economic status, referral source, and prior accommodation. **However, Supporting People categorise clients according to 'primary client group' but these are not mutually exclusive categories. For instance, one person might fit into 'single homeless', 'rough sleepers', 'offenders', 'people with mental health problems' and 'people with drug problems' but will only be presented in one primary client group.** This is likely to be a subjective judgement which may depend on which type of service has seen the client. The method fails to give due weight to the multiplicity of problems which beset the majority of homeless individuals. For example, people with 'alcohol problems' are only 2-3% of clients in the Supporting People data using the primary client group approach which is unlikely to be a true representation. **In addition, the information is collected each time an individual accesses a service so the data presented in this report are on contacts with services, and not with individual people.** SP receive only anonymised forms so it is not possible to identify unique individuals under the current system of data collection and reporting.

With these caveats, the information collected by Supporting People provides a detailed description of the homeless population receiving SP funded services in Cambridgeshire over the last five years.

#### **Supporting People data – 2004/05 to 2008/09**

Between April 2004 and March 2009, a total of 8,865 client record forms were completed for clients in Cambridgeshire. Overall, the number of clients remained stable throughout the reporting period to 2007/08 with an average of 1,700 client record forms (i.e. contacts with services) in each financial year. In 2008/09 there has been a 22% increase on the previous year.

**Table 4.1:** Number of presentations to Supporting People services by year and gender

Gender	Year of reporting					Total
	2004/05	2005/06	2006/07	2007/08	2008/09	
Female	803	816	814	706	851	3,990
Male	899	873	844	858	1,222	4,696
Total	1,709	1,699	1,690	1,694	2,073	8,865

Source: Supporting People. Note: this is the number of presentations to services and not the number of people.

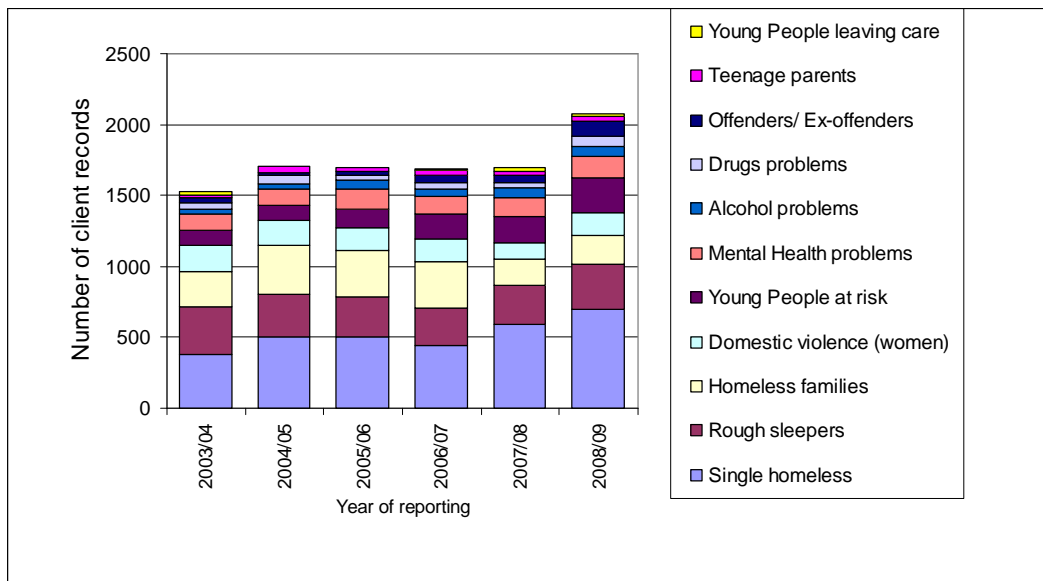
Table 4.2 shows the number of presentations to SP services in 2004/05 and 2008/09 and the percentage change by client group over the last five years. The breakdown by primary client group is also shown. Single homeless and rough sleepers were the largest client groups accessing SP funded services. In 2008/09, 49% of clients were recorded as single homeless or rough sleepers. Single homeless, young people at risk and offenders/ex-offenders form an increasing proportion of the total (Figure 4.4).

**Table 4.2:** Number of presentations to Supporting People services by primary client group in 2004/05 compared to 2008/09

Primary client group	Year of reporting				
	2004/05	2008/09	2004/05 % of total	2008/09 % of total	% change
Single homeless	500	694	29%	33%	+39%
Rough sleepers	303	322	18%	16%	+6%
Homeless families	349	199	20%	10%	-43%
Domestic violence (women)	169	161	10%	8%	-5%
Young people at risk	111	248	6%	12%	+123%
Mental health problems	116	149	7%	7%	+28%
Alcohol problems	37	74	2%	4%	+100%
Drugs problems	58	66	3%	3%	+14%
Offenders/ex-offenders	21	113	1%	5%	+438%
Teenage parents	37	35	2%	2%	-5%
Young people leaving care	8	12	0%	1%	+50%
Total	1,709	2,073	100%	100%	+21%

Source: Supporting People. Note: this is the number of presentations to services and not the number of people.

**Figure 4.4:** Number of clients accessing SP funded services by year of reporting and primary client group (presentations to services)



Source: Supporting People

**Referral of clients to services**

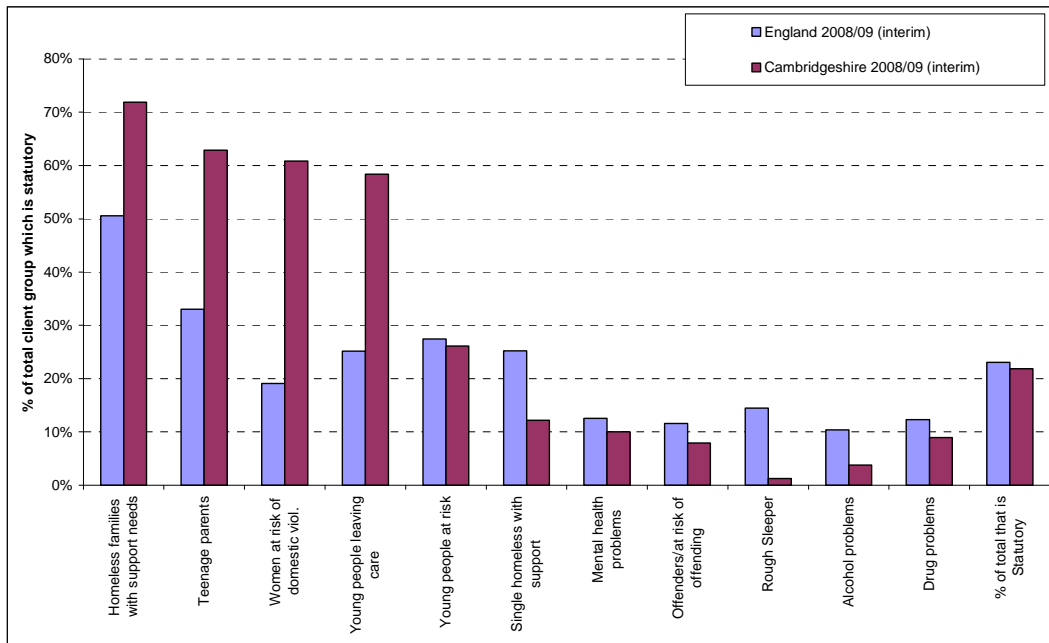
The top three sources of referral (2003-2008) include self-referrals (28%); local authority housing department (18%); and local housing associations (17%). Referrals from local authorities have reduced across client groups since 2003 when they were amongst the main referrers.

Referrals differ by referring organisation and by Client Group. Self referrals/direct applications are predominantly made by rough sleepers (52% of the total) and the single homeless (16%). 85% of referrals amongst rough sleepers are self referrals/direct applications. LA housing department referrals consist of the single homeless (39%) and homeless families (32%) as do Housing Association referrals (53% homeless families and 21% single homeless). Social services primarily refer the single homeless (54% of their total referrals).

**Statutory homelessness**

A breakdown showing whether or not the client was considered to be statutorily homeless and in priority need is shown in Figure 4.5. Overall, in 2008/09 22% of client referrals to Supporting People were for people who were statutorily homeless and owed a main homeless duty which is similar to the proportion found in the Supporting People data for England (23%). This differs by client group with 72% of homeless families receiving SP services being statutorily homeless and only 2% of rough sleepers. The proportion of families who are statutorily homeless and receiving SP services in Cambridgeshire is higher than the England figure (51%). In Cambridgeshire, few rough sleepers received services as part of a 'main duty' and the figure for England as a whole is higher (15% of rough sleepers).

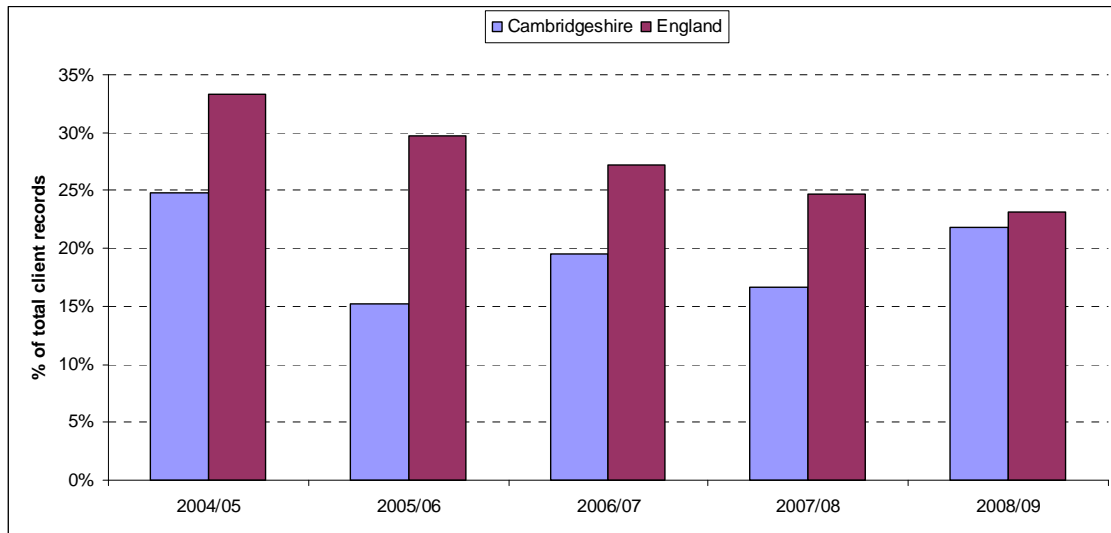
**Figure 4.5** Proportion of Supporting People clients who are statutorily homeless by client group



Source: Supporting People

The proportion of SP clients who were statutorily homeless in Cambridgeshire (22%) has reduced in Cambridgeshire over the last five years. The proportion is now similar to that of England (23%) (Figure 4.6).

**Figure 4.6:** Trend in proportion of Supporting People client groups who are statutorily homeless 2004/05 – 2008/09. Cambridgeshire and England.

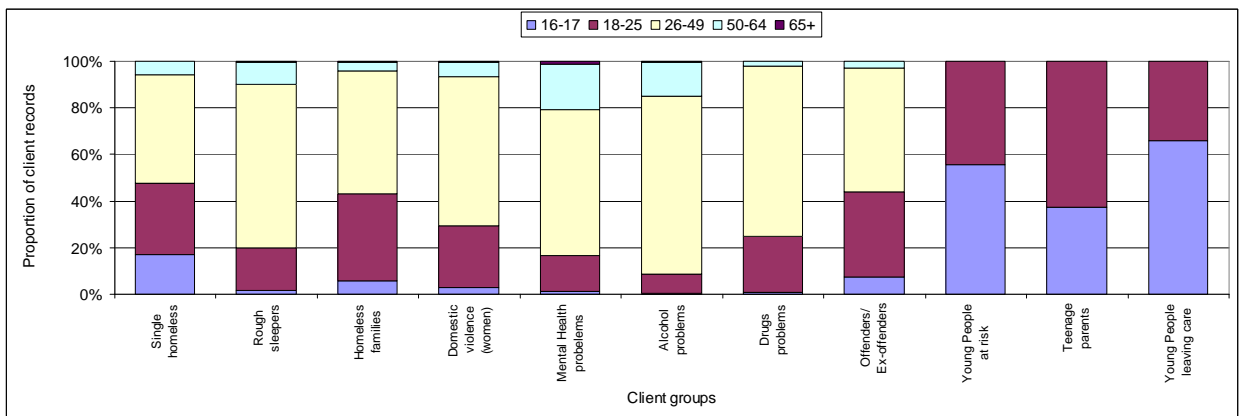


Source: Supporting People

**Age profile**

The age profile differs markedly by primary client group (Figure 4.7). Young people aged 16 to 17 years are primarily recorded in the young people at risk, teenage parent and offenders/ex-offenders client group with the remainder of those groups consisting of people aged 18 to 25 years. People aged 18 to 25 are spread across all client groups. The predominant age group is people aged 26 to 49 years with relatively few older people.

**Figure 4.7:** Age profile of Supporting People client records by primary client group



Source: Supporting People

**Ethnicity**

Overall, around 85% of service users are White British although this is higher in some client groups. The largest ethnic diversity is amongst women fleeing domestic violence where there is a larger proportion of Other White people as well as women from Pakistani, Bangladeshi and Indian background.

#### **4.4. Summary of Cambridge City data**

Since 2004, Cambridge City Council (CC) has collected information on people who present to the main providers of accommodation and support services for single homeless people in Cambridgeshire. Services which provide data are Cambridge Cyrenians, Centre 33, Crime Reduction Initiative Street Outreach Team (SOT), English Churches Housing Group (ECHG), Jubilee Project and the YMCA.<sup>14</sup> The majority of people included in this database are 'single homeless/ rough sleepers' – this group are often ineligible for housing under the homelessness registration and as such follow a different path to housing services compared to the statutory homeless.

Frontline staff complete an information form when the client first receives the service and again at the end of the period of service. Information collected includes reason for homelessness, what services the client is engaged with and what additional services the client requires. An assessment of needs and whether or not the client's needs are currently being met is made. There is also an assessment of the primary and (up to three) secondary *client groups*.<sup>15</sup> A quarterly report is produced to help identify gaps in services, unmet needs and general trends in homelessness.

#### **Data limitations**

It is important to note the limitations of the information provided which include:

- The assessment is only made once, at the point when the client first makes contact with a service – it is therefore a judgment on the state of that individual before the service begins to work with her/him
- Each assessment is made by an individual member of staff and because some of the pieces of information collected are subjective, opinions may vary between different services and members of staff
- The same issues apply to the use of the primary client group as in the Supporting People information. In reality, these categories overlap and this can not be taken into account.
- As in the SP data, information is collected on contacts with services and not with individual people.
- As mentioned above, not all service providers in Cambridge City are contributing information to the database.

With these caveats, the Cambridge City database provides further detailed information on the homeless population who access these services but the extent of the overlap with the SP data is not known.

#### **Demographics characteristics**

Between April 2004 and December 2008 3,709 presentations to homeless services were made (Table 4.3). The majority of the homeless people were male (80.7%), and aged between 18-49 years (84%). Over half (53%) were single homeless (Figure 4.8) and the predominant ethnic group was White (89%).

---

<sup>14</sup> The most significant provider that does not contribute information is Jimmy's Night Shelter. Description of these services is shown in Appendix 6.

<sup>15</sup> Classifications devised by *Supporting People* to describe groups of people who require support. Note that the same limitations apply to these data in that primary client groups are not mutually exclusive.

**Table 4.3:** Number of presentations to Cambridge City Homeless services by year and gender

Gender	Year of reporting					Total
	2004/05	2005/06	2006/07	2007/08	2008/09	
Female	143	127	186	149	124	715
Male	608	616	568	700	562	2,994
Total	751	743	754	849	686	3,709

Source: Cambridge City Council \*January-December 2008. Note: this is the number of presentations to services and not the number of people

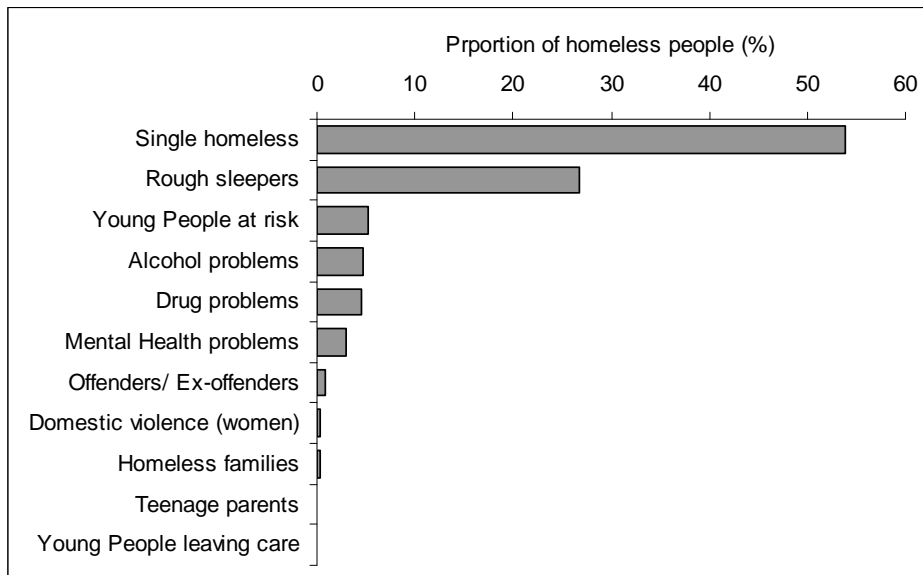
### **Multiple presentations to homeless services**

Over the five year period, 3,709 contacts were recorded with 1,990 individuals.<sup>16</sup> The majority of individuals (59.4%) had only one recorded contact, suggesting that there are a large number of people who have a small amount of contact with homelessness services. However, 40.6% of the individuals had multiple contacts with services with some individuals presenting as many as 18 times over the five year period.

### **Client groups**

As shown in Figure 4.8, the predominant client group represented in the Cambridge City database are the single homeless and rough sleepers.

**Figure 4.8:** Proportion of presentations to Cambridge City homeless services by primary client group from 2004/5 to 2008/9



Source: Cambridge City database

### **Reason for homelessness**

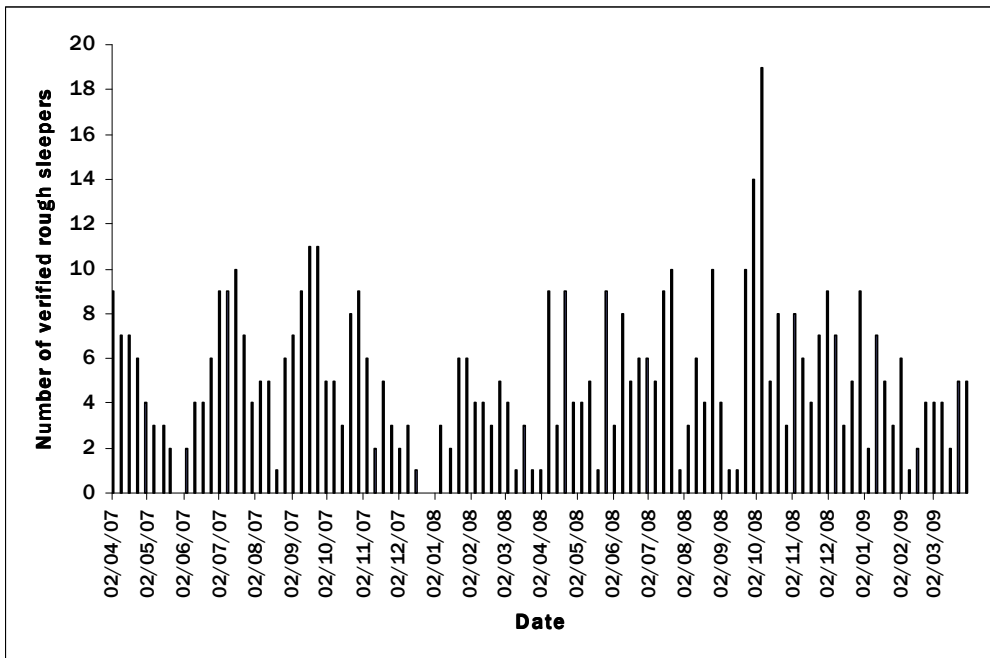
The top five recorded causes of homelessness were disputes with parents (21.6%), eviction from the current accommodation (16.7%); dispute with partner (11.8%). Over 10% of the homeless people reported the reason for being homeless as a lifestyle choice to seek independence and a further 10% gave the reason of leaving prison.

<sup>16</sup> Individual clients were identified by manual match of names

### ***Rough sleeper trends***

Cambridge City Council monitors rough sleeping through official rough sleeping counts (twice yearly) and routine weekly counts of rough sleepers by the Street Outreach Team (SOT). The official counts are likely to underestimate the rough sleeping problem. Routine counts by the SOT show that Cambridge City experiences a perennial rough sleeping problem with a weekly average of 5 people sleeping rough (range 0-19) (Figure 4.9).

**Figure 4.9:** Routine rough sleeper counts conducted by the SOT April 2007 to March 2009



Source: Street Outreach Team

### ***Reconnections policy***

The Reconnections policy, introduced in June 2007 aims to relocate service users not locally connected with Cambridge City to areas where they have a local connection or to areas where housing supply outstrips demand. This policy is monitored through a multi-agency *Reconnections Forum* which meets once a fortnight to discuss cases and share information on clients.

A local connection with Cambridge City (made with reference to the Homelessness Act 2002) would include either:

- 1) Residence - the service user is normally resident within the district. Normal residence is defined as six of the last 12 months or three of the last 5 years.<sup>17</sup>

<sup>17</sup> In Cambridge periods of time spent rough sleeping would qualify someone as being 'normally resident within the district'. However, this needs to be clearly verified e.g. clear evidence that the applicant has consistently appeared on the street outreach weekly reports for 6 months or more or proof of a claim for benefits for the periods stated above.

- 2) Employment. The service user has stable employment within the district  
 3) Family associations - the service user has parents, adult children, brothers or sisters who have been resident in the district for at least 5 years

In the period from June 2007 to March 2009 there were 617 presentations to the *Reconnections Forum* (Table 4.4). In 2008 there were, on average, 80 new presentations per quarter and 317 in the full year. Over the whole period (June 2007 to March 2009) 32% of people had a local connection to Cambridge City. A further 40% had no local connection to Cambridge City but were connected to districts within Cambridgeshire. 13% of people were from outside Cambridgeshire and in 15% of people this information was not known.

**Table 4.4:** Number of new presentations to Cambridge City and their connections reported from June 2007 to March 2009

Year & Quarter		2007		2008			2009	Total	
		Jun-Sep	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec		Jan-Mar
New presentations		122	87	79	83	65	90	91	617
Proportion with local connection to:	Cambridge City	34%	32%	25%	35%	31%	37%	31%	32%
	Elsewhere in Cambridgeshire	46%	43%	44%	30%	45%	32%	37%	40%
	Outside Cambridgeshire	8%	16%	13%	13%	15%	16%	10%	13%
	Local connection unknown/no connection	12%	9%	18%	22%	9%	16%	21%	15%

Source: Cambridge City Council

### Housing advice services

The housing advice team gives advice to Cambridge residents who have housing problems. Most of their clients are homeless or in housing need in unsatisfactory housing. They may be single people, couples or families. They also provide advice services for landlords who are having problems with tenants or rented homes. In 2008/09, 958 presentations were made to advice services, 51% were people looking for accommodation and 33% for the reason of 'homelessness'.



#### 4.5. *Summary of Cambridge Access Surgery data*

The health profile of homeless people registered at Cambridge Access Surgery is summarised in Appendix 7. A substantial proportion of this population are single homeless/rough sleepers who lead chaotic lifestyles.

The registered population more than doubled from the opening of the Surgery in 2003 to 2008 and appears to be stabilising at about 500 registered patients. There is a 4:1 male/female ratio with a relatively narrow age distribution about a mean of 38.5 years. There are no under 16s and very few over 60s.

**Table 4.5:** Number of people registered at CAS: 2003 – 2009

Age group	Year						
	2003	2004	2005	2006	2007	2008	2009
≤19	8	12	17	16	17	12	8
20-29	68	87	105	115	121	115	123
30-39	87	99	143	181	182	187	149
40-49	41	52	83	112	108	129	141
50-59	22	24	34	49	49	54	55
60+	5	8	8	13	17	12	13
All ages	231	282	390	486	494	509	489

Source: FHS Registration System (Exeter) January of each year (2003, October)

#### **Health profile of CAS population**

Patients tend to use health services frequently with some patients attending multiple clinics in a day. Consistent with current knowledge of health among the homeless, the CAS registered population has a substantial proportion of patients with mental health, substance misuse (drugs and/or alcohol) and 'dual diagnosis'. Other leading causes of morbidity such as liver and respiratory disease are clearly related to drug and alcohol misuse and adverse living conditions.

The data analysis (Appendix 7) reveals some clear and striking results about the health of this population. It is a preliminary effort which will enable us to refine future data analysis. We have experienced some difficulties in extracting and interpreting data from the EMIS medical software system. These are due to intrinsic limitations of the software system, the inadequacy of national Read Codes for describing health and social problems among the homeless and the difficulty in maintaining consistent data entry with staffing shortages.

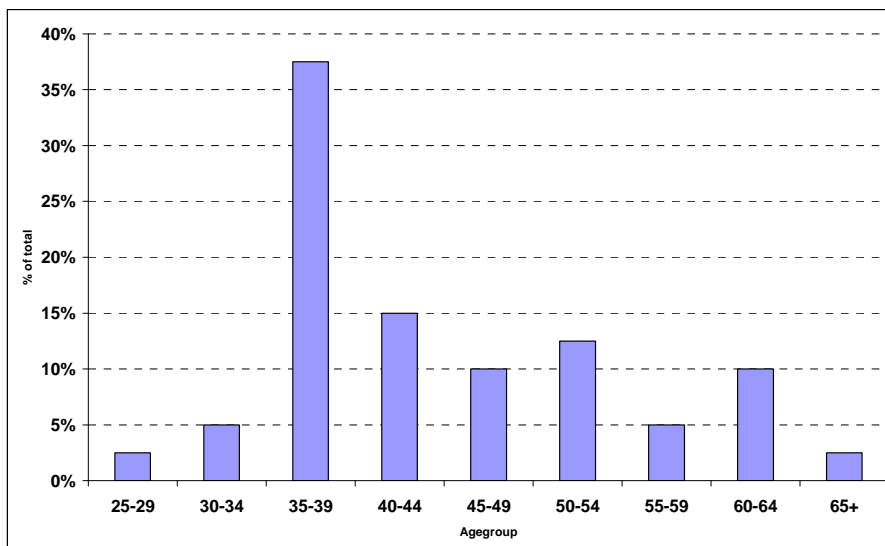
#### **Mortality**

Homeless people are much more likely to die young than people who are not homeless. Cambridge Access Surgery (CAS) is a dedicated GP practice largely for single homeless and rough sleepers with around 500 registered patients at any one time. Amongst the patients registered at CAS, 40 are known to have died over the last five years, their average age at death was 44 years. The registered patients at CAS are relatively young and range from young adulthood to middle age. Many are at the very lowest point in their lives. Of CAS patients, broadly speaking, ½ have an alcohol problem; 2/3 have a drug problem, ½ have a mental health problem and many people have two or all three of these problems. Taken together, drugs, alcohol and poor mental health play a major part in nearly all deaths among the homeless. Note that this

should not be confused with life expectancy. Life expectancy at birth for the general population of Cambridgeshire is 80 for men and 82 for women. This does not mean that life expectancy for the CAS population is half that of the rest of the population in Cambridgeshire but does highlight that, consistent with poor health outcomes and complex health needs, the mortality figures for the CAS population of single homeless and rough sleepers are comparatively very poor.

Figure 4.10 shows the age distribution of 40 deaths among CAS registered population recorded from 2003 to 2008. A recent review of causes of death occurring in 2008/9 among patients registered at CAS estimated the main causes of death were drug overdose (42.8%) and alcohol/ alcohol complications (28.6%); which are all entirely preventable causes. Taken together, drugs, alcohol and poor mental health play a major part in nearly all deaths among the homeless).

**Figure 4.10:** Age distribution of recorded deaths occurring among CAS registered population 2004-2006



Source: ONS Public Health Mortality File.

Note: there is known under-recording of mortality amongst this population. Not all deaths will be linked back to the GP practice where the deceased is registered.

#### **4.6. Secondary Care Data**

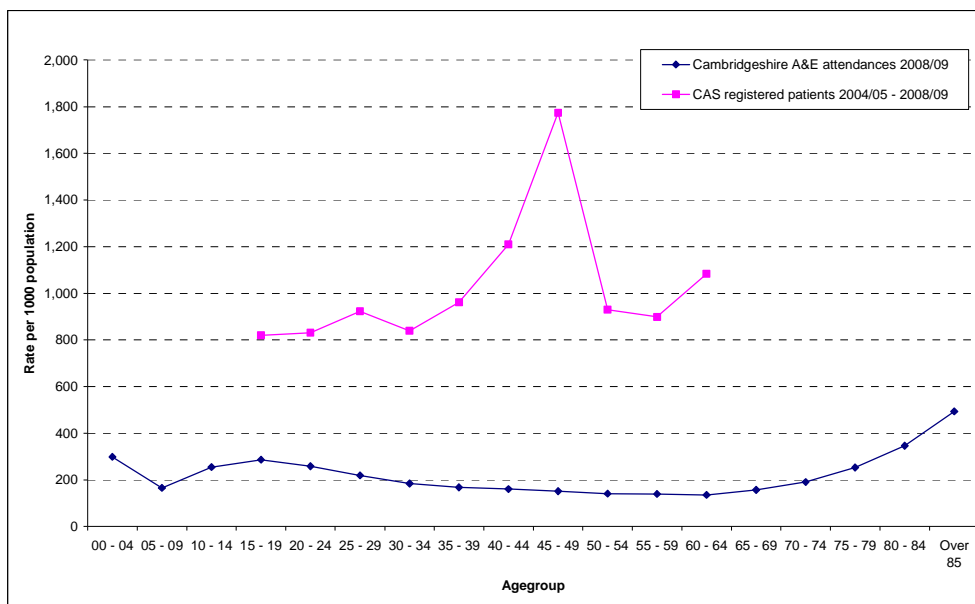
The rate of hospital admission amongst the homeless population is significantly higher than the local and national average. National data suggest that SHRS have 7 to 8 times the rate of hospital admissions as the rest of the population. Local data for those registered at CAS or those with either No Fixed Abode, a hostel or the default address of CAS as their home address all support this.

Between 2004/05 and 2008/09, 303 patients registered at Cambridge Access Surgery had 1,026 inpatient admissions, of which 84% were emergency admissions. The range of conditions for which an emergency admission was required is extensive but summarise to injuries, skin infections (many serious) and a mixture of drug and alcohol related admissions. Whilst 44% of people had only one emergency admission over the four year period, a further 40% had 2 – 4 admissions and 16%, 48 patients, had five or more. A small number of people had in excess of 20 emergency admissions over four

years. An additional 171 patients of 'No Fixed Abode' (postcode recorded in the hospital data as ZZ99 3VZ) accounted for a further 250 emergency admissions over the five year period.

Rates of attendance at Accident and Emergency (A&) are up to five times that of the general population in Cambridgeshire. The indirectly standardised attendance rate is 553 (95% CI 529 – 578) where Cambridgeshire as a whole is 100. Age-specific rates in certain age groups, as shown in the figure below are very high. Overall, 43% of total A&E attendances resulted in an admission to hospital. Although 65% of the 451 patients who attended A&E between 2004/05 and 2008/09 had attended only once or twice in one or two years, a small number of patients have experienced high levels of A&E attendance. Five people attended A&E 20 to 50 times over the four year period. An audit of A&E attendance in people who had attended A&E more than five times in a year (2006/07) found that for one-third of patients there was no written information from the hospital, one-fifth (19%) were assessed as 'unnecessary' and one-third (35%) of 'doubtful necessity'. Further information can be found in Appendix 8. Of the 352 additional A&E attendances by persons recorded as 'No Fixed Abode' at CUHFT (and not registered at CAS), 33% were from outside of Cambridgeshire.

**Figure 16.11:** Age-specific rate of A&E attendance by CAS registered patients compared with the Cambridgeshire average attendance.



Source: A&E database

#### 4.7. Chronically Excluded Adults

There is a number of individuals with very complex needs, who have usually experienced rough sleeping, and may currently be sleeping rough. This group has been identified as being 'chronically excluded' in 'Reaching Out – Action Plan for Social Exclusion' (Office of Social Exclusion, 2006). They are likely to have been in care and/or prison, and to have mental / physical health problems or learning difficulties, often combined with drug and alcohol addiction, self-harm and offending behaviour. Many have experienced abuse in childhood, and are current victims and / or perpetrators of abuse. These people are usually well known to multiple agencies.

The voluntary and statutory agencies in Cambridge have identified 27 clients they believe to be chronically excluded (New Directions team assessment, August 2009). Serious concern has been expressed locally that service provision may not be adequate for a number of such individuals.

Chronically excluded adults are likely to exhibit the following characteristics:

- A history of exclusion/care/abuse/repeatedly failed by services
- Often 'on the books' of multiple agencies
- Poor health prospects (physical and mental)
- Multiple needs that are not addressed holistically
- A history of offending and antisocial behaviour
- Huge costs to multiple agencies: prolific offenders / multiple hospital admissions and A&E visits / SHRS
- Chaotic lifestyles / behavioural, control +/-learning difficulties
- Skills deficits and limited economic and employment prospects
- These clients are often perceived to be difficult to engage. is this because they don't perceive services as meeting their needs? Or they can't access the services they want? Or they just don't care? Or are too chaotic?

Although their needs are multiple and complex, these people often do not meet eligibility criteria for services which often have specific remits around drugs and alcohol or mental health, learning disability or housing. They are often unable to access accommodation because their support needs are too high and cannot be met. Short term funding often hampers life long solutions for these people. Lack of coordination can lead to crises solutions requiring multi-agency responses with the real cost of exclusion hidden in separate budgets.

Most of the people in this group are vulnerable adults who are or who may be in need of community care services. This brings them under the remit of Adult Safeguarding.

The way systems and services may be failing the most challenging Rough Sleepers, and the range of barriers to, and failures of, service provision and safeguarding of this group, was reported at a subgroup of the Safeguarding Vulnerable Adults Homelessness Steering Group which focuses on Rough Sleepers. Agencies noted the devastating sense of being ultimately let down, and the resultant despair reported by such clients. This work is being taken forward by the group and options are being considered for both short term and longer term solutions.

**CASE STUDY: Jon**

- Jon is 45 years old. He was taken into care as a baby after a head injury resulting in brain damage and maintains that he suffered serious (including sexual) abuse whilst in care. He was diagnosed in 1997 with a specific learning disability
- Jon is a risk to himself and others: he drinks excessive alcohol, and self harms by cutting and burning himself and often becomes violent when drunk.
- Jon has committed around **400** offences since 1996 He has appeared in court around **260** times and served **120** short term prison sentences. There have been several orders made to get a mental health assessment.
- From 1996 to 2008, 12 different professionals were involved in Jon's care and 17 were involved in 2009 from 14 agencies/organisations.
- Jon has poor health and suffered a minor heart attack. Over the last 3 years he has attended Camdoc 2 times, Addenbrookes A&E 26 times, been admitted to Addenbrookes 16 times and Fulbourn Hospital 2 times. In addition to this there have been at least 2 hospital admissions outside of Cambridgeshire.
- During a 12 day period in June 2009 he when he was sleeping rough he was arrested 8 times. During this period Jon said to a SOT worker **"This always happens, people always promise they will help, but there is always a reason why they don't."** After another period in prison, and a SVA case conference, Jon was housed in temporary accommodation with CCC, with a raft of support in place , from the LDP, Mental health, SOT, CCC floating support, CCC housing offers. After a couple of weeks he was admitted to Fulbourn Friends ward but has now been discharged and is back in his accommodation, although he continues to drink heavily and meet his peer group. During the time in temporary accommodation with support Jon has only been arrested once. His case continues.

**4.8. Street Life**

Around 500 people are known to the police in Cambridgeshire as engaging in 'Street life' activity and it is estimated that 40-50 of these individuals are engaged in street life activity at any one time. Street Life activity can be defined as anti-social behaviours perpetrated by individuals or groups on the streets or in parks and open spaces. Typical behaviours are street drinking, begging, rough sleeping or drug dealing and other associated behaviours such as urinating in public places, littering, using abusive language and so on. Street drinking in particular can take place in groups and, aside from rough sleeping, none of these behaviours are exclusively exhibited by homeless people. Individuals will generally consider themselves to be part of a community and generally do identify with one another. While they may not all be homeless, individuals exhibiting a street-based lifestyle usually carry the hallmarks of a chronically excluded adult.

## 5. Mapping needs of the homeless

### CHAPTER SUMMARY

- Homeless people often present with multiple and complex needs. Individual outcomes may not be homogenous, just as the population described within this JSNA is not
- The most common needs recorded for people accessing Supporting People services are stated as support to maximise income, support to maintain accommodation and avoid eviction, support to access external groups and services and support to better manage substance misuse.
- The main reported reasons for these needs not being met are in relation to the client being unwilling or unable to engage or ceasing support before the outcome has been achieved.
- Existing services tend to view the homeless population as different client groups such as single homeless, rough sleepers, older people, ex-offenders, homeless families, young people (at risk, leaving care or teenage parents), people with disabilities, travellers, migrants, refugees and asylum seekers and also people with drug, alcohol, mental health and domestic violence problems. These groups have different needs but also overlap to a great extent.

### *5.1. Introduction*

The JSNA aims to identify the health and wellbeing needs of homeless people in the broadest sense, recognising that there is no simple way of describing 'need' that can adequately capture the requirements of the individuals that make up the homeless and at risk of homelessness population. There needs to be further work to identify the individual outcomes that the homeless population want and it should be recognised that those outcomes may not be homogenous, just as the population described within this JSNA is not.

### *5.2. Supporting People Outcomes Framework*

Since April 2008, all Supporting People funded services in Cambridgeshire are required to complete outcomes forms for service users once they have left the service. This is to show what the client has achieved during their time with the service and where something that was planned has not been achieved, why this was the case. The client and their support worker, when completing the form, indicates which areas the client required support in. For example, the forms returned for 349 single homeless people indicated that they needed support to maximise their income, e.g. by applying for the appropriate benefits. The form then asks whether an outcome, if it was required, has actually been achieved. In this case, 320 of the 349 single homeless people who required this support successfully achieved this outcome and maximised their income. For those that did not achieve the desired outcome, the support worker chooses from a list of options the reason why the outcome was not achieved.

In 2008/09, 1,569 clients leaving short-term<sup>18</sup> support services funded by SP had their outcomes assessed on departure from the service. Table 5.1 shows the areas of greatest reported needs by client group.

The areas of need most commonly represented in the Supporting People outcomes forms across all client groups are:

- Support to maximise income
- Support to maintain the accommodation and to avoid eviction
- Support to access external groups and services
- Support to better manage substance misuse

Provisional information, based on data for the first three quarters of the year, suggests that where needs had not been met, this was because clients were unwilling to engage with services or clients ceased to access services before outcomes were achieved. Possible reasons for this may include: clients with complex support needs or a lack of insight which prevents them from engaging with the support service; other factors relating to the service including staff skills and experience in the services or staff shortages or funding difficulties which mean that the service is not able to operate effectively.

---

<sup>18</sup> Short term services offer support for up to two years, by which time it is expected that the client would have moved on to independent living

**Table 5.1:** Areas of greatest reported needs for people leaving SP funded short term support services, Supporting People Outcomes Framework,<sup>19</sup> 2008/09

Client group	Greatest needs (based on SP outcome framework)	Number clients requiring service	Proportion clients requiring Service	Proportion of eligible clients achieved desired outcomes (%)
Single homeless people (n=540)	Maximising income	349	65%	92%
	Maintaining accommodation/avoiding eviction	319	59%	60%
	Accessing external groups or services, friends or family	251	47%	82%
	Support to better manage substance misuse	245	45%	52%
Rough sleepers (n=174)	Support to better manage substance misuse	90	52%	53%
	Maximising income	81	47%	89%
	Support to better manage physical health	67	39%	81%
Offenders / Ex-offenders (n=35)	Maximising income	32	91%	94%
	Complying with a statutory order	30	86%	57%
	Better manage substance misuse	23	66%	70%
	Accessing external groups or services, friends or family	22	63%	73%
Homeless families (n=214)	Maintaining accommodation	21	60%	57%
	Maintain accommodation/avoid eviction	118	55%	88%
	Maximising Income	117	55%	95%
Young People at risk (n=192)	Maximising income	161	84%	89%
	Maintaining accommodation	135	70%	53%
	Developing greater choice/ control/ involvement	133	69%	82%
	Accessing external groups or services, friends or family	111	58%	88%
	Reducing debt	97	51%	60%
	Participating in training or education	99	52%	65%
Teenage Parents (n=37)	Maximise income	33	89%	100%
	Developing greater choice/ control/ involvement	28	76%	96%
	Accessing external groups or services, friends or family	26	70%	100%
	Maintaining accommodation	23	62%	70%
People with drug problems (n=32)	Participating in training or education	16	43%	81%
	Support to better manage substance misuse	29	91%	52%
	Support to comply with a statutory order	20	63%	50%
	Maximising income	16	50%	81%
People with alcohol problems (n=52)	Mental health	14	44%	36%
	Support to better manage substance misuse	41	79%	54%
	Maximising income	35	67%	91%
Mental health problems (n=160)	Support to better manage physical health	35	67%	63%
	Better manage mental health	150	94%	57%
	Developing greater choice/ control/ involvement	108	68%	65%
	Maximising income	96	60%	82%
Domestic violence (women) (n=131)	Maintaining accommodation	71	44%	80%
	Reducing debt	64	40%	81%
	Minimise harm or risk of harm from others	117	89%	81%
	Developing greater choice/ control/ involvement	98	75%	79%
	Maximising income	97	74%	88%
	Accessing external groups or services, friends or family	73	56%	90%

<sup>19</sup> The Outcomes Framework is divided into five areas: economic wellbeing; enjoy and achieve; be healthy; stay safe; and make a positive contribution. See Appendix 5 for a full breakdown under these headings by Client Group.



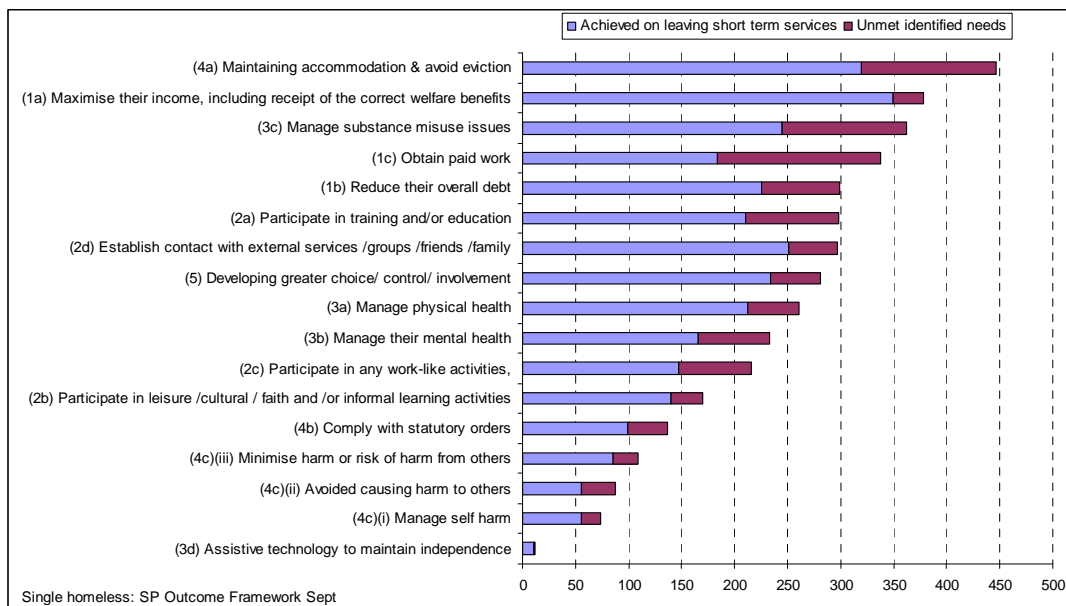
### 5.3. Summary of needs by client group

#### 5.3.1. Single Homeless / Rough Sleepers

Single homeless people, by the Supporting People definition, include people who have been accepted as homeless and in priority need and also people who have been turned down for re-housing or those who have not approached the local authority and have a range of support needs.

The Supporting People needs analysis as shown in Figure 5.1 identified 'maintaining accommodation or avoiding eviction', 'support in maximising income, 'accessing external groups or services, friends or family' and 'support to better manage substance misuse' as the main support needs.

**Figure 5.1:** Identified needs, and needs achieved by single homeless people leaving Supporting People funded short term services (2008/09)



Source: Supporting People. Note: 226 outcome forms were completed for single homeless people recorded as their primary client group in the period i.e. people who had left short term funded services.

Single homeless people formed the largest client group for Supporting People, making up about 25% of all client records. There were 694 client record forms completed in 2008/09 for people whose primary client group was single homeless. Males outnumbered females by 2:1 in 2008/09, a slight reduction on earlier years. Around 46% of people are aged 26 to 49 years, 15% aged 16 to 17 years and around 30% aged 18 to 25 years. The predominant ethnic group is White British (89%).

In terms of previous tenure, an increasing proportion of clients had been rough sleeping (14% in 2003/04 and 23% in 2008/09). Other groups had been previously staying with family (18% in 2003/04 reduced to 15% in 2008/09) and friends (13%). About 50% of single homeless people in SP are job seekers. The long term sick and disabled increased from 16% in 2003/04 to 28% in 2008/09.

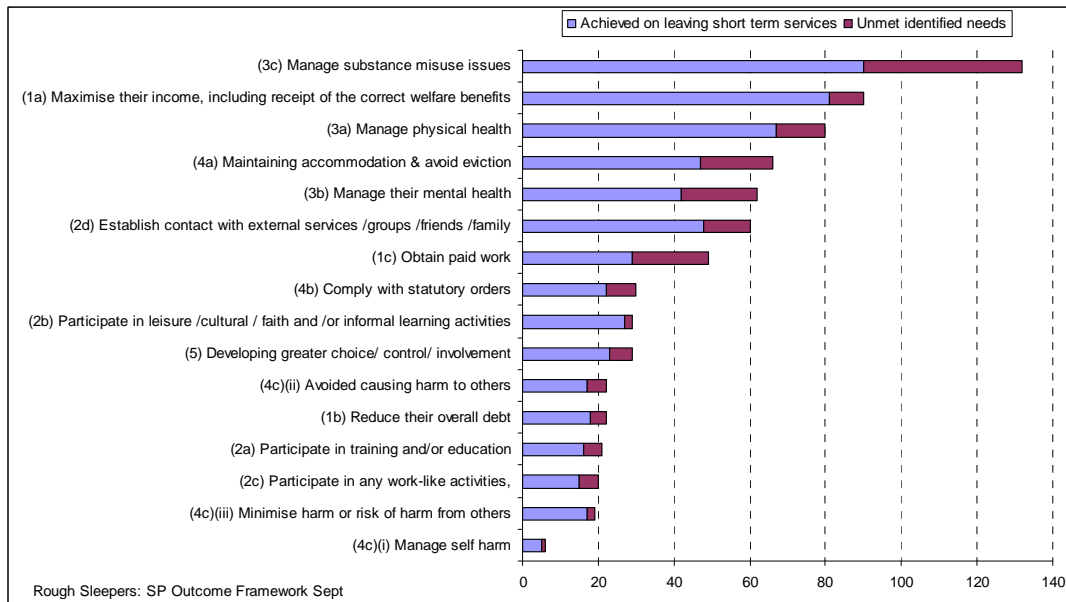
### **Rough sleepers**

Although only a small proportion of homeless people sleep rough, they represent the most extreme form of homelessness and the group with the highest concentration of multiple support needs. Groups particularly vulnerable to homelessness and rough sleeping include: young people leaving care; people who misuse drugs and alcohol; people with mental health problems; people leaving prison; people who have experienced family breakdown and people leaving the armed forces.

Rough sleepers made up 13% of the Supporting People client records in 2008/09, a reduction from 19% in 2003/04. In 2008/09 there were 322 client forms completed for people recorded as rough sleepers in Cambridgeshire. Over 80% of rough sleepers are male. The predominant age group was 25 to 49 years with small numbers of people aged under 18 and over 65. The majority of referrals were self-referrals (80%) or direct applications. In 2008/09, 61% of people had been sleeping rough prior to accessing the service. The proportion of people who had previously been staying in direct access hostels has reduced to 3% in 2008/09 from 15% in 2004/05.

The Supporting People needs analysis (Figure 5.2) identified 'managing substance misuse', 'support in maximising income, 'managing physical health' and 'maintaining accommodation' as the main support needs.

**Figure 5.2:** Identified needs, and needs achieved by rough sleepers leaving Supporting People funded short term services (2008/09)



Source: Supporting People. Note: 174 outcome forms were completed for rough sleepers recorded as their primary client group in the period i.e. people who had left short term funded services.

Specific health issues identified for rough sleepers include poor physical health e.g. higher rates of TB and hepatitis than the general population, poor condition of feet and teeth, respiratory problems, skin diseases, injuries following violence and infections. Mental health problems e.g. serious mental illnesses such as schizophrenia, as well as depression and personality disorders. Drug and alcohol dependency e.g. high misuse of heroin, crack cocaine and alcohol. Many rough sleepers will have a combination of the health issues described above, and some will suffer from poor physical and mental health, as well as having a drug addiction.

Consistent with current knowledge of health among the homeless, the CAS registered population has a substantial proportion of patients with mental health, substance misuse (drugs and/or alcohol) and 'dual diagnosis' (Appendix 7) Other leading causes of morbidity such as liver and respiratory disease are clearly related to drug and alcohol misuse and adverse living conditions.

### 5.3.2. Older People

The UK Coalition on Older Homelessness (COHP) defines older homeless people as those over the age of fifty, reflecting the fact that homeless people are likely to age prematurely and experience the same frailties and vulnerabilities of the rest of the older population at a younger age.

SP and CC data shows around 7% of clients are aged between 50 and 64 years (622 contacts with services in 2008/09) with small numbers of people aged over 65 (32 contacts in 2008/09). Supporting People does not monitor homeless older people separately from homeless people in general. Around 50% of people aged over 50 receiving services from SP fall into the single homeless or rough sleepers category. Only 2% of CAS patients are over 60 .

An audit carried out in 2007<sup>20</sup> which included older homeless people in Cambridge, found that 91% of the older homeless population were male with the majority living in temporary hostel accommodation and a small number living in B&Bs or accessing day centres for homeless people. 28% of this population had been in the same hostel for over 5 years and 16% for over 10 years.

This audit also highlighted that this is a population with high care and support needs with half the population being defined as institutionalised and dependent on living in a supported environment. The audit also found less than one-third were engaged in support planning and that mental health problems, alcohol and substance dependence were common. Other less common support needs were chronic and disabling physical health problems, poor self care, needing prompting to access health care, needing prompting to eat, being open to exploitation and in a smaller proportion, serious memory problems, an inability to keep their room habitable and incontinence. Project workers in hostels will not be trained or employed to address some of these problems. The audit also found that 36% of the population had one to three support needs, 26% had four to six support needs, 16% had seven to nine support needs and 18% had over 10 support needs.

### 5.3.3. Offenders / Ex Offenders

There is a strong association between leaving prison and other correctional settings and homelessness with around one-third of prisoners who are about to be released reporting having nowhere to stay.<sup>21</sup> It is estimated that around 27 to 41% of people lose their homes while in prison which could be because of the loss of local authority or private tenancies or breakdown in relationships with family and friends.<sup>21</sup> Higher reconviction rates among homeless offenders than those with stable accommodation have also been reported.<sup>22</sup>

A released prisoner who claims to be homeless is unlikely to have an automatic 'priority need' as defined by the local authority. In most cases their likely 'priority need' will be whether they are vulnerable because of their institutionalised background. This will involve the local authority assessing whether a person is any more at risk than the average homeless person because of their institutionalised background. There are no hard and fast rules as to what makes someone institutionalised, but an assessment will

include considering the length and frequency of imprisonment and whether the individual lacks the necessary experience to have an awareness of current society that allows rational assessment of risk so that they are likely to perpetuate a scenario or encounter that creates a high risk of attack or exploitation. Many prisoners on release would not necessarily fit into this definition.

Compared to the general population, prisoners are more likely to report disturbed childhoods, problems at school, literacy problems, a family history of criminality and mental health problems.

Drug and alcohol problems are also common, making them a particularly vulnerable group.<sup>21</sup> Within this group, there is anecdotal evidence that those with previous substance misuse problems, are less likely to re-use if adequate housing and social support is provided on release. There is also increased risk of drug overdose in the weeks following release due to reduced tolerance to heroin.

CC data report leaving prison as the fifth most common reason for homelessness with this being reported by 11% of homeless people on the CC database. SP client record data shows that the proportion of offenders has increased in 2008/09 from 2% of the total in 2003/04 to 5% in 2008/09 and from 33 to 113 presentations.

The Supporting People outcomes framework identifies the main needs of offenders or ex-offenders as being 'complying with a statutory order', 'better management of substance misuse', 'accessing external groups' and 'maintaining accommodation.'

#### **5.3.4. Homeless families**

A study conducted by Communities and Local Government (CLG) on the experiences of homeless families and 16 to 17 year olds,<sup>23</sup> found that 65% of families accepted as homeless were headed by a lone woman parent and usually contained one or two children, with the second biggest group (30%) being couples with children. Families and children tended to be young, with 32% of parents being under 25 years old and 50% of children being pre-school age. Up to 64% of families did not contain a working member. Family or educational disruption in childhood were common and 41% had experienced domestic violence as an adult.

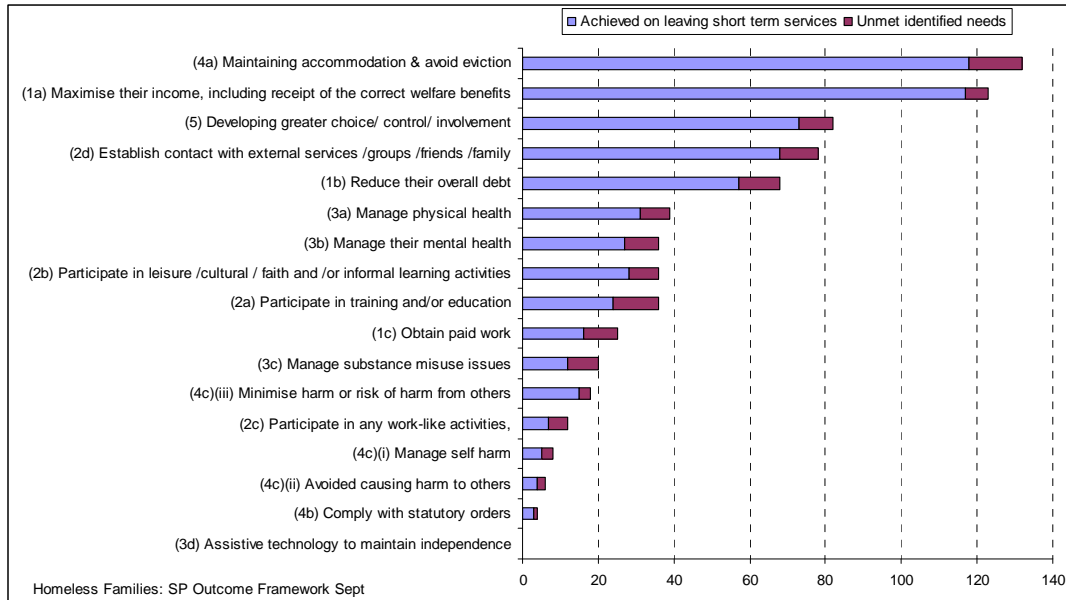
Although the adults in the families seemed to be disadvantaged in terms of health and social support, only a minority appeared extremely vulnerable and few had self-reported drug or alcohol problems. Children in the families appeared happy at school and home and in good health.

Around half of families had experienced at least one homelessness or insecure housing episode before being accepted as homeless. The main reasons for applying as homeless were relationship breakdown (38%), eviction (26%), overcrowding (24%) and 'overstaying their welcome' (20%).

The CLG study identified the key issues for this group as the length of time spent in temporary accommodation, with those families in settled housing reporting a better quality of life than those still in temporary accommodation. This study also identified a substantial negative impact on families' economic position since leaving their last settled accommodation and in children's participation in clubs/activities. An unmet need for practical support was also identified, particularly relating to practical or financial help with getting furniture or with money management.

The Supporting People needs analysis (Figure 5.3) identified 'maintaining accommodation or avoiding eviction', 'support in maximising income, 'developing greater choice and control and involvement' and 'accessing external groups or services, friends or family' as the main support needs.

**Figure 5.3:** Identified needs, and needs achieved by homeless families leaving Supporting People funded short term services (2008/09)



Source: Supporting People. Note: 214 outcome forms were completed for homeless families recorded as their primary client group in the period i.e. people who had left short term funded services.

### 5.3.5. Young People at Risk, Young People leaving care, Teenage Parents

Young people may become homeless for a variety of reasons, for example low income or unemployment may make finding affordable accommodation difficult and some may be homeless because they have experienced difficulties at home and may have run away or been thrown out.

The CLG study on the experiences of homeless families and 16-17 year olds, identified homeless 16-17 year olds as an extremely vulnerable group who had often experienced educational and/or family disruption, violence at home and mental health and/or substance misuse. Furthermore, this group were identified as being five times more likely than young people in the general population not to be in employment, education or training. The main reason for applying as homeless was relationship breakdown with parents or step parents.

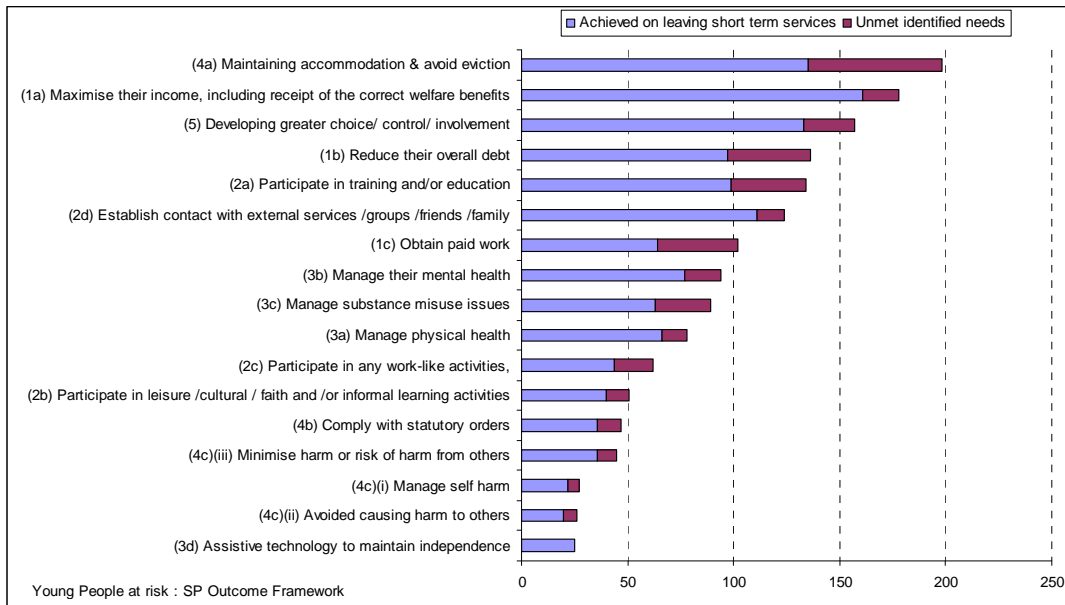
Young people are potentially at increased risk to health through association with an older, entrenched client group (e.g. drugs and alcohol) so teenagers under the age of 18 should be encouraged to register with a regular GP practice.

**Young people at risk**

Young people at risk is the third largest CC client group (5%) The overwhelming reason for homelessness self reported by the group was dispute with parents which was reported by 66%, followed by eviction (10%). SP client record data shows this client group make up 6% to 10% of clients, with a slight increase in the last three years. There are slightly more females than males in this client group.

The Supporting People needs analysis (Figure 5.4) identified ‘maintaining accommodation or avoiding eviction’, ‘support in maximising income, ‘ developing greater choice and control and involvement’ and ‘reducing their overall debt’ as the main support needs.

**Figure 5.4** Identified needs, and needs achieved by young people at risk leaving Supporting People funded short term services (2008/09)



Source: Supporting People. Note: 192 outcome forms were completed for young people at risk recorded as their primary client group in the period i.e. people who had left short term funded services.

**Young people leaving care**

SP client record data shows this is a small group making up between 0.5% and 1% of clients. There are slightly more males than females. Up to 2006/07 the majority of clients were age 16 to 17, but this has now changed to 78% being age 18 to 25 in 2008/09. More than half of referrals come from social services with 10% to 30% of referrals coming from Housing Authority nominations. Between 30% and 50% of clients have previously lived in foster care or a children’s home, except for 2006/07, when 55% of clients had previously lived with family. Around a third and more of people in this group are job seekers with another 20% of full-time students. Since 2004/05 the number of those in paid work has reduced to 0 in most years.

### **Teenage parents**

SP client record data shows that the proportion of this group has increased slightly from 1% to 2% over the years. Nearly all clients are female. The proportion of 16 to 17 year olds has reduced from 50% to 40% with an increase of those aged 18 to 25. Nominations from Housing Authority have increased from 20% to 34% in 2008/09, while referrals from local authority housing departments have gone down from 45% to 6% in 2008/09. The percentage of referrals that could not be classified has increased to make up 20% of referrals in 2008/09. The health services and social services made a few referrals for this client groups, but the YOT or the police did not. A large proportion of teenage parents lived with their family prior to accessing a service. This fluctuates between 30% and 60%. The proportion of those previously staying in supported housing has increased to 29% in 2008/09 from 11% in 04/05 and 6% in 2007/08. No teenage parents were staying in direct access hostels in the last two years and the percentage of those staying in other temporary accommodation is reducing. The majority of teenage parents are not seeking work (72% to 85%). Between 10% and 16% are job seekers and a smaller percentage are in full or part time work or studying.

As with homeless families, the CLG study found a substantial negative impact on young people's economic position since leaving their last settled accommodation. It was also highlighted that most young people in the study had spent some time in temporary accommodation but most appreciated the company of other young people and help from staff in temporary 'supported' accommodation. The young people in settled housing were only marginally more satisfied with their accommodation than those still in temporary accommodation. Housing support to help prepare for and maintain independent living is essential for this client group along with supported accommodation that offers the flexibility to remain as close to family as possible.

#### **5.3.6. People with disabilities, physical, learning**

The prevalence of learning disabilities among homeless people is largely unknown and many homeless sector staff have not been trained to assess such problems. It is suggested that one in twenty rough sleepers and hostel residents have a learning disability.<sup>21</sup>

There is a need for appropriate supported accommodation or housing, social care or health support to enable this client group to live independently along with the provision of high needs accommodation. Discharge from hospital is another area where support and joint working is needed. This client group is not included as a separate group for SP or CC.

#### **5.3.7. Travellers**

A Cambridge Sub-Region Traveller Needs Assessment carried out in 2006<sup>24</sup> identified that the Gypsy/Traveller population is one of the sub-regions largest ethnic minority groups, with total caravan numbers nearly doubling in 25 years. South Cambridgeshire and Fenland were identified as the districts with the greatest increase in caravan numbers, both doubling since 1997. The number of caravans on authorised council sites had fallen slightly since peaking in the 1990s, where as the number of private authorised caravans had grown within the study area. Unauthorised caravan numbers have risen sharply since 2000.

The Supporting People programme funds Travellers' sites, however very few Travellers access other SP funded services, such as homeless hostels. Therefore no SP data is available for this group.

The needs assessment found a pressing need for more sites of all kinds (public, private, long-stay and transit) and the preference among the Gypsy/Traveller community was for small, self-owned long-stay sites for family groups, preferably on the edge of a village and near established Gypsy/Traveller communities.

Other issues identified by the survey were changes in work type with increased competition contributing to severe economic disadvantage and social exclusion. A high incidence of serious health problems were also identified along with educational disadvantage, high levels of racism from neighbours, feelings of isolation and loss of identity and drug abuse on estates.

It is estimated that around three times the number of Gypsies and Irish Travellers now live in conventional housing than those with a traditional nomadic lifestyle.<sup>25</sup> Limited number of sites or increased support needs may necessitate Gypsies and Travellers to give up their mobile lifestyle. When moving into conventional housing, lack of support for this group may lead to problems such as isolation from family support network, failure to access key services, rent arrears, eviction, repeat homelessness and neighbourhood tensions.<sup>26</sup>

#### **5.3.8. Migrants/Refugees and Asylum Seekers**

Migrants, refugees and asylum seekers can be especially vulnerable to homelessness. They may lack the support networks of friends and family and may also have difficulties with language and understanding the British system, making it more difficult to access support services. There may also be confusion around entitlement to state benefits and support which may limit access to help such as hostel accommodation.

A survey conducted in 2006 found that over three-quarters of London homelessness services saw A8 nationals and 15% of people using the services were A8 nationals.<sup>27</sup> There appear to be two types of homeless A8 nationals, those who have problems with regards to substance misuse (often alcohol), poor health and experiences on institutionalisation and those that have experienced difficulty on arrival to the UK due to a lack of knowledge and may require advice and language skills to obtain employment.<sup>28</sup> These groups may have different support needs.

The Cambridge Access reports seeing a small number of people in this client group passing through. CAS has no dedicated funding for interpreters.

#### **5.3.9. Other groups**

Supporting People identify people with drug, alcohol, mental health problems and domestic violence as separate client groups.

##### ***People with drug and alcohol problems***

SP client record data shows that this group consistently made up 2% - 3% of SP clients each year. The gap between male and female clients has gradually widened with 88% of clients being male in 2008/09 as opposed to 63% in 2003/04. The proportion of 18 to



25 years olds dropped between 2005/06 and 2006/07 from 36% to 18%. There are very few clients below 18 or over 50.

A large proportion of referrals for this client group are self-referrals (between 30% and 56%). The proportion of Local Authority nominations has reduced from 12% in 2003/04 to 3% in 2008/09. Equally, referrals from Local Authority housing departments have reduced from 19% in 2003/04 to 4% in 2008/09. Probation services referrals have consistently made up about 12% of referrals and there was an increase of internal transfers between 2003/03 and 2007/08 (7% to 17%), with a sharp drop to 1% in 2008/09. Again, there are few referrals from the health services, the YOT, the police, the Community Mental Health team and Social Services. A large proportion of clients were rough sleeping prior to accessing the service (up to 33% in 2005/06, 19% in 2008/09).

### ***People with alcohol problems***

SP client record data shows that this group has doubled both in percentage and numbers from 2% or 35 client records in 2003/04 to 3% or 80 client records in 2008/09. The male female split is similar to that among drug users, with an increase in men accessing services (67% in 2003/04 and 75% in 2008/09). Hardly any clients were below 18 or over 65 with a fluctuating proportion age 18 to 25 (3% to 11%). The proportion of people age 50 to 64 has more than halved between 04/05 (18%) and 08/09 (8%).

The majority of referrals are self-referrals and the proportion has fluctuated over the years but reached a peak in 2008/09 with 76% (from 23% in 2003/04). A large group of clients were rough sleeping prior to accessing a service, although this proportion fluctuates between 14% in 2003/04 and 35% in 2008/09. The proportion of people who previously lived in a direct access hostel or in private rented accommodation has reduced from 14% to 1% and from 22% to 4% respectively.

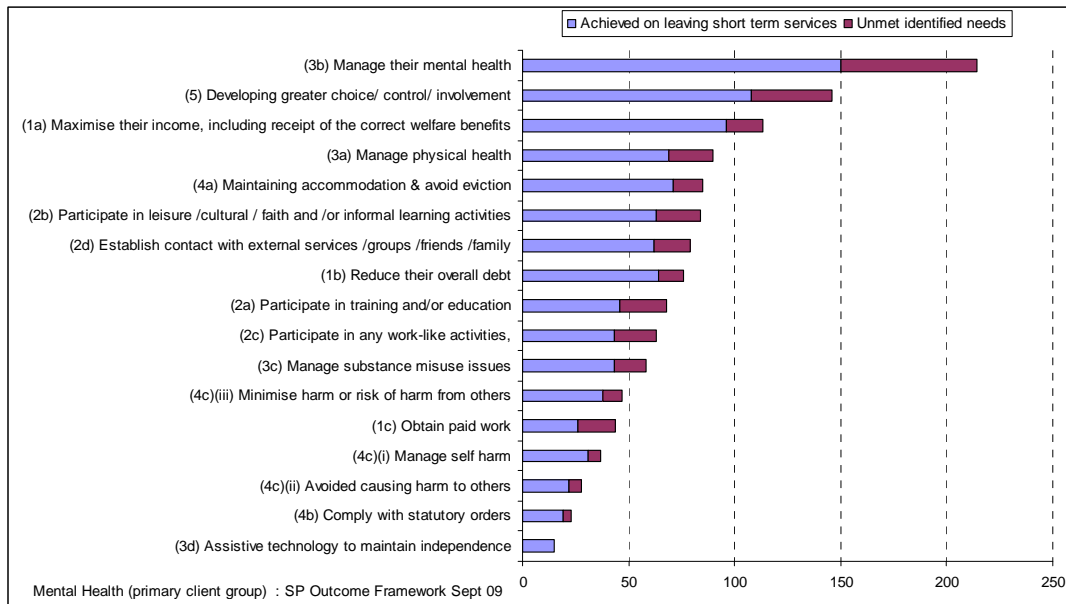
### ***People with mental health problems***

The incidence of mental illness, either alone or complicated by any combination of drug misuse, alcohol misuse, personality disorder and learning disability, is disproportionately high amongst the homeless. Previous studies have highlighted that 30-50% of rough sleepers have mental health problems - often major and untreated schizophrenia or bipolar disorder, and often compounded by personality disorder, offending behaviour and substance misuse problems.

Homelessness usually reflects a cycle of deprivation over many generations including mental health problems - including psychosis, personality disorder, depression, anxiety, bereavement, dual diagnosis, self-harm and suicidal ideation, forensic histories (past and present), non-compliance with treatment, non-engagement with services, repeat offending, unplanned discharge from hospital, and release from prison.

The Supporting People needs analysis (Figure 5.5) identified 'managing their mental health', developing greater choice and control and involvement', 'maximising income' and 'managing physical health' as the main support needs.

**Figure 5.5:** Identified needs, and needs achieved by people with mental health problems identified as their primary client group leaving Supporting People funded short term services (2008/09)



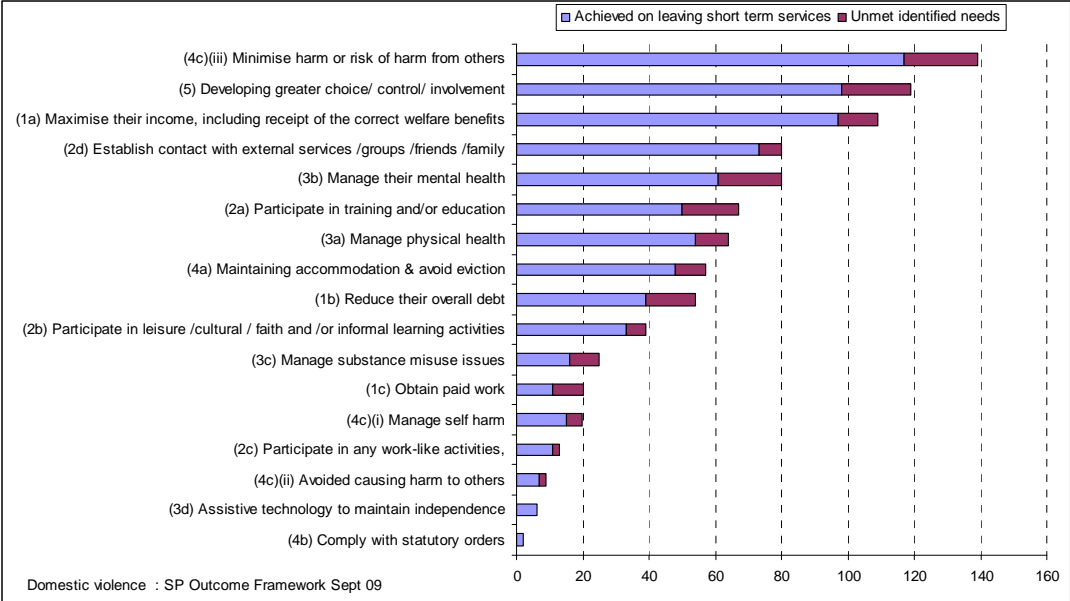
Source: Supporting People. Note: 160 outcome forms were completed for people with mental health problems recorded as their primary client group in the period i.e. people who had left short term funded services.

### **Domestic violence**

SP client record data shows that there has been a drop in clients from this group both from 11% in 2003/04 to 6% in 2008/09. All are female. The percentage of White British is slightly lower than in other client groups with 79% to 86%. There is a larger percentage of other white people (between 4% and 8%) as well as women from a Pakistani, Bangladeshi, and Indian background. Between 20% and 30% are self-referrals and about 10% are from the police – however with a drop to 3% in 2008/09. There is also a substantial number of referrals from the voluntary sector (11% to 31%). Few referrals from the health services and from the Community Mental Health team. Around 20% were LA general needs tenants and between 10% and 20% HA general needs tenants. Slightly fewer are private sector tenant. Clients from supported housing have gone down as well as those in other temporary accommodation. Between 10% and 28% lived with family. For the first time in 2008/09 there are clients who previously were owner-occupiers.

The main needs identified by the domestic violence group who left Supporting People funded short-term services between April and December 2008 were 'Support to better manage self-harm (89%)', 'Maximising income (74%)', 'Accessing external groups or services, friends or family' (56%) Better manage mental health (47%) Better manage physical health (41%).

**Figure 5.6:** Identified needs, and needs achieved by women experiencing domestic violence leaving Supporting People funded short term services (2008/09)



Source: Supporting People. Note: 131 outcome forms were completed women with domestic violence as their primary client group in the period i.e. people who had left short term funded services.

## 6. Mapping services for the homeless

### CHAPTER SUMMARY

- A range of services are provided to the homeless population in Cambridgeshire. Housing, health and meaningful occupation are the three basics of tackling homelessness.
- Services tend to be directed towards particular client groups or at particular problems which means that a range of different services need to be accessed to address support needs.
- The pathway of homelessness services differs for statutory and non-statutory homeless. The statutory homelessness pathway being is governed by homelessness legislation. For non-statutory homeless there are a range of entry points and the often chaotic lifestyle of this group means that their journey may not follow a clear pathway.
- A substantial proportion of all homelessness services are based in Cambridge City There are several reasons why homeless people, particularly street homeless, gather in certain towns or cities. Homeless people may be attracted by the services provided but other factors may include the perceived affluence of the area and having social contacts among other homeless people
- Homelessness services are commissioned independently, often covering different geographic and demographic domains. There are concerns that the fragmented commissioning of services does not work well for the homeless.

### 6.1. Introduction

The key public sector agencies involved in tackling homelessness in Cambridgeshire include: (1) Local authorities (including Cambridgeshire County Council and district councils); (2) Cambridgeshire Supporting People team; (3) NHS Cambridgeshire; (4) Cambridgeshire Drug and Alcohol Action team; (5) Cambridgeshire and Peterborough Mental Health Trust; and (6) voluntary and community organisations. A range of services are provided covering health, drugs, alcohol, mental health, accommodation based support, floating support and provided across over 100 different organisations/ services.

The homeless population are able to access services that are provided for the general population as well as specific services developed for the homeless, but may have difficulty either knowing about these services or accessing them.

One of the issues around services for the homeless is that services are directed at particular client groups or at particular problems such as alcohol. This does not recognise the complexity of homeless individuals and that some may fall into more than one group and have more than one problem with some groups having greater needs than others.

## **6.2. *Housing and Support Pathways to services for the homeless***

### **6.2.1. Housing Services**

The pathway through homelessness services for people presenting or referred to the local authorities is shown in Figure 6.1. The statutory homelessness pathway is undertaken by local authorities and is governed by the homelessness legislation.<sup>10</sup> Within this pathway, the overarching objective is homelessness prevention or providing alternative accommodation. Where this fails, then the homelessness legislation provides a safety net for people who are eligible and in priority need to be provided with temporary accommodation pending permanent rehousing. Ultimately, the homelessness legislation does not provide a safety net for all households threatened with homelessness. Local authorities have a duty to provide advice and help to find their own housing for others that are not owed a 'full housing duty'. However if they are unable to find housing following this, then the household may become homeless. If this is the case they will only be likely to be able to access services through the non-statutory pathway (Figure 6.2).

Figure 6.2 shows the pathways to services for non-statutory homeless. In Cambridge City, non-statutory homeless people gain contact with services through a variety of entry points. There is a range of accommodation services available to this group which graduate from temporary accommodation to more settled accommodation. The non-statutory are eligible to access other services for the homeless as well as mainstream services at any point within the pathway. However, this group lead relatively chaotic lifestyles and as a result their journey through these services often does not follow a clear pathway.

#### **Home-Link the Cambridge Sub- Regional Choice Based Lettings Scheme**

All local authorities were set the target of creating a choice based lettings scheme by 2010. The Home-Link scheme, covering the Cambridge Sub region, went live in February 2008 (with the exception of Fenland DC, who went live in November 2008). The Home-Link scheme involves applicants being proactive in seeking a home rather than waiting for a local authority or housing association to contact them about a property they can be 'allocated'. Properties are advertised on a fortnightly basis, and applicants may bid (express an interest) on up to three properties each bidding cycle. A short list is then produced and the property is offered to the applicant with the highest housing need for that type of accommodation. A banding system is used across the sub-region to assess and prioritise housing need which helps to achieve an understandable and transparent policy. The banding scheme includes four priority bands (urgent need, high need, medium need and low need). An Access Strategy has been developed outlining how support can be given to vulnerable applicants to prevent them from being excluded. Feedback from the first year of the scheme has been positive. For more information see Appendix 12.

Figure 6.1: Housing pathway for homeless people presenting or referred to local authorities

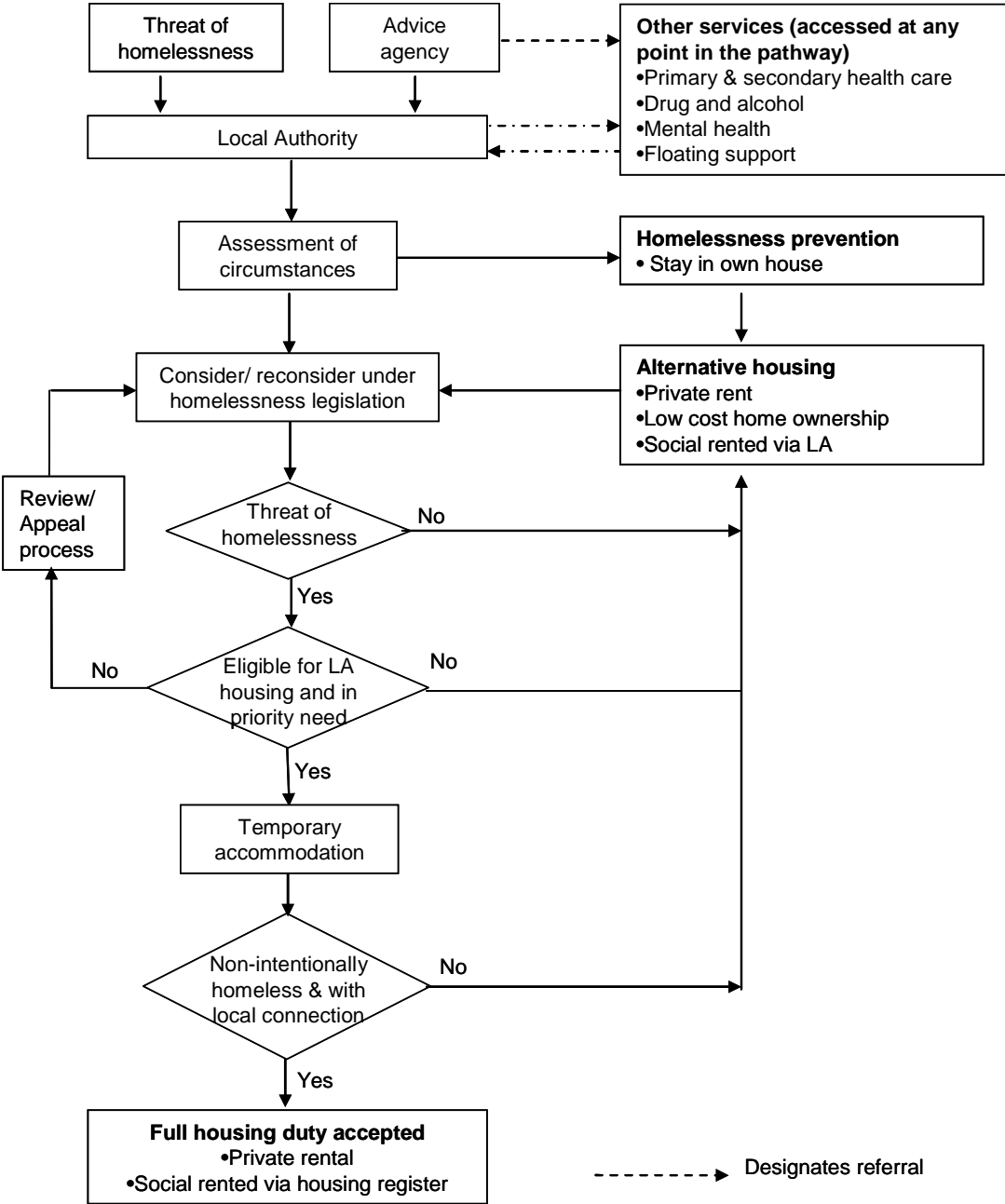
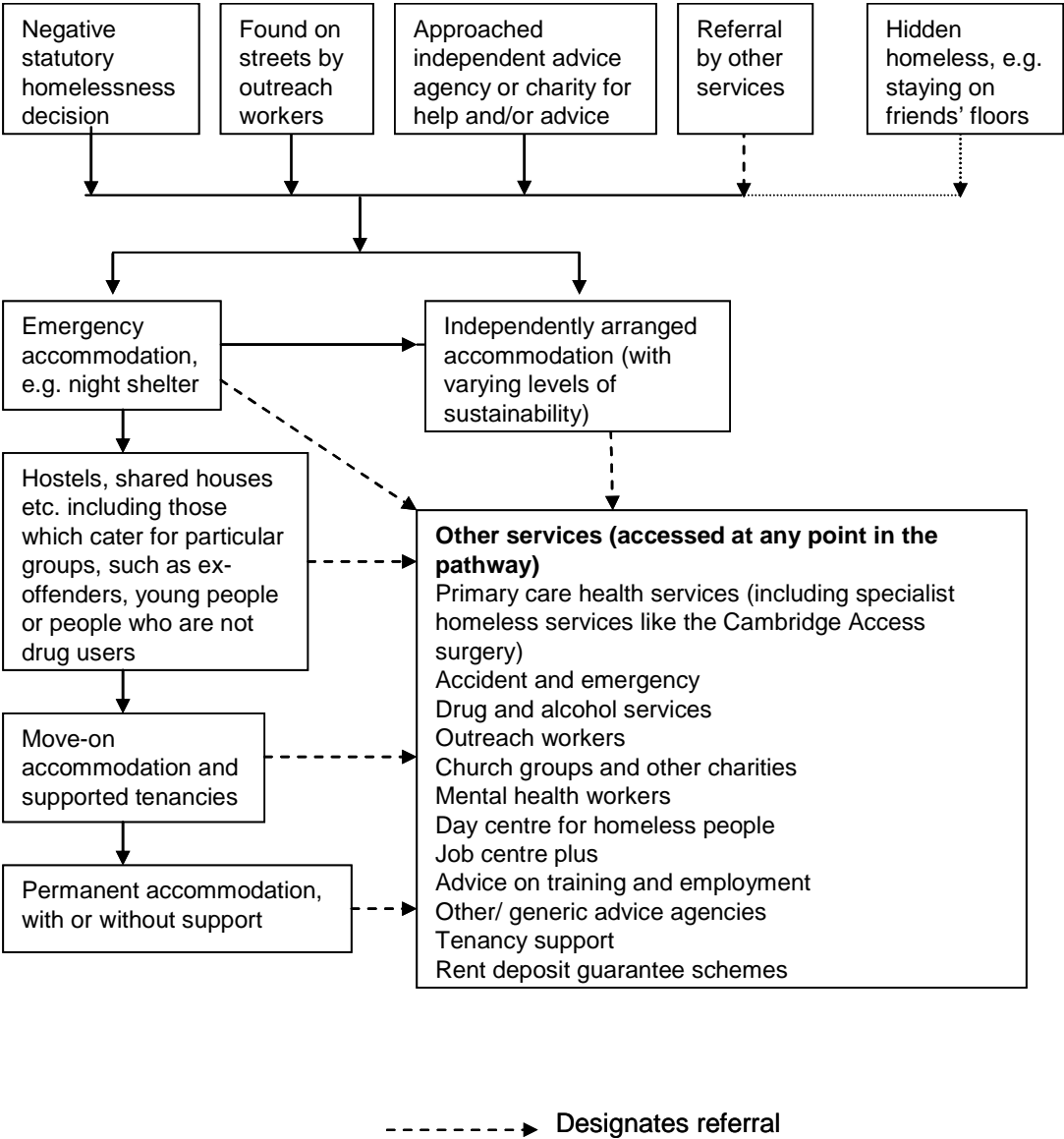


Figure 6.2: Housing pathway for non-statutory homeless people at Cambridge City Council



Source. Cambridge City Council

### 6.2.2. Accommodation based support

Accommodation based support provides a combined package of housing and support services. Staff are based on-site and generally provide a higher level of support to residents living in the scheme. Support in this context means support to help a person live independently, such as advice and guidance on essential daily living tasks, for example with cooking cleaning and budgeting. It does not include personal care, such as help with feeding and bathing.

These types of supported housing schemes are often aimed at specific client groups, for example Foyers supporting young people, direct access hostels supporting single homeless and Lone Parent schemes supporting single teenage parents. The support provided in these schemes is often directly linked, and a condition of, the accommodation being provided. The vision with supported housing schemes is that they provide a pathway for residents to develop the necessary skills to live independently once they no longer require the more intensive levels of support provided by these schemes.

Homeless people tend to migrate towards existing accommodation provision such as night shelters and hostels and towards other specialised services. The moderate size, pleasant facilities and student/tourist population of Cambridge are also a draw. Often agencies from neighbouring authorities advise homeless individuals to go to Cambridge.

A proportion of this migration is inevitable and the operation of a reconnections policy goes some way to reducing the burden on Cambridge City Housing. Nevertheless the onus falls on Cambridge services to assess single homeless for reconnection and support them in the meantime. The burden on housing is increased by cases in which assessment gets delayed for 6 months allowing the individual to claim the right to be housed or in which an individual has no viable connection elsewhere and is considered extra vulnerable because of ill health and is reclassified as 'statutory homeless'.

Even if accommodation is provided elsewhere in the County, there is often a lack of experienced support services to ensure tenancy sustainment. The migration into Cambridge could be addressed by providing homeless accommodation facilities elsewhere in the county.

Negotiating with surrounding authorities to provide more support services either in the form of a floating service purchased from experienced Cambridge City Teams or of more localised floating services using existing Cambridge City experience in training and development.

Accommodation based support is primarily funded via the Supporting People programme (see Appendix 4) and in 2008/09 1,071 accommodation based support places were funded across Cambridgeshire (excluding older persons services such as sheltered housing).

Examples of the types of accommodation based support schemes funded by the Supporting People programme that may be accessed by the homeless are: Jimmy's Night Shelter in Cambridge and the Ferry Project in March (for rough sleepers); the young persons' foyers in Wisbech and St Neots and the YMCA in Cambridge; and the Women's Refuges in Cambridge City, Fenland and Huntingdonshire. A list of accommodation services in Cambridgeshire is summarised in Appendix 9. This shows that accommodation services are mainly directed towards the single homeless/rough



sleepers i.e. those not in priority need. However, it is important to ensure that accommodation services are available for all non-statutory groups and particularly those with identified needs such as the older homeless population, females and young people.

### Development of Assessment Centre

The need for an assessment centre was identified as a priority for development in Cambridge City's Single Homeless and Rough Sleepers Strategy 2006-09 which recognized the need to transform the existing 31-bed dormitory-type accommodation and night shelter at Jimmy's into a 24-hour assessment centre with 20 rooms. The Supporting People Commissioning Strategy 2008-10 which set out a direction of travel for developing crises services in Cambridgeshire also identified this as a priority. A successful bid was made to the *Places for Change* programme which is run by Communities and Local Government and provides funding to enable hostels and day centres to transform environments and services in a way that will help their service users to gain the skills and confidence to move on with their lives. The bid proposed to develop the following areas:

- **Accommodation** – current dormitory style rooms to be replaced by single occupancy en-suite bedrooms. Conversion of ground floor into a multi-purpose space which will double as a dining area and space for learning and educational activities and inclusion in the basement of comfortable, relaxed rooms for assessments, office space, a training kitchen, a lounge and two multi-purpose rooms for further learning and development activities.
- **Assessments** - allowing more space and time for comprehensive needs, risk and skills assessments.
- **Priority access for rough sleepers** – half of the bed spaces ring-fenced for rough sleepers identified by the street outreach team.
- **Maximum length of stay** and improved resettlement outcomes
- **Reconnections** - The city council has developed a reconnections policy as part of its response to rough sleeping. Figures show that 65% of those presenting at the night shelter have no local connection with the city.

Project groups have been established to manage the transformation and consultations with staff and service users have taken place. It is estimated that the project will be completed by December 2011. The new centre will ensure that the needs of the service users are paramount in developing and delivering the service, providing a safe environment and positive and stable lifestyle choices for all residents.

### Supporting People Needs Analysis

The Supporting People Needs Analysis covers all 21 client groups, which are funded by Supporting People. The analysis uses a range of data sources to give a best estimate of the numbers who need housing related support services for each client group. It is important to note that projecting need is not an exact science but the methodology adopted attempts to locate and use the best information available. The approach aims to use and improve the evidence base for understanding need but it must be noted that the model is based on underlying assumptions and data sources.

In November 2008 the Supporting People Team in Cambridgeshire commissioned Consultants to develop a model to project housing support needs for each vulnerable client group within the SP programme. The model also takes account of future growth within the county.

The model looks at population at risk of needing housing support (a larger group) and from this population in need of housing support (a smaller group).

The needs analysis has shown that:

- The current SP provision meets the needs for young people at risk to a greater degree than those of teenage parents and young people leaving care. This will be worthy of further consideration when planning future services.
- Looking at other homeless groups including single homeless, rough sleepers, offenders, drug and alcohol and homeless families, SP may currently be focusing on the needs of single homeless generally and as a consequence not giving adequate attention to the other client groups. It would be worth considering all these groups together and exploring the extent to which SP can address outcomes for offending, drug and alcohol more effectively within a broad consideration of the needs of homeless people.
- The needs analysis indicates that a better balance could be struck between investment in floating support and accommodation based support with a greater amount of investment being required in floating support.
- At a district level there are a range of historical reasons, which have created significant variations in supply of accommodation-based services for each district. Moving forward, SP need to pay attention to the reasons why services exist in the first place but consider if any changes need to be made between districts. The wider work of the JSNA could be useful in furthering understanding of the district dimension to homelessness and complementing the SP needs analysis.
- Due to increases in population in Cambridgeshire we expect overall the demand for housing related support services for homeless people to increase over the next five years.

### **6.2.3. Floating support services**

Floating support is the term that is used to describe support services that are not provided as part of a package with specific housing. They are support services provided in the person's own home and when successful, can play a significant role in the prevention of homelessness by enabling people to maintain their home and so continuing to live independently.

Again, these types of services tend to be funded via the Supporting People programme and in 2008/09, 606 floating support places were funded across Cambridgeshire.

Floating support services can be client group specific (for example only for young people), or generic, providing support to any client that needs help with housing related support. Some floating support services are provided as outreach services from accommodation based services, supporting clients for a period of time in their own home once they have moved into the community. These types of services often help with difficult transition stages when a person may be most at risk of failing in their new home and so provide a valuable resource to give the greatest chance of success. A summary of floating support services can be found in Appendix 9.

The Supporting People programme is currently reviewing the range of floating support services it funds with a view to re-tendering services in 2010. This review is currently considering the split between generic and specialist (client group specific) services and will re-tender based on its findings. Initial thoughts from the review and the consultation that has taken place to date are that there will be a small number of client

group specific floating support services for clients with more specialist and complex needs and a more generic service that may be accessed by all client groups. All agencies involved in this JSNA will also be involved in the review of floating support services as they are partners to the Supporting People programme.

#### **6.2.4. Advice services**

Cambridgeshire has a wide range of organisations that provide advice and support to people who are homeless or at risk of homelessness. All local authorities have a statutory duty to provide specific advice and assistance to help people avoid homelessness or obtain accommodation. In addition to the local authority advice teams, many voluntary sector organizations provide a similar service: for example Citizens' Advice Bureau. Some of these are given grants by local authorities to carry out this work.

There are national and local agencies such as Shelter and Crisis which have help lines and advice resources available on paper or via the web. Cambridge City Council commissions a Street Outreach Team (see below) which is a fundamental service in Cambridge, providing support for rough sleepers and others with a street-based lifestyle and having a crucial role in resettlement. There is also a day centre in Cambridge which provides advice and support for single homeless people (see Wintercomfort below). Church groups and other charities (including the Salvation Army and soup runs) provide support on a less formal and uniform basis throughout the county.

#### **Cambridge Street Outreach Team (SOT)**

The CRI (Crime Reduction Initiatives) Cambridge Street Outreach Team is a service commissioned by Cambridge City Council to tackle rough sleeping, street based drug and alcohol use, begging and sex working in Cambridge City. The team currently consists of six Project Workers, a Project Manager and a Specialist Alcohol Community Psychiatric Nurse who undertake the following:

- A range of street shifts from 7am – 10pm working to identify and engage rough sleepers
- Carry out assessment of the support needs of rough sleepers and those engaged in street based anti social behaviour
- Support individuals in accessing primary health care, drug and or alcohol and mental health services
- Support rough sleepers to access accommodation and welfare benefits
- Work with a range of other agencies including the Police to promote a safer community and to help stop people behaving in a manner that causes distress alarm or harm to others or themselves.

#### **6.3. *Meaningful occupation***

One of the key proposals for change in 'Coming in from the Cold' was to provide opportunities for meaningful occupation, to help give people the self-esteem and lifeskills needed to sustain a lifestyle away from the streets. Meaningful occupation or purposeful activity includes training, skills, employment seeking and support, as well as art or music or drama groups, gardening projects, lifeskills, cookery courses etc.

basically any activities that aim to increase skills, self esteem, and prepare for move on and independent living.

The City Council appointed a meaningful activity coordinator in 2006 on a part time basis, funded till 2011. The role is essentially to implement the two strands of the new homelessness strategy regarding services for informal adult learning, skills for life i.e. numeracy and literacy, developing skills for employment, entry into employment and post employment support. It is also fundamentally about widening participation in adult learning and employment and tackling the many barriers homeless people face on the journey to integration in mainstream society.

- **Supporting and expanding the informal adult learning services for homeless people within the city which operates from Winter Comfort Day Centre (see below).**

The aim of the service is to deliver tailored opportunities to suit the specific learning needs of this client group, many of whom have undiagnosed learning disabilities. Future development will include building capacity and learning opportunities within the wider community – community colleges, community centres, libraries to provide move on opportunities and help homeless people to develop wider social networks in the process. The plan in the longer term is to offer accredited learning.

There is still a huge amount to be done removing barriers and working with some of the big educational institutions such as Cambridge Regional College to improve their access and support to Homeless people. Other gaps that have been identified include the need to increase the number of educational support staff competent in life coaching and motivational skills to empower, befriend and provide almost daily support to homeless individuals to make progress and take the next step to learning within a community. Much work still needs to be done regarding assessment of learning disabilities and special needs.

- **First steps to employment for homeless people**

In the current economic climate there remain significant barriers to homeless people in gaining and sustaining employment that is not low paid or seasonal and with a clear career pathway.

Communities and local government have identified many barriers that prevent people from gaining sustained employment.

- personal factors – health, drug and alcohol addiction
- lack of skills
- lack of good quality information, and guidance
  - high rents in hostels and in private rented sector
  - lack of good quality low paid accommodation
  - lack of support once in employment
  - low incomes
  - the complexity of the employability services on offer
  - changes to the benefit system.

The strategy hopes to achieve much stronger relationships and better delivery of service with Job Centre Plus and all the organisations that provide long term employability training.

### **Wintercomfort for the homeless**

Wintercomfort supports those who are homeless or at risk of losing their homes by offering a range of services to help them achieve greater autonomy. The services provided are:

- The Comfort Zone – basic amenities and welfare service including breakfast and refreshments, shower and bathing facilities, access to laundry and clothing store and support with housing and access to health care services.
- Centre Forward – learning and development service including structured recreational activities, on-site educational activities, one to one support and workshops with external agencies to discuss personal development.
- Winter Willow – Wintercomfort are in the process of developing a Social Enterprise in Willow Craft which will offer opportunities for occupation, training and employment across a range of disciplines.
- Winter Nights – a basic overnight service for people who sleep rough which operates from November to March when the temperature is predicted to be below freezing for three night or more in a row and offers a mattress, sleeping bag and hot soup.

## **6.4. Health Services**

### **6.4.1. Primary Care**

In theory, homeless people in Cambridgeshire can register with any GP. In practice, however, many GP practices are reluctant to accept homeless people due to their often erratic and chaotic behaviour. There are 75 GP practices within Cambridgeshire. The Cambridge Access Surgery (CAS), which provides primary care services to homeless people in Cambridge City, is currently the only dedicated GP Surgery for the homeless and those at risk of homelessness in Cambridgeshire. The lack of dedicated primary care services for the homeless outside of Cambridge City is a cause for concern. Unless homeless people migrate to Cambridge or other locations where homeless facilities exist, such as Bedford or Peterborough, both of which have night shelters, their needs may remain unmet. Although they have theoretical access to GP services throughout Cambridgeshire, the reality is often different and they do suffer social and institutional exclusion. Table 6.1 highlights issues that prevent the homeless from accessing mainstream primary care services.

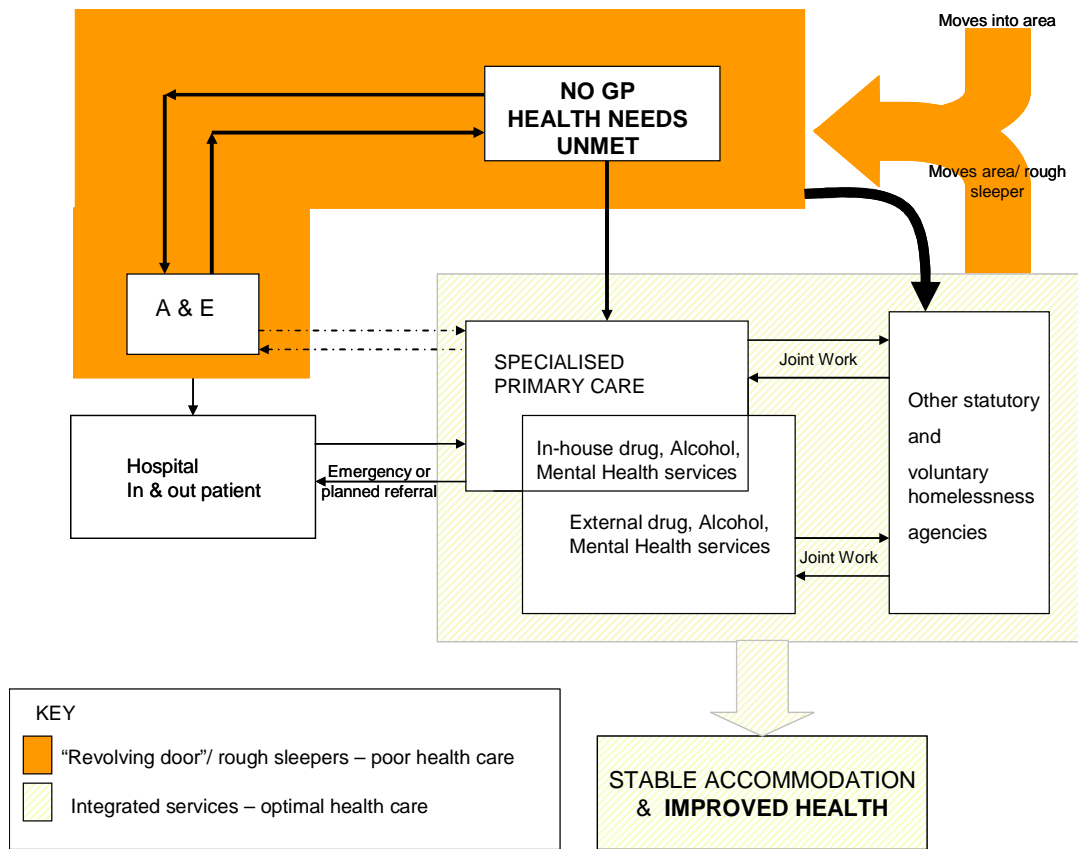
**Table 6.1:** Common problems occurring between homeless people and mainstream primary care

<b>Patient</b>	<b>Possible negative implications for mainstream GP</b>	<b>Effect on patient</b>	<b>Solution</b>
<b>Homeless</b> No Fixed Abode (NFA) frequent address change	Demands address Administrative problems	Turned away or Temporary registration	Fully register NFA patients Invent ways of coping with admin. Help from other services to locate
<b>Chaotic</b> Preoccupation with problems of daily survival Present erratically/in emergency Poor self-care	Poor attendance Inconvenient and cannot plan healthcare Staff and patients upset	GP seems inflexible GP not responding to patient's agenda Rejection/poor self-esteem	Flexible access Daily drop-in clinics Welcoming staff Multi-agency working
<b>Drug &amp; alcohol problems</b> Often intoxicated	Fear of violence Fear of drug-seeking behaviour 'Rational' consultation difficult GP feels threatened because lacks experience and self-confidence	GP does not want to help GP does not understand Patient can not tolerate withdrawal	GPs with special interest Clear referral options Stepped care from harm-minimisation and symptom control to full detox./treatment service Multi-agency working
<b>Multiple complex problems</b> Mixed health and social	Time consuming consultations Diagnostic problems Not financially rewarding	GP "won't listen" GP "doesn't care" GP only interested in own targets	Obtain past records Thorough new patient check (health and social) Cumulative assessment over time Multi-agency working

Source: Cambridge Access Surgery

### Cambridge Access Surgery

A primary care service for homeless people in Cambridge has been running under different guises since 1992. In 2003, a grant was obtained to purchase premises from which to provide an independent Primary Care Service, the Cambridge Access Surgery, but also to house three other key homeless services in the same building: the Street Outreach Team (managed by The Crime Reduction Initiative), the Mental Health Outreach Team (managed by the Cambridge Cyrenians) and the Tenancy Sustainment Team (managed by the English Churches Housing Group). This was a practical solution to the clearly identified need for a 'one stop shop' for the homeless population in Cambridge. CAS' close links with the other agencies in the building and with many other agencies including the City Council, night shelter, hostels, drug and alcohol agencies and secondary care (Addenbrooke's), enables it to offer a holistic, pragmatic and non-judgemental service dedicated to improving the health and chances of resettlement of its patients (Figure 6.3).

**Figure 6.3:** Healthcare pathway for the homeless in Cambridge

Following the Cambridge Access Surgery's establishment on 1 April 2003, its practice population increased steadily year-on-year until 2007, when it reached 500. It has remained at approximately that number during the past two years, 2007 to 2009. In 2008, CAS was incorporated into Cambridge Community Services, the provider arm of NHS Cambridgeshire.

The Cambridge Access Surgery provides a Monday to Friday 0800-1800 hours service staffed by specialised GPs, nurses and reception staff with a Drop-In Surgery each morning. A significant amount of nurse time is taken up by wound dressings. In addition to the above primary care services, CAS also provides specialist services such as the Joint CAS/Addaction Drug Clinics - Specialist Substance Misuse prescribing, weekly alcohol clinics, twice yearly Consultant Hepatologist Clinics for newly diagnosed Hepatitis C patients, hosts a weekly Multi-Agency Case Meeting to discuss homeless people at severe risk and hosts a weekly Mental Health Case Meeting. The CAS practice nurses make regular visits to the homeless hostels in Cambridge

All clinical staff at CAS work in close cooperation with Addenbrookes hospital. CAS patients often self-discharge against the advice of hospital staff before treatment has been completed. CAS patients with specific needs such as alcohol or drug dependence need to be managed during any in-patient spell in hospital. Robust arrangement for aftercare need to be in place prior to the discharge of CAS patients who are street homeless or living in hostels/night shelter.

Most new patients are referred by other homeless agencies such as Jimmy's Night Shelter or the Street Outreach Team. The chaotic lifestyles of the homeless results in a missed appointment rate of approximately 25% of all pre-arranged appointments. In some cases, key workers from the Street Outreach Team or Tenancy Sustainment Team accompany patients to appointments, which markedly improves attendance rates throughout both primary and secondary care.

The health profile of homeless people registered at Cambridge Access Surgery is summarised in Appendix 7. A substantial proportion of this population are single homeless/rough sleepers who lead chaotic lifestyles. There is a 4:1 male/female ratio with a relatively narrow age distribution about a mean of 38.5 years. There are no under 16s and very few over 60s.

Patients tend to use health services frequently with some patients attending multiple clinics in a day. Consistent with current knowledge of health among the homeless, the CAS registered population has a substantial proportion of patients with mental health, substance misuse (drugs and/or alcohol) and 'dual diagnosis'. Other leading causes of morbidity such as liver and respiratory disease are clearly related to drug and alcohol misuse and adverse living conditions.

### **RECOMMENDATIONS**

To ensure primary care is accessible and responsive to the needs of homeless by:

- Considering focused and innovative ways of improving access to mainstream primary health care services by homeless people in the entire county.
- Seeking primary care performance measures and rewards appropriate to this group to counteract the current disincentives to register homeless people, for example commissioning enhanced services within generic primary care (via LES or other means) according to local needs.
- Where there are high numbers of homeless people, commissioning and supporting development of specialist homeless primary care services – either patients to be fully registered in stand alone practices or arrangements embedded in mainstream practices
- Where there are lower numbers of homeless people, supporting specialist interest in homelessness throughout primary care by ensuring the identification and full registration of homeless patients.
- Developing a programme of education on homelessness and associated healthcare issues for GP Practices in Cambridgeshire, using existing expertise (for instance from CAS)
- Managing co-ordination and support from Drug, Alcohol and Mental Health Services to help primary care teams manage homeless patients.

#### **6.4.2. Dental services**

Data on the oral health status of homeless individuals is limited; however studies consistently report a high clinical and perceived need for oral health care within this



population.<sup>29</sup> They have a higher proportion of dmft (decayed, missing and filled teeth) than the general population and there is a greater prevalence of dental pain and periodontal (gum) disease.<sup>30</sup> Homeless people tend to have fewer remaining teeth and heavy plaque accumulation.<sup>31</sup> Despite these high levels of need, however, homeless people experience difficulty in accessing dental services<sup>32</sup>

NHS Cambridgeshire's Oral Health Strategy 2008<sup>33</sup> outlines the importance of taking account of the needs and demands of homeless people when planning and providing dental services. Although currently there are no local dedicated dental services providing care for homeless people NHS General Dental Services are available to all and are free to those who are exempt from dental charges.

Homeless people, particularly those with related drug and alcohol problems, are more likely to access services on an urgent basis and only when they are in pain. Ease of access, extended opening hours and services offering urgent and emergency dental appointments, such as those provided by Dental Access Centres, are more likely to meet this need. Cambridgeshire currently has three Dental Access Centres based in Cambridge, Huntingdon and Wisbech and these centres have the flexibility to offer mainstream dental services to the PCT population as well.

The advent of the new dental contract in 2006 introduced local commissioning of dental services. The PCT now has the opportunity to be flexible in its approach and commission NHS dental services, both from general dental practitioners and salaried providers, that are appropriate, accessible and acceptable to homeless people.

#### **RECOMMENDATIONS**

- The PCT should commission NHS dental services that are appropriate, accessible, acceptable to and affordable for homeless people
- Improving oral health for homeless people is best addressed using the Common Risk Factor Approach. This approach emphasises the need to tackle the common risk factors and conditions that are shared by chronic non-communicable diseases including tobacco use, poor diet, stress, alcohol consumption, drug use, poor hygiene and injuries.
- Structural barriers to dental treatment services should be minimised by facilitating access to urgent dental care, offering walk in and out of hours services as well as extended opening times.
- Dental treatment services should be well signposted through routes normally accessed by homeless people for example hostels and drop centres.
- The PCT should consider oral cancer screening for this group of people who exhibit associated high risk behaviour including smoking and drug and alcohol use.

#### **6.4.3. Traveller's Health Team**

The Traveller's Health Team was established in 2009, with the appointment of a Lead Nurse Gypsy & Traveller Health whose role is to focus on improving the health outcomes and reducing the health needs of the Gypsy & Traveller community of Cambridgeshire. The service is commissioned by NHS Cambridgeshire from Cambridgeshire Community Services. The team also includes advocacy support provided from Ormiston Children and Families Trust and education support provided by

Cambridgeshire Race Equality and Diversity Service (CREDS). The team is currently establishing a Health Trainers programme which will it is hoped will lead to the appointment of a health community development worker to develop a small team of health trainers from the Gypsy & Traveller Community to work with the Community.

#### 6.4.4. Secondary Care Services

The Emergency Department at Cambridge University Hospital NHS Foundation Trust is open 24 hours a day, 365 days a year. There is access to an Alcohol Nurse Specialist and a limited Brief Intervention service. There is a liaison psychiatric service. The hospital has recently employed a Consultant Psychiatrist with an interest in alcohol and substance misuse. There is a START team who try to arrange early safe discharge of vulnerable patients, usually elderly but also domestic violence victims and homeless people.

During 2008, 112 patients with a home address of 'NFA', 'Jimmy's Night Shelter' or '222 Victoria Road' were seen in the emergency department (ED) of CUHFT. Of these, 75% were registered at the Cambridge Access Surgery and one was not registered with a GP. 500 emergency department attendances were made by patients registered with the Cambridge Access Surgery. Assault was responsible for 9.5% of these attendances and deliberate self harm 7.9% with most of the rest being coded as 'other' which could be a range of reasons.

One of the main issues that arises from managing homeless people in the ED is related to communication regarding what community provision is available. ED staff are not always aware what community provision for drugs, alcohol and domestic violence is available and need to be kept informed of changes to services to improve access to this highly vulnerable patient group.

The development of posts in EDs such as 'harm reduction workers' whose role would be to receive referrals, perform risk assessments and signpost these vulnerable patients into the correct streams would be extremely beneficial. Emergency Departments throughout the US, Australia and Canada employ social workers to fulfil this role but this role is not really developed in the UK. There are beacon sites where individual patient groups receive support, such as alcohol nurse specialists or domestic violence advocates, however, all of these centres acknowledge that there are gaps as they are commissioned for single patient groups.

#### **RECOMMENDATIONS**

- Develop professional teams in each Hospital to ensure management of drug and alcohol problems within hospital and full liaison with community health, council run and voluntary services.
- Strengthen arrangements in emergency departments to ensure health needs of the homeless can be appropriately addressed in full co-operation with primary care, community care and housing.
- Improve discharge arrangements for inpatients by improving information streams and pre-discharge planning. Those responsible for non-elective care should be supported in developing a mechanism to signpost homeless people appropriately to services.

#### 6.4.5. Mental Health Services

There is a strong association between mental ill-health and homelessness. The homeless mentally ill frequently have drug and/or alcohol dependencies and may also suffer from Personality Disorder or Learning Disability in addition to one or more separate mental disorders. Mental illness and addictions are mutually reinforcing such that the mentally ill tend to slip down the social scale into homelessness and adopt the 'drug and alcohol lifestyle' which in turn can both exacerbate the illness and make assessment and treatment more challenging. Mental illness can also be the direct consequence of addiction as with Alcohol-Related Dementia or Drug Induced Psychosis. Addiction commonly leads to disintegration of family and support networks and thus depression and despair from which resort to addictive substances is the only relief. Many homeless people have a 'dual diagnosis' of both mental health and substance misuse problems. While the concept of 'dual diagnosis' has certainly been useful in underlining the frequent co-existence of mental illness with addictions, a narrow interpretation obscures the fact that often we are dealing with far more than two diagnoses across the spectrum of mental disorder and substance misuse.

Mental health and specialist learning disability services across Cambridgeshire are provided by the Cambridge and Peterborough Mental Health Partnership NHS Foundation Trust (CPFT) in partnership with CCC and NHS Cambridgeshire.

In Cambridge, access to specialist mental health services for homeless people is usually via the Cambridge Access Surgery. This service has direct input from a consultant psychiatrist in recognition of the high incidence of mental illness, difficulties in engagement and diagnostic problems amongst this group. There is a valuable CPFT Community Psychiatric Nurse post for the homeless in supported housing but no corresponding NHS CPN post for rough-sleepers, night shelter residents and "hidden homeless." The Cyrenian Mental Health Outreach Team (see below) facilitates engagement with some of this group but cannot provide full professional mental health assessment. There are weekly mental health case meetings involving a CAS GP, consultant psychiatrist, CPN and Cyrenians Team. There are currently no other specialist mental health services commissioned specifically for homeless people in other areas of the county

The need for dedicated mental health services for rough sleepers and the homeless with access difficulties has been highlighted in the NHS Cambridgeshire's Strategic plan. The introduction of these services will be phased over the five year period of the Strategic Plan. The priority is to ensure that homeless individuals get access to the same mental health services as the rest of the community and that adjustments to service models are made so that any particular barriers to access encountered by homeless people are overcome.

### **Cambridge Cyrenians Mental Health Team**

The Cyrenians Mental Health Team is solely funded by County Council and was set up in 1991 as a result of an identified need among the homeless individuals presenting to services in Cambridge City. It was found that many of these individuals were suffering with mental health issues but were not in touch with statutory mental health services.

Cambridge Cyrenians Mental Health Team consists of a part-time Coordinator and two full-time Mental Health Workers (with one Mental Health Worker post currently being vacant). The aim of the service is to enable the client to access statutory Primary Health Care, Specialist Mental Health Care as appropriate, seek suitable accommodation, prevent evictions from current housing, seek meaningful activities within the community and signpost to other services etc.

The team works with individuals who present in the City who report to be suffering from some sort of 'mental distress', a formal diagnosis is not required and it is a client led service and referrals can come from any source: self referral, housing providers, police, GPs, Street Outreach Team etc. The team works with individuals who are rough sleeping, in Jimmy's Nightshelter or in private or local authority accommodation and are at risk of homelessness. The service is a Monday to Friday service at present and usually operates within office hours though these are flexible according to the identified need of the individual client. The service offered is not time-limited it is based on identified need.

The local dual diagnosis strategy has recently been revised and will seek to ensure that the respective local providers of mental health, drugs abuse and alcohol misuse services work collaboratively to address the needs of homeless people with dual diagnosis issues.

Clients with a dual diagnosis have particular difficulties accessing supported accommodation. This is particularly true for people with a history of past / present drug misuse. Supported accommodation facilities are obviously concerned about the associated risk for their other residents - especially in relation to vulnerability and the potential for exploitation. As a result of this, services often have no alternative but to try and support individuals in their own tenancies. This is extremely challenging work as the client group often have poor life skills and poor coping strategies. The tenancies tend to deteriorate quickly - get taken over by other people / drug dealers and often result in eviction notices for anti-social behaviour or abandonment. It is not unusual for someone to choose to sleep out rather than stay in their tenancy due to the stress of the situation. This particular group of people require specialised housing and support in order to tackle their difficulties. This service is currently not available.

In order to address this web of interdependent problems, services are needed which recognise the interdependency and co-operate to assess, support and treat accordingly.

One model is to bring the services together in a primary care setting where they can be co-ordinated. Cambridge Access Surgery has been developing this model and currently has regular case meetings with a Consultant Psychiatrist who assesses and follows up patients at CAS. If these patients have addiction problems and are not already treated at CAS, their care is transferred from the main Cambridge Addiction base to the specialist GP prescriber at CAS. A new inter-agency Alcohol Worker post

will assist with supporting Alcohol detox by the CAS team or where this is not practical, liaise with the external community alcohol service.

### **RECOMMENDATIONS**

- To provide better integration of mental health services for the homeless with drug and alcohol services so that treatment is co-ordinated and the mental health of drug and alcohol users is properly addressed instead of dismissed.
- To provide an experienced NHS CPN service to work with street homeless, particularly in Cambridge city where a dedicated post is required.
- To provide specialist homeless accommodation for people with mental health problems to allow assessment, risk management and care planning in a safe community environment.

#### **6.4.6. Substance misuse**

##### **6.4.6.1. Cambridgeshire Drug and Alcohol Action Team (DAAT)**

Cambridgeshire Drug and Alcohol Action Team (DAAT) is a multi-agency partnership hosted by Cambridgeshire County Council (CCC) that works to implement the National Drug Strategy by deciding local drug strategy and how this is actioned, working with the County Council, NHS, police, probation service, district councils, prison service and other local services. The services commissioned by DAAT can be divided into young people and adults.

- **Service provision for young people**

DAAT are responsible for commissioning specialist substance misuse treatment for young people which aims to help young people resist drug and alcohol misuse and to achieve their full potential in society. A wide range of programmes are in existence across Cambridgeshire delivering education and prevention and supporting the treatment needs of young people in relation to substance misuse. Currently provision is fairly equitable across the county with a drug worker and alcohol worker covering each area.

Examples of services commissioned by DAAT include Young Users (YOUS) a Cambridgeshire and Peterborough NHS Foundation Trust service providing treatment for young people up to 19 years with co-existing mental health problems, need specialist prescribing treatment or have complex needs or are hard to reach. Other services include Drinksense and a Youth offending substance misuse team both county-wide and Dial Drug link (Huntingdonshire) and Bridgegate (Fenland).

In Cambridgeshire, there is a range of supported housing services which specialise in working with young people from 16-25, but none of these specialise in substance misuse. The majority of supported accommodation services for young people have explicit entry requirements which exclude young people with drug or alcohol problems, unless they are actively engaging with a treatment programme and abstaining from use of illicit drugs. The chaotic circumstances of being a homeless young person may mean it is difficult to engage effectively with treatment services and therefore make access to supported accommodation unlikely.

- **Service provision for adults**

*Addaction drug services*

In 2007, the PCT and Cambridgeshire County Council (CCC) pooled budgets to jointly commission adult drug treatment services. Addaction won the contract and from April 2008 began a phased implementation of the new services.

Addaction Cambridgeshire provides support and treatment for individuals aged 18 and over with substance misuse issues. Addaction do not provide alcohol services but will work with individuals who have both a drug and alcohol issue, but where the alcohol issue is significant, joint work would take place with alcohol services. Drug Treatment services are provided from four fixed sites covering the county and there is a dedicated outreach team and satellite surgeries and sessions. The four fixed sites are Cambridge (covering Cambridge City, South and East Cambridgeshire), Wisbech (covering Fenland), Huntingdon and St Neots (covering Huntingdonshire). Individuals can be referred to the service or can self refer. This may simply involve telephoning the service or walking through the door to access an immediate assessment.

Services provided include advice and Information, complementary therapies, harm reduction services (needle exchange services and integrated blood borne virus service), group work (including relapse prevention, stimulant group and personal development programmes,) specialist prescribing services and GP Shared Care and Structured Counselling Support (structured psychosocial interventions).

Addaction also provide a homeless link/co-ordination service. The aim of the service is to establish clear pathways and create joint working for substance misuse and homelessness services to ensure provision of accessible services for clients with substance misuse concerns within the homeless community of Cambridgeshire. This service has been engaging with hostels and accommodation providers to promote Addaction services and provides structured psycho-social nurse-led interventions to a caseload residing in temporary accommodation.

#### **6.4.6.2. Cambridgeshire Drug Intervention Programme (CDIP)**

CDIP involves criminal justice and treatment agencies working together with other services to provide a tailored solution for adults - particularly those who misuse Class A drugs - who commit crime to fund their drug misuse. There are two teams: DIP Southern based in Cambridge city (covering Cambridge City, East and South Cambridgeshire), and DIP Central based in Huntingdon (covering Huntingdon and Fenland area). The referral routes to CDIP include through police custody, self-referral, other drug treatment agencies, prison and probation. CDIP aims to introduce a minimum of 14 new clients per calendar month.

It is widely accepted that the homeless client group frequently have substance misuse issues and/or a history of offending. A client with these issues would not be excluded from applying to any homeless accommodation provider, but would be expected to respect the rules and policies in place for that accommodation, and would also be encouraged into treatment. Most housing providers have particular criteria that a potential resident must meet initially and then each client is assessed on their need and suitability as an individual. Many substance misusing clients may also have mental health problems. However housing providers that make provision for this client group

are reluctant to take clients with additional substance misuse issues, due to the vulnerability of the other residents.

Being homeless is seen as a barrier to treatment as far as drug treatment services are concerned. Many clients are not honest about their lack of accommodation when seeking alternate prescribing, believing it to be a barrier to being 'scripted'. Certainly the prescribing services are likely to offer supervised consumption only, whilst a client is sleeping rough.

It is also identified that at least one-third of the clients' records in NDTMS are without any accommodation status. During 2007/08, 47% of clients receiving structured drug treatment via DAAT services within Cambridgeshire were without accommodation data, 9% had a housing problem and 3% had an urgent housing problem. Addaction has two Accommodation officers and CDIP has two part-time housing workers and one female resettlement post.

#### **6.4.7. Alcohol services**

NHS Cambridgeshire commissions community health alcohol services from Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) and Drinksense. Drinksense is a registered charity providing advice, information, therapeutic counselling and a range of support services for people with alcohol related problems and their carers and families in Cambridgeshire.

Both Drinksense and CPFT have long standing experience of integrated systems in a number of locations. *Their mandate is for all localities to be in line with Models of Care for Alcohol Services and the local Enhanced Treatment Outcomes pilot.* There are numerous entry points through to one locality based referral process with targeted turn around and access times. All sites have direct access sessions and with additional CPN input will review and evaluate levels of delivery. Services include assessment, advice and information, support, therapeutic counselling, community and in-patient detoxification, relative support and a family support worker. Drinksense provide a Young Person's Service in Cambridge, Huntingdon and Fenland which offers support for young people.

There are some variations in services across the county with dedicated alcohol worker sessions in GP practices being available in Fenland and Huntingdonshire only. There are also variations in Community and Inpatient Detoxification Programmes with access in Fenland being stable and clear, but not so in Huntingdonshire and Cambridge City, South and East which is now being addressed. Drinksense also provides an Adult Outreach Service in Fenland and Cambridge which offers help, advice and support including resolving housing and homelessness issues, dealing with debts and other financial problems, ensuring health needs are met appropriately.

A decision was made in January 2009 to retender the service, with the new successful Provider(s) being awarded the contract and starting the service by July 2010. The new service will be a modern, community based, equitable service. The service specification will be made public for consultation by the end of July 2009.

There are no services which are commissioned specifically for homeless individuals but the current Providers and the new service model are aware that the service must be accessible by all marginalised groups, this includes the homeless population which is a priority in the service specification.

#### 6.4.8. Issues relating to drug and alcohol services

The development of an integrated drug and alcohol service for this client group may be favoured for a number of reasons. Firstly many homeless individuals will need treatment for both drugs and alcohol simultaneously or in sequence. The social life of homeless people tends to revolve around drugs and alcohol and many people have a dual dependency. Among others there is a tendency to slip between opiates, benzodiazepines and alcohol so that if one problem is successfully treated, another grows to fill the gap - evidence of more general addiction to mind-altering substances as a solution to mental health symptoms, or social or emotional distress. Secondly, two services with separate venues and waiting list may contribute towards poor attendance, duplication of effort and of key workers and poor co-ordination of treatments each of which will have implications for the other.

As noted previously there are variations in provision of alcohol services across the county. There are currently no drug or alcohol detox. beds in Cambridge in spite of this being a city with a substantial drug and alcohol problem and a large university teaching hospital.

There is a national policy to encourage drug treatment in primary care settings under the 'shared care' collaboration between specialist agency and GP. The take up of this arrangement has been better in the rest of the county than in Cambridge City.

High rates of drug and alcohol use are often seen in principal hostels for the single homeless. It is very difficult for homeless people without addiction problems or those who have struggled to overcome such problems not to acquire addictive habits in this environment. Hostel managers found a 'clean and dry' wing in a major hostel was impossible to maintain and therefore any solution would have to be spatially removed from known hot-spot locations.

#### **RECOMMENDATIONS**

- To integrate drug and alcohol services at least for homeless users and chaotic individuals with dual dependency at risk of losing accommodation.
- To build up successful drug and alcohol liaison Teams within secondary care. Such teams would coordinate treatment for drug and alcohol dependencies in hospital, provide expert advice to Hospital clinical teams and provide liaison and smooth discharge arrangements (see secondary care)
- To reconsider the range of hostel-type accommodation for the single homeless in order to provide less exposure to drug and alcohol problems for abstainers or those having undergone detox. or choosing to abstain.

#### **6.5. *Prison Services***

Homeless agencies and ex-prisoners are often frustrated by the difficulties in communicating with prisons and concerned about the effect of this on the housing status and health of ex-prisoners. While these issues apply to the prison population as a whole, ex-prisoners are over-represented among the homeless and the



consequences of poor housing and health are likely to be very much worse for this deprived population.

Prevention work with respect to housing needs to begin at the point of sentencing, to continue through the sentence irrespective of prison transfer and to follow the individual on release. This work needs to be translated into specific responsibilities allocated to identifiable workers who keep clear, accessible records so that there is no excuse for lack of information or failure to make contact between the prison service and the community.

Other issues identified include the lack of tenancy support, and support for those with poor tenancy history or arrears history. There is no tenancy support, nor any Probation Service support when the sentence is under one year and no other support services exist. For sentences greater than one year, the Probation Service offers some tenancy support and has referral processes into the services provided by Stonham Housing Association. These accommodation and support services are limited in the number of clients they can assist.

A history of previous anti-social behaviour, neighbour abuse and/or rent arrears can be a barrier to accessing social housing. A successful period of private tenancy is required to demonstrate change. It would be necessary to court private land lords to encourage them to accept the tenant. Ongoing tenancy support would be essential so that any problems arising were resolved rather than referred to the landlord – failure to do this would quickly alienate landlords and cause their withdrawal from the scheme. There is currently also no such service to address arrears through a re-payment plan. Support would be required to negotiate and achieve this.

There is a need for a floating support project – to allow access to accommodation and a system to allow prisoners to access the floating support scheme on release. Such service could also provide support to those with a poor tenancy or arrears history.

In the health field, Primary Care, Mental Health and Drug and Alcohol Service professionals can spend a large amount of time trying to extract crucial information about prison health care after release. Currently there is a lack of information sharing between prisons and primary care. This causes gaps in patient medical records which may pose significant risk in terms of continuity of care.

**RECOMMENDATIONS**

- To prevent custodial sentences from contributing to homelessness by
  - Intervention at Court to establish housing status and protect tenancies of those with sentences under 1 year.
  - Providing named workers within prisons with the specific role of identifying those who are likely to be homeless on release and to plan support, housing and health care on release with outside agencies in good time for a planned release.
- To ensure that prison sentences do not prejudice the current or future health of inmates
  - Establish a robust system for Prison health care services to receive information from community GP and drug/alcohol treatment services for each new prisoner.
  - Establish a system for prison Healthcare records to follow the patient on prison transfer and for the whole file to be immediately available to the community GP on release (in the same manner as records are transferred from one GP on registering with a new GP).

***6.6. Commissioning service issues***

A substantial proportion of all homelessness services are based in Cambridge City where single homelessness and rough sleeping is a perennial problem. Of new homeless people in Cambridge City only a third have a local connection with Cambridge City while a fifth have a local connection with the rest of the districts in Cambridgeshire. Despite the limitation in the data on the homeless, there are concerns that setting-up services may be a potential pull factor for homeless people. There are several reasons why homeless people, particularly street homeless, gather in certain towns or cities. Homeless people may be attracted by the services provided but other factors may include the perceived affluence of the area and having social contacts among other homeless people.

At present, Commissioning bodies commission services independently and often covering different geographic and demographic domains with some services being commissioned by more than one agency within the same areas. There appears to be an overlap of services within Cambridge City while in some of the districts the services appear sparse, despite the potential for homelessness being a problem in these districts. Some services are commissioned across county boundaries (for instance Cambridge and Peterborough) and some homeless people are likely to be receiving homelessness services outside Cambridgeshire county close to their home area. There are concerns that the fragmented commissioning of services does not work particularly well for the homeless and an integrated approach to providing services may be a more robust approach.

**RECOMMENDATIONS**

- Commissioners need to balance provision to both reduce homelessness and meet the needs of homeless people across Cambridgeshire
  - Between rural and urban areas
  - Between Cambridge City and the rest of the County
  - To consider Cambridgeshire services in the context of neighbouring authorities and the country as a whole
- Include excluded subgroups by providing appropriate housing, housing support and health solutions for
  - Aging homeless people: accommodation solutions recognising that this population ages prematurely and individuals often have additional needs and behavioural issues
  - Females: ensuring that services address the needs of the female minority among single rough sleepers and hostel dwellers and address the needs of women among the “hidden homeless”
  - Young people: proactive provision of accommodation, training and employment services, sexual health and contraceptive services and addiction services to prevent recruitment to the homeless community.

***6.7. Multi-Agency Risk Assessment***

The Multi-Agency Risk Assessment Conference (MARAC) is a concept that has been introduced to form a multi-agency response to domestic violence. The MARAC is used to share information about high risk cases between the various key statutory and voluntary agencies who might be involved in supporting a victim of domestic abuse. High risk victims are identified using a risk assessment tool and a typical MARAC meeting includes discussion of 15 to 20 high risk cases, followed by a creation of a simple multi-agency action plan to support the victim.<sup>34</sup>

This is an approach that could be used for chronically excluded adults. There appear to be some similarities between this group and those at high risk of domestic violence in terms of the number of agencies involved in supporting them and the benefits of information sharing and a co-ordinated approach. MARACs have been shown to reduce repeat victimisation and there is also some anecdotal evidence that the improved communication between agencies as a result of attending a MARAC has had an impact on resolving issues for ‘lower’ risk cases.<sup>34</sup>

**RECOMMENDATIONS**

- Consider development of a MARAC (multi-agency risk assessment conference) approach for chronically excluded adults
- Development of a multi-agency steering group to address the needs of chronically excluded adults in Cambridgeshire.

## 7. Evidence of effectiveness of interventions for the homeless

### CHAPTER SUMMARY

- Local authorities are required to have a prevention focussed approach to homelessness. There are a number of evidence-based approaches to preventing homelessness which vary in terms of cost-effectiveness.
- A Person centred records for the homeless (CHAIN) database has been developed to enable those working with rough sleepers in London to share information to help those they encounter.
- The evidence base on the effectiveness of health care services for homeless people is poorly developed. Factors that appear to be associated with successful health services include flexibility, outreach work, a holistic approach, inclusive practices, user involvement, effective joint working and integrated solutions.
- Jobs are one of the key routes away from social exclusion, offering a pathway towards financial and social independence.
- Person-centred information can drive strategic change in organisations and effect improvements in commissioning
- There is evidence to suggest that an integrated approach to service provision; and integrated, person centred, services delivered by multi-agency teams are better suited to improving the outcomes of the homeless.

### *7.1. Introduction*

One of the aims of the JSNA is to provide an evidence base of interventions or services that are effective in tackling problems identified in the JSNA. This section summarises these under the headings of :

- Homelessness prevention
- Tackling rough sleeping
- Primary health care services for homeless people
- Services for substance misuse and homelessness
- Meaningful occupation for homeless people
- User involvement in commissioning
- Integrated services for homeless people

### *7.2. Homelessness prevention*

Local authorities' obligation to prevent as well as respond to homelessness is longstanding, both in law and in good practice. Ever since the Housing (Homeless Persons) Act 1977, authorities have been legally required to assist people threatened with homelessness (and classed as 'in priority need') by taking reasonable steps to prevent them from losing existing accommodation. The government's wish for local authorities to develop a more interventionist approach to homelessness more generally was signalled in its 2002 policy paper *More than a Roof*.<sup>45</sup> *More than a Roof* advocated a number of practical initiatives seen as contributing to homelessness prevention. These included a greater stress on the provision of advice on housing,

employment and welfare benefits, together with the development of services such as family mediation, support in dealing with domestic violence, access to detoxification services, and employment training.

The Homelessness Act 2002 is central to the new 'prevention-focused' approach, having placed a new duty on every housing authority in England, to develop a strategy based on a review of homelessness in their area.<sup>3</sup> Government guidance stated that strategies must aim to prevent homelessness and ensure that accommodation and support will be available for people who are homeless or at risk of homelessness.

Whilst the evidence is fragmentary, project level data confirms that a significant proportion of certain types of interventions to prevent homelessness succeed in their objective and are cost-effective. The Department of Communities and Local Government has produced a good practice guide on homelessness prevention.<sup>35</sup> The evidence base from a recent evaluation of the effectiveness of different approaches to preventing homelessness is summarised below.<sup>36</sup>

### **7.2.1. Preventing homelessness through improved housing advice**

#### *What works?*

Effective housing advice services include:

- Early intervention;
- Landlord liaison (or 'mediation');
- Specific help for groups whose needs might not be adequately addressed through a 'generalist' approach to advice delivery;
- Outreach services (e.g. co-locating housing advice with benefits services, employment advice etc);
- Effective and appropriate referral procedures – i.e. which enable households needing housing advice to be referred to relevant agencies; and
- Active promotion of housing advice service among a network of other agencies.

#### *Cost-effectiveness*

Investment in housing advice to prevent homelessness is a cost-effective intervention. There are savings that arise from not having to house homeless households in temporary accommodation. However, cost-effectiveness is less clear-cut where assisted households would be unlikely to qualify as homeless and in priority need if they were assessed under the homelessness legislation. Wider public expenditure savings accrue from helping such households access better housing solutions.

### **7.2.2. Facilitating access to private tenancies; rent deposit schemes**

Rent deposit schemes (where the local authorities provide tenants with a deposit) is an effective way of facilitating access to private tenancies by the homeless.

#### *What works?*

- Appropriately targeted rent deposit and similar schemes can form a cost-effective means of preventing homelessness and can usefully offer a package of 'add-on services' directed at both tenants and landlords.

- Particularly where they are paid as straightforward grants (rather than deposit guarantees), local authority financial contributions can be used to secure acceptable property conditions and tenancy terms beyond the legal minimum.
- By tailoring schemes appropriately, rent deposit-type initiatives can be successfully employed for a range of client groups and purposes.
- In implementing any initiatives of this sort, it is clearly beneficial for local authorities (or their agents) to develop a detailed picture of private landlordism in their locality, and to use this as a basis for establishing friendly relations with rented property owners.

#### *Cost-effectiveness*

Rent deposit and similar schemes targeted at households otherwise likely to be accepted as statutory homeless can be highly cost-effective from the local authority viewpoint. That is, the savings in probable temporary accommodation expenditure outweigh the outlays involved in securing access to private tenancies (whether or not deposits are successfully recovered). Particularly in the light of subsequent homelessness case law, however, there are questions about the legality of schemes which involve informal referral of 'potentially priority need' households already homeless or threatened with homelessness.

### **7.2.3. Family Mediation**

#### *What works?*

- There is a variety of family mediation models, and what is advocated as 'good practice' by local authorities and mediation service varies.
- Generally, the strengths of mediation for young people are perceived by many practitioners to be those associated with mediation services more broadly; namely, that it is non-judgemental, impartial and empowering for clients.
- Mediation's role in 'building bridges' between young people and their parents, where relationships were either fraught or had broken down.
- One case study local authority stressed that mediation was most effective in cases where the risk of homelessness was due to routine teenage/parent arguments and tensions and with potential exclusions where homelessness has been 'contrived', perhaps due to a lack of perceived housing options.

#### *Cost-effectiveness*

Mediation services appear highly cost-effective. The cost-effectiveness of these schemes resulted from the fact that they were relatively inexpensive to run compared to the cost of providing temporary accommodation for young people accepted as homeless.

### **7.2.4. Domestic violence victim support**

The main types of homelessness prevention activities identified in this area include 'sanctuary' schemes to enable women to stay in their own homes, supporting women to make planned moves, crisis intervention services, floating support, and resettlement support.

*What works?*

Particularly given the evidence on longer-term sustainability, the creation of sanctuaries can be seen as an effective means of preventing homelessness among women facing the threat of violence from outside the home.

Realising the full potential of sanctuary schemes is dependent on:

- helping to maximise the chances of intervening to prevent homelessness by making known the existence of such schemes to specialist agencies to whom women threatened with having to leave their home due to violence might initially turn;
- effective referral, decision-making and liaison arrangements which enable the rapid installation of security works once a judgement has been made that this is a potentially appropriate action; and close liaison arrangements between the local authority (or contractor agency) and the Police.

*Cost-effectiveness*

Although this approach is relevant only in cases where women face having to leave home due to external threats of violence, there appears to be solid evidence of sanctuary schemes' potential to prevent homelessness. Such schemes are clearly capable of being highly cost-effective.

**7.2.5. Prison-based homelessness prevention**

A number of interventions have been trialled, including: saving existing tenancies; helping prisoners access new accommodation upon release; and providing post-release support (partly to promote tenancy sustainment).

*What works?*

- Peer-led and peer-involving models of housing support within prisons have benefits including: 1) capacity building for those directly concerned, likely to contribute to future employability; 2) peer workers' empathy for, and understanding of, the problems of fellow prisoners; and 3) prisoners' preference for discussing issues of concern with their fellows rather than people seen as representatives of officialdom; and value for money.
- Support at key phases in the custodial period, including support on entry, pre-release, at point of release, and post-release, as well as availability of support as required during custodial period is crucial.
- Supporting prisoners to renew or maintain family relationships was an important aspect of provision emerging from the research, reflecting the importance that supportive personal relationships can play in preventing homelessness.
- Evidence suggests the need for a range of services to address barriers related to being in custody in order to develop potential housing options, such as a lack of ID documentation upon entry into prison, and rent arrears.
- The research highlighted the importance of developing liaison mechanisms between prison-based housing advice providers and external agencies such as housing providers.
- There is a need to ensure appropriate post-release accommodation for this client group.

*Cost-effectiveness*

Because few ex-prisoners are likely to be classed as 'priority homeless', such schemes are less likely to generate savings in temporary accommodation expenditure compared to other forms of homelessness prevention. The cost effectiveness benefits of such schemes are not as easy to identify. However, given the very substantial public costs associated with re-offending (e.g. for Prison and Probation services) and the known close association between lack of accommodation and reoffending, there is a strong case that activities of this kind are economically beneficial.

**7.2.6. Tenancy sustainment**

Provision of support to help people with support needs retain their tenancies is important in reducing repeat homelessness, especially, among recently re-housed social renters.

*What works?*

- Two factors are key to enabling tenants to sustain their tenancies: 1) Flexible and client-centred service provision; and 2) close liaison between key agencies and commitment to building in support from other agencies.
- Timely intervention is critical for supporting tenants to maintain their tenancies,
- The commitment and experience of tenancy sustainment workers was identified as an essential element of the service in responding flexibly to clients' needs.
- The physical location of the service can also contribute to its accessibility and increase scope for joint working.
- The effectiveness of tenancy sustainment services depends on their being viewed by clients as independent and playing a befriending and advocacy role as opposed to a housing management/landlord role.

*Cost-effectiveness*

Assessing the cost-effectiveness of tenancy sustainment is problematic, mainly because the counter-factual scenario is not easy to identify. Nevertheless, the sample scheme assessed appeared to be highly cost-effective due to its assumed role in helping to reduce council evictions.

**RECOMMENDATIONS**

- Identify services enabling prevention of homelessness and early intervention for the newly homeless to improve individual lives and to reduce overall homelessness. Examples of situations are: risk of eviction, anticipated prison release, hospital discharge.

**7.3. *Tackling rough sleeping***

'No one left out: communities ending rough sleeping'<sup>8</sup> is a recent strategy that aims to eliminate rough sleeping in the UK. The report includes a 15 action plan for meeting this ambitious target. The report summarises how the 15 action plans will be achieved and builds on existing knowledge base and best practice.



The action plans key points from this report include:

- Promoting prevention of rough sleeping in all areas through effective housing options and a strengthened safety net.
- Supporting best practice in commissioning of services that prevent and tackle rough sleeping.
- Extending positive activities that motivate and empower people to take greater control in their lives.
- Tackling worklessness by strengthening joint working between Jobcentre Plus and the homelessness sector, disseminating targeted information on benefits and work issues, and promoting Local Employment Partnership in the homelessness sector.
- Improving access to health and social care services for people with multiple needs by commissioning better integrated services, and developing the Joint Strategic Needs Assessment process.
- Stepping up efforts across Government and with local partners to tackle rough sleeping among new migrant populations.
- Using the web to promote knowledge of local services and resources that can address rough sleeping and social isolation.
- Developing a community training programme to build capacity and skills that can support isolated people to avoid sleeping rough.
- Promoting personalisation including testing individual budgets to increase the control people have over the services they need working with Supporting People teams, CSIP, In Control, the City of London and other partners to promote learning and successful approaches.
- Driving for user involvement in services and active citizenship among people with experience of rough sleeping.
- Launching a new approach to help local authorities monitor progress and track people sleeping rough, ensuring that counts are not just an opportunity to identify levels of need but more importantly to do something about it.
- Bringing together existing data in new ways to understand and monitor outcomes for people who have slept rough.
- Using a new Champions programme, bringing together experts from across the country to support local areas and other services.
- Encouraging and supporting councils and regions to work strategically to end rough sleeping by supporting local authorities to implement their homelessness strategies and promoting strategies that aim to end rough sleeping.
- Renewing our focus on driving, co-ordinating and monitoring progress through our specialist advisers and regional resource teams and by working more closely across government departments.

#### ***7.4. Person centred electronic records for the homeless: CHAIN***

The Combined Homeless and Information Network (CHAIN; see URL <http://broadway.jamkit.com/CHAIN/>) is a database for people who work with rough sleepers and the street population in London. The system is used to help workers share information to ensure that they act as quickly and effectively as possible to help those they encounter. Reports based on information held in CHAIN help decision-makers monitor the needs of rough sleepers in London.

Workers record information on CHAIN about the following groups of people.

1) People who have been seen 'bedded down' on the streets by outreach workers. This group are known as 'Verified Rough Sleepers'. It is important to note that CHAIN does

not cover 'hidden homeless' groups such as those who are squatting or staying in places which are inaccessible to outreach workers.

2) The street population - this term refers to people who have a 'street lifestyle' such as street drinking or begging. Many people who have a street lifestyle are also rough sleepers but a minority are not.

The information recorded on CHAIN includes: a) basic identifying and demographic information; contacts made with outreach workers - both when a person is 'bedded down' and when they are not 'bedded down'; b) arrivals and departures from short term accommodation such as hostels and rolling shelters, including the reasons for departures; c) basic indications of support needs people have, for example drug misuse or physical health problems; and d) services such as outreach teams, hostels, day centres and resettlement teams. CHAIN holds sensitive information about vulnerable people. The entry, update, viewing and access of data in CHAIN is regulated by a series of protocols that strictly follow the provisions of the 1998 Data Protection Act.

Over 80 projects contribute information to CHAIN. Information is added to the system by people who work directly with rough sleepers and the street population in London. They are from: outreach Teams and Building Based Services; Day Centres; accommodation projects - night shelters, rolling shelters, hostels, second-stage accommodation projects; and resettlement teams. By having access to CHAIN, agencies and workers can: find background information about their clients; view information to help with support planning; access information to help with linking clients in with available services; and view the history of a client's engagement with services such as outreach teams, hostels, day centres and resettlement teams.

A recent report based on CHAIN database used the flow (first-time rough sleepers), stock (people recorded on the CHAIN as sleeping rough in the previous year as well as the one in question,) and returner (people who have been seen rough sleeping previously, but not in the preceding year) model to characterize the nature of rough sleeping, illustrate the changing demographic patterns of each group; and to identify the specific needs of people in each group. While the proportions of people in each of these groups has remained consistent, there is evidence to suggest that rough sleeping in London is on the increase, especially among immigrant population.<sup>37</sup>

### ***7.5. Primary Health care services for homeless people***

Personal Medical Services (PMS) schemes are locally negotiated alternatives to General Medical Services (GMS). They offer opportunities to provide new services to groups experiencing difficulty accessing GMS. PMS is implemented through contractual arrangements with the Primary Care Trusts to provide core primary care medical services to locally agreed priority groups, such as homeless people. By agreeing such priorities, schemes can target these groups to bring about improvements in their health and well being.<sup>38</sup>

Overall, the evidence base on the effectiveness of health care services for homeless people is poorly developed. Most of the current health services for the homeless have been policy driven often drawn from best practice rather than being evidence based. Nonetheless, existing evidence points to a number of factors that appear to be associated with successful health services, including flexibility, outreach work, a holistic approach, inclusive practices, user involvement, effective joint working and integrated solutions.

Evaluations of existing PMS projects provide some evidence which suggest that they are of value to the homeless. In Chester, the PMS project recorded an increasing numbers of homeless people registered and using services; the quality of health care provided by the PMS was perceived as excellent by the homeless people; and partnerships between PMS staff and other agencies working with homeless enabled referral of homeless people to the PMS.<sup>39</sup> The Leicester Homeless Primary Health Care Service has implemented an outreach type PMS model which has enabled the scheme to provide access to significantly more homeless people than one permanent centre. This is intended to reduce inappropriate A&E presentations and to increase the identification of high-risk individuals, who need on-going resettlement support to prevent recurring homelessness.<sup>38</sup> In Exeter, implementation of the Clock Tower Surgery was associated with an 84% reduction in inappropriate A&E in-hours attendances.<sup>38</sup>

While these models have been implemented with various levels of success, rigorous evidence on whether the PMS models improve health outcomes among the homeless. There have been concerns that segregation of homeless people through PMS, however well meaning, is unlikely to resolve the health inequalities of homelessness and may indeed hinder people re-integrating with the mainstream services once their homelessness problems have been tackled.<sup>40</sup>

### ***7.6. Services for substance misuse and homelessness***

Drug and alcohol problems are common among the homeless. *Drug services for homeless people: a good practice handbook*<sup>41</sup> advocates for the whole range of services that fall within the four substance misuse tiers, which include medically based interventions, needle-exchange programmes, harm minimisation advice, support groups, day care, family services, supported accommodation, detoxification and rehabilitation. The handbook recommends DAATs to have the lead role in ensuring effective drug services are available for homeless people by: adapting mainstream services so that they are accessible to homeless people and provide them with effective treatment; establishing specialist services where these are needed; and ensuring that the full range of accommodation and support needs are met for homeless people as a basis for successful drug treatment. There is a strong emphasis on the importance of partnership working in and ensuring flexibility and adaptability of services to meet the needs of the homeless.

A systematic review of international literature reviews evidence on effective substance misuse services for homeless and draws lessons for the Scottish context.<sup>42</sup> The review concluded that:

- A mixture/ range of integrated services is required for homeless substance misusers to effectively address their complex needs.
- Harm reduction/harm minimisation models appear to meet more success than total abstinence models.
- The 'Housing First' model of housing homeless people is more successful and cost effective than the Continuum of Care or "Staircase" model for this client group. The evidence base of the model of packaging floating support through case management and joint working is less developed.
- Evidence of effectiveness of preventative services to counteract potential homelessness in this client group was weak.

### ***7.7. Meaningful occupation for homeless people***

Jobs are one of the key routes away from social exclusion, offering a pathway towards financial and social independence. *Include Me In: How life skills help homeless people back into work*<sup>43</sup> offers one model for responding to the growing gap between improved outcomes in the short term and building sustainable foundations for social inclusion over much longer periods. Meeting basic needs can form only part of the story of an individual's return to the mainstream.

*Include Me In* suggests that connecting people with wider opportunities to get and keep work is a key way that we can enable people to maintain integration after an initial success in breaking away from homelessness. The book includes evidence of what works and outlines characteristics of effective programmes for addressing life skills, homelessness and unemployment.

### ***7.8. User involvement in commissioning***

Person-centred information can drive strategic change in organisations and effect improvements in commissioning. It has also described how this simple process can be practically useful to councils who are undertaking joint strategic needs assessments and/or are seeking to better understand and measure the outcomes of personalisation.

*'Working together for change: using person-centred information for commissioning'*<sup>12</sup> is a potentially powerful tool that councils can use to ensure that the current changes in adult social care are co-developed and co-produced with people and families. It is a tried and tested method for generating and analysing qualitative data for commissioning which can improve the linkages between strategic decision makers and the people that they serve. When used alongside other data sources, the information from this process can help commissioners to engage people in shaping the local availability of services.

### ***7.9. Integrated services for homeless people***

Apart from services offered at the Cambridge Access surgery, the homelessness services framework in Cambridgeshire appear fragmented in nature. Most of the services are designed for the general population with the assumption that homeless people will have access to these services. For some services, the data on accommodation is not well captured and therefore it is not possible to assess the extent to which people reported as homeless are accessing these mainstream services.

In practice agencies working with homeless are confronted with people in ill health who are in need of two sorts of care. These are *social care* for housing, income and activities, and *medical care* for addiction, mental and physical health problems. Generally, the provision of services in a fragmented manner does not work well for the homeless people. There is evidence to suggest that an integrated approach to service provision; and integrated, person centred, services delivered by multi-agency teams are better suited to improving the outcomes of the homeless.

Integrated treatment of substance use and other mental disorders is more effective than treatment directed at a single problem. A mixture/ range of integrated services is required for homeless substance misusers to effectively address their complex needs. Poor coordination between substance use and mental health services has resulted in

clients with co-occurring substance use and other mental disorders 'falling through the gaps'.<sup>42</sup>

## 8. Recommendations

### General

- 8.1 Refine work on homelessness by:
  - Recognising principle overlapping domains with differential access to housing and complexity of needs
    - Statutory Homeless: including families, older people, young people.
    - Rough sleepers /Single homeless: including prison and institution leavers
    - Hidden Homeless and those at risk of homelessness
  - Recognising different reasons for becoming homeless and remaining homeless.
  - Recognising the mobility and transience of the homeless population.
- 8.2 Develop a health strategy to address the health needs of the homeless population in Cambridgeshire as part of a joint commissioning strategy and action plans to support implementation and supporting the existing district homelessness strategies and action plans.
- 8.3 Develop tools for data collection which can be used across services to allow more holistic and person-centred identification of needs, commissioning of services and monitoring of outcomes.
- 8.4 Develop ways of unifying individual client records so they can be accessed across services.
- 8.5 Develop methods of ensuring that service users' experience and perceived needs are embedded in the care planning process. Information from individual care plans should be used to inform service development and commissioning.
- 8.6 Develop ways of identifying broader outcomes which span services and which can be meaningfully identified or measured in practice and meet the needs of homeless people.
- 8.7 Identify services enabling prevention of homelessness and early intervention for the newly homeless to improve individual lives and to reduce overall homelessness. Examples of situations are: risk of eviction, anticipated prison release, hospital discharge.
- 8.8 Development of a multi-agency steering group to address the needs of chronically excluded adults in Cambridgeshire.

## Commissioning

- 8.9 There should be direct input of homeless people and front-line service providers in the commissioning process.
- 8.10 Strengthen joint-commissioning of multi-agency services in order to address the complex interrelations between health, housing and social care amongst the different categories of homeless.
- 8.11 Provide for closer integration of services so that they meet the needs of the homeless by commissioning more integrated multi-agency services where possible including funded posts for liaison and co-ordination between services.
- 8.12 Commission clear patient pathways and co-ordinated interventions in a minimum of different locations through multi-disciplinary working between NHS and third sector services for SHRS which are most crucial to improving outcomes of the homeless. The principle services identified for this are:
- Primary care
  - Secondary care , particularly Emergency Departments
  - Mental Health Services including Learning Disability Services
  - Drug misuse services
  - Alcohol misuse services
  - Supporting People
- 8.13 Develop a process for the sharing and disseminating of knowledge and experience service provision for the homeless.
- 8.14 Commissioners need to balance provision to both reduce homelessness and meet the needs of homeless people across Cambridgeshire between rural and urban areas, between Cambridge City and the rest of the County and to consider Cambridgeshire services in the context of neighbouring authorities and the country as a whole.

## Services

- 8.15 Include excluded subgroups by providing appropriate housing, housing support and health solutions for
- Aging homeless people: accommodation solutions recognising that this population ages prematurely and individuals often have additional needs and behavioural issues
  - Females: ensuring that services address the needs of the female minority among single rough sleepers and hostel dwellers and address the needs of women among the “hidden homeless”
  - Young people: proactive provision of accommodation, training and employment services, sexual health and contraceptive services and addiction services to prevent recruitment to the homeless community.

8.16 To ensure **primary care** is accessible and responsive to the needs of homeless by:

- Considering focused and innovative ways of improving access to mainstream primary health care services by homeless people in the entire county.
- Seeking primary care performance measures and rewards appropriate to this group to counteract the current disincentives to register homeless people, for example commissioning enhanced services within generic primary care (via LES or other means) according to local needs.
- Where there are high numbers of homeless people, commissioning and supporting development of specialist homeless primary care services – either patients to be fully registered in stand alone practices or arrangements embedded in mainstream practices
- Where there are lower numbers of homeless people, supporting specialist interest in homelessness throughout primary care by ensuring the identification and full registration of homeless patients.
- Developing a programme of education on homelessness and associated healthcare issues for GP Practices in Cambridgeshire, using existing expertise (for instance from CAS)
- Managing co-ordination and support from Drug, Alcohol and Mental Health Services to help primary care teams manage homeless patients.

8.17 To improve the **oral health** of the homeless population:

- The PCT should commission NHS dental services that are appropriate, accessible, acceptable to and affordable for homeless people
- Improving oral health for homeless people is best addressed using the Common Risk Factor Approach. This approach emphasises the need to tackle the common risk factors and conditions that are shared by chronic non-communicable diseases including tobacco use, poor diet, stress, alcohol consumption, drug use, poor hygiene and injuries.
- Structural barriers to dental treatment services should be minimised by facilitating access to urgent dental care, offering walk in and out of hours services as well as extended opening times.
- Dental treatment services should be well signposted through routes normally accessed by homeless people for example hostels and drop centres.
- The PCT should consider oral cancer screening for this group of people who exhibit associated high risk behaviour including smoking and drug and alcohol use.



#### 8.18 **Secondary care** recommendations:

- Develop professional teams in each Hospital to ensure management of drug and alcohol problems within hospital and full liaison with community health, council run and voluntary services.
- Strengthen arrangements in emergency departments to ensure health needs of the homeless can be appropriately addressed in full co-operation with primary care, community care and housing.
- Improve discharge arrangements for inpatients by improving information streams and pre-discharge planning. Those responsible for non-elective care should be supported in developing a mechanism to signpost homeless people appropriately to services.

#### 8.19 **Mental health services:**

- To provide better integration of mental health services for the homeless with drug and alcohol services so that treatment is co-ordinated and the mental health of drug and alcohol users is properly addressed instead of dismissed.
- To provide an experienced NHS CPN service to work with street homeless, particularly in Cambridge city where a dedicated post is required.
- To provide specialist homeless accommodation for people with mental health problems to allow assessment, risk management and care planning in a safe community environment.

#### 8.20 **Drug and Alcohol Services**

- To integrate drug and alcohol services at least for homeless users and chaotic individuals with dual dependency at risk of losing accommodation.
- To build up successful drug and alcohol liaison Teams within secondary care. Such teams would coordinate treatment for drug and alcohol dependencies in hospital, provide expert advice to Hospital clinical teams and provide liaison and smooth discharge arrangements (see secondary care)
- To reconsider the range of hostel-type accommodation for the single homeless in order to provide less exposure to drug and alcohol problems for abstainers or those having undergone detox. or choosing to abstain.

#### 8.21 **Prison services**

To prevent custodial sentences from contributing to homelessness by

- Intervention at Court to establish housing status and protect tenancies of those with sentences under 1 year.
- Providing named workers within prisons with the specific role of identifying those who are likely to be homeless on release and to plan support, housing and health care on release with outside agencies in good time for a planned release.

To ensure that prison sentences do not prejudice the current or future health of inmates.

- Establish a robust system for Prison health care services to receive information from community GP and drug/alcohol treatment services for each new prisoner
- Establish a system for prison Healthcare records to follow the patient on prison transfer and for the whole file to be immediately available to the community GP on release (in the same manner as records are transferred from one GP on registering with a new GP).

8.22 Consider development of a MARAC (multi-agency risk assessment conference) approach for chronically excluded adults.

## APPENDICES

### CONTENTS

Appendix 1 What exactly is a JSNA

*Author: David Lea, NHS Cambridgeshire*

Appendix 2 Summary of health, homelessness strategies and data limitations

*Author: Dr Jeremiah Ngondi, NHS Cambridgeshire, JSNA Working Group:*

Appendix 3 P1E District Council Statutory Homelessness

*Author: Jon Cullen, Huntingdonshire District Council*

Appendix 4 Supporting People: Cambridgeshire client record data

*Author: Elske Janssen, Joe Keegan, Supporting People, Jeremiah Ngondi*

Appendix 5 Supporting People: Cambridgeshire client outcomes forms data

*Author: Elske Janssen, Joe Keegan, Supporting People, Jeremiah Ngondi*

Appendix 6 Cambridge City Council Homeless Database

*Author: Robert Young, Cambridge City, Jeremiah Ngondi*

Appendix 7 Health Profile of the Cambridge Access Surgery population

*Author: Jeremiah Ngondi, Dr Christine Hugh-Jones and CAS*

Appendix 8 Secondary Care Data

*Author: Jill Eastment*

Appendix 9 Services for the homeless in Cambridgeshire

*Author: Jessica Stokes, JSNA Working Group*

Appendix 10 House repossessions data

*Author: Polly Jackson, Research Group of Cambridgeshire County Council*

Appendix 11 Cambridge City Council Homeless Strategy Consultation

*Author: Robert Young, Jessica Stokes, Jeremiah Ngondi*

Appendix 12 Home-Link the Cambridge Sub- Regional Choice Based Lettings Scheme

*Author: Sue Carter, Housing Advice and Options Manager, South Cambridgeshire District Council*

## 9. Appendix 1: What exactly is a JSNA?

The acronym JSNA stands for joint strategic needs assessment. The concept of JSNAs was introduced in the Government's *Commissioning framework for health and well-being*<sup>1</sup>, which was published in March 2007. JSNAs "will describe the future health, care and well-being needs of local populations and the strategic direction of service delivery to help meet those needs"<sup>1</sup>.

Breaking the phrase down into its constituent parts is useful in defining what it means in practice:

- **Joint:** a key element of the JSNA is that it should involve all the important stakeholders in identifying needs and acting upon them. Crucially the JSNA provides a new framework for health and social care to collectively work in partnership to identify the needs of the population they serve and to work together in commissioning services to meet those needs.
- **Strategic:** the JSNA should identify those needs and service requirements that are most relevant and important to its population. The needs assessment process should provide health and social care organisations with an evidenced based identification of the key needs of its population and should therefore define the strategic direction in its commissioning of services. This strategic direction should consider both today's and future health and social care needs.
- **Needs assessment:** there are many definitions of needs assessment. In order to identify health and well-being needs the assessment process should make use of existing information, identify information gaps and should include the views of service users, patients and the population. Importantly the needs assessment must include outputs that can be translated into actions for the commissioning and delivery of health and social care services, health improvement and well-being programmes and other interventions. The process should consider social inclusion and should identify inequities and inequalities in health and well-being and in current service delivery.

The Department of Health document states that a 'good' JSNA should:

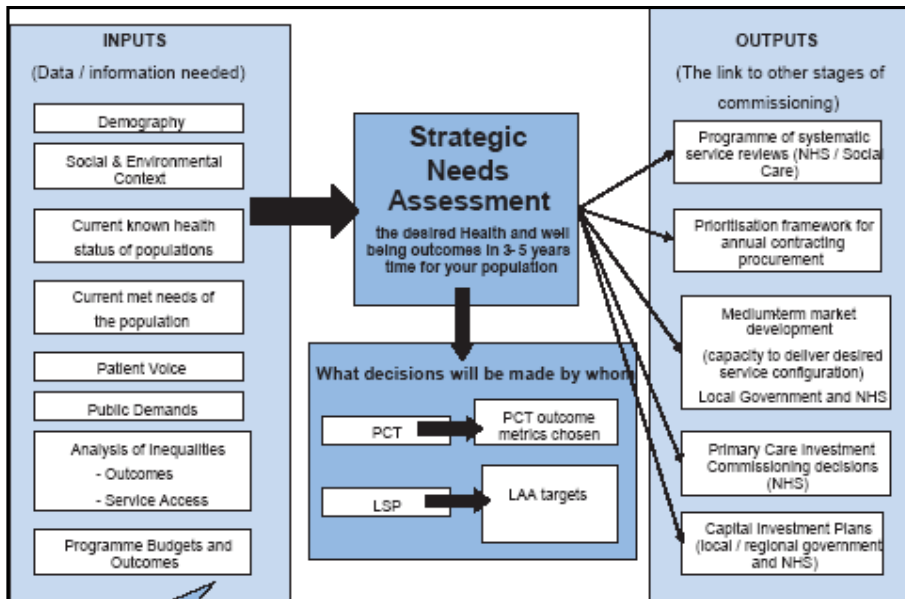
- 'provide analyses of data to show the health and well-being status of local communities
- define where inequities exist, and
- Use local community views and evidence of effectiveness of interventions to shape the future investment and disinvestment services<sup>1</sup>.'

The following outcomes should be delivered by the JSNA:

- 'define achievable improvements in health and well-being outcomes for the local community
- send signals to existing and potential providers of services about potential service changes
- support the delivery of better health and well-being outcomes for the local community
- inform the next stages of the commissioning cycle
- aid better decision-making
- underpin the local area agreement and the choice of local outcomes and targets as well as the PCT's own prospectus'.

Figure 1 below illustrates in summary the JSNA process.

Figure 9.1 : JSNA framework – inputs and outputs



Source: Department of Health, Commissioning framework for health and well-being<sup>1</sup>

## 10. Appendix 2: Summary of health, homelessness strategies and data limitations

### 10.1. Health strategies for the homeless

**Table 10.1:** Summary of health policies and strategies for the homeless

Policy/ strategy	Author/Year	Summary
Independent inquiry into inequalities in health: Report <sup>44</sup>	Department of Health, November 1998	The report recommended policies to: 1)Improve the availability of social housing for less well-off and homeless people. 2)Improve the quality of housing, given that poor quality housing is associated with poor health.
More than a roof: a report into tackling homelessness <sup>45</sup>	Department for Communities and Local Government, March 2001	This report underscores the complexity of addiction and ill health among the homeless and the difficulty of accessing mainstream health services experienced by the homeless. The report summarises key health issues among homeless people and suggests ways of improving access to health services by the homeless.
Saving lives: our healthier nation <sup>46</sup>	The HM Government, July 2009	The report pledged to place a new duty on local authorities to protect those who are homeless through no fault of their own and who are in priority need. The aim was to reduce the number of people sleeping rough by two thirds by 2002
Discharge from hospital pathway, process and practice <sup>47</sup>	Department of Health, January 2003	All acute hospitals should have formal admission and discharge policies which will ensure that homeless people are identified on admission and their pending discharge notified to relevant primary health care services and to homeless services providers. For patients in psychiatric hospitals/units a post-discharge care plan will be drawn up well in advance of discharge and procedures put in place to ensure appropriate accommodation and continuity of care is in place for each person discharged.
Tackling health inequalities: A Programme for Action <sup>48</sup>	Department of Health, July 2003	The Government's aim is to reduce health inequalities by tackling the wider determinants of health inequalities, such as poverty, poor educational outcomes, worklessness, poor housing, homelessness, and the problems of disadvantaged neighbourhoods. This white paper underscores the Government commitment to tackle and prevent all forms of homelessness through implementation of the Homelessness act of 2002 as well as: eliminate the use of bed and breakfast accommodation for homeless families with children; and sustain reductions in the numbers of people sleeping rough. The report recognises the role that Primary Care Trusts(PCTs) have in working closely with local partners to improve health outcomes for homeless people.
Achieving positive shared outcomes in health and homelessness <sup>49</sup>	Department of Health and Office of the Deputy Prime Minister, March 2004	The report advocates for Local authorities, Primary Care Trusts, Local Strategic Partnerships, Drug Action Teams, Drug and Alcohol Action Teams, Mental health Trusts and voluntary organisations to develop shared local outcomes to improve health and reduce homelessness. The reports suggests an outcome framework which includes: 1) improving health care for homeless families in temporary accommodation; 2) improving access to primary health care for homeless people; 3) Improving substance misuse treatment for homeless people; 4) Improving mental health treatment for homeless people; and 5) Preventing homelessness through appropriate, targeted health support.
Healthy Futures A Regional Health Strategy for the East of England 2005-2010 <sup>50</sup>	East of England Regional Assembly, December 2005	The focus of this Strategy is health and health inequalities within the East of England. The strategy highlights the relationship between housing and health and recognises that increased house prices have made housing unaffordable for many people resulting in increased homelessness. The strategy identifies young people (aged 16-17) as particularly vulnerable and likely to be excluded from access to relevant services at a critical moment in their life course.

Table: 10.1 continued.

Choosing Health: Making healthy choices easier <sup>51</sup>	Department of Health November 2004	The report highlights that children from homeless families are disproportionately affected by mental health problems and makes the case for effective and timely interventions to reduce the incidence of serious health and social problems later in life. The report calls for targeted advice and support to ensure disadvantaged young people receive advice about health issues, particularly those who often feel excluded from services – such as those who are looked after, disabled or from black and minority ethnic groups, or from families who have experienced homelessness.
Our health, our care, our say: a new direction for community services <sup>52</sup>	Department of Health, January 2006	This white paper underscores the following issues: The report call for housing and health services to work together to improve the well-being of homeless people and to prevent homelessness (Achieving positive shared outcomes in health and homelessness). Report calls for better partnership working: Department for Work and Pensions are piloting offering joint health and employment support in GP surgeries, making it easier for people to access the services they need in a single location. The paper suggest that providing different services in the same setting makes life easier for people, especially for vulnerable people such as people who are homeless or living in temporary accommodation, or the frail. It can also be the first step towards achieving greater integration between public services.
Developing integrated care pathways for homeless people <sup>53</sup>	Homeless Link, December 2006	The purpose of this fact sheet is to support health staff to: identify homeless people on admission; enable health staff to effectively manage people with complex health and social needs; assist health staff to work collaboratively with acute services, mental health, primary care and the voluntary sector; provide staff with guidance on appropriate measures which can support continuity of care following discharge.
St Mungo's Health Strategy 2008-2011 <sup>54</sup>	St Mungo's, June 2008	This strategy was developed for people living in St. Mungo's hostels who are mainly formerly rough sleepers. The policy seeks to: advance recognition of rough sleepers as a priority group with complex health needs; develop and pilot service models based on an elaborate healthcare pathway; embrace world class commissioning based on needs on rough sleepers rather than the administrative convenience of commissioners; improve the effectiveness of health interventions; and to strengthen the evidence base about the needs of the rough sleeper and other homeless people, and the effectiveness of interventions meeting them.
No-one left out – communities ending rough sleeping <sup>55</sup>	Department of communities and local government Nov 2008	Rough sleeping numbers have been driven down over the last decade and have stayed down due to concerted efforts across Government, the voluntary sector and community action. This strategy seeks to go even further and help end rough sleeping for good. It is a 15-point action plan which has been developed with leading rough sleeping charities and will use action, advice and assistance across England to prevent the flow of people onto the streets, as well as to support those already there to get off the streets into stability. The plan will call on communities to get more involved in supporting those in their area at risk of rough sleeping, to help stop the flow onto the streets, ensuring that the right resources reach the right people at the right time. For health, the report aims to improve access to health and social care services for people with multiple needs who are sleeping rough or in hostels (Action 5).
Tackling health inequalities: 10 years on <sup>56</sup>	Department of Health, May 2009	Homelessness legislation has been an important instrument in reducing the homeless population. Communities and Local Government (CLG) is working with the Department of Health to ensure improved access to health and social care services for people with multiple needs who are sleeping rough. As stipulated in the strategy <i>No One Left Out: Communities ending rough sleeping</i> .

## 10.2. Homelessness strategies

**Table 10.2:** Summary of key objectives of the homeless strategies in Cambridgeshire

Local Authority	Document	Period (years)	Summary of key objectives
Cambridge City Council	Homelessness Strategy 2009-12 Action Plan	2009-11	<p>Key themes:</p> <ol style="list-style-type: none"> <li>1. Temporary accommodation</li> <li>2. Homelessness prevention</li> <li>3. Access to longer-term housing options</li> <li>4. Sustaining settled lifestyles and tackling inequalities</li> </ol> <p>Cross-cutting themes:</p> <ol style="list-style-type: none"> <li>1. Service user involvement</li> <li>2. Equality of access to services</li> <li>3. Improving the quality of services</li> <li>4. Developing a Joint Strategic Needs Assessment (JSNA) process for homeless people and those at risk of becoming homeless</li> </ol>
	Homelessness Strategy	2003-08	<ol style="list-style-type: none"> <li>1. Improving the service offered to people presenting as homeless</li> <li>2. To reduce use of B&amp;B as temporary accommodation</li> <li>3. Investigate the current use of temporary accommodation</li> <li>4. To offer good quality permanent accommodation</li> <li>5. Homelessness prevention services</li> <li>6. Specific clients needs (rough sleepers, young people, ethnic minorities and asylum seekers, domestic violence, ex-offenders, families)</li> <li>7. Increase the involvement of homeless people in service provision</li> <li>8. To ensure that homelessness strategy continues to be closely linked with other relevant strategies and initiatives.</li> <li>9. Robust information and data management systems</li> </ol>
	Single Homeless and Rough Sleepers Strategy	2006-09	<ol style="list-style-type: none"> <li>1. Maintain target of reducing rough sleeping</li> <li>2. Improve rehabilitation outcomes for drug and alcohol users</li> <li>3. Improve the quality of single homeless and rough sleeping services</li> <li>4. Develop common assessment systems</li> <li>5. Increase user involvement</li> <li>6. Tackling anti social behaviour</li> <li>7. Implement effective homelessness prevention strategies</li> <li>8. Development of new services and meeting health needs</li> <li>9. Improve the status, confidence and skills base of single homeless population</li> </ol>
East Cambridgeshire District Council	Homelessness Strategy and Action Plan	2008-11	<ol style="list-style-type: none"> <li>1. Services for young people</li> <li>2. Services for vulnerable adults</li> <li>3. Liaison and joint working with other agencies</li> <li>4. Services for people fleeing violence, harassment and domestic violence</li> <li>5. Services for Gypsies and Travellers</li> <li>6. Consolutions with partners and stake holders</li> <li>7. Improving homelessness prevention services</li> <li>8. Temporary accommodation</li> <li>9. Developing choice based lettings system</li> <li>10. Increasing corporate and member commitment</li> <li>11. Administering homelessness more effectively</li> </ol>
	Homelessness Strategy	2003-08	<ol style="list-style-type: none"> <li>1. To prevent homelessness</li> <li>2. To ensure good quality, safe temporary accommodation is available in suitable locations for homeless people.</li> <li>3. Ensure homeless people whom the Council has a duty to housed in suitable permanent accommodation as quickly as possible.</li> <li>4. Assist homeless people who the Council does not have a statutory duty to house, to access housing that is suitable for their needs</li> <li>5. Ensure support and healthcare is available to homeless people when they need it</li> <li>6. To continuously improve the Council's homeless services, and to work in partnership with other organisations to implement, monitor and review this Strategy</li> </ol>



Table 10.2: continued.

Fenland District Council	Homelessness Strategy	2008-11	<ol style="list-style-type: none"> <li>1. Prevention of homelessness and housing options</li> <li>2. Temporary accommodation</li> <li>3. Research and monitoring</li> <li>4. Resources and training</li> <li>5. Reaching our customers</li> <li>6. Accessibility and standards</li> <li>7. Diversity</li> <li>8. Partnership working</li> <li>9. Consultation</li> </ol>
	Homelessness Strategy	2003-08	<ol style="list-style-type: none"> <li>1. Preventing homelessness</li> <li>2. Housing options: temporary and long-term</li> <li>3. The needs of specific priority need groups (households with children, young people, young lone parents, older people, people with mental health problems, minority ethnic groups, people fleeing violence, rough sleepers, refugees and asylum seekers, people leaving hospital, offenders, people using drugs and alcohol, people leaving armed forces)</li> <li>4. Services for people found to be intentionally homeless or not in priority need</li> </ol>
Huntingdonshire District Council	Homelessness Strategy	2003-08	<ol style="list-style-type: none"> <li>1. Increasing housing options; via private sector landlords; increasing self contained temporary accommodation</li> <li>2. Meeting the needs of specific groups: tenancy support and sustainment services; substance misuse clients, young people and equalities issues.</li> <li>3. People found to be intentionally homeless or not in priority need: single young people; prevention and intentionality protocol for families with children and involved with social services</li> </ol>
	Homelessness Strategy	2006-08	<ol style="list-style-type: none"> <li>1. Prevent homelessness by maintaining households in their current home whenever possible</li> <li>2. Providing a range of accessible and affordable housing options across all tenures</li> <li>3. Reduce the number of households in temporary accommodation by 50% by 2019 (baseline Dec 2004)</li> <li>4. Performance management, organisational efficiency and cross boundary collaboration</li> </ol>
South Cambridgeshire District Council	Homelessness Strategy	2008-13	<ol style="list-style-type: none"> <li>1. Preventing homelessness</li> <li>2. Ensuring that sufficient accommodation is and will be available for people who are or may become homeless</li> <li>3. Securing satisfactory provision of support for people who are of may become homeless or who have been homeless and need support to prevent them becoming homeless again</li> </ol>
	Homelessness Strategy	2003-08	<ol style="list-style-type: none"> <li>1. Homelessness prevention</li> <li>2. Improving existing services</li> <li>3. Provision of temporary accommodation</li> <li>4. Access to permanent accommodation</li> <li>5. The role of the private sector</li> </ol>

**10.3. Cambridge sub-regional homelessness action plan****Table 10.3:** Cambridge Sub-region homelessness action plan

Key Task	Milestone
Produce a professionals' guide for partners and stakeholders to reinforce the multi agency approach to homelessness prevention and raise awareness about support services available and the referral routes to these services.	Each LA to produce their own professionals guide
Introduce a Cambridgeshire-wide protocol between the Housing Authorities and the Office of Children and Young People to reinforce joint working on homelessness amongst young people and children	Joint protocol introduced for South Cambs and City, Hunts have separate OCYPS. East Cambs and Fenland to agree separate joint protocol
Identify Courts where there is no Court Desk provision for possession hearings and identify funding to ensure the provision of these services.	Each LA to ensure that possession Court hearings are covered by a Court Desk service
Introduce a sub regional vulnerable persons protocol between the housing authorities and the RSLs	Joint protocol to be introduced
Integrate homelessness prevention work into PSHE programme for all Cambridgeshire schools	Each LA to identify schools in own area and carry out prevention work
Identify initiatives to develop training and employment opportunities for households threatened with homelessness	Establish formal links with Job Centre Plus and implement actions from the Enhanced Housing Options programme
Reduce the number of households in temporary accommodation by 50% by April 2010 (from baseline figure of December 2004)	All LAs to achieve their own target
Implement a Cambridgeshire-wide supported lodgings scheme for vulnerable young people faced with the threat of homelessness	Identify models of good practice and funding opportunities to implement the scheme
Implement database system to monitor the levels of homelessness prevention and housing options work, and homelessness casework across the sub region	Agree format of database with Locata to provide a 'pathways' based system
Ensure the development of Cambridgeshire floating support services to ensure appropriate models of support for households faced with the threat of homelessness or actually homeless	Participate in the Supporting People review of floating support services and commission new services based on an agreed model
Review the Home-Link CBL scheme and implications on homelessness prevention, impact on households in temporary accommodation and residents moving on from supported housing	Each LA to participate in the Home-Link review and amend their individual Lettings Policies as required
Develop & agree good practice, benchmarking & quality assurance standards for the value for money exercise	Report to be produced for CSHG
Ensure links to other strategic groups so that homelessness issues across the sub region are fully represented. For example, Supporting People DIG, the Disability Housing Strategy group, Home-Link Operational group, etc	Sub regional Homelessness Strategy group to map other groups and ensure appropriate representation
Develop a Cambridgeshire-wide Joint Strategic Needs Assessment (JSNA) process for homeless people and those at risk of becoming homeless	Working group established by Dec 2008 JSNA developed by end of March 2009

Source: From Cambridge Sub-Region Homelessness Group. Note the Cambridge Sub Region includes Forest Heath and St Edmundsbury districts in Suffolk.

#### 10.4. Summary of key data sources and their limitations

**Table 10.4:** Limitations of data sources

Data source/ Theme	Description	Potential gaps & limitations
Statutorily homeless (P1E statistics)	Summary data on local authorities decisions on homelessness applications and the key characteristics of households found to be statutorily homeless are collected quarterly. The quarterly statistics are National Statistics, which mean they are produced in accordance with the Code of Practice and its protocols.	Data does not capture all the needs of the homeless - only the primary reason for homelessness is recorded. The P1E returns do not include non-statutory homeless, hidden homeless (sofa surfers) and houses with multiple occupancy.
Supporting people client record database	Supporting People (SP) Client Record forms provide information on housing-related support services: client characteristics, economic status, ethnicity, client group, source of referral and previous tenure are just some of the variables collected and analysed. Quarterly data sets are distributed to CLG and Administering Authorities.	Double counting is a huge limitation since a new record is completed every time a client accesses services providers. No unique identifiers, data provides access to service counts.
Supporting People National Outcomes Framework	The outcomes framework provides information on the types of support required by each client, whether the desired outcome had been achieved at the time of departure from the service and, in case an outcome had not been achieved, why this had been the case.	Although the form should be completed with the client, this may not always be possible if the client moves in an unplanned way or abandons the service. As with the client record forms, a new form is completed each time a user leaves a service although he may have accessed the same service on numerous occasions.
Cambridge City homelessness database	In addition to the P1E, SP client record form, Cambridge City collect data routinely on needs, engagement with services. The street outreach team collects additional data on reconnections policy. Cambridge City also have data on consultations of their homelessness strategy and review.	Until the 2008/9 year, P1E data was not collecting data on homeless prevention routinely. Data on acceptance has limitation in that the number of people presenting as homeless is unknown.
Cambridge Access Surgery	Cambridge Access Surgery is a specialised GP service offering healthcare to homeless people.	It is not possible to directly link health outcomes data to other homelessness services databases.
NHS Cambridgeshire Secondary Care data	Data from outpatient attendance, accident & emergency, and hospital admissions data will be extracted for people who have no fixed abode, and patients of CAS.	It is not possible to directly link health outcomes data to homelessness services databases.
The National Drug Treatment Monitoring System (NDTMS)	Cambridgeshire DAAT uses drug and alcohol treatment data for commissioning services. All services that provide structured treatment for drug and/or alcohol users are asked to submit data to The National Drug Treatment Monitoring System (NDTMS). This information is analysed by the National Drug Evidence Centre to produce the figures published via this web portal.	Data on accommodation are incomplete with over 50% of the records missing data.
Ex-offenders and homelessness	An issues paper on 'Homelessness among ex-prisoners; reducing the rate of homelessness to reduce re-offending'.	Data are limited at the moment.
Home repossessions data	There is a need to set-up a surveillance system to monitor people at risk of homelessness and respond to potential effects the 'credit crunch' on homelessness. At present, Cambridgeshire County Council research compiles the Strategic Housing Market Assessment. Data on home repossessions is published by the criminal justice system.	Data on house repossessions can only be aggregated by the courts where the hearing was made. Therefore it is no possible to get repossession statistics specific to Cambridgeshire.

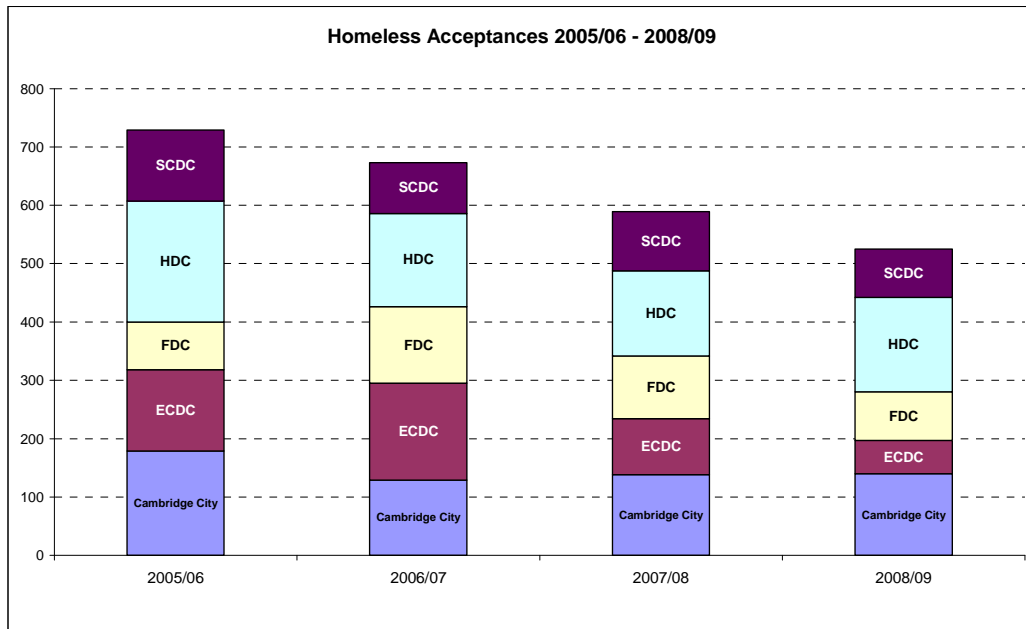
## 11. Appendix 3: P1E District Council Statutory Homelessness

Each local authority records data on the instances of homelessness it becomes aware of in its own area. These data record the reason for homelessness, information about the households size and type, the priority need the household may have as defined in legislation, and the outcome of the local authorities investigations into whether it accepts a full housing duty to help that household. These data are collated and submitted to central government on a quarterly basis (P1E returns).

Figure 11.1 below shows the overall downward trend of homelessness acceptances across the county, broken down by each local authority. The data show that since 2005/06 there has been a steady decrease in the number of households that the Cambridgeshire local authorities have accepted as homeless (a 28% decrease from 729 households accepted in 2005/06 to 525 households accepted in 2008/09). This has primarily been as a result of the successful homelessness prevention measures and alternative housing options that have been put in place over this period of time, meaning that households have been able to remain in their own accommodation or assisted to find alternative housing and so avoided homelessness altogether.

In 2008/09 the P1E returns included for the first time the number of cases where households were helped to avoid homelessness through advice, assistance or action taken by the local authority. The section was included during the first quarter of the year and so is not complete data where some local authorities did not have systems in place to monitor this information from April 2008. However, from the instances that were recorded, there were 695 cases where households were helped to avoid homelessness. Although data is not fully recorded on this at this stage a significant proportion of these were helped to find housing in the private rented sector through local authority Rent Deposit schemes. Changes to the Housing Benefit Local Housing Allowance scheme in the coming year may, however, significantly reduce the number of households that local authorities help into private sector tenancies, where they are reliant on Housing Benefit to help them pay the rent. If this is the case and there are no other alternatives for these households then becoming homeless may be their only option, with the local authorities then considering what help they may provide under the safety net of the homelessness legislation.

Despite the decrease in homelessness in the county over the last four years, if trends follow historic patterns, the current economic climate is likely to lead to an increase in homelessness as households struggle to keep their current home or find alternative housing due to factors such as unemployment, reduced working hours and tighter restrictions on mortgage lending. Huntingdonshire District actually saw an increase in homelessness in 2008/09 as the impact of the recession began to be felt with the other local authorities likely to experience similar trends in 2009/10.

**Figure 11.1:** All homeless 'Acceptances' by Cambridgeshire Districts 2005/06 – 2008/09

Source: P1E data collated by District Councils

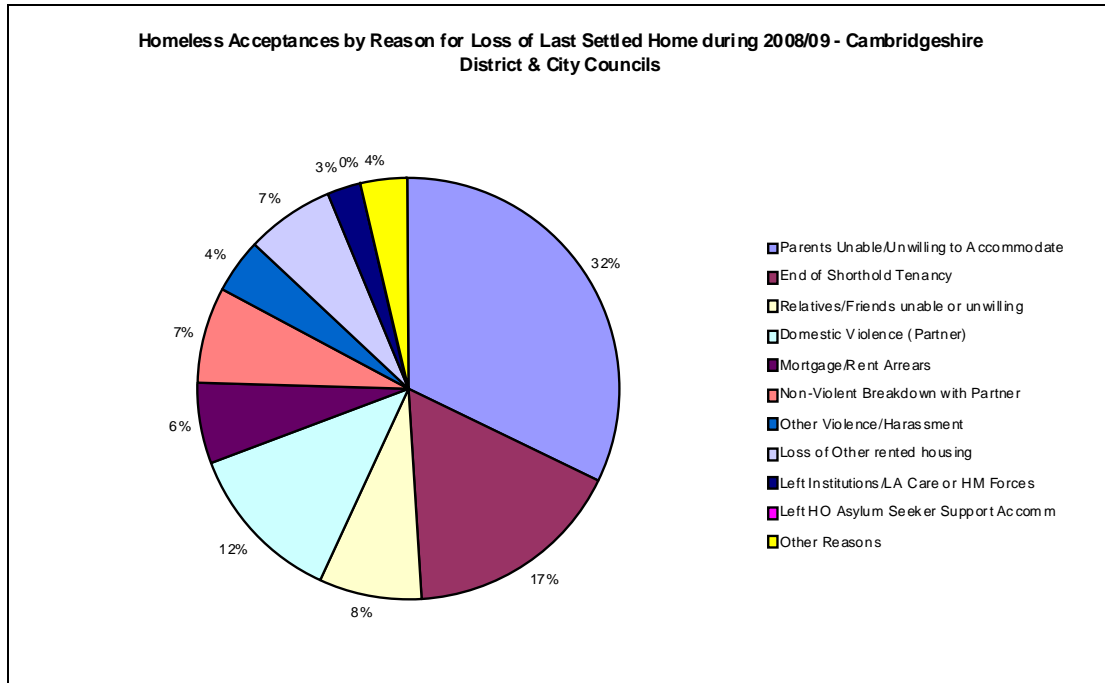
### Reasons for Homelessness

The figure 11.2 shows the break down of the reasons for homelessness across the Cambridgeshire local authorities. Homelessness, as recorded in the P1E returns, shows that 40% of all homelessness in Cambridgeshire in 2008/09 was as a result of parents, other relatives or friends no longer being willing or able to provide housing. A similar picture is seen across England and Wales with this being the single largest reason for homelessness. Homelessness arises where relationships break down with parents, other relatives or friends which may be caused because of family disputes or simply because of things like overcrowding. This does not include homelessness as a result of a relationship breakdown between partners.

Where a relationship has broken down, homelessness can arise as a result of one or both of the couple being unable to resolve their housing difficulties following the split. In 2008/09 7% of all households (40) accepted as homeless were as a result of a non-violent relationship breakdown. However, 12% (67 households) was as a result of a violent relationship breakdown.

The second largest cause of homelessness in 2008/09 was due to households losing their private rented tenancies, through no fault of their own, and being unable to find alternative housing. This was the situation with 90 households (17% of all acceptances).

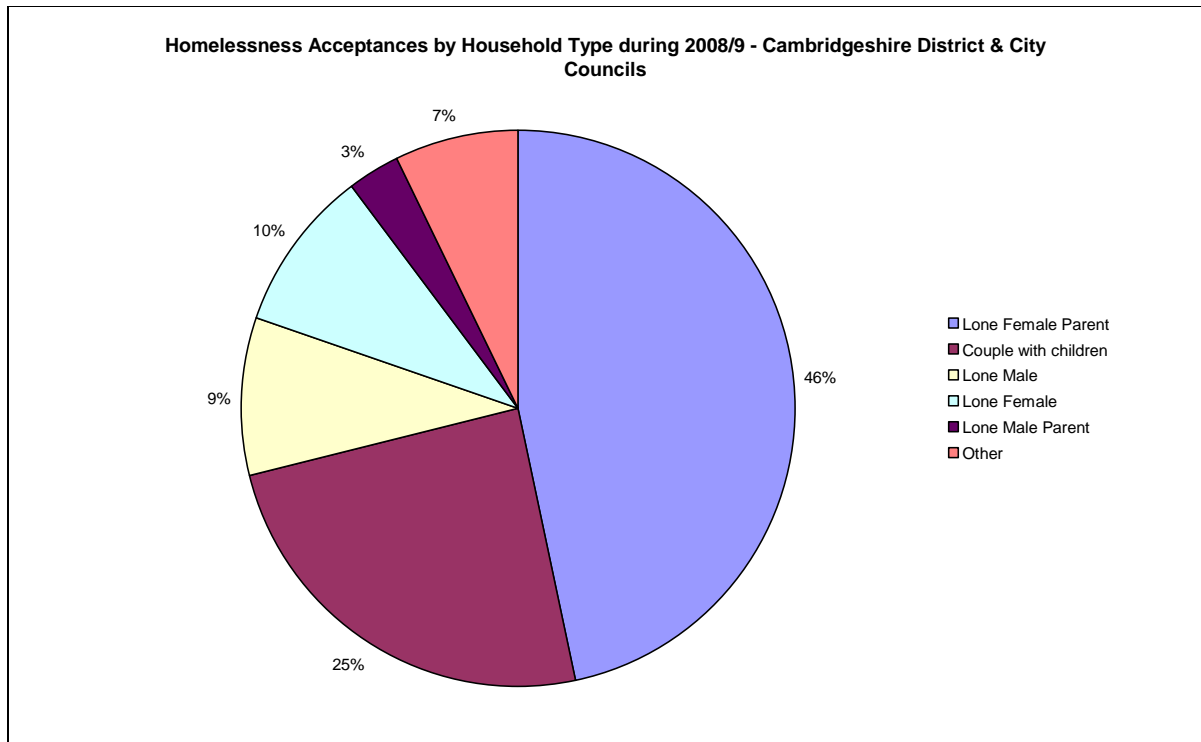
**Figure 11.2:** Reasons for homelessness, Cambridgeshire, 2008/09



Source: P1E collated by District Councils

### Household types accepted as homeless

As previously explained, households with children have a defined ‘priority need’ for housing if threatened with homelessness. It is therefore not surprising that 74% of households accepted as homeless by the Cambridgeshire authorities in 2008/09 had a dependant child as part of the household. Of these 46% (253 households) were lone female parents and 25% (133 households) were couples with children. The remaining 3% were lone male parent households. Ten percent (10%) of households (52) were lone females, a proportion of which may have also been pregnant with their first child, whereas 9% (49 households) were lone males. Figure 11.3 shows the break down of household types accepted as homeless by the Cambridgeshire authorities in 2008/09.

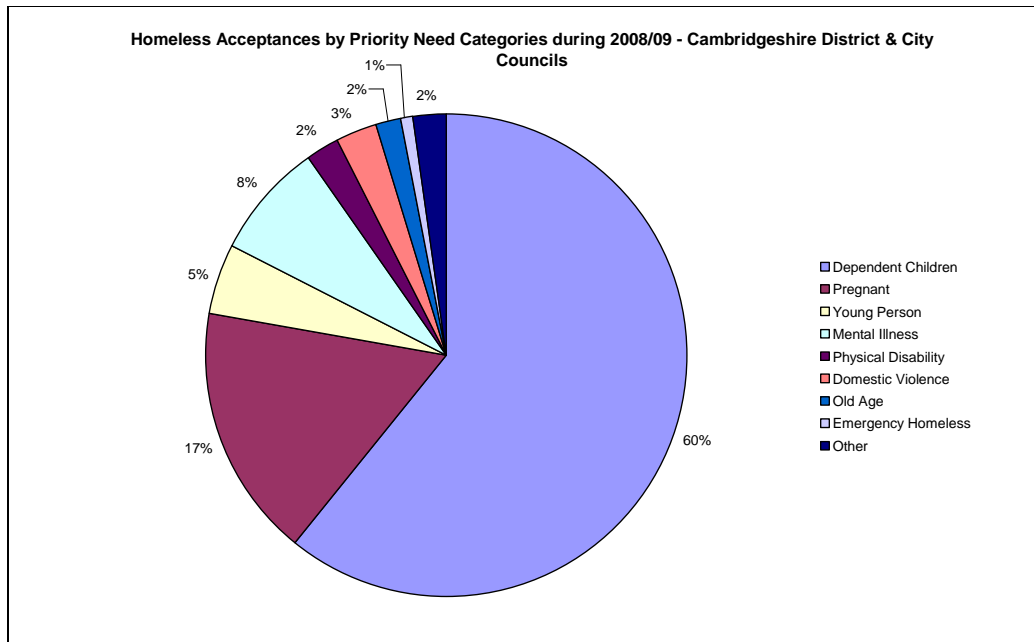
**Figure 11.3:** Homelessness Acceptances by Household Type, 2008/09

Source: P1E collated by District Councils

### Reason for priority need of households

Each local authority must record the primary reason why a household accepted as homeless has a defined 'priority need' for housing. Households may have more than one defined priority need but as only one must be proven local authorities tend to record the most obvious of these. Therefore, where a household contains a child this is more likely to be recorded compared to, for example, some form of medical vulnerability. The following statistics are based on what each local authority has recorded as the households primary priority need.

Figure 11.4 shows the break down of households by priority need type and accepted as homeless by the Cambridgeshire authorities in 2008/09. 60% (328 households) accepted as homeless in 2008/09 had a priority need because they contained a dependant child. 17% (92) had a pregnant woman expecting her first child. Mental illness was recorded as the single largest vulnerability with 8% of households (42) having this recorded as an issue.

**Figure 11.4:** Homelessness Acceptances by Household Type, 2008/09

Source: P1E returns collated by District Councils

### Age ranges of households accepted as homeless

The age of the head of the household accepted as homeless is recorded by local authorities and as may be expected, younger households struggling to make their first steps onto the property ladder see significantly higher instances of homelessness. In 2008/09 237 of the 525 household heads (45%) were aged from 16 to 24 years of age. 262 households (50%) were aged from 25 to 44 years. The most challenging age group to assist with housing tends to be 16 and 17 year olds. In 2008/09, 25 16 to 17 year olds were accepted as homeless almost 5% of all acceptances. Options are being considered across the county to consider how alternative options can be put in place for this age group so that homelessness can be avoided altogether or, where it cannot, they are provided with the best chance of developing the necessary skills to be able to live independently.

Homelessness amongst older households does occur and 16 households (3%) were aged 60 years or over. However, with older households, housing options offered by the local authorities, such as elderly persons designated housing, tends to be more readily available and so where homelessness is threatened it can be more easily avoided by offering this type of accommodation.



## **12. Appendix 4: Supporting people Cambridgeshire client record data**

### ***12.1. Introduction***

The Supporting People programme funds housing related support services for vulnerable people. These services support people to access appropriate accommodation or maintain their current accommodation. The programme funds services for a range of client groups, including homeless hostels, temporary accommodation, street outreach and supported accommodation for vulnerable groups such as teenage parents or offenders.

### ***12.2. Methods***

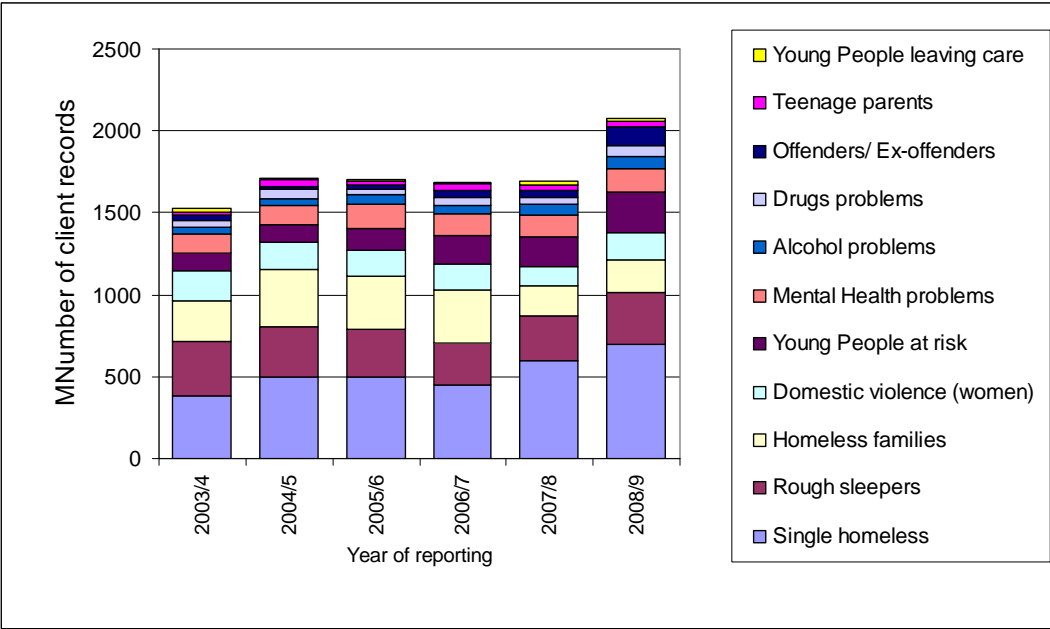
Supporting People providers are required to complete and submit a Client record form for each person entering their services. These forms gather information on age, ethnicity, gender, primary and secondary client group and so forth. It should be noted that while individuals might fall into more than one client group, e.g. primary client group rough sleeper, secondary client group offender, this report only looks at the information based on primary client groups. Individuals are therefore not counted twice, but some detail does get lost on the needs, depending on how individuals were categorised when entering the services. Individuals might access one or more services several times within a year, e.g. stay with a service for three months, then leave and come back six months later. In this case, a new client record form would have been completed and it is not possible to match individuals against several forms and to trace people who access services more than once. Therefore the number of those accessing a service in a year may be bigger than the number of actual individuals in that client group.

This section provides information on the clients who have accessed supporting people services between April 2003 and March 2009 and trends, by focusing on the different client groups relevant to the Homelessness JSNA, male: female ratios, ethnicity and other relevant factors.

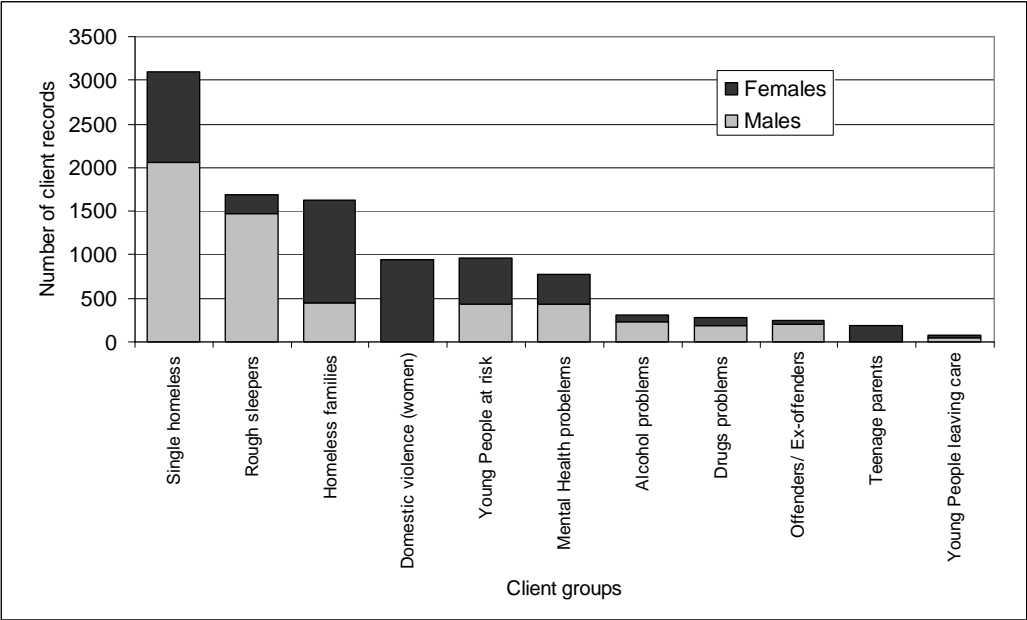
### ***12.3. Results***

Between April 2003 and March 2009, a total of 8,865 clients were recorded at SP funded services for the homeless in Cambridgeshire. Figure 12.1 shows the number of clients by client group and year of reporting. Overall, the number of clients has remained stable throughout the reporting period with an average of 1,700 clients in each financial year. For each year, single homeless and rough sleepers comprised the biggest proportion of client-group accessing SP funded services. Overall, 46% of clients were reported to be single homeless or rough sleepers and 53% of all clients were male (Figure 12.2). Overall, 90.5% of clients were aged 16-49 years and only 0.3% were aged above 65 years (Figure 12.3). A substantial proportion of the clients were of white ethnicity (93.8%) (Figure 12.4).

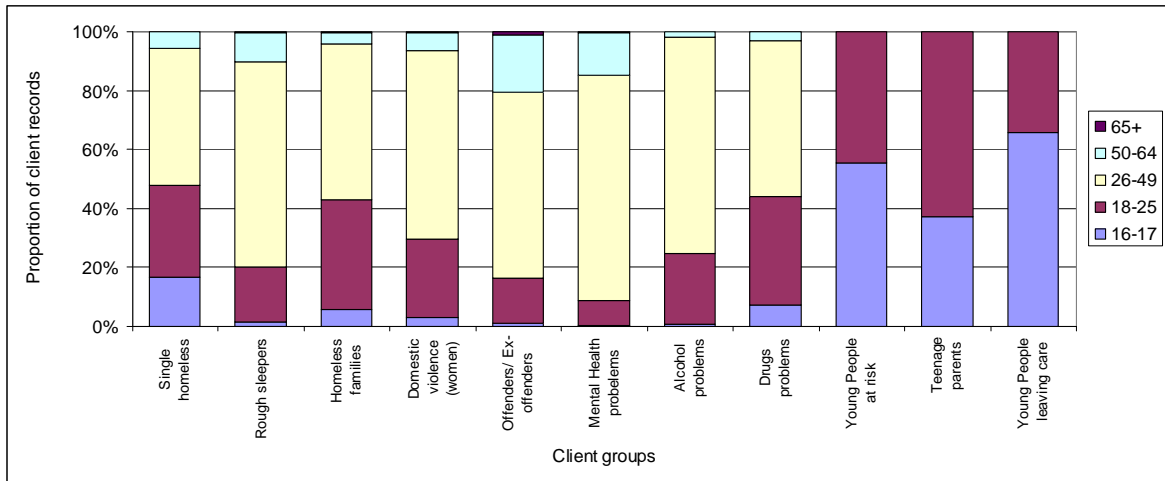
**Figure 12.1** Number of clients accessing SP funded services by year of reporting and client group



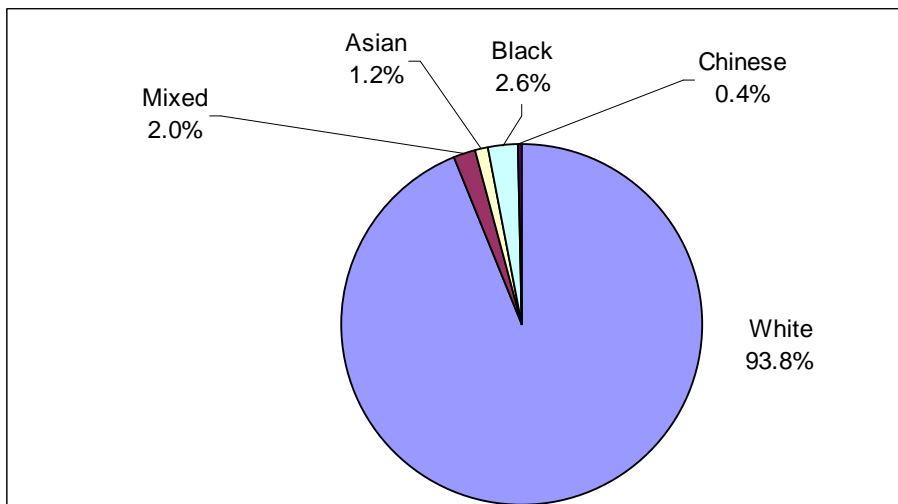
**Figure 12.2** Number of clients accessing SP funded services client group and gender



**Figure 12.3** Age distribution of clients accessing SP funded services by client group



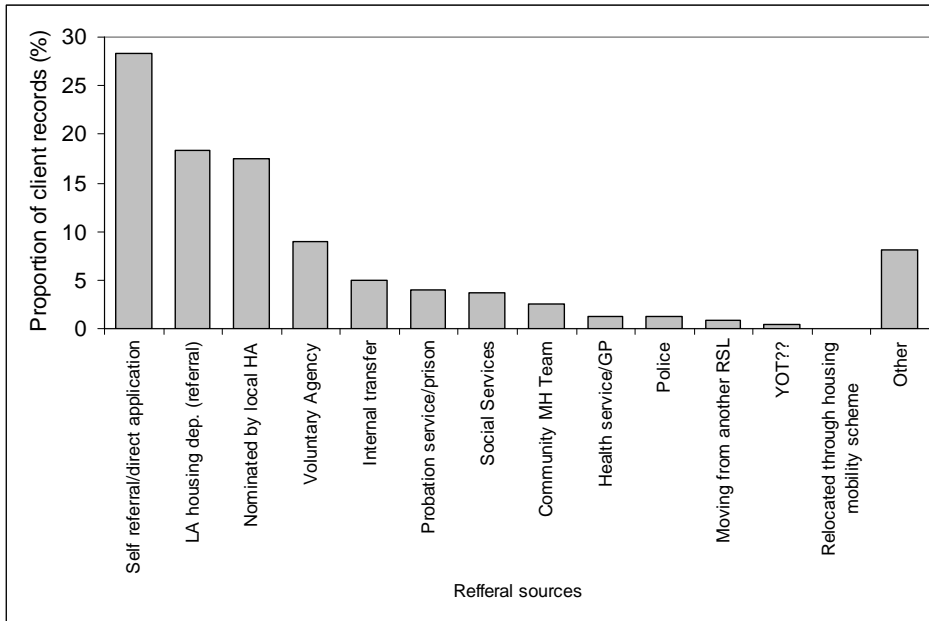
**Figure 12.4** Distribution of clients accessing SP funded services by ethnicity



**Referral of clients to services**

Figure 12.5 shows the modes of referral of homeless people to SP funded services. The top three sources of referral include: self (28.3%); local authority housing department (18.3%); and local housing association (17.4%).

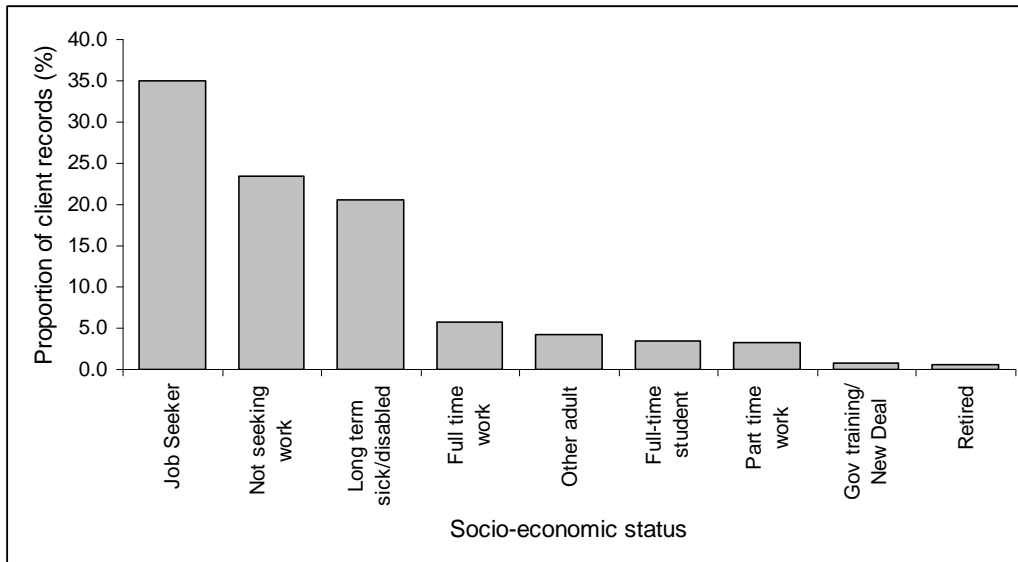
**Figure 12.5** Sources of referral of homeless people to SP funded services



**Socio-economic status of clients**

Figure 12.6 shows the distribution of socio-economic status (SES) of homeless people before accessing SP funded services. Overall, 35.1% were job seekers, 23.4% were not looking for work and 20.6% were long term sick/disabled

**Figure 12.6:** Socio-economic status of clients before joining SP funded services



**Client Group Data**

**Single Homeless / Rough Sleepers**

The Supporting People Programme defines single homeless people as those who have been accepted as homeless and in priority need and also those who have been turned

down for re-housing or have not approached the local authority and have a range of support needs.

Single homeless people form the largest client group, making up about 25% of all new clients. SP data shows that the male to female ratio has changed from nearly 2.5 to 1 in 2003/04 to 2 to 1 in 2008/09. The majority of people are age 26 to 49. About 15% of clients are age 16 to 17 and around 30% are age 18 to 25. 5 to 7% are 50 to 64 and a very small number are over 65. About 89% of all clients are white British. The lowest presentation comes from Asian groups (Indian, Pakistani, Bangladeshi and other Asian background) and the Chinese community who is not represented at all.

When the SP programme started in 2003, a large proportion of referrals for this client group came from the Local Authority (LA) Housing Departments (24%), followed by Housing Authority (HA) nominations and voluntary agency referrals (14% each). In 2008/09 this picture has changed with a large proportion of self-referrals (29%), followed by referrals from Voluntary Agencies (24%) and Local Authority Housing Department referrals only 10%. Very few referrals come from Health Services, the YOT or the police (1% or less each year).

In terms of previous tenure, an increasing proportion of clients have been rough sleeping (between 14 and 16% 2003-2008, but with a sharp increase to 23% in 2008/09), followed by people who previously stayed with family (18% in 2003/04, reduced to 15% by 2008/09) and friends (about 13%).

About 50% of single homeless people are job seekers. The second largest group are the long-term sick or disabled. This group increased from 16% in 2003/04 to 28% in 2008/09. About 5% of single homeless are in full-time and about 3% in part timework.

The Supporting People programme defines a rough sleeper as someone who is bedded down for the night on the street or sleeping out or sleeping in buildings or other places not designed for habitation, for example stations, car park and sheds.

Data collected from Support People client records shows that the proportion of rough sleepers has slightly reduced from 19% in 2003/04 to 13% in 2008/09. Over 80% of rough sleepers are male. The majority of clients are age 26 to 49 with small numbers below 18 and over 65. The vast majority of rough sleepers (87% plus) are white British, with white Irish and white other making up another 2 to 4% each. There is hardly any representation from other groups, especially Asian and Chinese.

The vast majority of referrals (80% plus) are self-referrals or direct applications. This percentage has increased in the last 2 years to 92% in 2008/09. In 2003/04 there was a substantial percentage of referrals from voluntary agencies (11%), but this has decreased sharply to 1% in 08/09. Hardly any referrals come from the Community Mental Health Team, Health services, the YPT and the Police.

Between 69% (2003/04) and 61% (2008/09) of clients had been sleeping rough prior to accessing the service. Direct access hostel was the second most common previous accommodation between 2003/04 and 2005/06 (between 8 and 15%), however it since went down to only 3% in 2008/09. The third most common previous accommodation is staying with friends, fluctuating between 5 and 17% throughout. In 2004/05 a substantial proportion (10%) had been private sector tenants.

A large part of rough sleepers are job seekers (44 to 54%). The second largest group are long term sick or disabled (24 to 37%), with a slight increase in the last year. The

proportion of those not seeking work has gone down considerably from 17% in 2003/04 to 3% in 2008/09. There are few people in full time or part time work.

### **Older People**

The Supporting People client record and outcomes data for older people accessing homeless hostels and other short term accommodation is included in the other client groups listed here, such as single homeless and people with alcohol problems.

### **Ex Offenders**

The Supporting People programme defines offenders or people at risk of offending as people who either have offended or are at risk of offending and who are homeless or who are having difficulty in relation to sustaining their accommodation or managing to live independently.

SP client record data shows that the proportion of offenders has increased in 08/09 from 2% to 5%. The majority of clients are male with very few clients below 18 or 50 plus and there are fluctuations between the other age groups. Over 87% are white British and again there are no clients from Asian or Chinese background in this client group and only few clients of black/black British ethnic origin. An increasing number of people do not complete this section.

The majority of referrals come from the probation service. Whilst the percentage has gone down from 64% in 2003/04 to 43% in 2008/09, the total number of referrals has not gone down. However there has been a sudden increase of referrals from the police from 0% in the first 5 years to 32% (37 referrals) in 2008/09. Self-referrals have also increased in 2008/09.

The majority of people lived in prison prior to entering a service, however in recent years the proportion (and numbers) of those staying with family has increased. For the first time in 2008/09, there was 1 owner-occupier and 1 person living in a caravan among the clients.

More than half of this client group are job seekers. There has been a slight increase in people who are long term sick or disabled in 2008/09 and there has also been an increase in people not seeking work.

### **Homeless families**

The Supporting People programme defines homeless families as families who have been accepted as statutorily homeless and are placed in temporary accommodation. This group includes homeless single parents with dependent children.

SP client record data shows that the percentage of homeless families among all clients has gone down by half from 18% in 2004/05 to 8% in 2008/09. The percentage of homeless families headed by males has reduced from 36% in 2003/04 to 17% in 2008/09. This might indicate that more homeless families are made up of single mothers with children rather than 2 parents.

The proportion of 18 to 25 year olds has increased from 36% in 03/04 to 47% in 08/09. The proportion of 16 to 17 year olds has halved in the same time (from 6 to 3%). About 84% of homeless families are white British, followed by around 7% white: other. All

other ethnicities make up only 2% or less, with Chinese and Indians being the smallest groups.

The largest number of referrals made comes through Housing Authority nominations (up to 76% in 2008/09). Local Authority Housing Department referrals have dropped from 22% in 2003/04 and 40% in 2005/06 to only 12% in 2008/09. Again, very few referrals come from the Health service and the YOT and none from the police and the Community Mental Health Team.

In terms of previous accommodation, use of B&B has increased from 15% in 2003/04 to 41% in 2008/09. Between 20 and 30% of homeless families previously lived with family and between 10 and 20% were private sector tenants. For the first time there were 3 homeless families who had previously been owner-occupiers in 2008/09. A large group of homeless families are not seeking work (33% in 2003/04 and 44% in 2008/09). Interestingly, however, the second largest group are those in full-time work (between 15 and 23%). A slightly smaller group are jobseekers.

### **Young People at Risk, Young People leaving care, Teenage Parents**

#### ***Young people at risk***

The Supporting People programme defines young people at risk as people aged 16 to 25 who are homeless or in insecure accommodation, and those who are unable to take care of themselves or to protect themselves from harm or exploitation who are having difficulty in relation to sustaining their accommodation or managing to live independently.

SP client record data shows this client group make up 6% to 10% of clients, with a slight increase in the last 3 years. There are slightly more females than males in this group. The proportion of people age 16-17 has reduced from 60% to 43% with an increase among the 18-25 year olds. The proportion of white British lies between 87% and 95%. There are small numbers of clients from all other ethnic backgrounds present as well, between 1 and 2%.

Nominations by local housing authorities have reduced from 27% to 6% while referrals from local authority housing departments have remained roughly stable at just above 20% and increase to 35% in 2008/09. Referrals from social services have also gone down from 26% to 8%. However self-referrals and referrals from voluntary agencies are on the up (from 12% to 16% and from 1% to 6% respectively).

Around a third of people have lived with family prior to entering a service. The second largest group lives with friends (15% to 25%). The percentage that has been rough sleeping is increasing from 3% in 2003/04 to 9% in 2008/09. Around half of clients in this group are job seekers. The second largest group are students (12% to 20%).

Young people at risk is the third largest CCC client group (5%). The overwhelming reason for homelessness self reported by the group was dispute with parents being reported by 66%, this was followed by eviction (10%).

#### ***Young people leaving care***

The Supporting People programme defines young people leaving care as young people leaving Local Authority care who have been looked after for a continuous period

of at least 13 weeks after the age of 14 who are having difficulty in relation to sustaining their accommodation or managing to live independently.

SP client record data shows this is a small group making up between 0.5% and 1% of clients. There are slightly more males than females in this group. Up to 06/07 the majority of clients were age 16 to 17, but this has now changed to 78% being age 18 to 25 in 08/09. The majority of young people in this group are white British. People from Irish, white mixed, Indian, Pakistani, Bangladeshi, Black/Black British and Chinese ethnic backgrounds are not represented.

More than half of referrals come from social services with 10% to 30% of referrals coming from Housing authority nominations. No referrals from the Community Mental Health Team, Voluntary agencies, health services or the police.

Between 30% and 50% of clients have previously lived in foster care or a children's home, except for 2006/07, when 55% of clients had previously lived with family. Around a third and more of people in this group are job seekers with another 20% of full-time students. Since 2004/05 the number of those in paid work has reduced to 0 in most years.

### **Teenage parents**

The Supporting People programme defines Teenage Parents as young single parents aged less than 20 needing support and vulnerable young women in this age group who are pregnant who are having difficulty in relation to sustaining their accommodation or managing to live independently.

SP client record data shows that the proportion of this group has increased slightly from 1% to 2% over the years. Nearly all clients are female. The proportion of 16 to 17 year olds has reduced from 50% to 40% with a simultaneous increase of those aged 18 to 25. Around 90% plus of clients are white British, however this years figures have seen a reduction to 86%.

Nominations from Housing Authority have increased from 20% to 34% in 2008/09, while referrals from local authority housing departments have gone down from 45% to 6% in 2008/09. The percentage of referrals that could not be classified has increased to make up 20% of referrals in 2008/09. The health services and social services made a few referrals for this client groups, but the YOT or the police did not.

A large proportion of teenage parents lived with their family prior to accessing a service. This fluctuates between 30% and 60%. The proportion of those previously staying in supported housing has increased to 29% in 2008/09 from 11% in 04/05 and 6% in 07/08. No teenage parents were staying in direct access hostels in the last 2 years and the percentage of those staying in other temporary accommodation is reducing.

The vast majority of teenage parents are not seeking work (72% to 85%). Between 10% and 16% are job seekers and a smaller amount is in full or part time work or studying.

### **People with disabilities, physical, learning**

The SP client record and outcomes data for people with disabilities accessing homeless hostels and short term accommodation is included in the data for the other client groups listed here.



## **Travellers**

The Supporting people programme defines travellers as a person with a cultural tradition of nomadism or of living in a caravan and all other persons of a nomadic habit of life, whatever their race or origin, including such persons who, on grounds only of their own or their family's or dependents' educational or health needs or old age, have ceased to travel temporarily or permanently and members of an organized group of traveling show people or circus people (whether traveling together or not).

The SP client record and outcomes data for travellers accessing homeless hostels and short-term accommodation is included in the data for the other client groups listed here.

## **Migrants/Refugees and Asylum Seekers**

The Supporting People programme defines refugees as people who have been officially accepted as refugees, or who have been given indefinite or exceptional leave to remain who are having difficulty in relation to sustaining their accommodation or managing to live independently. As with the travelers, client record and outcomes data for migrants/refugees and asylum seekers accessing homeless hostels and short-term accommodation is included in the data for the other client groups listed here.

## **Other groups**

Supporting People have also collected separate data on people with drug problems, people with alcohol problems and people with mental health problems and domestic violence.

### ***People with drug problems***

The Supporting People Programme defines people with drug problems as people with drug problems who are homeless or who are having difficulty in relation to sustaining their accommodation or managing to live independently as a result of their drug problems.

SP client record data shows that this group consistently made up 2% - 3% of SP clients each year. The gap between male and female clients has gradually widened with 88% of clients being male in 2008/09 as opposed to 63% in 2003/04. The proportion of 18 to 25 years olds dropped between 05/06 and 06/07 from 36% to 18%. There are very few clients below 18 or over 50. Over 90% of clients are from a white British background. There is no representation at all from Chinese or Asian people.

A large proportion of referrals for this client group are self-referrals (between 30% and 56%). The proportion of Local Authority nominations has reduced from 12% in 2003/04 to 3% in 2008/09. Equally, referrals from Local Authority housing departments have reduced from 19% in 2003/04 to 4% in 2008/09. Probation services referrals have consistently made up about 12% of referrals and there was an increase of internal transfers between 2003/03 and 2007/08 (7% to 17%), with a sharp drop to 1% in 2008/09. Again, there are few referrals from the health services, the YOT, the police, the Community Mental Health team and Social Services.

A large proportion of clients were rough sleeping prior to accessing the service (up to 33% in 2005/06, 19% in 2008/09). LA general needs has reduced from 24% in 2003/04 to 3% in 2008/09, while HA general needs has seen slight increases from 2% to 10%. A substantial amount of clients have also lived with friends or family.

The largest proportion of clients is long term sick or disabled (between 30 and 50%), with another 38% to 23% jobseekers. This proportion has reduced over the years. Very few people are in either full or part time work.

***People with alcohol problems***

The Supporting People Programme defines people with alcohol problems as people with alcohol problems who are homeless or who are having difficulty in relation to sustaining their accommodation or managing to live independently as a result of their alcohol problems.

SP client record data shows that this group has doubled both in percentage and numbers from 2% or 35 clients in 2003/04 to 3% or 80 clients in 2008/09. The male female split is similar to that among drug users, with an increase in men accessing services (67% in 2003/04 and 75% in 2008/09). Hardly any clients were below 18 or over 65 with a fluctuating proportion age 18 to 25 (3% to 11%). The proportion of people age 50 to 64 has more than halved between 04/05 (18%) and 08/09 (8%). Again, the vast majority of people in this client group are white British (85 to 100%). Whilst the proportion of white British people has reduced in recent years, this seems mainly due to refusal to give this information rather than actual increase in other groups.

The majority of referrals are self-referrals and the proportion has fluctuated over the years but reached a peak in 2008/09 with 76% (from 23% in 2003/04). Referrals from voluntary agencies and Local authority housing departments have reduced from 23% in 03/04 to 3% in 08/09 and 14% (03/04) to 3% (08/09) respectively. Referrals from the Health services are slightly higher in this client group (up to 6%), but only very few referrals come from the Community Mental Health team, the police and the YOT.

A large group of clients were rough sleeping prior to accessing a service, although this proportion fluctuates between 14% in 03/04 and 35% in 08/09. The proportion of people who previously lived in a direct access hostel or in private rented accommodation has reduced from 14% to 1% and from 22% to 4% respectively. For the first time in 2008/09 clients entered services who previously lived in a caravan or were homeowners.

The majority of people in this client group are long-term sick/disabled (between 30% and 54%). The second largest group are job seekers (22 to 41%). A very small number are in either full or part time work. A substantial amount of information is missing from the forms submitted in 2007/08, as people refused to give the information, which will affect these figures.

***People with mental health problems***

The Supporting People Programme defines people with mental health problems as people who fall into any of the following categories:

- people with enduring but relatively low level mental health problems that interfere with their ability to cope or function on a day to day basis,
- people whose behaviour is a concern for their own safety or that of others,
- people at risk of suicide or depression or complete loss of everyday reality,
- people who have been diagnosed as mentally ill and who have had, or are having, specialist treatment.

SP client record data shows this group make up about 7% of clients with 50% - 65% males. There have been no 16 to 17 year olds in this client group since 06/07. There are few people age over 65 and a larger proportion of 50-64 year olds (around 20%) than 18-25 year olds (around 15%). In the last 2 years, 9% and 8% of clients did not give this information. The proportion of white British clients is 88% to 91% with a dip to 83% in 07/08. However in that year a larger than usual number of clients did not give this information, which affected the figures. The largest part of the remaining clients is white Irish or white other. Nearly all other ethnicities are represented, albeit in very small numbers.

The largest number of referrals are made by the Community Mental Health Team (between 12% and 37%). Referrals from the local authority-housing department have reduced from 22% in 03/04 to 8% in 08/09. Self-referrals are the second largest group (between 11% and 19%). A substantial amount of referrals in 07/08 came from the health services (17%). Up to 29% of clients previously lived in LA general needs housing. Clients who had previously lived in Housing Association general needs housing increased from 7% in 03/04 to 20% in 08/09. Clients who previously lived in supported accommodation went down from 17% to 10% and those who stayed in hospital went down from 14% to 9%. However there has been an increase of people previously living in private rented accommodation from 4% in 03/04 to 10% in 08/09. The majority of clients are long-term sick/disabled (56% to 72%). The second largest group are not seeking work (10% to 17%). A small number are working either full or part time (together between 3% and 6%). It should be noted that a lot of the clients in this group live in long-term supported housing.

### ***Domestic violence***

The Supporting People Programme defines people at risk of domestic violence as people who are experiencing, or are at risk of experiencing, domestic violence and who have left their home, or who are having difficulties in maintaining their home or their personal safety and security.

SP client record data shows that there has been a drop in clients from this group both from 11% in 03/04 to 6% in 08/09. All are female. About a quarter are age 18 to 25 and 4% or so 16 to 17. 50 to 64 year olds make up to 10%. The percentage of White British is slightly lower than in other client groups with 79% to 86%. There is a larger percentage of other white people (between 4% and 8%) as well as women from a Pakistani, Bangladeshi, and Indian background. However no Chinese people are represented.

Between 20% and 30% are self-referrals and about 10% are police – however with a drop to 3% in 08/09. There is also a substantial number of referrals from the voluntary sector (11% to 31%). Few referrals from the health services and from the Community Mental Health team. Around 20% were LA general needs tenants and between 10% and 20% HA general needs tenants. Slightly fewer are private sector tenant. Clients from supported housing have gone down as well as those in other temporary accommodation. Between 10% and 28% lived with family. For the first time in 2008/09 there are clients who previously were owner-occupiers. Between 66% and 79% are not seeking work. 7% to 13% are long term sick or disabled.

## **13. Appendix 5: Supporting People Cambridgeshire client outcome forms data**

### ***13.1. Methods***

Since April 2008, all Supporting People funded services in Cambridgeshire are required to complete outcomes forms for service users once they have left the service. This is to show what the client has achieved during their time with the service and where something that was planned has not been achieved, why this was the case. The Outcomes Framework is divided into 5 areas: economic wellbeing; enjoy and achieve; be healthy; stay safe; and make a positive contribution.

In each section there are a number of areas a client might require support in. Firstly the support worker, when completing the form, indicates which areas the client required support in. For example, the forms returned for 163 single homeless people indicated that they needed support to maximise their income, e.g. by applying for the appropriate benefits. The form then asks whether an outcome, if it was required, has actually been achieved. In this case, 152 of the 163 single homeless people who required this support successfully achieved this outcome, i.e. maximised their income. For those that did not achieve the desired outcome, the support worker chooses from a list of options the reason as to why the outcome had not been achieved.

### ***13.2. Results***

Table 13.1 summarises the needs of clients based on the outcome framework of clients accessing SP short-term support services. Between April 2008 and March 2009, 1,851 clients leaving short-term support services had their outcomes assessed.

**Table 13.1:** Needs of clients leaving SP funded short term support services for homeless (2008/09)

Outcomes	Client groups											Total	
	Single homeless	Homeless families	Rough sleepers	People with drug problems	People with alcohol problems	Teenage Parents	Young People at risk	Young People leaving care	Offenders / Ex Offenders	People with mental health problems	Domestic violence (women)		
Achieve Economic Wellbeing	(1a) Maximise their income, including receipt of the correct welfare benefits	64.6	54.7	46.6	50.0	67.3	89.2	83.9	100.0	91.4	60.0	74.1	64.9
	(1b) Reduce their overall debt	41.7	26.6	10.3	31.3	26.9	29.7	50.5	50.0	42.9	40.0	29.8	35.1
	(1c) Obtain paid work	34.1	7.5	16.7	37.5	19.2	13.5	33.3	50.0	51.4	16.3	8.4	24.0
Enjoy and Achieve	(2a) Participate in training and/or education	39.1	11.2	9.2	28.1	15.4	43.2	51.6	50.0	31.4	28.8	38.2	31.3
	(2b) Participate in leisure /cultural / faith and /or informal learning activities	25.9	13.1	15.5	12.5	17.3	37.8	20.8	0.0	20.0	39.4	25.2	19.4
	(2c) Participate in any work-like activities,	27.2	3.3	8.6	37.5	23.1	10.8	22.9	50.0	22.9	26.9	8.4	44.7
	(2d) Establish contact with external services /groups /friends /family	46.5	31.8	27.6	40.6	50.0	70.3	57.8	50.0	62.9	38.8	55.7	44.7
Be Healthy	(3a) Manage physical health	39.4	14.5	38.5	28.1	67.3	35.1	34.4	0.0	8.6	43.1	41.2	35.7
	(3b) Manage their mental health	30.7	12.6	24.1	43.8	40.4	21.6	40.1	0.0	31.4	93.8	46.6	36.8
	(3c) Manage substance misuse issues	45.4	5.6	51.7	90.6	78.9	0.0	32.8	50.0	65.7	26.9	12.2	35.9
	(3d) Assistive technology to maintain independence	2.0	0.0	0.0	6.3	5.8	0.0	13.0	0.0	0.0	9.4	4.6	4.0
Stay Safe	(4a) Maintaining accommodation & avoid eviction	59.1	55.1	27.0	53.1	53.9	62.2	70.3	100.0	60.0	44.4	36.6	52.8
	(4b) Comply with statutory orders	18.3	1.4	12.6	62.5	17.3	2.7	18.8	0.0	85.7	11.9	1.5	15.4
	(4c)(i) Manage self harm	10.2	2.3	2.9	9.4	17.3	2.7	11.5	0.0	2.9	19.4	11.5	9.4
	(4c)(ii) Avoided causing harm to others	10.4	1.9	9.8	21.9	13.5	10.8	10.4	0.0	37.1	13.8	5.3	10.0
	(4c)(iii) Minimise harm or risk of harm from others	15.7	7.0	9.8	18.8	25.0	35.1	18.8	0.0	28.6	23.8	89.3	22.3
Make a Positive Contribution	(5) Developing greater choice/ control/ involvement	43.3	34.1	13.2	37.5	40.4	75.7	69.3	50.0	37.1	67.5	74.8	47.4
Number of client records (N)		540	214	174	32	52	37	192	2	35	160	131	1569

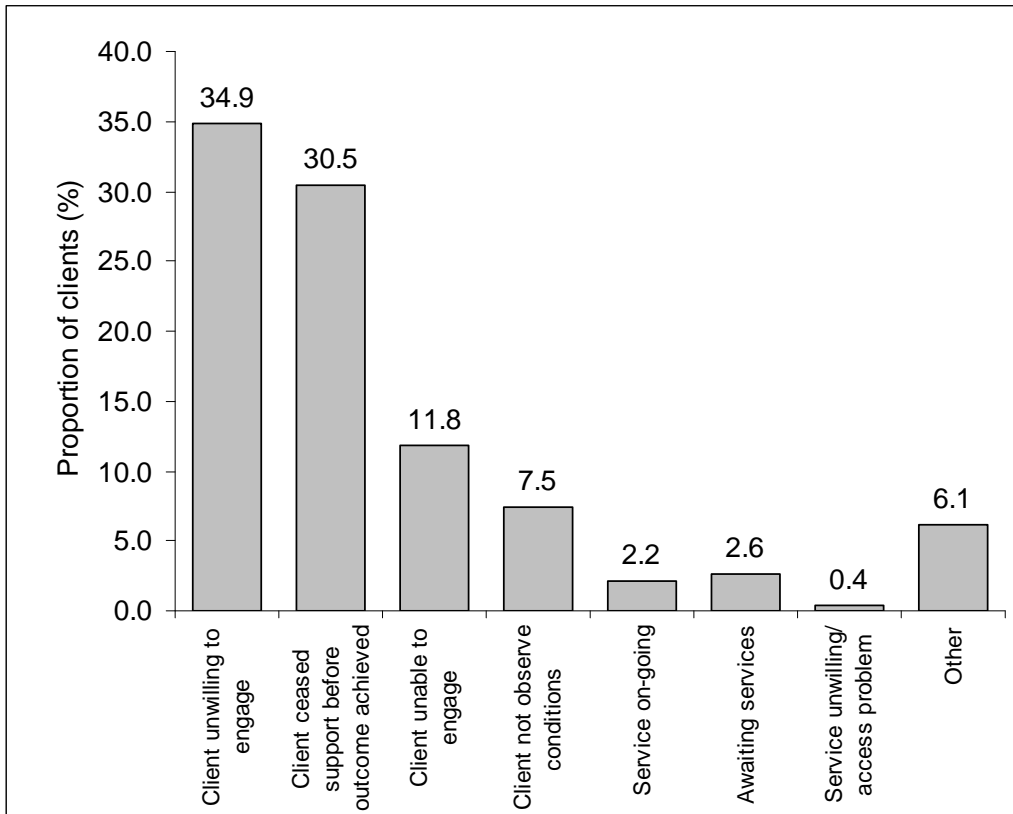
**Table 13.2:** Proportion of eligible clients leaving SP funded short term support services for homeless whose needs were achieved (2008/09)

Outcomes		Client groups											
		Single homeless	Homeless families	Rough sleepers	People with drug problems	People with alcohol problems	Teenage Parents	Young People at risk	Young People leaving care	Offenders / Ex Offenders	People with mental health problems	Domestic violence (women)	Total
Achieve Economic Wellbeing	(1a) Maximise their income, including receipt of the correct welfare benefits	91.7	94.9	88.9	81.3	91.4	100.0	89.4	100.0	93.8	82.3	87.6	90.4
	(1b) Reduce their overall debt	67.1	80.7	77.8	30.0	64.3	90.9	59.8	100.0	53.3	81.3	61.5	68.2
	(1c) Obtain paid work	16.3	43.8	31.0	0.0	30.0	40.0	40.6	100.0	11.1	30.8	18.2	23.9
Enjoy and Achieve	(2a) Participate in training and/or education	58.8	50.0	68.8	44.4	37.5	81.3	64.7	100.0	27.3	52.2	66.0	59.5
	(2b) Participate in leisure /cultural / faith and /or informal learning activities	78.6	71.4	92.6	25.0	88.9	92.9	72.5	0.0	57.1	66.7	81.8	76.4
	(2c) Participate in any work-like activities,	53.1	28.6	66.7	25.0	50.0	75.0	59.1	100.0	25.0	53.5	81.8	53.6
	(2d) Establish contact with external services /groups /friends /family	81.7	85.3	75.0	76.9	88.5	100.0	88.3	100.0	72.7	72.6	90.4	83.3
Be Healthy	(3a) Manage physical health	77.5	74.2	80.6	44.4	62.9	100.0	81.8	0.0	66.7	69.6	81.5	76.6
	(3b) Manage their mental health	59.6	66.7	52.4	35.7	52.4	100.0	77.9	0.0	45.5	57.3	68.9	61.7
	(3c) Manage substance misuse issues	52.2	33.3	53.3	51.7	53.7	0.0	58.7	100.0	69.6	65.1	43.8	54.4
	(3d) Assistive technology to maintain independence	90.9	0.0	0.0	100.0	100.0	0.0	100.0	0.0	0.0	100.0	100.0	98.4
Stay Safe	(4a) Maintaining accommodation & avoid eviction	59.9	88.1	59.6	47.1	50.0	69.6	53.3	50.0	57.1	80.3	81.3	65.4
	(4b) Comply with statutory orders	61.6	66.7	63.6	50.0	88.9	100.0	69.4	0.0	56.7	79.0	100.0	64.3
	(4c)(i) Manage self harm	65.5	40.0	80.0	33.3	22.2	100.0	77.3	0.0	100.0	80.7	66.7	67.3
	(4c)(ii) Avoided causing harm to others	42.9	50.0	70.6	0.0	85.7	75.0	70.0	0.0	76.9	72.7	71.4	58.6
	(4c)(iii) Minimise harm or risk of harm from others	71.8	80.0	88.2	16.7	61.5	53.9	75.0	0.0	70.0	76.3	81.2	74.9
Make a Positive Contribution	(5) Developing greater choice/ control/ involvement	79.9	87.7	73.9	58.3	61.9	96.4	82.0	100.0	76.9	64.8	78.6	78.2

### **Reason for failure to meet needs**

Figure 13.1 shows the reasons for failure to meet needs by clients leaving SP short-term support services. Over a third of the clients not meeting needs were unwilling to engage with services while 30.5% of clients ceased to access services before outcomes were achieved. Note that this information on Reason for failure to meet needs was only available for the first three quarters of the year at the time this report was produced.

**Figure 13.1:** Reasons for failure to achieve needs



### **Areas of greatest need by client group**

Table 13.3 summarises the areas of greatest (top three) need by client group. The data are based on outcomes of people who left SP funded short-term services between April 2008 and March 2009 as the outcomes form is completed on departure from the service. For instance, 69% of single homeless people (people who's primary client group was determined as single homeless) required support to maximise their income. 93% of these 69% achieved this, i.e. maximised their income.

**Table 13.3:** Summary of areas of greatest needs based on the SP outcomes framework

Client group	Greatest needs (based on SP outcome framework)	Number clients requiring service	Proportion clients requiring Service	Proportion of eligible clients achieved desired outcomes (%)
Single homeless people (n=540)	Maximising income	349	65%	92%
	Maintaining accommodation/avoiding eviction	319	59%	60%
	Accessing external groups or services, friends or family	251	47%	82%
	Support to better manage substance misuse	245	45%	52%
Rough sleepers (n=174)	Support to better manage substance misuse	90	52%	53%
	Maximising income	81	47%	89%
	Support to better manage physical health	67	39%	81%
Offenders / Ex-offenders (n=35)	Maximising income	32	91%	94%
	Complying with a statutory order	30	86%	57%
	Better manage substance misuse	23	66%	70%
	Accessing external groups or services, friends or family	22	63%	73%
Homeless families (n=214)	Maintaining accommodation	21	60%	57%
	Maintain accommodation/avoid eviction	118	55%	88%
	Maximising Income	117	55%	95%
Young People at risk (n=192)	Maximising income	161	84%	89%
	Maintaining accommodation	135	70%	53%
	Developing greater choice/ control/ involvement	133	69%	82%
	Accessing external groups or services, friends or family	111	58%	88%
	Reducing debt	97	51%	60%
	Participating in training or education	99	52%	65%
Teenage Parents (n=37)	Maximise income	33	89%	100%
	Developing greater choice/ control/ involvement	28	76%	96%
	Accessing external groups or services, friends or family	26	70%	100%
	Maintaining accommodation	23	62%	70%
People with drug problems (n=32)	Participating in training or education	16	43%	81%
	Support to better manage substance misuse	29	91%	52%
	Support to comply with a statutory order	20	63%	50%
	Maximising income	16	50%	81%
People with alcohol problems (n=52)	Mental health	14	44%	36%
	Support to better manage substance misuse	41	79%	54%
	Maximising income	35	67%	91%
	Support to better manage physical health	35	67%	63%
Mental health problems (n=160)	Better manage mental health	150	94%	57%
	Developing greater choice/ control/ involvement	108	68%	65%
	Maximising income	96	60%	82%
	Maintaining accommodation	71	44%	80%
Domestic violence (women) (n=131)	Reducing debt	64	40%	81%
	Minimise harm or risk of harm from others	117	89%	81%
	Developing greater choice/ control/ involvement	98	75%	79%
	Maximising income	97	74%	88%
	Accessing external groups or services, friends or family	73	56%	90%



## 14. Appendix 6: Cambridge City Council Homeless Database

### 14.1. Introduction

The Cambridge City Council (CC) Homeless Database contains information that has been collected since April 2004 from most of the main providers of accommodation and support services for single homeless people in Cambridge (the most significant provider that has not contributed information is Jimmy's Night Shelter). Frontline staff at these services complete an information form about each of their clients when the client first receives the service and then again at the end of the period of service. Information provided includes reason for homelessness, an assessment of needs and whether or not the client's needs are currently being met.

It is important to note the limitations of the information provided. They include:

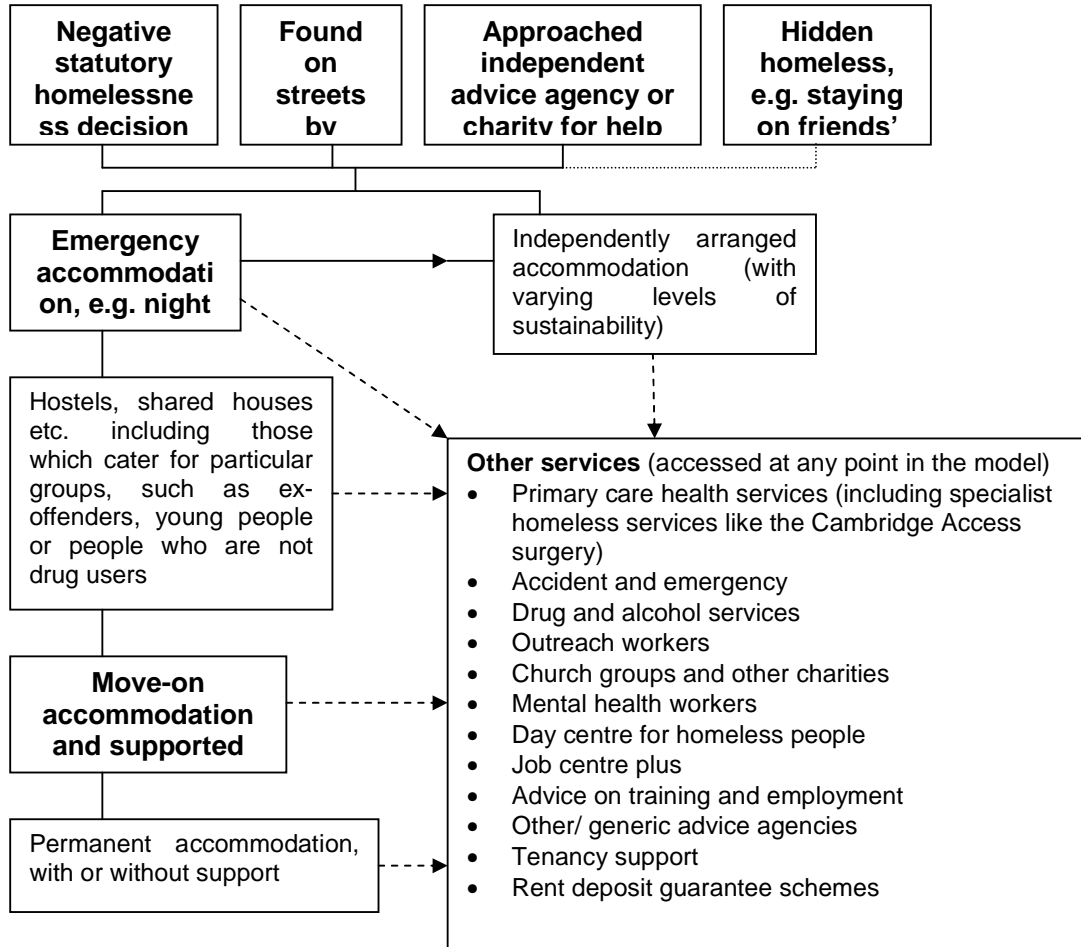
- The assessment is only made once, at the point when the client first makes contact with a service – it is therefore a judgment on the state of that individual before the service begins to work with her/him
- Each assessment is made by an individual member of staff and because some of the pieces of information collected are subjective, opinions may vary between different services and members of staff

The homeless services which provide data are: Cambridge Cyrenians; Centre 33; Crime Reduction Initiative Street Outreach Team (SOT); English Churches Housing Group (ECHG); Jubilee Project; and YMCA (Box 14.1). Almost everyone included in this paper is 'single homeless/ rough sleepers' – this group are often ineligible for housing under the homelessness registration and as such follow a different path to housing services (Figure 14.1) compared to the statutory homeless (accepted as homeless and owed a main homelessness duty by local authority). A significant number of them are current or former rough sleepers, including the majority of those included in data provided by the Street Outreach Team.

**Box 14.1:** Main services for single homeless/ rough sleepers in Cambridge

**Centre 33** – young people's advice and advocacy service  
**Cambridge City Council housing advice** – team within city council which provides free independent advice on housing matters and receives and determines statutory homelessness applications  
**Street Outreach Team** – service provided by *Crime Reduction Initiatives* and commissioned by city council to provide assertive outreach service for rough sleepers and other people on the streets  
**Cambridge Cyrenians** – provider of (mostly) supported accommodation for 60 people in shared houses and bedsits  
**ECHG Youth Foyer** – foyer and move-on flats, accommodation for 28 young people  
**ECHG dispersed houses** – shared houses and flats providing move-on accommodation for 27 people  
**ECHG Victoria Road hostel** – 74 bed hostel with support  
**ECHG Willow Walk hostel** – 22 bed hostel with high support  
**Jubilee Project** – accommodation tied to employment for 8 people  
**Wintercomfort** – day centre offering recreation, education and other services to people who are homeless or at risk of homelessness  
**YMCA** – large supported hostel for young people  
**Cambridge Access Surgery** – a specialised PMS GP surgery providing dedicated primary health care services for homeless.

**Figure 14.1:** Flowchart showing the single homeless/ rough sleepers access and pathway to various homelessness services in Cambridge City.



This table shows a possible route through homelessness services for an individual who is not statutorily homeless according to homelessness legislation. It should be noted that the client group in question are relatively chaotic and therefore their journey through these services often deviates from this model.

## 14.2. Methods

The services which have provided the information in this section provide an update to Cambridge City Council each time a client starts or ceases to receive a service. The information includes an assessment by a frontline worker of details including the reason for homelessness, what services the client is engaged with and what additional services the client requires. There is also an assessment of the primary and (up to three) secondary *client groups* – these groups are classifications devised by *Supporting People* to describe the various groups of people who require support. This information is only collected once, at the point when a client first accesses a service, so it does not reflect any improvements in the client's circumstances brought about by access to the service. This information is stored in a database by Cambridge City Council. The database contains information dating back to April 2004 and provides an insight into the changing needs and characteristics of homeless people.

Four times a year Cambridge City Council produces a report based, in large part, on this database and circulates it widely. The report is used to help identify gaps in services, unmet needs and general trends in homelessness and is therefore an invaluable tool in the commissioning and ongoing provision of homelessness services.

In addition to the more basic data that are produced, the database contains names of service users, so it is possible to run reports showing patterns of use of services. Many people talk about 'revolving doors' homelessness (where individuals go from one service to another sometimes over a period of many years), but it is difficult to find data to back up commonly held views about this. This database, containing five years' worth of information, allows us to see how many people are accessing how many different services, and how long those who are currently receiving services have been accessing services in Cambridge.

Since the introduction of the Reconnections policy in June 2007, Cambridge City Council has been collating data on 'connections' for people presenting as homeless. The Reconnections policy aims to relocate service users not locally connected with Cambridge City to areas where they have a local connection or to areas where housing supply outstrips demand. Service users should only be relocated to areas they are not connected to in secure tenancies or in supported sustainable accommodation (i.e. with immediate relatives or in a supported housing project). This policy is monitored through a multi-agency *Reconnections Forum* which meets once a fortnight to discuss cases and share information on clients.

As well as this main data source, Cambridge City Council holds other information which is shared by agencies which work closely with it, such as the Street Outreach Team (which sends a weekly report about all those who are known or thought to be sleeping rough in the city), Jimmy's Night Shelter and its own Housing Options team which gives advice to people experiencing housing problems.

### 14.3. Results

#### Demographics characteristics

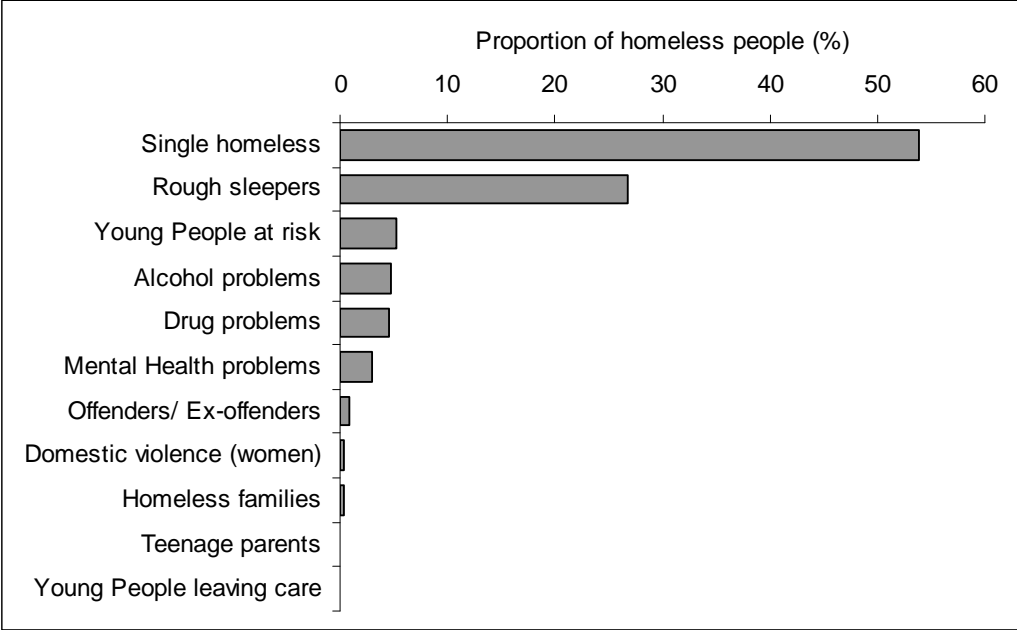
A total of 3,709 presentations to homeless services occurred between April 2004 and December 2008 (Table 14.1). The majority of the homeless people were male (80.7%), and aged between 18-49 years (84%). Over half (53%) of the homeless people were single homeless (Figure 14.2) and the predominant ethnic group was White (89%) [Figure 14.3].

**Table 14.1:** Number of presentations to Cambridge City Homeless services by year and gender

Gender	Year of reporting					Total
	2004/05	2005/06	2006/07	2007/08	2008/09*	
Female	143	127	186	149	110	715
Male	608	616	568	700	502	2,994
Total	751	743	754	849	612	3,709

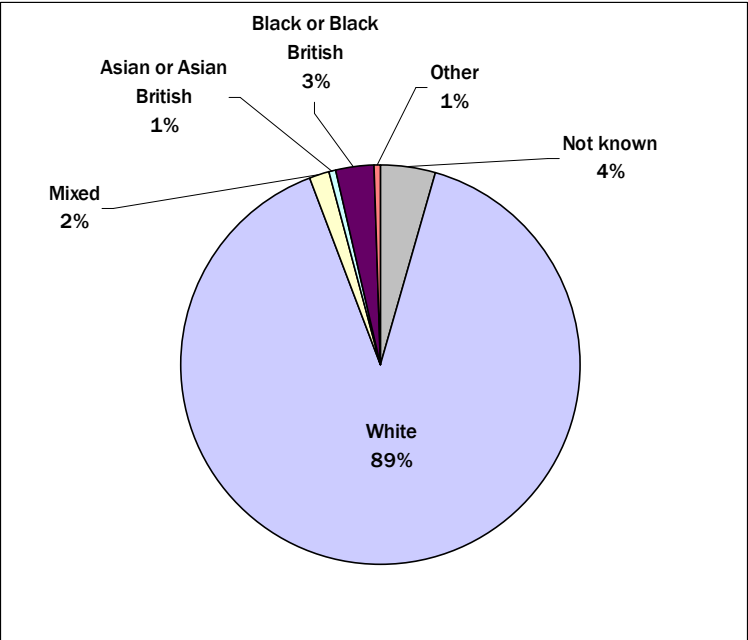
Source: Cambridge City Council \*January-December 2008

**Figure 14.2:** Proportion of presentations to Cambridge City homeless services by primary client group from 2004/5 to 2008/9



Source: Cambridge City Council

**Figure 14.3:** Proportion of presentations to Cambridge City homeless services by ethnicity from 2004/5 to 2008/9

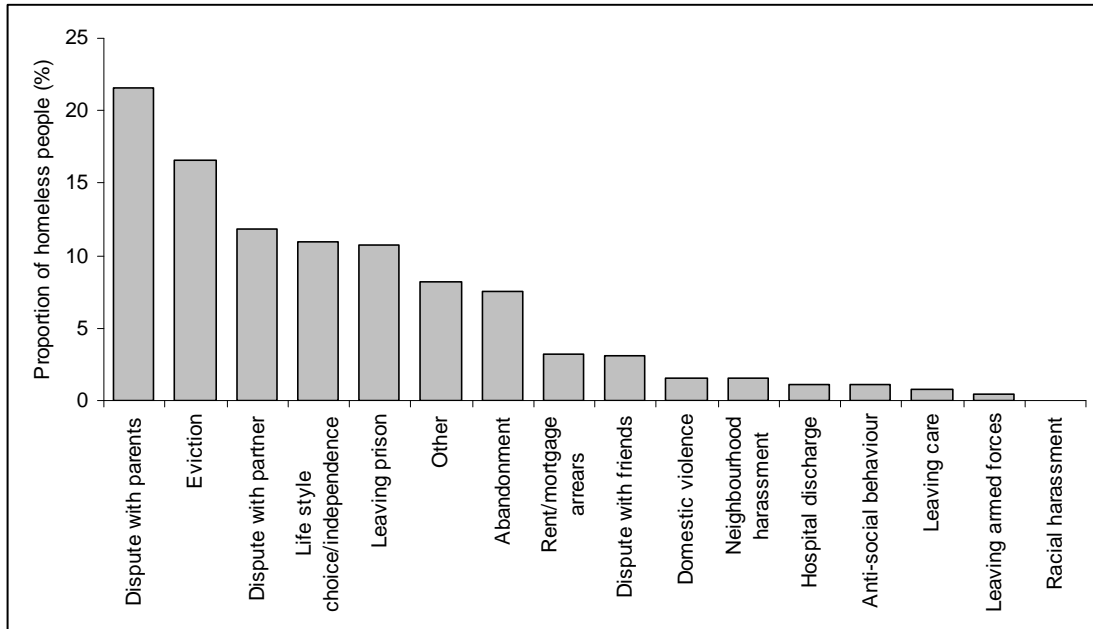


Source: Cambridge City Council

**Reason for homelessness**

Figure 14.4 summarises the self-reported reasons for being homeless. The top five causes of homelessness were: disputes with parents (21.6%); eviction from the current accommodation (16.7%); dispute with partner (11.8%). Over 19% of the homeless people reported the reason for being homeless as a lifestyle choice to seek independence.

**Figure 14.4:** Frequency distribution of self-reported reasons for homelessness from 2004/5 to 2008/9

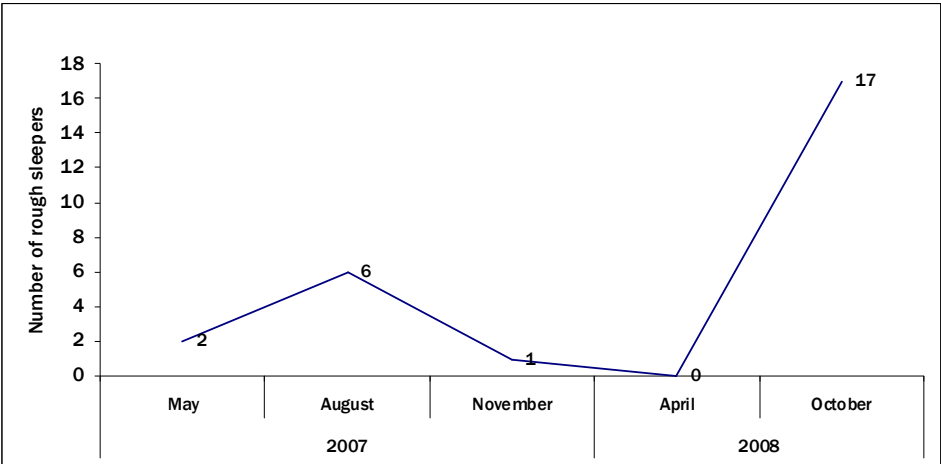


Source: Cambridge City Council

**Rough sleeper trends**

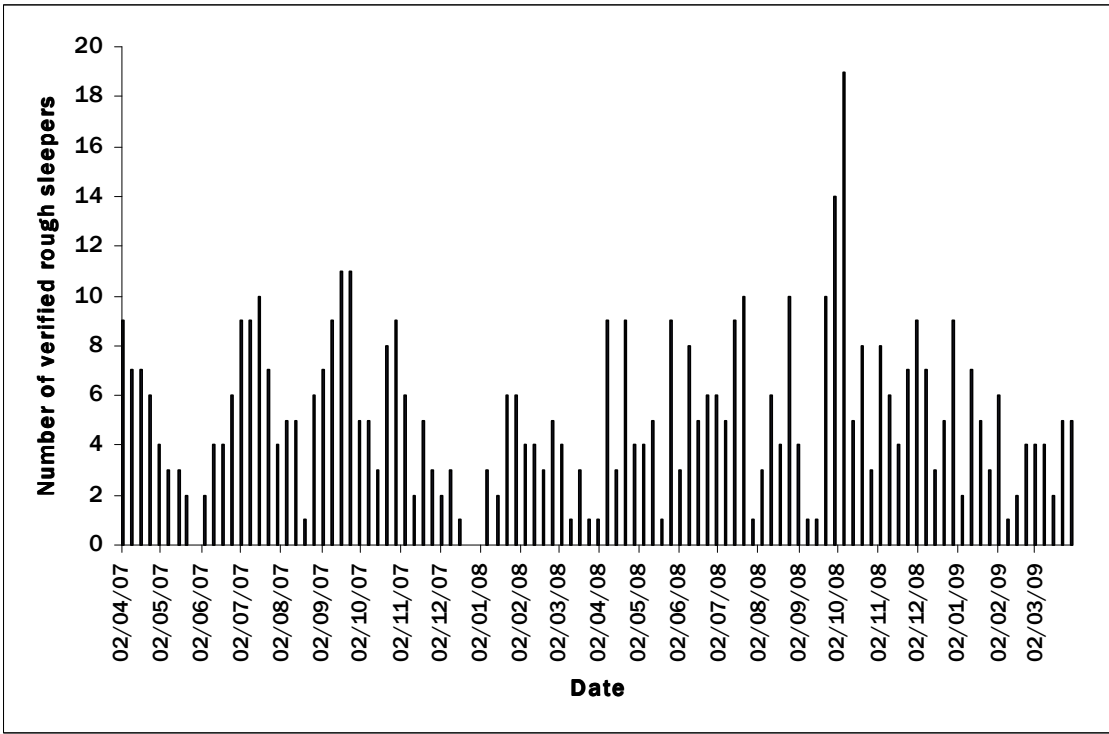
Cambridge City tracks rough sleeping through official rough sleeping counts and routine counts of rough sleepers by the Street Outreach Team (SOT) (counts of rough sleepers conducted on a single night usually twice a year). The official counts have limitation in that this is done only twice a year and are therefore likely to underestimate the rough sleeping problem (Figure 14.5). The routine counts of rough sleepers by the SOT are compiled weekly and show that Cambridge City experiences a perennial rough sleeping problem (Figure 14.6)

**Figure 14.5:** Official rough sleeper counts conducted by the Cambridge City Council between April 2007 and March 2009



Source: Cambridge City Council

**Figure 14.6:** Routine rough sleeper counts conducted by the SOT between April 2007 and March 2009

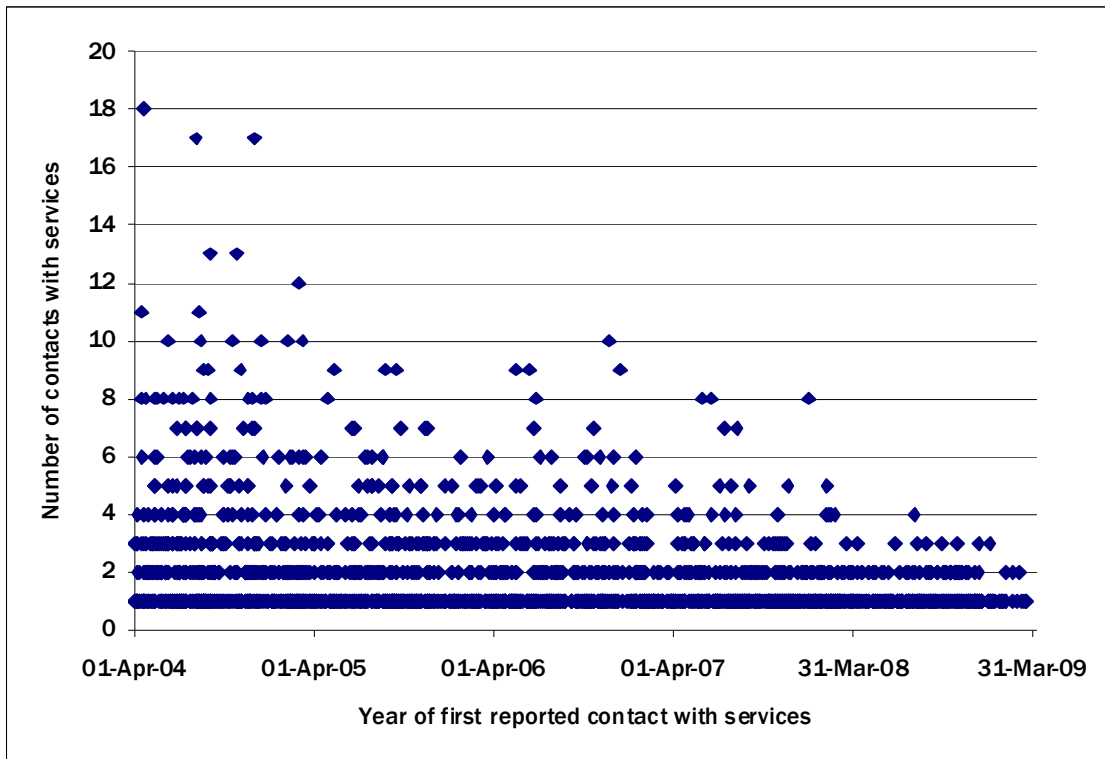


Source: Street Outreach Team, Cambridge City Council

### Multiple presentations to homeless services

Figure 14.7 shows the number of contacts each client has had, plotted against the date of her/his first contact since 1<sup>st</sup> April 2004. Each client is represented by a point. Over the five year period 3,709 contacts were recorded with 1,990 individuals. The majority of individuals (59.4%) had only one recorded contact, suggesting that there is a large number of people who have a small amount of contact with homelessness services. However, 40.6% of the individuals had multiple contacts with services with some individuals presenting as many as 18 times over the five year period.

**Figure 14.7:** Number of presentations to homeless services

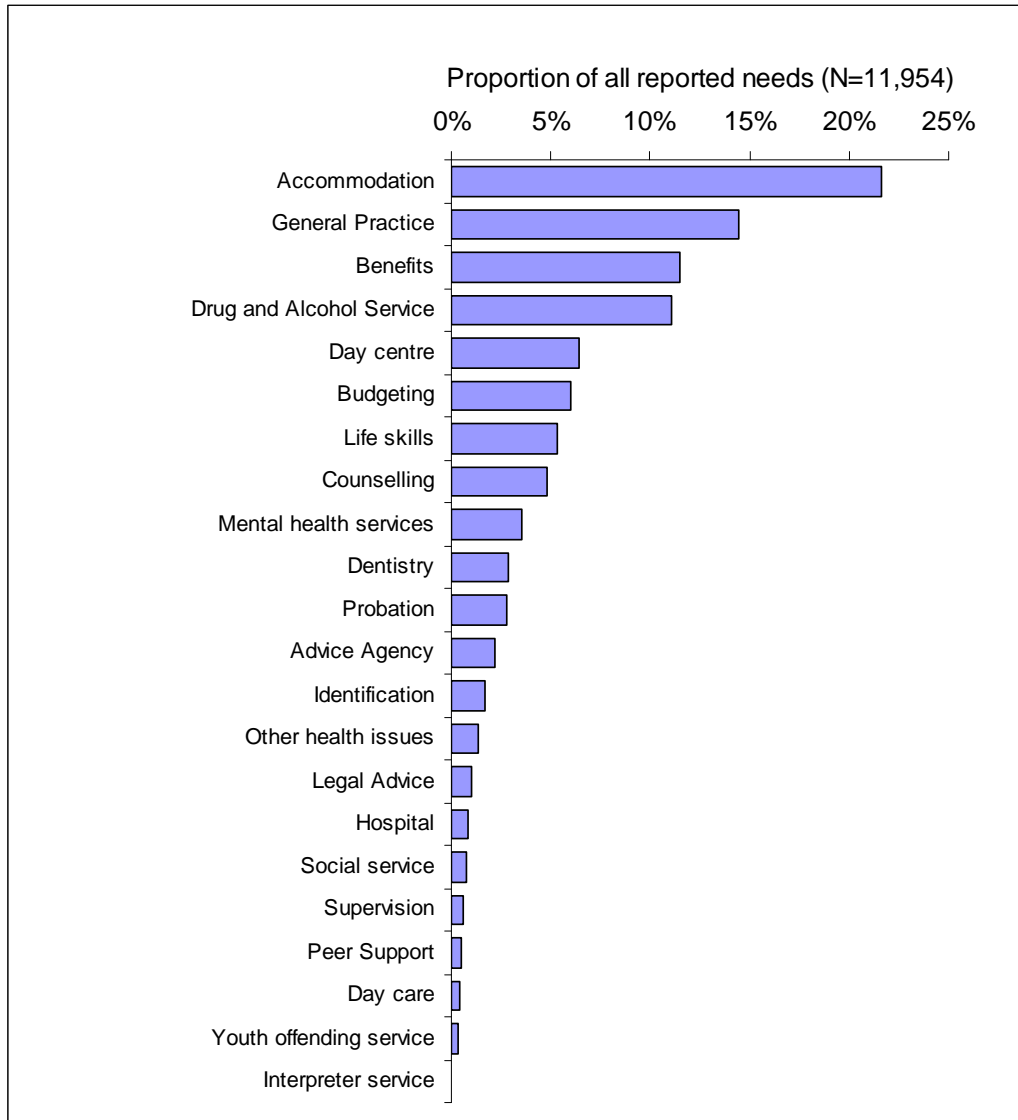


Source: Cambridge City Council

### Needs of homeless and gaps in homelessness services

Figure 14.8 shows the frequency distribution of the needs among homeless people presenting to services. For every person, the frontline worker assesses the problems that a person presents with to services and records these on the assessment form. Of all reported needs, the top four needs among the homeless were: accommodation (21.6%); General Practice services (14.4%); access to benefits (11.5%); and drug and alcohol services (11.1%).

**Figure 14.8** Distribution of needs among homeless people presenting for services at Cambridge City between April 2004 to March 2009

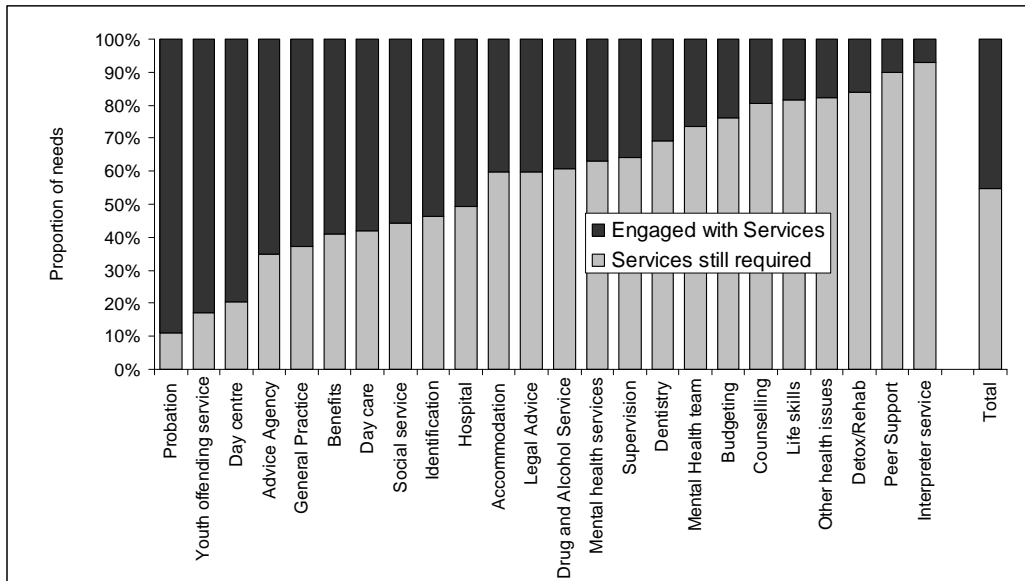


Source: Cambridge City Council

Figure 14.9 shows the distribution of reported needs compared to the needs where the client was reported to have engaged with services. Overall, clients engaged with services for 45.4% of all the identified needs. There were substantial gaps in services with over 50% of the identified needs not being met among homeless people requiring the following services: hospital; accommodation; legal advice; drug and alcohol service; mental health services, supervision; dentistry; budgeting; counselling; life skills; other health issues; peer support; and interpreter services (Figure 13.9).



**Figure 14.9:** Distribution of reported needs and clients engaging with homeless services



Source: Cambridge City Council

**Reconnections policy**

In recent years there has been very high demand for homelessness services in Cambridge. Much of this demand has been created by newcomers to Cambridge who have no connection to the city. One result of this was that some of the services, like the night shelter and some of the hostels were stretched and often had to turn away people who needed their help. Cambridge City Council introduced a Reconnections Policy on 4<sup>th</sup> June 2007. The policy was intended to make it more difficult for new people to come to Cambridge and access homelessness services on a long-term basis, so that the organisations could concentrate on serving people who are here already. Since June 2007 the *Reconnections Forum* has been meeting once a fortnight to discuss cases and share information on clients.

In the period from June 2007 to March 2009 there were 617 presentations to the *Reconnections Forum*. About two-thirds of these people had no local connection to Cambridge. Of all new presentations, 13% were identified to have connections to other District Councils in Cambridgeshire (Table 14.2).

**Table 14.2:** Number of new presentations to Cambridge City and their connections reported from June 2007 to March 2009

Year & Quarter	2007		2008			2009		Total	
	June-Sept	Oct-Dec	Jan-Mar	Apr-June	July-Sept	Oct-Dec	Jan-Mar		
New presentations	122	87	79	83	65	90	91	617	
Proportion with local connection to:	Cambridge City	34%	32%	25%	35%	31%	37%	31%	32%
	Elsewhere in Cambridgeshire	46%	43%	44%	30%	45%	32%	37%	40%
	Outside Cambridgeshire	8%	16%	13%	13%	15%	16%	10%	13%
	Local connection unknown/no connection	12%	9%	18%	22%	9%	16%	21%	15%

Source: Cambridge City Council

**Housing advice services**

The housing advice team gives advice to Cambridge residents who have housing problems. Most of their clients are homeless or in housing need in unsatisfactory housing. They may be single people, couples or families. They also provide advice services for landlords who are having problems with tenants or rented homes. Part way through the financial year 2004-5 the city council's housing advice began to use a new database which is used to this date to record their advice cases.

**Table 14.3:** Distribution of advice services provided in Cambridge City from 2004/5 to 2008/9 by type of advice

Type of advice	Year of reporting				
	2004/5	2005/6	2006/7	2007/8	2008/9
Benefits	0.0%	3.6%	5.6%	3.1%	7.1%
Debt	0.6%	1.3%	1.0%	0.8%	1.3%
Disrepair	0.0%	0.9%	0.2%	0.2%	0.1%
Domestic violence	1.7%	2.7%	3.3%	2.9%	4.9%
Eviction	6.2%	4.1%	3.7%	4.2%	7.0%
Harassment and illegal eviction	0.3%	1.3%	1.1%	0.5%	2.1%
Homelessness	38.4%	22.0%	16.9%	17.0%	32.8%
Landlord/ tenant issues	1.4%	7.9%	9.3%	8.1%	7.7%
Looking for accommodation	45.2%	41.5%	39.3%	44.7%	50.9%
Mortgage arrears	0.3%	0.6%	0.6%	0.4%	1.1%
Parental eviction	0.3%	1.6%	5.0%	4.8%	6.2%
Racial harassment	0.3%	0.2%	0.3%	0.0%	0.3%
Relationship breakdown	3.1%	5.7%	6.9%	6.7%	8.1%
Rent arrears	2.0%	2.4%	2.2%	1.5%	2.4%
Other	0.3%	4.3%	4.7%	5.0%	5.8%
Total presentations to advice services	277	1,480	1,443	1,318	958

Source: Cambridge City Council

#### ***14.4. Discussion***

This report summarises data on mainly single homeless/ rough sleepers presenting to homeless services at Cambridge City. The report does not include data on people accepted as homeless by the City council, which has been presented in a different analysis for the entire Cambridgeshire county (Appendix 3)

The data presented in this report has a number of limitations. Firstly, these data are on people who present to services and exclude hidden homeless people (such as sofa surfers, squatters, people living in houses with multiple occupations) whose magnitude is difficult to estimate since there is no routinely available data on this group. The data considered in this report only report on a client at the point when that individual begins to receive a service. Although most people who are accessing services for homeless, single homeless/ rough sleepers lead a chaotic lifestyle, have rapidly changing lives, and move in and out of services relatively rapidly.

Cambridge City collates person identifiable data for all presentations to services. On this basis, an attempt was made to identify the number of presentation for individual homeless people based on a system of identifying records for each person using the names, title, NI number collected at service points. While double counting due to spelling mistakes on the names cannot be excluded, the data also reveals that a substantial proportion of homeless people present to services on multiple occasions. This observation is consistent with the chaotic lifestyles experience by this group of homeless people.

## 15. Appendix 7: Health profile of the Cambridge Access Surgery population

### 15.1. Background

Homeless people experience poorer levels of general physical and mental health (Box 15.1) than the general population and in addition, they experience complex and multiple morbidity. The health of the homeless has been an area of focus over the last decade.

#### Box 15.1 Diseases commonly found among homeless people

1. **Drug dependence syndrome** — usually Heroin, Crack Cocaine, Benzodiazepines, Cannabis etc.
2. **Alcohol dependence syndrome**
3. **Mental ill-health**  
schizophrenia and other psychotic illness including drug- and alcohol -related psychoses, depression and chronic anxiety. Personality disorder, learning disability, self harm and suicide, secondary impaired cognition and memory loss.
4. **Adverse effects of all substance misuse (including alcohol)**
  - Malnutrition (vitamin B deficiencies with alcohol), self-neglect, loss of income, criminal behaviour, family breakdown

**Adverse effects of opiates**

  - Respiratory depression – sometimes leading to death
  - Constipation

**Adverse effects of stimulants including cocaine**

  - Psychoses
  - Crack lung
  - Cardiotoxicity

**Adverse effects of injecting drugs**

  - Thromboembolism: deep vein thrombosis, pulmonary embolus, & septic emboli leading to empyema, bacterial endocarditis, osteomyelitis, encephalitis etc.
  - Blood borne virus infection (Hepatitis C, Hepatitis B, HIV)
  - Skin & subcutaneous infections and abscesses often involving MRSA or Streptococci
  - Leg ulcers – risk of therapeutic amputation

**Adverse effects of alcoholism**

  - Alcoholic hepatitis, liver cirrhosis, liver failure
  - Gastritis, peptic ulceration, bleeding oesophageal varices
  - Pancreatitis
  - Neurological deficits: seizures, peripheral neuropathy, encephalopathy, degenerative brain disease, haemorrhagic CVA, erectile dysfunction.
  - Cardiomyopathy and increased risk IHD
  - Cancers of upper GI tract
  - Mental health disorders: depression, anxiety, self harm and suicide, psychosis, memory and cognitive impairment
5. **Skin problems**
  - Infestations :body, pubic and head lice, scabies
  - Infections including MRSA, Streptococci and fungal
  - Dermatitis and psoriasis (exacerbated by alcohol)
6. **Respiratory problems (smoking incidence high)**
  - Asthma, COPD, CA lung
  - Bronchitis, Pneumonia, TB
  - URTI (crowded or adverse living conditions)
7. **Trauma**
  - Foot trauma (related to poor hygiene, walking in poor footwear etc.)
  - All accidental and inflicted trauma increased, with increased complications (due to high incidence of assault , intoxication, self-neglect)
8. **Dental**
  - Dental caries frequently needing dental clearance.

Source: CAS

Despite the poor health status among homeless people, generally in the UK, they experience severe difficulties with accessing health services; this poor access also impacts on their health status. For instance a survey of 117 General Practice in Bristol revealed that only 27% were prepared to permanently register a homeless person and although one third would offer temporary registration, almost one quarter would only offer emergency treatment.<sup>57</sup> Table 15.1 summarises the causes of poor access to mainstream health services by the homeless.

**Table 15.1:** Common problems occurring between homeless people and mainstream primary care

<b>Patient</b>	<b>Possible negative implications for mainstream GP</b>	<b>Effect on patient</b>	<b>Solution</b>
<b><u>Homeless</u></b> NFA frequent address change	Demands address Administrative problems	Turned away or Temporary registration	Fully register NFA patients Invent ways of coping with admin. Help from other services to locate
<b><u>Chaotic</u></b> Preoccupation with problems of daily survival Present erratically /in emergency Poor self-care	Poor attendance Inconvenient and cannot plan healthcare Staff and patients upset	GP seems inflexible GP not responding to patient's agenda Rejection/poor self-esteem	Flexible access Daily drop-in clinics Welcoming staff Multi-agency working
<b><u>Drug &amp; alcohol problems</u></b> Often intoxicated	Fear of violence Fear of drug-seeking behaviour "Rational" consultation difficult GP feels threatened because lacks experience and self-confidence	GP does not want to help GP does not understand patient can't tolerate withdrawal	GPs with special interest Clear referral options Stepped care from harm-minimisation and symptom control to full detox./treatment service Multi-agency working
<b><u>Multiple complex problems</u></b> Mixed health and social	Time consuming consultations Diagnostic problems Not financially rewarding	GP "won't listen" GP "doesn't care" GP only interested in own targets	Obtain past records Thorough new patient check (health and social) Cumulative assessment over time Multi-agency working

Source: CAS

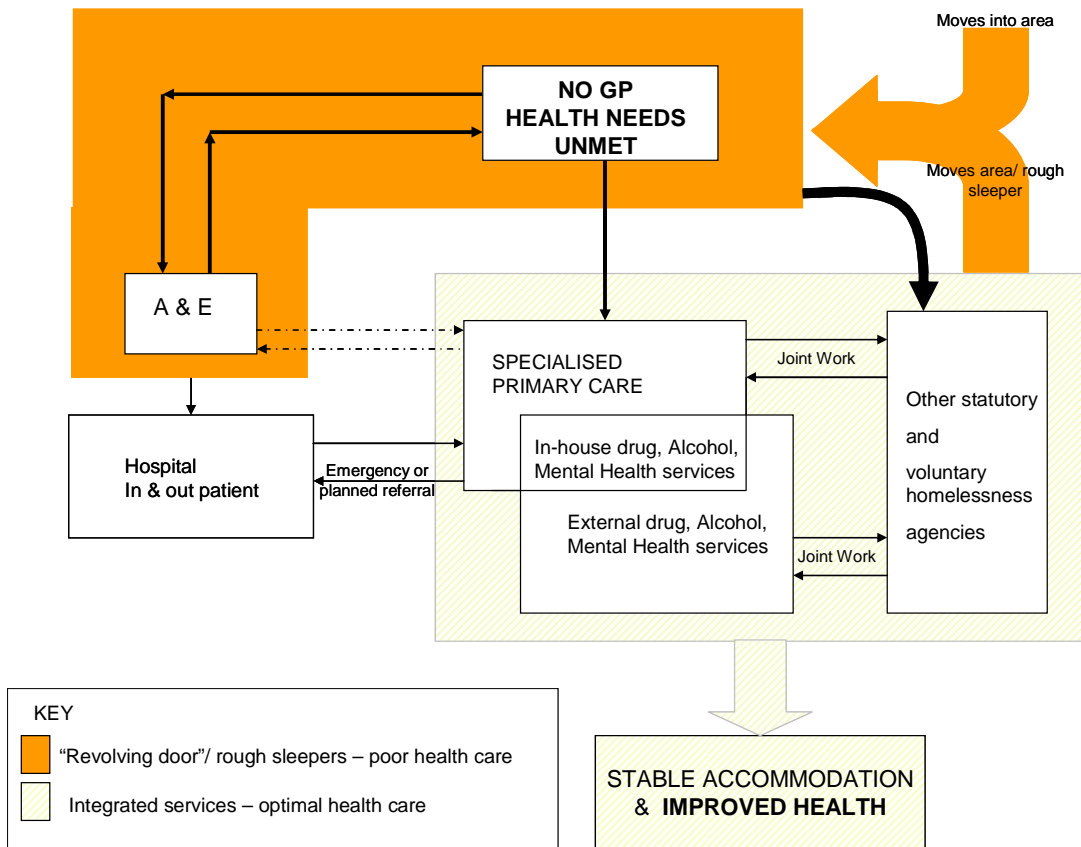
Given the peculiar nature of health problems among the homeless and the challenge of poor access to mainstream health services, approaches to enhance health services for the homeless have been suggested. These range from services that advocate modifications to mainstream NHS provision, through to specialist primary care services that are designed solely for homeless people.<sup>58</sup>

Overall, the evidence base on the effectiveness of health care services for homeless people is poorly developed. Most of the current health services for the homeless have been policy driven often drawn from best practice rather than being evidence based. Nonetheless, existing evidence points to a number of factors that appear to be

associated with successful health services, including flexibility, outreach work, a holistic approach, inclusive practices, user involvement, effective joint working and integrated solutions.

In theory, homeless people in Cambridgeshire can register with any GP. In practice, however, many GP Surgeries are reluctant to accept homeless people due to their often erratic and chaotic behaviour. The Cambridge Access Surgery (CAS), is currently the only dedicated GP Surgery for the homeless, and those at risk of homelessness, in Cambridge City and the entire Cambridgeshire County. CAS close links with the other agencies in the building and with many other agencies including the City Council, night shelter, hostels, drug and alcohol agencies and secondary care (Addenbrooke's), enables it to offer a holistic, pragmatic and non-judgemental service dedicated to improving the health and chances of resettlement of its patients (Figure 15.1).

**Figure 15.1:** Healthcare pathway for the homeless in Cambridge



## **15.2. Methods**

### **Registered population**

Registered population data were extracted from the Family Health Services (**FHS registration system (Exeter)**), which is a centralised database of all people registered with a GP in England. A population pyramid was then developed in Ms Excel<sup>®</sup>. For attendance activity, data was extracted from the appointment calendar of the Emis medical software system used at CAS.

### **Health profile of CAS population**

To describe the health problems among the CAS registered population, data were extracted from a random sample of 216 patients. The sample size allowed for estimation of an expected prevalence of 50% within a 5% error limit, and 95% confidence limit, given a registered population size of 489 people. Data on the health problems were extracted by manually trawling through the diagnosis recorded in the patients' summaries in EMIS and compiled into Ms Excel<sup>®</sup> worksheets under five domains: drug problem; alcohol problem, mental health problems; blood-borne viruses; and other health problems. All the significant present health problems were included in the data extraction, while past health problems dating back to 2003/4 were included in the data extraction. For patients with multiple diagnosis of the same diagnostic category of health problem, this problem was only counted once. The proportion of people with a given health problem was estimated by dividing the persons identified to have had the problem with the sample size as the denominator, and the 95% confidence intervals of the point estimate calculated.

### **Mortality among CAS registered population**

Mortality data was extracted from Office of National Statistics (ONS) Public Health Mortality database. Standardised mortality ratio (SMR) was calculated using indirect age-standardisation method with the Cambridgeshire PCT population as the standard.

## **15.3. Results**

### **Demographic characteristics**

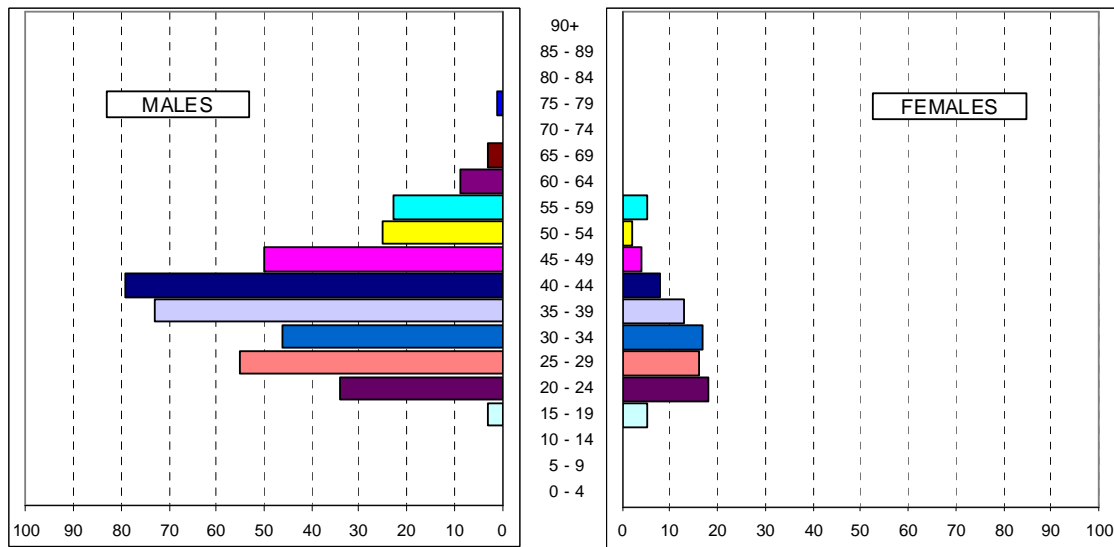
Table 15.2 shows the registered population at CAS by year while Figure 15.2 shows the population pyramid of the registered population as at January 2009. The registered population more than doubled from opening of the Surgery in 2003 to 2008 and appeared to be stabilising at about 500 registered patients. The mean age of CAS population was 38.5 years compared with 39 years for the general population registered with Cambridgeshire GPs. Although the mean age is similar, the CAS population has a much narrower age-spread. The CAS population shows a marked sex imbalance, with 82 % males compared to 49.3 % in the general Cambridgeshire GP population. The 4:1: male:female pattern is found in many similar homeless primary care services in the UK.

**Table 15.2:** Number of people registered at CAS: 2003 – 2009

Age group	Year						
	2003	2004	2005	2006	2007	2008	2009
≤19	8	12	17	16	17	12	8
20-29	68	87	105	115	121	115	123
30-39	87	99	143	181	182	187	149
40-49	41	52	83	112	108	129	141
50-59	22	24	34	49	49	54	55
60+	5	8	8	13	17	12	13
All ages	231	282	390	486	494	509	489

Source: FHS Registration System (Exeter) January of each year (2003, October)

**Figure 15.2:** Population pyramid of CAS registered population as at January 2009



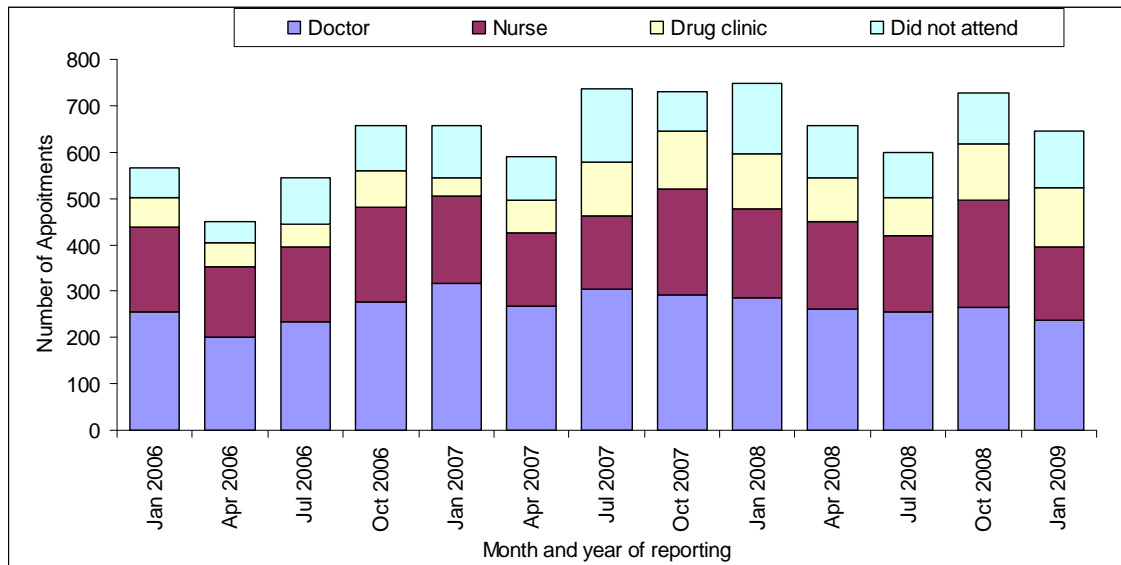
Source: FHS Registration System (Exeter)

**Attendance activity**

Figure 15.3 shows the attendance activity at the beginning of each quarter from January 2006 to January 2009. There was a seasonal pattern in the number of appointments with summer troughs and winter peaks. The surgery has both appointment-based and drop-in type clinics. The pattern of attendance is such that many patients have multiple appointments in a given period and also attend multiple clinics (for example: Doctor, Nurse, Drug treatment) at a single visit.



**Figure 15.3:** Number of appointments recorded at CAS by type for the first month of each quarter from January 2006 to January 2009 inclusive



Source: CAS appointments calendar (EMIS)

#### Health profile of CAS population

Table 15.3 summarises the health profile of the CAS registered population based on the present and past significant health problems. The top three diagnostic categories of health problems among this population included: drug dependence (62.5%); mental ill-health (53.7%); and alcohol dependence problems (49.1%). 31.0% of the registered population had both a drug and an alcohol problem. A substantial proportion (42.6%) of the registered population had a 'dual diagnosis' of a mental health problem as well as a substance misuse problems (drug and/or alcohol misuse). Other leading cause of morbidity in this population included: injuries/assault (26.4%); hepatitis C virus (HCV) infection (17.6%); respiratory diseases (16.7%) liver disorders (15.7%); and other infections (13.9%). \*need to specify HCV infection

Compared to the majority of statutory homeless adults, the CAS population appears to have a staggering drug, alcohol and mental health illness problem. A recent survey by the Centre for Housing Policy, University of York, investigated the prevalence of self-reported history of substance use and mental health problems among adults accepted as statutorily homeless and found that: 27% had mental health problems; 9% had drug problems; and 6% reported alcohol problems.<sup>59</sup> While these latter survey results are subject to reporting bias, they do suggest a huge difference in the profiles of these two types of homeless population.

**Table 15.3:** Main diagnostic categories of recorded health problems among the CAS registered population (N=216)

Health problem	%	95% CI
Drug dependence syndrome	62.5	(52.0-73.0)
Mental ill-health	53.7	(43.9-63.5)
Alcohol dependence syndrome	49.1	(39.7-58.4)
Dual diagnosis*	42.6	(33.9-51.3)
Injuries/Assault	26.4	(19.5-33.2)
Hepatitis C Virus antibody positive	17.6	(12.0-23.2)
Respiratory diseases	16.7	(11.2-22.1)
Liver disorders/ abnormalities	15.7	(10.4-21.0)
Other infections (sepsis, abscesses, MRSA, C-diff)	13.9	(8.9-18.9)
Other health problems**	31.5	(24.0-39.0)

Source: CAS

\*Mental health and substance misuse problem

\*\*Dental problems, gastroenterological diseases, deep venous thrombosis (DVT), skin conditions, epilepsy/ fits, urogenital diseases, learning/ physical disability, anaemia, cardiovascular diseases and cancer.

Of the CAS patients with recorded drug dependence, 63.7% were injecting drug users. A substantial proportion of the patients with a drug problem were poly-drug users. Mental ill-health problems were the second most common cause of morbidity in this population. Table 15.4 summarises the distribution of mental health diagnosis among CAS population. Over a third of the mental ill-health diagnosis was self-harm (37.9%) and depression/ depressive disorders (34.5%). A third of people with mental ill-health had two or more mental health diagnosis.

**Table 15.4:** Distribution of mental health diagnosis recorded among CAS registered population (N=116)

Mental health diagnosis	%
Self-harm (mutilation, drug over-dose)	37.9
Depression/ Depressive disorder	34.5
Personality disorder	15.5
Schizophrenia	12.9
Anxiety	12.9
Suicidal	10.3
Psychosis/ Drug psychosis	8.6
Panic disorder	4.3
Attention-deficit/hyperactivity disorder	1.7
Bipolar disorder/ Mood disorder	1.7
Paranoid	1.7
Delusional disorder	1.7
Obsessive compulsive disorder	0.9
Two or more mental health problems	36.2

### Services recorded among CAS population

Using patient medical record summaries, we looked at the numbers of patients who had been recorded as receiving drug treatment services, alcohol services, hepatitis screening and immunisation, and specialised mental health services. Nearly three fifths (59.3%) of people with drug problems had been recorded as receiving drug treatment services. Drug treatment services were being offered at three main centres (in-house at CAS or, elsewhere in Cambridge, at Addaction HQ or CDIP). At the selected level of data interrogation it was not possible to identify why a client went to a particular

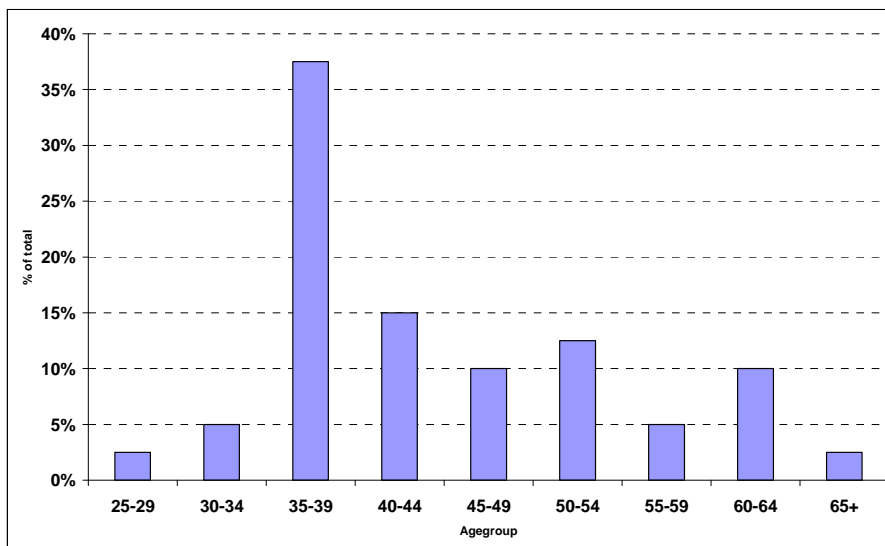
service. Alcohol treatment was documented in 25.5% of people with alcohol problems however, differentiation between in-house treatment and referral to other agencies could not be made. The figures for both drug and alcohol treatment would not include the advice and harm-minimisation work which is a routine part of all CAS consultations.

Over 50% of the population had undergone screening for Hepatitis B virus (HBV) and Hepatitis C virus (HCV), and 42 % had been screened for HIV. Immunization for hepatitis A virus and HBV had been documented in 40.7% and 48.1% of the registered population, respectively. A third (30.2%) of the people with mental ill-health had been documented to have received one or more specialist mental health services including: psychiatric referral (6.9%); psychiatric assessment (8.6%); psychiatric monitoring (7.8%); community CPN visit (2.6%); and voluntary or involuntary admission (12.1%). A recent audit of patients with HCV revealed that, of the 81 PCR +ve patients (16% of registered population): 8.6% had either received, were receiving or were about to receive treatment; nearly half (38 patients) had been referred for treatment; and the rest of the patients (36 patients) were being worked up for referral or were presently not eligible for referral/ treatment due to other contraindications for treatment.

### Mortality

Figure 4.10 shows the age distribution of 40 deaths among CAS registered population recorded from 2003 to 2008. A recent review of causes of death occurring in 2008/9 among patients registered at CAS estimated the main causes of death were drug overdose (42.8%) and alcohol/ alcohol complications (28.6%); which are all entirely preventable causes.

**Figure 15.4:** Age distribution of recorded deaths occurring among CAS registered population 2004-2006



Source: ONS Public Health Mortality File.

Note: there is known under-recording of mortality amongst this population. Not all deaths will be linked back to the GP practice where the deceased is registered.

## 15.4. Discussion

### Summary of findings

This report summarises the health profile of homeless people registered at Cambridge Access Surgery. A substantial proportion of this population are single homeless/ rough sleepers who lead chaotic lifestyles. There is a 4;1 male/female ratio with a relatively narrow age distribution about a mean of 38.5 years. There are no under 16s and very few over 60s. The patients tend to use the health services frequently with some patients attending multiple clinics in a day. Consistent with current knowledge of health among the homeless, the CAS registered population has a substantial proportion of patients with mental health, substance misuse (drugs and/ or alcohol) and 'dual diagnosis'. Other leading causes of morbidity such as liver and respiratory disease are clearly related to drug and alcohol misuse and adverse living conditions. The epidemic proportions of overlapping drug misuse, alcohol misuse and mental illness imply a need for effective corresponding services.

#### **Limitations of the methods**

The methods used in this report have limitations. Read-coding of health problems at CAS has been inconsistent up until the last 18 months due to shortage of permanent staff and the inherent unhelpfulness of Read-codes for collecting statistics on health problems of this population (for instance, there is no code for Hepatitis C PCR positive – the status that indicates active hepatitis C disease). Recently, clinical staff have taken a pragmatic approach in agreeing how to apply existing imprecise codes and thus standardise coding of the most common and critical health problems and procedures. For the purpose of this report, the in-built EMIS data-search protocols did not appear to offer a consistent way of retrieving and interpreting data. As a result, a manual trawling of the present and past “significant problems” in the EMIS patients medical summaries was used to arrive at the broad diagnostic categories mentioned in this report.

There are a number of reasons why the figures in this report are unable to fully represent the extent of the health problems encountered at CAS and the corresponding clinical work-load. The figures fail to capture the fact that CAS deals with very ill patients with health problems that tend to be complex, a mixture of acute and chronic, over-lapping and compounded by long-term neglect of chronic health problems. CAS patients often have 2 or 3 consultations (for instance: doctor, nurse, drug clinic) on any single visit and may attend CAS several times in a week. A substantial amount of clinical staff time is also spent on dealing with wounds and infections which require constant dressing and reviews. These may be classified as “minor” and thus excluded from this study because the EMIS default is to record problems as “minor”.. The method used here records an individual problem once, irrespective of the number of times it occurs or is the subject of consultations and treatment. Since the data were analysed over a time period, incidence and prevalence are not properly distinguished and the results do not reflect the recurring or chronic nature of problems. An incidence study would go some way to addressing the under-representation but , since many of the problems are chronic or chronic-relapsing, it would be difficult to define boundaries between separate incidents. . The data do not distinguish between in-house and external services received by CAS patients and external services can only be recorded if CAS is notified about them. Nonetheless, the data presented are consistent with the profile of health problems for the single homeless from other studies.

#### ***15.5. Conclusions and recommendations***

Despite the limitations in the methods, the results suggest that patients registered at CAS experience multiple morbidity, die much younger compared to the general population and have substantial drug, alcohol and mental health problems. Drug and

alcohol treatment are among the enhanced services provided by CAS but CAS is under-resourced to provide all the necessary drug and alcohol services in-house. The study demonstrates the severity of drug, alcohol and mental health problems in this group. This evidence supports the widespread concern expressed by contributors to the homelessness JSNA about the unsatisfactory and fragmented services available for this crucial matrix of problems.

The data analysis reveals some clear and striking results about the health of this population. It is a preliminary effort which will enable us to refine future data analysis. We have experienced some difficulties in extracting and interpreting data from the EMIS medical software system. These are due to intrinsic limitations of the software system, the inadequacy of national Read Codes for describing health and social problems among the homeless and the difficulty in maintaining consistent data entry with staffing shortages.

The following recommendations are suggested.

*Recommendations for Cambridge Access Surgery*

1. CAS should continue to develop consistent coding and recording of commonly occurring health problems, results of investigations, patient attendance, and other aspects of services.
2. A performance framework for monitoring activity and outcomes of patients registered at CAS should be developed.
3. Commissioners should consider extending integration of services for the registered population so that services are patient-centred rather than service focused, including commissioning:
  - CAS to provide in-house drug treatment for all patients;
  - CPN post to engage and work with mentally ill rough-sleepers and night shelter residents;
  - Alcohol detox. beds in Cambridge;
  - Improved communication between CAS, Addenbrooke's and Mental Health services so that CAS in-patients receive seamless, optimal drug and alcohol management;
  - Additional GP time to enable interaction with other key stakeholder agencies;
  - Forward planning of larger premises (possibly through the purchase of adjacent property) to preserve the successful "one-stop shop model" currently at 125 Newmarket Road.

*Recommendations for Cambridgeshire countywide healthcare for the homeless*

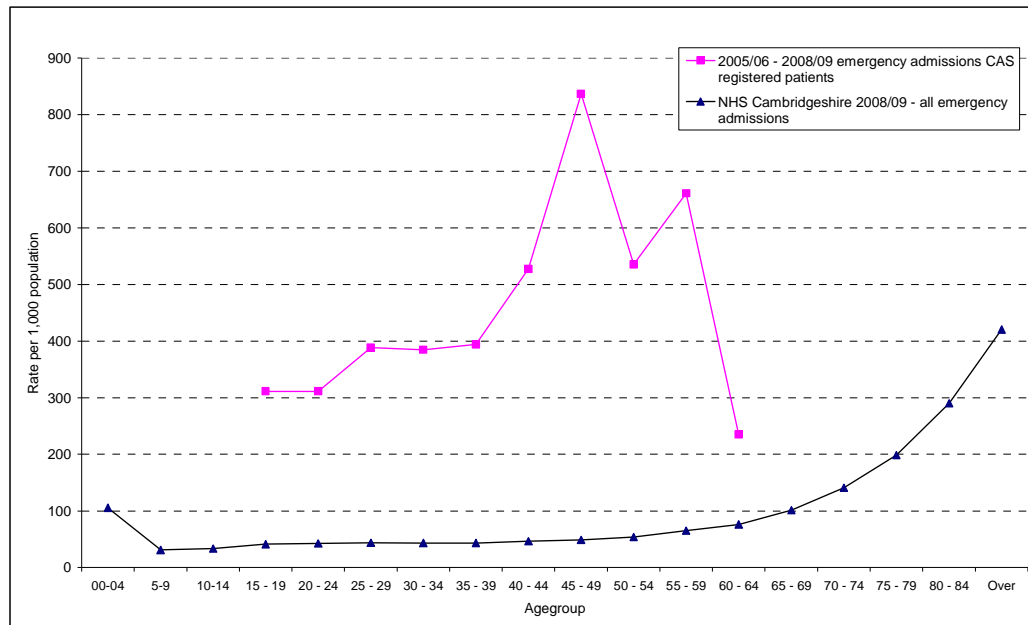
1. As homelessness is a perennial problem in Cambridgeshire, focused and innovative ways of improving access to mainstream primary health care services by homeless people should be considered across the entire county.
2. Commissioners should consider means of improving services throughout the county, establishing specialised primary care or enhanced service within generic primary care (via LES or other means) according to local needs.
3. A programme of education on homelessness and associated healthcare issues should be made available for GP Practices in Cambridgeshire, using existing expertise (for instance from CAS)

## 16. Appendix 8: Secondary Care Data usage by the homeless population

### 16.1. Emergency inpatient admissions

The rate of hospital admission amongst the homeless population is significantly higher than the local and national average. Age-specific rates of emergency hospital admission for the registered population of Cambridge Access Surgery (CAS) are shown in the figure compared with the average emergency admission rate for all Cambridgeshire registered patients. Age-specific rates in certain age groups are up to 8 times higher than that of the general population. If the Cambridgeshire rate is applied to the CAS population and the expected number of admissions compared with the 'actual', the resulting 'indirectly standardised' rate of emergency admission is 377 (95% confidence interval 352 – 403), where the Cambridgeshire rate is 100. The rate of emergency admission is thus 3 – 4 times that of the general population. However, further comparison with other areas in the country that have similar GP practices would be useful.

**Figure 16.5:** Emergency admissions – CAS registered patients (2005/06 – 2008/09) compared with all NHS Cambridgeshire emergency admissions (2008/09). Age-specific rate per 1,000 population



Source: ASP Commissioning Data Set (CDS)

Between 2004/05 and 2008/09, 303 patients registered at Cambridge Access Surgery had 1,026 inpatient admissions, of which 84% were emergency admissions (n=858). Of these emergency admissions, 92% (n=794) were as a result of an A&E attendance, a further 5% from the GP. A substantial proportion (94%, n=808) of these emergency admissions were to CUHFT (Addenbrooke's Hospital).

### Reason for emergency admission

The range of conditions for which an emergency admission was required is extensive but summarise to injuries, skin infections (many serious), and a mixture of drug, but predominantly **alcohol related diagnostic admissions**. **This could be explored further in the alcohol needs assessment work currently being carried out in Cambridgeshire.**

### Frequency of admission

Using NHS Number to identify individual patients, it was possible to identify that the 858 admission episodes related to 303 patients. Of these, 134 (44%) had only one emergency admission over the four year period, a further 121 had 2-4 emergency admissions (40%) and 48 patients (16%) had five or more. A small number of people had in excess of 20 emergency admissions over four years. 16 people averaged over 10 emergency admissions per year over the four year period (total number of admissions in the range of 10-25). Some people are admitted every year as an emergency admission, frequently more than once. In these data, 7 people were admitted an average of 4 times per year over four years.

### Patients of 'No Fixed Abode' (NFA) – emergency admissions

In addition to hospital admission data from CAS patients, it is possible to query the inpatient data using postcode of patient coded to 'No Fixed Abode' (postcode ZZ99 3VZ). This code is also used for armed forces and for prisoners so it was necessary to exclude those from this analysis. Amongst the NFA patients identified, a number were registered patients at CAS. These have been shown separately in the table below.

**Table 16.5:** Patients of No Fixed Abode – number of admissions and number of people

	2004/05	2005/06	2006/07	2007/08	2008/09	Total
NFA – no. people (excluding CAS)	28	29	19	32	33	171
NFA – no. people (CAS)	10	15	15	20	14	71
NFA – total no. people	38	44	34	43	47	236*
NFA – no. admissions (excluding CAS)	56	52	28	58	56	250
NFA – no. admissions (CAS)	17	32	28	33	38	148

Source: ASP CDS \* 6 people registered with more than one GP practice over the period

### Hospital discharge

There is little information from the inpatient dataset on the outcome of the hospital admission. A national survey was carried out in 2008 on patients discharged from acute hospital to No Fixed Abode.<sup>60</sup> CUHFT was able to supply this information for the survey and the numbers show a decreasing trend locally from 115 patients in 2003 to 64 patients in 2007. However, this was not the case across the country.

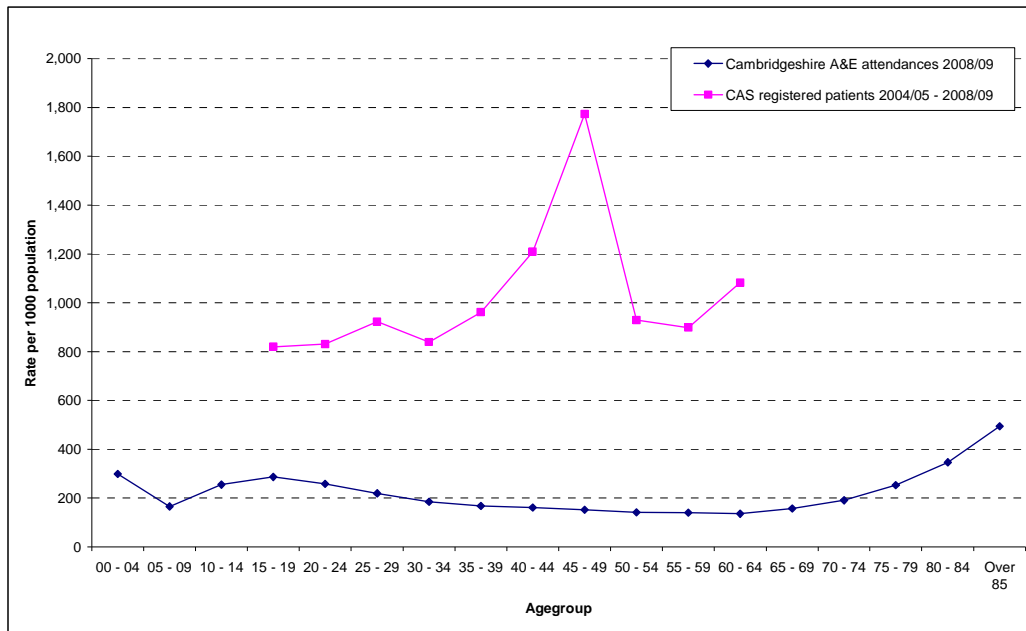
Local hospital discharge protocols have not been formally reviewed at this stage of the JSNA. In 2005 an ODPM report<sup>61</sup> cited Cambridge City Council Housing Services – Information Sharing Protocol to Prevent Homelessness as an example which identified the importance of information collection and data sharing across housing, health and social care boundaries which aimed to promote joint working.



**16.2. Attendances at Accident & Emergency (A&E)**

The homeless population of CAS registered patients, have rates of A&E attendance far above the local average. The indirectly standardised attendance rate is 553 (95% CI 529 – 578) where Cambridgeshire as a whole is 100. CAS patients have a rate of A&E attendance over five times that of the general population.

**Figure 16.6:** Age-specific rate of A&E attendance by CAS registered patients compared with the Cambridgeshire average attendance.



Source: A&E database

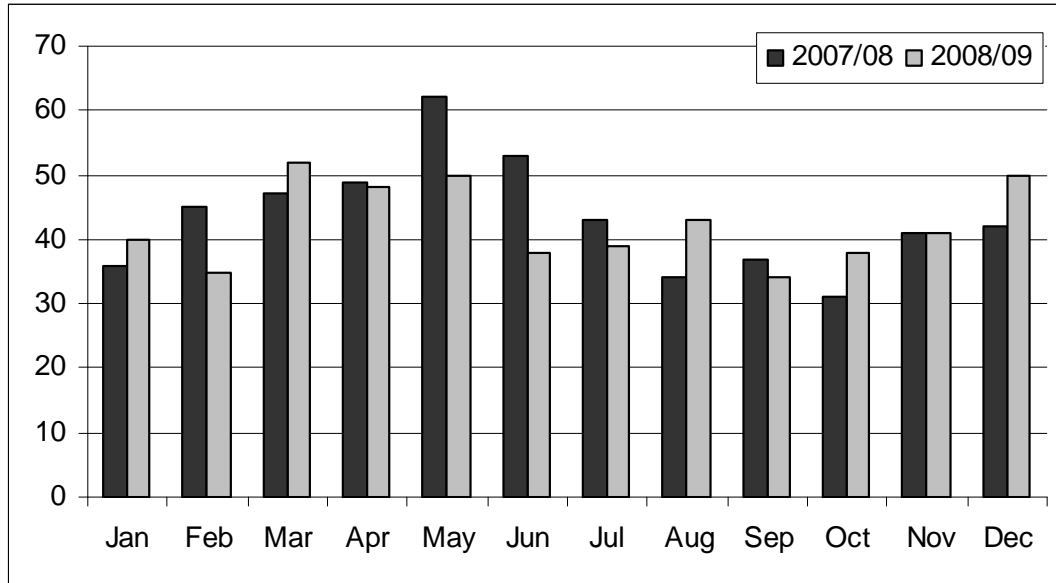
The table shows the number of A&E attendances by CAS patients since 2005/06 as recorded by CUHFT (Addenbrooke's). Between 2005/06 and 2008/09, 451 registered patients of CAS were identified as having had 1,733 attendances at Accident and Emergency in CUHFT.

**Table 16.6:** Number of people and attendances at CUHFT A&E 2005/06 – 2008/09 by CAS registered patients

	Year			
	2005/06	2006/07	2007/08	2008/09
Number of people	148	173	197	179
Number of attendances	353	420	506	454

Source: A&E database

The figure shows the distribution of A&E attendances by month for the most recent two years.

**Figure 16.7:** Attendances at A&E by CAS patients, 2007/08 and 2008/09 by month

Source: ASP A&E database

As previously described, A&E is the main source of inpatient hospital admissions for CAS registered patients. The table shows the outcome of the A&E attendance between 2004/05 and 2008/09 for CAS registered patients. Overall, 43% of total A&E attendances between 2004/05 and 2008/09 resulted in an admission to hospital. There is evidence (source CAS) that the recording of those leaving department before treatment/refused treatment (total 15%) should be explored further.

**Table 16.7:** A&E attendances by CAS registered patients 2005/06 to 2008/09

	2005/06	2006/07	2007/08	2008/09	Total	% of total
Admitted to Hospital bed	154	203	206	198	761	43%
Discharged - no GP follow up required	86	107	147	140	480	27%
Left Department Before Being Treated	37	39	73	54	203	11%
Discharged to GP	28	12	43	46	129	7%
Referred to Other Outpatient Clinic	18	17	9	26	70	4%
Left Department Having Refused Treatment	9	17	9	16	51	3%
Referred to Fracture Clinic	12	14	7	14	47	3%
Transferred to Other Health Care Provider	2	8	10	6	26	1%
Referred to A&E Clinic	<6	<6	<6	<6	-	<1%
<b>Total</b>	<b>353</b>	<b>420</b>	<b>506</b>	<b>503</b>	<b>1782</b>	<b>100%</b>

Source: ASP A&E database

### A & E attendance – diagnosis

Information on 'diagnosis' or the primary reason for attendance at A&E is poorly recorded. In 2008/09 there was no diagnostic information coded and for 2007/08 there was too much missing data for this to be informative.

### Frequency of A&E attendance

33% of patients (151/451) attended A&E on one occasion only in the last five years; this represents 9% of all attendances (151/1733). A further 32% (146/451 people) had attended A&E twice in the last four years on either one or two different years; this represents 29% (188/1733 total attendances) In total, 297/451 (65%) of CAS patients had attended A&E either once or twice in one or two years. A small number of individual patients have experienced high levels of A&E attendance. Five people have attended A&E 20 to 50 times over the four year period.

### Audit of A&E attendance 2006/07

CAS undertook a retrospective audit for the period 1/3/2006 - 31/03/2007. Patients who had attended A&E five or more times were identified from CATCH Indicative Budget and electronic and paper records discharge summaries. Where the information allowed, attendance was classified as necessary, of doubtful necessity or unnecessary. Categories generated depended on the clinical judgement of the GP researcher after reviewing the available information and were acknowledged to be inherently subjective.

**Unnecessary:** The patients problem could have been dealt with in primary care, either by CAS or by the CAMDOC out of hours service. This decision was based on the patients presentation and what might reasonably have been within the capability of primary care, rather than what could have been done with the aid of hindsight.

**Necessary:** Attendance at A&E or Hospital admission was indicated: the patients' problem could not have been dealt with in primary care.

**Doubtful necessity:** it may have been possible to deal with the problem in primary care.

**Not known:** no written communication from hospital (A&E report or discharge summary) to explain the attendance. Verbal reports did not qualify as 'written communication'.

**Table 16.8:** Results of CAS Audit of A&E attendance

Total number of patients attending 5 or more times (2006/07) (range 5-15)	21
Total number of attendances between these 21 patients	173

	Number of attendances (%)
Unnecessary	33 (19%)
Necessary	61 (35%)
Doubtful	22 (13%)
Not known	57 (33%)
Total number of attendances	173 (100%)

### Key points

For one third of patients there was no written information from the hospital

One fifth (19%) of attendances were assessed as unnecessary

One-third (35%) were assessed as necessary

### A&E Attendances – No Fixed Abode

As with the inpatient admissions, it is also possible to query the A&E database by postcode used for patients of No Fixed Abode (ZZ99 3VA). District was assigned using GP Practice of the patient. This shows that of all attendances at CUHFT between

2005/06 and 2008/09 (excluding CAS), 33% (excluding CAS NFA) and 20% of the total, are not registered with Cambridgeshire GP practices. Cambridge City GP Practices other than CAS account for 172 attendances by people who are NFA and other districts, chiefly South Cambridgeshire (n=22) and East Cambridgeshire (n=26) account for the majority of the remainder.

**Table 9:** Attendances at CUHFT A&E 2005/06 – 2008/09 by people who are of No Fixed Abode (attendances by CAS registered patients who are NFA shown separately)

	2004/05	2005/06	2006/07	2007/08	2008/09	Total
Cambridge City	60	25	37	31	19	172
Other districts (in Cambs)	14	16	9	15	10	64
Out of area (ie not Cambs)	26	40	6	11	33	116
Total NFA (excl CAS)	100	81	52	57	62	352
CAS NFA patients	-	53	54	52	73	232
Total A&E Attendances NFA	100	134	106	109	135	584

Source: A&E database

### 17. Appendix 9: Services for homeless in Cambridgeshire

Table 17.1: Accommodation services in Cambridgeshire. Source: Homeless UK, April 09

Area	Organisation name	Client groups														Services						Further details				
		Single homeless/Rough sleepers	Homeless families	Young people/ Young people leaving Care	Teenage Parents	Offenders/Ex-Offenders	People with Disability	Older People	Travellers	Migrants/Refugees and Asylum Seekers	Women	Alcohol	Drug problems	Domestic violence	Mental health problems	Accommodation	Support	Health	Drugs	Alcohol	Access to move on	Places	Age group	Self referral	Minimum length of stay	Maximum length of stay
Countywide	Cambridge YMCA	x		x											x	x				x	x	80	16-25	No	3 months	2 years
Cambridge City	Cambridge City Council - Ditchburn Place	x													x	x	x	x		x	x	28	18-64	No	2 years	3 years
	Cambridge Cyrenians - Controlled drinking project	x														x	x	x		x	x	6	40+	No	6 months	None
	Cambridge Cyrenians - Long stay accommodation	x														x	x	x		x	x	8	18+	No	None	None
	Cambridge Cyrenians - Short stay accommodation	x														x	x	x		x	x	16	18+	No	1 month	None
	Cambridge Housing Society - Mill Road	x														x	x			x	x	7	18-25	Yes	None	2 years
	Cambridge Housing Society - Railway House	x		x												x	x			x	x	12	16-21	Yes	None	2 years
	Cambridge Women's Aid		x													x	x			x	x	11	16+	Yes	1 night	2 years
	Cambridge Women and Homelessness Group - Corona House	x														x	x			x	x	6	18+	Yes	None	2 years
	English Churches Housing Group (ECHG) - Cambridge Youth Foyer	x		x												x	x	x		x	x	18	16-25	No	6 months	2 years
	ECHG - Willow Walk	x														x	x			x	x	22	18-60	No	1 night	18 months
	Jimmy's Nightshelter	x														x	x	x		x	x	31	18-65	Yes	1 night	None
	Jubilee Project	x														x	x			x	x	8	18-60	No	3 months	18 months
	Richmond Fellowship - Castle Project	x		x												x	x			x	x	17	16-25	No	6 months	2 years
	Stonham - Cambridge Corner House	x														x	x			x	x	10	18-64	No	3 months	2 years
	ECHG - Victoria Road	x														x	x	x		x	x	74	18-60	No	None	2 years
Whitworth House	x		x												x	x			x	x	13	16-25	Yes	1 month	2 years	
East Cambridgeshire	Cambridge Housing Society - Wheatsheaf Close	x		x											x	x			x	x	12	16-21	Yes	None	2 years	
Fenland	Refuge - Fenlands		x																		12	16+	Yes	1 night	2 years	
	Ferry Project - Wisbech (Luminus Group)	x													x	x			x	x	30	16+	Yes	1 night	2 years	
	Stonham - The Staithe (Wisbech)	x		x											x	x			x	x	10	16-25	Yes	None	2 years	
	Stonham - Wisbech dispersed (March)	x		x											x	x			x	x	3	16-25	Yes	6 months	2 years	
	Wisbech Foyer	x		x											x	x			x	x	17	16-25	No	6 months	2 years	
Huntingdonshire	Granta Housing Society - Coneygear Court (Huntingdon)	x	x	x											x	x			x	x	28	16+	No	4 weeks	1 year	
	Paine's Mill Foyer (St Neots)	x		x											x	x	x		x	x	19	16-25	Yes	3 months	2 years	
	Salvation Army - Kings Ripton Court	x		x											x	x			x	x	36	16-35	No	6 months	2 years	
	Stonham - Huntingdon Ex-offenders	x													x	x			x	x	6	18-65	No	6 months	2 years	
	Stonham - Huntingdon young people at risk	x		x											x	x			x	x	8	16-21	No	6 months	2 years	
South Cambridgeshire	Granta - People with mental health support needs (Comberton)	x													x	x	x		x	x	132	18+	Yes	2 years	Long term	
	Emmaus Cambridge (Landbeach)	x													x	x			x	x	30	18+	Yes	None	long term	
<b>TOTAL</b>			28	3	14	0	2	1	0	1	0	4	2	0	2	3	30	30	9	4	9	30	710			

Table 17.2: Advice services in Cambridgeshire. Source: Homeless UK, April 09

Area	Organisation name	Client groups														Service				Further Details			
		Single homeless/ Rough sleepers	Homeless families	Young people/ Young people leaving Care	Teenage Parents	Offenders/Ex-Offenders	People with Disability	Older People	Travellers	Migrants/Refugees and Asylum Seekers	Women	Alcohol	Drug problems	Domestic violence	Mental health problems	Support	Health	Drugs	Alcohol	Advice	Age group	Drop In	
Countywide	Addenbrookes NHS Trust PALS																				Not specified	Yes	
	Age Concern - Cambridgeshire						x								x							Not specified	Yes
	Cambridge and District Community Mediation Service																					Not specified	No
	Cambridge rape crisis centre																					Not specified	No
	Cambridge Samaritans																					Not specified	Yes
	Cambridgeshire and Peterborough Mental Health Partnership NHS Trust PALS																					Not specified	No
	Cambridgeshire PCT PALS																					Not specified	No
	Cambridgeshire Social Services - Head Office																					Not specified	No
	Cambridgeshire, Norfolk and Suffolk ICAS																					Not specified	No
	Immigration Advisory Service - Peterborough																					Not specified	No
	META																					Not specified	Yes
	National Probation Service - Cambridgeshire																					Not specified	Yes
	Papworth Hospital NHS Foundation Trust - PALS																					Not specified	Yes
	Peterborough Rape Crisis Counselling Group																					Not specified	No
	Refugee Council - Eastern Region One Stop Service																					Not specified	Yes
	Southend Women's Aid - Dove Project																					Not specified	No
	St Neots Abuse Project																					Not specified	No
Cambridge City	Addaction - Mill House Drug Service																					18+	No
	Bridge Alcohol Information and Treatment Service																					Not specified	No
	Cam - Mind																					Not specified	No
	Cambridge Access Surgery	x																				Not specified	Yes
	Cambridge CAB																					Not specified	Yes
	Cambridge Chinese Community Centre																					Not specified	Yes
	Cambridge City Council - Housing options and advice	x																				Not specified	Yes
	Cambridge Family Mediation Service																					Not specified	No
	Cambridge Law Centre																					Not specified	Yes
	Cambridge Refugee Support Group																					Not specified	Yes
	Cambridge SOFA																					Not specified	No
	Cambridgeshire Vietnamese Refugee Community																					Not specified	Yes
	Centre 33 (Cambridge)																					25 and under	Yes
																						13 to 19 years, up to 25 years with additional needs	Yes
	Connexions - Cambridge Youth Advice Centre																					Not specified	No
	Drinksense - Cambridge City, South and East																					Working age	Yes
	Jobcentre plus - Cambridge																					Not specified	Yes
Salvation Army - Cambridge Community Centre	x																				Not specified	Yes	
Wintercomfort for the homeless	x	x																			Not specified	Yes	
East Cambridgeshire	Connexions - Ely																					13 to 19 years, up to 25 years with additional needs	Yes
	East Cambridgeshire District Council - Housing advice and homelessness	x	x																			Not specified	Yes
	Ely and District CAB																					Not specified	Yes
	Jobcentre plus - Ely																					Working age	Yes
	Newmarket CAB																					Not specified	Yes

Table 17.3: Advice services in Cambridgeshire continued. Source: Homeless UK, April 09

Area	Organisation name	Client groups														Service					Further Details	
		Single homeless/ Rough sleepers	Homeless families	Young people/ Young people leaving Care	Teenage Parents	Offenders	People with Disability	Older People	Travellers	Migrants/Refugees and Asylum Seekers	Women	Alcohol	Drug problems	Domestic violence	Mental health problems	Support	Health	Drugs	Alcohol	Advice	Age group	Drop in
Fenland	Addaction Wisbech														x				x	Not specified	Yes	
	Bridgegate drug services - Peterborough		x												x		x		x	Young people 13 to 19 years, up to 25 years with additional needs	Yes	
	Connexions - March			x															x	13 to 19 years, up to 25 years with additional needs	Yes	
	Connexions - Wisbech			x											x				x	Not specified	Yes	
	Drinksense - Fenland														x				x	Not specified	No	
	EAST (Eastern AIDs Support Triangle)														x				x	Not specified	Yes	
	Fenland @ your service shop - Chatteris Housing Options	x	x																	x	Not specified	Yes
	Fenland @ your service shop - March Housing Options	x	x																	x	Not specified	Yes
	Fenland @ your service shop - Whittlesey Housing Options	x	x																	x	Not specified	Yes
	Fenland @ your service shop - Wisbech Housing Options	x	x																	x	Not specified	Yes
	Fenland CAB																			x	Not specified	Yes
	Hope Social Enterprises (March)																			x	Not specified	Yes
	Jobcentre plus - Wisbech																			x	Working age	Yes
	Mind - Fenland																			x	18 to 65	Yes
Rosmini Centre - Wisbech																			x	Not specified	Yes	
Huntingdonshire	Connexions - Huntingdon			x																13 to 19 years, up to 25 years with additional needs	Yes	
	Connexions - St Neots			x																x	13 to 19 years, up to 25 years with additional needs	Yes
	Dialdruglink			x																x	Young people	Yes
	Disability Information Service - Huntingdonshire																			x	Not specified	Yes
	Drinksense - Huntingdonshire																			x	Not specified	No
	Huntingdon CAB																			x	Not specified	Yes
	Huntingdon Law Centre																			x	Not specified	No
	Huntingdonshire District Council - Housing Needs and Resources Dept	x	x																	x	Not specified	Yes
	Hunts Mind																			x	Not specified	Yes
	Information shop for young people - Huntingdon			x																x	Not specified	Yes
	Jobcentre plus - Huntingdon																			x	13 to 19 years	Yes
	Peterborough and District Samaritans																			x	Working age	Yes
	St Neots CAB																			x	Not specified	No
	St Neots CAB																			x	Not specified	Yes
South Cambs	North Hertfordshire and District CAB - Royston																			x	Not specified	Yes
	Sawston CAB																			x	Not specified	Yes
	South Cambridgeshire District Council - Housing Advice Service	x	x																	x	Not specified	No
<b>TOTAL</b>		11	8	10	0	1	1	1	0	6	3	5	5	2	4	58	6	7	7	67		

Floating support services in Cambridgeshire. Source: Homeless UK, April 09

HOMELESSNESS JSNA v1

Area	Organisation name	Client groups											Further details								
		Single homeless/ Rough sleepers	Homeless families	Young people/ Young people leaving Care	Teenage Parents	Offenders/Ex-Offenders	People with Disability	Older People	Travellers	Migrants/ Refugees and Asylum Seekers	Women	Alcohol	Drug problems	Domestic violence	Mental health problems	Max no of users	Age group	Self referral	Drop in	Minimum length of support	Maximum length of support
Countywide	Cambridgeshire Mental Health Floating Support													x	91	16-64	Yes	Yes	None	2 years	
	Luminus - Tenancy Support and Resettlement														15	16-74	Yes	Yes	None	2 years	
	Muir Group - Fenland and Hunts Floating Support														40	18+	Yes	No	None	2 years	
	Tenancy Support and Resettlement Service (Female)					x								x	10	18+	Yes	Yes	None	2 years	
Cambridge City	Cambridge City Council Housing Support Service														83	16+	Yes	Yes	3 months	2 years	
	Cambridge Cyrenians - Older Persons Project	x												x	Varies	50+	Yes	Yes	None	None	
	Cambridge Pringle Home and Community Support Service														No max	18-64	Yes	Yes	None	2 years	
	Cambridge Women's Aid - Floating Support														Not specific	16+	Yes	No	None	2 years	
	ECHG - Tenancy Sustainment Team	x												x	75	18-65	Yes	Yes	None	2 years	
East Cambridgeshire	East Cambs Housing and Floating Support Service														56	16-64	Yes	Yes	None	2 years	
Fenland	Axiom HA - Floating Support (Probation)														24	18+	No	No	None	2 years	
	Stonham - Fenland Young People			x											24	16-25	Yes	Yes	None	2 years	
Huntingdonshire	CDIP Tenancy Support and Resettlement														15	18+	No	No	None	2 years	
	Huntingdonshire Drug and Alcohol Floating Support														20	18-64	Yes	Yes	None	2 years	
South Cambridgeshire	South Cambridgeshire DC Floating Support (Cambourne)														32	25+	Yes	Yes	3 months	2 years	
	South Cambridgeshire Floating Support Service (Histon)	x	x	x											35	16-25	Yes	No	None	2 years	
TOTAL		3	1	2	0	2	0	1	0	0	2	1	2	1	2						

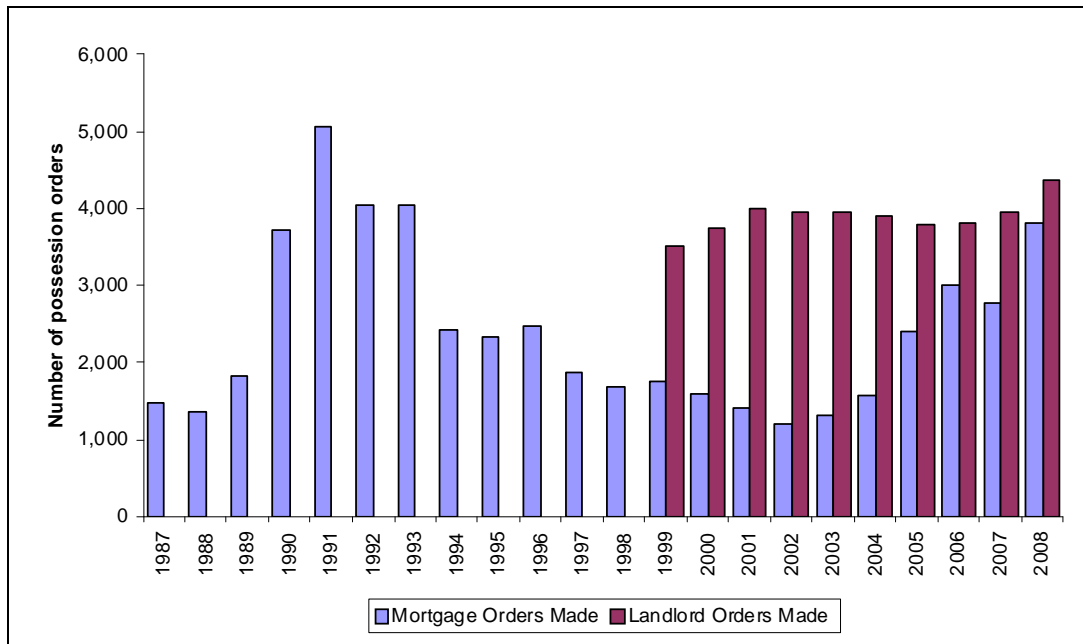


## 18. Appendix 10: House repossessions data

This paper looks at some of the data about housing repossessions. There are three sources of data for repossessions: the Council of Mortgage Lenders (CML), the Ministry of Justice (MoJ) and the Financial Services Authority (FSA). There are some differences in the way the data is collected by each organisation, so the figures are different. These differences in these data sources are explained in Table 18.1.

This section looks at the Ministry of Justice data. This provides the highest estimate of repossessed properties, but is the only one which provides local level data.

**Figure 18.1:** Mortgage and Landlord possession orders made 1987-2008 in Cambridgeshire, Norfolk and Suffolk Courts



Source: Ministry of Justice

Figure 18.1 uses MoJ data for the Cambridgeshire/ Norfolk/ Suffolk area for consistency reasons. For example, the court in Wisbech closed in 1996 and from the data it looks as though the caseload for that court moved to King's Lynn. There is also no data for court boundaries and therefore no way of knowing for example where someone from March would be recorded – Peterborough, King's Lynn or Huntingdon? Data on landlord orders was only collected from 1999 onwards. The number of these is higher than the number of mortgage orders made. However, most of this period the number of mortgage possession orders has been increasing, while the number of landlord possessions appears to have been relatively consistent. However in 2008 the number of landlord orders rose to more than 4,000 in 2008.

Between 1997 and 2004 the number of mortgage orders made per year was below 2,000. Since this time it has been increasing, but the increase has not yet reached the levels recorded between 1991 and 1993. The drop between 2006 and 2007 is due to changes in reporting. A new system was introduced in 2006 and only courts with access to the system record orders made. In the area covered, this was Cambridge, Peterborough, Norwich and Ipswich. Data for Huntingdon, Bury St Edmunds, King's

Lynn and Lowestoft was not collected. There were 1,057 more mortgage possessions made in 2008 than there were in 2007 – a 38% increase.

**Table 18.1** Description of data sources for house possession orders

	Council of Mortgage Lenders (CML)	Financial Services Authority (FSA)	Ministry of justice (MoJ)
Geographical Coverage	UK	UK	England & Wales, regionally and locally by court
Loan Coverage	Covers all 1 <sup>st</sup> charge mortgages for CML members (around 98% of the mortgage market). Include BTL in total, but also reports BTL data separately.	Covers all loans by regulated lenders, so includes second charges, BTL and other unregulated mortgages. Lenders that only carry out unregulated mortgages are not include in the total.	Reports by court rather than loan type.
Arrears coverage	Reports arrears cases by the number of months in arrears. Also reported by percentage of balance outstanding, where the balance is more than 2.5%.	Groups arrears figures by the amount of balance outstanding that the arrears represent. Unlike the CML outstanding balances below 2.5% are included. Includes 2 <sup>nd</sup> charge loans.	Does not include arrears data
Possessions coverage	Records all properties taken into possession by CML members relating to first charge mortgages. No distinction is made between voluntary possessions and court ordered ones.	Covers voluntary and court ordered possessions. Covers all mortgages accounts in possession (including 2 <sup>nd</sup> charges). For this reason there is some double counting and the figure is likely to be higher than CML figures.	Cover all possession orders made but do not include voluntary possessions. A court order does not necessarily mean the property will eventually be possessed, which means they are always likely to exceed the other two sources.
Access to data	Limited information available for free. More detailed information available for subscription of £7,000	Free	Free

## 19. Appendix 11: Cambridgeshire City Council Homeless Strategy Consultation

In order to develop the Cambridgeshire City Council Homeless Strategy a consultation was undertaken which involved writing to a wide range of organisations working directly or indirectly with homeless people. The comments received were formulated into four themes:

- temporary accommodation
- homelessness prevention
- access to longer term housing options and sustaining settled lifestyles
- and tackling social exclusion.

The second stage of the consultation involved four events (each about two hours in length). Current and former users of homelessness services and frontline staff who work with homeless people were invited to the events held at times and locations which homeless people would find convenient. Flexible techniques, such as splitting up into smaller groups, were used to elicit the fullest and most honest response possible.

These comments were incorporated into the strategy where appropriate and/or used in the finished strategy document. The comments made during the consultation have been summarised below into the four themes:

### Temporary accommodation

- **Making best use of existing hostel accommodation** –ensure that level of support available in accommodation is appropriate to the needs of residents and that support and tenancy sustainment are provided from the point when people move into temporary accommodation. Ensuring that move-on accommodation is readily available would reduce the pressure on temporary accommodation
- **Demand for new accommodation** - Specific areas of need highlighted were services for dual diagnosis clients (drugs, alcohol, mental health) and rehabilitation places and also accommodation for young vulnerable people, those straight out of prison, those who are multiply excluded, refuge provision for victims of domestic violence and a 'clean' hostel. The need for a range of accommodation for people who are not ready for independent living such as training flats, supported lodgings, shared houses was also raised as well as ensuring that people are placed appropriately in accommodation that meets their needs. A phased approach to reducing larger hostel accommodation in favour of dispersed specialist schemes is needed.

### Homelessness prevention

- **Tenancy breakdown: support and advice** - On-going support for vulnerable people in tenancies as well as accessible debt and advice services. Pro-active identification of tenants at risk and early intervention. Review of failed tenancies and eviction criteria/policies.
- **Mortgages, rents and arrears** – schemes to support people with difficulties paying mortgage and rent and review rent arrears procedures.
- **Family and partner relationship breakdown** - More work with children's service and schools, early intervention work to prevent relationship breakdown and use mediation and conciliation in family breakdown cases. Small grants for families to

make changes that would mean young people are more likely to be able to stay at home.

- **Emergency provision**
- **Work with specific client groups** - Need for early intervention homelessness prevention work for young people and close working between agencies working with young people at risk of homelessness. Supported lodgings to keep young people out of hostels. Review of prison release procedures. Education about the realities of homelessness.

### **Access to longer term housing options**

- **Increasing the use of private rented accommodation** - more support and initiatives available to help the transition from temporary into permanent accommodation. More links with the private rented sector and support for those who access it. Improve cooperation between statutory, voluntary and private sectors.
- **Specialist accommodation** - increase availability of move-on options for young parents (especially couples, as most provision is currently for single parents), older people, including shared accommodation, people who are not ready for independent living (and maybe never will be), but do not need hostel accommodation with 24 hour support. Sheltered accommodation for clients with enduring support needs and supported housing for people with high care needs. Development of a series of small accommodation projects: shared houses and a homeless sheltered accommodation linked to work with realistic expectations of clients
- **Working with hostel residents** - there is a need to motivate the unmotivated (some people seem not to want to move on) and give people realistic expectations of what they can achieve. Advocacy and support are very important and lacking as well as education on issues such as housing benefits. Development of move-on options including availability and appropriate support
- **Practical support** - Continue floating support for as long as it is needed

### **Sustaining settled lifestyles and tackling social exclusion**

- **Work and learning** - more learning opportunities for young people and promotion of existing return to work schemes for homeless people. Better relationships with voluntary and educational organisations to improve work and learning opportunities. Better education about the realities of getting back into employment.
- **Tenancy support** – accessible non time-limited support and advice required. Identification of and extra support for high risk cases.
- **Solutions focused on the individual** - work and learning opportunities should be focussed on interests and skills. Assessment of individuals' needs before placing them in accommodation

### **Other key issues**

- More help for migrant families (with or without recourse to public funds)
- Alcohol services now lag behind drug services. More detox and rehab required. Alcohol and drug detox and rehab must be meaningful and responsive
- Better partnerships and coordination between different local authorities and their various strategies and priorities. Improve protocols between agencies e.g. health and social services. Better communication between different professionals working with clients
- More help required for young people making the transition between YP and adult services

## 20. Appendix 12: Home-Link the Cambridge Sub- Regional Choice Based Lettings Scheme

The Government set all local authorities the target of creating a choice based lettings scheme by 2010. The Home-Link scheme, covering the Cambridge Sub region, went live on 22<sup>nd</sup> February 2008 (with the exception of Fenland DC, who went live with the scheme in November 2008, due to their large scale voluntary transfer of housing stock).

Under the Home-Link scheme applicants are required to be proactive in seeking a home rather than wait for a local authority or housing association to contact them about a property they can be 'allocated'. Properties are advertised on a fortnightly basis, and applicants may bid (express an interest) on up to three properties each bidding cycle. A short list is then produced and the property is offered to the applicant with the highest housing need for that type of accommodation. It is therefore important that the system is straightforward, understandable, transparent and fair.

The Home-Link scheme has a sub-regional framework and whilst each partner organisation has its own lettings policy, these include the same sub-regionally agreed principles. This includes a banding system that is used across the sub-region to assess and prioritise housing need. This helps to achieve an understandable and transparent policy. The banding scheme includes four priority bands A – D (Table ).

Table: Banding for prioritising housing need within the Home-Link scheme

Band A: Urgent Need	Band B: High Need	Band C: Medium Need	Band D: Low Need
<ul style="list-style-type: none"> <li>Urgent transfer</li> <li>Statutorily overcrowded</li> <li>Urgent Health &amp; Safety Risk</li> <li>Urgent medical need</li> <li>Current Supported housing resident</li> <li>Homeless households (main homelessness duty owed)</li> <li>Urgent multiple needs</li> </ul>	<ul style="list-style-type: none"> <li>High Health &amp; Safety Risk</li> <li>High medical need</li> <li>Victims of harassment, violence or abuse</li> <li>Lacking two bedrooms</li> <li>Under-occupancy by two or more bedrooms or release of adapted property.</li> <li>Homelessness prevention (prior to homelessness decision being made)</li> <li>Confirmed rough sleeping</li> <li>Multiple needs</li> </ul>	<ul style="list-style-type: none"> <li>Medium Medical Need</li> <li>Under-occupancy by one bedroom</li> <li><b>Need to move for social reasons</b></li> <li>Housing conditions.</li> <li>Lacking one bedroom</li> <li>Other homelessness</li> </ul>	<p>An applicant assessed as having low housing need will be placed in band D</p>

Within such a scheme as this, it is important that the needs of vulnerable applicants are considered to prevent them from being excluded. In view of this an Access Strategy was produced, which many agencies, including the partner organisations have signed up to. This includes a number of ways in which support can be given to vulnerable applicants including:

- Translation of documents

- Providing documents in alternative formats such as large print
- Posting property magazines to housebound applicants
- Enabling applicants to appoint an advocate
- Enabling family and friends to bid on behalf of an applicant
- Partner organisations and other stakeholders assisting applicants to bid for available homes.

As part of a review of the scheme a questionnaire was sent to 2,312 customers (10.51% of the sub-regional register). A total of 364 questionnaires were returned (a response rate of 15.74%). Those who responded to the questionnaire understood how the Home-link scheme worked (79%), had sufficient scheme information (73%) and knew where to get a copy of the Home-Link magazine (72%). Respondents liked the ease of use, transparency and choice the scheme offered as well as the greater geographical area now available to them.

During the first year of operation, questions regarding the scheme have been placed on the web site on a regular basis. Questions are posted as the bidding cycle begins and they remain in place until a new question is posted at the beginning of the next cycle.

Table: Responses to web internet based questionnaire on the Home-Link scheme

Questions	Response	
	Yes (%)	No (%)
Do you understand how the scheme works (May 2008)	90.2	9.8
Do you understand how the scheme works (November 2008)	88.0	12.0
Do you find the Home-Link web site easy to use (May 2008)	90.4	9.6
Do you find the Home-Link web site easy to use (August 2008)	93.3	6.7

## 21. References

---

- 1 Department of Health, 2007. Commissioning framework for health and well-being
- 2 Warnes. A, Crane. M, Whitehead. N, Fu. R, 2003. Homelessness fact file. University of Sheffield, Sheffield Institute for Studies on Ageing,. Available via the internet URL: [http://www.crisis.org.uk/publications/factfile\\_Full.pdf](http://www.crisis.org.uk/publications/factfile_Full.pdf)
- 3 Department for Communities and Local Government, 2001. Homelessness strategies: a good practice handbook. Available via internet URL: <http://www.communities.gov.uk/documents/housing/pdf/156720.pdf> (accessed on 27<sup>th</sup> July 2009)
- 4 Taske et al. (2005). Housing and public health: a review of reviews of interventions for improving health Evidence briefing. NICE [http://www.nice.org.uk/niceMedia/pdf/housing\\_MAIN%20FINAL.pdf](http://www.nice.org.uk/niceMedia/pdf/housing_MAIN%20FINAL.pdf) (Accessed 15/06/2009)
- 5 In the Census, for the household projections and mid year estimates a household is defined as: one person living alone, or a group of people living at the same address who share common housekeeping or a living room. Source: Communities and Local Government in Housing section: <http://www.communities.gov.uk/housing/housingresearch/housingstatistics/housingstatisticsby/householdestimates/notesdefinitions/> (Accessed 17/06/2009)
- 6 Chartered Institute of Environmental Health (CIEH), 2008. *Good Housing Leads To Good Health: A toolkit for environmental health practitioners*. Available via the internet URL: [http://www.cieh.org/library/Policy/Publications\\_and\\_information\\_services/Policy\\_publications/Good\\_Housing\\_Leads\\_to\\_Good\\_Health\\_2008.pdf](http://www.cieh.org/library/Policy/Publications_and_information_services/Policy_publications/Good_Housing_Leads_to_Good_Health_2008.pdf) (Accessed on 14 July 2009).
- 7 British Columbia. Ministry of Social Development and Economic Security, 2001. Homelessness : causes & effects. Volume 1. The relationship between homelessness and the health, social services and criminal justice systems : a review of the literature. Available via the internet URL: <http://www.housing.gov.bc.ca/housing/homeless/vol1.htm>
- 8 Department for Communities and Local Government, 2008. No one left out: Communities ending rough sleeping. Available via internet URL: <http://www.communities.gov.uk/documents/housing/pdf/endingroughsleeping>
- 9 Gould M, 2009. The homeless and health. Health Services Journal. Available via the internet URL: <http://www.hsj.co.uk/the-homeless-and-health/1970518.article>
- 10 Her Majesty's Stationery Office, 2002. Homelessness Act 2002. Available via the internet URL: [http://www.opsi.gov.uk/acts/acts2002/ukpga\\_20020007\\_en\\_1](http://www.opsi.gov.uk/acts/acts2002/ukpga_20020007_en_1) (Accessed on 15 July 2009).
- 11 Homeless Link <http://www.homeless.org.uk/developyourservice/serviceusers>
- 12 Department of Health, 2009. Working together for change: using person-centred information for commissioning. Available via internet URL: [http://www.dhcarenetworks.org.uk/library/Resources/Personalisation/Personalisation\\_advice/WTF\\_C\\_Final.pdf](http://www.dhcarenetworks.org.uk/library/Resources/Personalisation/Personalisation_advice/WTF_C_Final.pdf) (Accessed on 20 August 2009).
- 13 Seal JK, Graham PS. 2002
- 14 RISIS, 2004. Hidden homelessness Britain's invisible city. Available from the internet URL: [http://www.crisis.org.uk/publications/HHBIC\\_backgroundpaper%5B1%5D.pdf](http://www.crisis.org.uk/publications/HHBIC_backgroundpaper%5B1%5D.pdf) (accessed on 6<sup>th</sup> Aug 2009).
- 15 Robinson D and Coward S; CRISIS, 2004. HIDDEN HOMELESSNESS: Your Place, Not Mine The experiences of homeless people staying with family and friends. Available

- via internet URL: [http://www.crisis.org.uk/publications/YourPlace\\_Full.pdf](http://www.crisis.org.uk/publications/YourPlace_Full.pdf) (accessed on 6<sup>th</sup> August 2009).
- 16 eeve K and Coward S; CRISIS, 2004. HIDDEN HOMELESSNESS: Life on the Margins. The experiences of homeless people Living in squats. Available via internet URL: [http://www.crisis.org.uk/pdf/lifemargins\\_Full.pdf](http://www.crisis.org.uk/pdf/lifemargins_Full.pdf) (accessed on 6<sup>th</sup> August 2009).
- 17 Financial Services Authority, 2009. Statistics on Mortgage Lending : June 2009 Edition. Available via internet URL: <http://www.fsa.gov.uk/pages/Doing/Regulated>Returns/IRR/statistics/index.shtml> (Accessed on 22 July 2009).
- 18 IDEA/LGA/SOLACE, 2008. Survey of the impact of economic downturn on local authorities. Available via internet URL: <http://www.lga.gov.uk/lga/aio/1396274> (Accessed on 22 July 2009)
- 19 Homeless Link, 2008. The impact of the 'credit crunch'. An online survey of the Homeless Link member organisations. Available via internet URL: <http://www.homeless.org.uk/policyandinfo/research/creditcrunch/> (Accessed on 22 July 2009)
- 20 Gorton, S. Audit of older homeless people September 2007 Summary of findings. October 2007.
- 21 Warnes. A, Crane. M, Whitehead. N, Fu. R, 2003. Homelessness fact file. University of Sheffield, Sheffield Institute for Studies on Ageing,. Available via the internet URL: [http://www.crisis.org.uk/publications/factfile\\_Full.pdf](http://www.crisis.org.uk/publications/factfile_Full.pdf)
- 22 Shapps, G. Prison break: breaking the prison to homelessness cycle
- 23 Communities and Local Government. Statutory Homelessness in England: The experiences of families and 16-17 year olds. 2008.
- 24 Cambridge sub-region traveller needs assessment. Commissioned from Anglia Ruskin University and Buckinghamshire Chilterns University College by Cambridgeshire County Council for a consortium of public authorities. Principal authors: Robert Home and Margaret Greenfields. May 2006.
- 25 Commission for Racial Equality. Common Ground: Equality, good race relations and sites for Gypsies and Travellers, 2006.
- 26 Shelter. Good Practice: briefing Gypsies and Travellers. February 2007.
- 27 Homeless Link. A8 nationals in London Homelessness Services. 2006.
- 28 McNaughton, C C Homelessness among A8 Nationals in the UK. Paper presented at: Housing Studies Association Annual Conference, 2 - 4 April 2008, University of York . Available at: <http://www.york.ac.uk/inst/chp/hsa/spring08/presentations/McNaughton.doc>
- 29 King TB, Gibson G. Oral health needs and access to dental care of homeless adults in the United States: a review. Spec Care Dentist 2003 Jul-Aug; 23(4): 143-7.
- 30 Luo Y, McGrath C Oral health status of homeless people in Hong Kong. Spec Care Dentist. 2006 Jul-Aug;26(4):150-4.
- 31 De Palma P, Frithiof L, Persson L, Klinge B, Halldin J, Beijer U. Oral health of homeless adults in Stockholm, Sweden. Acta Odontol Scand. 2005 Feb; 63(1): 50-55.
- 32 Conte M, Broder HL, Jenkinds, G, Reed R, Janal MN. Oral health, related behaviours and oral health impacts among homeless adults. J Public Health Dent. 2006 Fall; 66(4): 276-8
- 33 Oral Health Strategy. NHS Cambridgeshire. 2008. Complete ref.
- 34 CAADA, 2009. The CAADA MARAC Guide 2009 – From Principles to Practice. Available via internet URL: [http://www.caada.org.uk/qualityassurance\\_accreditation/THE%20CAADA%20MARAC](http://www.caada.org.uk/qualityassurance_accreditation/THE%20CAADA%20MARAC)



- [%20GUIDE%202009%20%20FROM%20PRINCIPLES%20TO%20PRACTICE%20\\_final%20version\\_.pdf](#)
- 35 Communities and Local Government, 2006. Homelessness Prevention: A Guide to Good Practice. Available via internet URL: <http://www.communities.gov.uk/documents/housing/pdf/150973.pdf> (accessed on 16 March 2009).
- 36 Communities and Local Government, 2007. Evaluating homelessness prevention. <http://www.communities.gov.uk/documents/housing/pdf/573347.pdf> (accessed on 16 March 2009).
- 37 National Centre for Social Research , 2008. Profiling London's rough sleepers: A longitudinal analysis of CHAIN data. Available via internet URL: <http://www.broadwaylondon.org/ResearchInformation/Research/ProfilingLondonsRoughSleepers> (accessed on 20 August 2009).
- 38 Homelessness and Health. Information Sheet Number 1: Personal Medical Services. Available via internet URL: <http://www.communities.gov.uk/documents/housing/pdf/137866.pdf> (accessed on 20 August 2009)
- 39 Alford s & Perry C, 2005. Providing health care for the homeless population: An evaluation of Chester City Homeless PMS pilot. Centre for Public Health Research. University of Chester. Available via the internet URL: <http://cke.chester.ac.uk/cphr/reports/029.pdf> (accessed on 20 August 2009)
- 40 Lester H, et al. Developments in the provision of primary health care for homeless people. Br J Gen Pract. 2002 February; 52(475): 91–92.
- 41 Randall G & DrugScope, 2002. Drug services for the homeless: a good practice handbook. Available via internet URL: <http://drugs.homeoffice.gov.uk/publication-search/dip/drug-services-homeless-people.pdf> (Accessed on 20 August 2009)
- 42 Pleace N, 2008. Effective services for substance misuse and homelessness in Scotland: evidence from an international review: Available via internet URL: <http://www.scotland.gov.uk/Resource/Doc/233172/0063910.pdf> (Accessed on 20 August 2009)
- 43 CRISIS, 2005. Include Me In: How life skills help homeless people back into work. Available via internet URL: <http://resources.socialfirms.co.uk/files/resources/IncludeMeIn.pdf> (Accessed on 20 August 2009).
- 44 Department of Health, November 1998. Independent inquiry into inequalities in health: Report. Available via internet URL: [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4097582](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4097582)
- 45 Department for Communities and Local Government, 2001. More than a roof: a report into tackling homelessness. Available via internet URL: <http://www.communities.gov.uk/documents/housing/pdf/156600.pdf>
- 46 Department of Health, July 1999. Saving lives: Our healthier nation. Available via internet URL: <http://www.archive.official-documents.co.uk/document/cm43/4386/4386.htm>
- 47 Department of Health, 2003. Discharge from hospital pathway, process and practice. Available via internet URL:

- 
- [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4003252](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4003252)
- 48 Department of Health, 2003. Tackling health inequalities: A Programme for Action. Available via internet URL:  
[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4008268](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4008268)
- 49 Department of Health and Office of the Deputy Prime Minister, 2004. Achieving positive shared outcomes in health and homelessness. Available via internet URL:  
<http://www.communities.gov.uk/publications/housing/achievingpositiveshared>
- 50 East of England Regional Assembly, 2005. Healthy Futures A Regional Health Strategy for the East of England 2005-2010. Available via internet URL:  
<http://www.eera.gov.uk/GetAsset.aspx?id=fAAzADQAFAB8AEYAYQB8AHMAZQB8AHwAMAB8AA2>
- 51 Department of Health, 2004. Choosing Health: Making healthy choices easier. Available via internet URL:  
[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4094550](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4094550)
- 52 Department of Health, 2006. Our health, our care, our say: a new direction for community services. Available via internet URL:  
[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4127453](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4127453)
- 53 Homeless Link, 2006. Fact Sheet 4, Developing integrated care pathways for homeless people. Available via internet URL:  
<http://www.homeless.org.uk/policyandinfo/issues/health/discharge/factsheets/Factsheet4.pdf>
- 54 St Mungo's, 2008. St Mungo's Health Strategy 2008-2011. Available via the internet URL: <http://www.ucl.ac.uk/gheg/marmotreview/stmungoshealth>
- 55 Department for Communities and Local Government, 2008. No one left out: Communities ending rough sleeping. Available via internet URL:  
<http://www.communities.gov.uk/documents/housing/pdf/endingroughsleeping>
- 56 Department of Health, May 2009. Tackling health inequalities: 10 years on. Available via internet URL:  
[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_098936](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_098936)
- 57 Wood, N, Wilkinson, C and Kumat, A, 1997. 'Do the homeless get a fair deal from General Practitioners?' Journal of the Royal Society of Health, 117 (5): pp.292-297.
- 58 Quilgars, D and Pleace, N, 2003. Delivering health care to the homeless people: an effectiveness review. University of York, Canter for Housing Policy. Available via URL:  
<http://www.york.ac.uk/inst/chp/publications/PDF/effectiveness-NHSS.pdf>
- 59 Department for Communities and Local Government, 2008. Statutory Homeless in England: the experience of families and 16-17 year olds. Available via internet URL:  
<http://www.communities.gov.uk/documents/housing/pdf/733835.pdf>
- 60 Discharged to no fixed abode. A study into the number of hospital patients released onto the nation's streets. Report by Grant Shapps MP, Shadow Housing Minister.  
[www.shapps.com/reports](http://www.shapps.com/reports)
- 61 Homelessness and Health Information Sheet, Number 4 Hospital Discharge. ODPM 2005.