# Rapid Scoping
# Health Needs Assessment of
# Homeless People in Portsmouth

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## Scope

The aim of this rapid scoping health needs assessment is to determine the current level of homelessness in Portsmouth and to understand the health needs of this population, with a particular focus on those with complex needs involving mental health and substance misuse. Different models of care will be considered in the context of addressing Portsmouth's needs.

## Introduction

Ill health is both a cause and consequence of homelessness. Chronic homelessness is characterised by tri-morbidity: physical ill health, mental ill health and substance abuse. People who experience homelessness often die at a much younger age than the general population and have a much poorer quality of life. Being homeless for even a short period of time increases the risk of long-term health problems.[1]

Improving access to healthcare is therefore crucial. It also has the potential to save significant expense in the long run. Compared to the average person of similar age, homeless people are considerably less likely to be registered with primary care services, access accident and emergency departments (A&E) five times as frequently, and use eight times more hospital inpatient resources altogether totalling some £85 million per year.[2]

Welfare and housing services have traditionally acted as a buffer between unemployment, poverty and homelessness. Recent government reforms to reduce national welfare spending by £12 billion[3], including cuts to housing benefits, are eroding this buffer.

The definitions of homelessness are complex and variable. They encompass many people beyond the relatively few who are roofless and sleeping rough on the streets. Accurate numbers are elusive as even official homelessness statistics only tell a small part of the story. In England, fewer than half of the 111,900 people who officially approached a local authority for assistance in 2014 met the criteria to be considered 'statutorily homeless'. Broadly, these criteria specify that the person must not have accommodation that they have a legal right to occupy, which is accessible and physically available to them and their household, and which it would be reasonable for them to continue to live in; nor can they have 'intentionally' made themselves homeless. Furthermore, local authorities are obliged to intervene only if a statutorily homeless applicant is in 'priority need', usually this is because they have young children or are particularly vulnerable. Unfortunately, there remains a much larger pool of 'hidden homeless', estimated at several hundred thousand nationally, who have not come to the attention of local authorities, and may be living in insecure accommodation or hostels, or 'sofa surfing' with friends and relatives.[4] Definitions of homelessness and local authority obligations are detailed in Appendix 1.

# Housing

## National homelessness statistics

A 2013 poll of 2000 UK adults by the charity Crisis found that 14% had been homeless (including sofa-surfing and staying with friends) at some point in their lives.[5] Homelessness Monitor estimate that if homelessness prevention and relief services are included alongside statutory rehousing activity, as many as 280,000 people sought help for actual or imminent homelessness in 2014.[6] That year, 111,900 households in England made a homeless application to their local authority, of which 53,410 (48%) were accepted as statutorily homeless and in priority need[7].

Of the 53,410 households found to be statutorily homeless and in priority need in 2014, precipitating causes of homelessness include: relatives or friends no longer able to accommodate (34%), loss of rented accommodation (23%), relationship breakdown (18%, of which 71% involved violence), mortgage or rent arrears (5%), and other causes (19%). The main reasons for being considered as in priority need were: dependent children in the household (67%), pregnancy of a household member (7%), mental illness (8%), physical disability (7%), domestic violence (3%), and other reasons (8%).[8]

There were 1,271 accommodation projects in England for single homeless people in 2014, providing 38,534 bed spaces; a 3% reduction from the year before[9]. In addition, 2,744 people were estimated to be sleeping rough in England every night in 2014; a 55% rise since 2010.

Data from 27 health needs audits of some 3355 homeless people across England between 2011 and 2015 found that: 71% were male, 93% were UK residents, 89% were white, 9% were sleeping rough, and 41% were accommodated in hostels. The age profile of respondents is illustrated below (figure 1), showing that a majority of respondents were under 35 years old.[10]

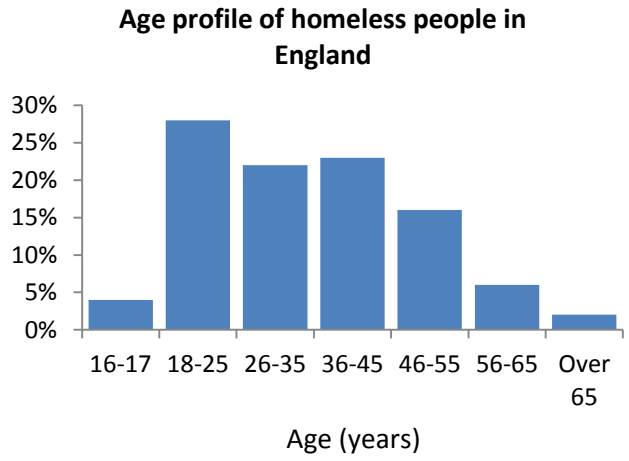



Figure 1. Age profile of homeless people in England 2011-2015[11]

## Local homelessness statistics

Public Health England found that in 2015 Portsmouth's rate of homelessness of 5.3 per thousand households was significantly higher than the national rate of 2.3 per thousand households[12]. In Portsmouth in 2014, 1,884 households approached Housing Options (Portsmouth City Council's advice and information service for anyone over 16 with a housing need) because of imminent or actual homelessness. Most of these did not make a formal homelessness application as the threat of homelessness was prevented through the use of discretionary housing payments, negotiation with the landlord, or provision of advice and assistance to help the household resolve the housing problem themselves. 597 (32%) of the approaches led to a formal homeless application; and 422 (70%) of these formal applicants were accepted as statutorily homeless, not intentionally homeless, and in priority need. The city council has a 'main housing duty' towards these 422 households and is obliged to secure housing for them.

Housing Options moved 156 young people (under 18) into services over the past two years, with the majority of referrals following parental evictions. They also moved 230 single homeless people into services, the majority of whom had substance misuse issues, mental health problems, or behavioural disorders.

In the first quarter of 2015, Central Point (a third-sector provider) secured housing for 114 people who had not met the criteria to be owed a main housing duty by the city council.

There are 10 third-sector providers in the city who contribute to supported, floating support, and moving on accommodation for those who do not meet the criteria of statutory homelessness. Just over 700 bed spaces are provided within these housing support services, and at present a further 10 single adults and 3 families are provided with emergency housing in bed and breakfasts.

In the autumn of 2014 a point estimate found there were 8 rough sleepers in Portsmouth. Although a direct count was not undertaken, local support services providers were consulted at length. Of the 8 identified rough sleepers, 7 were British nationals with a local connection, and 6 were male. Numbers are likely to fluctuate however, and a study in Cardiff found seasonal variations with numbers of people sleeping rough halving over winter compared to summer.[13]

## Local housing and support services

There are several housing services available in Portsmouth, run by both the local authority and independent providers. The following brief descriptions describe their major roles.

**Housing Options**[14] is run by Portsmouth City Council to provide advice and help to anyone who is homeless or at risk of becoming homeless. They assess homelessness applications and have a duty to find housing for anyone who has unintentionally become statutorily homeless and is in priority need.

**Central Point**[15] is run by Rethink Mental Illness and works on behalf of Housing Options to provide help for between 5 and 30 single homeless people per day, particularly those who have been sleeping rough or do not meet the statutory criteria of Housing Options. The centre is direct-access and open every day of the year to people who are "homeless, sofa surfing, inappropriately housed

or at risk of becoming homeless". Services include a communal area, hot meals, bathing and laundry facilities, storage, telephone access, and a care-of address. The team assesses service users' needs and provides support, advice and guidance about finding housing and tackling problems that led to homelessness. To help those unable to raise the deposit to rent private accommodation, the centre runs a bond deposit scheme. The team also undertake outreach work to contact anyone sleeping rough and introduce them to the services available.

Central Point also plays an important role by being responsible for daily allocation of single people to four emergency beds in the Hope House hostel, managed by the Salvation Army. Three of these beds are used as part of the national 'No Second Night Out'[16] initiative to help those who are new to rough sleeping. The fourth emergency bed is reserved for people with a local connection who are being released from prison, or anyone being discharged from hospital.

**The Roberts Centre**[17] is a child-focused charity in Portsmouth with a range of services offering support and assistance to families facing homelessness or dealing with relationship breakdown. They offer a temporary accommodation service for those awaiting an eligibility decision for local authority housing; intervention projects for individuals and families with complex needs; a supported housing service to help vulnerable families maintain their own tenancy and obtain secure tenancy with the city council; and a *Boost Project* to improve the independent living skills of young people looked after by the local authority or about to leave care.

**Advice Portsmouth**[18] is a drop-in and telephone service (funded by Portsmouth City Council and delivered by The YOU Trust) which provides advice on housing, debt, welfare benefits, employment and family law.

**Citizens Advice Bureau**[19] can provide advice on all aspects of housing including: rights and responsibilities of landlords and tenants, tenancies, housing benefit, rent problems, establishing 'fair rents', advice on eviction and problems with neighbours. If the problem is complex they will arrange for an appointment with a specialist adviser.

**Faith-based groups** offer a wide range of services including soup kitchens[20] and food banks[21], and some have been known to offer shelter to members of their community.

**Swain & Co solicitors**[22] operate the Housing Possession Court Duty Scheme at Portsmouth County Court, where they can provide free advice and representation to people at risk of losing their home as a result of rent or mortgage arrears.

**StreetLink**[23] is a national website-based service run by Homeless Link which enables the public to alert local authorities throughout England about people sleeping rough, so that other local agencies can make contact and offer help.

There are also 10 third-sector providers of housing-related support, with just over 700 bed spaces across the city for those who required housing related supported services. A diagram and map of housing-related support services can be found in appendices 2 and 3. Those people with particularly complex needs that are not readily met within any existing service, often because of 'dual diagnoses' of mental health problems and drug or alcohol misuse, may have their needs discussed between different services who will strive to share their expertise and collaborate in providing care.

# Health

## National health issues of homeless people

Ill health is both a cause and consequence of homelessness. Chronic homelessness is characterised by tri-morbidity: physical ill health, mental ill health and substance abuse. Being homeless for even a short period of time increases the risk of long-term health problems.[24]

Compared to the average person of similar age, one estimate found homeless people are up to 40-times less likely to be registered in primary care, access A&E five times as frequently, and use eight times more hospital inpatient resources totalling some £85 million per year.[25] Data from 27 health needs audits across England found that 78% of homeless people report suffering a physical health problem, and 44% report a long-term problem. 86% report a mental health difficulty although only 44% have a formal diagnosis.[26] Overall, homeless people have much poorer health and suffer a hazard ratio of all-cause mortality that is 4.4 times that of non-homeless cohorts matched for age and sex.[27]

Common health problems found among homeless people nationally:

- Musculoskeletal
- Dental
- Malnutrition
- Poor self-care
- Injuries from assault
- Foot and skin infection
- Tuberculosis
- HIV
- Hepatitis B
- Hepatitis C
- Alcohol dependence
- Drug dependence
- Depression
- Post traumatic stress disorder

Several serious communicable diseases are much more common among homeless people than the general population. Unfortunately, inconsistent testing practices and difficulties collating data hinder accurate estimates of disease prevalence. Surveys[28] of 2675 homeless people across England found: 4% had tested positive for Tuberculosis, 26% had tested negative, and a 70% majority had not been tested; 5% had tested positive for HIV, 32% had tested negative, and 64% had not been tested; 9% had tested positive for hepatitis C, 27% had tested negative, and 64% had not been tested. These rates are all much higher than for the general population, and true prevalences could be higher as there may be large numbers of undiagnosed cases among those who have not been tested.

Homeless women are at particular risk of violence, and 20% became homeless to escape violence from someone they knew.[29] Further, 28% of homeless women have formed an unwanted sexual partnership and 20% have engaged in sex work to obtain shelter. Interviews with 336 homeless people of both sexes in 2004 found that over the previous year 8% had been victims of sexual assault and 52% had been victims of violence[30].

Lifestyle risks to health are marked among homeless people. In addition to malnutrition and enduring harsh physical conditions, 27% consider themselves to have an alcohol problem, 41% use drugs or are in recovery, and 78% smoke.[31]

Delivery of end of life care can be particularly challenging as hostels and temporary accommodation are rarely able to provide the environment needed to support the terminally ill. Homeless people may instead frequently resort to emergency services or short-term hospital visits where specific crises are managed, but longer-term planning can be insufficient.

## National models of healthcare for homeless people

Homeless populations are disinclined to engage with services, and have difficulty accessing traditional health care. Altogether, there is a significant under-delivery of health care to this vulnerable group. Tailored services are required, and several models to better deliver these have been developed.

Primary care, usually through a general practitioner (GP) practice, is the mainstay of health delivery[32], and is one of the most trusted places for seeking health advice[33]. However registration is low among the homeless population with 8% not being registered with primary care, and 18% reporting having been refused the opportunity to register with a GP or dental practice. Among 16-17 year olds this figure was as high as 29%. Difficulty accessing primary care contributes to increased presentations to acute hospital services: 34% of homeless people reported visiting A&E in the last 6 months.[34]

Factors contributing to homeless people's difficulty accessing primary care include: the need for a fixed address to register with most GP practices; mobile and erratic lifestyles making it difficult to attend a specific GP practice or keep appointments; prioritisation of more immediate needs such as shelter, housing, and money; poor self-esteem and low valuation of their own health; a sense of stigmatisation; and previous bad experiences from health care professionals.

Measures that can improve access to primary care include: allowing patients to use the address of a hostel or the primary care practice itself for registration and receipt of healthcare-related mail; provision of walk-in clinics open to anyone and requiring neither registration nor appointments; extending opening hours; using standardised electronic medical records to track referrals and improve information sharing between locations and practitioners; close coordination between secondary and primary care; co-locating multiple services that address both medical and social needs; and developing specialised teams with thorough understanding of the particular issues faced by homeless people. Outreach and mobile clinics have also shown promise for engaging users who would otherwise not present or be able to travel.[35]

Homeless people's complex health and social needs require coordination of many different services including prescriptions, minor injuries, immunisations, rehabilitation, dental care, mental health, sexual health, alcohol and drug detox and rehabilitation, optometry, and chiropody. In addition, housing and welfare services are very valuable in providing the stability required to allow engagements with healthcare, and ultimately can provide an escape from homelessness. These diverse services have traditionally functioned relatively independently, but the emerging consensus is that if the diverse services coordinate their work and move towards a co-located and integrated service, this improves communication, information sharing between services, and data gathering to assess community needs.

Fully integrated care combines medical, behavioural and social services to deliver seamless care. That is, for almost any problem, clients feel they have come to the right place[36]. Further, an important goal is the integration of health and social care which can continue even when the client is no longer critically unwell.[37]

A local example of a model where a single provider operates a broad range of health and housing services can be found in West Sussex. Here, Stone Pillow[38] run day hubs, provide access to medical treatment, and offer night hostels and 'move on' accommodation. Cardiff Council are currently in the process of moving to a single point of access for all homeless, health, social and housing needs.

University College Hospital in London (UCLH) has developed the 'Pathway'[39] model of healthcare for homeless people that emphasises person-centred care focuses on improving the coordination of different health services. Pathway teams work in acute hospitals visit all homeless patients and support clinical staff to care for them and plan for discharge. Expert advice is offered on how to treat patients with multiple co-morbidities including mental health, drug and alcohol problems. Effort is made to map local hospital, primary care, statutory and voluntary sector community based services so that coordinated and effective care can be delivered. This has been found to improve the standard of care for homeless people admitted to hospital, and early analysis has found a notable improvement in quality of care delivered, and a 30% reduction in bed days.

## Local health issues of homeless people

It has proven very difficult to obtain comprehensive or reliable data for health issues affecting local homeless people. Local problems are likely to be broadly similar to results from national surveys, but there are several particularly concerning local needs.

One local problem is the high rate of blood borne viruses such as hepatitis B and C, and HIV. Historically, Portsmouth has had high numbers of injecting drug users (IDUs). Low take-up of needle exchange services led to the average needle being reused 6 times. In 2009 the Health Protection Agency estimated that the prevalence of hepatitis C among the roughly 460 injecting drug users in Portsmouth was 57% (the highest in the South East)[40]. Local needle exchange programmes have recently been enormously upgraded and rates of transmission should therefore decline between IDUs, although other routes of transmission also require consideration. However, the high prevalence of hepatitis C will not only lead to consequently high rates of liver disease, but may have been accompanied by high rates of transmission of other blood-borne viruses such as hepatitis B and HIV. Concerningly, there is no systematic screening for blood-borne viruses locally outside of

maternity services, and absolute numbers of people recorded as being infected by these blood-borne viruses are low (of the nearly 6000 patients registered at GHWHC, 14 had recorded diagnoses of HIV, 2 of hepatitis B, and 5 of hepatitis C), indicating there is likely to be significant under-diagnosis and under-treatment in Portsmouth.

Portsmouth in 2008-2012 was within the highest quintile nationally for alcohol-related admissions and liver cirrhosis[41]. It is likely that this heavy alcohol intake both contributes to homelessness and increases the burden of ill-health. Alcohol screening and treatment services have been established in local hospitals and communities, but a heavy-drinking culture is firmly established and will take many years to address.

One housing support provider in the city collected data from those they accommodated, and found that residents' main health priorities were: substance misuse 16%, mental health problems 13%, and physical health problems 2%, while 21% did not identify a primary health need. This sample was small and does not take account of co-morbidities, but it does give some idea of health priorities among homeless people.

## Local health services for homeless people

**Guildhall Walk Healthcare Centre** (GHWHC) is an NHS GP-led health centre. These centres are known as *Darzi centres*, after Lord Darzi's 2008 report[42] which led to the centres' foundation under the Equitable Access to Primary Medical Care (EAPMC) programme. GP-led health centres were set up to provide a walk-in service for minor conditions to any member of the public, as well as having a registered practice list. The centres were to be open between 8am and 8pm, 7 days a week; to be situated in easily accessible locations; to be responsive to local needs; to foster integrated care; and to be co-located where possible with other community-based diagnostic, therapeutic, pharmacy and social care services.[43]

After consideration of local needs, Care UK was contracted to manage the GHWHC service to provide General Medical Services for 'hard to reach' populations such as homeless people and drug or alcohol misusers, providing physical and mental health checks, and brief alcohol interventions.[44] It is located in the commercial centre of the city convenient to where many homeless people congregate.

GHWHC currently operates services for its registered patient list similarly to many other GP practices. It is popular among local university students and office workers, providing morning and afternoon GP and nurse-led clinics, with home visits in the middle of the day. Longer, fifteen minute appointments are offered as standard to allow more comprehensive assessments. Barriers to accessing primary and secondary care are reduced by allowing homeless people to use the centre as their registered address for all medical communication.

Data about registered patients from the GHWHC in August 2015 appears in the table below. Unfortunately, data were not available for patients who had used the walk-in centre but were not registered with GHWHC:

| | |
|---|---|
| Registered at a Hostel | 46 |
| No Fixed Abode | 44 |
| Sofa Surfers | 123 |
| U18s with Child Protection Order | 56 |
| Asylum Seekers | 11 |
| Criminal record/prison record | 32 |
| On probation | 3 |
| Mental Health Issues | 1329 |
| Substance + Alcohol Misuse | 250 |
| HIV Positive | 14 |
| Hepatitis B | 2 |
| Hepatitis C | 5 |
| **GHWHC Practice List Size** | **5892** |

**St Mary's NHS Treatment Centre**[45] is located beside St Mary's Hospital and run by Care UK. It provides a range of outpatient and diagnostic procedures. These include a nurse-led Minor Injuries/Illnesses Unit with extended opening hours every day of the year for which appointments are not necessary.

**Queen Alexandra Hospital**[46] is a 1200-bed general hospital in nearby Cosham, providing a full-service Emergency Department that is always open. A wide range of inpatient and outpatient secondary care facilities are also provided.

**Alcohol Interventions Team**[47] based in Queen Alexandra Hospital accepts referrals from within the hospital and from primary care in Portsmouth and Hampshire. In 2014/2015 a total of 855 new Portsmouth patients were referred into the alcohol specialist nurse service. Portsmouth has the highest rate of alcohol-related hospital admissions in the South East, with some 12 people admitted for alcohol-related reasons daily[48]. Due to the widely accepted relationship between alcohol and housing problems, this service attempts to collect housing data from all those who are referred into the service.

Out of the 855 new Portsmouth patients entering the service: 75 (8.8%) were classed as having no fixed abode; 63 (7.4%) were classed as having a housing problem. Therefore, 138 (16.1%) Portsmouth residents who entered the service were clearly identified by the service as having a housing problem or being homeless. Of the 855 new patients, 50 (5.8%) were registered at the GHWHC; the largest share of patients from a single Portsmouth practice.

**Recovery Hub**[49] is located in Elm Grove and provides a one-stop access point for drug and alcohol services. After assessment, clients are directed to some of the several residential and community detox and rehabilitation services. They also work with counselling and peer support services such as the Portsmouth Users Self Help community (PUSH) and 12 step programmes.

In August 2015, of the 787 active substance misuse clients registered in Portsmouth, 86 (11%) were registered with the GHWHC. 601 of the clients were in structured treatment of which 14% were registered with the GHWHC. This is the highest percentage of clients from any one practice.

**Mental Health Recovery Team**[50] based at St Mary's Hospital is an entry point to mental health services and accepts medical and police referrals. It saw 2846 patients over the 2014/15 financial year, or whom 62 were recorded as being homeless. 144 of the 2846 patients were registered with GHWHC, of whom 10 were homeless.

**University of Portsmouth Dental Academy**[51] partners with local community groups to offer an outreach service for homeless people with students providing dental health promotion and treatment.

## Discussion of current housing and health services in Portsmouth

There are many providers of services for homeless people in this city. Individually they work hard to help their clients. However, the services do not seem to communicate fluently or to reliably coordinate their work. Homeless people are required to navigate a geographically disparate and complex system of providers of housing, welfare, healthcare, and social services. A round trip walk between GHWHC, Housing Options, Central Point, and St Mary's Hospital is nearly four miles long.

There is no clear pathway to ensure that people leaving hospital, social care, or prison have their housing and health needs addressed so that they have the best chance of successfully reintegrating with the community. In areas where pathways have been established, poor communication and data sharing can cause people to lose access to temporary accommodation even while waiting for a space within supported housing services to become available. Better communication between services would ensure that urgent safety information reaches those who need it, reduce duplication of work, and avoid delays in assessment and provision of care. It has been difficult to gather data on who the diverse services help, how services interrelate, and how the pathways between services work. Standardised data is not adequately collected, shared and analysed, and as a result it is not clear whether services are meeting the needs of the city's population.

## Considerations for planning health services for homeless people in Portsmouth

Thirteen local service providers across the city, and commissioners from five directorates within Portsmouth City Council were interviewed by telephone or in person about the access to healthcare of homeless people, how the work the GHWHC relates to their services, and what they believed were the most important considerations for planning any future services. This information was supplemented with previously published case studies and reports on healthcare delivery from a variety of national, academic, and third-sector bodies.

### Access to healthcare

Several themes emerged about the problems homeless people face in accessing healthcare:

- Those with complex needs and chaotic lifestyles find it difficult to enter healthcare pathways, may struggle to navigate these, and are also prone to repeatedly missing appointments and not progressing through treatment plans
- Low self-esteem may lead to undervaluation of their own health
- Other priorities such as housing may displace healthcare

- Many report poor experiences with mainstream healthcare, a general distrust of services, and a sense of ostracisation which deters them from seeking healthcare
- They may have been excluded from services such as primary care because their behaviour was felt to be too challenging for the service to work with

### Important considerations for service design

Important features of future healthcare services if they are to meet the needs of homeless people include:

- Standardised data collection and sharing between services should be prioritised so that local needs can be reliably measured and services accurately audited and adapted
- The health issues that affect homeless people occur within a larger social context which needs to be considered and addressed
- Efforts to move towards co-located and integrated health and social services will ensure user needs can be addressed quickly, comprehensively and efficiently
- Geographic and organisational structures must be conducive to good user access and communication between services
- User transition-points between primary care, hospital care, housing, social and community voluntary services should be carefully coordinated; with particular attention given to identifying and bridging situations that are likely to lead to homelessness, such as young people leaving social care or prison
- People with complex needs and dual diagnoses where mental health problems and alcohol or drug misuse coexist can be particularly difficult to provide adequate care for. It is important to design joined-up healthcare systems for this group
- Appropriately trained and experienced staff are needed who understand the particular physical, mental and social needs of homeless people, and are able to cope with behavioural issues that might lead to exclusion from mainstream services
- Healthcare should be available outside normal working hours and without an appointment
- Capacity to offer longer-than-standard consultations will permit complex health and social needs to be explored and managed effectively
- People without a fixed address should be facilitated to access services
- Regular cost effectiveness analyses will encourage best standards of care to be delivered on tight budgets. Factors considered should include not only the immediate costs of running particular services and the benefits to their users, but also the knock-on costs and savings to other services and the community in both the short and long term

## Opportunities

### Review of current services

Regular reassessment of the city's current services and planning of their development is essential if services are to be accurately tailored to local needs. The complex interactions between health and social needs mean that incremental changes to old models of services may not be optimal. There is now an impetus to audit and review services and, if necessary, make large-scale changes that will be able to develop as the city changes in years to come.

### Healthcare for homeless people

The complex health needs of homeless people and their ability to access ordinary primary care services leave significant scope for improvement. Careful evaluation of the health needs of homeless people will ensure that the city's services can continue to match the needs of local people. This requires much more comprehensive and standardised data collection and sharing between services so that an accurate picture of local need can be discerned. Successful models from elsewhere can be adopted and trialled locally. Contractual mechanisms to promote the demonstration of specific health goals, such as improved screening for blood-borne viruses, could be explored.

### Guildhall Walk Healthcare Centre walk-in centre

Consideration about recommissioning this centre is a chance to ensure it is fulfilling its remit as a GP-led health centre with a special duty towards hard to reach populations, and consider ways in which this care and interaction with other services could be improved. The centre is well thought of locally, but the careful collection and analysis of patient and service data would allow the centre to demonstrate whether it meets its remit and to identify gaps in the service which may be addressed.

### New service arrangements

Consideration of existing and alternative models of healthcare delivery, and local health needs, will allow the city to provide services that are effective and efficient now, and able to adapt to changing needs in the future. The need is clear for services that are wherever possible evidence-based and auditable. Efforts to create integrated services will cause short term disruptions to services which should not be dismissed, but nor should they preclude changes that would lead to longer-term benefits.

## Options for providing health and housing services to homeless people in Portsmouth

### 1. Homeless healthcare services that are attached to other services such as a walk-in centre or a GP practice

This model co-locates services for homeless people with other existing services. This may harness existing expertise and facilitate development of joint-working between different services and improved delivery models. The extent of co-location of services will depend partly on whether adequate space is available. This option reflects the current situation in Portsmouth, where GHWHC operates a service for homeless people attached to a GP practice and walk-in centre. Theoretically, services for homeless people could be attached to any GP practice or walk-in centre in the city, or even run by a third-sector provider if it were able to obtain appropriate medical support.

### 2. Using mainstream primary care services

Improving access to mainstream primary care through existing GP practices could lessen the need for a specialised service for homeless people. Funding might be re-distributed from specialist services to allow development of widespread expertise across primary care to care for these complex and often challenging patients, and to ensure their needs are sensitively addressed. One

difficulty is that many local GP practices are nearing capacity, and there is a growing shortfall of GPs and specialist nurses as recruitment struggles to keep pace with retirement. The capacity of other practices to absorb the extra workload if the GHWHC no longer operates would require careful assessment.

## 3. A dedicated homelessness service that is closely integrated with allied services

A stand-alone service for homeless people would allow thorough specialisation and careful adaptation to their needs. Healthcare could be delivered in close conjunction with other services addressing mental health, drug and alcohol recovery, education, employment, housing, and welfare. A 'one-stop shop' would not only improve delivery, and make it simple for users to understand and access, but would also promote joint problem solving among services. This would additionally offer an opportunity for standardised information gathering and referral routes between services.

A good skill mix could be developed with on-site with medical and nursing care provided alongside housing and social services. Co-location would improve services and help to integrate services, but will require extensive planning to manage service disruptions arising from relocation. Meanwhile, geographic and travel considerations mean that a dedicated homelessness service should ideally be in a central location with good access to St Mary's Hospital, Housing Options, and Central Point.

## 4. The Pathway model

This model uses a specialised team to actively coordinate and advise the many services that homeless people use so that they interact more efficiently. Providers based in primary care may visit homeless people when they are in hospital to provide expert advice and support. They ensure that discharge planning addresses each patient's needs and that there is coordination of care during the transition from hospital to primary care or community services. This model could be adapted to ease other difficult transition points such as leaving care services, or prison. Improved joint-solution finding between primary and secondary care can prevent a cycle of repeated emergency admissions to hospital. While direct delivery of expertise is possible, this model primarily complements and assists delivery of services by other groups.

## 5. Mobile outreach services

These could be associated with any of the other options to improve access to healthcare and overcome any geographic barriers. Outreach services may act as a gateway to encourage homeless people to attend other existing services. Options include a truly mobile service on wheels, or occasional use of various local premises by a team. Particular services could choose to travel to areas where they are most needed. Portsmouth does not appear to have an entrenched rough sleeping population that would require a dedicated mobile outreach team.

## Recommendations

The third option above, a dedicated integrated service located with other services, holds the most advantages in terms of user access and benefit. It is in line with current best practice models and offers greater cost efficiency. The first option, which represents the current situation and involves a healthcare service for homeless people attached to a walk-in centre, GP practice, or other provider with medical support, may be a first step towards achieving such integrated services. However, there is scope to develop this further and improve the delivery of care. Transition from the current situation to one with integrated care, resembling the third option, will require much greater co-location of services, and so it is important to carefully consider the physical premises required and both the short- and long-term disruption and benefits to all stakeholders from moving various services.

It is not possible to have absolutely every service that a homeless person may use in one location, and continuous effort will be required to maintain high-quality communication between services. Therefore the fourth option, the use of a specialised team to coordinate continuity of care for homeless people, will have an important role. The Pathway model has shown a lot of promise in achieving this, and consideration should be given for its adoption in Portsmouth.

As housing services are crucial for both delivery of healthcare and providing a route out of homelessness, they should work closely with the services delivering healthcare. Key features of an effective and resilient system will include: clear referral routes among housing services and health services, standardised information gathering and sharing systems, and the flexibility to provide for the needs of people who may be chaotic and have complex substance misuse and mental health problems.

Crucial to any effort to improve healthcare for homeless people is detailed information gathering and analysis. This will provide accurate information about of Portsmouth's local health needs and make possible the ongoing development and optimisation of services.

## Appendix 1 - Definition of homelessness

"In United Kingdom homelessness is most commonly defined and discussed in terms of Homelessness Legislation, the first of which was introduced as the Housing (homeless persons) Act in 1977. Whilst the legal definition of homelessness is pitched in broad terms those who are actually accepted as homeless (the statutory homeless) and eligible for support by Local Authorities are a much narrower group. Those who are not clearly entitled to support are largely single people (people without dependents) they are the Hidden Homeless."[52]

"A household will be considered as statutorily homeless by their local authority if they meet specific criteria set out in legislation. Such households are rarely homeless in the literal sense of being without a roof over their heads, but are more likely to be threatened with the loss of, or are unable to continue with, their current accommodation.

"Broadly speaking, somebody is statutorily homeless if they do not have accommodation that they have a legal right to occupy, which is accessible and physically available to them (and their household) and which it would be reasonable for them to continue to live in. It would not be reasonable for someone to continue to live in their home, for example, if that was likely to lead to violence against them (or a member of their family).

"In cases where an authority is satisfied that an applicant is eligible for assistance, is in priority need, and has become homeless through no fault of their own, the authority will owe a main homelessness duty to secure settled accommodation for that household. Such households are referred to as acceptances.

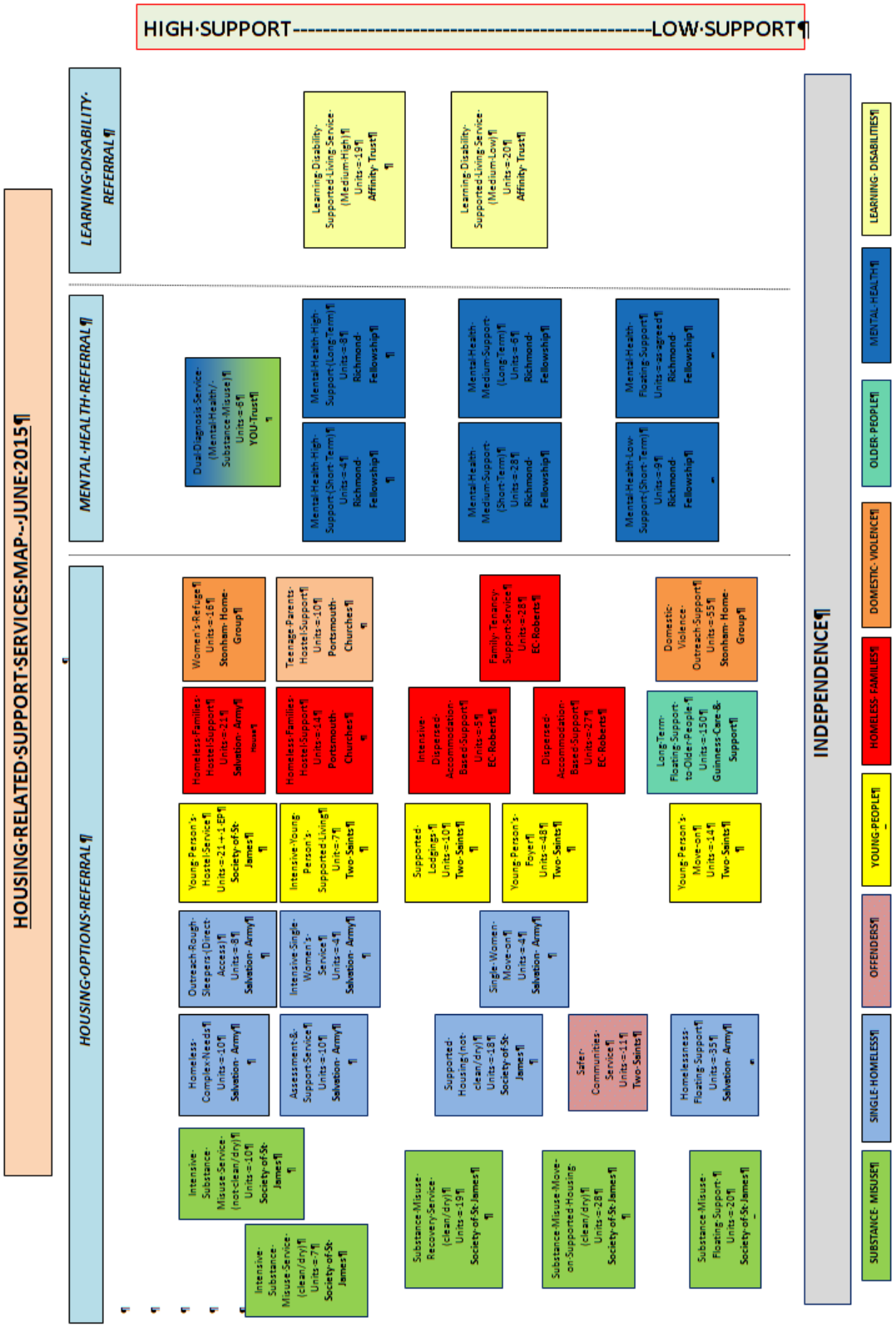
"Priority need groups include households with dependent children and/or a pregnant woman and individuals who are vulnerable in some way. Individuals are classed as vulnerable if they: have mental illness or physical disability; are a young person (16 to 17 years old, or 18 to 20 years old and vulnerable as a result of previously being in care); were vulnerable as a result of previously being in custody; were vulnerable as a result of previously being in HM Forces; or were forced to flee their home because of violence or the threat of violence.

"When a main duty is owed the authority must ensure that suitable accommodation is available until a settled home becomes available. Households are either assisted to remain in their existing accommodation (duty owed, no accommodation secured) or are placed in temporary accommodation to await an offer of settled accommodation.

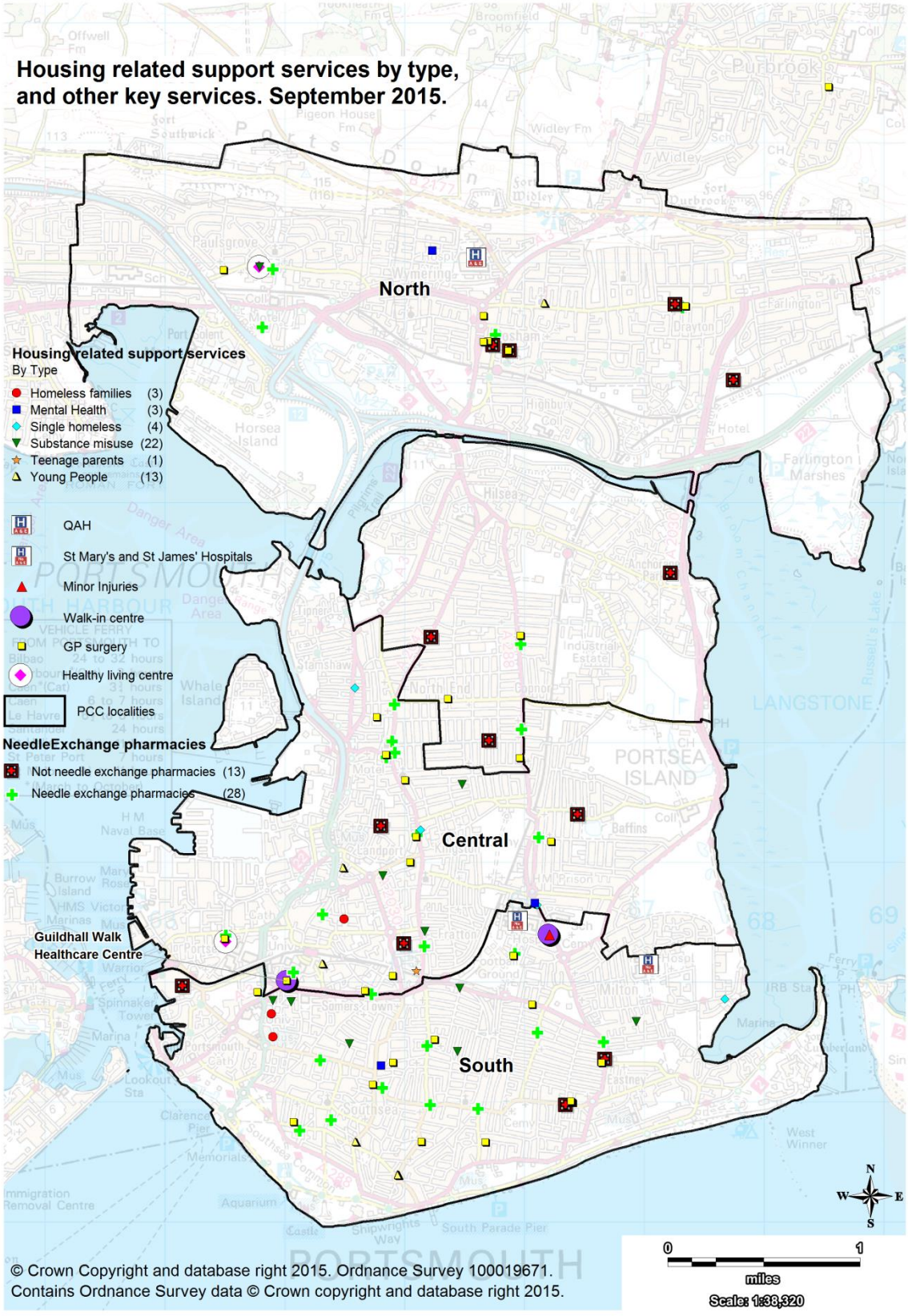
"When a main duty is not owed (e.g. where the household is found to be intentionally homeless, not in priority need or not homeless), the authority must make an assessment of their housing needs and provide advice and assistance to help them find accommodation for themselves. Where an applicant falls into a priority need group but is intentionally homeless the authority must ensure that accommodation is available for a reasonable time to allow the household to find a home."[53]

Complete copies of the legislation around the Housing Acts are available online.[54]

# Appendix 2 - Diagram of Portsmouth housing-related support services



## Appendix 3 - Map of Portsmouth housing-related support services by type



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