



RESPONSE TO THE PUBLIC CONSULTATION DRAFT OF THE LONDON HEALTH INEQUALITIES STRATEGY - JANUARY 2010

Homeless Link is the national membership organisation for agencies working with people who are homeless across England. We have more than 490 members, whose services range from local authority housing services, day centres, outreach services, residential care homes, hostels, supported housing, floating support through to employment, training and education.

INTRODUCTION

Twenty years after the launch of the first Rough Sleepers Initiative, homeless people continue to experience complex health needs and find themselves facing some medical problems which have been all but eliminated from the general population. This situation is exacerbated by the obstacles many face in accessing the physical and mental health services they need. Life expectancy amongst the most socially excluded homeless people remains lower than that in parts of the developing world¹. Health remains an area where life-chances for people who have experienced homelessness still lag far behind those who have not. It is in this context that we welcome the London Health Inequalities Strategy as extremely timely and strongly endorse the Mayor's commitment to prioritise the health needs of society's most marginalised individuals.

STRUCTURE OF THIS RESPONSE

Clearly the Mayor has very few powers over the operational running of health services in London. However, we hope that he will use his considerable influence as London's senior politician to drive forward the implementation of the strategy. To assist with this, we have restricted ourselves in this response to concentrating mainly on practical advice, examples of good practice and our ideas on how best to ensure the strategy is delivered to homeless people. We have structured our comments around three main themes in the strategy - empowerment; improved access; and joined-up delivery.

PART 1 - EMPOWERING HOMELESS PEOPLE TO IMPROVE THEIR OWN HEALTH AND WELL-BEING

Homeless Link welcomes The Mayor's commitment to equipping all Londoners with the tools to improve their own health. There is a common perception that homeless people do not prioritise their own physical and mental well-being. However, we

¹ The last piece of systematic research into this was Crisis's *Still Dying for a Home* which found an average age of death of 42 amongst rough sleepers. Only 7 countries out of the 226 that exist have a lower life expectancy; http://www.nationmaster.com/graph/hea_lif_exp_at_bir_tot_pop-life-expectancy-birth-total-population

believe that, historically, public health campaigns have often missed homeless people out², even when compared to those in lower socio-economic classes.³ To reach the most socially excluded health improvement services need to focus on communicating with homeless people and providing appropriately targeted information.

We recommend two practical ways of achieving this:

1. Encourage peer-led approaches to promote health initiatives and identify health needs. There is evidence that homeless people are more willing to discuss their health needs and take advice from those they perceive as understanding their experiences.
2. Support voluntary sector homelessness services to disseminate information and promote health advice by using their ongoing informal contact to engage clients in health issues and signpost them to appropriate services.

We welcome the Mayor's commitment to help individuals address any "misperceptions" they may have of their own ability to effect their health. The evidence is that many homeless people will engage with health promotion programmes if they are devised, resourced and communicated correctly. Homelessness agencies play a key role in promoting health programmes and are well placed to facilitate such activities. While not a substitute for the role of health services and campaigns, it is important that the role the voluntary sector plays is recognised and agencies are supported in this. We hope to illustrate this shortly with the launch of our forthcoming "Sport For All" health initiative.

PART 2 - IMPROVING ACCESS TO LONDON'S HEALTH SERVICES FOR HOMELESS PEOPLE

For the Mayor to achieve his wish of empowering homeless people to make good health choices, it is essential to ensure they have access to the services they require.

Success in this area has often been judged purely on GP registration rates amongst the homeless population. However, our Survey of Needs and Provision⁴ found that there maybe more subtle obstacles to health care access, for example 94% of homeless people have access to a GP, but yet further research suggests that nearly half of homeless people have been to an Accident and Emergency Department in the last 6 months⁵. This high rate implies that some homeless people may be using A&E as a de facto primary health care service. Our informal discussions with service providers and clients support this theory and offer a number of explanations as to why this might be the case. These include:

Staff Attitudes - There is evidence that a feeling of stigmatisation is the largest deterrent to homeless people accessing some front-line medical services.⁶

Inflexibility - Large numbers of homeless people live chaotic life-styles⁷. These individuals, who may well be amongst those most in need, will often struggle to access services based upon a rigid appointment system.

² A government survey in 2002 found that 65% of Health and Improvement Modernisation Plans did not mention homeless people

³ For example in social class groups C1, D & E about one-in-four of the population smoke, amongst homeless people the percentage is around 85%.

⁴ See www.homelesslink.org.uk/snap

⁵ This was a finding from a sample of homeless clients who took part in Homeless Link's Health Needs Audit see <http://www.homeless.org.uk/health-needs-audit>

⁶ Thompson 2003

⁷ Over two-thirds of people seen sleeping rough in 2008-09 had one or more support need around alcohol, drugs and/or mental health

Information - For an increasing number of homeless people English is not their first language⁸. Others have poor levels of literacy, and many are simply not used to "navigating" their way around different parts of the health service.

Temporary Registration - Evidence is starting to come to light which suggests some GP registrations are of a temporary nature, lasting only for a short-time (possibly because of the perceived financial disincentives for GPs to register homeless people longer than they are obliged to). If this is the case, it may be creating poor relationships between homeless patients and GP surgeries⁹.

The Importance of Commissioning

We believe that to address these issues, services must be configured in ways which meet the needs of different groups within the homeless population.

In terms of rough sleepers and those with extremely chaotic lives, we perceive a need for targeted specific services within day centres and on the streets. However, we are concerned that because of the relatively small number of entrenched rough sleepers in London,¹⁰ local PCTs may be reluctant to commission this type of service. Therefore, we strongly endorse the Mayor's statement that commissioning for this group may need to take place on a pan-London/sub-regional level. To this end we welcome the current cross-borough inner-London commissioning initiative for rough sleepers being led by Westminster PCT and hope it may serve as a model for elsewhere.

Whilst the concentration on rough sleepers is extremely important, we feel it is vital that the health needs of the wider homeless and vulnerably housed population are not forgotten. Thus, whilst we favour specialist services for chaotic rough sleepers, we feel there is work needed to ensure the health care of less visible homeless groups is included in mainstream provision. Evidence suggests that people living in hostels, temporary accommodation and unsuitable housing have much higher rates of ill-health (at least twice that of people living in settled accommodation). Common problems include depression, diabetes, epilepsy, mental ill-health, sight and respiratory problems, drug and alcohol misuse, tuberculosis and suicide¹¹.

To make this mainstreaming a reality, commissioners need to have better knowledge about the health needs of excluded groups and understand the strategic and financial value of providing suitable health services which can prevent individuals having to fall back on more acute care. Homeless Link is keen to assist commissioners in making decisions around future services. To this end we are currently piloting a tool which will gather evidence about the health needs of homeless clients to better inform service development¹². This will eventually be replicable across all localities.

PART 3- THE IMPORTANCE OF STRATEGIC AND PARTNERSHIP WORKING

Homeless people with multiple support needs often find themselves slipping through gaps in the welfare "safety-net". Traditionally, this situation has been exacerbated by a lack of integration between primary care and other services (such as housing, employment, social services and criminal justice). To avoid this, we believe issues of

⁸ Particularly since EU expansion in 2004 & 2007. 14% of people seen sleeping rough 2008-09 came from this group

⁹ New data is being gathered on this by the Combined Homeless and Information Network

¹⁰ Although 3472 were seen sleeping rough last year in London, it is estimated that on any given night the number on the streets is only around 250

¹¹ "Healthy Hostels" report

http://www.dhcarenetworks.org.uk/_library/Resources/Housing/Support_materials/Reports/Report13_healthy_hostels_final.pdf

¹² More details at: <http://www.homeless.org.uk/health-needs-audit>. The pilot is taking place in a number of areas including one in London (Brent)

health inequality should be integral to all relevant areas where the Mayor has strategic responsibility. A good example of where this has been successful can be found in the work of the Health Sub-Group of the London Delivery Board which is exploring innovative ways of turning the Mayor's commitment to reducing health inequality into a reality for rough sleepers.

To ensure the strategy is delivered, it maybe beneficial for the Mayor to take the lead in bringing together key stakeholders. This approach has worked well in delivering his other strategies. Last year homelessness services saw nearly 3,500 people sleeping rough and accommodated 25,000 in residential projects across the capital. We believe homelessness services, therefore, constitute one of these key stakeholders which can help inform and deliver the strategy.

Finally, at the micro political level, Homeless Link welcomes the Mayor's leadership in challenging local decision-makers to champion health equality. Local leadership has never been more important with initiatives such as Local Area Agreements, Joint Strategic Needs Assessments and Personalised Budgets offering unprecedented opportunities for Councils and Primary Care Teams to work collaboratively to achieve better outcomes for the most socially excluded groups in their areas.

PART 4 - MONITORING SUCCESS

Finally, we feel it is vital that there is good quality data available on whether the strategy is successful in reaching homeless people. This will then facilitate the identification of gaps and the prioritising of future actions. We feel that recording systems at the moment are unhelpful. For example the "No Fixed Abode" category does not give details about whether someone is rough sleeping, in a hostel or unwilling to provide an address. We have recently worked with the National Offender Management Scheme in London to refine their definitions and provide guidance to staff. We would be happy to replicate this work in the area of health if it was considered beneficial for us to do so.

FURTHER INFORMATION AND CONTACT DETAILS

This response has focused upon the strategic aspect of delivering health care to homeless people in London, rather than the specific medical conditions homeless people face. However, the interim findings of our health needs audit identify some of the major issues around physical health, substance misuse, mental health and vaccinations/screenings.¹³

Prior to submitting this response, we undertook a consultation with our member agencies and held a meeting with 15 homelessness agencies to discuss the draft strategy.

We would welcome the opportunity to discuss any of the issues raised in our response or contribute further information which might be of benefit.

If you have any questions regarding this response please contact:

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¹³http://beta.homelesslink.org.uk/sites/default/files/Interim%20findings_HL_HealthNeedsProject_Oct09.pdf

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