

# Needs to know

## Including single homelessness in Joint Strategic Needs Assessments

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## Foreword

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. It does this through advocacy, partnerships, world class science, knowledge and intelligence, and the delivery of specialist public health services. We recognise that one of the most important determinants of health, in addition to being employed, is having a home and living in a safe and supportive environment.

People who are homeless, and the reasons for this are many, frequently suffer from a range of health problems and homelessness can exacerbate these existing health problems, whether mental, emotional or physical, and actually create further risks to health and wellbeing.

It is important to recognise the particular ways different types of homelessness – street homelessness, statutory homelessness, living in hostels, living in unfit and poor accommodation – affects health. Joint Strategic Needs Assessments (JSNAs) offer an important opportunity to better understand the needs of our communities and address the health needs of people who are homeless.

As Needs to Know illustrates, there are already some excellent examples of JSNAs that identify the needs of single homeless people, as well as the wider impact of homelessness on health. However, the research also shows that this is not yet consistent across England. I hope Health and Wellbeing Boards will find this publication helpful in planning their support services.

**Duncan Selbie, Chief Executive, Public Health England**

# Executive summary

## Homelessness is a social determinant of health:

it is both a cause and effect of poor health. A recent health audit by Homeless Link<sup>1</sup> found that:

- **41% of single homeless people have a long term physical health problem** (compared to 28% of general population)
- **45% had been diagnosed with a mental health issue** (25% among general population).

People who are statutory homeless and those living in insecure, temporary or poor housing are also at risk of health problems. Understanding how different types of homelessness affects health and wellbeing in different ways<sup>2</sup> is essential.

### Single homeless: what do we mean?

This document is concerned with **'single homeless people'**, generally understood to be those who are homeless but do not meet the priority need criteria<sup>3</sup> to be housed by their local authority. Many, nevertheless, have significant support needs. They may live in supported accommodation, e.g. hostels and semi independent housing projects, sleep rough, sofa surf<sup>4</sup> or live in squats. Single homeless people may be in a relationship, or have children who are not currently living with them.

Each Health and Wellbeing Board is required to produce a Joint Strategic Needs Assessment (JSNA), identifying health needs in the local area. JSNAs are intended to inform local Joint Health and Wellbeing Strategies (JHWS), with the overall aim of improving the health and wellbeing of local communities and reducing health inequalities. They should capture data on the health of all local people, including those who are homeless. However, evidence shows that homelessness, and single homelessness in particular, is frequently overlooked in this process, presenting a risk of the needs of the most vulnerable being missed in local commissioning.

JSNAs should consider **all** types of homelessness within the local housing context when measuring the health needs of the local population. It is also important to consider those at risk of homelessness and people living in unstable and vulnerable housing including temporary accommodation, overcrowding and homes in poor condition.

### The research:

Homeless Link and St Mungo's Broadway carried out an audit of the JSNAs, JHWSs and clinical commissioning group (CCG) commissioning plans (where these could be identified) of 50 upper tier local authority areas. A purposive sample was selected to include a diverse range of areas. We wanted to find out if and how the health needs of single homeless people in the local area were included in these needs assessments and plans.

<sup>1</sup> Homeless Link (2014) *The unhealthy state of homelessness: health audit results 2014* <http://www.homeless.org.uk/sites/default/files/site-attachments/The%20unhealthy%20state%20of%20homelessness%20FINAL.pdf>

<sup>2</sup> For example, see McCormick, B (2010) *Healthcare for single homeless people* Office of the Chief Analyst, Department of Health <http://www.qni.org.uk/docs/healthcare%20for%20single%20homeless%20people%20NHS.pdf>

Barnes, M, Cullinane, S, Scott, S and Silvester, H (2013) *People living in bad housing – numbers and health impacts*, published by Shelter [http://england.shelter.org.uk/\\_\\_data/assets/pdf\\_file/0010/726166/People\\_living\\_in\\_bad\\_housing.pdf](http://england.shelter.org.uk/__data/assets/pdf_file/0010/726166/People_living_in_bad_housing.pdf)

<sup>3</sup> Priority need groups established in the 1996 Housing Act and the Homeless (Priority Need) Order 2002 criteria are intended to protect pregnant women and those with dependent children; those vulnerable as a result of old age, mental illness or disability or other special reason; 16 and 17 year olds and care leavers under 21; victims of domestic violence; people who have been made homeless by a disaster and people who meet certain definitions of vulnerability. [http://england.shelter.org.uk/get\\_advice/homelessness/help\\_from\\_the\\_council\\_when\\_homeless/priority\\_need](http://england.shelter.org.uk/get_advice/homelessness/help_from_the_council_when_homeless/priority_need)

<sup>4</sup> Sofa surfers are people who habitually stay with friends, family or acquaintances rather than in accommodation that they themselves own or rent

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## Key findings:

The audit has highlighted the variation in how single homelessness is understood and identified by Health and Wellbeing Boards. The key findings from the research are:

- Most JSNAs (86%) make some reference to homelessness. In total, 30% of the sample provide only minimal detail and exploration of the health needs associated with any homelessness. **Worryingly, 14% do not mention any form of homelessness at all.**
- Inclusion of single homeless in JSNAs is inconsistent. **Only 28% of JSNAs include substantial information on single homelessness.** Almost two thirds of JSNAs (64%) make no mention of single homelessness or rough sleeping.
- **Fewer than one in ten JHWSs (6%) have a dedicated section for single homelessness and more than six in ten (61%) make no reference to homelessness at all.**
- There is no correlation between the level of homelessness in an area and the priority given to single homelessness in the JSNA. In total, 32% of areas with high levels of single homelessness were classed as giving it high priority. This means that 68% of these JSNAs do not consider single homelessness.
- 33% of areas with low levels of homelessness were also classed as giving it high priority in their JSNA.
- **Only 20% of JSNAs refer to plans to improve the health of homeless people** – this is most likely where there are higher levels of single homelessness.

- It was difficult to assess clinical commissioning group (CCG) plans given the wide variation in these, but again, there was little evidence of efforts to commission services targeted at single homeless people.

## Recommendations:

We believe that addressing the health needs of single homeless people is an urgent issue. We call on all Health and Wellbeing Boards to ensure their JSNA identifies:

### 1. The extent of single homelessness in the area.

This should include an assessment of both statutory and non statutory homelessness as distinct groups.

### 2. The health needs of people who are single homeless locally.

Sources of data that can contribute to the JSNA and target both single homelessness and wider determinants of local housing need include:

- Housing related support client data<sup>5</sup>
- Internal client monitoring data collected by homelessness agencies about client need, demographics and outcomes
- Case studies of homeless people's experiences of health and social care
- Data from a Homeless Health Needs Audit<sup>6</sup>
- An area's Housing Needs Assessment,<sup>7</sup> which should include information on unmet housing need including estimates in the number of homeless households, overcrowded households, concealed households, and those living in temporary accommodation
- An area's Housing Stock Condition survey, which will help identify the number of dwellings in poor condition and households at risk of homelessness due to disrepair.

<sup>5</sup> This can include Supporting People data, which is based on information collected about people who enter housing related support services. Prior to April 2011, data collection was mandatory but it has since become the responsibility of individual administering authorities. Consequently, data is not available for all areas since this date. For more information see <https://supportingpeople.st-andrews.ac.uk/> and <http://www.sitra.org/policy-good-practice/housing-related-support-data/>

<sup>6</sup> For information on carrying out a local Homeless Health Needs Audit see <http://www.homeless.org.uk/our-work/resources/health-needs-audit-toolkit>

<sup>7</sup> Guidance on carrying out an assessment of local housing need <http://planningguidance.planningportal.gov.uk/blog/guidance/housing-and-economic-development-needs-assessments/methodology-assessing-housing-need/>

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We are also calling on local authorities to:

**3. Provide clear channels through which voluntary sector organisations can contribute views and data as part of the process of identifying single homeless people and their health needs.** Efforts should also be made to include the needs of those excluded or not engaging with treatment.

**4. Work with client involvement groups to ensure that needs assessments, strategies and commissioning decisions are informed by the experience of people who are homeless.**

Homeless people themselves are a vital source of information about health needs, and especially about gaps or obstacles in services. This may be delivered through working with local homelessness agencies and with local Healthwatch organisations, who should work with client involvement groups or consider ways of facilitating this where there are no existing groups. This could be achieved through working with the homelessness sector.

A revised briefing on including single homelessness in your JSNA has been published by St Mungo's Broadway and Homeless Link, and is available online:

**<http://www.mungosbroadway.org.uk/documents/5378/5378.pdf>**

# I. Introduction

## **Single homelessness is a social determinant of health:** it is both a cause and effect of poor health.

A recent health audit by Homeless Link found that:

- 41% of homeless people have a long term physical health problem (compared to 28% of general population)
- 45% had been diagnosed with a mental health issue

### **Statutory and single homelessness**

**Statutory homelessness:** Under the 1996 Housing Act, local authorities have a statutory duty to find accommodation for households deemed to be homeless, eligible and in 'priority need'.<sup>8</sup>

**Single, or 'non statutory' homelessness:** generally understood to be those who are homeless but do not meet the priority need criteria to be housed by their local authority. Many nevertheless have significant support needs. Single homeless people may be in a relationship, and/or have children who are not currently living with them.

People who are single homeless may live in supported accommodation, e.g. hostels and semi independent housing projects, sleep rough, be 'hidden homeless', live in a squat, or 'sofa surf' (habitually staying with friends, family or acquaintances rather than in accommodation that they themselves own or rent).

Each **Health and Wellbeing Board** is required to produce a **Joint Strategic Needs Assessment (JSNA)**, identifying the health needs in the local area. These are intended to capture data on the health of all local people, in order to inform local health and wellbeing strategies (**Joint Health and Wellbeing Strategies, or JHWSs**) and commissioning. Given the link between single homelessness and poor health, St Mungo's Broadway<sup>9</sup> and Homeless Link produced a guide to including the needs of single homeless people in JSNAs in 2011.

We wanted to know what progress had been made in assessing the needs of single homeless people in JSNAs, and whether this was reflected in local plans. A review of JSNAs carried out by the Department of Health in January 2013 found little evidence of the assessment of the health needs of people in vulnerable circumstances, including people who are homeless.

To find out whether this has since improved, St Mungo's Broadway and Homeless Link collaborated to carry out an audit of JSNAs, JHWSs and related clinical commissioning group plans of 50 upper tier local authorities. This report sets out our findings, which have informed a revised version of our guidance:

**<http://www.mungosbroadway.org.uk/documents/5378/5378.pdf>**

<sup>8</sup> Priority need groups established in the 1996 Housing Act and the Homeless (Priority Need) Order 2002 criteria are intended to protect pregnant women and those with dependent children; those vulnerable as a result of old age, mental illness or disability or other special reason; 16 and 17 year olds and care leavers under 21; victims of domestic violence; people who have been made homeless by a disaster and people who meet certain definitions of vulnerability [http://england.shelter.org.uk/get\\_advice/homelessness/help\\_from\\_the\\_council\\_when\\_homeless/priority\\_need](http://england.shelter.org.uk/get_advice/homelessness/help_from_the_council_when_homeless/priority_need)

<sup>9</sup> As St Mungo's. In April 2014, St Mungo's merged with Broadway to form St Mungo's Broadway.

## 2. Homelessness determinant of health

### 2.1 Impact of single homelessness on health

People who are homeless, and particularly those who are single homeless – living on the streets, in hostels, in squats, or sofa surfing – face significant health inequalities.

#### How many people experience single homelessness?

It is difficult to capture the total number of single homeless people in England. The homeless population is very transient, and many people fall outside the official figures. By its nature, 'hidden homelessness' is difficult to measure. The Department for Communities and Local Government (DCLG) publishes annual figures on rough sleeping in England based on one off street counts or estimates from local authorities. In autumn 2013, this data suggested there were 2,414 people sleeping rough on a single night in autumn 2013 – a 5% increase compared to 2012, and a 37% increase on 2010.<sup>10</sup>

In London, the Combined Homelessness information Network (CHAIN) found that, in total, 6,508 people were counted sleeping rough in London alone in the year up to April 2013 – a 1% increase on the same period in the previous year, and 77% higher than in 2009/10.<sup>11</sup> There has been a 3% fall in the number of bed spaces available in accommodation projects for single homeless people between 2012/13 and 2013/14.<sup>12</sup>

**Homelessness is associated with greater levels of poor physical and mental health.** The Homeless Link Health Needs Audit 2014,<sup>13</sup> based on information from more than 2,500 people, revealed that:

- **73%** of people who are homeless have a physical health problem
- Common physical health concerns among homeless people include joint/muscular problems, chest and breathing issues, dental problems, eye problems and stomach complaints
- **41%** reported a long term health problem (compared to **28%** of the general population)
- **80%** had a mental health issue and **45%** had been diagnosed with a mental health issue (compared to **25%** of the general population)
- **39%** said they take drugs or are recovering from a drug problem
- **27%** said they have or are recovering from an alcohol use problem.

These health problems can have a significant impact on people's lives and can make it harder for them to recover from homelessness. Different types of homelessness affects health and wellbeing in different ways. For example, rough sleeping is particularly marked by poor respiratory and muscular skeletal problems as a result of sleeping outdoors.<sup>14</sup> Poor housing conditions such as overcrowding, damp, indoor pollutants, and cold have all been shown to be associated with physical illnesses including eczema, hypothermia and heart disease.<sup>15</sup> It is also important to consider those at risk of homelessness and people living in unstable and vulnerable housing, including temporary accommodation, overcrowding and homes in poor condition, when considering the impacts on health.

<sup>10</sup> Department for Communities and Local Government, Rough Sleeping Statistics England – Autumn 2013 Official Statistics [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/284024/Rough\\_Sleeping\\_Statistics\\_England\\_-\\_Autumn\\_2013.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/284024/Rough_Sleeping_Statistics_England_-_Autumn_2013.pdf)

<sup>11</sup> Broadway (2013) *CHAIN Annual Report: Street to Home* [http://www.broadwaylondon.org/CHAIN/Reports/S2h2013/Street-to-homereport-2012\\_13.pdf](http://www.broadwaylondon.org/CHAIN/Reports/S2h2013/Street-to-homereport-2012_13.pdf)

<sup>12</sup> Homeless Link (2014) *Support for Single Homeless People in England Annual Review 2014* <http://www.homeless.org.uk/sites/default/files/site-attachments/Support%20for%20Single%20Homeless%20People.pdf>

<sup>13</sup> Homeless Link (2014) *The unhealthy state of homelessness: health audit results 2014* <http://www.homeless.org.uk/sites/default/files/site-attachments/The%20unhealthy%20state%20of%20homelessness%20FINAL.pdf>

<sup>14</sup> McCormick, B (2010) *Healthcare for single homeless people* Office of the Chief Analyst, Department of Health <http://www.qni.org.uk/docs/healthcare%20for%20single%20homeless%20people%20NHS.pdf>

<sup>15</sup> Barnes, M, Cullinane, C, Scott, S and Silvester, H (2013) *People living in bad housing – numbers and health impacts* [http://england.shelter.org.uk/data/assets/pdf\\_file/00101726166/People\\_living\\_in\\_bad\\_housing.pdf](http://england.shelter.org.uk/data/assets/pdf_file/00101726166/People_living_in_bad_housing.pdf)

Many people who are homeless have complex and multiple needs. In the latest annual review of the single homelessness sector, services reported that a quarter of their clients had complex needs.<sup>16</sup> More than a quarter of St Mungo's Broadway clients have at least one problem in each of physical, mental or substance use. Many more have problems in two areas. The Making Every Adult Matter (MEAM) coalition estimates that approximately 60,000 adults at any one time in England experience several problems (mental health, homelessness, drugs and alcohol use and/or offending) at the same time.<sup>17</sup> This complexity can make it more difficult for them to access appropriate health care.

## 2.2 Barriers to homeless health care

People who are single homeless face a number of specific barriers to accessing care. These include:

- Being required to provide a permanent address when registering with a GP
- A lack of flexibility in appointments systems, which can be challenging for people with chaotic lives
- Gaps in provision of support for homeless people with mental health problems, substance use needs or dual diagnosis (mental health *and* substance use needs)<sup>18</sup>
- Discrimination from staff at health and other services
- Difficulties dealing with staff, particularly for those with bad experiences in the past
- A lack of stable housing can make it difficult for individuals to prioritise or address their health needs.

## 2.3 Use of health services

These challenges can mean that ultimately, people who are homeless tend to make higher use of some health services, although this is not reflected in their health outcomes. The Health Needs Audit<sup>19</sup> found that:

- **35%** had been to A&E in the past month – A&E visits per homeless person are four times higher than for the general public
- **26%** had been admitted to hospital over the past six months
- There were **1.8** hospital admissions per year compared to **0.28** among the general public.

In part, this heavy use of hospital services, in particular, reflects the difficulty people experience in managing health conditions without stable housing, and in accessing appropriate healthcare at an early stage. Too often, their health problems remain untreated until their condition becomes severe, requiring an admission to hospital that should have been avoidable.<sup>20</sup> Although progress has been made, many homeless people are discharged from hospital straight on to the streets or into hostels, without an appropriate care plan. This can result in their conditions rapidly deteriorating and readmission to hospital.<sup>21</sup>

It has been estimated that the use of hospital services by people who are homeless costs at least £85 million a year.<sup>22</sup> Addressing the barriers that homeless people face to accessing healthcare and other support is essential for reducing health inequalities, and would ease financial pressure on the NHS.

<sup>16</sup> Homeless Link (2014) *Support for Single Homeless People in England Annual Review 2014* <http://www.homeless.org.uk/sites/default/files/site-attachments/Support%20for%20Single%20Homeless%20People.pdf>

<sup>17</sup> Making Every Adult Matter (MEAM) coalition <http://meam.org.uk/multiple-needs-and-exclusions/>

<sup>18</sup> Homeless Link (2014) *Support for Single Homeless People in England Annual Review 2014* <http://www.homeless.org.uk/sites/default/files/site-attachments/Support%20for%20Single%20Homeless%20People.pdf>

<sup>19</sup> Homeless Link (2014) *The unhealthy state of homelessness: health audit results 2014* <http://www.homeless.org.uk/sites/default/files/site-attachments/The%20unhealthy%20state%20of%20homelessness%20FINAL.pdf>

<sup>20</sup> Hewitt, N and Halligan, A (2010) 'Homelessness is a healthcare issue' in *Journal of the Royal Society of Medicine* 103 pp.306-307; McCormick, B (2010) *Healthcare for single homeless people* Office of the Chief Analyst, Department of Health <http://www.qni.org.uk/docs/healthcare%20for%20single%20homeless%20people%20NHS.pdf>

<sup>21</sup> Homeless Link and St Mungo's (March, 2012) *Improving hospital admission and discharge for people who are homeless* <http://www.mungosbroadway.org.uk/documents/3432/3432.pdf>

<sup>22</sup> McCormick, B (2010) *Healthcare for single homeless people* Office of the Chief Analyst, Department of Health <http://www.qni.org.uk/docs/healthcare%20for%20single%20homeless%20people%20NHS.pdf>

# 3. Key findings

Joint Strategic Needs Assessments (JSNAs) are the key statutory tool for identifying health needs in local areas. Single homelessness is a problem in every area; the health needs of homeless people should be understood and examined in every JSNA to reflect local need. Without this, commissioners will be ill equipped to provide appropriate services.

While inclusion of homelessness in JSNAs in areas of high homelessness is critical, the role of homelessness as a key determinant of health must not be overlooked elsewhere. Understanding the needs in areas of low single homelessness is also crucial as, while there may be fewer individuals, access to services may be equally or more difficult and including them in the JSNA will help prevent further issues developing or their needs increasing.

This audit reveals inclusion is not yet happening in a consistent way. With a few significant exceptions, the attention paid to homeless health in Joint Strategic Needs Assessments is minimal. **Just over a third (36%) of JSNAs surveyed included reference to single homelessness and/or rough sleeping.** This means that 64% made no mention of single homelessness or rough sleeping.

Far more common is an emphasis on statutory homelessness only, or a generic mention of 'homelessness', without an exploration of the different demographic groups affected and the differing health implications. Furthermore **there does not appear to be a direct correlation between the level of homelessness in an area, and the level of detail provided on homeless health included in the JSNA.**

## Case study 1: Separate homelessness JSNAs: The Triborough JSNA (Westminster, Kensington and Chelsea, and Hammersmith and Fulham)

The boroughs of Westminster, Kensington and Chelsea, and Hammersmith and Fulham made a combined Triborough JSNA focusing on the issue of rough sleeping. These areas have some of the highest levels of homelessness both in London and nationwide so a combined effort enables a broad response meeting a considerable need.

*“There are nearly 3,500 people recorded as sleeping rough in our inner London boroughs of Hammersmith and Fulham, Kensington and Chelsea, and Westminster.”*

As they neighbour each other, it is especially useful to coordinate responses as homeless people are likely to drift between boroughs. Collaborating enables the local authorities to cover a wider area accounting for this transience.

*“This report makes clear, with evidence, that the health of homeless people is important for us not only as GPs and commissioners of healthcare, looking to get the best quality and most affordable outcomes, but as members of a caring society, which values people’s lives. Furthermore, it shows that there is a case to be made for changing the way we do things in primary and secondary care, and in partnership with other organisations – in particular, our local authorities.”*

This JSNA, which included a review of the health needs and healthcare costs of rough sleepers, included in depth analysis and illustrated the issue well (for example the rate of A&E attendances by rough sleepers). It explored both the barriers to services experienced by rough sleepers and the negative impact on health services themselves through failure to address the needs of rough sleepers. It takes a problem solving approach by following analysis of the issue with approaches to resolving it. Effective practice suggestions include accompanying people to appointments, GP registration without identification and setting up health services in day centres and hostels.

[www.jsna.info/document/rough-sleepers](http://www.jsna.info/document/rough-sleepers)

Our audit found that homelessness is less likely to be included in Joint Health and Wellbeing Strategies than in JSNAs. **Fewer than one in ten JHWSs (6%) have a dedicated section for single homelessness and more than six in ten (61%) make no reference to homelessness at all.**

Clinical commissioning group plans are least likely of the documents audited to include mention of homelessness, which may reflect that many JSNAs

provided only relatively little detail on homelessness, and single homelessness in particular. It certainly suggests that, at present, little attention is being given to specific commissioning of accessible health services for people who are homeless.

The full methodology of the study is included in the Appendix at the end of this document. The following sections explore the findings in more detail.

### 3.1 Identification of single homelessness

Our analysis involved assessing the attention given to single homelessness in each JSNA, according to the definitions set out in table 1.

**Table 1: Classifications of inclusion of homelessness in JSNAs**

<b>High</b>	Dedicated section or separate document on homelessness including substantial reference to single homelessness and/or rough sleeping, or significant detail under several other sections
<b>Medium</b>	Mentions single homelessness and/or rough sleeping, but provides little detail
<b>Low</b>	Mentions homelessness with detail or targets, but does not refer to single homelessness or rough sleeping
<b>Very low</b>	Mentions general homelessness but with little detail or no targets identified, no mention of single homelessness or rough sleeping
<b>None</b>	No mention of homelessness in any documents

The analysis showed that Health and Wellbeing Boards, which included any mention of single homelessness and rough sleeping in their JSNA are in the minority.

As table 2 shows, just over a quarter (28%) provided detailed assessment of the health needs of single homeless people sleeping (including a dedicated section with substantial reference to single homelessness, or significant information in other sections); another 8% makes some mention without going into detail.

**Table 2: References to single homelessness and rough sleeping in JSNAs**

Levels of detail	Local authorities	As a percentage of total audited
<b>High</b>	14	28%
<b>Medium</b>	4	8%
<b>Low</b>	10	20%
<b>Very low</b>	15	30%
<b>None</b>	7	14%

In total, just over a third of JSNAs audited make any mention of single homelessness and rough sleeping. A further 50 per cent mention homelessness – either referring generically to ‘homelessness’, or referencing statutory homelessness specifically. **Worryingly, 14% of JSNAs make no reference to homelessness at all.**

### **Case Study 2: Exploring the impact of single homelessness on health needs – Newcastle Upon Tyne HWB**

The Newcastle Upon Tyne Health and Wellbeing Board provides another good example of a dedicated Homelessness JSNA. It explains: *“The purpose of this Homelessness JSNA is to examine the prevalence, causes and risks of homelessness in the city, how this impacts on health and wellbeing and to recommend actions to increase the prevention of homelessness and, where this is not possible, to reduce the most adverse consequences.”*

This Homeless JSNA identifies different types and explores the different causes and experiences of homelessness. It provides targeted recommendations for meeting the needs of homeless people in the area:

*“The evidence of this Assessment and of national research is that homelessness is often a multi-dimensional problem and that this is more likely resolved by holistic responses. We have evidenced the effectiveness of joint working initiatives like linking debt advice to housing and drugs agencies partaking in common case management. However, most of the more sophisticated measures have tended to come from housing providers extending their range of services by securing additional, often short term funding. The reduced public sector funding combined with the evidence of the value of integrated responses to complex problems, makes a compelling case for considering joint commissioning and the alignment of provision.”*

[http://www.newcastle.gov.uk/sites/drupalncc.newcastle.gov.uk/files/wwwfileroot/housing/housing\\_advice/jsna\\_final\\_january\\_2012\\_.pdf](http://www.newcastle.gov.uk/sites/drupalncc.newcastle.gov.uk/files/wwwfileroot/housing/housing_advice/jsna_final_january_2012_.pdf)

## **3.2 Impact of homelessness levels on priority given to single homelessness**

We believe that single homelessness, as a key determinant of health, should be considered in all JSNAs, whatever the level of homelessness in the area. Indeed some examples of good practice in understanding and including single homelessness in JSNAs are from areas where there are low levels of homelessness.

We categorised inclusion of homelessness according to whether the Health and Wellbeing Board area has a ‘high’, ‘medium’ or ‘low’ level of single homelessness. We found no clear correlation between the level of single homelessness in an area and the attention given to this issue in the JSNA.

Table 3: References to single homelessness and rough sleeping by level of homelessness

Single homelessness or rough sleeping referenced		
All Health and Wellbeing Boards	18	36%
High homelessness	8	32%
Medium homelessness	6	46%
Low homelessness	4	33%

Table 3 shows that while overall, 36% of JSNAs referred to single homelessness and/or rough sleeping, this was the case for only 32% of those for areas with higher levels of homelessness. This was a similar proportion compared to areas with low levels of homelessness – and 10% less than areas with medium levels of single homelessness. While these findings should be treated with caution given the smaller sample size for areas with medium and low levels of homelessness, they suggest that even where there is a relatively high level of need, single homeless people may be overlooked.

### Case Study 3: Using data on homelessness effectively to assess future need - Southampton HWB

The JSNA for Southampton gives a high priority to single homelessness even as one of the areas with the lowest levels of homelessness out of those we reviewed. This JSNA stands out from others for its proactive consideration of the future; it anticipates future increases in homelessness due to economic circumstances and encourages proactive planning to deal with these problems.

For example: *“Levels of homelessness, and rough sleeping, in England have been increasing since 2009-10 and are projected to increase further in the*

*coming years. Policy research has attributed some of this increase to the impact of the economic recession. This increase has been accompanied by a reduction in available support services for homeless people across the country.”*

This is important because it guides necessary planning to prevent homelessness and meet the needs with an increasing homeless population.

<http://www.publichealth.southampton.gov.uk/HealthIntelligence/JSNA/default.aspx>

### 3.3 Moving from assessment to action: plans to improve homeless health

It is not enough to acknowledge the health needs of homeless people: action is needed to meet these needs and prevent further homelessness. To assess the extent to which local Health and Wellbeing Boards and their partners are setting out plans regarding the health needs of homelessness, we also looked at the extent to which plans to take action were mentioned in JSNAs.

The audit revealed it is rare for JSNAs to include specific plans to improve the health of homeless people: there was no mention of such plans in 80% of those reviewed.

Table 4: JSNAs that clearly include homelessness in planning

Plans relating to single homelessness?	Number of JSNAs	Percentage of JSNAs
<b>Yes</b>	10	20%
<b>No</b>	40	80%

The degree to which plans are noted does correlate with the level of homelessness in the area covered: however, even though areas with high levels of homelessness were more likely to make plans to improve the health of homeless people, even in these areas less than a quarter of JSNAs had done so. See Table 5 for more detail.

Table 5: JSNAs that clearly include homelessness in planning (by level of homelessness)

	High homeless level local authorities			Medium homeless level local authorities			Low homeless level local authorities		
		Number of JSNAs	%		Number of JSNAs	%		Number of JSNAs	%
Plans identified to improve the health of homeless people?	Yes	6	24%	Yes	2	15%	Yes	1	8%
	No	19	76%	No	11	85%	No	11	92%

## Case Study 4: From identification to planning - Luton Health and Wellbeing Board

Luton's JSNA not only includes substantial detail about the health needs of single homeless people, it proactively addresses the issues that they face.

It emphasises the importance of improving access to both primary and secondary health services and acknowledges some of the barriers to care. For example, it identifies a lack of mental health provision for people with substance use problems and sets out the intention to address this. In addition to the information provided in the JSNA itself, Luton has also carried out a Homeless Health Needs Assessment. This set out the following aims:

- Improve access to primary care health services for Luton's homeless population and those threatened with homelessness
- Improve access to secondary/universal health services for Luton's homeless population and those threatened with homelessness

- Improve access to mental health services for homeless people with drug and alcohol problems.

Luton's Homeless Health Needs Assessment initiated a review of health services in the area with the view of their effectiveness in dealing with the needs of homeless clients.

Luton's Annual Public Health Report gives examples of changes made as a result of this review. One example is of an agreement between Luton clinical commissioning group and three Luton GP practices to provide enhanced services to homeless and hard to reach groups. These include a twice weekly outreach service at The Day Centre run by NOAH Enterprise, a welfare centre and street outreach team.

[http://www.luton.gov.uk/Community\\_and\\_living/Luton%20observatory%20census%20statistics%20and%20mapping/Pages/Joint%20Strategic%20Needs%20Assessment%20-%20JSNA.aspx](http://www.luton.gov.uk/Community_and_living/Luton%20observatory%20census%20statistics%20and%20mapping/Pages/Joint%20Strategic%20Needs%20Assessment%20-%20JSNA.aspx)

### 3.4 Joint Health and Wellbeing Strategies

To find out to what extent the needs of single homeless people are seen as a strategic priority, we also audited the Joint Health and Wellbeing Strategies (JHWSs), which set the priorities for collective action. These were much less likely than JSNAs to make mention of single homelessness, or homelessness more generally. See Table 6.

Table 6: Joint Health and Wellbeing Strategies - level of detail on single homelessness

Level of detail	Definition of priority level	Number of JHWSs	Percentage of JHWSs
<b>High</b>	Dedicated section or separate document on homelessness including substantial reference to single homelessness and/or rough sleeping, or significant detail under several other sections.	3	6%
<b>Medium</b>	Mentions single homelessness and/or rough sleeping, but provides little detail	2	4%
<b>Low</b>	Mentions homelessness with detail or targets, but does not refer to single homelessness or rough sleeping	2	4%
<b>Very Low</b>	Mentions general homelessness but with little detail or no targets identified, no mention of single homelessness or rough sleeping	12	25%
<b>None</b>	No mention of homelessness in any documents	30	61%

More than half of JHWSs did not mention homelessness at all. Only a tenth of JHWSs mentioned single homelessness or rough sleeping. Only 6% included an in depth focus on homelessness, and another 4% referenced it. 24% made only a brief reference to generic homeless, while six in 10 made no mention whatsoever. Even in areas where single homelessness and/or rough sleeping were a high or medium priority in JSNAs, this did not feed in to the JHWS. Out of the 18 areas where JSNAs gave high or medium priority only a third of these identify single homelessness and rough sleepers in their JHWS.

We recognise that the omission of single homelessness from the JHWS does not necessarily mean these needs are not being addressed locally. For example, there may be mention of health in the homelessness strategy. However, the impact of homelessness on health and wellbeing, suggests areas where there is a high level of health need among single homeless people identified in the JSNA, it should be identified as a local health priority.

### 3.5 Clinical commissioning group plans

It was difficult to identify the most relevant clinical commissioning group (CCG) planning documents, and there was substantial variation in format between these. There were a few CCG plans that set out plans for targeted homelessness commissioning. Hammersmith and Fulham CCG for example, referred to commissioning a specialist outreach nurse to work with homeless hostels in the borough.

On the whole, however, little mention to homelessness was made in the documents identified. While we recognise that plans to commission accessible services may be included elsewhere, this suggests that CCGs are missing an opportunity to develop more accessible healthcare services and improve their record on reducing health inequalities.

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## 4. Conclusions

Health and Wellbeing Boards are still relatively new, and are in the process of establishing and refining their approach to completing Joint Strategic Needs Assessments. However, it is clear that as yet few Health and Wellbeing Boards are making the most of the opportunity offered by the requirement to produce a JSNA to understand and examine the needs of single homeless people. While there has been some progress since the Department of Health's review in 2013, there are still significant gaps in coverage. As a result, there is a risk that efforts to improve health and reduce health inequalities will be hampered if locally available data is not collated.

The audit revealed areas for improvement of homelessness in JSNAs and local planning. The first is the need for greater recognition of homelessness as a social determinant of health. Homelessness has a severe impact on health and wellbeing, and on access to healthcare and support. The combination of ill health and poor access creates pressure on the health system due to a reliance on emergency care. The failure to identify the lack of a stable home as a significant determinant of health means that exploration of the link between health and housing is often underdeveloped. Health and Wellbeing Boards should use the JSNA to develop an understanding of the links.

Second, even where there is recognition of homelessness as a social determinant of health, there is inconsistent understanding of the different types of homelessness,

and how these have different effects on health and wellbeing, and support needs. JSNAs should identify the impact of the different types of homelessness on health and wellbeing. This is important even where levels of single homelessness are low. Given the complex and often severe health needs many single homeless people experience, the impact on health inequality indicators and on services of a few individuals can be dramatic, especially where there are few accessible services.

While 'housing' is more often mentioned, and is given greater priority in joint JHWSs, the failure to identify the lack of a stable home as a significant determinant of health means that exploration of the link between health and housing is often underdeveloped.

Finally, identifying need is only the first step to improving the health of single homeless people. JSNAs will only be effective if they are translated into action. As the new health system is embedded further, we would hope to see a greater recognition of homelessness in both JHWSs and in CCG commissioning plans.

Despite these areas for improvement, there are positive signs regarding the inclusion of single homelessness, and a number of Health and Wellbeing Boards provide examples of good practice. These show that it is possible to use JSNAs to develop an understanding of the health needs of homeless people in a way that can drive real change in attitudes and commissioning.

# 5. Appendix: Methodology

## 5.1 The sample

A sample of 50 Health and Wellbeing Boards was analysed to examine their treatment of single homelessness. Purposive sampling was used to generate a sample that reflected a diverse range of areas: factors that may affect the approach taken to single homelessness were considered and used to ensure a mix of areas.

The primary factor for selecting the sample was the level of homelessness in each Health and Wellbeing Board area. However, there is no single or comprehensive source of data on levels of single homelessness because of the transient nature of the homeless population. The various forms of homelessness are counted in different, but sometimes overlapping ways – many more people who are single homeless, staying with friends or family, squatting, hidden from sight, or sleeping on buses will not be counted at all.

A number of different data sources were collated to provide an estimate of single homelessness in that area. Where there is two tier local government, the data for the second tier local authorities (which deal with housing) were added together to find a total for the upper tier area.

The data collected was:

- The total number of single person households accepted by the local authority
- Total estimate of rough sleeping (based on either counts or estimates)
- CHAIN data where available (London only)
- The number of people found to be homeless but not in priority need by the local authority.

The local authorities were then grouped into three groups of 50 based on whether they were in the top third for levels of homelessness, the middle third or the lowest third.

This was then used to select areas for analysis. In total, 25 were selected from the areas with highest levels of homelessness, 13 from those in the middle and 12 from those with the lowest level. More were drawn from high level areas as it could be argued homelessness poses a greater need. However, areas with low to medium levels of single homelessness were also included because those people who are homeless will still have health needs, and the lower concentration may mean that there are fewer services. Conversely, it may reflect more successful activity to reduce and prevent homelessness.

In addition to the primary sampling criteria of levels of single homelessness, a number of secondary indicators were also used to help select and define the sample.

These were:

- Population density (persons per hectare) to ensure an urban and rural mix
- Geographical location to ensure HWBs were selected in each of the nine English regions.

## 5.2 Carrying out the audit

Based on preliminary reading of a small sample of JSNAs and JHWSs, references to homelessness were identified using a keyword search.

The keywords searched were:

**Homeless**  
**Rough sleeping**  
**Housing**

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We then collected the following information in a spreadsheet:

- |   |
|---|
| <b>1. Type of homelessness identified</b> <ul style="list-style-type: none"><li>a. Not defined (i.e. simply 'homelessness')</li><li>b. Statutory homelessness</li><li>c. Non statutory homelessness</li><li>d. Rough sleeping</li><li>e. Overcrowding and poor housing</li></ul>  |
| <b>2. Local statistics: are these included and which statistics are included?</b> <ul style="list-style-type: none"><li>a. Not defined (i.e. simply 'homelessness')</li><li>b. Statutory homelessness</li><li>c. Non statutory homelessness</li><li>d. Rough sleeping</li><li>e. Overcrowding and poor housing</li></ul>  |
| <b>3. In what sections of the document is homelessness addressed?</b> <ul style="list-style-type: none"><li>a. Does it have a separate document, section or subsection on homelessness in general</li><li>b. Does it have a separate document, section or subsection on single homelessness and/or rough sleeping specifically?</li><li>c. Are single homelessness/rough sleeping mentioned in other sections, e.g. on migrants, domestic violence, tuberculosis?</li></ul> |
| <b>4. Targets and plans</b> <ul style="list-style-type: none"><li>a. Are there any ongoing or future plans or targets relating to the health of single homelessness or rough sleepers</li></ul>   |

Once data had been collected for each area, the attention they gave single homelessness was assessed using the following ranking system:

Rating	Level of detail on single homelessness
None	No mention of homelessness in any documents
Very Low	Mentions general homelessness but with little detail or no targets identified, no mention of single homelessness or rough sleeping
Low	Mentions homelessness with detail or targets, but does not refer to single homelessness or rough sleeping
Medium	Mentions single homelessness and/or rough sleeping, but provides little detail
High	Dedicated section or separate document on homelessness including substantial reference to single homelessness and/or rough sleeping, or significant detail under several other sections.

We used this to determine the priority given to single homelessness in each area. We also looked for patterns and differences in the way in which Health and Wellbeing Boards approach the JSNA, how these relate to JHWSs and CCG planning, as well as whether there are any links between these issues and how single homelessness is dealt with.

### 5.3 Limitations

A few limitations should be acknowledged. First, we recognise that the documents being audited are not the only ones in which the needs of homeless people, including their health needs, are included. A lack of inclusion in a particular local authority's JSNA, JHWS or CCG plans does not in itself mean that the needs are not being considered or addressed. However, we believe that it is appropriate for the health needs of people who are homeless to be included in these specific health assessments and strategies. It is useful to be able to understand the health needs of people who face particular challenges as a result of homelessness, rather than simply considering, for example, them as cardiovascular patients, or people with mental health problems.

The findings set out percentages of the documents which gave high, medium, low etc attention to single homelessness. However, we recognise that this is not a representative sample; the sample was aimed to give an understanding of the diversity in approaches, and highlight where there are gaps.

The ranking of prioritising is in part subjective, not least because the lack of a required format for the documents means that very different approaches have been taken in producing them, making comparison more difficult. However, this analysis was carried out by one researcher, to limit the chance for different criteria being applied, and again, is intended to provide more of a snapshot of differences and similarities between areas.

## Contact us for further information

 Homeless Link is the national membership charity for organisations working directly with homeless people in England. We work to make services for homeless people better and campaign for policy change that will help end homelessness.

**[www.homeless.org.uk](http://www.homeless.org.uk)**

Through this work, we aim to end homelessness in England.

 St Mungo's Broadway provides a bed and support to more than 2,500 people a night who are either homeless or at risk, and works to prevent homelessness, helping about 25,000 people a year. We support men and women through more than 250 projects including emergency, hostel and supportive housing projects, advice services and specialist physical health, mental health, skills and work services.

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Thank you to everyone who has contributed to this report.

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**To receive future briefings or other St Mungo's Broadway information, visit [www.mungosbroadway.org.uk](http://www.mungosbroadway.org.uk) and sign up to our e-newsletter.**

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