Nottinghamshire Health & Wellbeing Board

Topic information	
Topic title	Health and Homelessness JSNA
Topic owner	Homeless Executive Steering Group
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Topic quality reviewed	September 2019
Topic endorsed by	Homeless Executive Steering Group
Topic approved by	Health and Wellbeing Board November 2019
Current version	
Replaces version	N/A
Linked JSNA topics	An assessment of the impact of housing on health and wellbeing (2013), An assessment of the Health Needs of Single Homeless People in Nottinghamshire (2013), Older Adults Mental Health (2017) Suicide prevention (2016) Substance misuse: Young people and adults (2018) Youth offenders (2014) Child Poverty (2016) Mental health (adults and older people) (2017), Viral Hepatitis (2017) Domestic Abuse (2019) Sexual Abuse (2014) Winter Warmth and Excess Winter Deaths (2014)

Executive summary

Introduction

Shelter defines homelessness as not having a home[1]. You are homeless if you have nowhere to stay and are living on the streets, but you can be homeless even if you have a roof over your head. You count as homeless if you are:

- staying with friends or family
- staying in a hostel, night shelter or B&B
- squatting (because you have no legal right to stay)
- at risk of violence or abuse in your home
- living in poor conditions that affect your health
- living apart from your family because you don't have a place to live together

Homelessness is an issue of concern across the country and Nottinghamshire is not exempt from this picture. Homelessness is a far wider a problem than the aspect that is most visible to the public – rough sleeping which is considered the tip of the iceberg[2].
The causes of homelessness and who is most at risk of homelessness and rough sleeping is complex and warrants action to both address those that are at risk of and who are currently

homeless as well as attention to how we can prevent homelessness in the future. This can only be done by agencies from across the public sector working together in a more systematic and joined up way over an extended period.

People who are homeless experience worse health outcomes than the general population. Consequently, the focus of this JSNA chapter is on the physical and mental health needs of the homeless population as well as identifying who is at greatest risk of becoming homeless, the causes of homelessness and evidence of what works to prevent homelessness and respond to homelessness when it arises.

This JSNA chapter was endorsed by the Homeless Executive Steering Group with additional feedback provided by local organisations that formed the JSNA steering group or contributed towards the local views section. Whilst this JSNA chapter does not replace any previous version it does provide a more up to date narrative on the health and wellbeing of those who are homeless than the A*ssessment of the impact of housing on health and wellbeing (2013)* JSNA chapter and builds on the 2013 *assessment of the Health Needs of Single Homeless People in Nottinghamshire.*

Unmet needs and service gaps

Housing and health need in Nottinghamshire must be set in the context that levels of statutory homelessness and rough sleeping remain low in the County and well below the England average. However, rough sleeping numbers have shown a steady increase since 2010, with variation across districts and boroughs, and higher rates occurring in Mansfield and Bassetlaw. This gives an indication of a rising level of unmet health, social, welfare or housing need.

Housing supply and welfare

This JSNA has highlighted a number of factors that are known to affect availability of affordable and appropriate housing, in particular for the most vulnerable populations at risk of homelessness due to complex needs and debt arrears. Specific issues highlighted within this JSNA include

- Lack of affordable housing
- Housing benefit set at rates lower than landlord can obtain in rent on the open market
- Private landlords unwilling to consider housing people in receipt of benefits
- Private rental barriers to housing people aged under 35 years
- Need for support in tenancy to prevent eviction
- Housing options to support people with experience of homelessness and existing rent arrears
- Recent trend in increased use of bed and breakfast accommodation in some areas within Nottinghamshire

Whilst approaches to address housing supply in these cases are critically important to securing positive outcomes and reducing homelessness, these are rightly covered within the Homelessness Strategies produced by local Housing Authorities. Therefore, the recommendations of this JSNA will focus on the non-housing risk factors leading to homelessness and how these wider needs can be met.

It is clearly acknowledged that neither housing approaches nor wider health and social care support can be truly effective in isolation to prevent homelessness. These needs are interconnected and therefore implementing effective solutions requires dedicated and strongly aligned partnership working.

Primary prevention approaches

The role of upstream primary prevention initiatives is not yet fully understood or embedded within strategic approaches, either nationally or locally. This is likely driven by, amongst other factors:

- The need to focus limited local resources on addressing the most acute and immediate needs of those at risk of homelessness
- The diffuse and system wide nature of risk factors leading to homelessness

It is recognised that a range of local provision which commissioners currently invest in has the potential to significantly contribute to the prevention of poor outcomes through homelessness. These include, but are not limited to:

- Debt, tenancy sustainment and welfare advice
- Veteran support strategies
- Housing adaptations secured through disabled facilities grant
- Substance misuse services
- Domestic abuse and sexual violence support services
- Family mediation
- Coping and resilience approaches in school settings
- Improving Access to Psychological Therapies (IAPT), talking therapies, social prescribing and befriending initiatives
- Employment support
- Ex-offender support strategies

It is difficult and possibly counter productive to identify unmet need in any single preventative approach, in particular as evidence points to the fact that those at risk of homelessness are far from a homogenous cohort and benefit from personalised approaches taking into account a range of support needs.

The opportunity across existing primary prevention approaches is for commissioners and providers to recognise that housing plays a critical role in health and wellbeing outcomes, and the services they provide have additional benefits of reducing future risk of homelessness. Strong joint working across services alongside improved awareness and skills in considering the housing needs of clients has the potential to maximise health outcomes for clients with complex needs within existing resource. The “duty to refer” introduced in the Homelessness Reduction Act provides an opportunity to engage a wider frontline workforce on the impact of housing on health and identify needs earlier.

Early Intervention and support

Consultation with local stakeholders showed a perception that support where available was not well known about, nor readily accessible. There was also a perception that support was not offered early enough and did not cover the broad range of the needs experienced by service users. Whilst the introduction of the Homelessness Reduction Act may address the need for earlier identification and support to some extent, consideration needs to be given to how support offers can be made more visible and accessible. In particular, for individuals who experience complex needs or chaotic lifestyles consideration needs to be given to targeted or tailored outreach approaches which reduce the barriers to engaging with services for support, in order to reduce the risk of exclusion and worsening health inequalities.

Services and commissioners may also need to consider how the profile of available support can be raised in frontline settings, to facilitate a “no wrong front door” approach to support at the point of care.

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Governance and leadership

The wide range of services which have a role in supporting better health outcomes for those at risk of homelessness means that strong governance and leadership is needed at strategic level, to drive, support and hold to account effective delivery across a partnership. Stakeholders have described current partnership arrangements as operational rather than strategic, which may limit effectiveness to drive system change such as strategic commissioning of care pathway approaches. The Rough Sleeping Strategy suggests the introduction of Homelessness Reduction Boards which would take on the role of leading system change.

Healthcare

Users of homeless services locally have reported particular barriers to accessing healthcare appointments and mental health services. This can be considered in the context that national evidence shows individuals who are rough sleeping or in temporary accommodation are high users of healthcare. The combination of difficulties accessing care, with high levels of health need (mental and physical) leads to high volume service use for potentially preventable conditions. In order to better meet the healthcare needs of this population, flexible, innovative and targeted approaches are needed which specifically address the barriers presented by having no fixed abode, no access to transport, multiple health needs and in some cases chaotic lifestyles. Some examples of such innovative practice have been piloted in primary and secondary care settings in Nottinghamshire but are not as yet commissioned in line with population need in an integrated approach. Given the relatively small numbers of individuals who present with high levels of complex need or in crisis (as compared to the population as a whole), a targeted approach, delivered in settings most accessible to homeless individuals, with high levels of support and case management, is most likely to be effective in meeting need. Effectiveness is likely to be enhanced by delivery alongside providers with existing trusted relationships in homeless communities.

This JSNA highlights that substance misuse, musculoskeletal (MSK), dental and respiratory problems are likely to be the most prevalent physical health needs, along with a broad range of presenting common and severe mental health conditions. In addition, homeless populations face inequalities in access to screening programmes for both communicable and non-communicable conditions. Inclusion health standards highlight that providing equitable care in this population requires opportunistic approaches to offer screening and treatment.

Integrated commissioning and care pathways

Both service users and commissioners have reflected that commissioned support appears fragmented, potentially duplicative, and in some cases with lack of clarity as to thresholds and eligibility criteria. Where service users present with multiple or complex needs this can result in multiple assessments, referrals and delays in care, which in a worst-case scenario leads to disengagement by the service user and difficulty in supporting recovery within temporary accommodation settings. One strategy to support service users in navigating care is the use of a case worker, however it is unclear whether case worker capacity is sufficient to meet existing needs, and fragmented care pathways will also impact on the effectiveness of case workers themselves.

The service gaps particularly noted include management of support for those with mental health and/or social care needs, although interactions between all services are perceived as challenging.

Therefore, there is a critical need for commissioners (together with providers) to work jointly in creating effective care pathways which will deliver better value for individual services through more efficient processes, and better outcomes for service users through joined up person centred approaches.

The evidence base suggests that care-pathways designed around critical time intervention, identifying high risk groups at specific points, such as discharge from prison or other institution can offer an effective risk stratified approach. Examples of such approaches are currently being trialled as part of the Rapid Rehousing Pathway, providing navigators for prisons, hospitals and mental health services. To maximise the opportunities for effectiveness in these pilots, specific partner commitment is needed for:

- Robust evaluation and sharing of learning across the local system
- Development of integrated care pathways which address wider health and social needs in addition to housing provision
- Development of sustainable financial investment to embed effective practice emerging from the pilot

Knowledge gaps

This JSNA has relied on a combination of local views, local commissioned research and national data to develop a picture of health needs for those at risk of homelessness. There is very little reliable local data available to allow robust assessment of the scale of homelessness and the range of local health need.

This is a gap mirrored at national level and highlighted in the Rough Sleeping Strategy. Further work is needed for commissioners and providers to routinely collate and share information locally on the risk factors and health, housing and social care needs of those accessing services, as a starting point for estimating true population health need. It is expected that the new Homelessness Case Level Information Collection (H-CLIC) data will provide some useful data to better quantify need in those owed a support duty.

Recommendations for consideration by commissioners

	Recommendation	Lead(s)
Strategic Leadership, Governance and Partnership Working		
1.	Establish formal governance arrangements in line with Ministry of Housing, Communities and Local Government (MHCLG) proposals for a **Homelessness Reduction Board**, to provide leadership and accountability for improving health and homelessness outcomes, including delivery of JSNA recommendations.	Housing Authorities, Commissioners of Supported Housing
2.	Establish a coordinated or integrated strategic commissioning forum to address gaps in provision and enable effective care pathways across housing, social care, mental health and primary and secondary healthcare.	Housing Authorities, Supported Housing Commissioners, Clinical Commissioning Group (CCG), Adult and Children's Social Care
3.	Identify opportunities through the Homelessness Strategies of Nottinghamshire Housing Authorities to support prevention and early identification of homelessness by partners across the system, including best use of duty to refer.	Housing Authorities

4.	Consider the recommendation of the Rough Sleeping Strategy that strategic leadership is provided through a dedicated Homelessness lead on the Health and Wellbeing Board.	Health and Wellbeing Board
Integrated Commissioning and Care Pathways		
5.	Develop and implement a commissioned care pathway for critical time intervention with specific high-risk groups: ex-offenders, mental health needs, veterans, substance misuse.	Strategic Commissioning Forum
6.	Identify opportunities to align funding to evidence based primary prevention of homelessness, including through family mediation, debt advice, healthy lifestyles, tenancy sustainment initiatives, and education/support in at risk groups.	Homelessness Reduction Board
7.	Develop the healthcare offer across primary, secondary and community care to meet the specific health needs of those with no fixed abode or in temporary accommodation, in line with inclusion health standards.	CCG, Health Care Providers
8.	Identify opportunities to strengthen effectiveness of Street Outreach and Rapid Rehousing Pathway initiatives through system wide engagement, pathway development and advocacy for longer term funding settlements.	Homelessness Reduction Board
9.	Identify and implement strategies for opportunistic screening and treatment for communicable diseases including blood borne viruses and tuberculosis, in settings most accessible to at risk homeless populations.	Public Health England (PHE), Health Protection Strategic Group, CCG
Implementation - Service Models, evaluation and data collation		
10.	Embed evidence based psychological approaches to managing and recovering from complex trauma into front line delivery of service, including Psychologically Informed Environments and trauma informed services (ReACH)	Service Providers
11.	Develop robust and shared methods for data collation and evaluation for existing services, to improve local knowledge of risk factors and health needs for those at risk of homelessness	Strategic Commissioning Forum
12.	Develop a strategic assessment of the Housing First model, as an option for securing long term health and social gains for individuals with complex and enduring needs, including substance misuse.	Strategic Commissioning Forum
13.	Develop shared protocols across service provision to improve accessibility and visibility of early identification and support options.	Service Providers

Nottinghamshire Health & Wellbeing Board

Full JSNA report

What do we know?

Overview

Homelessness is an issue of concern across the country and Nottinghamshire is not exempt from this picture. Homelessness is a far wider a problem than the aspect that is most visible to the public – rough sleeping which is considered the tip of the iceberg[2].

The causes of homelessness and who is most at risk of homelessness and rough sleeping is complex and warrants action to both address those that are at risk of and who are currently homeless as well prevention of homelessness in the future. This can only be done by agencies from across the public sector working together in a more systematic and joined up way over an extended period.

As things currently stand the national picture is concerning with homeless charities such as Shelter reporting increasing numbers of homeless people in 2018.

"According to Shelter there were 320,000 people recorded as homeless in Britain in 2018. That is 13,000, or four per cent, more than the previous year and means that 36 new people become homeless every day. Many people are in precarious situations known as "hidden homeless" which can involve moving in and out of hostels and emergency shelters, or sofa surfing, and so beyond the reach of most forms of support. On 30th June 2018 the number of households in temporary accommodation was 82,310, up five per cent from 78,540 on 30th June 2017, and up 71 per cent on the low of 48,010 on 31 December 2010. Meanwhile the number of families in Bed & Breakfast (B&B) style accommodation has more than tripled in the same time period. This has drastic effects on already vulnerable people and it is also extremely costly. Local authorities (LA's) in England spent £1.39billion on homelessness services in 2017-18. This is the cost of a reactive approach to acute social problems. That money would be far better spent on preventative services that stop people becoming homeless in the first place[1]". There are significant knock on costs. The estimated average cost to the public purse, across a range of service areas, of a single homeless person rough sleeping for twelve months ranges between £20,128 and £34,500.[2,3]

Consequently, some national measures have been introduced over the last year or two including the introduction of new legislation through the Homelessness Reduction Act (2017), the development of a national Rough Sleeping Strategy (2018) and the availability of national (often short-term) funding streams.

The purpose of this JSNA is to establish a coherent picture in terms of the health needs of those who are homeless and to identify those who are at increased risk of homelessness as well as what we can do about this locally. Owing to an absence of published research that establishes a sufficiently robust evidence base to support specific ways forward this JSNA relies on a mixture of opinions from leading organisations in the sector such as Crisis, Homeless Link and Shelter, that have published guidance and best practice. Further to this data presented is at times, based on national estimates or local counts for national data set returns which are still deemed experimental* rather than more robust known prevalence rates that are reliable and applicable to our local homeless population.

* Considered experimental and not official statistics until more than 12 months of LA data is collected and data quality is assured more information available here

i. Defining Homelessness

Shelter defines homelessness as not having a home[1]. You are homeless if you have nowhere to stay and are living on the streets, but you can be homeless even if you have a roof over your head. You count as homeless if you are:

- staying with friends or family
- staying in a hostel, night shelter or B&B
- squatting (because you have no legal right to stay)
- at risk of violence or abuse in your home
- living in poor conditions that affect your health
- living apart from your family because you don't have a place to live together

Homelessness is often the consequence of multiple factors. It describes a range of circumstances from living on the streets to residing in insecure housing. Crisis UK uses the terms 'core homelessness' and 'wider homelessness' which relate to the severity of the housing situation.

'Core homelessness' refers to households who are considered homeless at any point in time due to experiencing the most acute forms of homelessness or living in short-term or unsuitable accommodation.

'Wider homelessness' refers to those at risk of homelessness or who have already experienced it and are in accommodation which is on a temporary basis (Table 1).

Table 1: Definitions of Core and Wider Homelessness

Core Homelessness
Rough Sleeping
Sleeping in tents, cars, public transport
Squatting (unlicensed, insecure
Unsuitable non-residential accommodation e.g. 'beds in sheds/
Hostel residents
Users of night/winter shelters
Unsuitable temporary accommodation (which includes bed and breakfast basis/wanting to move, in crowded conditions (this does not include students)
Wider Homelessness
Staying with friends/relatives because unable to find own accommodation (longer term)
Eviction/under notice to quit (and unable to afford rent/deposit)
Asked to leave by parents/relatives
Intermediate accommodation and receiving support
In other temporary accommodation (e.g. conventional social housing, private sector leasing)
Discharge from prison, hospital and other state institution without permanent housing

Source: Bramley, G. (2017)[4]

ii. Homelessness Legal Framework

Local Housing Authorities in England have a duty to secure accommodation for unintentionally homeless households who fall into a 'priority need' category under Part 7 of the Housing Act 1996 (amended). People in priority need include care leavers, those with dependent children, pregnant women, disabled, fleeing domestic abuse etc[5]. The Act also requires that Local Housing Authorities must have an allocation scheme for determining priorities between applicants for housing which sets out the procedure to be followed when allocating housing. There is no duty to secure accommodation for all homeless people.

The Homelessness Reduction Act (2017)[6] came into force in April 2018 and introduced a new requirement (which supplemented the requirements of the 1996 Act) that local authorities work to prevent and relieve homelessness for all eligible homeless applicants. The Act extends the length of time a household can be considered at threat of homelessness from 28 to 56 days. Local authorities will be required to take action to support the household in finding alternative accommodation at the beginning of the notice period, rather than the end.

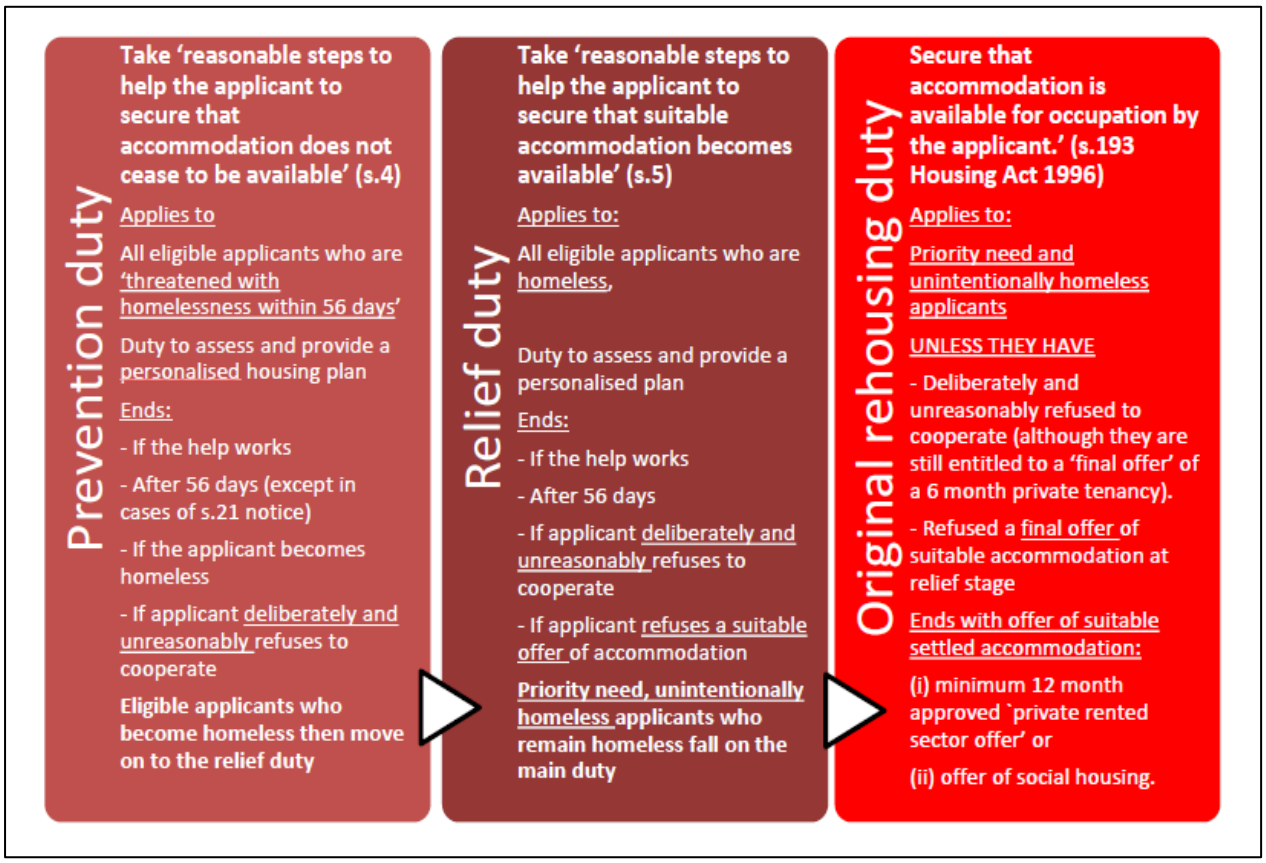
Additionally, with effect from October 2018, the Act requires specified public authorities to refer service users who they think may be homeless or threatened with homelessness to LA housing teams. The specified public authorities can be found here and include:

- prisons
- young offender institutions
- secure training centres
- secure colleges
- youth offending teams
- probation services (including community rehabilitation companies)
- Jobcentres in England
- social service authorities (both adult and children's)
- emergency departments
- urgent treatment centres
- hospitals in their function of providing inpatient care
- Secretary of State for defence in relation to members of the regular armed forces

The Homelessness Act 2002, requires all housing authorities to have in place a homelessness strategy based on a review of all forms of homelessness in their district. The strategy must be renewed at least every 5 years. Further information and guidance on homelessness legislation can be found here.

At the end of 2018, the Government published the national Rough Sleeping Strategy which set out ways to help people who are sleeping rough now and to put in place the structures to halve rough sleeping by 2022 and end it by 2027. Within this, there is a requirement for Local Housing Authorities to refresh their homelessness strategies and re-badge as homelessness and rough sleeping strategies by winter 2019.

Figure 1: Summary of changes introduced by the Homelessness Reduction Act

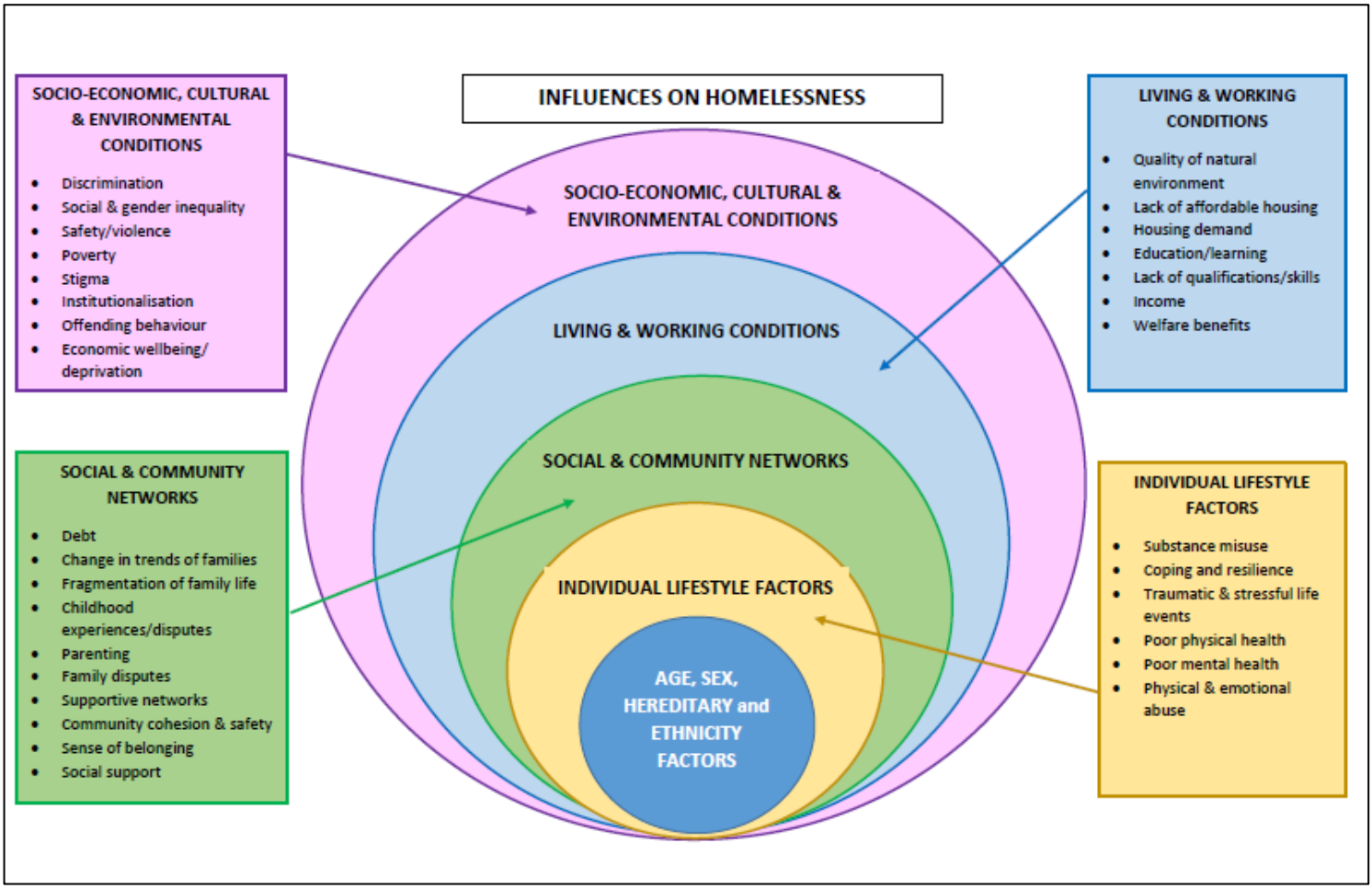


Source: Shelter (2017)[7]

1) Who is at risk and why?

The determinants or influences on a person's risk of homelessness is multifactorial and complex and can range from the individual's lifestyle factors, social and community networks, socio-economic environments and living and work conditions, as shown in Figure 2.

Figure 2: Influencing factors on homelessness



Source: Adapted from Social Determinants of Health; Dahlgren and Whitehead (1991)

1.1) The root causes of homelessness

The factors or causes of homelessness are typically described as either structural or individual, as listed in Figure 3. These causes, and their relationship, vary across the life course.

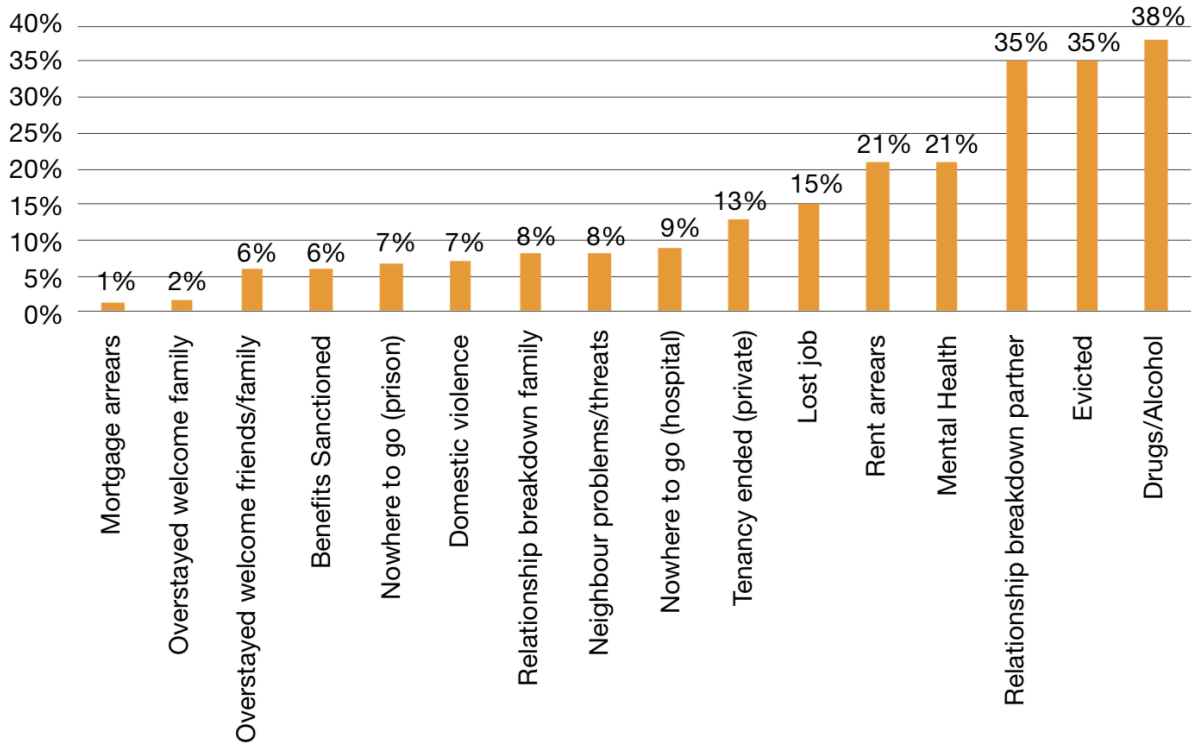
Figure 3: Causes of Homelessness

Structural factors	Individual
Housing demand (linked to demographic trends)	Family disputes / Childhood disputes
Lack of affordable housing (Eviction / Re-processions)	Veterans
Poverty	Physical and emotional abuse
Unemployment / welfare benefits	Poor physical health and mental health problems
Ethnicity	Institutionalism / Offending behaviour (Care, prison, armed forces
Changing trends in family formation and fragmentation	Drug and Alcohol misuse
	Lack of qualifications and skills
	Social networks
	Debt

Source: Harding, Irving and Whowell (2011)[8]

Figure 4 highlights some of the main underlying causes of single people becoming homeless. This research highlights underlying individual factors (more than one may apply) where as local and national level data identifies loss of tenancy and or eviction as two of the main presenting factors. This research highlights some of the reasons behind this where health (e.g. mental health) and health related behaviours (e.g. drug and alcohol use) are substantial factors.

Figure 4: Reported causes of single homelessness (individual factors)



Source: Pleace and Culhane (2016)[2]

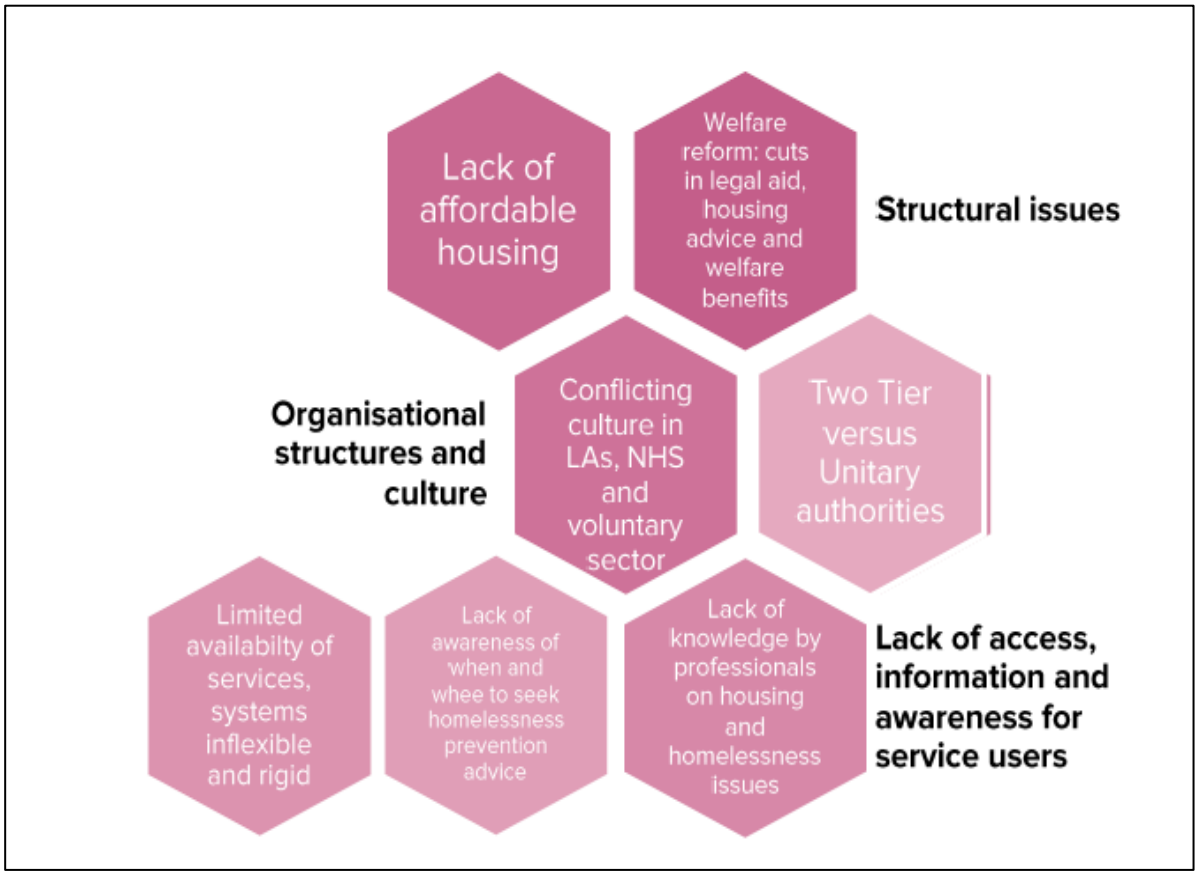
Several factors are driving the recent rise in homelessness in England, affecting both the vulnerability of individuals and families to homelessness and the wider societal conditions that give rise to homelessness. These factors are multi-faceted and include:

- **Individual circumstances - health, social and behavioural risk factors** which are the focus of this report including complex and overlapping needs, substance misuse, mental ill health, offending behaviour and certain groups such as veterans, care leavers and or those being released from prison and offenders. Socioeconomic factors, such as; relationship breakdown, unemployment, rising relative poverty and problematic debt.

- **Wider forces -** the **supply** of affordable housing and changes to the **welfare system.**

- **Complex interplay** -Structural and individual factors are often interrelated (Figure 5); individual issues can arise from structural disadvantages such as poverty or lack of education and/or poor quality housing that can lead to worsening of health conditions, such as; respiratory conditions. While personal factors, such as family and social relationships, can also be put under pressure by structural forces such as poverty[9].

Figure 5: Interrelationship of the Structural causes of Homelessness



Source: Homeless Link (2015) Preventing homelessness to improve health and wellbeing[9]

1.2) Health, social and behavioural risk factors

In May 2019, the Ministry of Housing, Communities and Local Government (MHCLG) published The Homelessness Case Level Information Collection (H-CLIC) data from 1st of April 2018 to 31st of December 2018 for the monitoring the Homelessness Reduction Act 2017[10]. Currently, this is considered as test data but in the longer term should provide a better understanding of the issues and factors with regard to homelessness. This data has been utilised to compile an estimate of homelessness in Nottinghamshire in section 2.

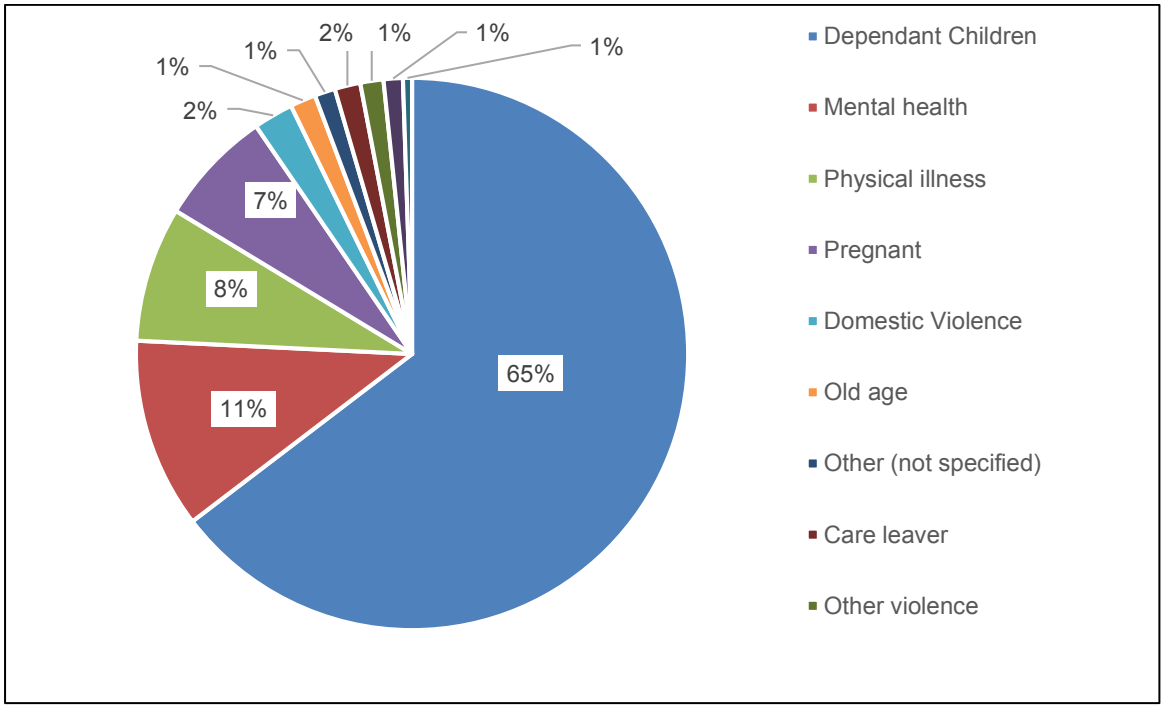
Characteristics of Homeless Vulnerable Households

Figure 6 shows the national profile for recordings of priority need taken from statutory homeless application statistics and gives an indication of the characteristics that make a household more vulnerable.

People who present as priority needs are often those with dependent children/ pregnancy, accounting for three quarters of all homeless applications nationally. However, it is possible that despite this being recorded as the priority need category there is another reason for their homelessness (for example domestic abuse).

Ill health as a factor in terms of vulnerability to homelessness is the second and third highest categories with mental health and physical illness occurring in approximately one fifth of priority need applications nationally.

Figure 6: % Priority need of applicants – January to March 2018



Source: P1E returns

Homelessness and Gender

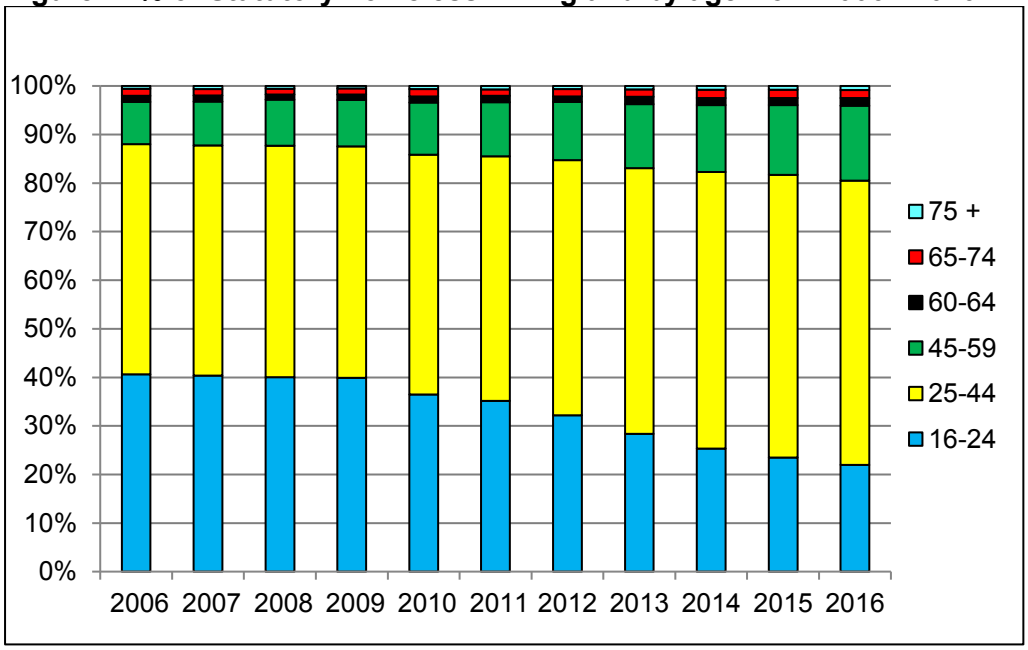
Of those identified as lone parents that presented to homeless services in England in 2016/17 (Q3) 92% were accepted as statutory homeless. This represents the largest household group at 47% of total homeless acceptances in that period. Women are also susceptible to homelessness if their housing situation changes due to pregnancy (particularly young women who are no longer able to live with their parents).

The number of women who become homeless is also often underestimated as there is thought to be a prevalence of hidden homelessness amongst women who will seek accommodation options with family and friends to avoid rough sleeping[11]. By contrast, government statistics from 2018[12] show 84% of rough sleepers are male and the majority of single homeless people accessing accommodation and support are male[13].

Statutory Homelessness and age

Figure 7 shows the national picture of statutory homelessness by age. With the highest proportion of statutory homeless being in the 25-44 age range. Since 2010, the proportion of young people between the ages of 16-24 years has steadily decreased. However, this could be an underrepresentation of the true number of homeless young people because of the level of hidden homelessness amongst this cohort. For instance, research by Homeless Link into young people and homelessness based on surveys with local authorities, service providers and interviews with young people found that most homeless young people were staying temporarily at the homes of friends, family members or acquaintances (e.g. sofa surfing) prior to accessing support[14]. These figures do not show the numbers of children amongst homeless families. The Children's Commissioner for England reports that there are124,000 children living in temporary accommodation in England in 2018 an increase of 80% from 2010[15]. This report highlights that the term "temporary" is misleading as for some families this is for extended periods of time which from a child's perspective does not feel temporary. Additionally, the report identifies that official statistics are likely to underestimate the actual numbers due to the hidden nature of homelessness that goes unreported to authorities where children and families are staying with friends or sofa surfing.

Figure 7: % of Statutory homeless in England by age from 2006 - 2016



Source: Ministry of Housing, Communities and Local Government (HCLG) (2016)

Domestic abuse

Domestic violence and abuse is also a common reason for people becoming homeless and the majority of survivors are women. Metropolitan Police statistics show that male violence against women made up 85% of reported domestic violence incidents[16]. Research by St Mungo's shows a complexity in homeless women's support needs because of the prevalence of violence and abuse they have experienced[17].

The national Homelessness code of guidance for local authorities[18] states that women can be at increased risk of homelessness if they are escaping honour based violence, including forced marriage and female genital mutilation. Both men and women are at risk of homelessness if they have been involved or associated with gang violence or a victim of modern slavery or trafficking.

Homelessness and Sexual/Gender identity

According to a 2014 report from the Albert Kennedy Trust[19], 77% of young Lesbian Gay Bi-sexual Transgender (LBGT) homeless people believed their sexual / gender identity was a causal factor in rejection from home. Shelter reported in 2007 that "there is very little information and research on the housing needs of lesbian and gay older people". A decade later this still seems to be the case.

Homelessness and Ethnicity

The national rough sleeping count in Autumn 2018 estimated that 4,667 people slept rough on a single night in England. Of these 64% were UK nationals, compared to 71% in 2017. 22% were EU nationals from outside the UK, compared to 16% in 2017. 3% were non-EU nationals, compared to 4% in 2017[12]. Further to this there are uncertainties in terms of eligibility for housing in relation to the Britain's pending withdrawal from the European Union.

1.3) The supply of affordable housing and changes to the welfare system

It is widely recognised that there is an undersupply of good quality, affordable housing in most areas of the country. This is due to a number of factors including a shortage in the delivery of new housing of all tenures; an expansion of Right to Buy and a shortage of available properties in the Private Rented Sector to house people in housing need. The House of Commons Communities & Local Government Committee report into Homelessness (2016)[20] concluded that the increase in homelessness is due to the affordability and availability of housing.

Estimates have put the number of new homes needed in England at between 240,000 and 340,000 per year. In 2017/18, the total housing stock in England increased by around 222,000 homes (a gap of over 100,000 homes per year)[21]. However, the Institute for Public Policy Research (IPPR) stresses that it is not just the number built but also the balance of tenures and affordability which need to be thought through for an effective housing strategy[22].

MHCLG data[23] shows that the delivery of affordable housing has generally reduced over the past 10 years. In 2011/12, 58,327 homes were developed in England, of which 38,823 were Affordable or Social rented. This compares to 32,618 in 2015/16; 42,198 in 2016/17 and 47,124 in 2017/18. The pressures of supply not keeping pace with demand has contributed to increased house prices and increased rental values and therefore increased pressures on the availability of affordable housing and the gap between average earnings and average house prices continuing to widen.

According to the Office of National Statistics[24] in 2002, the East Midlands Median Gross annual wage was £19,513. This increased to £27,606 in 2018 (an increase of 42%). Over the same period, the average property value in the East Midlands has increased from £110,306 to £177,656 (an increase of 60%)[25].

The increase in house prices is also reflected in rent levels in the Private Rented Sector. During the financial year 2018/19, the average (median) rent for a 2 bedroom property in Nottinghamshire as recorded by the Valuation Office Agency[26] was £500 per calendar month (this varies across the County as £475 in Ashfield, Bassetlaw and Mansfield to £650 in Rushcliffe).

Housing Benefit rates are calculated by reference to a claimants eligible rent. In brief, this is calculated based on a Local Housing Allowance rate which is fixed 30th percentile point for rents in each size category of dwelling in the local area (known as the Broad Rental Market Area (BRMA), as based on market rents paid by tenants who are not receiving housing benefit. This means that in higher value areas within the BRMA, Housing Benefit will tend to not cover the rent that a landlord would be able to obtain in the open market.

Social Housing and Right to Buy

The tenure profile of housing in England has changed over time. As at 31st March 2018, there were an estimated 24.2 million dwellings in England[27]. Of these, 15.3 million were owner occupied; 4.0 million were affordable rented dwellings i.e. rented from Councils or Registered Providers and 4.08 million were rented from private landlords or were linked to a job with the remainder being classified as 'other public sector dwellings'.

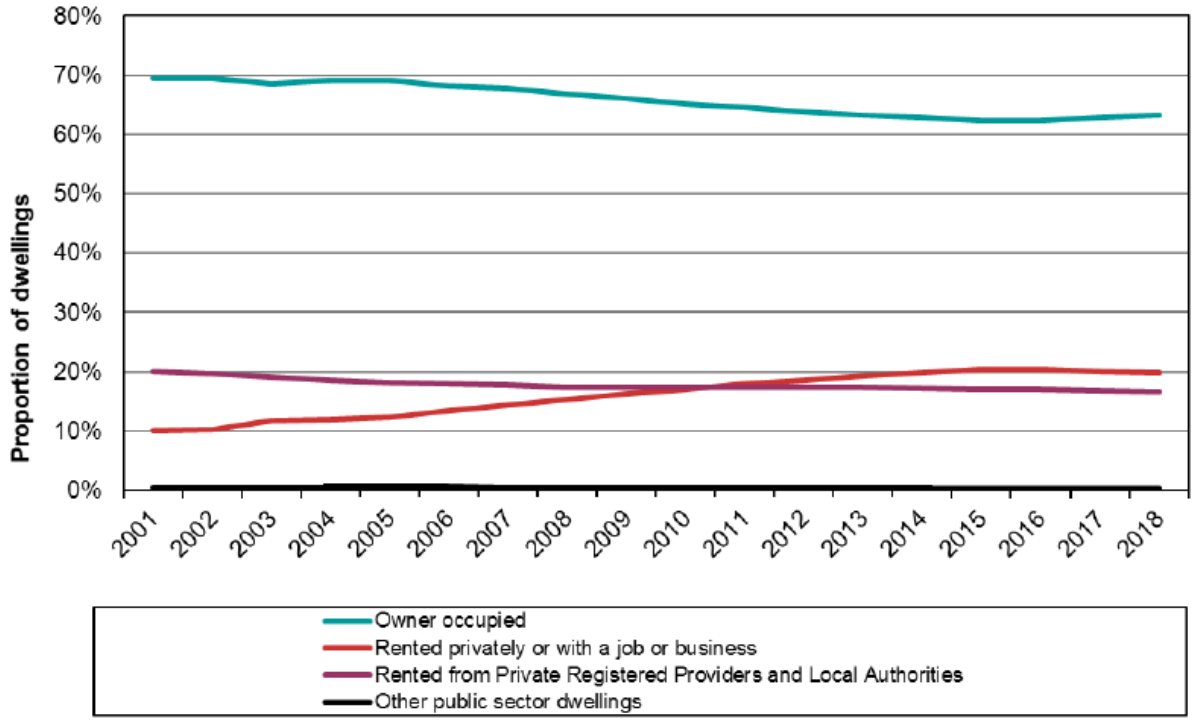
Over the last near to 20 years the shift in tenure has seen a reduction in the % of owner occupier and renting from council and an increase in % private rents (Table 2).

Table 2: Change in housing tenure in England by type 2002 - 2018

Tenure	%		
	2002	2018	Direction
Owner Occupied	70%	63%	↓
Council Rented or Registered providers	19.7%	16.7%	↓
Private Rental Sector	10.3%	19.9%	↑

Figure 8 shows that in 2001 only 10% of the population lived in the private rental sector but by 2014 this proportion had risen to 20% of total households and has remained at this level since[27]. This substantial shift from social to private renting means that there is significantly less opportunity to shape the housing market to meet housing need with many private landlords being unwilling to consider housing people who are in receipt of benefits.

Figure 8: Proportion of dwellings in England by tenure from 2001 to 2018



Source: ONS Housing Statistical release MHCLG dwelling stock estimates [27]

The changes in tenure are due to a number of factors with the reduction in social housing being primarily due to the popularity of the Right to Buy Scheme which has seen nearly two million homes have been bought in England under the scheme. In Nottinghamshire (County) alone, this equated to over 30,000 homes[28]. In the same period local authorities nationally built only 350,450 homes with borrowing restrictions imposed, alongside a requirement to spend resources on modernising existing stock.

Housing and Planning

It is reported that successive Governments have not built sufficient homes to meet the growing need[29]. Recent government housing policy has been outlined in the Housing and Planning Act 2016[30] and Housing White Paper 2017[31], both of which are heavily focussed on planning and building for home ownership at the expense of affordable rental dwellings, which is not directly helping to prevent the risk of homelessness for low income households. This approach has limited impact on assisting people who are most in housing need.

Where recent legislation does relate to social housing and the Private Rented Sector (PRS) it introduces measures that will potentially further limit access to affordable housing. For example, the move to end lifetime tenancies builds in the notion that people should only live in social housing when in need and when circumstances change they should move out and make room for the next household in need. This brings with it implications around stability and security of tenure and balance in communities and neighbourhoods.

Impact of Welfare Reform

Since 2010, there have been significant changes to the UK's benefits system. The changes are intended to reduce benefit dependency; to incentivise work for those who are able to work and to make the system more affordable for Government. This includes the introduction of Universal Credit; reductions in the annual increase in benefits and tax credits to a maximum of 1% per year and changes to Housing Benefit levels as well as a host of other measures, many of which removed the eligibility of claimants who previously received relatively small

awards. Additionally, a number of reforms were intended specifically to introduce more stringent entitlements to benefits for claimants.

Several of the reforms have been recently introduced or are still being rolled out, therefore, it is still early stages for a full assessment of the cumulative impacts of benefit changes to be undertaken. However, Homelessness Monitor 2019 identifies, "There is considerable concern amongst local authority respondents of the ongoing expected impact of welfare reform on homelessness in their area. The full roll out of universal credit is the subject of greatest concern with nearly two thirds of LAs anticipating a "significant" homelessness increase as a result. Aside from anxieties on universal credit, most LAs anticipated that homelessness would "significantly" increase due to the freeze in Local Housing Authority rates (53%) and other working age benefits (51%), with almost as many LAs (47%) reporting likewise for the lowered benefit cap"[32].

1.4) Homelessness and Health and Wellbeing

Homelessness and Mortality

Homeless people are more likely to die young, with an average age of death of 47 years old, compared to 77 years for the general population. It is important to note that this is not life expectancy; it is the average age of death of those who die on the streets or while resident in homeless accommodation. Standardised mortality ratios for excluded groups, including homeless people are around 10 times that of the general population[33].

Homeless people aged 16-24 years are at least twice as likely to die as their housed contemporaries; for 25-34 year olds the ratio increases to four to five times, and at ages 35-44, to five to six times. Even though the ratio falls back as the population reaches middle age, homeless 45-54 year olds are still three to four times more likely to die than the general population, and 55-64 year olds one and a half to nearly three times[33].

Drug and alcohol abuse are common causes of death amongst the homeless population, accounting for just over a third of all deaths. Homeless people have seven to nine times the chance of dying from alcohol-related diseases and 20 times the chance of dying from drugs compared to the general population[34]. When homeless people die, they do not commonly die as a result of exposure or other direct effects of homelessness they die of treatable and or often preventable diseases[35].

Homelessness and physical and mental health

There is a paucity of evidence on the health of homeless people nationally. However, what exists tends to be focused on rough sleepers and single homeless people. This section looks at national evidence on a range of health conditions which affect homeless people and where applicable is compared to the general population.

There is consistent evidence that this group experiences worse mental and physical health than the general population[36,37]. This is described throughout much of the literature as 'a tri-morbidity of physical illness, mental health problems and substance misuse'[366].

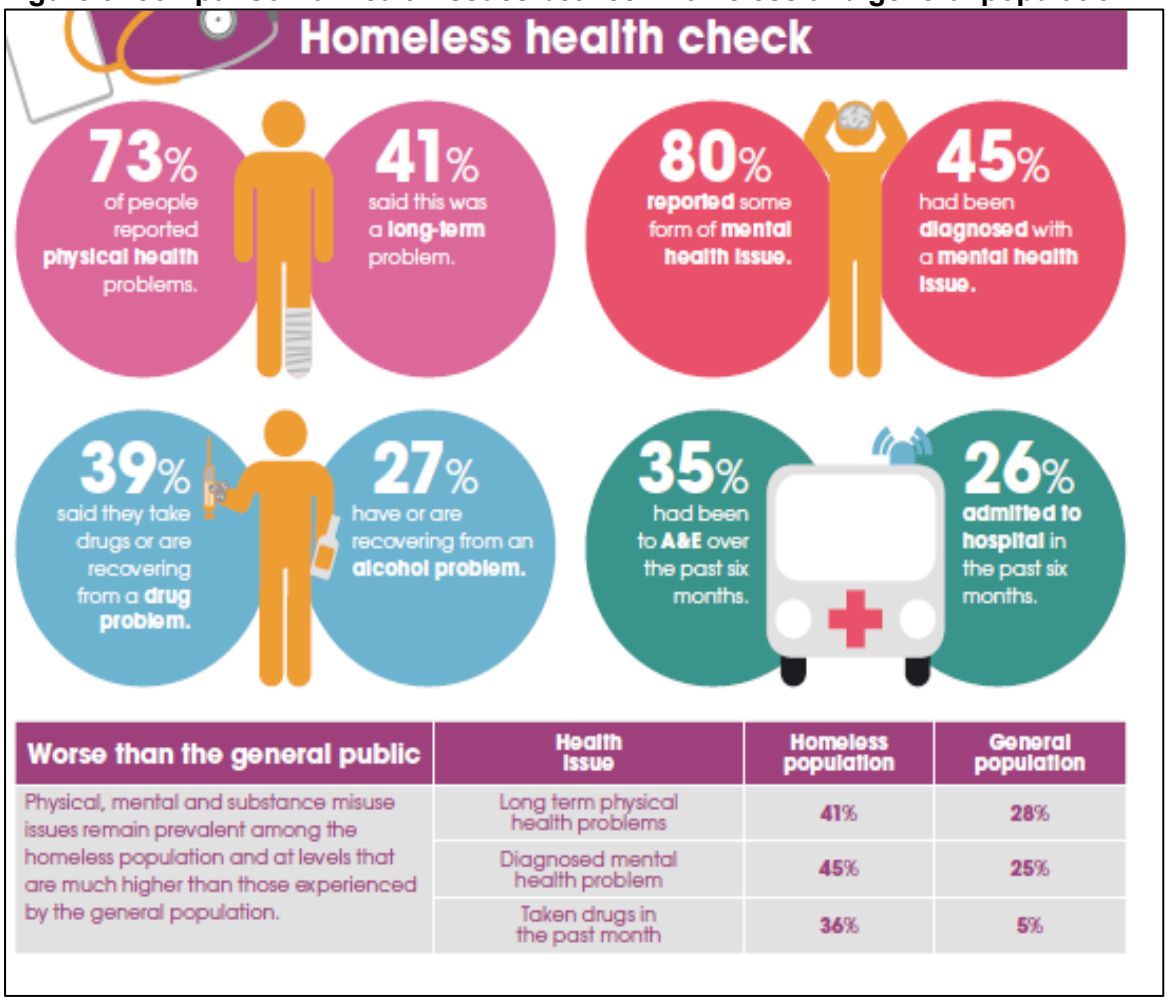
- Poorer health amongst this group compared to the general population is compounded by the inverse care law: those in greatest need have most difficulty accessing healthcare[38].
- Common physical health and mental health problems are described throughout the literature as disproportionately affecting people who are homeless, and that homelessness may be both a cause and a symptom of ill health is described[39].
- Rough sleepers report the worst physical health compared to single homeless or hidden homeless groups[38].

- Rough sleepers were also statistically more likely to report alcohol and/or drug use compared to single homeless or hidden homeless groups. No difference was found for smoking prevalence[38].

Physical Health

Homeless Link (2014)[40] reports that "available comparable data shows that almost all long-term physical health problems are more prevalent in the homeless population than in the general population" with 41% of the homeless population experiencing long term physical health problems compared to 28% of the general population (Figure 9).

Figure 9: comparison of health issues between homeless and general population



Worse than the general public	Health issue	Homeless population	General population
Physical, mental and substance misuse issues remain prevalent among the homeless population and at levels that are much higher than those experienced by the general population.	Long term physical health problems	41%	28%
	Diagnosed mental health problem	45%	25%
	Taken drugs in the past month	36%	5%

Source: Homeless Link (2014)

Mental Health

Homelessness and poor mental health often go hand in hand. Having a mental health problem can create the circumstances which can cause a person to become homeless in the first place. Yet poor housing or homelessness can also increase the chances of developing a mental health problem or exacerbate an existing condition. In turn, this can make it even harder for that person to recover – to develop good mental health, to secure stable housing, to find and maintain a job, to stay physically healthy and to maintain relationships.

Single homeless people are much more likely to have mental health problems compared to the general population. In 2015, 32% of single homeless people reported a mental health problem, and depression rates are over 10 times higher in the homeless population. Other

psychological issues such as complex trauma, substance misuse and social exclusion are also common[41].

The prevalence of serious mental illness (including major depression, schizophrenia and bipolar disorder) is reported as 25–30% in the street homeless population and those living in direct-access hostels. Homelessness is also associated with higher rates of personality disorder, self-harm and attempted suicide[42].

For accessing accommodation, the initial assessment of 'priority need' is not made by a mental health professional. Some local authorities commission private companies to assess mental health status and these assessments are usually made on the basis of written evidence submitted by the local authority, rather than a personal assessment[43]. Other local authorities ask for a letter from the GP.

Adverse Childhood Experiences (ACEs)

ACEs can be categorised into three direct and six indirect experiences that have a negative impact on a child and includes; verbal abuse, physical abuse, sexual abuse, parental separation, domestic violence, mental illness, alcohol abuse, drug use and incarceration. ACEs can significantly affect physical, mental and personal well-being throughout life.

An increase in ACEs has been found to result in an increase in negative health and well-being outcomes. This includes; risky behaviours such as smoking, alcohol and drug use or sexual risk taking, and also an increased risk of different types of diseases such as depression, liver disease and ischaemic heart disease. It is estimated that approximately 50% of homeless people have four or more Adverse Childhood Experiences (ACEs)[44, 45].

Communicable Diseases

A high prevalence of communicable diseases such as tuberculosis (TB), hepatitis and bacterial infections such as streptococcal and staphylococcal infections can be found among those living on the streets or in hostels.

The national enhanced TB surveillance system (ETS), data is collected on the presence or absence of four social risk factors (SRFs) known to increase the risk of TB. SRFs include, current alcohol misuse that would impact on the patient's ability to take treatment, current or history of drug misuse, homelessness and/or imprisonment. The number of cases of tuberculosis in the UK peaked in 2011 and subsequently the number of people notified with TB has fallen by nearly 40% to 5,102 in 2017. However, this reduction has not occurred consistently across all population groups. For example, since 2013 there has been a slight increase in the proportion of TB cases amongst homelessness people rising to 4.7% (217/4,584) in 2017[46].

People who are street homeless are at higher risk of developing Group A Streptococcal (GAS) infections. Group A Streptococcus can cause a range of disease from non-invasive manifestations such as pharyngitis, impetigo and scarlet fever to life threatening invasive disease such as necrotising fasciitis or Group A Streptococcal septicaemia.

There are particular challenges in screening and treating this group for TB, hepatitis and bacterial infections. Unstable housing, homelessness and lack of recourse to public funds can make it more difficult for patients to complete the lengthy TB treatment regimens required for cure, thereby increasing the risk of transmission and poor treatment outcomes. Non-completion of treatment can contribute to drug resistance, relapse and onward transmission of the disease. TB cases can also occur in individuals who face particular challenges in accessing affordable, suitable and stable homes, such as people with close links to high

incidence countries who may be ineligible for social security; people with a history of imprisonment; people who misuse drugs and alcohol[47]. Poor access to health services may make treatment of bacterial infections such as Group A Streptococcus challenging and treatment adherence may also be difficult when living on the streets.

In terms of infectivity and access to health services it is important to note that whilst TB treatment is free in the UK, those with no recourse to public funds (e.g. undocumented migrants or refused asylum seekers) will not normally have access to welfare payments, local authority/housing association accommodation or social care services. Public Health England report that these issues can influence a person's ability to successfully complete treatment and may also increase the public health risk they pose to others due to prolonged periods of infectivity.

Blood borne virus screening rates in the homeless population are unknown as other SRFs apart from injecting drug use are not routinely recorded at a national or local level. As a result, homeless people may not receive preventive vaccines against hepatitis B or be identified for potentially curative treatment against hepatitis C.

Cancer Screening

Cancer prevalence, risks and uptake of cancer screening remains understudied in the homeless population[48]. However, access to screening can be largely dependent on a person being registered with a GP[49] and population groups without a postal address may also face challenges in accessing health services, including screening, as they have no address to which information about appointments can be sent[50].

A study conducted in Toronto, Canada, explored the perceptions of women living in homeless shelters and women with severe mental health challenges about the factors influencing their decision-making processes regarding breast and cervical cancer screening. The study recommended that to improve uptake of cancer screening for women with complex needs, appropriately designed intervention programmes for marginalised women are required, as well as sensitivity training for health care providers. Tailored and effective health promotion strategies leading to life-long cancer screening behaviours among marginalized women may improve clinical outcomes[51].

Long-term Conditions

As the demographic profile of those who are homeless has shifted towards older age, the incidence of chronic diseases and age-related conditions, such as cognitive impairment and functional decline, has increased. Additionally, homeless individuals aged 50 years and older have higher rates of age-related conditions (functional impairments, cognitive impairments, falls, and urinary incontinence) than a general population comparison that is 20 years older[52].

Oral Health

Healthy Mouths is a research study into the oral health of people experiencing street homelessness, which was conducted by Groundswell and was led by Peer Researchers[53]. The study engaged 262 people who are currently homeless in London, utilising focus groups and one-to one interviews and also engaged over 50 professionals working in this area. The Healthy Mouths study reveals that homeless people suffer extremely poor oral health compared to the general population.

The oral health of participants was very poor and significantly worse than the general population.

- 90% have had issues with their mouth since becoming homeless. Particularly common were bleeding gums (56%), holes in teeth (46%) and dental abscesses (26%).

- Many participants had experienced considerable dental pain. 60% had experienced pain from their mouths since they had been homeless. 30% were currently experiencing dental pain.
- 70% reported having lost teeth since they had been homeless and 7% had no teeth at all. 35% had teeth removed by a medical professional, 17% lost teeth following acts of violence and 15% of participants pulled out their own teeth.

The report identified some key factors underlying poor oral health in homeless people

- High levels of sugar consumption
- High rates of drug and alcohol misuse and smoking tobacco
- Rates of cleaning teeth were significantly lower than the advised minimum levels
- Rates of attendance and "sign up" at dentists were far lower than in the general population.

Alcohol and drugs were commonly used in an attempt to manage oral health issues. 27% of participants have used alcohol to help them deal with dental pain and 28% have used drugs. This may be contributing to continued drug and alcohol misuse[40].

Substance Misuse, Smoking and Alcohol

Homeless people are at increased risk of a wide range of health problems related to substance misuse: this can be both a cause and consequence of homelessness.

National and local research indicates high prevalence of usage of illegal and prescribed drugs, and of tobacco and alcohol.

According to the national Homeless Link Health Audit[54]:

- 27% of homeless people reported that they have or are recovering from an alcohol problem.
- Data on the regularity and amount homeless people drink implies that these needs may be more common. 39% of homeless men and 25% of women who took part in the audit drink twice or more a week, and around two-thirds of homeless men and women drink more than the recommended amount each time they drink.
- By comparison, one-third of the general public drink more than recommended amount on at least one day each week. Males appear to be more likely to drink more frequently than females.
- The audit also identified a higher prevalence of smoking, 77% in the homeless population compared to 20% in the general population, of whom fewer wanted to quit smoking (41% of homeless smokers compared to 63% of the general population).

Nutrition

A review of research studies of street homeless people's diet found a recurrent theme of high levels of saturated fat, low fruit and vegetable intake and numerous micronutrient deficiencies, thus highlighting the presence of malnutrition. In summary: "For the homeless individual even the basic survival requirements of food can be limited, resulting in a daily struggle both physically and mentally" [55].

Use of Health Services

Research carried out in 2010 identified total cost of hospital use by homeless people was estimated to be four times that of the general population with inpatients costs increasing to eight times higher amongst homeless people[56].

According to the national Homeless Link Health Audit[54]:

- 90% of surveyed homeless people said they are either permanently or temporarily registered with a GP. 21% of homeless people said they had used opticians in the last six months. 32% had visited a dentist.
- On average there were 1.18 hospital admissions per year for homeless people compared with 0.28 per year for the general public. This reflects previous research which found that homeless people usually stay in hospital for longer than the general public, mainly because of their more acute health issues.
- Single homeless people are five times more likely to use Accident & Emergency Services than the general public and 3.2 times more likely to have hospital admissions with longer lengths of stay[57].
- Poor health can be exacerbated by limited access to appropriate health services and limited integration between services. The poor outcomes homeless people often experience from the health service mean that health conditions are not always treated effectively and can in turn lead to worse conditions developing.

Homelessness and Inclusion Health standards

Bodies that represent the main medical specialities (e.g. Royal College of GPs, the British Medical Association) have endorsed homeless and inclusion health standards to better address the needs of homelessness people[58]. The standards incorporate the findings of the evidence of what works in inclusion health[59] which recommends implementing policies that address the upstream causes of exclusion such as poverty and ACEs whilst accentuating some key principles to inclusive health services:

- build trust and relationships through continuity by clinician/team
- access to include walk in provision, in-reach to hostel, street outreach
- integrated, multi-disciplinary, collaborative care
- person centred care
- involvement of those with lived experience in planning and delivery of care
- recovery focused
- where specialist services are provided they should act as a catalyst to improving care throughout local health system
- work closely with public health functions to address serious communicable diseases
- link hospital to community through integrated care / hospital in-reach
- treat those who have no recourse to public funds

2) Size of the issue locally

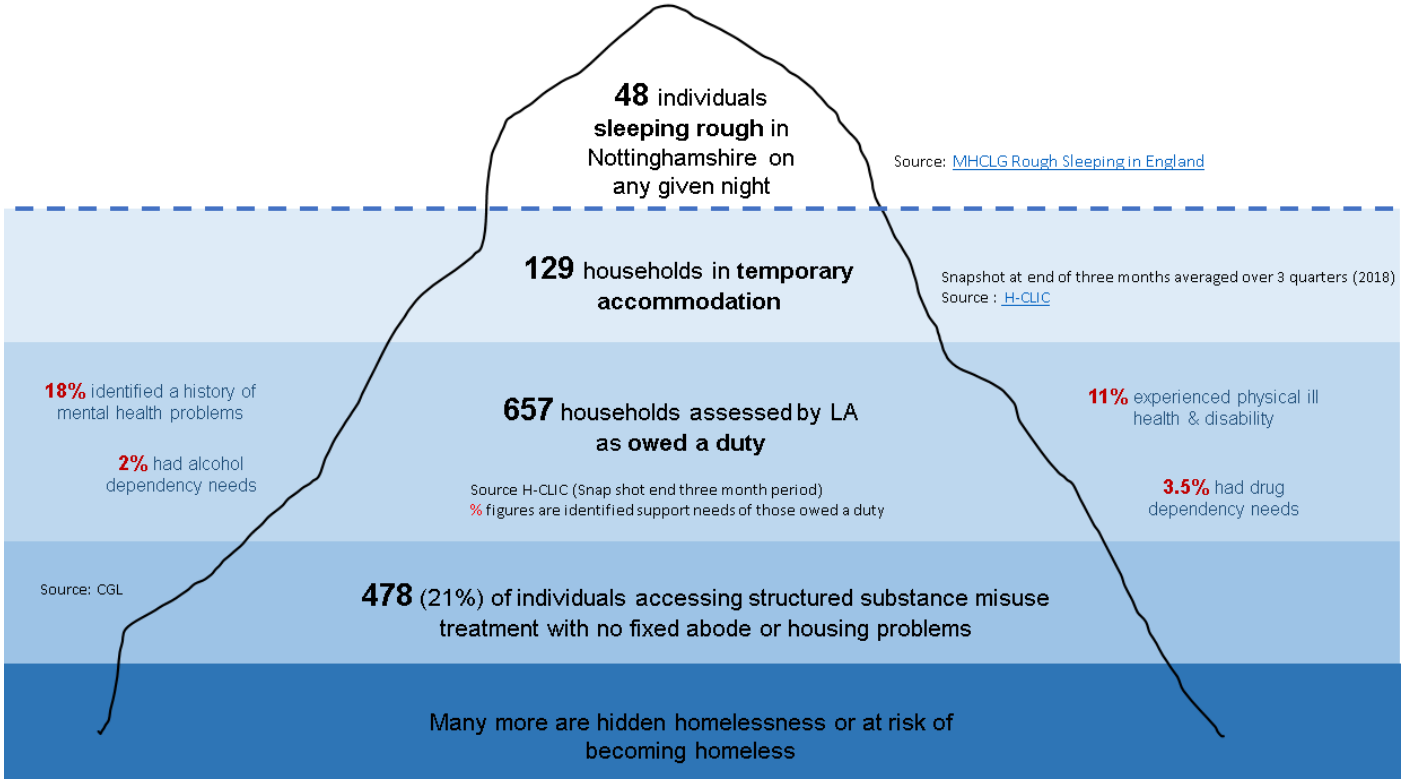
A substantial number of metrics are routinely recorded and reported by local authorities to central government (for example households accepted as being homeless and in priority need, eligible homeless not in priority need, households in temporary accommodation etc).

Only two of these measures are presented in the Wider Determinants of Health section of the Public Health Outcomes Framework†. Whilst this is an important data source that enables comparison with other Local Authorities and the national and regional rate, it does not quite express the presenting issue in a way that enables a shared understanding across our local partnership of organisations that collectively need to work together to reverse the current situation.

2.1) Estimate of the numbers of homeless people in Nottinghamshire

An estimate of the homelessness need in Nottinghamshire has been compiled using some key data points

Figure 10: Estimate of homeless population in Nottinghamshire at any one point in time



Adapted from Shelter https://twitter.com/shelter/status/1092147212069556225

† PHOF 1.15i Statutory Homelessness and PHOF 1.15ii Statutory Homelessness

Rough Sleeping

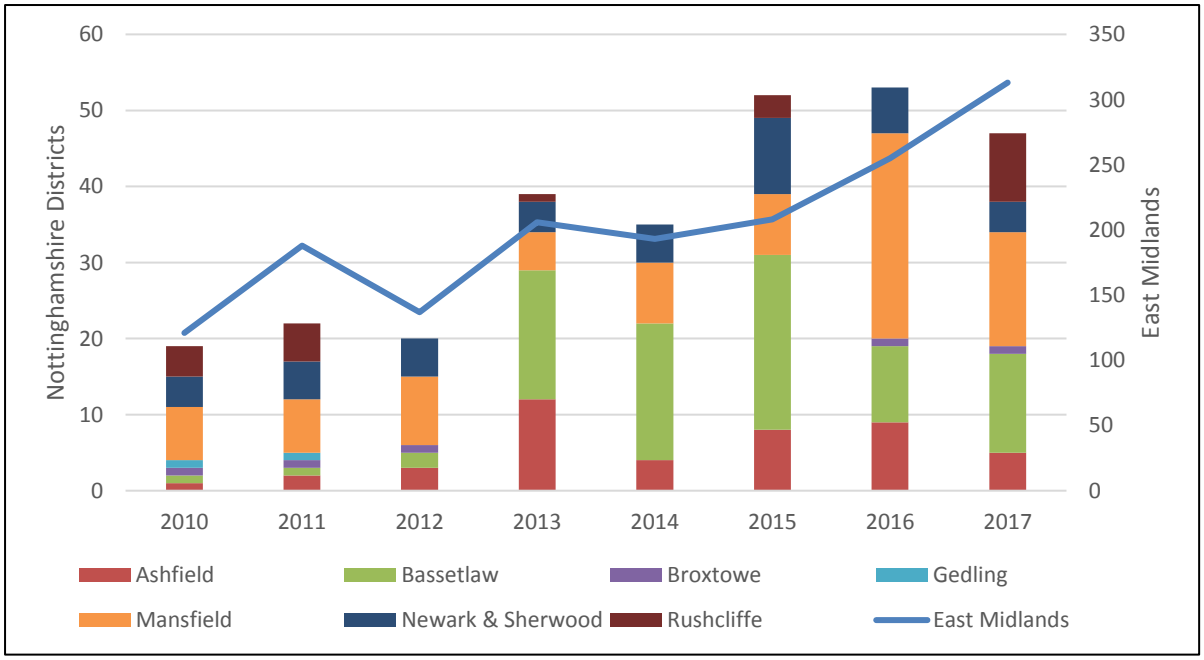
Formal rough sleeper counts take place annually on one night of each year between 1st October and 30th November. The count is to provide Government with an estimate of the number of rough sleepers in an area. Accurately counting or estimating the number of people sleeping rough within a local authority is inherently difficult given the hidden nature of rough sleeping. There are a range of factors that can impact on the number of people seen or thought to be sleeping rough on any given night. This includes the weather, where people choose to sleep, the date and time chosen, and the availability of alternatives such as night shelters[12].

In line with an East Midlands trend, there has been a steady rise in the number of rough sleepers across Nottinghamshire since 2010.The 2018 rough sleeper count tells us that it is estimated that 48 individuals sleep rough on any given night across Nottinghamshire, 90% of whom are male and aged over 26. This figure is similar to the previous year. However, rough sleeping is not distributed evenly across the county with Bassetlaw (16) and Mansfield (17) having the highest estimate and the southern boroughs the lowest number of rough sleepers in Nottinghamshire.

Additionally, rough sleeping is the most visible form of homelessness that tends to be experienced by single people with a wide range of health issues. In the year from April 2018 to March 2019 the Street Outreach Team encountered a total of 336 individuals sleeping rough across the County. The vast majority (more than 90%) of these had significant support or care needs relating to their mental and/ or physical health, alcohol, drug or New Psychoactive Substance (NPS) misuse. A significant proportion (more than 70%) of rough sleepers experienced multiple or complex needs.

Figure 10a shows the number of rough sleepers by each Nottinghamshire District from 2010 to 2017. In line with the East Midlands trend, since 2010 there was a steady rise in the number of rough sleepers across all Nottinghamshire Districts with Bassetlaw and Mansfield having the highest number.

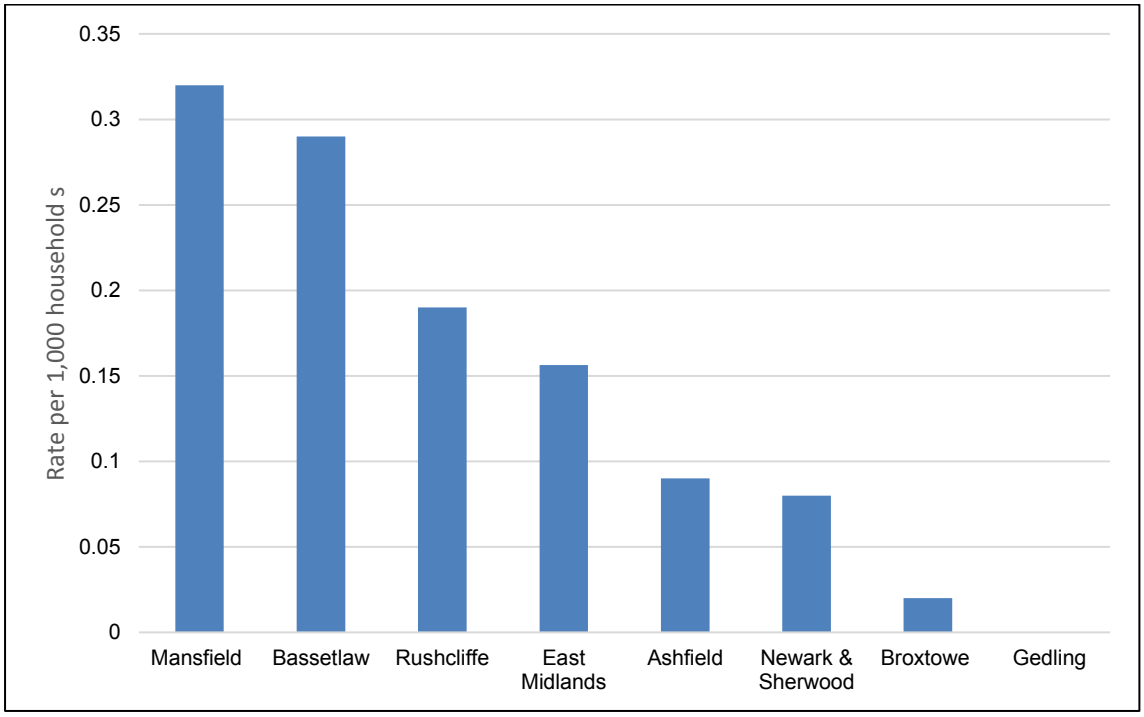
Figure 10a: Number of Rough Sleepers by Nottinghamshire Districts from 2010 to 2017



Source: Ministry of Housing, Communities & Local Government

Figure 10b, shows the rate per 1,000 household of rough sleepers for each Nottinghamshire District. In 2017, Mansfield, Bassetlaw and Rushcliffe were higher than the East Midlands rate of 0.15 per 1,000 household.

Figure 10b: Rate per 1,000 household of rough sleepers by each Nottinghamshire District compared to the East Midlands Region in 2017



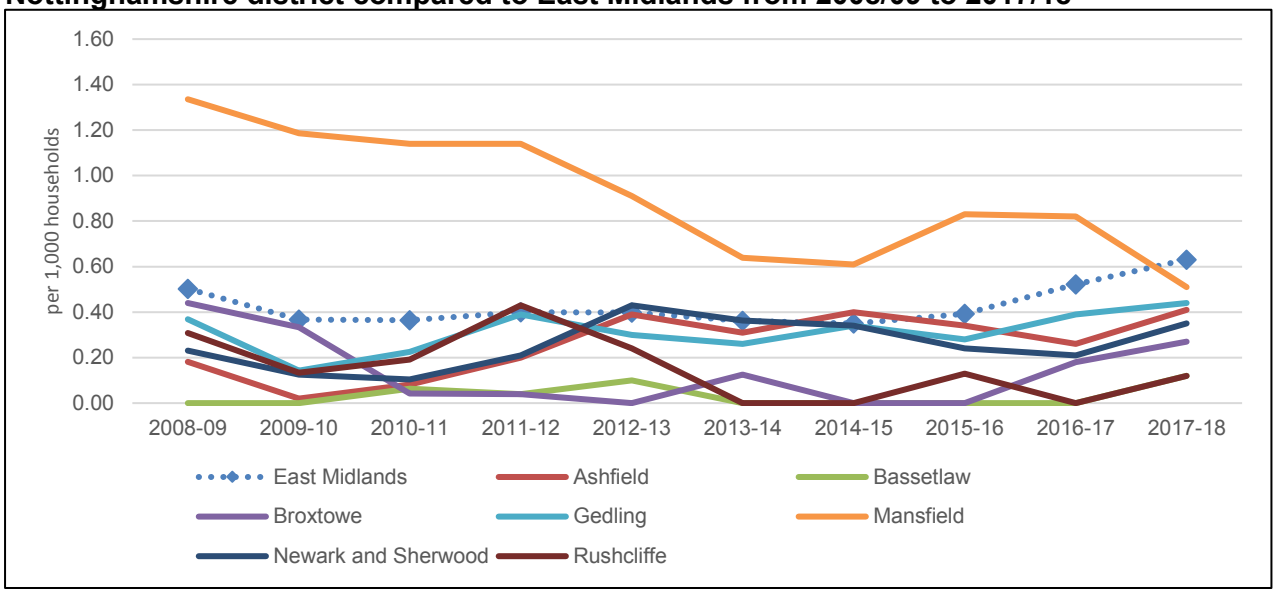
Source: Ministry of Housing, Communities & Local Government

Temporary Accommodation

Temporary accommodation includes Bed and Breakfast (B&B) accommodation; hostels; use of Local Authority and Housing Association accommodation on a temporary basis; private sector leased accommodation as well as other types including through the private rented sector. Data on households in temporary accommodation is based on a snapshot at the end of each quarter and could potentially under-represent the numbers experiencing homelessness during the reported period. Data reported to MHCLG on households in temporary accommodation are currently deemed experimental statistics.

Based on the three reported periods in 2018 Nottinghamshire had on average 129 households per quarter placed in temporary accommodation (112 in Apr-June; 134 in July-Sept and 141 in Oct-Dec 2018). Greater numbers of households placed in temporary accommodation existed in Mansfield, Ashfield, Newark and Sherwood and Gedling with fewer households in Bassetlaw, Broxtowe and Rushcliffe. However, trends in the rates of households in temporary accommodation over time show that the majority of Nottinghamshire districts experience a lower rate than that of the East Midlands with Mansfield district showing the greatest decline in rate over the ten-year period 2008/09 to 2017/18.

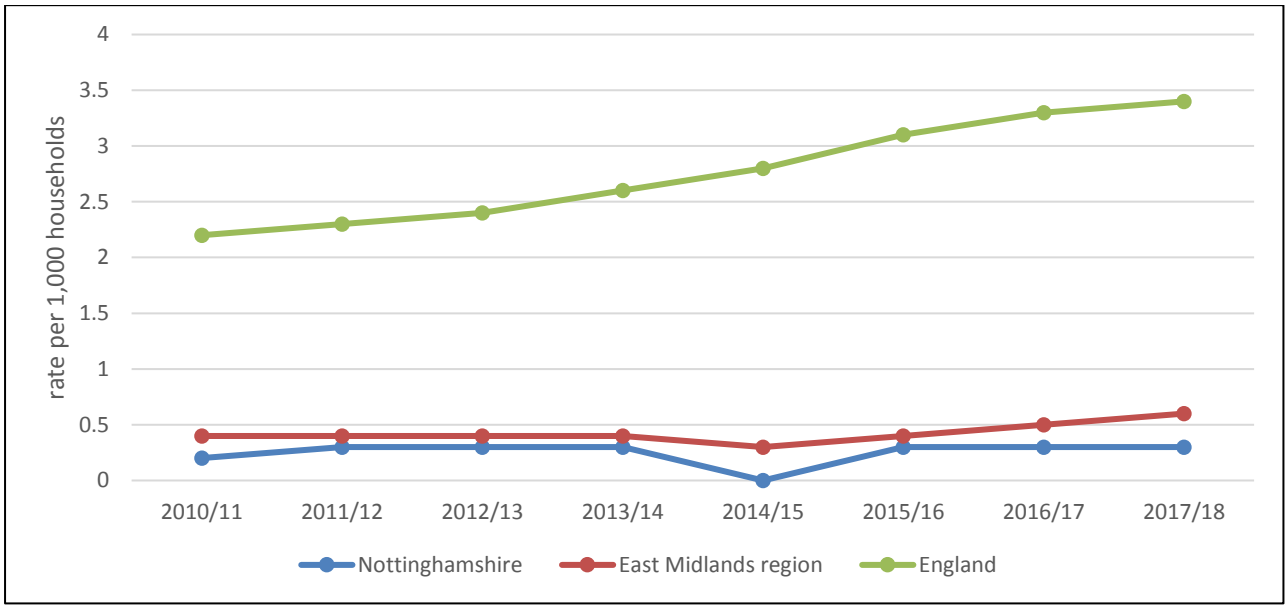
Figure 11: Rate per 1,000 household in temporary accommodation by each Nottinghamshire district compared to East Midlands from 2008/09 to 2017/18



Source: P1E data

The Nottinghamshire rate per 1,000 households in temporary accommodation has remained relatively unchanged at 0.2 per 1,000 households in 2010/11 to 0.3 per 1,000 households in 2017/18. This equates to 80 households in 2010/11 to 110 household in 2017/18. Nottinghamshire is consistently lower when compared to England and the East Midlands region.

Figure 12: Nottinghamshire rate per 1,000 household compared to England- Statutory Homelessness – households in temporary accommodation 2010/11 to 2017/18



Source: Ministry of Housing, Communities & Local Government

Total households assessed by Local Authority as owed a duty
Since the introduction of the Homelessness Reduction Act 2017, data is reported to MHCLG on initial assessments. However, this data is still relatively new and thereby considered as experimental statistics. This data provides an indication of the number of households owed a duty by the LA as a result of the initial assessment.

This is utilised in two ways in this section on our estimate of the size of the issue locally.

This data return can tell us, of the number of households assessed how many households are owed a duty - whether this be support to prevent them becoming homeless (prevention duty) or action to address their homeless situation (relief duty) or whether following assessment the household is not threatened with homelessness within 56 days (no duty owed).

Secondly of those owed a duty by their LA, information is documented on their physical health, mental health and drug and alcohol support needs. Thereby helping us build a picture of the potential health needs we can seek to address sooner thereby avoiding health conditions deteriorating alongside a potential homelessness situation arising.

In Nottinghamshire in 2018 on average 730 households were assessed over a three month period of whom 657 households were owed a duty by their local authority. Of these 657 households 121 (18%) identified a history of mental health needs, 74 (11%) experienced physical ill health and disability, 23 (3.5%) experienced drug and 14 (2%) alcohol dependency needs. It is acknowledged that whilst each health status is self-reported and not validated at the point of assessment this data alongside the health profile presented in section 2 provides us with some useful information about the health need of homeless people in Nottinghamshire.

Further to this, one specific cohort of vulnerable people we do know the housing status of is those who are in structured substance misuse treatment. Of the 2,265 people accessing structure substance misuse treatment in December 2018 in Nottinghamshire, 478 (21%) disclosed having no fixed abode or housing problems at one point in time (December 2018).

2.2) Health needs of the homeless in Nottinghamshire

Nottinghamshire Homelessness Health Check

There is very little health data collected on the Nottinghamshire homeless population, mainly due to housing status not being routinely recorded in healthcare. Therefore, to calculate the local crude rate of physical and mental health problems in the homeless population, the national health status estimates[60] of the homeless population were applied to the local Nottinghamshire population accepted as being homeless and in priority need. The prevalence of the following estimates relating to health and wellbeing are based on a Nottinghamshire figure of 628 homeless people (MCHLG 2017-18 numbers accepted as being homeless and in priority need). However, this cohort is not exactly the same as those who form the sample in the Homeless Link's Health Audit Data which was users of homeless services. Thereby this data may overestimate the health needs of all Nottinghamshire homeless people.

Smoking, Drugs and Alcohol Use

Table 3 below gives the crude estimates of the smoking status, drug and alcohol use across the Nottinghamshire homeless population.

- The estimated number of smokers is significantly higher than the general population, 78% compared to the general population, 14.9%.

- Approximately, 84% are consuming alcohol higher than the recommended guidelines with 35% drinking heavily, 10+ units on a typical drinking day.
- Cannabis use is the most common drug of choice, 62%. However, it is likely that a number are combining alcohol consumption with poly drug use.

Table 3: Crude Estimates - Number/% of the Nottinghamshire accepted as being homeless and in priority need population - smoking, drug and alcohol use status

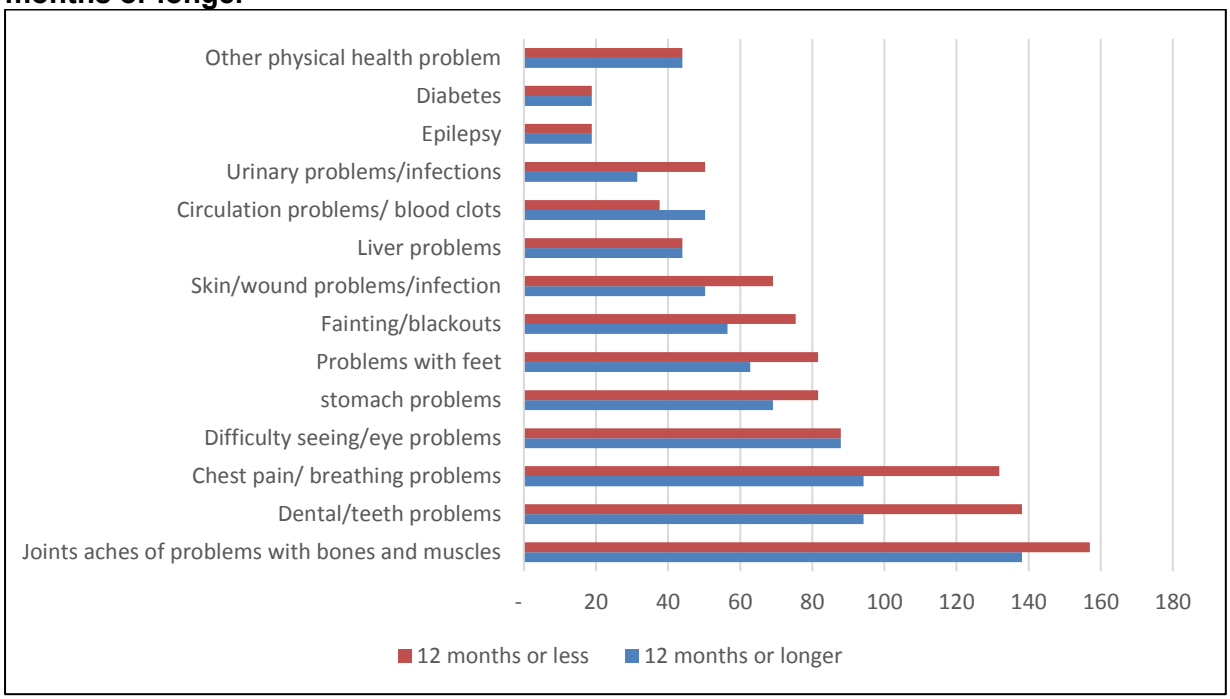
Unhealthy lifestyle behaviour	Use and Frequency	Number	%
Smoking Status			
Currently smoke	Yes	489	*78*
Would like to stop smoking?	Yes	251	*40*
Has been offered advice or help to stop smoking?	Yes, and took this up	94	*15*
	Yes, but did not take this up	333	*53*
Alcohol Use			
Drinking frequency	Every day	94	*15*
	4-6 times per week	31	*5*
	2-3 times per week	88	*14*
	2-4 times per month	94	*16*
	Monthly or less	151	*24*
	Never	157	*25*
Average units consumed on a typical drinking day	1-2 units	100	*16*
	3-4 units	132	*21*
	5-6 units	107	*17*
	7-9 units	75	*12*
	10+ units	220	*35*
Drug Use			
Used heroin in the last month	Yes	188	*30*
Used crack/cocaine in the last month	Yes	170	*27*
Used cannabis/week in the last month	Yes	389	*62*
Used amphetamines/speed in the last month	Yes	113	*18*
Used benzodiazepines in the last month	Yes	119	*19*
Used prescription drugs in the last month	Yes	188	*30*
Used methadone	Yes	195	*31*

Source: Homeless Link (2014) ***Drug use for some individuals includes poly drug + alcohol use**

Physical Health Problems

It is estimated that muscular skeletal problems, followed by dental and chest pain / respiratory problems are the greatest physical health problems amongst the Nottinghamshire homeless population, as shown in figure 13.

Figure 13: Crude Number Estimates of Nottinghamshire accepted as being homeless and in priority need population – reported physical health conditions - previous12 months or longer

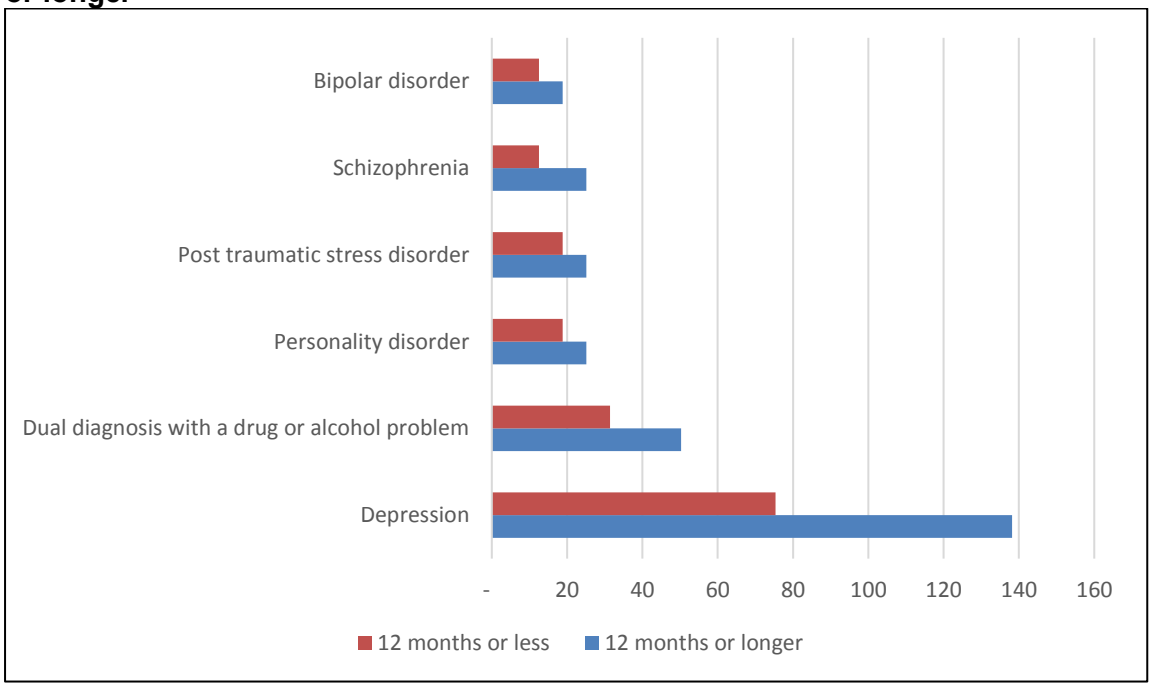


Source: Homeless Link Health Needs Audit

Mental Health Problems

For mental health problems, as shown in figure 14, long term depression rates the highest followed by mental health problems with co-existing substance misuse problems.

Figure 14: Crude Number Estimates of Nottinghamshire accepted as being homeless and in priority need population – reported mental health problems - previous12 months or longer

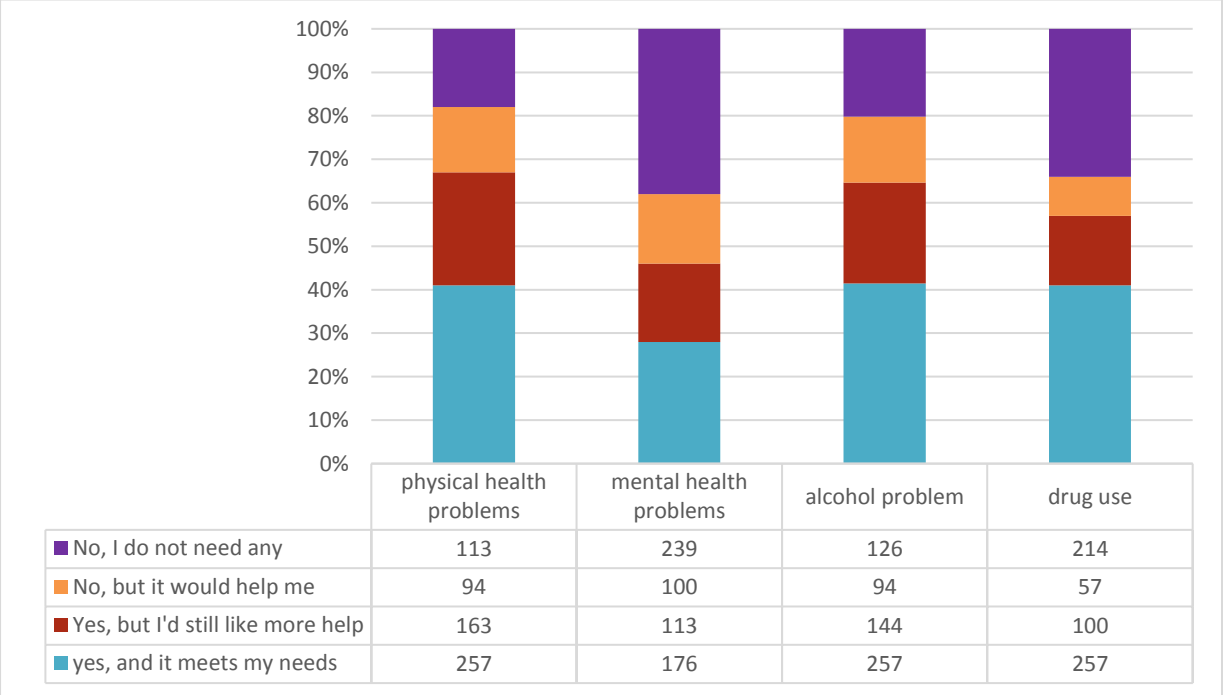


Source: Homeless Link Health Needs Audit

Access to Health Interventions and Treatment

Improving access to health services and access to ongoing treatment is wanted across physical and mental health as well as substance misuse services, as shown in figure 15.

Figure 15: Crude Number Estimates of Nottinghamshire accepted as being homeless and in priority need population – access to health interventions and treatment



	physical health problems	mental health problems	alcohol problem	drug use
No, I do not need any	113	239	126	214
No, but it would help me	94	100	94	57
Yes, but I'd still like more help	163	113	144	100
yes, and it meets my needs	257	176	257	257

Source: Homeless Link Health Audit

In terms of types of healthcare used in the past 6 months General Practice is the most frequently used followed by visits to A&E as shown in table 4.

Table 4: Crude estimates – Number/% of healthcare usage

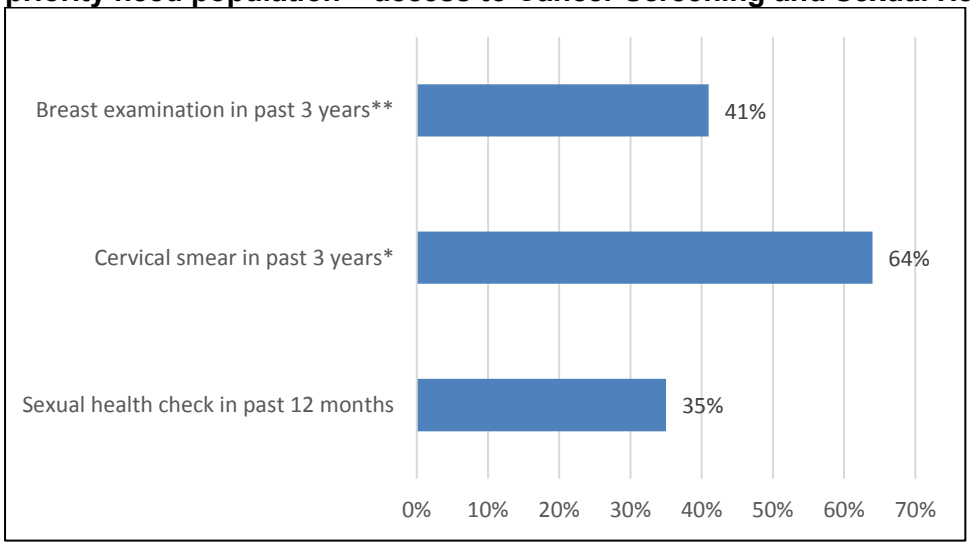
Type of healthcare usage	Over 5 times		3-5 times		1-2 times		Yes	
	Number	%	Number	%	Number	%	Number	%
Used a GP in the past 6 months	188	*30*	126	*20*	201	*32*		
Used a dentist in the past 6 months	13	*2*	25	*4*	182	*29*		
Used an ambulance in the past 6 months	13	*2*	19	*3*	132	*21*		
Visited A&E in the past 6 months	31	*5*	38	*6*	170	*27*		
Admitted into hospital in the past 6 months	13	*2*	19	*3*	132	*21*		
Hospital staff ensured suitable discharge							446	*71*

Source: Homeless Link Health Audit

Access to Sexual health, breast and cervical cancer screening

As shown in Figure 16, the estimated uptake of breast and cervical cancer screening in the homeless population of Nottinghamshire is lower when compared to the general population, 71.1% and 75.2%, respectively. The rate of uptake in the general population in accessing sexual health checks is not quantifiable due to the confidential nature of sexual health service provision. Therefore, the estimate of homeless people accessing sexual health services cannot be compared against the general population.

Figure 16: Crude Estimates – % of Nottinghamshire accepted as being homeless and in priority need population – access to Cancer Screening and Sexual Health checks



Source: Homeless Link Health Audit *** women over the aged 25 only **women over the age 45 only**

Friary Drop in General Practitioner Sessions

The Friary Drop in service holds two General Practitioner (GP) sessions per week. On average, approximately 5 clients attend the session. The gender ratio of clients attending the GP session is 2:1 male with the majority in the age range between 20 to 40 years. However, clients accessing the service have been as old as 60-70 years.

The presenting health problems range from sore throats, coughs through to pneumonia, unexplained lumps and concern about a cancer diagnosis. Occasionally, sepsis or a Deep Vein Thrombosis (DVT), Pulmonary Embolus has been detected. Mental health problems, may present in crisis and need emergency access to mental health crisis care.

The pathway to access the GP is self-referral and the clinic does not hold an appointment system to support ease of access. However, appointments can be arranged if a client is brought to the clinic by their key worker.

Approximately 50% of clients are registered with a GP but many are unable to access health care for reasons such as; moved away from the area or do not have phone credit to make or receive appointments or have difficulty in navigating the system. When clients are not registered with a GP, the Friary Drop in GP will encourage a client to register with their local GP.

Occasionally, referrals are made directly to acute and secondary care hospitals but is dependent on the level of urgency and risk.

3) Targets and performance

There are three national outcomes frameworks (listed below)

I. Public Health Outcomes Framework (PHOF)
II. NHS Outcomes Framework (NHSOF)
III. Adult Social Care Outcomes Framework (ASCOF)

Public Health England has produced a comprehensive guidance document entitled Homelessness: Applying all our Health[76]**.** This document outlines the links between homelessness and health and lists the relevant health outcome measurements as outlined below in Table 5.

There are 2 specific indicators in the Public Health Outcomes Framework (PHOF) which relate to statutory homelessness.

- Eligible homeless people not in priority need (1.15i)
- Households in temporary accommodation (1.15ii)

Table 5: National Outcomes Framework specific indicators relating to Health and Homelessness

Indicator	PHOF	NHSOF	ASCOF
Wider Determinants of Health			
Social readiness	√		
Pupil absence (1.03)	√		
Proportion of adults in contact with secondary mental health services who live in stable and appropriate accommodation	√		√
Domestic abuse (1.11)	√		
First time offenders and re-offending levels (1.13)	√		
Health Improvement			
Self-reported wellbeing	√		
Smoking prevalence in adults (2.14)	√		
Successful treatment of drug treatment – opiate users (2.15i)	√		
Successful treatment of drug treatment – non-opiate users (2.15ii)	√		
Successful treatment of alcohol treatment (2.15iii)	√		
Cancer screening coverage – breast cancer (2.20i)	√		
Cancer screening coverage – cervical cancer (2.20ii)	√		
Cumulative % of the eligible population aged 40 to 74 offered an NHS health check (2.22iii)	√		
Cumulative % of the eligible population aged 40 to 74 offered an NHS health check who received an HNS health check (2.22iv)	√		
Cumulative % of the eligible population aged 40 to 74 who received an NHS health check (2.22v)	√		
Health related quality of life for people with mental illness	√	√	√
Employment for people with mental illness		√	
Employment for those who are in contact with secondary mental health services		√	
Total health gain as assessed by patients accessing psychological therapies		√	
Recovery in quality of life for patients with mental illness		√	
Excess under 75 mortality rate in adults with serious mental illness	√	√	
Excess under 75 mortality rate in adults with common mental illness	√	√	
Patient experience of community mental health services		√	
Health protection			
Population vaccination coverage – Flu (at risk individuals) (3.03xv)	√		
People presenting with HIV at late stage of infection (3.04)	√		

Incidence of TB (3.05ii)	√		
Treatment completion for TB (3.05i)	√		
Healthcare and premature mortality			
Mortality rate from causes considered preventable (persons) (4.03)	√		
Mortality from communicable diseases (4.08)		√	
Emergency readmissions within 30 days discharge from hospital (4.11)		√	√
Excess winter deaths (4.15)	√	√	√

4) Current activity, service provision and assets

Many assets are in place in order to respond to homelessness within Nottinghamshire however the amount of provision of such services is not necessarily sufficient or equitable across the county.

In addition to statutory services such as local authority housing departments our local assets include provision of:

- Advice services such as debt, welfare, legal and housing advice
- Accommodation in terms of supply of places to live – local authority housing, registered social landlords, private rents
- Accommodation based support services e.g. support in hostels, support in tenancy, floating support
- Emergency accommodation for young people in a housing crisis and refuge accommodation for those fleeing domestic abuse
- Support with specific groups of people Care Leavers, Younger People, mothers with babies, mental health, disabilities, autism
- Clinical services both primary, secondary, mental healthcare and substance misuse services
  Outreach services to those who are currently experiencing rough sleeping
- Prevention, education and training providers, advice to prevent homelessness

Appendix 2 provides a breakdown of the Health and Homelessness prevention, early intervention and treatment and recovery activity service provision, commissioned services and assets within Nottinghamshire. The majority of activity and provision targets those people who are already homeless rather than focusing on preventing homelessness from arising in the first place.

Primary and secondary healthcare

General practice provides primary care services to registered patients, patients can be registered temporarily however transient and homeless individuals may find it difficult to register with some GP practices[61 62]. One approach to address this is via a GP locally enhanced service (LES). There are currently 4 practices (3 in Nottingham City) and 1 in Mid Notts that adopt this approach locally. The CCG is the commissioner of this enhanced provision aimed at meeting the needs of homeless patients.

In Mid Notts Sherwood Forest Hospital NHS Trust provide a Street Health outreach provision working in partnership with a faith based organisation in central Mansfield. Services are being brought together in a community setting where homeless and rough sleeping people regularly attend to access hot meals, support and other services. The GP providing the LES, a mental health worker from Nottinghamshire Healthcare NHS Trust and a substance misuse worker

from Change Grow Live (CGL) is also contributing to a multidisciplinary team approach in this setting.

Nottinghamshire Local Offer for Care Leavers

Nottinghamshire County Council and the seven district councils in Nottinghamshire are the legal 'corporate parents' for care leavers and must provide a certain range of services and support by law, up to the age of 25 years. In preventing homelessness in care leavers, setting up a home support is offered and includes;

- Help with finding somewhere to live and supporting to manage tenancy and bills.
- Help to stay with foster families until 21, if wanted or for those18, and wish to stay with their foster family until the end of the summer term to finish school or college courses
- For care leavers with children of their own, accommodation is provided
- Help to find housing in an emergency
- Do not pay Council Tax until 25 years of age
- Are classified as a high priority on district council housing waiting lists

Street Outreach Team

In 2016, a joint proposal to Government by Nottinghamshire District Councils and Nottingham City enabled Framework Housing to develop a Street Outreach Service. The Framework County Street Outreach Team works across Nottinghamshire and exists to support those that are rough sleeping in the community. Teams go out in the early hours responding to referrals and directly engaging with individuals living on the street.

The service has three main functions;

- To engage with and support rough sleepers
- To quantify the extent of street homelessness in any area
- To work in partnership with other agencies such as the Local Authority.

The support offered by the Street Outreach Team is dependent on the need of the individual and may involve (but is not limited) to the following;

- Find safe and secure accommodation
- Find appropriate treatment for underlying substance, alcohol and mental health issues
- Secure access to medical help
- Re-engage with estranged family members
- Support to return to home region or home country where they can link in with existing support networks
- Claim whatever benefits they may be entitled to

The teams actively look for new and existing rough sleepers in known 'hot-spots' around the County. Further details of the Street Outreach team delivery and activity can be found in Appendix 3.

Friary

The Friary homelessness drop-in centre provides a range of services for people who are homeless or vulnerably housed with the purpose to empower people to rebuild their lives by offering practical services, advice and emotional support.

Data from The Friary homeless day centre (Oct-Dec 2018) shows that there were 327 individuals accessed the service. Of which, 145, 44% were deemed to be statutorily

homeless. Appendix 4 gives a further overview of the Friary Drop in client demographic profile, current housing status, activity and delivery.

Framework Housing Association

Framework Housing Association is a charitable organisation delivering housing, health, employment, support and care across Nottinghamshire and offers services to people with a diverse range of needs from supporting people who are homeless, preventing others from losing their homes and help them sustain their own tenancies.

Framework Supported Accommodation Service is commissioned by Nottinghamshire County Council. The service provides intensive support in short-term hostel accommodation (up to 18 weeks) for single homeless people in immediate housing need, and less intensive support in Move-On accommodation (typically for 6 months and up to 12 months or more) for those whose history and/ or support needs makes it especially difficult for them to access mainstream social or private sector tenancies. The service aims to assist service users to achieve a range of outcomes including self-care, living skills, managing money, motivation, taking responsibility for themselves, managing their accommodation/ tenancy, reducing offending and meaningful use of time.

In the twelve months to March 2019 the Supported Accommodation Service (both hostel and move on comprising 238 units in all) was used by 413 separate individuals. The profile of this user group was similar to that of the rough sleeping population, a high percentage having significant and frequently complex support and care needs.

In the final quarter of 2018/19, a total of 39 new referrals were accepted into the short-term hostel element of the service (comprising 63 of the 238 units) and 31 people exited it in a planned way. Over the same period, 29 people accessed the move-on element with the same number (29) exiting it in a planned way. Among the barriers to leaving both the hostel and the move-on elements, and similar services provided by other specialist organisations, are the lack of availability of social housing and the expensive/ poor quality nature of private sector housing. This is exacerbated by the reluctance of landlords to grant tenancies to people with a history of rent arrears, offending or anti-social behaviour and the absence of provision for ongoing floating support.

Substance Misuse

Nottinghamshire County Council commission Change Grow Live (CGL) service to support people with substance misuse issues. Latest data from CGL shows that at December 2018, there were 2,265 service users in structured treatment and that 21% (478) disclosed to having No Fixed Abode (NFA) or having housing problems which further demonstrates the significant links between housing issues and substance misuse. Housing problems included those with acute housing problems; being in unsuitable housing or being in ‘housing risk’.

Table 6 show the number and % by district for CGL clients reported being either NFA or having housing problems. Mansfield followed by Bassetlaw had the highest number experiencing NFA or housing problems, 35% and 23%, respectively. With opiate use being the highest substance of use for this cohort, 84% (table 7).

Table 6: Number/% of CGL clients with No Fixed Abode (NFA) or a Housing Problem – December 2018

Locality	Reported NFA/Housing Problem at assessment	% of total clients reporting housing problems (rounded)
Mansfield	166	35%
Bassetlaw	111	23%
Ashfield	80	17%
Newark and Sherwood	49	10%
Broxtowe	37	8%
Gedling	25	5%
Rushcliffe	10	2%
Grand Total	**478**	**100%**

Source: CGL performance data

Table 7: Number/% of CGL clients with No Fixed Abode (NFA) or a Housing Problem by type of substance misuse– December 2018

Drug Category	Reported NFA/Housing Problem at assessment	% of total clients (rounded)
Opiate	400	84%
Alcohol	43	9%
Non-Opiate	16	3%
Non-Opiate and Alcohol	19	4%
Grand Total	**478**	**100%**

Source: CGL performance data

5) Evidence of what works

Homelessness Prevention

Tackling homelessness at the crisis stage is estimated to cost between £20,128 and £34,500[2,3] per person per year. Whilst investing in homeless prevention can substantially reduce costs in direct service provision and provide further benefits of reduction in expenditure across the wider system, in areas such as health and policing[3].

The prevention of homelessness was a stated priority under the Coalition Government and in 2012 the Ministerial Working Group on Homelessness published Making Every Contact Count: A joint approach to preventing homelessness[63]. This report brought together the Government's commitments to:

- Tackle troubled childhoods and adolescence, including promoting innovative approaches to youth homelessness;
- Improve health, including improving outcomes for homeless people with dual substance misuse, and mental health needs; and helping improve hospital discharge practices;
- Reduce involvement in crime;
- Improve skills; employment; and financial advice;
- Pioneer social funding for homelessness – through a Social Impact Bond for rough sleepers and support to local commissioners to turn social investment propositions into a reality.

Preventative action can be split into three levels – in relation to health and healthcare and the prevention of disease this is routinely referred to as primary, secondary and tertiary where:

Primary prevention is to do with preventing or minimising the risk of a problem arising in the first place
Secondary prevention targets action towards individuals or groups who are at high risk of the problem, and
Tertiary prevention is intervening once there is a problem to stop it progressing further or getting worse.

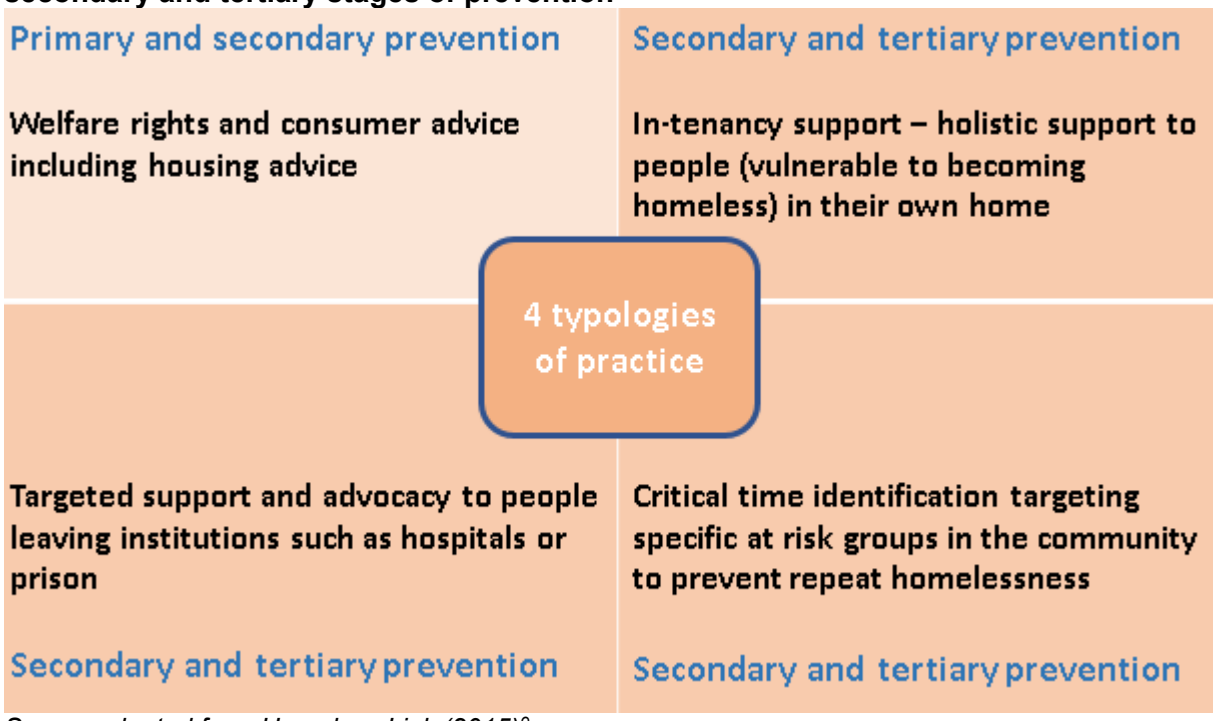
It is acknowledged that the evidence of the effectiveness and cost effectiveness of homeless prevention that takes place in relation to health and wellbeing is currently limited. Evidence in this field relates to the more acute end of homelessness namely secondary and tertiary prevention. However, there is learning based on evaluation of pilot and small-scale projects that can be used to inform preventative action in relation to homelessness[9].

Homeless Link's 2015 review of evidence into preventing homelessness to improve health and wellbeing[9] highlights prevention activity identified in the homeless sector where:

- Primary homelessness prevention involves action to avoid households becoming homeless such as action where there is a perceived threat e.g. eviction date and structural intervention such as increasing supply of affordable homes
- Secondary homelessness prevention includes action to prevent future homelessness from occurring for specific targeted groups such as young people or care leavers and
- Tertiary homelessness prevention includes interventions such as rapid rehousing that minimise repeat homelessness for those that have already experience homelessness.

In relation to current actions taken in response to homelessness and how these can fit within a preventative approach four typologies emerge from the 2015 review of evidence.

Figure 17: How current approaches to addressing homelessness fit within primary, secondary and tertiary stages of prevention



Source adapted from Homeless Link (2015)[9]

Critical time identification targets those in the community that have already experienced homelessness and whose current circumstance mean that even when accommodation is resolved are more likely to become homeless again.

Research[64, 65] identifies four phases of engagement to support individuals and families to develop sustainable strategies to live securely:

1. **Identify high risk groups** (e.g. prison discharge, mental illness, army veterans)
2. **Transition phase**: intensive support and advocacy from case worker to establish practical approaches (e.g. furniture, bill payments, moving in)
3. **Try-out phase**: case manager adopts a more hands-off approach but can step back in to support the individual as required. Ensures that mainstream services (e.g. doctors appointments, counselling sessions) are accessed
4. **Transfer phase**: a planned end to the support, involving individual reflection and recognition of the ongoing support available through universal services.

Emerging evidence from evaluations [63, 66, 67, 68] into homeless prevention identify some tangible steps which can be taken to reduce the risk of homelessness include:

- Provision of expert 'enhanced' housing advice, aimed at helping households to gain access to, or to retain private or social rented tenancies and providing information around entitlements and service access. This works best when delivered as a link worker/ case manager package to encourage advocacy and co-ordination. Advice work often includes liaison with private landlords and may also have an 'outreach' dimension targeted at vulnerable groups.

- Rent deposit schemes, or other schemes to increase access to private rented tenancies.
- Family mediation. This tends to focus on preventing youth homelessness, with attempts made to reconcile parents and young people in order to prevent eviction from the family home. It can also involve facilitating young people's access to family support to assist them with independent living.
- Domestic abuse support. This includes a range of interventions such as 'sanctuary schemes' (security measures to enable victims to remain in their own homes after the exclusion of an abusive partner), supporting planned moves, crisis intervention services and resettlement support.
- Tenancy sustainment support, to help vulnerable tenants to retain their tenancies. These services often provide 'floating' support to people living in mainstream accommodation but are very diverse with respect to the intensity and duration of support they offer and the client groups targeted. Typically, help is provided with claiming benefits, budgeting, furnishing accommodation, accessing health and other services, in addition to seeking 'purposeful activity'.
- Intensive, time critical case management, for example prison-based homelessness interventions, and at other critical transition points e.g. leaving care, the armed forces, or hospital
- Sustained, person-centred, multi component support, for example long-term mentoring of individuals with chaotic lives (e.g. the Nightsafe[69] programme in Blackburn which involved one to one mentoring and coaching for young people to stay positively engaged and to overcome barriers to living safely and securely)
- Housing vouchers and subsidies (for example, medium-term subsidies for veterans and families in crisis has been shown to help homeless people to develop competencies to sustain their tenancy;
- Co-production of joint action plans. Plans should involve an element of choice and also be realistic.
- Fast, flexible access to financial support. Not just limited to use for rent, bills or deposits, but available to provide creative solutions

The prevention of homelessness can be undertaken by a wide range of services and sectors beyond housing, and interventions often target the factors which can put people's housing at risk – e.g. debt problems, poor mental health.

Early intervention in the context of homelessness

A number of studies highlight the risk of becoming homeless in the future is increased significantly if there are particular experiences in early childhood. It follows that, one key way to prevent or reduce such outcomes would be to identify and intervene at the earliest opportunity. Preventing childhood adversity and/or finding ways of mitigating against the negative outcomes associated with such experiences is crucial[70].

Similarly, Shelton et al[71] believe that young people at the greatest risk of becoming homeless should be identified early through schools, paediatric services, social services and other similar types of contact points with children and families. Also, they recommend that prevention efforts should also be directed towards other factors that appear to predispose young people to homelessness such as a diagnosis of depression and receiving psychiatric care in the past 5 years (mid to late teens).

Fitzpatrick et al[72] advise that preventative interventions should focus on earlier signs of distress wherever possible. For example, with schools, drug and alcohol services, and the criminal justice service who are likely to come into contact with those vulnerable to homelessness well before housing and homelessness agencies do.

For early intervention to prevent homelessness an inclusive integrated strategic and commissioning of services commitment and approaches is required to improve the health and wellbeing of local vulnerable communities to reduce health inequalities for all ages. Local authorities, clinical commissioning groups (CCGs), Health and Wellbeing Boards, Healthwatch, representatives of local voluntary and community sector organisations and communities themselves need to consider the health and social care and housing needs in disadvantaged areas or vulnerable groups who experience health inequalities. This applies to those who find it difficult to access services and those with complex and multiple needs, such as; gypsies, Travellers and Roma; the homeless and rough sleepers; sex workers; and vulnerable migrants[73].

Integrated working and system wide approaches

Johnsen et al[74] found that enforcement to combat street drinking and begging could result in positive outcomes for those who are homeless if there are also strong integrated working practices in place. This integration leads to less opportunities for vulnerable people to fall through the gaps between services and professionals and enables strong and coherent pathways for people.

One of the key examples of where integrated working and a system wide approach is vital is at the points in time when a person is leaving some form of institutionalised care be that a hospital, prison or mental health facility. The point of discharge from an institution is a particularly challenging time for any individual, but again having strong integrated pathways of care and support would reduce the impact of such experiences in relation to homelessness.

The Mental Health Needs of Nottingham's homeless population: an exploratory research study[75] undertaken by Sheffield Hallam University in 2018 highlights approaches that work effectively with people with complex needs including:

- ***Improving access*** through; interagency working, innovative referrals, e.g. without the need for GP referral, anonymous referrals, 'out of hours' or extended provision, direct access, co-location, empathetic and non-judgemental approach, outreach and in-reach
- ***Interagency working*** (assessment, referral, ongoing support), including: common assessments, co-location, information sharing, partnership networks and agreements
- ***Key working principles***, including: service navigators, or case co-coordinator, long-term support, follow-on or aftercare support, or onward referral, intensive support.

Further to this the report highlights good practice that includes – common single assessment, direct access services, peer support, dedicated mental health worker input, intensive support, key working, working in partnership, co-creation of services and strength based models.

Public Health England Homelessness: applying all our health

The PHE Homelessness: applying all our health guidance[76] outlines that for most people who are at risk of, or experiencing, homelessness and rough sleeping there isn't a single intervention that can tackle this on its own, at population, or at an individual level.

The guidance goes on to describe the action required to support better-integrated health and social care, and to help people to access and navigate the range of physical and mental health and substance misuse services they require in order to sustain stable accommodation.

Health and care professionals play an important role, working alongside other professionals to:

- Identify the risk of homelessness among people who have poor health, and prevent this

- Minimise the impact on health from homelessness among people who are already experiencing it
- Enable improved health outcomes for people experiencing homelessness so that their poor health is not a barrier to moving on to a home of their own.

The guidance recommends that there needs to be clear local action, partnership working (across the local authority, clinical commissioning group and other local organisations) and understanding and alignment of commissioning decisions to prevent and respond to homelessness across the life course. This can include:

- Reducing the risk of homelessness to children and young people to strengthen their life chances
- Enabling working-age adults to enjoy social, economic and cultural participation in society
- Breaking the cycle of homelessness or unstable housing by addressing mental health problems, or drug and alcohol use, or experience of the criminal justice system

This requires strong local leadership and prioritisation to identify unmet need, funding and actions to address gaps in provision

NICE guidelines

While there are no specific guidelines on homelessness, other guidelines do recognise the relationship between homelessness and specific health conditions, such as TB, alcohol and drug misuse and mental health problems.

Further evidence of what works is detailed in Appendix 6 and mapped against Health and Homeless promotion and prevention, Homeless early identification and Homeless treatment and recovery.

Homeless Treatment and Recovery Interventions

There are a range of interventions discussed in the literature linked to homelessness and rough sleeping.

Key interventions include:

- ***No Second Night Out*** [77, 78] – offers a 24 hour helpline and website so that members of the public can report and refer rough sleepers. An outreach worker dispatched to contact the person as quickly as possible, rapid assessment and helped to access a place of safety
- ***Housing First*** [79],[80],[81] – offers stable, affordable housing alongside ongoing, intensive person-centred support to enable people to keep their housing and avoid returning to homelessness. It operates in a harm reduction framework and is designed to provide open-ended support to long-term and recurrently homeless people who have high support needs, including severe mental illness, poor physical health, long-term limiting illness, physical disabilities and learning difficulties compared to the general population. Clients do not have to be abstinent from drugs or alcohol to access services and getting housing or remaining in housing is not conditional on accepting support or treatment.
- ***Psychologically Informed Environments (PIE)*** [82] enables clients to make changes in their lives. Usually this approach would enable changes in behaviour such as reduce drug or alcohol use and/or change in emotions such as being less fearful. However, the report notes that people who are homeless or insecurely housed are among those most in need of psychologically informed help, but are also among those least able to access mainstream psychological therapy services. An explicitly

psychological framework can legitimise and inform the different approaches staff can adopt providing additional insight into how people may behave. Training all staff within an agreed framework or combination of frameworks will help them work more effectively with clients with complex trauma.

- ***Personalised Services*** [83] - Homeless Link carried out a review of services, which aim to deliver personalised responses to rough sleeping and entrenched homelessness. They examined how 5 projects working with long-term rough sleepers and people with complex needs who had often been sleeping rough were using personalised approaches to support people sleeping on the streets. This approach whilst small in scale reported positive outcomes including increased self-confidence, taking responsibility, feeling better about themselves, reduce substance use and sustaining tenancy arrangements, increased hope. Personalised approaches were deemed to be most effective where workers were given time and flexibility to support clients as they require, with no imposed time limits for support and hold small case loads of clients.

6) What is on the horizon?

Tackling Homelessness Together national consultation

In February 2019, MHCLG published a consultation[84] on local structures relating to homelessness. The consultation sought views on how the Government could improve partnership arrangements and local accountability for the delivery of homelessness services in relation to:

- Existing accountability arrangements
- Homelessness Reduction Boards (HRB)
- Other ways of achieving effective partnership working.

The consultation asked for comments around the role, membership and geographical focus of the HRBs and suggested that the role of the HRB may include:

- Setting the strategic vision for reducing homelessness in the locality and monitoring progress in achieving it
- Using data, evidence, and user and lived experience to identify the homelessness challenges in the area, including those that may apply to particular groups of people, and priority actions
- Evaluating the effectiveness of service provision and interventions
- Mapping homelessness services and the delivery chain in the locality, redesigning them where appropriate to improve effectiveness and outcomes
- Identifying and co-ordinating across all partners the effective use of funding for homelessness services and interventions
- Promoting and facilitating the joint-commissioning of homelessness services and interventions.

Nottinghamshire submitted a joint consultation response and at time of publication of this JSNA is awaiting the government's response to the full consultation.

Nottinghamshire Homelessness Executive Steering Group - in line with the above consultation partners have taken steps to establish a countywide homeless strategic group. The group comprises of Public Health, Adult Social Care; CCGs; Children and Young Peoples Services and City and District Councils. However, it is proposed that the group should have a wider remit and, subject to the outcomes of the national consultation, could form the basis of the Homelessness Reduction Board.

Rough Sleeping Initiative

Funding that ceased for Homeless Street Outreach in April 2019 coincided with securing additional monies from MHCLG under the Rough Sleeping Initiative. This 2 year funding alongside some local investment from Public Health and district councils provides additional capacity to address rough sleeping and in particular to provide substance misuse and mental health support along with access to emergency accommodation. Further consideration will need to be given to what happens beyond the short term two year funding allocation from government.

Rapid Rehousing Pathway

The Rapid Rehousing Pathway was launched as part of the Rough Sleeping Strategy in August 2018. The pathway brings together 4 policy elements (Somewhere Safe to Stay, Supported Lettings, Navigators and Local Lettings Agencies) that will help rough sleepers, and those at risk of rough sleeping, access the support and settled housing they need to leave the streets for good. Nottinghamshire was successful in securing funding for 2019/20 and has begun this work. Further consideration will need to be given to what happens beyond the short term two year funding allocation.

A brief overview of planned implementation includes:

Call before you serve	An independent service provided by Decent and Safe Homes (DASH) which aims to engage with and support landlords if they are considering action to repossess a property to try to find solutions to sustain tenancies, or if it is not possible to work with that landlord to see if they would let their property to someone referred by the local council.
Social lettings	A private lettings agent has been commissioned to work with other private landlords to encourage them to let their properties to council referred people, by offering a range of support services and incentives, such as • Tenancy Liaison, and tenant identification • Access to the call before you service scheme – available to all landlords • Tenancy management This service will provide general needs housing for the local authorities.
Homeless Navigators	The navigators will have a small case load and a budget of £500 per person to help with rehousing costs, and their purpose is to engage with the most challenging cases, often requiring a multi discipline / service approach. To assist with our objective of delivering a more preventative as opposed to reactionary service, the 6 navigator posts will be located at the main sources of rough sleeping within the city and county Prison Navigators - two workers covering Nottingham and Ranby prisons one for the city one for the county. Hospital Navigators - two workers covering the hospitals one for the city one for the county. Mental health Navigators - two workers focussed on mental health, one based at Kingsmill hospital the other working with the moving forward team.
Supported lettings	The YMCA and The Friary have so far identified 8 units with a further 4 to follow These properties will assist with the rehousing of those applicants with additional needs

	Derventio Housing are undertaking similar work in mid Nottinghamshire
Landlord liaison officers	These posts will work with landlords to access additional affordable homes and provide support to tenants who may be experiencing difficulties with their landlord. 4 posts across the county as follows: - 1 Bassetlaw - 1 Mansfield - 1 Broxtowe, Gedling, Rushcliffe - 1 Ashfield and Newark

Nottinghamshire Supported Housing Strategy

The Nottinghamshire county-wide Supported Housing Strategy has been formulated to establish a strategic framework for meeting the needs of the most vulnerable people in Nottinghamshire through the appropriate and efficient use of housing, well-being and linked social care resources. Its purpose is to promote collaboration amongst partners, achieve a better outcomes for individuals and a rationalise and streamline the approach to service provision. It provides a cohesive response to the national and local policy agendas.

The strategy recognises that housing is a key contributor to health and wellbeing and that an integrated approach should be at the heart of policy development and operational implementation. Partnership working supports the strategy in promoting an effective interface between housing and social care services.

The current document is a hybrid which forms the basis for the further development of a finalised strategy on the one hand and on the other provides a strategic and practical framework for how the partners should work together going forward.

The partners to the strategy are the seven district councils within Nottinghamshire each of who have a homelessness and rough sleeping strategy or a homeless prevention strategy: Ashfield District Council, Bassetlaw District Council, Broxtowe Borough Council, Gedling Borough Council, Newark and Sherwood District Council, Mansfield District Council, Rushcliffe Borough Council as well as Nottinghamshire County Council.

Universal Credit in Nottinghamshire

Crisis reports widespread anxieties about the likely homelessness impacts of future welfare reforms already programmed to take effect over the next two years. They state nearly two thirds of local authorities anticipate a “significant” increase in homelessness as a result of the full roll-out of Universal Credit, with a further 25 per cent expected some level of increase[32].

At the end of 2018, the whole of Nottinghamshire became a full digital area meaning that most new claims from working age people for any type of benefit will be for Universal Credit. The government plans to start transferring people who are still on existing benefits or tax credits onto Universal Credit from July 2019 and expect to complete this process by March 2023.

Domestic Abuse Consultation

In January 2019, HM Government published the Transforming the Response to Domestic Abuse Consultation Response and Draft Bill[85] and identifies nine measures that require primary legislation to be implemented. The measure relating to Homelessness Prevention is where a local authority, for reasons connected with domestic abuse, grants a new secure

tenancy to a social tenant who had or has a secure lifetime or assured tenancy (other than an assured shorthold tenancy), this must be a secure lifetime tenancy. The Domestic Abuse Bill will establish a commissioner, expected to play a key role in ensuring councils deliver support for victims and funding is expected to support this. Following the prorogation of parliament in September 2019 this bill has been cancelled but the government has indicated that a new domestic abuse bill will be developed[86].

Homelessness projections

It is difficult to make homeless projections in part due to the range of social and economic factors that influence rates of homelessness and in part because the likely impact of the Homelessness Reduction Act is not yet fully understood. Homelessness data from Wales suggests that following legislative changes in 2014 a 43% increase in approaches from households who were homeless or threatened with homelessness. The HCLIC data we use in this chapter is currently deemed experimental however this will become more established providing a clearer picture moving forward.

7) Local Views

Throughout the development of the JSNA, views have been sought from stakeholders, professionals and service users on homelessness need with regard to health, social and economic need and homeless prevention and recovery services in the County. This included;

- Establishment of a JSNA steering group which has included input from a wide range of partners including District/ Borough Councils; CCGs; Adult Social Care; County Children and Young Peoples Services, Public Health England and Public Health
- An on-line stakeholder survey
- Local exploratory research into mental health needs of Nottingham's homeless population
- Homelessness service user interviews
- Linking in with a commissioned pieces of work undertaken by Homelessness Link regarding the housing and support needs of under 35 year olds in the County (with a focus on the Ashfield, Broxtowe, Gedling and Rushcliffe areas) and the development of the mid-Nottinghamshire Homelessness Strategy (Ashfield, Mansfield, Newark and Sherwood).

Exploratory Research into the Mental Health Needs of the Nottingham population

The Mental Health Needs of Nottingham's homeless population: an exploratory research study[60] highlights the many difficulties and challenges encountered by homeless people and professionals in meeting the mental health and associated needs of homeless people with mental ill health summarised in the report as;

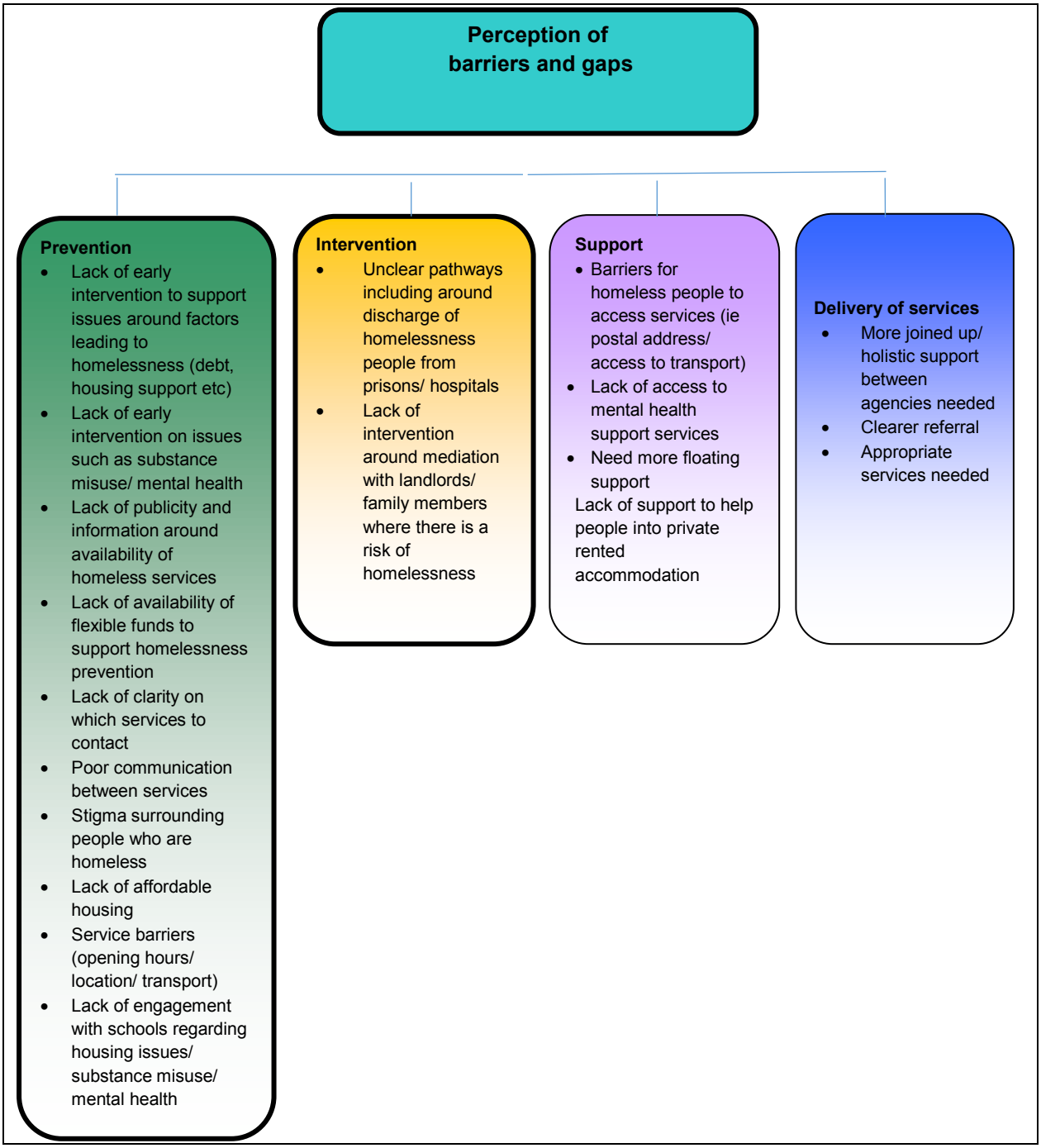
- **Accessibility**: many of the key barriers identified in this study related to accessing services, rather than problematic experiences with service provision or professionals.
- **Continuity of care**: including intensity and length of support.
- **Limited services working with people with complex needs**: this is a 'complex needs' population group, and service developments designed to better meet their needs will have to be informed by this fact.

Stakeholder Survey

An online survey undertaken in January/February 2019. The survey was emailed to key stakeholder partners including Framework; The Friary; Notts YMCA; Emmaus Trust; Broxtowe Youth Homelessness; Women's Aid; NCHA; Equation; Brighter Futures; DASH; Lighthouse Homes; District Councils; CCGs; County Adult Social Care; County Children and Young Peoples Services; Substance Misuse Services; Nottinghamshire Police. In total, 18 individual responses were received.

A summary of the findings from the stakeholder survey is detailed below in Figure 18. Full results from the stakeholder survey are detailed in Appendix 7.

Figure 18: Stakeholder Survey Health and homelessness perceptions of barriers and gaps in homelessness prevention, early identification, support and delivery of services



Private Landlords Forum

In October 2018, two private landlords' forums were undertaken to gain their views on housing people on benefits, in particular younger people (under 35s). A total of 80 private landlords from South Nottinghamshire and Nottinghamshire Private Landlords Forums took part.

Table 8 below summarises the forum responses.

Table 8: Private Landlords forum common themes on housing people under 35 years

Discussion	Common Themes
Issues with renting to people under 35	Main barriers were around property condition, such as; **Behaviour:** - Lack of respect for the property and potential damaging to the dwelling; - Behaviour including anti-social behaviour and causing a disturbance **Tenancy:** - High rate of tenancy abandonment - High rate of eviction - Tenancy turnaround (18-25) - Greater risk of tenancies failing due to rent arrears (18-25) - Property left in poor condition - Rent paid in advance **Knowledge:** - Maturity – less rental history and references to assess - Lack of knowledge and support on how to maintain a property - More likely to change location meaning higher turnover; **Financial:** - Being more likely to end up in arrears and not pay rent; - Lack of guarantor - Selective licencing increases costs for the landlord **Property:** - Affordability
Easier to rent to young people under 35 (and in particular to those on low income/ benefits)	- Some landlords suggested that nothing would persuade them to rent to younger people - Some stated that incentives such as rent deposits, rent guarantees or rent in advance may provide an appropriate incentive **Support:** - Access to key contacts and a 'dedicated support person' within councils - Helpful to deal with issues such as rent arrears, disturbance complaints, vacancies between tenancies and anti-social behaviour - Helpful to explore faster eviction processes for tenants that were causing very significant issues - Incentives should include rental guarantees; compensation if tenants cause significant physical damage to properties - A mediation service - Additional support where complex needs are evident - Education, training and employment - More work opportunities and removal of 0% contracts. - Employment support services/training - Pre-Tenancy training/Tenancy support - More engagement from this group with RSL/Community Group

Friary Drop In service user engagement

To gain a service user perspective on current homeless services and gaps, in-depth service user one to one interviews were conducted at the Friary Drop In. A total of three service users agreed to a one to one interview. All three of the service users were sleeping rough at the time of the interview.

Prior to becoming homeless, all participants experienced significant ***homelessness risk factors*** such as;

- Feeling unsafe in current tenancy and/or hostel accommodation due to verbal and physical abuse from neighbours
- Loss of employment due to mental health problems and alcohol use
- Loss of tenancy due to the 28 days' notice period
- No accommodation on release from prison

A number of ***health and support needs*** were identified and includes;

- Complex mental health problems
- Substance misuse
- Long term physical conditions

All of the participants expressed the difficulty in ***accessing health services*** when homeless. For reasons such as;

- Travel to health appointments when physical disabled and not eligible for a bus pass due to being homeless
- Walking long distances to health care appointments worsening the physical long term condition
- Not having a mailing address or mobile phone do not receive notification of health care appointments so miss health care appointments

Under 35 study

In 2018, Ashfield District Council, Broxtowe Borough Council, Gedling Borough Council and Rushcliffe Borough Council commissioned Homeless Link to carry out a study of housing options and choices for low-income single person households for people under 35. This came about in response to Government proposals to extend Housing Benefit Local Housing Allowance limits to social housing for people in this age group. The study is available at: www.ashfield.gov.uk/media/5729/housing-options-for-under-35s-final.pdf.

The study recognises the need to ensure an effective and joined up approach to preventing and relieving homelessness.

Key recommendations broadly fell into 2 themes of increasing supply and improving partnership working to maximise the contribution each agency/sector can make.

Further detail of the under 35 study can be found in appendix 3.

What does this tell us?

8) Unmet needs and service gaps

Housing and health need in Nottinghamshire must be set in the context that levels of statutory homelessness and rough sleeping remain low in the County and well below the England average. However rough sleeping numbers have shown a steady increase since 2010, with variation across districts and boroughs, and higher rates occurring in Mansfield and Bassetlaw. This gives an indication of a rising level of unmet health, social, welfare or housing need.

Housing supply and welfare

This JSNA has highlighted a number of factors that are known to affect availability of affordable and appropriate housing, in particular for the most vulnerable populations at risk of homelessness due to complex needs and debt arrears. Specific issues highlighted within this JSNA include

- Lack of affordable housing
- Housing benefit set at rates lower than landlord can obtain in rent on the open market
- Private landlords unwilling to consider housing people in receipt of benefits
- Private rental barriers to housing people aged under 35 years
- Need for support in tenancy to prevent eviction

- Housing options to support people with experience of homelessness and existing rent arrears
- Recent trend in increased use of bed and breakfast accommodation in some areas within Nottinghamshire

Whilst approaches to address housing supply in these cases are critically important to securing positive outcomes and reducing homelessness, these are rightly covered within the Homelessness Strategies produced by local Housing Authorities. Therefore, the recommendations of this JSNA will focus on the non-housing risk factors leading to homelessness and how these wider needs can be met.

It is clearly acknowledged that neither housing approaches nor wider health and social care support can be truly effective in isolation to prevent homelessness. These needs are interconnected and therefore implementing effective solutions requires dedicated and strongly aligned partnership working.

Primary prevention approaches

The role of upstream primary prevention initiatives is not yet fully understood or embedded within strategic approaches, either nationally or locally. This is likely driven by, amongst other factors:

- The need to focus limited local resources on addressing the most acute and immediate needs of those at risk of homelessness.
- The diffuse and system wide nature of risk factors leading to homelessness.

It is recognised that a range of local provision which commissioners currently invest in has the potential to significantly contribute to the prevention of poor outcomes through homelessness.

These include, but are not limited to:

- Debt, tenancy sustainment and welfare advice
- Veteran support strategies
- Housing adaptations secured through disabled facilities grant
- Substance misuse services
- Domestic abuse and sexual violence support services
- Family mediation
- Coping and resilience approaches in school settings
- Improving Access to Psychological Therapies (IAPT), talking therapies, social prescribing and befriending initiatives
- Employment support
- Ex-offender support strategies

It is difficult and possibly counter productive to identify unmet need in any single preventative approach, in particular as evidence points to the fact that those at risk of homelessness are far from a homogenous cohort and benefit from personalised approaches taking into account a range of support needs.

The opportunity across existing primary prevention approaches is for commissioners and providers to recognise that housing plays a critical role in health and wellbeing outcomes, and the services they provide have additional benefits of reducing future risk of homelessness. Strong joint working across services alongside improved awareness and skills in considering the housing needs of clients has the potential to maximise health outcomes for clients with complex needs within existing resource. The “duty to refer” introduced in the Homelessness Reduction Act provides an opportunity to engage a wider frontline workforce on the impact of housing on health and identify needs earlier.

Early Intervention and support

Consultation with local stakeholders showed a perception that support where available was not well known about, nor readily accessible. There was also a perception that support was not offered early enough and did not cover the broad range of the needs experienced by service users. Whilst the introduction of the Homelessness Reduction Act may address the need for earlier identification and support to some extent, consideration needs to be given to how support offers can be made more visible and accessible. In particular, for individuals who experience complex needs or chaotic lifestyles consideration needs to be given to targeted or tailored outreach approaches which reduce the barriers to engaging with services for support, in order to reduce the risk of exclusion and worsening health inequalities.

Services and commissioners may also need to consider how the profile of available support can be raised in frontline settings, to facilitate a "no wrong front door" approach to support at the point of care.

Governance and leadership

The wide range of services which have a role in supporting better health outcomes for those at risk of homelessness means that strong governance and leadership is needed at strategic level, to drive, support and hold to account effective delivery across a partnership. Stakeholders have described current partnership arrangements as operational rather than strategic, which may limit effectiveness to drive system change such as strategic commissioning of care pathway approaches. The Rough Sleeping Strategy suggests the introduction of Homelessness Reduction Boards which would take on the role of leading system change.

Healthcare

Users of homeless services locally have reported particular barriers to accessing healthcare appointments and mental health services. This can be considered in the context that national evidence shows individuals who are rough sleeping or in temporary accommodation are high users of healthcare. The combination of difficulties accessing care, with high levels of health need (mental and physical) leads to high volume service use for potentially preventable conditions. In order to better meet the healthcare needs of this population, flexible, innovative and targeted approaches are needed which specifically address the barriers presented by having no fixed abode, no access to transport, multiple health needs and in some cases chaotic lifestyles. Some examples of such innovative practice have been piloted in primary and secondary care settings in Nottinghamshire but are not as yet commissioned in line with population need in an integrated approach. Given the relatively small numbers of individuals who present with high levels of complex need or in crisis (as compared to the population as a whole), a targeted approach, delivered in settings most accessible to homeless individuals, with high levels of support and case management, is most likely to be effective in meeting need. Effectiveness is likely to be enhanced by delivery alongside providers with existing trusted relationships in homeless communities. This JSNA highlights that substance misuse, musculoskeletal, dental and respiratory problems are likely to be the most prevalent physical health needs, along with a broad range of presenting common and severe mental health conditions.

In addition, homeless populations face inequalities in access to screening programmes for both communicable and non-communicable conditions. Inclusion health standards highlight that providing equitable care in this population requires opportunistic approaches to offer screening and treatment.

Integrated commissioning and care pathways

Both service users and commissioners have reflected that commissioned support appears fragmented, potentially duplicative, and in some cases with lack of clarity as to thresholds and eligibility criteria. Where service users present with multiple or complex needs this can result in multiple assessments, referrals and delays in care, which in a worst-case scenario leads to disengagement by the service user and difficulty in supporting recovery within temporary accommodation settings. One strategy to support service users in navigating care is the use of a case worker, however it is unclear whether case worker capacity is sufficient to meet existing needs, and fragmented care pathways will also impact on the effectiveness of case workers themselves.

The service gaps particularly noted include management of support for those with mental health and/or social care needs, although interactions between all services are perceived as challenging.

Therefore, there is a critical need for commissioners (together with providers) to work jointly in creating effective care pathways which will deliver better value for individual services through more efficient processes, and better outcomes for service users through joined up person centred approaches.

The evidence base suggests that care-pathways designed around critical time intervention, identifying high risk groups at specific points, such as discharge from prison or other institution can offer an effective risk stratified approach. Examples of such approaches are currently being trialled as part of the Rapid Rehousing Pathway, providing navigators for prisons, hospitals and mental health. To maximise the opportunities for effectiveness in these pilots, specific partner commitment is needed for:

- Robust evaluation and sharing of learning across the local system.
- Development of integrated care pathways which address wider health and social needs in addition to housing provision.
- Development of sustainable financial investment to embed effective practice emerging from the pilot.

9) Knowledge gaps

This JSNA has relied on a combination of local views, local commissioned research and national data to develop a picture of health needs for those at risk of homelessness. There is very little reliable local data available to allow robust assessment of the scale of homelessness and the range of local health need. In addition to this there is currently insufficient information available to inform commissioning in relation to the needs of certain groups known to be at greater risk of being homeless e.g. veterans, offenders and people being released from prison.

This is a gap mirrored at national level and highlighted in the Rough Sleeping Strategy. Further work is needed for commissioners and providers to routinely collate and share information locally on the risk factors and health, housing and social care needs of those accessing services, as a starting point for estimating true population health need. It is expected that the new H-CLIC data collection will provide some useful data to better quantify need in those owed a support duty.

Nottinghamshire Health & Wellbeing Board

What should we do next?

10) Recommendations for consideration by commissioners

	Recommendation	Lead(s)
Strategic Leadership, Governance and Partnership Working		
1.	Establish formal governance arrangements in line with Ministry of Housing, Communities and Local Government (MHCLG) proposals for a **Homelessness Reduction Board**, to provide leadership and accountability for improving health and homelessness outcomes, including delivery of JSNA recommendations.	Housing Authorities, Commissioners of Supported Housing
2.	Establish a coordinated or integrated strategic commissioning forum to address gaps in provision and enable effective care pathways across housing, social care, mental health and primary and secondary healthcare.	Housing Authorities, Supported Housing Commissioners, Clinical Commissioning Groups (CCG), Adult and Children's Social Care
3.	Identify opportunities through the Homelessness Strategies of Nottinghamshire Housing Authorities to support prevention and early identification of homelessness by partners across the system, including best use of duty to refer.	Housing Authorities
4.	Consider the recommendation of the Rough Sleeping Strategy that strategic leadership is provided through a dedicated Homelessness lead on the Health and Wellbeing Board.	Health and Wellbeing Board
Integrated Commissioning and Care Pathways		
5.	Develop and implement a commissioned care pathway for critical time intervention with specific high-risk groups: ex-offenders, mental health needs, veterans, substance misuse.	Strategic Commissioning Forum
6.	Identify opportunities to align funding to evidence based primary prevention of homelessness, including through family mediation, debt advice, healthy lifestyles, tenancy sustainment initiatives, and education/support in at risk groups.	Homelessness Reduction Board
7.	Develop the healthcare offer across primary, secondary and community care to meet the specific health needs of those with no fixed abode or in temporary accommodation, in line with inclusion health standards.	Clinical Commissioning Groups (CCG), Health Care Providers
8.	Identify opportunities to strengthen effectiveness of Street Outreach and Rapid Rehousing Pathway initiatives through system wide engagement, pathway development and advocacy for longer term funding settlements.	Homelessness Reduction Board
9.	Identify and implement strategies for opportunistic screening and treatment for communicable diseases including blood borne viruses and tuberculosis, in settings most accessible to at risk homeless populations.	Public Health England, Health Protection Strategic Group, CCG

Implementation - Service Models, evaluation and data collation		
10.	Embed evidence based psychological approaches to managing and recovering from complex trauma into front line delivery of service, including Psychologically Informed Environments and trauma informed services (ReACH)	Service Providers
11.	Develop robust and shared methods for data collation and evaluation for existing services, to improve local knowledge of risk factors and health needs for those at risk of homelessness	Strategic Commissioning Forum
12.	Develop a strategic assessment of the Housing First model, as an option for securing long term health and social gains for individuals with complex and enduring needs, including substance misuse.	Strategic Commissioning Forum
13.	Develop shared protocols across service provision to improve accessibility and visibility of early identification and support options.	Service Providers

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Appendices:

Appendix 1: Number of eligible homeless in Nottinghamshire from 2013/14 to 2017/18

District	Year	Eligible, intentionally homeless and in priority need	Eligible, homeless but not in priority need	Eligible, but not homeless	Total decisions
Ashfield	2013-14	10	0	34	133
	2014-15	13	11	36	146
	2015-16	14	10	21	138
	2016-17	21	9	33	163
	2017-18	14	6	20	163
Bassetlaw	2013-14	11	39	81	172
	2014-15	30	53	101	275
	2015-16	22	66	84	237
	2016-17	20	32	51	191
	2017-18	16	10	49	152
Broxtowe	2013-14	8	8	10	36
	2014-15	5	9	10	34
	2015-16	0	0	7	24
	2016-17	0	0	7	28
	2017-18	10	8	13	46
Gedling	2013-14	0	0	16	74
	2014-15	0	0	14	91
	2015-16	0	0	30	114
	2016-17	0	0	19	124
	2017-18	0	0	20	128
Mansfield	2013-14	33	21	95	299
	2014-15	26	18	87	268
	2015-16	15	15	75	219
	2016-17	19	14	79	281
	2017-18	24	5	51	269
Newark & Sherwood	2013-14	6	0	8	145
	2014-15	0	0	10	139
	2015-16	0	0	18	128
	2016-17	15	0	0	131
	2017-18	22	0	0	124
Rushcliffe	2013-14	5	0	9	28
	2014-15	0	0	16	33
	2015-16	0	0	7	32
	2016-17	0	0	5	30
	2017-18	0	0	0	36

Nottinghamshire Health & Wellbeing Board

Appendix 2: Nottinghamshire Health and Homelessness current activity, service provision and assets

1. Healthy housing													
Homeless Risk Factor/ client group	**Name of service/ asset**	**Description**	**District coverage**							**Commissioner/ funder**	**Service**	**Asset**
			Bassetlaw	Newark & Sherwood	Mansfield	Ashfield	Broxtowe	Gedling	Rushcliffe			
Young people	Broxtowe Youth Homelessness	Provide educational programme in schools and some pre-tenancy training and support					√		√	Lottery funded, some funding from Broxtowe BC and other sources	√	
	Bassetlaw Floating Support Service (Framework Housing Association)	Provides flexible housing related support for people who live in their own home or tenancy. We work to prevent homelessness, promote independence and ensure that the people we support can sustain their homes. We offer an individual support plan around: benefits, homelessness prevention, attending court, rent arrears, money management, debts, training and help with social inclusion.	✓									

Nottinghamshire Health & Wellbeing Board

2. Homelessness prevention													
Homeless Risk Factor/ client group	**Name of service/ asset**	**Description**	**District coverage**							**Commissioner/ funder**	**Service**	**Asset**
			Bassetlaw	Newark & Sherwood	Mansfield	Ashfield	Broxtowe	Gedling	Rushcliffe			
All	The Ark	Housing, benefits advice						√		?	√	
Young people	Centre Place	Debt and homelessness advice to young people who are LGBT		√						Charitable trusts, Big Lottery	√	
Individuals with aspergers/ autism/ learning difficulties	Brighter Futures	Floating support for individuals with Asperger's/autism/learning difficulties			√					Commissioned	√	
All needing legal housing advice	Direct Help and Advice (DHA)	Wednesday afternoon sessions at Civic Centre for advice on housing and homelessness issues						√		Legal Advice Agency	√	
Homeless prevention	Citizens Advice Broxtowe	Specialist housing worker giving independent advice and debt advice service					√			Grant aid funded and funded through Broxtowe BC	√	
Homelessness prevention	Citizen's Advice Newark and Sherwood	**Debt advice service**		√						NSDC and NS Homes	√	

Nottinghamshire Health & Wellbeing Board

Homelessness prevention	DASH – Call Before You Serve	Early intervention project to prevent landlords serving eviction notices (being developed)					√	√		District Council funded	√	
3. Treatment, recovery and rehabilitation												
Homeless Risk Factor/ client group	**Name of service/ asset**	**Description**	**District coverage**							**Commissioner/ funder**	**Service**	**Asset**
			Bassetlaw	Newark & Sherwood	Mansfield	Ashfield	Broxtowe	Gedling	Rushcliffe			
Domestic abuse (women)	Newark Women's Aid	Refuge accommodation for women and their families fleeing domestic abuse		√						Independent with HB to cover rent and support	√	√
Domestic abuse (women)	Nottinghamshire Women's Aid	Floating Support for women suffering Domestic Abuse		√	√	√				Commissioned service	√	
Domestic abuse (men)	Equation	Support for men fleeing threat of domestic violence	√	√	√	√	√	√	√			
Domestic Abuse (women)	Midland Women's Aid	Refuge accommodation for women fleeing domestic abuse.					√			An independent service with HB entitlement to cover rent and support	√	√

Domestic Abuse (women)	Women's Aid Integrated Service (WAIS)	Floating support for women experiencing DV					√	√	√	Commissioned service	√	
Domestic Abuse (women)	Broxtowe Women's Project	Floating support for women experiencing domestic abuse					√			Lottery funded	√	
Single people not in priority need	Framework Supported housing accommodation	Provider Framework Housing Association – Russell House/The Old Dairy – Supported housing for single homeless 10-12 bed spaces in Newark town centre.		√						County Public Health	√	√
Substance misuse	Framework Support housing accommodation	Pelham Mews – Newark Delivered for single residents with drug or alcohol issues		√						County Public Health	√	√
Rough sleepers	Framework – street outreach	Outreach service for Rough Sleepers	√	√	√	√	√	√	√	Government funded through bid to March 2019	√	
Aged 18+ with medium to low support needs	Framework – Elizabeth House supported accommodation	Supported housing for clients 18+ with medium to low support needs. 21 bed space accommodation (provision is shared between southern districts)					√	√	√	Commissioned service with HB to cover rent and support element	√	√
Unknown	Hope into Action	Supported housing						√		?		V

Homeless	HOPE	Direct Access hostel, 14 beds. Support plans, debt advice, legal advice, signposting to mental health, drug and alcohol. Average 100 per year	√							Self-Funding via Housing Benefit		
Young families	Bond Street Arnold	Young family accommodation						√		??		V
Rough Sleepers	Emmanuel House	Drop in service for street homeless people						√	√	??	√	√
Rough sleepers	The Friary	Advice for people facing homelessness, benefit advice, food bank	√	√	√	√	√	√	√		√	√
Single Homeless People	Derventio Housing Trust	Supported accommodation for single homeless in PRS leased properties.					√			Funded through HB to cover rent and support.	√	√
Males aged 18+ with medium to low support needs	Canaan Trust	Supported accommodation for males aged 18+ medium to low support needs 10 bed spaces					√			Independent service funded through the Trust	√	√
Singles and mother and baby provision	NCHA – Branching Out	Supported housing for young people aged 16 – 21. Service is for singles and mother and baby provision. Core service in Newark town centre + dispersed throughout district. https://www.ncha.org.uk/home		√						Commissioned with HB to cover rent and support	√	√

Young people (16-21)	NCHA (in partnership with New Roots) – Branching Out	Support to 79 young people aged 16-21, with an additional 2 emergency beds for young people in a housing crisis. There are 'core' services located in Newark, Retford and Worksop which are staffed 24 hours a day, and 'cluster' properties throughout Newark and Sherwood and Bassetlaw where young people receive visiting support (funded to July 2020 with the option to extend by total of 24 months)	√	√						Nottinghamshire County Council Commissioning and Placements Group	√	√
Young people (16-21)	Framework – Transitions North	Service provides support to 91 young people aged 16-21, with an additional 3 emergency beds for young people in a housing crisis. There are 'core' services located in Ashfield and Mansfield which are staffed 24 hours a day, and 'cluster' properties throughout both districts where young people receive visiting support.			√	√				Nottinghamshire County Council Commissioning and Placements Group	√	√
Young people (16-21)	Framework – Transitions South	Service provides support to 50 young people aged 16-21, with an additional 2 emergency beds for young people in a housing crisis. There is a 'core' service which is staffed 24 hours a day in Rushcliffe, and 'cluster' properties throughout Gedling, Rushcliffe and Broxtowe where young people receive visiting support.					√	√	√	Nottinghamshire County Council Commissioning and Placements Group	√	
Mental health	Framework and NCHA– Moving Forward	Mental Health Floating and accommodation based Support Also includes crisis link workers based on MH wards whose aim is to prevent people losing their home if being admitted to a MH ward and facilitate discharge in relation to any housing issues. http://www.frameworkha.org/framework_near_me/221_moving_forward_steps_to_independence	√	√	√	√	√	√	√	Commissioned by NCC ASCH	√	

Rough Sleepers	Framework – complex needs worker	1:2:1 support for entrenched rough sleepers http://www.frameworkha.org/		√						Community Safety Partnership	√	
Homeless	Sherwood Street Centre	Hostel 18+			√							
People facing homelessness	The Friary, Musters Road, W Bridgford	Advice for people facing homelessness, benefit advice, food bank						√	√			
Young people aged 16/17	High Needs DPS	23 LAC aged 16/17 with individual placement agreements with a range of providers. There are approximately 25 providers on the DPS to support young people unable to manage in the 16+ supported accommodation services. Contract duration is dependent on the provisions of the IPA	√	√	√	√	√	√	√	Nottinghamshire County Council Commissioning and Placements Group	√	√
Singles and mother and baby provision	Emmaus Trust	Supported housing for young people aged 16 – 25. Service is for singles and mother and baby provision. Approximately 35 bed spaces in Newark town centre https://www.emmaus.org.uk/		√						Independent service with HB to cover rent and support	√	√
Homeless	YMCA Shakespeare Street, Nottingham	Hostel (16-25 occasionally 35) Can self refer			√	√						

Homeless	YMCA	Hostel (16-25 occasionally 35) Can self refer	√					√				
Rough sleepers	Newark Churches Together – Impact	Drop in service for rough sleepers providing meals, washing facilities, clean clothing and a mentor service		√						Churches/ donations	√	
Homeless	Beacon Project	Day service – food, clothes, showers			√					More detail	√	
Homeless	Lighthouse	Hostel for males 18+			√	√				More detail		
Individuals with aspergers/ autism/ MH issues facing homelessness	Chatsworth House Framework	24 units in Sutton in Ashfield aimed at preventing people from becoming homeless and developing independent living skills.				√	√	√	√	NCC ASCH		

Appendix 3: Under 35 study

Increasing the availability of single person accommodation for people under 35 with low incomes with measures including improving access to advice, assistance and mediation; working with social landlords to seek to remove the perceived barriers to accessing housing, including rent in advance, historic anti-social behaviour and minor rent arrears etc; seeking to effectively use discretionary housing payments, rent deposit support etc to improve access to accommodation; work with landlords to support them accommodation people in housing need; consider using a housing first approach to respond to homelessness and complex needs; piloting house sharing models; consideration of utilisation of ex sheltered housing to young persons accommodation; procuring accommodation and bringing empty properties back into use.

Improving prevention/tenancy sustainment

With measures including commissioning support for people to sustain their accommodation through advice, assistance and remediation; further developing floating support to prevent loss of accommodation, support for moving into a new property and support for moving on from supported housing. Additionally, the report recommends more pre-tenancy training and financial literacy to ensure young people are better able to sustain their tenancy.

Increase the amount and range of supported options

Recommendations include commissioning accommodation based supported housing for people with additional needs; Commissioning a Housing First approach for those people who have the most complex needs; commissioning refuge accommodation; enabling access to extra support from Adult Social Care to support agencies in working with people who are close to thresholds; exploring Social Impact Bonds models (SIBS) for 18-24 year olds not in employment, education or training; working with partners to explore supported lodgings with well-trained and well-supported hosts in the social and the private sector

Improve move-on rates from supported housing

Standardising the placement of people ready to move on into band 2 housing registers across all areas; developing a move-on plan protocol to inform what type of accommodation is needed.

Advice and Information on housing and homelessness

Promoting information and advice about housing and homelessness; promoting access to floating support; maximising social media such as Twitter and Facebook.

Improve skills, training and employability of young people

Creating better linkages to develop training programmes and apprenticeships and exploring LEP funding to support training and development initiatives.

Build on existing partnerships and develop new ones

To further develop joint working between Districts and County Council teams and other partners (including mental health; drug and alcohol services etc) and to ensure effective shared understanding of key data relating to homelessness to plan effective joint measures; work with partners such as Jobcentres and faith groups; Ensuring that young people are actively involved in designing services that affect them.

Appendix 4: Street Outreach Team

From October to December 2018, a total of 2,231 individual interviews were conducted. Figure 3A gives a breakdown of the nature of support interventions offered. Welfare (refers to practical assistance given in the form of food parcels, clothing & toiletries) support intervention rated the highest, 60%.
There are 4 ways that individuals can self-refer or agencies can refer to us;

1. BY PHONE – Our 0800 number is free from any landline or mobile and is answered 24 hours a day, 7 days a week
2. BY EMAIL –sotnottinghamshire@frameworkha.org
3. BY STREETLINK – The National Rough Sleeping Referral mechanism www.streetlink.org.uk Can be downloaded on a phone or tablet as an app.
4. BY TEXT – No credit required and can text 80800 starting the message with SOT and we will respond

Table A below give a breakdown of all referrals from April 2017- March 2018 by District and the number of Street Outreach interventions delivered. Mansfield District had the highest number of Street Outreach interventions delivered, followed by Ashfield. However, as with all outreach services, a referral does not always mean someone is rough sleeping.

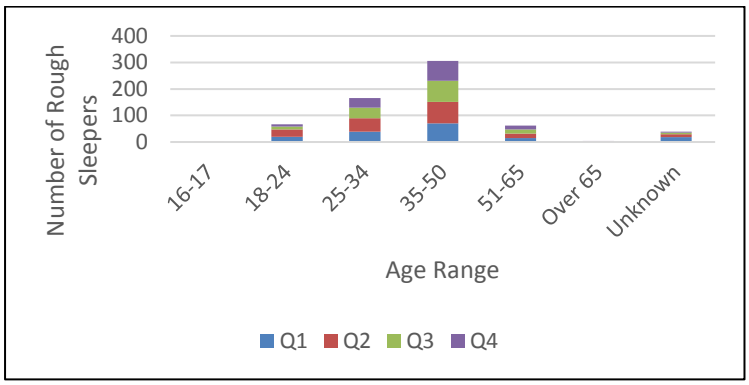
Table A: Number of Street Outreach interventions delivered by Nottinghamshire District – April 2017 – March 2018

Interventions	District							
	Ashfield	Bassetlaw	Broxtowe	Gedling	Mansfield	Newark & Sherwood	Rushcliffe	Total
People helped off the streets	27	32	1	8	62	11	24	**165**
Individual rough sleepers supported	50	56	10	11	122	24	49	**322**
Outreaches completed in area	82	65	38	37	100	39	66	**427**

Source: Framework Housing Association

Figure A shows the number of Street Outreach contacts by age range for each quarter in 2017/18. The highest proportion were aged between 35 to 50 years followed by 25 to 34 years.

Figure A: Number of individuals worked with the Street Outreach Team during 2017/18, by age range



Source: Framework Housing Association

Appendix 5: Friary Homelessness Drop In – Activity and Delivery

Table A1 shows the demographic breakdown for those attending the Friary between October and December in 2018. The district breakdown shows where people are of no fixed abode this refers to the area which they have the greatest connection. Of the 327 individuals accessing the service, majority of clients were from Nottingham City, 70.0% followed by Rushcliffe, 23%. With the majority in the18 to 49 years age range, 72% and predominantly male, 75%, and 69% White British. With majority, aged between 18 to 49 years, 72%, male, 75% and White British, 69%.

Table A1: Demographics of Friary Drop In clients

District of greatest connection	**Number**	**%**
City	241	*70.0*
Rushcliffe	79	*23.0*
Broxtowe	7	*2.0*
Mansfield	0	*0.0*
Ashfield	0	*0.0*
Newark and Sherwood	0	*0.0*
Bassetlaw	0	*0.0*
Age Range	**Number**	**%**
17 years and under	<5	*1.0*
18 to 49 years	235	*72.0*
50 to 59 years	42	*13.0*
60 to 64 years	20	*6.0*
65+ years	10	*3.0*
Not stated	16	*5.0*
Gender	**Number**	**%**
Male	258	*75.0*
Female	87	*25.0*
Ethnic Background	**Number**	**%**
White British	238	*69.0*
White other	64	*19.0*
Black British	28	*8.0*
Black other	5	*1.0*
Asian (incl Chinese)	<5	*1.0*
Not stated	8	*2.0*

Figure A1 below shows that the majority of the Friary drop in clients where living in private rental accommodation followed by temporary accommodation, 37% and 20%, respectively. 9% were rough sleeping.

Figure A1: Number/% of Accommodation Status of Clients attending the Friary Drop in Service – October – December 2018.

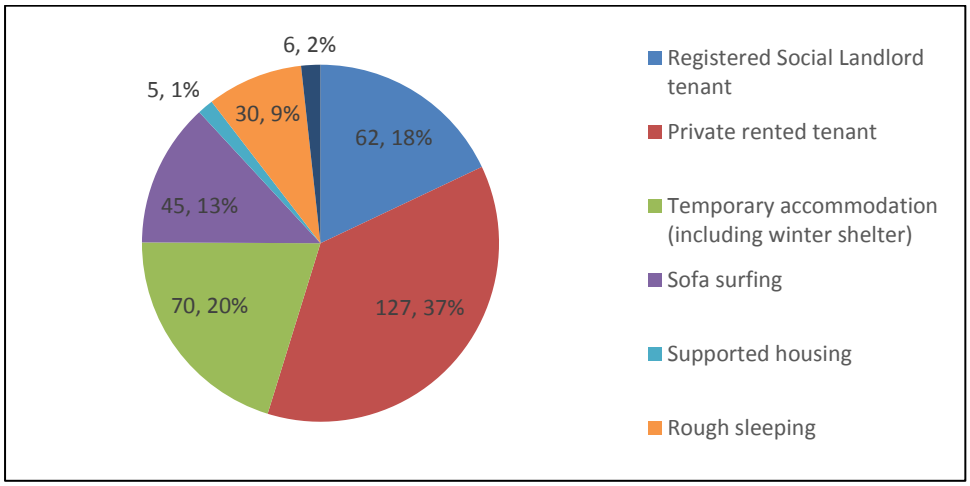
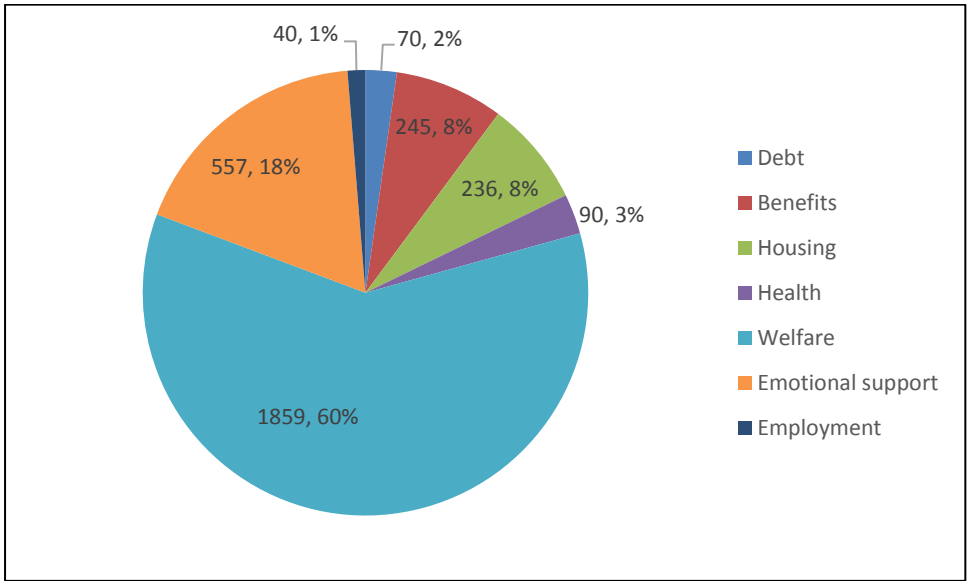


Figure B1: Number/% of support intervention offered to Clients attending the Friary Drop in Service – October – December 2018.



In table B1 below, shows the breakdown of facilities offered, with the highest being free meals followed by access to a shower and laundry facilities.

Table B1: Number of facilities offered to Clients attending the Friary Drop in Service – October – December 2018.

Free meals	620
Shower	581
Laundry	517

IT suite	336
GP consultations	104
Nurse joint with GP	48
Chiropodist	15
Optician	14

Nottinghamshire Health & Wellbeing Board

Appendix 6: Evidence of what works - mapped against Health and Homeless promotion, Homeless prevention and treatment, recovery and rehabilitation.

Evidence of what works	Health of the Homeless Promotion and Prevention	Homelessness Prevention	Homelessness Early Identification	Homelessness Recovery and rehabilitation
National Policies and Guidance				
Homeless Reduction Act Homeless Reduction Act (HRA) (2017) extends the length of time a household can be considered at threat of homelessness from 28 to 56 days. Local authorities will be required to take action to support the household in finding alternative accommodation at the beginning of the notice period, rather than the end. The HRA brings a number of new duties to the local authority as follows: • Duty to assess - and develop personalised housing plans • Duty to prevent – to help stop a household from losing their accommodation • Duty to relieve – to help a household transition straight from one accommodation to another • Duty to refer – duty on other public sector bodies to identify people at risk of homelessness and refer them for assessment and support	x	x	x	x
Rough Sleeper Strategy Rough Sleeper Strategy (2018) is a wide ranging document which lays out the government's plans to help people who are sleeping rough now and to put in place the structures to end rough sleeping by halving rough sleeping by 2022 and ending it by 2027. Specifically, the Strategy makes funding available to tackle rough sleeping and homelessness more broadly.	x	x	x	x
PHE Homelessness: applying all our health Public Health England (PHE) Homelessness: applying all our health (2016) guidance provides examples to help healthcare professionals: • identify and advocate to prevent the risk of homelessness among people who have poor • health minimise the impact on health from homelessness among people who are already experiencing it enable improved health outcomes for people experiencing homelessness so that their poor health is not a barrier to moving on to a home of their own	x	x	x	x
Local Homelessness Strategies				
Local Housing Authorities (LHAs) are required to undertake an assessment of homelessness needs and provision and publish a homelessness strategy at least every 5 years. In the case of Nottinghamshire, the Local Housing Authorities are the seven District and Brough Councils.				
Bassetlaw Homeless Prevention Strategy (2017-2022): https://www.bassetlaw.gov.uk/media/2883/homeless-prevention-strategy-delivery-plan.pdf			x	x

At local level the Bassetlaw Homeless Prevention Strategy links to the new Council Plan, (2017 to 2020), and focuses on the ambition: Enhancing Home and Place, under the following priorities; • Support the delivery of a wide variety of homes across all sectors, (town & rural areas). • Work with the private rented sector to improve the quality of homes. • Use our full range of powers to protect local people and the place they live. • Support the health & wellbeing of local people through early intervention and initiatives.				
South Nottinghamshire (Broxtowe, Gedling, Rushcliffe) Homeless Strategy (2017 -2021) https://www.rushcliffe.gov.uk/media/1rushcliffe/media/documents/pdf/housing/homelessness/south%20nottinghamshire%20homelessness%20strategy%202017-2021-dr22086.pdf The strategy sets the framework for improving access to housing. Supporting vulnerable people and minimising rough sleeping continue to be our priorities, together with a greater emphasis on developing clear pathways and effective preventive interventions. Since publication in 2013, there has been significant progress through the implementation of South Nottinghamshire's first homelessness strategy through stronger partnership working between the three councils and our partners. The strategy was based on the following main strategic objectives: • No one should have to sleep rough in South Nottinghamshire • All local authorities will work with partners to reduce the number of homeless applications they need to consider year on year • All councils will minimise the use of Bed & Breakfast accommodation for homeless households, with the long term aim of ending it altogether • Knowing that there is insufficient social housing to meet demand, all potentially homeless clients will get the help they need to access private rented housing • All young people in South Nottinghamshire should learn about homelessness, realistic housing options, domestic abuse and healthy relationships in school • All client groups with special needs will have clear and up to date referral pathways so that it is clear which agency is responsible for providing services to them at what time.		**x**	**x**	**x**
Mid Nottinghamshire are currently working with Homelessness Link to develop a homelessness strategy				
Public Health Guidance				
Older people and alcohol misuse: helping people stay in their homes Guidance (2016) Guidance on how to prevent and reduce harmful drinking in older people	**x**	**x**	**x**	**x**
Hidden needs: identifying key vulnerable groups in data collections: vulnerable migrants, gypsies and travellers, homeless people, and sex workers (2014) This report, from the Data and Research Working Group of the National Inclusion Health Board (NIHB): • identifies where to find good data and the gaps in information and data where the burdens of ill health and untimely death are greatest for vulnerable groups (vulnerable migrants, gypsies and travellers, homeless people, and sex workers)	**x**		**x**	

• is for data providers, healthcare professionals, commissioners and others working to improve the health of the vulnerable groups The report concludes that: • it is impossible to obtain a comprehensive picture of the vulnerable groups' health • the health needs of some of the most vulnerable people in society continue to be invisible to health commissioners and the wider health system planners • the health needs of the vulnerable groups sometimes place heavy and unpredictable demands on the health service, which may result in multiple avoidable visits to hospital • the data gaps prevent effective monitoring of health care use and seriously undermine local efforts by NHS and local government to understand and prioritise the local needs of the vulnerable groups				
Commissioning inclusive health services: practical steps (n.d) While there are many vulnerable groups, the Inclusion Health programme has identified as an initial priority those with the poorest health, where information on their needs and successful interventions is relatively weak, and crucially where there has been much less focus in JSNAs. These are the focus of this guide: Gypsies, Travellers and Roma; the homeless and rough sleepers; sex workers; and vulnerable migrants. This guide includes a section for each of these groups describing their health needs and barriers they face to accessing services; and with practical advice for developing inclusive JSNAs and JHWSs.	**x**			**x**
Tackling tuberculosis in under-served populations (2019) Outline the roles of those involved alongside the TB clinical teams in meeting the needs of under-served populations. These chapters cover the roles and responsibilities of local government, TB Control Boards, CCGs and the third sector. With 'models of care' that can be used to meet the needs of under-served populations with TB.	**x**			
Tuberculosis (TB) and homelessness This leaflet advises people who work in the homelessness sector how to recognise TB and help clients access NHS treatment.	**x**			
NICE quality standards				
Quality standard for drug use disorders (QS23) (2012) This quality standard covers assessment and treatment of drug use disorders in adults (aged 18 and over). It includes treating the misuse of opioids, cannabis, stimulants and other drugs in all settings, including inpatient and specialist residential and community-based treatment settings, and prison services. It describes high-quality care in priority areas for improvement.	**x**			x
NICE Clinical Pathway for Hepatitis B and C testing (2017) This guidance gives and overview on Hepatitis B and C testing pathways, policy and commissioning on hepatitis B and C testing, increasing the uptake of hepatitis B and C testing and hepatitis B vaccination	**x**			
NICE Transition between inpatient hospital settings and community or care home settings for adults with social care needs NG27 (2015) This guideline covers the transition between inpatient hospital settings and community or care homes for	**x**			**x**

adults with social care needs. It aims to improve people's experience of admission to, and discharge from, hospital by better coordination of health and social care services.				
NICE clinical Pathways				
NICE Oral health: local authorities and partners QS141 (2014) This guideline covers improving oral health by developing and implementing a strategy that meets the needs of people in the local community. It aims to promote and protect people's oral health by improving their diet and oral hygiene, and by encouraging them to visit the dentist regularly	**x**			
Tuberculosis (NICE guidelines NG33) This guideline covers preventing, identifying and managing latent and active tuberculosis (TB) in children, young people and adults. It aims to improve ways of finding people who have TB in the community and recommends that everyone under 65 with latent TB should be treated. It describes how TB services should be organised, including the role of the TB control board.	**x**			
Borderline personality disorder: treatment and management (CG78) (2009) This guideline covers recognising and managing borderline personality disorder. It aims to help people with borderline personality disorder to manage feelings of distress, anxiety, worthlessness and anger, and to maintain stable and close relationships with others	**x**			
Antisocial behaviour and conduct disorders in children and young people: recognition, intervention and management (CG158)(2017) This guideline covers recognising and managing antisocial behaviour and conduct disorders in children and young people aged under 19. It aims to improve care by identifying children and young people who are at risk and when interventions can prevent conduct disorders from developing. The guideline also makes recommendations on communication, to help professionals build relationships with children and young people and involve them in their own care.	**x**	x		
Alcohol-use disorders: Diagnosis and clinical management of alcohol-related physical complications (CG100) (2017) This guideline covers care for adults and young people (aged 10 years and older) with physical health problems that are completely or partly caused by an alcohol-use disorder. It aims to improve the health of people with alcohol-use disorders by providing recommendations on managing acute alcohol withdrawal and treating alcohol-related conditions	x	x		**x**
Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence (CG115) (2011)This guideline covers identifying, assessing and managing alcohol-use disorders (harmful drinking and alcohol dependence) in adults and young people aged 10–17 years. It aims to reduce harms (such as liver disease, heart problems, depression and anxiety) from alcohol by improving assessment and setting goals for reducing alcohol consumption.	**x**	x		x
Drug misuse – psychosocial interventions (CG51) (2007) This guideline covers using psychosocial interventions to treat adults and young people over 16 who have a problem with or are dependent on opioids, stimulants or cannabis. It aims to reduce illicit drug use and improve people's physical and mental health, relationships and employment.	**x**	x		x
Severe mental illness and substance misuse (dual diagnosis) (2016) This guideline covers how to improve services for people aged 14 and above who have been diagnosed as having coexisting severe mental illness and substance misuse. The aim is to provide a range of coordinated services that address people's wider health and social care needs, as well as other issues such as employment and housing.				x
Evidence Reviews				
Preventing homelessness to improve health and wellbeing Research and analysis (2015) A rapid evidence review into interventions that are effective in responding to health and wellbeing needs, in households at risk of homelessness.	x	x		

PHE Homeless adults with complex needs: evidence review (2018) gives an overview of the homeless situation across England with insights into the current evidence base to support action to prevent and reduce homelessness. This review is aimed at local authorities and other stakeholders who are developing strategies and interventions to prevent homelessness and support adults with complex needs. It advises a system-wide, integrated approach to dealing with homelessness and identifies some tools and guidance which may be of use to local authorities in developing their work in this area.	**x**	**x**	**x**	**x**
Strategies and Policies				
Tuberculosis (TB): collaborative strategy for England Policy paper (2015) Public Health England (PHE) and NHS England's strategy for dealing with tuberculosis (TB) from 2015 to 2020.	x			
Reports and Resources				
Health and wellbeing: a guide to community-centred approaches Research and analysis (2015) This guide outlines a 'family of approaches' for evidence-based community-centred approaches to health and wellbeing. Peer-based interventions approaches aim to recruit and train people on the basis of sharing the same or similar characteristics as the target community, often with the aim of reducing communication barriers, improving support mechanisms and social connections. In the UK peer methods have been applied across a range of health issues, for example; people experiencing homelessness[87] Although all peer approaches aim to tap into the social influence of people who share similar experiences or characteristics, peer education focuses on teaching and communication of health information, values and behaviours between individuals, peer mentoring involves one-to-one relationships that model and support positive behaviour and peer support involves providing positive social support and helping buffer against stressors There is a clear link between peer support roles and mutual aid interventions that aim to encourage self-help and create supportive networks[88].	x			x
Making every contact count: A joint approach to preventing homelessness Making Every Contact Count is the government's strategy for reducing homelessness through joint working and preventative measures. It sets out ten recommendations to local authorities9: 1. Adopt a corporate commitment to prevent homelessness which has buy in across all local authority services 2. Actively work in partnership with voluntary sector and other local partners to address support, education, employment and training needs 3. Offer a Housing Options prevention service, including written advice, to all clients 4. Adopt a *No Second Night Out* model or an effective local alternative 5. Have housing pathways agreed or in development with each key partner and client group that includes appropriate accommodation and support 6. Develop a suitable private rented sector offer for all client groups, including advice and support to both clients and landlords 7. Actively engage in preventing mortgage repossessions including through the Mortgage Rescue Scheme 8. Have a homelessness strategy which sets out a proactive approach to preventing homelessness and is reviewed annually so that it is responsive to emerging needs 9. Not place any young person aged 16 or 17 in Bed and Breakfast accommodation	x			x

10. Not place any families in Bed and Breakfast accommodation unless in an emergency and then for no longer than 6 weeks[89]				
Homeless health needs: audit toolkit Research and analysis (2015) The Homeless Health Needs Audit offers a practical way to improve the health of people who are homeless in your local area.	x			
Planning Guidance				
Gypsy and Traveller health: accommodation and living environment Independent report (2016) National Inclusion Health Board (NIHB) report: effect of insecure housing and poor living conditions on health of Gypsies and Travellers.	x	x		

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Appendix 7: Stakeholder Survey

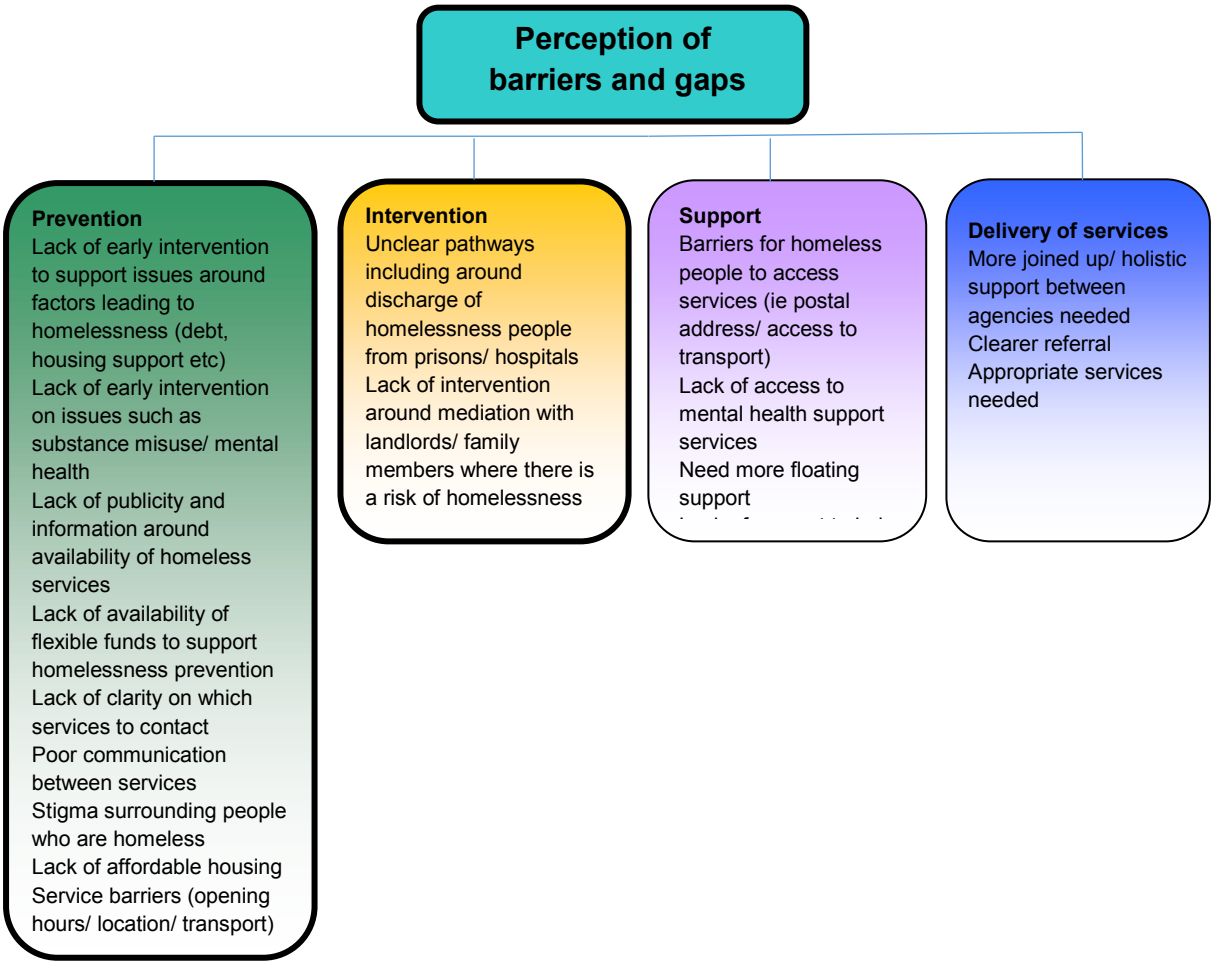
Views of professionals and service users.

Throughout the development of the JSNA, views have been sought from professionals and service users with regard to Health and Homelessness health, social and economic needs and homeless prevention and recovery services in the County.

This has included:

- Establishment of a JSNA steering group which has included input from a wide range of partners including District/ Borough Councils; CCGs; Adult Social Care; County Children and Young Peoples Services and Public Health
- An on-line stakeholder survey
- Homelessness service user interviews
- Linking in with a commissioned pieces of work undertaken by Homelessness Link regarding the housing and support needs of under 35 year olds in the County (with a focus on the Ashfield, Broxtowe, Gedling and Rushcliffe areas) and the development of the mid-Nottinghamshire Homelessness Strategy (Ashfield, Mansfield, Newark and Sherwood).

Summary of findings



Views of professionals

1. Methodology and responses

An online survey was opened on 18th January 2019 and ran until 1st February 2019. The survey was emailed to key stakeholder partners including Framework; The Friary; Notts YMCA; Emmaus Trust; Broxtowe Youth Homelessness; Womens Aid; NCHA; Equation; Brighter Futures; DASH; Lighthouse Homes; District Councils; CCGs; County Adult Social Care; County Children and Young Peoples Services; CGL; Police and others.

In total, 18 responses were received from a range of partner organisations.

Respondents **area of work** by top tier local authority and district (respondents could give more than 1 response)

District	N =
Ashfield	6
Bassetlaw	6
Broxtowe	3
Gedling	4
Mansfield	4
Newark & Sherwood	3
Rushcliffe	2
All of the Nottinghamshire area	2
Not answered	1
Prefer not to say	0
Total	31

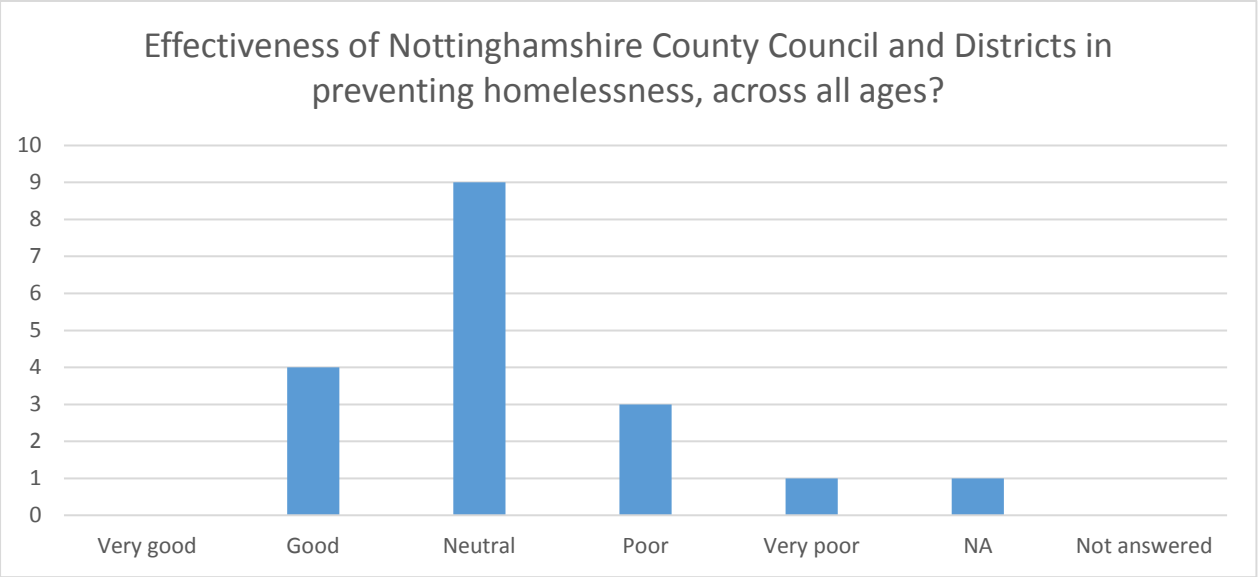
Table xx shows the organisations and professional groups represented by the respondents. This provided a good mix of commissioners and service providers.

Survey respondents by organisations and professional group represented

Organisation	N =	Professional Group/s
CCG	3	Administrator Deputy Chief Nurse Head of Adult Nursing
Local Authority	5	Senior Community Engagement Officer Housing and Welfare Support Manager Housing Manager Housing Strategy Lead Homelessness Engagement and Development Officer
Service provider	9	Project Manager Head of Service Centre Co-ordinator Manager Manager Deputy Manager Site Manager Services Director
Missing	1	
Total	**18**	

General views

i) **Stakeholders were asked to rate the effectiveness of Nottinghamshire County Council and partners in preventing homelessness, across all ages. In total, 18 responded, as follows.**



ii) Stakeholders were asked to comment on what effective awareness, support and interventions (if any) are needed to be put in place to prevent homelessness, across all ages. Recurring points included:

- Earlier intervention before people become homeless
- More of a joined up approach across agencies
- A more holistic approach to support people to make sense of benefit changes
- More support for care leavers
- Better embedding of systems to identify and support people who are homeless clearer/ earlier referral mechanisms
- To seek to remove the barriers that are in place for homeless people to access services
- Support and training for tenants to be able to sustain tenancies and more help/ education for landlords to access support
- More publicity by Local Authorities as to what support is available, including cold weather shelters
- Health checks for the homeless
- Case studies to understand how people become homeless
- Consider Housing First model
- Better interventions around Mental Health and Substance Misuse at an earlier stage before crisis point
- Longer tenancies
- Improved floating support
- Improved advice for younger people around housing and preparing for living independently
- That no-one is discharged homeless from an institution
- Greater involvement of those with lived experience to help design clearer homelessness pathways and more collaborative working between partners
- Supporting people who are under-occupying to move to smaller accommodation to free up accommodation
- Ensuring smaller organisations have opportunities to bid for contracts

- Improved substance misuse awareness programmes
- Flexible resources which can be deployed rapidly to support early interventions to support people at risk of homelessness through low level interventions (simple referral is key)

iii) **Stakeholders were asked to comment on what could be done differently at an early stage to support people who are currently at risk of homelessness. Recurring points included:**

- For agencies to intervene at an earlier stage before crisis point ie sorting rent arrears; educating on preventing repeat homelessness; signposting for specialist support; providing more face to face advice
- Sharing referrals between all support agencies and improving sharing of information
- Support the VCS in supporting people at risk of homelessness
- Improve availability of information in other sources than just the internet – perhaps a free phone number?
- Proactively working with landlords to sustain tenancies and avoid evictions
- Improved support for mediation with family members where this can avoid someone becoming homeless
- Offering free legal advice to tenants regarding their rights
- Better understanding homelessness pathways and what opportunities there are to prevent homelessness earlier
- Better partnership working between agencies to prevent and tackle homelessness
- Flexibility of funding to support rapid homelessness prevention (including ie flexible funding for tenants to pay off arrears, where appropriate)

iv) Stakeholders were asked whether, when working with homeless people, they asked them about their health needs.

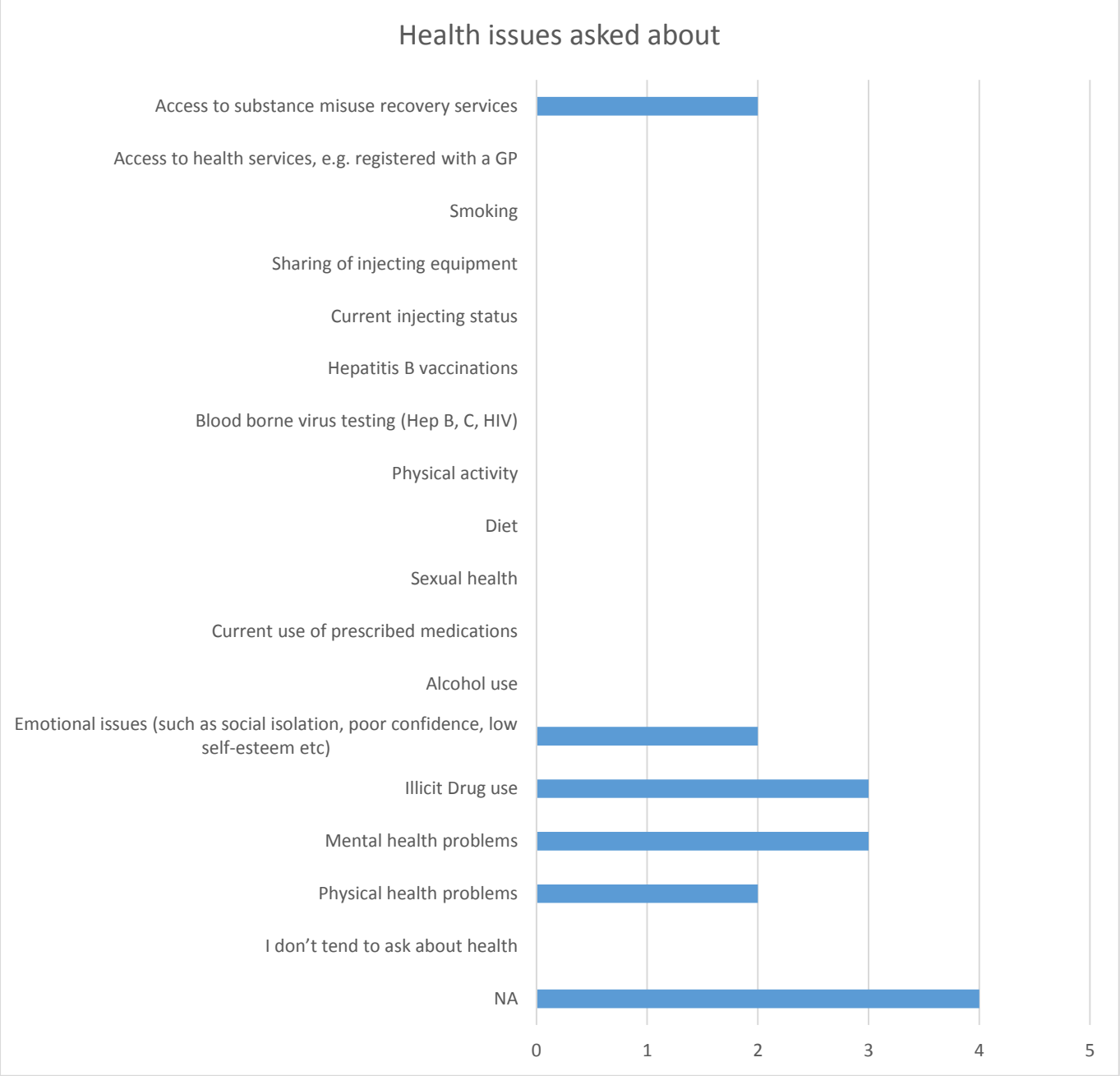
In total, 18 stakeholders responded to this question as follows:

Response	Number of responses
Yes, always	12
Yes, sometimes	1
Never	0
NA	5
Not answered	0

v) Stakeholders were asked which health needs they ask homeless people.

A total of 16 stakeholders responded to this question but stakeholders were asked to tick all that apply.

Stakeholders stated that the main health issues they ask about relate to substance misuse (2 cases); emotional issues (2 cases); drug usage (3 cases); mental health issues (3 cases) and physical health issues (2 cases)



vi) Stakeholders also had the option of stating any further questions that they asked.

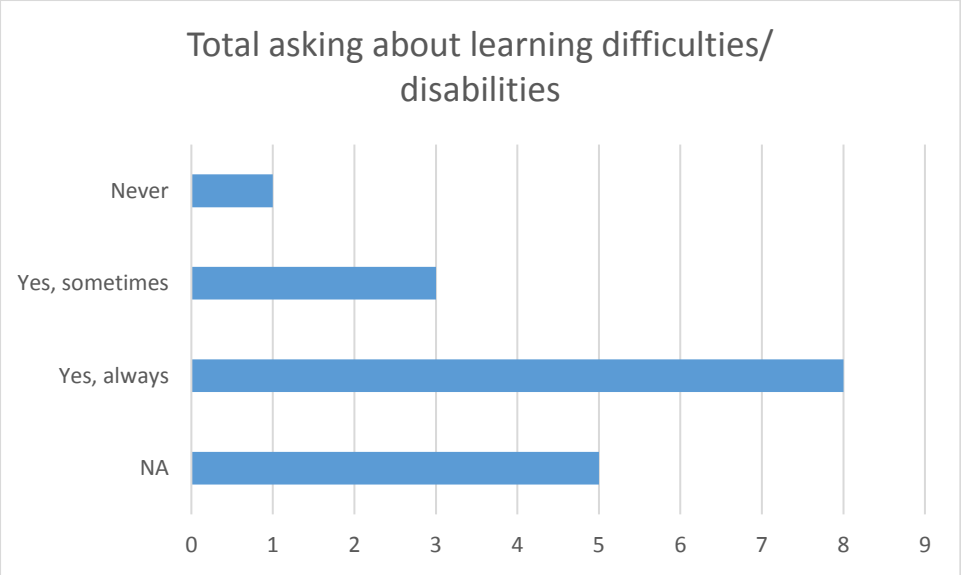
<u>Some respondent noted that they were only able to select one choice and wished to select more than one</u>

Responses included:

- Biggest issue is seeking and getting mental health support
- All of the above is explored when we assess an individual regardless of homelessness status, we would support the individual with a majority of the above issues. However, we have noted that most people do not wish to wish their substance use when they are homeless
- Tend to ask people whom I meet in the community about their general wellbeing and give them a chance to open up or to establish if they want help or assistance

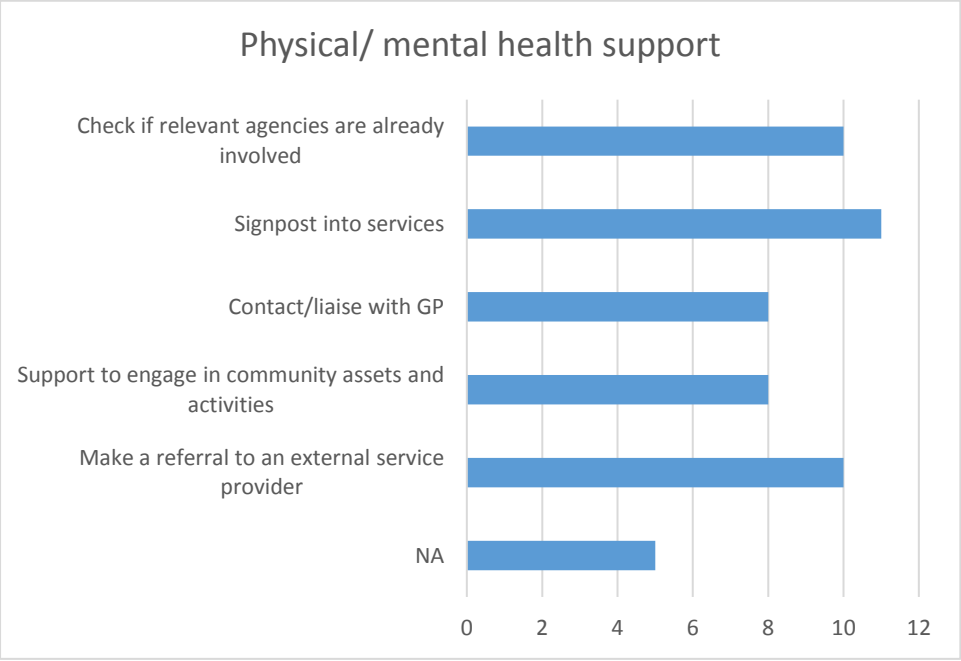
vii) **Stakeholders were asked whether they ask any questions regarding learning difficulties or learning disabilities during the initial assessment or at any other contact with the client**

A total of 17 stakeholders responded to this question.



viii) **Stakeholders were asked whether during initial assessment or at any other stage of assessment and follow-up interventions or treatment, what do you usually do if you suspect a client has a specific physical or mental health condition which may require additional support. Stakeholders could tick all that apply.**

A total of 52 stakeholder responses were included to this question.

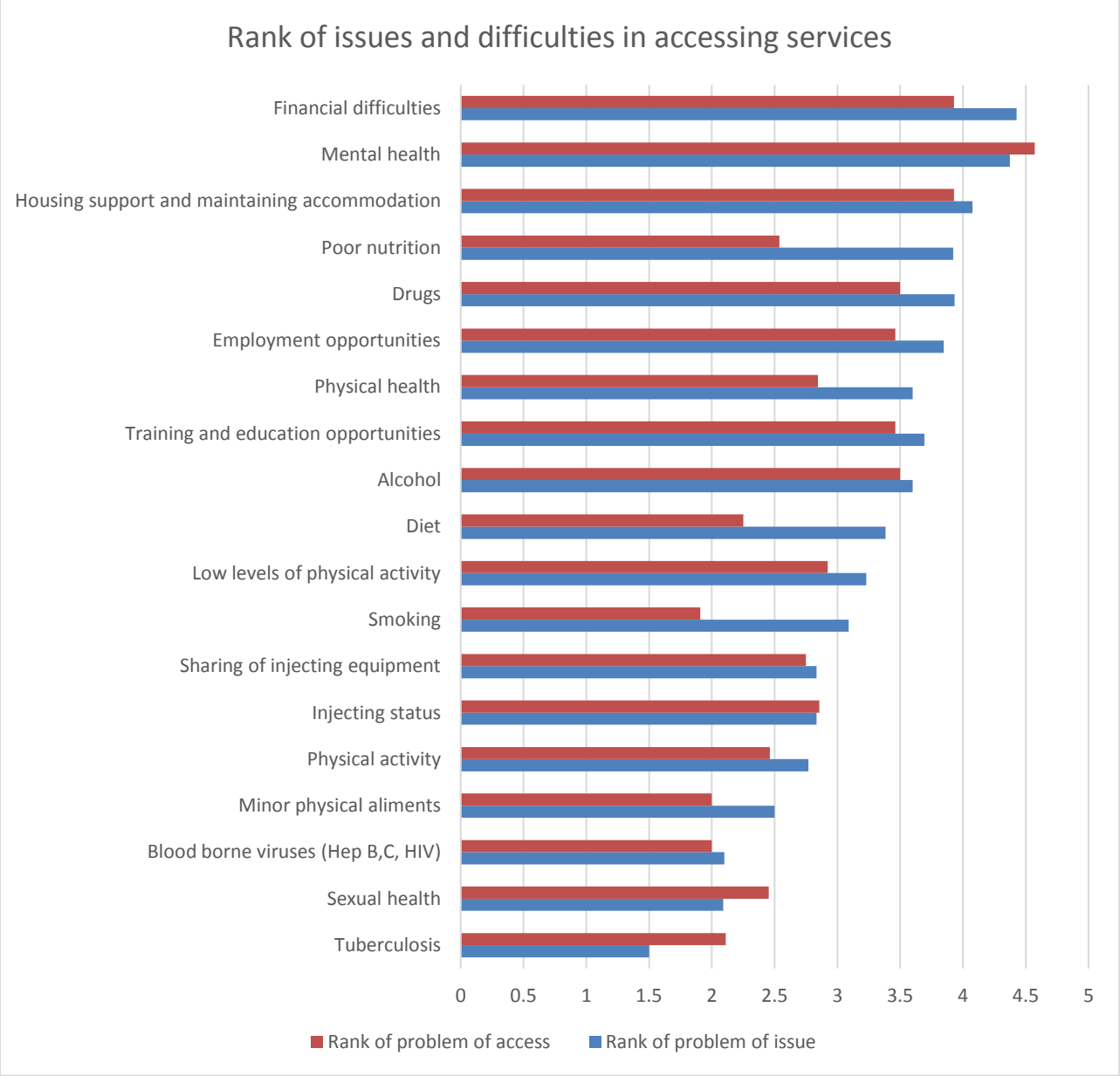


ix) **Stakeholders were asked to rate on a scale of 1-5, (with 1 being the least health/ social problem and 5 being the greatest health/ social problem) their perception of health / social problems for those clients who are homeless. Respondents were also asked to rate on the same scale the difficulties in referring clients to health and social care type services. Chart XXX shows the averages of those responding.**

With regard to the perception of health/ social problems and difficulties of access, the following were ranked as an average of 3 or higher as either an issue or difficulties in accessing services.

Issue	Ranking of issue	Ranking of difficulties in accessing services
Financial difficulties	4.43	3.93
Mental health	4.38	4.57
Housing support and maintaining accommodation	4.08	3.93
Poor nutrition	3.92	2.54
Drugs	3.93	3.50
Employment opportunities	3.85	3.46
Physical health	3.60	2.85
Training and education opportunities	3.69	3.46
Alcohol	3.60	3.50
Diet	3.38	2.25
Physical activity	3.23	2.92
Smoking	3.09	1.91

Issues around financial difficulties; mental health and housing support and maintaining accommodation were seen as the most significant issues and also the issues were it was perceived that services were most difficult to access. Notably, mental health services are seen as the most difficult to access for homeless clients. Of the 14 respondents to this question, 10 scored as 5 and a further three scored as 4.



x) Stakeholders were also asked whether there were any other key health or social issues that had not been listed. Two stakeholders responded to this question by responding:

Loneliness; family & friendship support; feeling a part of a community – belonging; getting back into 'mainstream' living; stigma; feeling isolated in society and no longer part of things that so many of us take for granted, family, friends, feeling safe, feeling valued, feeling loved, receiving unconditional support even when we make mistakes.

xi) Stakeholders were also asked whether there were any other key health or social access issues that had not been listed, stakeholders stated. Two stakeholders responded to this question by responding:

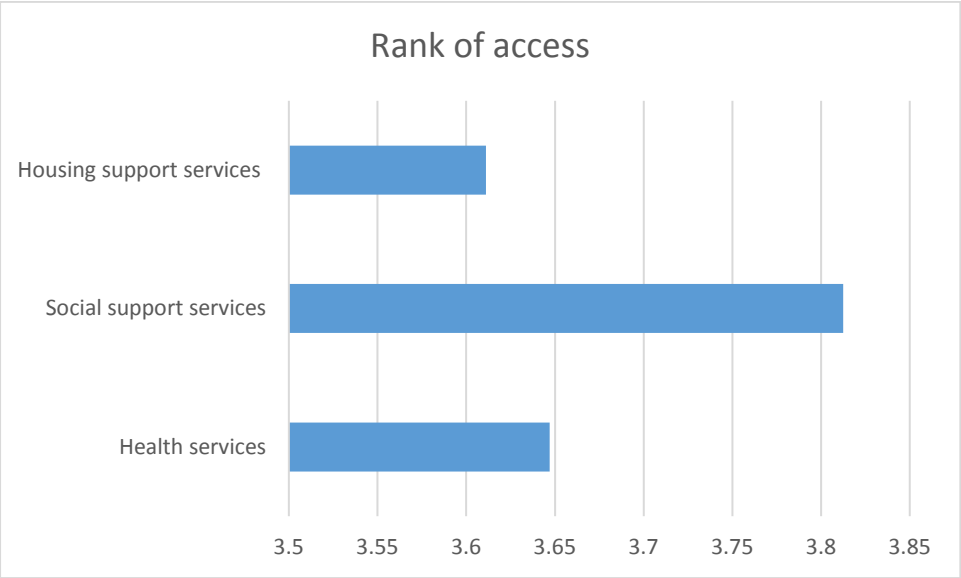
- I know working for a drug and alcohol team in a previous role a number of the caseload were homeless or no fixed abode. It is difficult to keep patient's engaged and willing to attend appointments and although they do receive incredible support from workers it is on

an individual basis for them to recognise their need to change to make things better for themselves which can take time.

- The reason I have scored all 5 is that if someone is homeless how do you send them an appointment, how do they travel to and from appointments, do they still have a NI number etc.

xii) Stakeholders were asked to rate on a scale of 1-5, (with 1 being the least health/ social problem and 5 being the greatest health/ social problem) their perception of health / social problems for those clients who are homeless.

Whilst housing support; social support and health services all gave an average score over 3.6, social support services were seen as the most difficult to access. Of the 16 responses relating to social support, 12 rated access difficulties as a 4 or 5.



xiii) **Stakeholders were asked what, in their opinion, are the reasons for the difficulties for homeless people to access health, social and other support services**

Recurrent responses included:

- Lack of ID to join GP practices, especially street homeless and young people. No address. Bar is set to high for social care and does not take into account how difficult it can be to engage when you are homeless without basic facilities.
- Homeless people are negatively stereotyped
- Referrals can be delayed
- There is a lack of information as to what support may be available
- In our experience they find if difficult to have a routine which means attending pre arranged appointments is unlikely in most cases without reminders. We have to capture people when they are with us or give them the tools to allow communication such as giving them a cheap phone, we have tried this and it has led to better communication.
- Own pride, possibly needing an advocate to help with the situation, fear of the unexpected, not wanting to be helped, fear of being judged
- The one number. This is truly the most awful decision ever made by the council and has led to the deterioration of health of Nottinghamshire residents. Failure to access service. Quadrupled council work time due to failure for an enquiry to be dealt with first time by the

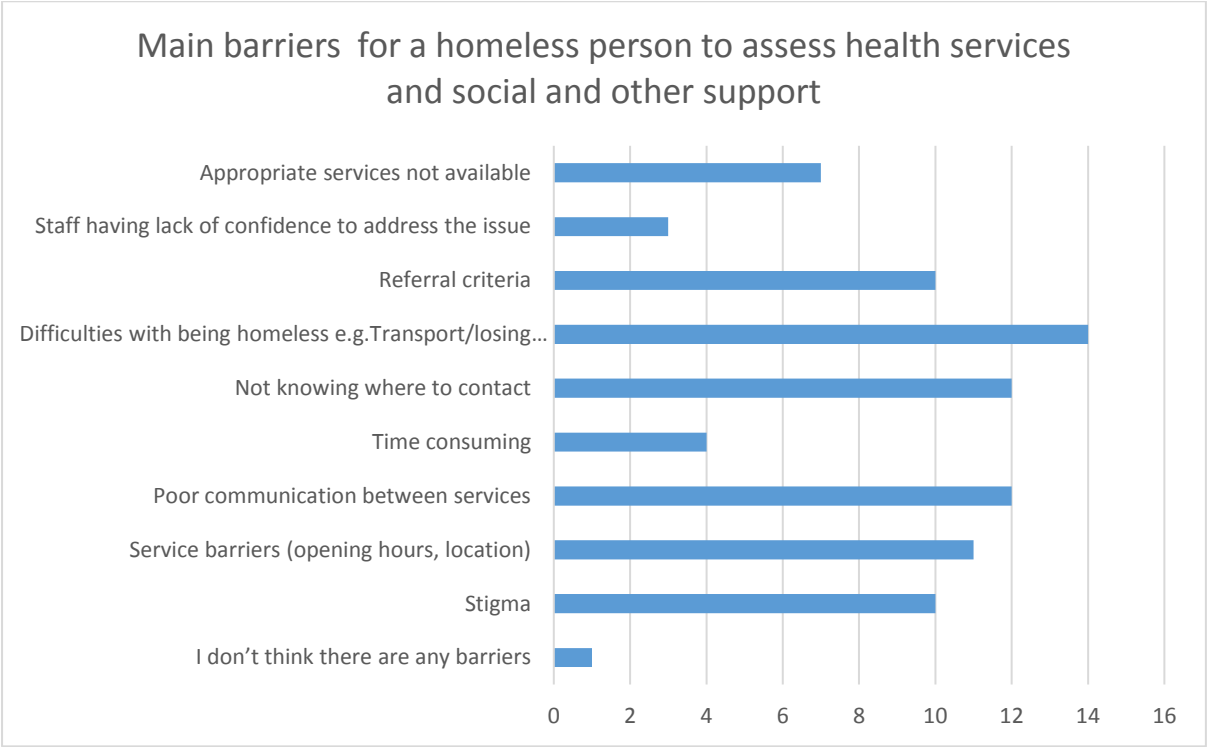
right member of the team. This antiquated and most expensive method of dealing with the public is appalling. Speak to professor John Seddon or read one of his books on the call centre chaos.

- Chaotic lifestyles, transport, high thresholds, lack of services, waiting lists, contact (no phone), postcode lottery
- I do not think they are always aware of what support they can get and where from. Some are difficult to engage with and don't easily accept or look for help.
- It depends where they are in Bassetlaw, as previously mentioned I think Worksop may have more opportunities for homeless people to go to than Retford, maybe because the population needs there are different. They may also not be aware of how or who to contact. Transport is a major issue.
- The reason I have scored all 5 is that if someone is homeless how do you send them an appointment, how do they travel to and from appointments, do they still have a NI number etc. Perceptions of those working in these areas towards the homeless person.
- Officiousness of organisations
- They need support and need to feel comfortable, if unsupported the homeless client gets anxious and frustrated and often walks out. The processes need to be client friendly and more support given
- With the complex lives that rough sleepers have, they need someone to advocate for them to remind them of appointments and speak for them if they can't communicate.
- Thresholds and access arrangements to mental health and social care assessment and services are serving as barriers to homeless people. Long waits, location of appointments, referral protocols are problematic for those with insecure accommodation. Particular issues are present for those with multiple needs where services may determine that their presentation should primarily be seen as an issue for another agency

xiv) Stakeholders were asked what they felt were the main barriers for a homeless person to access health services and social and other support. Stakeholders could tick all that apply.

A total of 84 responses were included.

The main barriers were identified as difficulties with being homeless e.g. Transport/losing appointment times etc (14 responses); not knowing where to contact (12 responses) and poor communication between services (12 responses).



xv) Stakeholders were asked to state one thing that they would change to help address the needs of a homeless person

- To make homeless people feel valued
- safe and secure accommodation, temporary or social
- A service which is proactive in working with individuals who are at risk of homelessness and looking at prevention.
- That we break down the barriers of being able to approach homeless people bearing in mind one's own safety whilst doing so and how we may help.
- The one number
- Services attitudes - there are going to be missed appointments, being late, not being in the area, etc. Need to consider alternative waiting list and not put to bottom due to things outside their control
- More temporary accommodation and affordable accommodation. Better links with Private Rented sector
- Posters in town centres particularly around the cold weather time promoting shelters. Posters also advertising where help can be sought.
- Local communities awareness raising and action to support those homeless people in their areas in new ways.
- Secure Housing
- Join up services
- Don't just talk the talk, be genuine and sincere and make them feel valuable.
- More funding to third sector to allow more support at grass roots level
- More floating support to address the complex needs that rough sleepers have with access to bonds and rent in advance, housing first model.
- More Hostels that were equipped with the Counsellors, Talking Therapists and Staff Team that were equipped to meet the needs of those that use addictions to hide from Trauma and

- Services that are better co-ordinated and that communicate and work collaboratively towards sustained positive outcomes for the individual.

xvi) Stakeholders were asked if they had any further comments

- I believe that in order to assist homeless people you need to understand that they no longer think like we do on a daily basis, they say that it takes 6 weeks to mentally adapt to living rough and it takes longer to adapt back. We need to have a little bit more patience and understanding, all people make mistakes but if you are homeless or have chaotic needs the consequences always seem to be more severe
- support services work with accommodation providers
  when finding private rent, how can they find money to pay for admin fees to letting agents ??
- To treat a homeless person with respect, providing help where possible. Having the knowledge of how to help someone and refer them wherever they need to go to obtain help required
- A multi-agency preventative strategy would help however the voice of the homeless person should be at the centre.
- Building more houses is not the answer. Services need to join up to ensure communication is synced.
- We need funding aimed at local organisations
- School visits from those that have gone though recovery and know the pit falls of experimental drug taking.
- A range of services need to be in place that are welcoming and can intervene appropriately wherever the individual presents and at whatever stage their homelessness situation has reached - early and at risk or late and in immediate crisis.

Views of service users

Focus group methods

One to one service user interviews were undertaken by Susan March (Senior Public Health Commissioning Manager) and John Sheil (Public Health Commissioning Manager) at the Friary Homelessness Drop-In Centre on 17th December 2018. Additional views were considered through engagement undertaken by Homelessness Link work in development of the Under 35s Housing and Support Study and Mid Nottinghamshire Homelessness Strategy.

Three in-depth service user interviews were conducted and staff were also interviewed. The aim of the sessions were to gain a service user perspective on current homeless services and gaps in provision from the service user perspective. At the time of the interviews, all three of the service users were sleeping rough.

All service users were advised that the feedback from the interviews would be anonymous and that no identifiable information would be used.

Whilst a framework of questions was available and partially used, service users were given significant opportunity to discuss their experiences in a free-flowing manner.

Key messages

There were a number of key issues and barriers around homelessness expressed by the participants and also the staff at the Friary. In particular, the following issues were identified:

- Suggestion of a lack of support where residents are being bullied in shared accommodation or in private accommodation which can lead to homelessness

- Suggestion that housing providers evict residents too easily if there are issues, such as arrears; disruptive behaviour or substance misuse
- In discussing their backgrounds, all participants spoke of significant issues regarding both mental and physical ill health
- One interviewee spoke of the importance of dogs to homeless people, that they are an important companion to people who may lack other friendships. One participant advised that he would not give up his dog even if that meant continuing to sleep on the streets. It was felt important that opportunities to maximise provision of support to enable homelessness people to remain with their dogs are maximised
- There was a suggestion from all participants that different services do not communicate well between themselves on support plans and do not fully consider input from the service user
- Participants expressed that caseworkers have limited time to support individuals due to large caseloads and that case workers need to work more closely with service users around how to appointments ie are letters always the best method?
- Suggestion that waiting lists to access support (in particular, mental health support) are too long
- Issue that if someone has no fixed abode, they may be disadvantaged in accessing services ie free bus passes.
- There was a suggestion that there was a lack of provision for people with complex needs
- Participants expressed frustration with delays they had experienced in accessing benefits

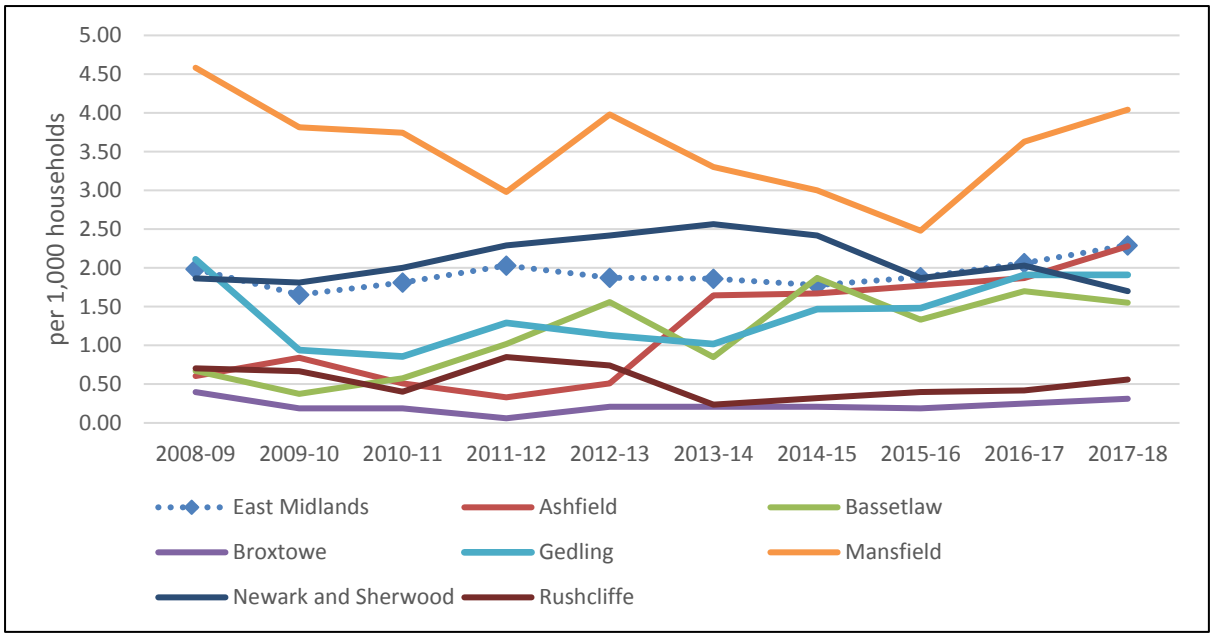
Appendix

Further information to accompany section 2. Size of the issue locally

Nottinghamshire Risk of Homeless Presentations

Nottinghamshire (All Districts) Homeless Eligibility
Figure i below shows the rate per 1,000 households accepted as homeless in priority need by Nottinghamshire districts, with Mansfield District since 2008/09 to 2017/18 consistently having the highest rate of household accepted as homeless in priority need followed by Newark and Sherwood and Ashfield districts.

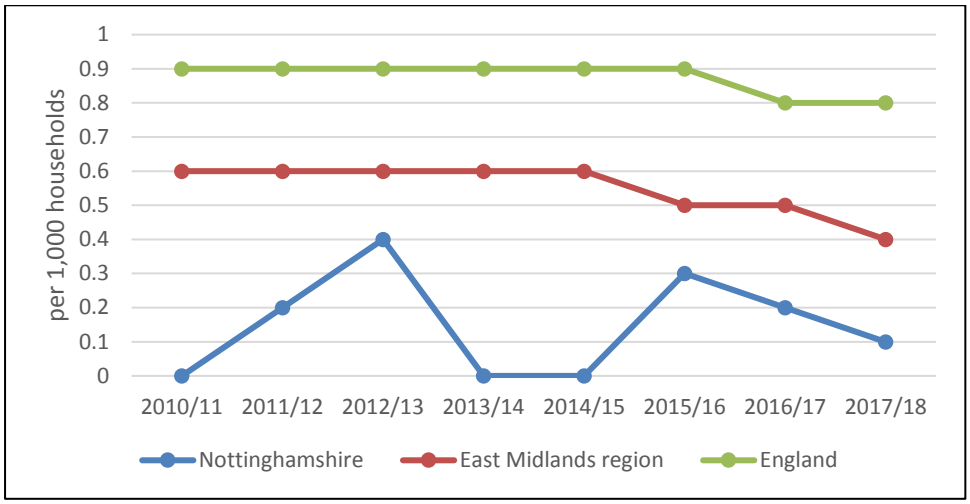
Figure i: Nottinghamshire by districts accepted as being homeless in priority need, compared with East Midlands, standardised rate per 1,000 households from 2008/09 to 2017/18



Source: P1E data

<u>Nottinghamshire Statutory Homelessness – eligible homeless not in priority need</u>
The Public Health Outcomes Framework (PHOF) Statutory Homeless indicator 1.15i demonstrates the number of household that have presented to local authorities but have been deemed not to be in priority need. As shown in figure ii below, in 2011/12 the Nottinghamshire rate per 1,000 household was highest at 0.4 per 1,000 households. There has been a decrease in the rate per 1,000 household in Nottinghamshire for eligible homeless not in priority need to 0.1 per 1,000 households in 2017/18. This equates to 145 households in 2011/12 to 45 households in 2017/18. In 2010/11, 2013/14 or 2014/15 the rate was zero, this could be due to missing data. Consistently, Nottinghamshire is lower than England and the East Midlands region.

Figure ii: 1.15i – Nottinghamshire rate per 1,000 household compared to England - Statutory Homelessness – eligible homeless not in priority need – 2010/11 to 2017/18

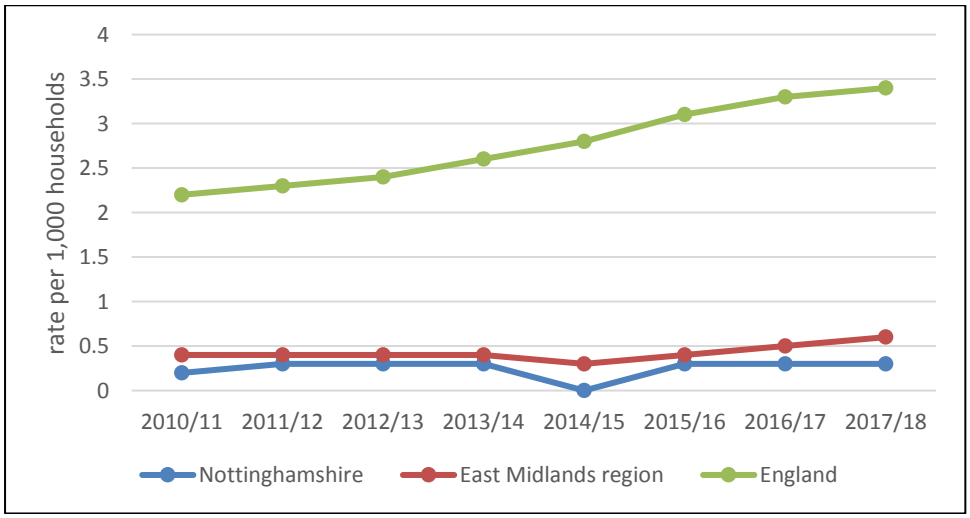


Source: Ministry of Housing, Communities & Local Government

Nottinghamshire Statutory homelessness - households in temporary accommodation

Figure iii below indicates for Nottinghamshire the rate per 1,000 households in temporary accommodation has remained relatively unchanged at 0.2 per 1,000 households in 2010/11 to 0.3 per 1,000 households in 2017/18. This equates to 80 households in 2010/11 to 110 household in 2017/18. Once again Nottinghamshire is consistently lower when compared to England and the East Midlands region.

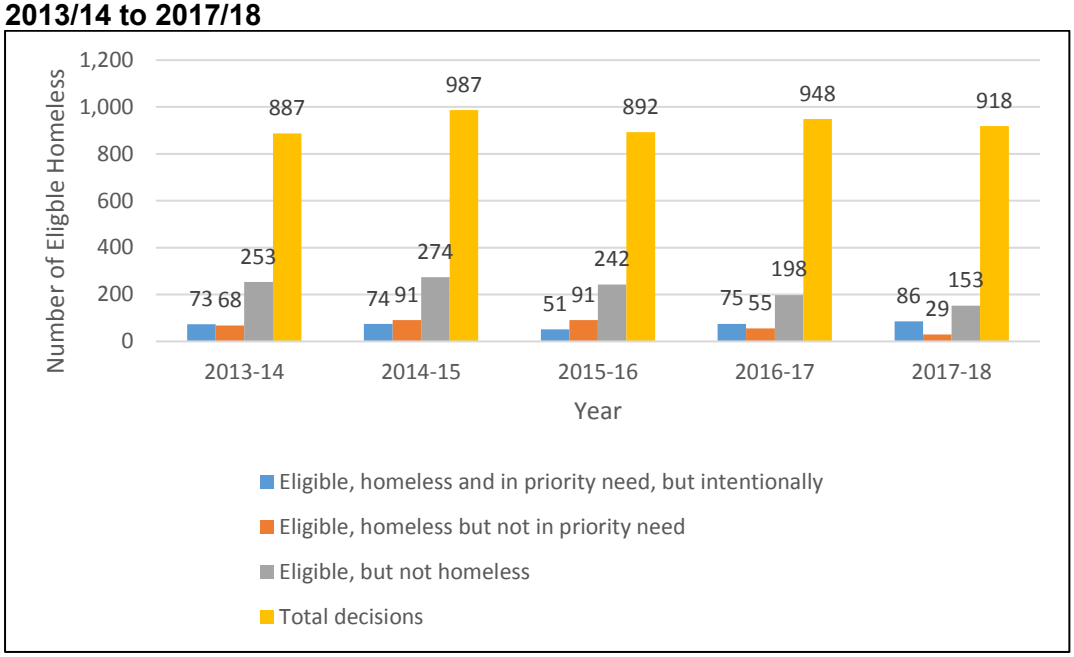
Figure iii: 1.5ii – Nottinghamshire rate per 1,000 household compared to England- Statutory Homelessness – households in temporary accommodation 2010/11 to 2017/18



Source: Ministry of Housing, Communities & Local Government

During 2017/18, there were a total of 918 homelessness decisions across all Nottinghamshire district and borough councils. Of these, 650 were accepted as being homeless and in priority need whilst the remaining were eligible but not homeless (153); Eligible, homeless but not in priority need (29) or Eligible, homeless and in priority need, but intentionally (86) Since 2008/09, this figure has stayed generally stable, as shown below in Figure iv.

Figure iv: Number of eligible homelessness decisions– Nottinghamshire County – 2013/14 to 2017/18



Source: P1E data

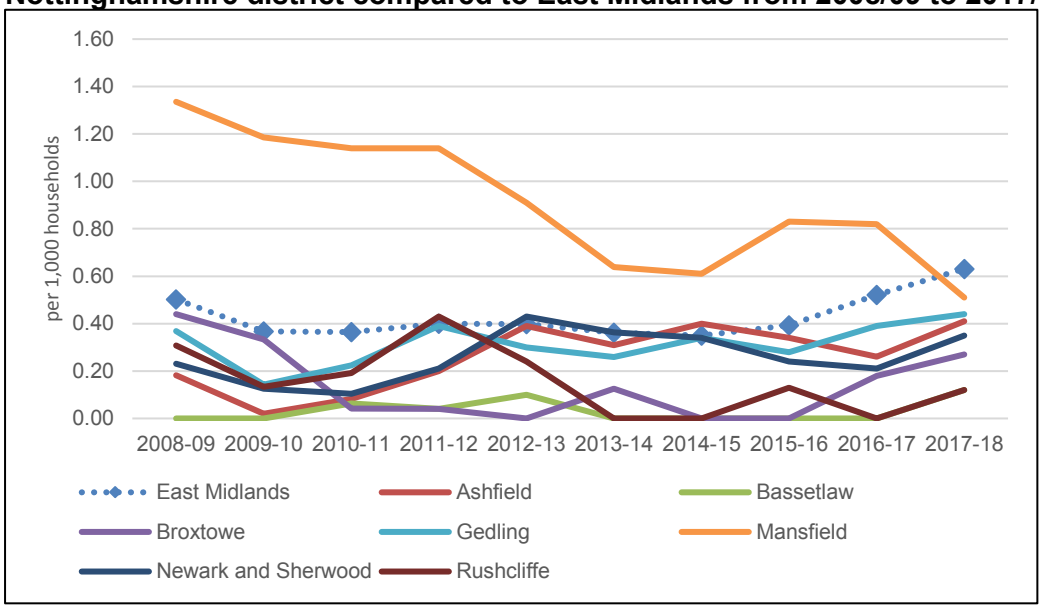
A further breakdown by district is shown Appendix 1 highlighting the total decisions made from 2013/14 to 2017/18. The two areas with the highest number who are intentionally homeless and in priority need are Mansfield and Newark & Sherwood Districts. With lowest number in Rushcliffe and Gedling Districts. In 2017/18 shows a wide variation between districts, with the highest number of decisions made in Mansfield District (269) compared to the lowest in Rushcliffe District (36).

Temporary Accommodation

Temporary accommodation includes Bed and Breakfast (B&B) accommodation; hostels; use of Local Authority and Housing Association accommodation on a temporary basis; private sector leased accommodation as well as other types including through the private rented sector. Local Authorities are required by government to ensure that families in B&B accommodation are for no more than six weeks[90].

Figure v shows the rate per 1,000 households in temporary accommodation for each Nottinghamshire District from 2008/09 to 2017/18. Mansfield District has shown a steady decline with the remaining Districts have remained unchanged. In 2017/18, all Nottinghamshire Districts rate per 1,000 household in temporary accommodation was slightly lower than the East Midlands rate of 0.63 per 1,000 household.

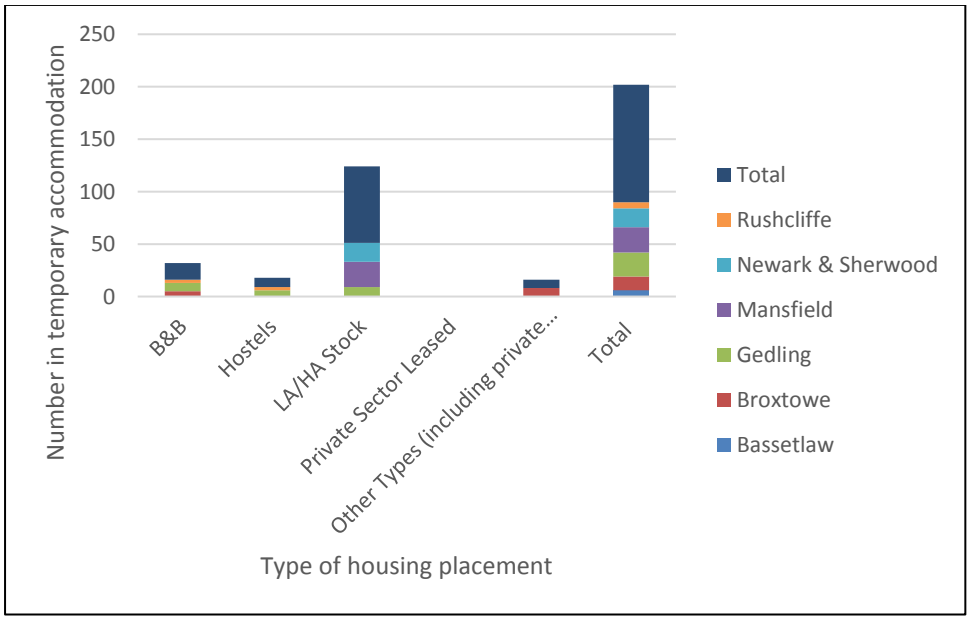
Figure v: Rate per 1,000 household in temporary accommodation by each Nottinghamshire district compared to East Midlands from 2008/09 to 2017/18



Source: P1E data

With regard to Government returns, data is based on a snapshot of people in temporary accommodation at the end of each quarter and could potentially lead to under-representing the numbers in temporary accommodation. The numbers placed into temporary accommodation for each Nottinghamshire District are shown in figure vi below. In 2017/18 Local Authority and Housing Association – Housing stock has the highest rate of temporary accommodations usage (73) with Mansfield District having the highest usage (24).

Figure vi: Number and type of temporary accommodation placement for all Nottinghamshire Districts in 2017/18



Source: P1E data

Bed and breakfast

Bed and Breakfast (B&B) accommodation is used by District and Borough Councils where there are limited other options as it is recognised that B& B is the least suitable form of accommodation for most households and should be used as a last resort[91]. District and Borough Councils recognise the negative impacts of the use of B&B accommodation and therefore seek to minimise usage.

As shown in Table A below, in 2017/18, across all Nottinghamshire Districts there were 191 B&B accommodation used with the highest proportion, 63% allocated to single people. Gedling followed by Broxtowe had the highest usage of B&B accommodation, 63 and 52, respectively with Newark and Sherwood had no B&B accommodation usage. A total of £219,680 was spent on B&B accommodation across Nottinghamshire.

Table A: Bed and Breakfast Accommodation allocation and spend by each Nottinghamshire District in 2017/18

District/ Borough	Total Number of B&B placements	Cost
	Number	£
Gedling	63 (31 to single people)	82,000
Rushcliffe	23 (17 to single people)	68,500
Bassetlaw	36 (20 to single people)	38,400
Broxtowe	52 (42 to single people)	23,380
Ashfield	17 (10 to single people)	7,400
Newark and Sherwood	0	0
Mansfield	0	0
TOTAL	**191 (of which 120 to single people)**	**£219,680**

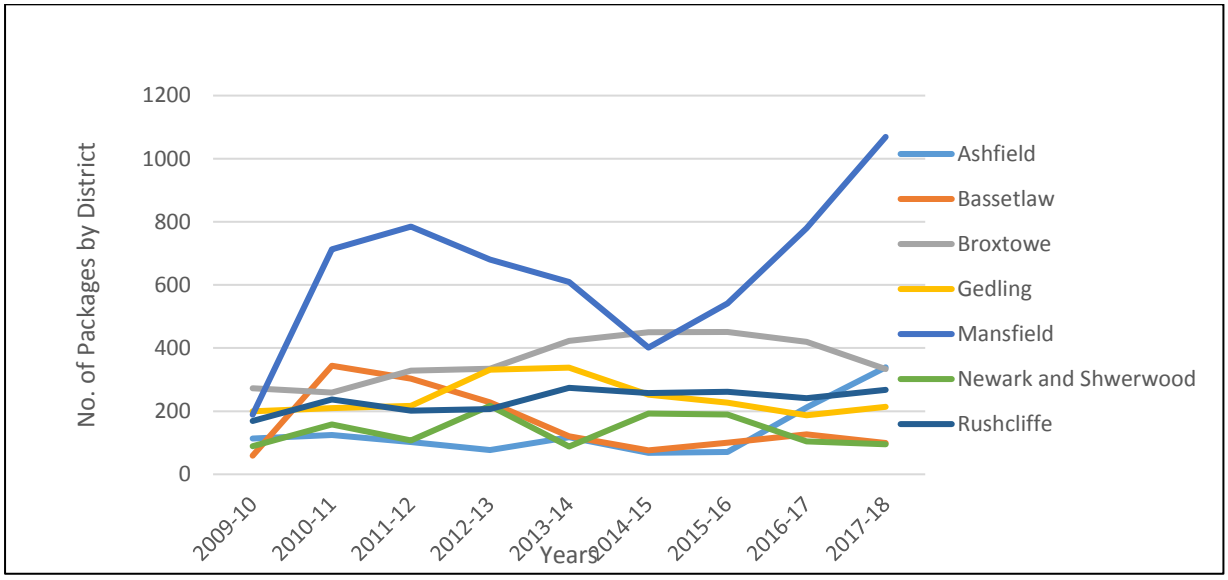
Source: P1E data

Homelessness Relief Packages

Homeless relief packages are offered by local housing authority at the point when homelessness prevention is not possible and the person/family are at certain risk of becoming homeless. A relief 'package' includes measures such as finding alternative accommodation; paying a deposit to secure alternative accommodation or acting as guarantor. It should noted that there where changes as highlighted in 1.2 section of this JSNA that the HRA (2017) has changed the way relief packages are applied.

Figure vii shows that across all Nottinghamshire Districts, Mansfield consistently have offered the highest number of Homeless Prevention Relief Packages from 2009/10 to 2017/18. This could be due to the number of presentations for homelessness prevention support but also due to Mansfield District having well-resourced homelessness prevention support packages and/or a different homeless relief criteria.

Figure vii: Number of Homelessness Prevention Relief Packages by District, from 2009 to 2018



Source: P1E data

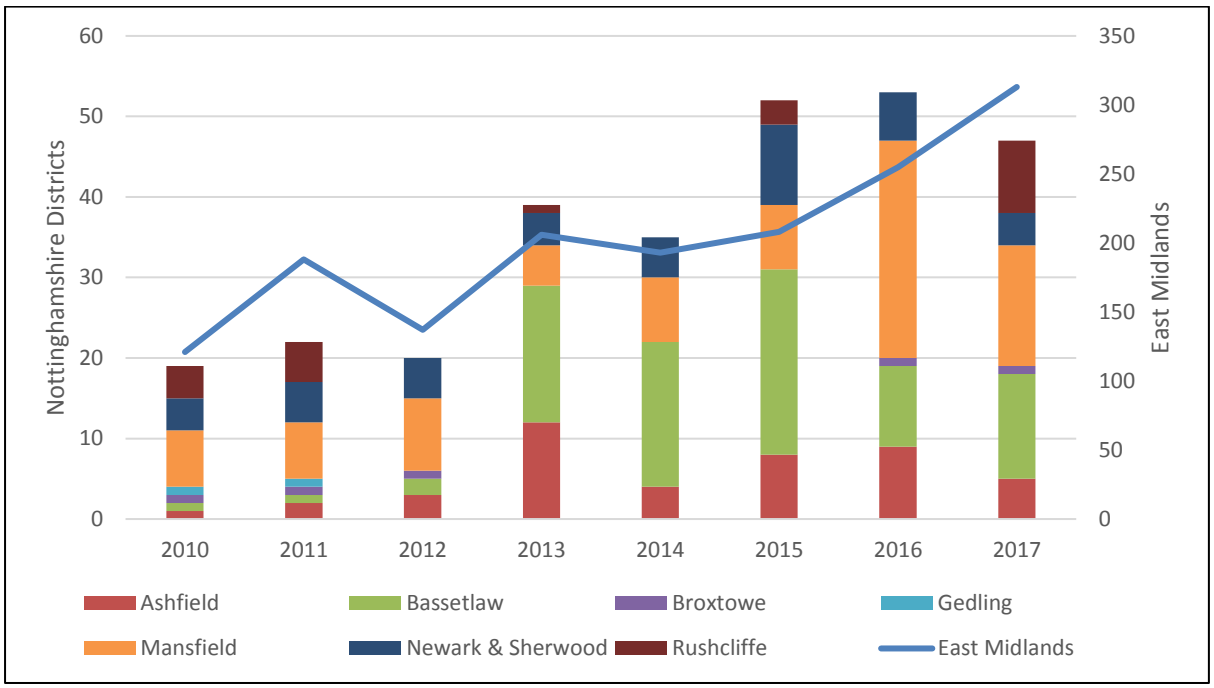
Rough Sleepers

Rough sleeping is normally considered to be the most extreme and visible form of homelessness. The impacts of rough sleeping on mental and physical health are very significant and wide ranging, as outlined in Section 3.

Formal rough sleeper counts take place annually on one night of each year between 1st October and 30th November. This is to provide an estimate to be submitted to Government of the number of rough sleepers in an area. There are a number of caveats to this including that it is generally seen that the count under-estimates the number of rough sleepers in an area due to the extent of ability to search for rough sleepers and also that the count is only over one night. However, it does provide a useful basis for measuring trends in rough sleeping and areas of high prevalence.

Figure viii below shows the number of rough sleepers by each Nottinghamshire District from 2010 to 2017. In line with East Midlands trend, since 2010 there was a steady rise in the number of rough sleepers across all Nottinghamshire Districts with Bassetlaw and Mansfield have the highest number. In 2017, the number of rough sleepers declined slightly across all districts with a total of 47 people rough sleeping with Mansfield and Bassetlaw Districts remaining the highest for the number of people rough sleeping, 25 and 13, respectively.

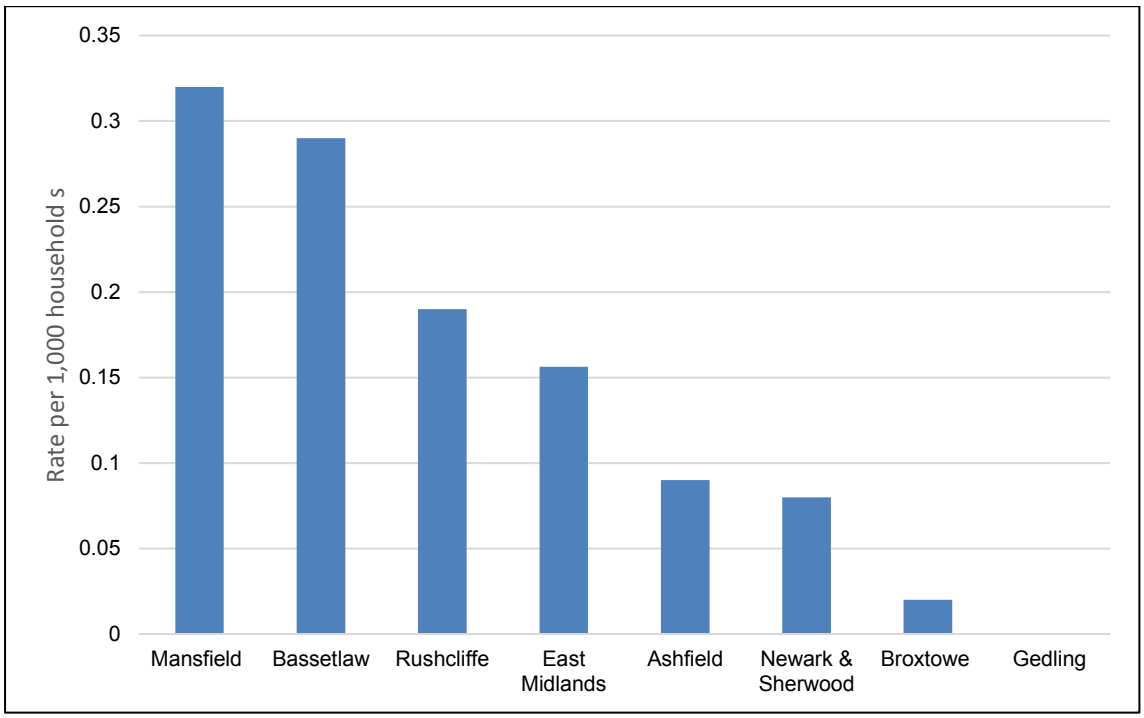
Figure viii: Number of Rough Sleepers by each Nottinghamshire District from 2010 to 2017



Source: Ministry of Housing, Communities & Local Government

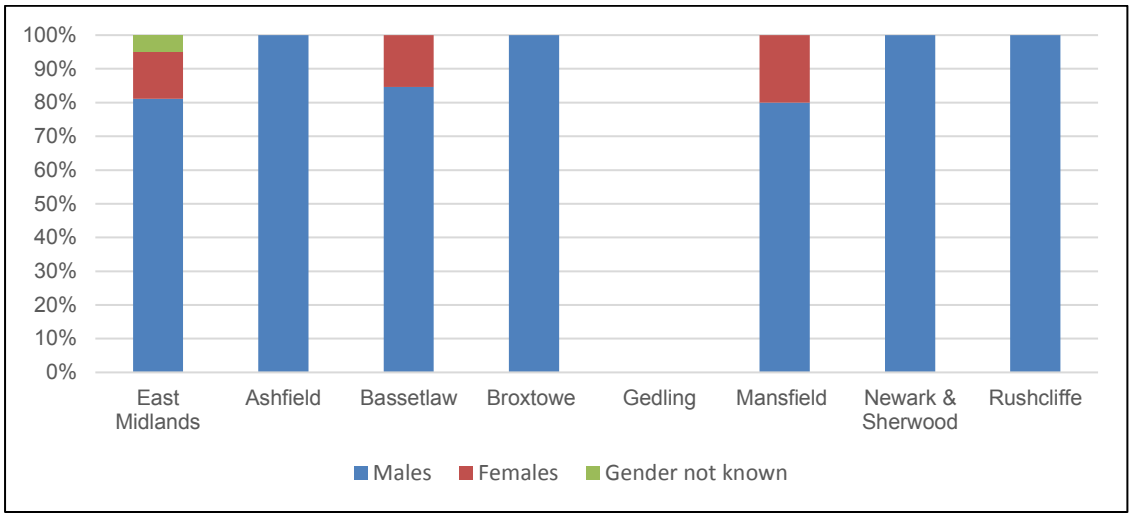
Figure ix, shows the rate per 1,000 household of rough sleepers for each Nottinghamshire District. In 2017, Mansfield, Bassetlaw and Rushcliffe were higher than the East Midlands rate of 0.15 per 1,000 household. As shown in figure X, the proportion of males rough sleeping was significantly higher compared to females, 84% and 16%, respectively.

Figure ix: Rate per 1,000 household of rough sleepers by each Nottinghamshire District compared to the East Midlands Region in 2017



Source: Ministry of Housing, Communities & Local Government

Figure X: Gender of Rough Sleepers by each Nottinghamshire District in 2017



Source: Ministry of Housing, Communities & Local Government

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