Committee(s): Health and Wellbeing Board – For comment	**Dated:** 24 November 2023
Subject: Introduction to CoL Homeless Health Work	**Public**
Which outcomes in the City Corporation's Corporate Plan does this proposal aim to impact directly?	1, 2, 3, 4, 9, 10
Does this proposal require extra revenue and/or capital spending?	**N**
If so, how much?	**N/A**
What is the source of Funding?	**N/A**
Has this Funding Source been agreed with the Chamberlain's Department?	**N/A**
Report of: Judith Finlay, Executive Director of Community and Children's Services	**For Information**
Report author: Nana Choak, DCCS	

Summary

The report provides Members with an introduction to the Homelessness Health Workplan, a summary of progress to date, and a brief mention of upcoming actions.

The City of London homelessness health workplan has been developed to coordinate short- and medium-term interventions to address health inequalities for people experiencing homelessness in the Square Mile and increase the stakeholders' understanding of the geographical specificity of the City in the context of health disparities. These interventions are laid out in the workplan summary page (appendix 1). The priorities and activity areas are designed to meet the specific local context and National Institute for Health and Care Excellence (NICE) guidelines on tackling health inequalities. The workplan focuses on developing specialist primary care provision, broadening our partnership work, embedding lived experience in service design and delivery.

Recommendation(s)

Members are asked to:

- Note the report.

Main Report

Background

1. In November 2022, the City of London created a new post to focus our work on the health inequalities experienced by rough sleepers and those in

immediate housing crisis. The Homeless Health Coordinator role is only funded until 31 March 2025 by the Department for Levelling Up, Housing and Communities (DLUHC) Rough Sleeping Initiative (RSI) grant funding.

2. The Homeless Health Workplan links directly to the Homelessness and Rough Sleeping Strategy 2023-27 through the Service Development plans; it reports regularly at the Rough Sleeping Strategic Group and twice yearly at the Homeless and Rough Sleeping Subcommittee.

3. The Homelessness Health Coordinator does not work at a service delivery level, it is a system approach to coordinating and integrating healthcare into all homelessness services in the Square Mile, statutory and commissioned.

4. We work on behalf of vulnerable, socially and healthcare excluded people.

5. Mental Health is the most prevalent support need, 10% higher than the London average. Those with multiple support needs from alcohol, drugs and mental health represent 51% of all rough sleepers – which is the same figure as 2021/22 and is 16% higher than the London average.

6. The physical health needs of people experiencing homelessness are shown in the Homeless Health Needs Audit*, developed by Homeless Link and administered by homelessness service providers to people living in supported accommodation, emergency accommodation, and rough sleeping, with 522 usable responses.

    - 63% of respondents reported that they had a long-term illness, disability or infirmity, compared to 22% within the general population.
    - 78% (408) of respondents reported having a physical health condition.
    - 80% of those with a physical health problem have more than one such condition, with 29% having between 5-10 diagnoses.

7. The mean age of death for people experiencing homelessness across UK, in 2021 (the most recent data) was 45.4 for men and 43.2 for women. For the same year, the highest rate of deaths in homeless client group was seen amongst men between 45 and 49 years old. In women, 40 – 44 age group had the highest number of deaths.

8. A study** conducted in 2020 in a supported hostel in London, found high prevalence of frailty and geriatric conditions, similar to the levels found in care homes for older people, where frailty scores for participants with an average age of 56 were comparable to those of 89-year-olds in general population.

9. Frailty is defined by weakness, slow walking, weight loss (unintentional), fatigue, low physical activity; geriatric conditions include cognitive impairment, urinary incontinence, falls, risk of fractures, hypotension, visual impairment, low grip strength, mobility impairment, etc.

*Unhealthy state of homelessness 2022, Unhealthy State of Homelessness 2022: Findings from the Homeless Health Needs Audit | Homeless Link

** Rogans-Watson, R., Shulman, C., Lewer, D., Armstrong, M. and Hudson, B. (2020), "Premature frailty, geriatric conditions and multimorbidity among people experiencing homelessness: a cross-sectional observational study in a London hostel", *Housing, Care and Support*, Vol. 23 No. 3/4, pp. 77-91. https://doi.org/10.1108/HCS-05-2020-0007

Current Position

10. This report is structured thematically, addressing work currently ongoing and future actions.

11. Since 15th February 2023 a mobile primary care clinic has been deployed in the Square Mile to address some of the health inequalities people experiencing homelessness are facing; the deployment is coordinated by City of London and jointly delivered by NHS East London Foundation Trust (ELFT) via Greenhouse surgery, Turning Point (substance misuse), and City and Hackney Public Health via the Community Wellbeing Team, with the invaluable support of Thames Reach outreach workers and Groundswell peer workers.

12. The flu and Covid-19 vaccination programme has been jointly planned in an effective and timely way by City of London and City and Hackney Public Health, and this year it includes a walk-in vaccination opportunity from a local pharmacy and an outreach component for increased accessibility and uptake.

13. As part of the London-wide women's census, City of London have planned and coordinated an additional wellbeing event, specifically aimed at women experiencing homelessness, known or unknown to services in the City. The Homelessness Health Coordinator supported the action with coordinating the delivery of health and wellness services, including a hairdresser, massage therapist, GP, nurse practitioner, and services for women involved in prostitution.

14. To capture the real impact of homelessness on individuals and to inform any future interventions, we have reviewed the Common Assessment Tool (CAT) to include the individuals' self-assessed/reported health and wellbeing (using quality of life as an indicator) and the emerging evidence of early onset frailty.

15. This tool is compliant with housing legislation, and it is used by all homelessness statutory and commissioned services in City.

16. One of the swift and practical approaches to address health inequalities involved setting up a clinical in-reach service in Grage Rd hostel; the service is run by a specialist inclusion health nurse, and it is delivering onsite health consultations, vaccinations, and referrals to secondary services for further support.

17. We have conducted a survey, aimed at stakeholders in the City of London's homelessness and rough sleeping partnership, to better inform our collaboration and further possible health-focussed interventions. Responses showed that our stakeholders are aware of the work that CoL is undertaking around homelessness health, and they feel included in discussion and the

decision-making process. Additional suggestions support the provision of a drop in hub that is accessible and local to people experiencing homelessness in the Square Mile, as well as peer led outreach provision.

18. We are embedding coproduction in the health work and to this effect we have set health specific performance indicators for the newly commissioned coproduction service. Furthermore, we conducted a service users' survey, with questions coproduced with residents from one of the City's supported hostels, with the main objective of amplifying the voice of the experts by experience.

Next steps

- Design and deliver clinical in-reach into the Rough Sleeping Assessment Centre and coordinate stakeholders to provide wrap-around wellbeing opportunities.
- Integration of adult social care and homelessness health work to better serve people facing multiple and complex needs.
- Build on existing training and learning opportunities for frontline staff to increase knowledge and skills in inclusion health.
- Evaluate efficacy of existing primary health care provision for people experiencing homelessness and explore alternative models of practice.
- Develop a business case to pilot new specialist primary care provision based in the Square Mile.

Options

19. There are no options arising from this paper

Proposals

20. There are no proposals arising from this paper

Key Data

None

Corporate & Strategic Implications

Strategic implications – none

Financial implications - none

Resource implications - none

Legal implications - none

Risk implications - none

Equalities implications – none

Climate implications - none

Security implications - none

Conclusion

21. In conclusion, the primary aim of the Homeless Health Coordinator and the Homeless Health Workplan is *'to permanently eliminate health inequalities for rough sleepers and other groups vulnerable to homelessness.'*

22. The interventions listed above and the priorities catalogued in the work plan (appendix 1) are set to increase the focus on homelessness health, support more accurate data collection, so that we are building a more realistic picture of the health and wellbeing needs of the people as they experience them, as well as collating and using evidence to inform further interventions.

23. Progress has been made on:

    - the delivery of the mobile delivery of health care.
    - on the vaccination programme, delivered both ad hoc as well as a targeted outreach model.
    - embedding coproduction in the design and delivery of health work
    - supporting the gender informed work the homelessness services are undertaking by delivering a women specific health and wellbeing hub
    - actively involving relevant stakeholders in homelessness health work.

24. Other interventions are needed to effectively address health disparities for people experiencing homelessness and the first priority is piloting a localised specialist service.

Appendices

- Appendix 1 – Homelessness Health Work Plan Summary Page

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