Committee(s): Homelessness and Rough Sleeping Subcommittee	**Dated:** 03/07/2023
Subject: Homeless Health Work Plan Update Report	**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**
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Summary

The report provides Members with an introduction to the new Homelessness Health Workplan and a summary of some notable progress to date.

The City of London, through the new workplan, has developed and is coordinating short and medium-term interventions to address health inequalities for people experiencing homelessness in the Square Mile. These interventions are laid out in the workplan (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

Members are asked to:

- Note the 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 is funded by the Department for Levelling Up, Housing and Communities (DLUHC) Rough Sleeping Initiative (RSI) grant funding. The post is funded to 31 March 2025.

2. The Homeless Health Work Plan will link directly to the Homelessness and Rough Sleeping Strategy 2023-27 Action Plan.

3. The health needs of people experiencing homelessness are shown in the Homeless Health Needs Audit. The survey was developed by Homeless Link and administered by homelessness service providers to people experiencing homelessness, 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.

4. Research study Groundswell have coproduced and conducted in 2018, with people experiencing homelessness, also shows that physical pain is widespread with 47% of the respondents experiencing pain on a daily basis; 53% reported experiencing chronic pain (10 years or more).

5. 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.

Current Position

6. The report is set out by priority area, with an example of early progress for each. A fuller explanation of the workplan, priorities and activity areas can be found at appendix 1.

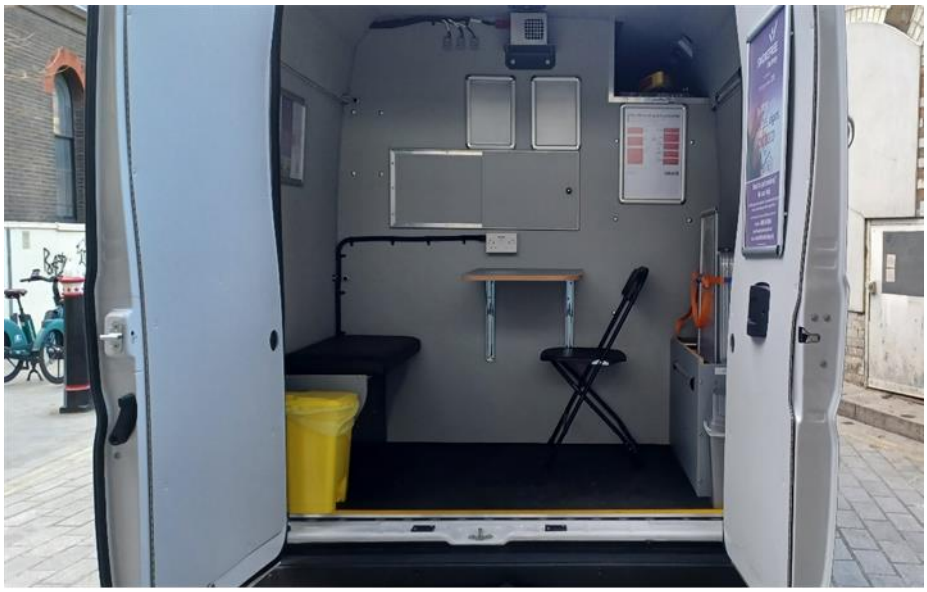
7. Members will receive an updated summary on progress on a twice-yearly basis and through reports dedicated to more substantial initiatives and outcomes as they arise.

PRIORITY 1. DEVELOPING THE PRIMARY CARE PROVISION

MOBILE PRIMARY CARE CLINIC

8. Vehicle based clinical model jointly coordinated by the City of London Homelessness Health coordinator and the Operations Support Manager at City and Hackney Public Health.

9. The clinic was first deployed in the City of London on 15th February 2023 and is scheduled weekly on Wednesday mornings. The clinic is supported by the Thames Reach outreach team and clinical staff from the East London Foundation Trust (ELFT) – a nurse prescriber or GP and a healthcare assistant.



10. The chosen location is accessible, offering a good level of privacy for attendees.

11. Since the first deployment, outreach workers made over 230 contact attempts with rough sleepers and provided 44 health specific offers. 14 clients accompanied by the outreach worker have attended the clinic, 23 have declined, and 7 attended unaccompanied at a later time.

12. Next steps include increasing the clinical outreach element of the provision (clinician on foot/bike to engage with clients at sleep site) and embedding lived experience in the health-focussed engagement work.

CLINICAL IN-REACH TO GRANGE RD HOSTEL

13. A practical approach to addressing health inequalities for people experiencing homelessness, through maximising opportunities for engagement with health offers (consistently available, easily accessible, and local) and through care coordination. An inclusion health specialist registered nurse weekly runs the clinics.

14. The intervention available include:
    - Onsite general health assessments
    - Onsite drop-in or booked consultations with a nurse.
    - Onsite screening for blood born viruses and infections.
    - Onsite vaccinations
    - Referrals to services for further support - substance misuse, mental health, dental clinics, pharmacies, opticians, urgent care centres or A&E
    - Additional referrals to employment and training can be made, thus adding social value to the project.

PRIORITY 2. IMPROVED COLLABORATION

HOSPITAL DISCHARGE

15. Through collaboration with key stakeholders at the Homerton Hospital NHS Trust, we have developed guidelines for frontline workers, aligned with the NHS processes and targets for reducing length of stays in hospital.

16. The next step is to embed it into the toolkit for frontline staff which is currently under development.

STAKEHOLDER NEEDS SURVEY

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.

MAXIMISE COLLABORATION AND KNOWLEDGE SHARING

18. The Homelessness Health Coordinator, with clinical input from an inclusion health specialist GP at Homerton hospital, designed and co-delivered a health specific training to outreach workers, aiming at providing them with more knowledge and

practical tools to support client engagement around health and wellbeing and improve the assessment and recording of needs for people experiencing homelessness in the City of London.

19. With the increased need to support people experiencing homelessness during periods of extreme heat, we have devised an assessment matrix which quantifies health related risk factors in order to support the frontline workers to prioritise their targeted shifts.

PRIORITY 3. USE OF DATA AND INFORMATION

BUILDING ON CURRENT OUTREACH RECORDING OF HEALTH NEEDS PRACTICE

20. We have reviewed the Common Assessment Tool (CAT), which is used by our commissioned services and is compliant with housing legislation, to include clients' self-assessment of their health and wellbeing.

21. The revised CAT will capture realistic and accurate data on frailty and quality of life as experienced by clients as well as being specific to the local needs and/or service gaps.

22. The assessment tool has the added benefit of acting as a tracker of health and wellbeing throughout the client's engagement with City commissioned support services. This will help generate clearer longitudinal data to inform our commissioning and partnership work.

EMBEDDING HEALTH IN COL'S COPRODUCTION WORK

23. Health has been built in the commissioning work around coproduction, with the expectation that, once commissioned, the service will lead on the design of a peer-led outreach service to deliver health-focussed client engagement and support.

PRIORITY 5. BETTER ACCESS

BUILDING PARTNERSHIP WITH SERVICES TO DELIVER WRAP-AROUND SUPPORT

24. In addition to the primary care delivery, the clinical van is now supported by:
    - Positive East, who are providing rapid testing for HIV and other sexually transmitted infections, as well as general advice around sexual health and referrals to sexual and reproductive health clinics for further support and
    - Turning Point, substance misuse service, who can deliver onsite assessments and rapid prescribing in some cases.

25. Developing a dental care referral pathway to community clinics (specialist in meeting specific needs otherwise not met by high street dentists) and expanding on practical support (i.e., delivery of hygiene packs and advice adjusted to circumstances)

26. Next steps - women's health provision (prioritising screening for cervical cancer) with the support of City and Hackney Public Health and Greenhouse surgery.

Corporate & Strategic Implications

Financial implications – none

Resource implications – none

Legal implications – none

Risk implications – none

Equalities implications – none

Climate implications – none

Security implications - none

Conclusion

27. The overarching 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.'*

28. The Homeless Health Workplan will link directly to the Homelessness and Rough Sleeping Strategy 2023-27 Action Plan

29. The priorities referenced above and in appendix 1 have been designed to increase the health focus on homelessness work, support more accurate data collection so that we are building a realistic picture of the health and wellbeing needs as experienced by people engaging with support services in the City, as well to provide supporting evidence for developing longer term interventions (where longer term interventions often equates to impact over longer term for clients, as per NICE recommendations).

30. Early progress has been made by mobilising a mobile primary care clinic, developing hot weather risk assessment tools to support the outreach team, establishing new partnerships at Homerton Hospital and reviewing our assessment tools.

Appendices

- Appendix 1 – Homeless Health Workplan Summary Page

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