Health and Homelessness in Salford
A rapid review of health needs

June 2011

Public Health Directorate

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Thanks also go to the following people for contributing their time, views and expertise.

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1. BACKGROUND
Homelessness is a major public health problem. People who are homeless are amongst the most socially excluded, vulnerable and disadvantaged groups within society. They are exposed to a range of social and health inequalities and as a result experience serious and chronic morbidity and have a significantly reduced life expectancy. Their needs; relating to housing, social care, health care, education and employment are multiple and complex and cannot be addressed fully by any one agency. This report builds on a recent review of primary care services for homeless people in Salford (see Appendix 1) and explores the local picture of health and homelessness. The report illustrates the vast inequalities that people who are homeless experience and provides recommendations that respond to local health needs.

2. HOMELESSNESS: AN OVERVIEW

2.1 Defining Homelessness
2.1.1 Stereotypical notions of homelessness are predominantly associated with rough sleeping however the range and scale of the problem is much more complex. The legal definition of homelessness, according to the 1996 Housing Act, classifies a person as homeless if:

- They have no accommodation that they are entitled to occupy; or
- They have accommodation but it is not reasonable for them to continue to occupy that accommodation.

This covers a wide range of circumstances including:

- having no accommodation at all
- having accommodation that is not reasonable to live in, even in the short-term (e.g. because of violence or health reasons)
- having a legal right to accommodation that cannot be accessed (e.g. legal eviction)
- living in accommodation for which there is no legal right to occupy (e.g. living in a squat or staying with friends temporarily).

2.1.2 Local authorities have a statutory responsibility to provide advice and assistance to people who are legally defined as homeless, or threatened with homelessness. However, not all those who present as homeless fall within the legal definition and therefore do not necessarily qualify for temporary accommodation. The 1996 Housing Act requires local authorities to categorise people who present as homeless into one of the following three categories:

- Unintentionally homeless and in priority need
- Intentionally homeless and in priority need
- Housed in temporary accommodation pending enquiries and a homelessness decision, or housed under discretionary power.

2.1.3 Those defined as in priority need are: pregnant; have dependent children living with them, are over 60 years of age, are unable to find a home due to illness or disability, are homeless because of a fire or flood, are 16 or 17 years old or are leaving an institution such as the armed forces or prison
2.2. **Statutory Homelessness**

2.2.1 For people in priority need and assessed and accepted as homeless, the local authority has a duty to identify suitable accommodation both temporary and permanent. These individuals are regarded as the ‘statutory’ homeless population and are predominantly lone female families.

2.3 **Non Statutory Homelessness**

2.3.1 By contrast, the ‘non-statutory’ homeless are, those to whom the local authority has no obligation to accommodate, either because they are deemed intentionally homeless, or are not in a priority need categories. If someone has a priority need but is intentionally homeless, the local authority must secure temporary accommodation for long enough to provide a reasonable opportunity for the applicant to obtain accommodation for him or herself and must ensure that advice and assistance is provided. If someone is homeless through no fault of his or her own but does not have a ‘priority need’ (e.g. a single person or a couple who do not have a child and are not vulnerable), the authority must ensure that such applicants are provided with advice and assistance to help them obtain accommodation for themselves.

2.3.2 This group is referred to as the non statutory homeless and also includes those who do not present as homeless to the local authority. Non statutory homelessness affects mainly single people who are not registered as homeless with the local authority and do not appear in homelessness statistics. As a consequence, this group is also described as the ‘hidden’ homeless and typically includes those rough sleeping, sofa surfing\(^1\), living in hostels, staying with friends and squatters. Although data on the levels of hidden homelessness is limited in England it is estimated that there are 1,768 people sleeping rough\(^2\).

2.3.2 Homelessness is not therefore a single entity but rather a spectrum of housing need, ranging from those who live for a short time in temporary accommodation to those who are regularly rough sleeping. As a consequence there are different groups of homeless people:

- Homeless families accepted and re-housed by local authorities.
- Individuals who sleep rough or live in temporary accommodation, not accepted by local authorities and referred to the private sector.
- People seeking asylum.
- Those who are adequately housed, who face poor quality housing or overcrowding.

2.4 **Routes into homelessness**

2.4.1 The causes and effects which influence homelessness are complex and often overlapping. They include:

- Economic.
- Legislative.

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\(^1\) ‘Sofa surfing’ is a form of homelessness that affects many homeless young people. Sofa surfers could have often just left home, for whatever reason, and are staying with friends. They may find themselves sleeping on a sofa in a shared living room for one or two nights before moving on to stay with another friend.

• Social landlords, policy and housing benefit administration.
• Private landlords.
• Social factors including family breakdown, substance misuse.
• Morbidity.
• Probation policy.
• Effects of national policy.
• Local housing market demand/lack of affordable housing

2.4.2 Principally, homelessness is intrinsically linked with the economic climate. The current financial landscape has created a number of conditions which facilitate homelessness specifically:
• The effect of the credit crunch/recession on house prices and the number of repossessions.
• The decline of the buy to let mortgage market.
• Changes to the housing benefit subsidy system for temporary accommodation in 2010.
• Changes to overcrowding standards.
• Emerging communities of migrant workers.
• Asylum seekers and actions from the Border and Immigration Service in granting leave to remain.

2.4.3 The ‘individual’ risk factors associated with homelessness include poverty, unemployment, sexual or physical abuse, family disputes and breakdown, drug or alcohol misuse, school exclusion and poor mental or physical health. There is also emerging evidence that psychological disorders strongly predict homelessness, in particular youth homelessness and rough sleeping. This research also found evidence that the behaviours that lead to homelessness may be associated with mental health problems in childhood.

2.4.4 Nationally, between 2004 and 2007, the number of people officially recognised as homeless declined by around one third. However there are concerns that current economic conditions will increase the number of people both statutory and non statutory homelessness over the next few years. Given that Salford already has higher than average levels of homelessness (see 3.1.3) and significant levels of deprivation the local effect could be exacerbated.

2.4.4 It is also important to note that for people who are homeless, particularly the hidden homeless who may have been homeless for a considerable period of time, the ‘lifestyle’ of homelessness can be difficult to leave making the move to settled accommodation problematic. For many friends become family and everyday functioning, such as household tasks e.g. paying bills, shopping, cleaning etc, is unfamiliar which can make the adjustment to settled living problematic.

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4 ‘Single homelessness - An overview of research in Britain’, Suzanne Fitzpatrick, Peter Kemp and Susanne Klinker, 3 April 2000 , Joseph Rowntree Foundation.
difficult. Furthermore, breaking the cycle of homelessness is also dependent on the resolution of the underlying causes which often include mental health issues and/or substance dependency.

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3. **HOMELESSNESS IN SALFORD**

The majority of people who are homeless in Salford are those classified as officially homeless and for whom the local authority has a duty to provide suitable temporary and permanent accommodation. There is a smaller proportion (approx 4 – 30) of ‘hidden’ homeless people, who have not presented or are not classified as in priority need and therefore are ineligible for statutory settled accommodation.

3.1 **Statutory Homelessness in Salford**

3.1.1 Salford data\(^8\) for the period 2010/2011 indicates that there were 443 homeless presentations during 2010/2011 of which 56% (247) were assessed as officially homeless (see Figure 1). The remaining 44% (133) did not meet the statutory homeless criteria. Of these 62 were eligible but either intentionally homeless (10) or not in priority need (53).

![Figure 1: Salford City Council Homelessness Presentations 2010/2011](https://via.placeholder.com/150)

Source: SCC P1E Data

3.1.2 This data broadly reflects the figures for 2009/2010 during which time the same number of homeless presentations were recorded (443). Of these applications 54% were assessed as officially homeless. During 2009/2010 a greater number of applicants were recorded as intentionally homeless (28) compared to data for 2010/2011.

3.1.3 Over the last two financial years the number of homelessness presentations has remained consistent. However, the number of statutory homeless in Salford is significantly worse than the England average\(^9\) (2.47/1,000 households versus

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\(^8\) Salford City Council P1E Data

1.86/1,000 households). Furthermore, a significant proportion of presentations (approximately 45%) are ineligible for support from the Council.

3.1.4 Consistent with data for England the majority of those presenting and being assessed as statutory homeless were lone female led families (61% of all applications assessed as in priority need); the majority of whom (67%) had dependent children. This is an indicator of both deprivation and social exclusion. 10% of applicants were assessed as in priority need due to a mental illness or disability and a further 6% due to a physical disability.

3.1.5 The main reported reason for homelessness (See Table 1) was domestic violence (36% of applications) followed by those required to leave National Asylum Support Service (NASS) accommodation (23%). 44% of applicants reported relationship breakdown as the cause of their homelessness. Just 3% was related to financial arrears (mortgage or rental) and less than 2% reported leaving an institution (e.g. prison, hospital, Care, HM forces) as the cause of their homelessness.

### Table 1: Reasons for homelessness (statutory homeless)

<table>
<thead>
<tr>
<th>Main Cause</th>
<th>2009/2010</th>
<th>2010/2011</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parents no longer willing or able to accommodate</td>
<td>24</td>
<td>7</td>
<td>31</td>
</tr>
<tr>
<td>Friends or other relatives no longer willing or able to accommodate</td>
<td>11</td>
<td>11</td>
<td>22</td>
</tr>
<tr>
<td>Non violent relationship breakdown</td>
<td>15</td>
<td>7</td>
<td>22</td>
</tr>
<tr>
<td>Violent breakdown of relationship involving partner</td>
<td>84</td>
<td>92</td>
<td>176</td>
</tr>
<tr>
<td>Violent breakdown of relationship involving associated persons</td>
<td>12</td>
<td>5</td>
<td>17</td>
</tr>
<tr>
<td>Racially motivated violence</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other violence</td>
<td>5</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Racially motivated harassment</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Other forms of harassment</td>
<td>6</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>Mortgage arrears</td>
<td>1</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>Rent arrears on a LA or other public sector dwelling</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Rent arrears on registered social landlord or other</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Rent arrears on private sector dwellings</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Loss of rented or tied accommodation due to termination of tenancy</td>
<td>14</td>
<td>12</td>
<td>26</td>
</tr>
<tr>
<td>Loss of rented or tied accommodation due to reasons other than termination</td>
<td>1</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>Required to leave NASS accommodation</td>
<td>44</td>
<td>67</td>
<td>111</td>
</tr>
<tr>
<td>Left prison/on remand</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Left hospital</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Left other institution or LA care</td>
<td>0</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Left HM Forces</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Other Reason</td>
<td>16</td>
<td>14</td>
<td>30</td>
</tr>
</tbody>
</table>

*Source: SCC P1E Data*
3.1.6 Between 2009 and 2011, the majority (61%) of those assessed as statutory homeless were aged 25 – 44 years (296) followed by those aged 16 - 24 (25%/122) (See Graph 2).

3.1.7 The majority of those assessed as statutory homeless during 2009 – 2011 reported themselves as ‘White’ (63%); 20% as ‘Black’, 5% as ‘Asian’, 3% as ‘Mixed’ and 7% as ‘Other’. Only 7 applicants did not state their ethnicity.

**Graph 2: Salford City Presentations by Age 2009 - 2011**

3.2 **Non Statutory Homelessness in Salford**

3.2.1 By contrast, there is little known about the non statutory homeless who do not present to, or who are not accepted by, local authorities. This group usually includes single males (typically rough sleepers or sofa surfers) and illegal migrant workers.

3.2.2 Salford City Council estimate that there are small numbers of ‘hidden’ homeless residing in Salford, with rough sleepers typically migrating towards Manchester. A head count census in November 2010, as part of the national Rough Sleeping England - Autumn 2010 estimate\(^{10}\), identified 4 rough sleepers in Salford. Anecdotal evidence from a local shelter provider however indicates that the actual figure maybe around 20 – 30. Furthermore, there are currently 79 homeless patients registered with the specialist homeless GP service. Data included in the 2008 HM Government Strategy *No one left out: Communities*

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ending rough sleeping\textsuperscript{25}, suggested that Salford had the ninth highest concentration of rough sleepers in the country.

3.2.3 It is therefore accepted that these figures capture a partial element of the local picture of ‘hidden’ homelessness, which by its nature is hidden, chaotic and transient.

3.3 Services for homeless people in Salford

3.1.1 The Local Authority may not be able to provide a council home for every person who is homeless but it can facilitate other accommodation facilities. On occasion, the council may have to use emergency accommodation depending on availability, individual needs and circumstances. The most likely type of accommodation offered will be one of the following:

- (B&B) a form of emergency accommodation used if the council's allocated temporary accommodation is unavailable.
- Self Contained Accommodation (private sector leased), these are flats and houses not owned by the council or managed by them.

Figure 2: Type & Location of Temporary Accommodation in Salford

3.1.2 Salford also benefits from a strong voluntary sector; consequently there is a good range of temporary accommodation provision. There are 10 emergency/supported accommodation and/or hostels across Salford and 1 night shelter (See Appendix 3). Each provider has specific eligibility criteria e.g. female or male only, young people etc. There are 3 which cater for single men over 18
years of age, 1 for single women, 4 for single young people aged 16 – 25 and 1 ‘wet’ hostel. Short stay emergency B & B accommodation is also available via Salford City Council and there are 2 female/family refuges available locally. The type and location of the temporary and supported accommodation available in Salford is illustrated in Figure 2 on page 11.
4. HEALTH NEEDS: Mortality & Morbidity in the Homeless Population

4.1.1 Homelessness is a major public health problem, being not only common, but also commonly associated with a range of significant and chronic health issues. There is considerable and strong evidence that homelessness is associated with increased risk of physical, and mental, ill health and significantly reduced life expectancy. The average age of death, from predominantly preventable morbidity\textsuperscript{11}, for homeless people\textsuperscript{12} is 40.2 years\textsuperscript{26}.

4.1.2 As has been previously described the homeless population is not a homogenous group. The spectrum of health need reflects the diversity of the population (See Appendix 2). Those officially classified as homeless tend to be young families, headed by a lone female, whose health problems are of a general health and mental health nature\textsuperscript{13}\textsuperscript{14}. The ‘unnofficially homeless’ tend to be older males who are more likely to be rough sleeping or living in a hostel and are the most vulnerable in terms of health need and outcomes. Their health problems are predominantly related to substance misuse and/or specific psychiatric disorders\textsuperscript{13}\textsuperscript{14}. Estimates suggest that half of all rough sleepers have an alcohol problem, three fifths report a drug problem, a third have physical health problems and over half a mental health issue\textsuperscript{15}.

4.1.3 Amongst rough sleepers, those using night shelters, common lodging houses and hostels, there is increased mortality from accidents, suicide, violence and alcoholism and increased morbidity due to communicable disease (skin infestations, pneumonias, tuberculosis), musculo-skeletal disorders, dental/oral disorders, neurological disorders (including epilepsy) and gastrointestinal disease (including liver disorders)\textsuperscript{19} (See Figure 3, page 14).

4.1.4 People who sleep rough for a significant period of time are likely to have pre-existing health-related difficulties and will be less well equipped to access the healthcare they need. Their conditions can deteriorate and without targeted and proactive health services the complexity of their health needs result in a case mix that is far more costly to treat than that of the general population\textsuperscript{26}.

4.1.2 The health status of the ‘temporarily homeless’ in bed and breakfast (B&B) hotels has also been shown to be worse than age and sex matched controls who have a permanent home. Utilisation studies show that adults and children in B&B hotels have higher than expected rates of A&E use and emergency admissions\textsuperscript{20}. Burns/scalds and infections are also more common in children living in B&B accommodation\textsuperscript{20}.

4.1.3 For the young homeless, who may become involved in drug use or prostitution, HIV represents a particular risk. Whilst other communicable disease such as hepatitis A, B and C are also prevalent, especially amongst injecting drug users.

\textsuperscript{12} This refers to those that have been rough sleeping since the age of 16.
A homeless drug user admitted to hospital is seven times more likely to die within 5 years than a housed drug user admitted with the same problem\textsuperscript{16}.

4.1.4 A wide range of mental health problems are also prevalent amongst the homeless population. Severe mental health problems are most common in rough sleepers amongst whom there is a high incidence of self-harm and suicide. Studies in homeless hostels also show a high prevalence of schizophrenia amongst residents, as well as a high prevalence of substance abuse. Depression, amongst adults, and behavioural disturbance amongst children, living temporary B & B accommodation is common\textsuperscript{17,18}.

\textbf{Figure 3: Health problems commonly found amongst single homeless people}\textsuperscript{19}

<table>
<thead>
<tr>
<th>Health problem</th>
<th>Description and examples from NMJ Wright, 2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental ill-health</td>
<td>Schizophrenia, depression and other affective disorders, psychosis, anxiety states, personality disorder, earlier onset of drug use and severity of alcohol use.</td>
</tr>
<tr>
<td>Physical trauma</td>
<td>Injury, foot trauma and dental caries due to self neglect.</td>
</tr>
<tr>
<td>Skin problems</td>
<td>Inflammatory conditions e.g. erythromelalgia, infestations e.g. scabies or body lice, infections e.g. cutaneous diphtheria impetigo.</td>
</tr>
<tr>
<td>Respiratory illness</td>
<td>Pneumonia, influenza, tuberculosis (often latent).</td>
</tr>
<tr>
<td>Infections</td>
<td>Blood-borne viruses e.g. Hepatitis B, C and HIV. Hepatitis A. Secondary to louse infestations e.g. typhus, trench fever, relapsing fever.</td>
</tr>
</tbody>
</table>

4.1.5  Crucially homeless people demonstrate a tri-morbidity of physical illness, mental health problems and substance misuse. Moreover, ill health, particularly poor mental health, can be a cause and/or consequence of homelessness\textsuperscript{20}. Expert opinion suggests that the majority (circa two thirds) of serious chronic health problems amongst homeless people pre-exist before the person becomes homeless (and may be part of the cause of the transition to homeless), though will often be exacerbated by the person being homeless\textsuperscript{26}.

\textsuperscript{20} 'Homelessness and ill health', Report of a working party of the Royal College of Physicians, 1994
5. Health service access and utilisation

5.1.1 Health service access and utilisation is a major issue for those who are homeless. Crucially access to, and utilisation of, health care services is both problematic and erratic. Despite having greater health need they are less likely to engage with health services than the general population\(^{21}\). Complex health needs and chaotic lifestyles make it difficult for homeless people to access, and navigate services. Many homeless people have low health aspirations, poor expectations and limited opportunities to shape their care. They often report feeling ‘invisible’ or discriminated against\(^{27}\). Furthermore, the homeless may have pressing ‘survival’ needs or for other reasons, including low self-esteem, do not recognise their health as a priority.

5.1.2 GP registration is the gateway to health services. It is however common for homeless people not to be registered with a GP and for there to be other barriers to accessing care, such as having previously experienced negative attitudes\(^{22}\). Consequently, homeless people may leave health problems untreated until they reach a crisis point and then present inappropriately at A&E\(^{23}\). It is estimated that this client group use around 4 times more acute hospital services than the general population. For inpatient costs, the figure rises to 8 times when the client group is compared to the general population aged 16-64, being admitted 4 times as often and staying three times as long as the housed population\(^{26}\). The most common reasons for admission include toxicity, alcohol or drugs, and mental health problems.

5.1.3 A 2002 report submitted to the Office of the Deputy Prime Minister\(^{15}\) detailed the access barriers to primary care for homeless people as: surgery opening times; appointment procedures; location; financial disincentives; and negative perceptions relating to violence, transience or antisocial behaviour.

5.1.4 Health professionals lacking awareness, skills and training compound this. Moreover the limited understanding of the health needs of homeless people inhibit the effective treatment of homeless patients. There is also a tendency to focus on presenting symptoms rather than underlying issues. Health promotion, prevention and recovery are often inadequately addressed\(^{27}\).

5.1.5 Health services generally lack the flexibility to respond to the complex needs and chaotic lifestyles of homeless people. There are key gaps in and barriers to provision (e.g. access to mental health services for those with a dual diagnosis), consequently it is easy for homeless people to fall between the gaps of different services.

5.1.6 Evidence suggests that homeless people may be more willing to engage with primary care services where relationships and trust can be built, dictating continuity of care\(^{27}\). This is dually beneficial in terms of case management, particularly for long term conditions and prescribing governance. Supporting

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\(^{22}\) ‘Critical condition’, Crisis, 2002

\(^{23}\) Wright N, Smeeth L, Heath I. Moving beyond single and dual diagnosis in general practice: many patients have multiple morbidities, and their needs have to be addressed. *BMJ*. 2003;**326**(7388):512–514.
continuity both in terms of longevity of care, and as people navigate between health (and other) services, is an essential feature of successful services.

5.1.7 Typically homeless people find it easier to access unplanned care settings than traditional primary care. Evidence from the literature suggests over utilisation of emergency and acute care. A recent study found on average there was one ambulance call out for each six hostel bed spaces annually, with acute emergencies due to an existing condition.

5.1.8 Many homeless people rotate between hospital discharge and readmission because there is nowhere suitable to discharge them or because they sometimes have challenging behaviour, which can include drug or alcohol use, leading to discharge against medical advice or disciplinary discharge. It is estimated that 30% of homeless patients discharged from hospital and 11% of A & E attendees left without a care plan. This is not only a large drain on resources, but also has negative implications for patients’ health as there is limited continuity of care. It is also more costly for commissioners who will pay for a number of short spells rather than one long stay which resolves the medical problem.

6. NATIONAL & LOCAL POLICY CONTEXT

6.1 National Policy

6.1.1 Following the Homelessness Act 2002, preventing homelessness became the cornerstone of national and local policy direction. The Act imposed a statutory duty on local authorities to produce a homelessness strategy for addressing prevention and recurrence of homelessness.

6.1.2 *No One Left Out: communities ending rough sleeping*, published under the last Labour government in 2008, is the most recent government strategy designed to tackle homelessness and aims to end rough sleeping by 2012. The strategy is focused upon diverting people from the streets to ensure no one needs to remain sleeping rough and to circumvent people becoming entrenched and exacerbating problems such as poor mental health, substance misuse and physical ill health. One of the key actions outlined in the strategy was to improve access to health and social care services for people with multiple needs in an attempt to address the health related causes and compounders of homelessness. Specifically this action aimed to:

- work with the Department of Health to strengthen the economic case for commissioning better integrated services, and developing the Joint Strategic Needs Assessment process
- promoting and evaluating roll out of the Hospital Discharge Protocol
- involving regional Locality Managers working alongside the Regional Improvement and Efficiency Partnerships, strategic health authorities and others in targeted areas to improve targeting of services
- working with the regional health observatories and the Care Services Improvement Partnership to develop and disseminate tools to support needs assessment and promote good practice through a health and homelessness website
- developing effective responses to people with the most chaotic lives and complex needs who have experienced childhood trauma
- considering how the health trainers programme could improve the health of people who have slept rough.

6.1.3 The new coalition government has yet to publish its policy response to homelessness in England. However, a working group on homelessness has been established which includes Ministers from eight government departments. The working group is focused upon people living on the streets and in temporary or insecure accommodation, such as hostels, shelters and squats. In addition, the Department for Communities and Local Government is investing £400m over four years in the Preventing Homelessness Grant to support the work of local authorities and the voluntary sector.

6.2 Local Policy

6.2.1 *Promoting Positive Prevention*, Salford’s homelessness strategy 2008 – 2013, responds to the Homelessness Act and aligns with the national prevention agenda. The Strategy has four key aims:

- To reduce the use of temporary accommodation
- Deliver early intervention to prevent homelessness

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• Widen housing choice and increase economic activity
• Provide effective co-ordinated support to vulnerable young people

The strategy is delivered through an action plan which does not currently include a health component. However, Salford City Council is in the process of developing a homelessness prevention action plan (Housing Options) which will include a health component, to improve health and reduce health inequalities. It will focus on people who are already housed or those in priority need. Salix Housing Limited is leading on this part of the plan.

6.2.2 The Joint Strategic Needs Assessment (JSNA) highlights the health and wellbeing issues facing the Salford population and points to the commissioning priorities that need to be considered to improve life expectancy and reduce health inequalities. However, reflecting the current limited local intelligence on the health needs of people who are homeless, the JSNA currently makes limited reference to the needs of homeless people.
7. **Health & Homelessness: Evidence for Effective Commissioning**

7.1.1 Reflecting the health needs of the homeless population national policy guidance on health and homelessness focuses almost exclusively on the needs of the ‘hidden’ homeless as the group who experience the most extreme health inequalities and outcomes.

7.1.2 *Healthcare for Single Homeless People*\(^26\) was published by the Department of Health in March 2010 and provides an overview of health needs and the healthcare cost of people who are homeless; specifically rough sleepers or those sleeping in a hostel, squat or friend’s floor. The rationale being that their health needs are most extreme. The report acknowledges that this group is:

- predominantly male
- consume significantly more acute care compared with the rest of the population, primarily due to toxicity, alcohol and or drugs and mental health problems.
- experience many barriers to healthcare

The report recommends that PCT’s commission specialist homelessness primary care services suited to both the size of the client group in the area and the extent of existing services. Four models of care are described and are represented in Figure 4 below:

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**Figure 4: Models of care for specialist primary care provision**

1. **Mainstream practices**
   *Provide services for homeless*  
   A GP from a mainstream practice holds regular sessions for homeless people in a drop-in centre or sees them in his/her own surgery. May not register patients and no 24/7 provision.

2. **Outreach team of specialist homelessness nurses**  
   An outreach team of specialist nurses provide advocacy and support, dress wounds etc. and refer to other health services incl. dedicated GP clinics. Unlikely to register patients and no 24/7 provision.

3. **Full primary care specialist homelessness team**  
   A team of specialist GPs, nurses and other services (CPN, podiatry, substance misuse specialists) provide dedicated and specialist care. Co-located with a hostel / drop-in centre. Usually register patients and provide 24/7 cover.

4. **Fully coordinated primary and secondary care**  
   A team of specialists spanning primary and secondary care provide an integrated service including: specialist primary care, out-reach services, intermediate care beds and in-reach services to acute beds.

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Models 1 and 2 are recommended for PCTs with small homeless populations. Model 3 is suggested for major urban centres with larger homeless populations. Services that are suitable in areas with a very large population can include frequent walk in sessions or regular clinic sessions with Consultant Psychiatrists. It has been argued that the major urban centres such as London, Manchester and Birmingham have a sufficiently large homeless population for a fully integrated primary and secondary care service as per Model 4. Pilots are currently underway that seek to increase the integration of care for homeless patients. These include homelessness ward rounds in central London hospitals and care navigators: people with experience of homelessness, who can offer emotional support and assertive outreach for those most in need and link them up with services. This type of model could be achieved via a GM joint commissioning arrangement or through supra-district joint commissioning.

The Department of Health acknowledge that some PCTs may not have sufficient numbers of homeless people to justify a specialist homelessness service. In such cases, it is recommended that PCTs consider one of the less intensive models of provision (Model 1 or 2) or commission a more specialist service jointly with neighbouring PCTs.

The report also accepts that as single homeless people are unlikely to be captured in population data, which is used as the basis for PCT revenue allocations, PCT’s may not be appropriately funded for their homeless populations. The report recommends that work is undertaken at PCT level to:

- Determine an accurate estimate of the number of single homeless people.
- The location of homelessness and;
- Health needs.

7.1.3 Inclusion Health: improving primary care for socially excluded people was published alongside Healthcare for Single Homeless People as a practical guide to support PCT’s in commissioning to improve primary care services for socially excluded people, including homeless people. The guidance highlights best practice case studies and identifies a series of underlying principles and features which are present in services which successfully meet the needs of socially excluded people (several of which are described in section 7.1.6 of this report). As well as very practical commissioning solutions the guidance makes the following high level recommendations:

- Acknowledge the issue and gain support at senior level
- Work with partners, including the third sector, to:
  - better identify need
  - jointly reduce instability of individuals and make more use of resources
- Be pro-active and employ methods of outreach. Including:
  - The use of advocates/support worker to improve navigation around the system and help individual’s access treatments by keeping appointments, securing medication etc.
- Integrate services/and or service pathways.

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• Support (Primary Care Providers) to:
  - train frontline staff
  - make reasonable adjustments to services
  - build networks which support workforce
• Be opportunist and build services around existing ‘touch points’.
• Involve clients from start to finish.
• Build in an ethos of continuous improvement for individuals wherever possible.

7.1.4 The 2007 Framework for planning and commissioning of services related to health needs of people who are homeless or living in temporary or insecure accommodation published by the Department of Communities and Local Government\(^{28}\) provides a framework for all relevant local partners (public and voluntary) in joint planning to improve access to local health services for all people who are homeless or living in temporary or insecure accommodation and to promote joint commissioning where appropriate. The rationale being that:

• It will facilitate joined up service delivery.
• Address current gaps.
• Improve health and housing outcomes for homeless people, including prevention of, and a reduction in repeat, homelessness, a reduction in premature mortality and a reduction in the number of people with unaddressed health needs.
• Address gaps identified in the first round of homelessness strategies in the area of health need.
• Encourage spend-to-save solutions for addressing the health and housing needs of high cost patients and people who are frequently either in-patients or users of A & E and who do not have settled accommodation.
• Ensure maximum cost-effectiveness of services, by reviewing the current provision and jointly planning future provision.
• Have a positive effect in other areas of working with vulnerable people via bringing together the individuals and agencies through the process of joint planning.

The document recommends that partners:

• Identify the number of rough sleepers, people in insecure accommodation and people in temporary accommodation locally.
• Identify existing protocols/service level agreements/contracts relating to the above client groups.
• Identify existing health and associated provision for people in these client groups, with associated costs.
• Consult service users.
• Process map ideal, local, integrated health care pathways for people in each of the three client groups.
• Carry out a gap analysis.
• Develop a joint action plan.

\(^{28}\) Department of Communities and Local Government (2007) Framework for planning and commissioning of services related to health needs of people who are homeless or living in temporary or insecure accommodation published by the Department of Communities and Local Government. London. January 2007
7.1.5 In addition to national guidance the voluntary sector have also published a number of supporting documents which look specifically at the health needs of homeless people. The most recent of these is the 2011 *Standards for commissioners and service providers*\(^2^9\) published by The Faculty for Homeless Health, a collaboration between Pathway London and the College of Medicine. This guidance aims to set clear standards for planning, commissioning and providing health care for homeless people and other multiply excluded groups. Overarching standards for commissioning, clinical care and all services are included in Appendix 4. There are also specific standards outlined for services which are central to addressing the health needs of homeless people. The include: Primary care services, migrant health services, community mental health services, personality disorder services, counselling services, prison medical services, dentistry, podiatry, substance misuse services and respite care.

The guidance reiterates the importance of an integrated approach and advocates the Boston model of care\(^3^0\) as described in *Healthcare for Single Homeless People* and illustrated in Figure 5.

*Figure 5: Integrated approach to commissioning of homeless health services*

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\(^{29}\) The Faculty for Homeless Health (2011) Standards for commissioners and service providers. Version 1.0 May 2011.

7.1.6 Whilst the evidence base does not prescribe any specific service model recommending a locally designed service solution based on the profile, and needs, of the local homeless population; the following are key features of effective health programmes for homeless people:

- Joint and integrated provision, located where need is greatest.
- Outreach and co-located services to promote integration.
- Where services can not be co-located, service users are supported in practical and hands-on ways to access and navigate services.
- Partners work together to address the observed pattern of tri morbidity commonly presented by homeless people. This may involve the development of specific protocols which reflect the complexity of health need and which reduce the number of people ‘falling’ between services. This is especially important if services are not located together.
- Multiple access and registration points including A&E, pharmacies, hostels and the local authority.
- All health providers have readily available and up to date information about primary care provision, including GP registration and access points, for homeless patients.
- Services managing long-term conditions are flexible and accessible for homeless people. Early identification, intervention and management of long and chronic conditions are also important to ensure long term health benefits and to minimise costs.
- There are pathways, in and out of acute care, between hospital discharge teams, primary care providers and homelessness services to establish appropriate care, support and accommodation on discharge from hospital. More integrated pathways mitigate fragmented and crisis led use of service which incurs higher costs.
- Clearly, living conditions on the streets are not conducive to recovery from poor health; neither do hostels provide all elements of a good environment for recovery. Intermediate care, provided via an ‘extra care’ model, offers some potential solution. This would involve the spot purchase of ‘extra care’ in existing hostels, with care commissioned as and where it is required. Under this model, care could be provided at a wider number of existing hostels, as opposed to a permanent standalone facility or permanent provision in a small number of hostels. An extra care model, which separates the provider of accommodation and support from the provider of care, means that the premises would not need to be registered, allowing greater flexibility. This approach has worked successfully in Liverpool.
- There are support networks for clinical and non clinical staff working with homeless service users to facilitate reflective practice, inform ongoing service provision and to provide training and education opportunities.
- Protocols are in place which facilitate information sharing amongst health service providers in order to ensure that care is co-ordinated. This is especially important in the case of homeless patients who often present with numerous chronic conditions and to ensure appropriate, and to mitigate against duplicate, prescribing.
- The number of ambulance call outs, A&E attendances, unscheduled hospital admissions and ‘revolving’ door patients are routinely monitored.
• Services use the Homeless Link Audit Tool to record and evidence the health needs of their clients. This then informs overall health need locally.

7.1.6 The chaotic nature of the homeless lifestyle means that traditional performance models may not be effective or reflect performance adequately. Outcome measures therefore should seek to ensure continuous improvements with models of care that allow stabilisation of clients with complex needs and which avoid the deterioration of pre-existing long term conditions; alongside positive pathways to recovery\textsuperscript{27}. Outcomes for homeless populations need to be an integral part of the NHS, Public Health and Social Care Outcomes Framework allowing measurement of the proposed indicators within homeless populations\textsuperscript{29}.

7.1.7 It is important to recognise however that there is a lack of research evidence on the potential for improved primary care to reduce secondary care costs and improve health outcomes. It is likely however, that better primary care will improve health outcomes, producing valuable additional years of healthy life. It is also plausible that better primary care will reduce secondary care use and save money to PCTs, though improved primary care may also raise utilisation of secondary care via increased referrals for previously undiagnosed conditions. This should however improve outcomes and therefore give better value for money. The overall effect on costs and outcomes is not known.
8. Health & Homelessness in Salford

8.1 Local Health Needs

8.1.1 The evidence suggests that whilst there is a spectrum of health need, reflecting the composition of the homeless population, the hidden homeless, particularly rough sleepers, are those most vulnerable; with complex physical and mental health needs. The health needs of rough sleepers are severe, neglected, complex and overlapping and, as a population, are hard to reach through mainstream services. Though small in number, this population account for the majority, recurrent and prolific group of urgent care services users locally. This group is also most vulnerable to serious morbidity and premature mortality. Addressing the health needs of chronically excluded adults, sleeping rough or living in the hostel system, is therefore a priority, rather than those who otherwise resolve their homelessness. This reflects national priorities which suggest work should be targeted towards:

- Rough sleepers
- Hostel and night shelter residents
- Squatters
- People staying temporarily with friends and relatives

8.1.2 It is however acknowledged that the homeless population is diverse and that there are a number of sub groups whose needs may not be adequately addressed, in particular young people and families.

8.1.3 The health needs of young homeless people are significant and, whilst not as chronic or complex as those experienced by rough sleepers and or excluded homeless adults, they have specific health needs in relation to sexual health and other communicable disease (particularly BBV).

8.1.4 Other people living in poor conditions (such as those in overcrowded or unfit homes) or those that are officially homeless, but resident in temporary or permanent accommodation, may also suffer from increased health problems linked to their housing situation. However they are not subject to the same barriers to accessing mainstream health care, and are not recognised to have health needs that are substantially different from the general population. This includes female led families, who typically remain with their existing GP or register with a new GP following relocation and whom are accustomed to accessing primary care services for general health needs. Dedicated primary care services, which address specific health needs, are also available for asylum seekers locally.

8.1.5 Information regarding health service utilisation by homeless people locally is limited across the entire health economy. Identifying local health needs for this population is therefore challenging. However, NHS Salford has invested in a specialist general practice service for homeless patients for over a decade. Salford Health Matters, a local general practice provider, is contracted, under a LES, to provide basic and enhanced primary care for homeless people. Consequently there is some data regarding the 79 homeless patients who are registered with this practice. This data indicates that:

- The majority of registered homeless patients are male.
- 1 patient is recorded as having a learning disability.
• Of those with a recorded status, 95% smoke and 30% are registered drug users.
• Only 5 patients are recorded as having a mental health issue.

There is limited data available locally to indicate the number of alcohol dependent registered patients. However anecdotal evidence provided by both primary and secondary health professional stakeholders locally report alcohol and mental health as significantly prevalent and the reason for repeated attendance.

8.1.6 There is also limited local data from which to assess acute health care needs and demand for acute and unscheduled care by homeless people in Salford. Last year however a homeless, rough sleeper was recorded as the patient with the highest number of emergency admissions at SRFT, with a subsequent average length of stay of 4 days. The emergency admission costs for this patient totaled £22,000.

8.1.7 Local anecdotal evidence suggests that emergency admissions for homeless patients predominantly relate to alcohol and mental health which reflects national evidence. Wound care and physical trauma conditions are also common. Demand is anecdotally recognised as being concentrated amongst a small number of prolific and chronic service users who are rough sleepers. It is also anticipated that a number of alcohol related frequent fliers are homeless, although there is no available data to substantiate this claim.

8.1.8 The health and social care needs of homeless patients are often significant and interrelated therefore complex care and case management is required. Whilst there is no active case management of homeless patients at SRFT, one of the ED Consultants has assumed informal responsibility for vulnerable and or violent patients including homeless people. This facilitates consistent acute care for recurrent service users and consequently informal monitoring of conditions and prescribing. The ED Consultant undertakes an informal care co-ordination role, liaising with a range of other agencies, in order to address the presenting and underlying health and social care needs of patients. However this is not formalised, is time consuming and frustrating as patients often ‘fall’ between services e.g. not fitting the service criteria particularly in the case of dual and or tri morbidity/diagnosis.

8.2 Health Services for Homeless Patients in Salford

8.2.1 NHS Salford currently commission Salford Health Matters (SHM) to provide 20 hours of essential and enhanced primary care specifically for homeless patients. The service combines ‘outreach’ nurse triage at the Windsor Centre, a night shelter for single homeless people, and ‘in-reach’, integrated primary care services delivered at Eccles Gateway.

8.2.2 The service model includes an outreach, nurse led triage service, supported by an Admin/Support Worker, at the Windsor Centre 4 days a week (Monday, Tuesday, Thursday & Friday) providing triage, registrations, health promotion, screening and health checks. GP, drugs, alcohol and mental health services are provided on an appointment basis at Eccles Gateway on Thursday afternoon’s
for 3.5 hours. On call GP services are also available for emergency appointments on Monday, Tuesday and Friday at any of the SHM sites across Salford.

8.2.3 Patients, using the SHM Service, are typically signposted by the Windsor Centre and other temporary accommodation providers as well as SRFT Emergency Department.

8.2.4 This report grew out of a review of the existing primary care service (see Appendix 1) which recommended revisions to the existing LES contract in order to better reflect local health needs and to facilitate and improve access. This is now being taken forward by a Commissioning Department led Steering Group.

8.2.5 In addition to a specialist general practice for homeless patients, a dedicated dental service is also available specifically for homeless people.

8.2.6 Currently the drug, alcohol and mental health service input into the specialist primary care team is on an ad hoc basis and is governed neither by a commissioning specification or a specialist pathway/protocol. Similarly, the SRFT acute consultant time, dedicated to homeless patients, is not formalised either contractually or via a specialist pathway. Resources to undertake current health care provision for homeless patients are therefore achieved on an ‘in kind’ basis, with the exception of the primary care service for which there is a recurrent £100k annual investment.
9. **Health & Homelessness: The Salford experience**

9.1.1 As part of the review of primary care services for homeless people in Salford a patient engagement process with homeless people was conducted in June 2011 in order to further understand:

- The socio-demographics and health needs of the local homeless population.
- The awareness and use of services.
- Access and experience of health services.
- Expectations and aspirations of health needs and services.
- Priorities and preferences for health care provision.

9.1.2 This process used a combination of face to face interviews conducted at the Windsor Centre and assisted questionnaires which were sent to 7 hostels across Salford for completion by residents. A total of 41 questionnaires were returned and 10 interviews were conducted. The majority of respondents were male (49), aged between 25 – 44 years and ‘White’ (82%) although 14% of respondents did identify themselves as being of BME ethnicity. Most respondents were residing in hostels, 1 was sleeping rough, 8 had recently moved from homelessness into privately rented accommodation and 1 was living in supported accommodation.

9.1.3 Appendix 5 includes a copy of the full and detailed engagement report. The results are which are summarised below.

9.2 **Health needs**

9.2.1 Amongst those responding to the questionnaire; 36% reported having a disability. However this rose to 80% amongst those interviewed, which is much in excess of the housed population. Despite the high levels of chronic ill health this did not appear to impact upon respondents' assessment of their own levels of health with only 10% reporting they had bad or very bad health.

9.2.2 Mental health was reported as the main disability (57%) followed by back pain (39%). Other reported conditions included ‘other’, COPD, Asthma and Arthritis. Despite the high prevalence of poor mental health only 16 people reported that they were receiving help and a further 23 said they would like more support to address their mental health needs. The evidence reported suggested that LTC's were poorly managed with only a small minority receiving treatment for their condition.

9.3 **Substance use**

9.3.1 Consistent with national, and local anecdotal, evidence 83% of respondents reported a substance dependency. A third of respondents reported being dependent on alcohol. All those interviewed reported either a drug or alcohol dependency.

9.3.2 Whilst some respondents reported receiving treatment to address their substance dependency the majority were not, but expressed a desire for more support. This replicates the experience of those with mental health needs.
9.4 Use of Health Care Services
9.4.1 79% of respondents reported being registered with a GP; 20% of these were registered with SHM and 4% as a temporary patient. 17% were not registered with a GP with the reported reasons being; not in need or that they had been repelled by past experiences.

9.4.2 The majority of respondents registered with a GP had used the service within the past 12 months, however use of GP out of hours and walk in centres were less well utilised. Corresponding to national, and local anecdotal, evidence A & E use was predominantly linked to alcohol, mental health and/or injury.

9.4.3 71% patients reported a preference to be seen at a local GP practice. Those interviewed reported the co-location of the GP at the Windsor Centre, an arrangement that no longer exists, particularly convenient.

9.5 Access to Health Services
9.5.1 Transport was reported as the main barrier to accessing health services, a finding consistent with the national evidence and policy base, illustrating the importance of location. Other barriers reported included getting through to the surgery, getting an appointment, privacy and choice of doctors.

9.5.2 Confidentiality and understanding was rated as the highest priority in terms of care needs followed by quality.

9.5.3 The case studies provided by those interviewed starkly illustrates the chronic and multiple health needs of homeless people in Salford. This group also reported a lack of understanding of health needs and perceived prejudice against homeless people, those with mental health and dependency issues as a barrier to accessing services.

9.5.4 The findings from the patient engagement process concord with the national, and local anecdotal, evidence on the health needs of single homeless people. The feedback indicates that many chronic conditions are either undiagnosed and/or are inadequately managed with the majority of respondents expressing need for support and/or treatment.

9.5.5 The findings also suggest that the majority of homeless people are engaged and registered with primary care. Practical issues such as transport illustrate the importance of location whilst the experience and perception of prejudice when homeless people interface with health services are implicated as barriers to services.
10. **FINDINGS & CONCLUSION - Health & Homelessness in Salford**

10.1.1 The number of homelessness presentations in Salford has remained consistent over the last two financial years, with levels of statutory homelessness higher than the England average. There is some suggestion that levels of homelessness will increase in response to the current economic climate and that this may affect Salford more adversely as a locality already subject to socioeconomic disadvantage.

10.1.2 The majority of people who are homeless in Salford are those classified as statutory homeless. Single female led families, whose route into homelessness is the product of violent relationship breakdown usually involving domestic violence, dominate this sub group of the homeless population. This is an indicator of both deprivation and social exclusion, the health impact of which extends both to the parent and dependent children. Their health needs are of a general health nature but they also have additional mental health needs. For children who are homeless they are at increased risk from accidents and behavioural disturbance. Crucially there is evidence to suggest that, without early intervention, the circumstances, which led to, and the period of, homelessness experienced by children and young people are likely to cause adult homelessness and ongoing mental health problems.

10.1.3 A smaller proportion of the homeless population in Salford are those classified as ‘hidden’. In Salford, estimates suggest that there are between 4 – 30 people who fall into this sub group population. However, this group experience the most extreme health needs and inequalities, which extend to both access and treatment. Rough sleepers, in particular, are especially vulnerable. Mental health is a common problem usually co presenting with alcohol and drug misuse; the cause or consequence of which being interrelated and difficult to unpick. This pattern of tri-morbidity is frequently reported by services working with homeless people and is cited as the predominante cause of frequent, and repeat, hospital attendances and admissions.

10.1.4 The socio-demographic characteristics and health needs of the official homeless differ substantially from those of rough sleepers and those living in insecure accommodation and as such require different responses. Whilst it is apparent that rough sleepers, squatters and sofa surfers experience the poorest health outcomes and have greatest needs all homeless groups experience poorer health, particularly mental health, compared to the rest of the population. Furthermore the complexity of homelessness, its causes and consequences, inevitably mean that homeless people are engaged with multiple public services.

10.1.5 Ill health can be both a cause and consequence of homelessness. 16% of people assessed as officially homeless have an existing health issue (either physical or mental). Health is a pre-requisite to independent living and employment. The SCC homelessness strategy action plan is currently being developed to include a health and health inequalities component (being led by Salix Housing). However, given the clear link between housing, deprivation and health, the lack of leadership and input into the action plan by health services may diminish opportunities to improve health services for homeless patients and for health to enhance its role in prevention and/or breaking the cycle of homelessness.
10.1.6 The Salford experience of homelessness, as reported in the patient engagement process, reflects the national, and local anecdotal, evidence which indicates that the health needs of homeless people are multiple and chronic. Mental health was reported as the dominant chronic health issue amongst those questioned. Over 80% reported a substance dependency, a third of which was related to alcohol. These issues were also reported as the primary reason for contact with acute health services. The majority of respondents reported that despite having either a mental health or dependency issue only a small number were receiving support and or treatment with the majority expressing a need for more care. It is unclear from the findings of the patient engagement process why their needs were not being met. Furthermore despite the high prevalence of chronic illness, and/or dependency, amongst a largely young population (25-44), only 10% regarded their health as bad or very bad. Transport, poor patient experience and prejudice were all implicated as barriers to service access. The majority of respondents were however registered with a GP.

10.1.7 As well as good provision of temporary accommodation, provided through a strong voluntary sector, Salford has a long-standing contract with a primary care provider for basic and enhanced general practice provision, enabling GP registration and access to a range of primary care services. This includes outreach delivery and informal integration of drugs, alcohol and mental health services on an ad hoc basis. The current LES for this service is being updated to more appropriately reflect local health need. A specialist dental service for homeless people is also available.

10.1.8 Contrary to national evidence, demand for acute care by homeless patients locally is concentrated amongst a small (approximately 5) group of rough sleepers. These are however chronic and recurrent users of acute care repeatedly presenting with mental health and substance use issues. This is expensive and results in poor patient outcomes as underlying issues remain unresolved.

10.1.9 Despite the availability of dedicated primary care for homeless people, health services for homeless patients are fragmented and uncoordinated across the health economy. Much of what is provided locally is reliant on voluntary relationships between services and informal arrangements which are often ad hoc. This is not appropriate for a chaotic client group. There are no pathways of care between primary and secondary care or between drugs, alcohol and mental health services. The complex and chronic health needs of the homeless community dictate that this is essential. It is evident that specific protocols are imperative for this client group not only in terms of addressing their health needs but also in the contribution towards breaking the cycle of homelessness.

10.1.10 There is no routine collection of data regarding use of health services amongst homeless people across the health economy. Consequently, there is a lack of understanding of the problem as well as the magnitude of current health spend on the homeless population in Salford. This inhibits accurate health needs assessment, effective service planning as well as information sharing between agencies to offer effective and appropriate advice and support. In particular there are major gaps in information regarding the non-statutory homeless. This may
stem from a mistaken belief that homelessness is no longer a significant problem because of the reduced numbers counted in street counts and/or a belief that homelessness is primarily a housing issue and not a health / mental health / substance misuse issue.

10.1.11 Reflecting their increased health needs, government policy and national guidance predominantly focus on the needs of single homeless people living on the streets or in insecure accommodation. Addressing the health consequences of homelessness is a form of secondary prevention, reducing the harm associated with entrenched and increasing inequality in society. The evidence base is clear that understanding local health needs and reducing barriers to care, through integration and outreach, is critical to improving health outcomes for homeless people in particular for the ‘hidden’ homeless. Shifting the emphasis of care from crisis management to prevention, service linkage, case management and respite reduces in patient stay and the risk of future hospitalisations.

10.1.12 Longer term responses require a primary prevention approach through the reduction of poverty and tackling the root causes of homelessness and disadvantage. The reorganisation of NHS commissioning offers an opportunity to improve arrangements for health care delivery for homeless people. Specifically, the integration of public health into the local authority facilitates the opportunity to develop a comprehensive and integrated response to homelessness, configured around the health needs identified in this report. Both efficiency and effectiveness can be improved through the active linkage of existing health and social care. Furthermore, targeted and integrated health interventions for homeless people have been shown to reduce the amount of time that people spend homeless.
11. RECOMMENDATIONS

1. A working group should be established to address the issues identified in this report. A proposed membership is attached in Appendix 6. This group should formalise links between providers of primary and secondary care, hostels (including other temporary accommodation providers) and the local authority to maximise opportunities to prevent, reduce and break the cycle of homelessness and to improve the health outcomes of homeless people. This group should also contribute to the health component of the SCC homelessness strategy action plan, which should use the information included in this report to inform planning.

2. There needs to be a stronger recognition of the health needs of homeless people in local commissioning. Specifically:
   - The JSNA should be updated to include the health needs of homeless people as identified in this report.
   - Commissioners should use the information outlined in this report to inform specifications with key services, in particular primary care, mental health, drugs and alcohol services, recognising the role of, and the potential impact of demand, on these services.
   - All relevant partnership commissioners should seek to facilitate integration between key services.
   - National guidance documents should be used to inform service specifications and outcome frameworks.

3. There should be better engagement and pathways between primary and secondary care as well as the homelessness sector to improve identification and management of chronic conditions, particularly around prescribing, hospital admission and discharge.

4. Drugs, alcohol and mental health services should work more closely together to address the observed pattern of tri-morbidity commonly presented by homeless people in Salford. Specifically this work should include:
   - The development of specific protocols which reflect the complexity of health needs and which reduce the number of people ‘falling’ between services.
   - Pathways of care, which also recognise the role of primary and secondary care, should be developed that acknowledge the flexibility required by services to address homeless health needs relating to tri-morbidity.

5. Information systems should be developed to improve recording regarding the use of health services by homeless patients alongside protocols, which enable information sharing between services and across agencies.

6. Building on the patient engagement process conducted as part of this review, services should develop a system for ongoing dialogue with homeless patients.

7. The health needs and access issues experienced by homeless people should be communicated through the staff training process across the health economy.
1. EXECUTIVE SUMMARY
Homeless people are amongst the most socially excluded and vulnerable within society. They are exposed to a range of social and health inequalities and as a result experience serious and chronic morbidity and have a significantly reduced life expectancy. Access to, and utilisation of, health care services is both problematic and erratic. This paper outlines the emerging findings from the review of primary care services for homeless people in Salford in response to the limited understanding of the health needs of homeless people locally. The emerging evidence from this review indicates that there is a small but prolific group of homeless patients with complex and chronic health needs who are recurrent users of urgent care services. It is also apparent that the current LES needs to be revised to reflect local health need and priorities and evidence based models of provision. This report makes a number of recommendations based on these emerging findings.

2. BACKGROUND & INTRODUCTION
2.1.1 The purpose of this paper is to outline the emerging findings from the review of primary care services for homeless people in Salford. It describes the population and health needs of the homeless in Salford; evidence based models of care and the current provision, and use of, services locally. Information to complete this review has been drawn from a range of sources including national policy, guidance and research, local data, and from evidence provided by local stakeholders (See Appendix 1).

2.1.2 Homelessness is a major public health problem, being not only common, but also commonly associated with a range of significant and chronic health issues. In response NHS Salford commission Salford Health Matters (SHM) to provide general practice services specifically for homeless patients. This review examines the health needs of the local homeless population and the existing primary care service, to inform future commissioning arrangements.

2.1.3 Prior to this review there has been no formal health needs assessment of, or engagement with, the local homeless population to inform local primary care commissioning. Instead, the existing primary care service has evolved incrementally and has been predominantly service led.

2.1.4 During the last 12 months the existing service has been sporadically delivered owing to staffing issues resulting in recurrent changes, and subsequently concerns about the accessibility of the service for existing patients registered with the service.
2.2 Policy context and homelessness in Salford

2.2.1 Homeless people are amongst the most socially excluded, vulnerable and disadvantaged groups in society. They often have multiple and complex needs relating to housing, social care, health care, education and employment that cannot be addressed fully by any one agency.

2.2.2 Homelessness is not however a single entity but rather a spectrum of housing need, ranging from those who live for a short time in temporary accommodation to those who are regularly rough sleeping. Consequently there are different groups of homeless people:

- Homeless families accepted and re-housed by local authorities.
- Individuals who sleep rough or live in temporary accommodation, not accepted by local authorities and referred to the private sector.
- People seeking asylum.
- Those who are adequately housed, who face poor quality housing or over-crowding.

2.2.3 Local authorities have a statutory responsibility to provide advice, information and accommodation to people who are in priority need and present as homeless. Those defined as in priority need are:

- pregnant
- have dependent children living with them
- are over 60 years of age
- are unable to find a home due to illness or disability
- are homeless because of a fire or flood
- are 16 or 17 years old
- are leaving an institution such as the armed forces or prison

For people in priority need and assessed and accepted as homeless, the local authority has a duty to identify suitable accommodation both temporary and permanent. These individuals are regarded as the 'official' homeless population.

If someone has priority need but is intentionally homeless, the local authority must secure temporary accommodation for long enough to provide a reasonable opportunity for the applicant to obtain accommodation for him or herself and must ensure that advice and assistance is provided. If someone is homeless through no fault of his or her own but does not have ‘priority need’ (e.g. a single person or a couple who do not have a child and are not vulnerable), the authority must ensure that such applicants are provided with advice and assistance to help them obtain accommodation for themselves.

2.2.4 Salford data for the period 2010/2011 indicates that there were approximately 247 people assessed as officially homeless. These were predominantly single, female led families (61% of all applications assessed as in priority need); the majority of whom (67%) had dependent children. The main reported reason for homelessness was domestic violence (37% of applications) followed by those seeking asylum (27%). 19% of applicants cited physical or mental ill health as the cause of their homelessness.
2.2.5 By contrast, there is little known about those that do not present to, or who are not accepted by, local authorities and, as a consequence, are referred to as the ‘hidden’ homeless. This group usually includes single males (typically rough sleepers or sofa surfers) and illegal migrant workers.

Salford City Council estimate that there are small numbers of ‘hidden’ homeless residing in Salford, with rough sleepers typically migrating towards Manchester. A head count census in November 2010 identified 4 rough sleepers in Salford. Evidence from a local shelter provider however indicates that the actual figure maybe around 20 – 30. Furthermore, there are currently 79 homeless patients registered with SHM. It is therefore accepted that these figures capture a partial element of the local picture of ‘hidden’ homelessness, which by its nature is hidden, chaotic and transient.

2.3 Health needs

2.3.1 There is strong evidence that homelessness is associated with increased risk of physical, and mental, ill health and significantly reduced life expectancy. The average age of death, from predominantly preventable morbidity, for homeless people\(^\text{31}\) is 40.2 years.

2.3.2 The homeless are however not a homogenous group. The spectrum of health need reflects the diversity of the population. Those officially classified as homeless tend to be young families, headed by a lone female, whose health problems are of a general health and mental health nature. The ‘unofficially homeless’ tend to be older males who are more likely to be rough sleeping or living in a hostel and are the most vulnerable in terms of health need and outcomes. Their health problems are predominantly related to substance misuse or specific psychiatric disorders.

2.3.3 Amongst rough sleepers, those using night shelters, common lodging houses and hostels, there is increased mortality from accidents, suicide, violence and alcoholism and increased morbidity due to communicable disease (skin infestations, pneumonias, tuberculosis), musculo-skeletal disorders, dental/oral disorders, neurological disorders (including epilepsy) and gastrointestinal disease (including liver disorders).

People who sleep rough for a significant period of time are likely to have pre-existing health-related difficulties and will be less well equipped to access the healthcare they need. Their conditions can deteriorate and without targeted and proactive health services the complexity of their health needs result in a case mix that is far more costly to treat than that of the general population.

2.3.4 The health status of the ‘temporarily homeless’ in bed and breakfast (B&B) hotels has also been shown to be worse than age and sex matched controls who have a permanent home. Utilisation studies show that adults and children in B&B hotels have higher than expected rates of A&E use and emergency admissions. Burns/scalds and infections are also more common in children living in B&B accommodation.

\(^{31}\) Rough sleepers
2.3.5 For the young homeless, who may become involved in drug use or prostitution, HIV represents a particular risk. Whilst other communicable disease such as hepatitis A, B and C are also prevalent, especially amongst injecting drug users.

2.3.6 A wide range of mental health problems are also prevalent amongst the homeless population. Severe mental health problems are most common in rough sleepers amongst whom there is a high incidence of self-harm and suicide. Studies in homeless hostels also show a high prevalence of schizophrenia amongst residents, as well as a high prevalence of substance abuse. Depression, amongst adults, and behavioural disturbance amongst children, living temporary B & B accommodation is common.

2.3.7 Crucially homeless people demonstrate a tri-morbidity of physical illness, mental health problems and substance misuse. Moreover, ill health, particularly poor mental health, can be a cause and/or consequence of homelessness. Expert opinion suggests that the majority (circa two thirds) of serious chronic health problems amongst homeless people pre-exist before the person becomes homeless (and may be part of the cause of the transition to homeless), though will often be exacerbated by the person being homeless.

2.4 Health service access and utilisation
2.4.1 Health service access and utilisation is a major issue for those who are homeless. Complex health needs and chaotic lifestyles make it difficult for homeless people to access, and navigate services. Many homeless people have low health aspirations, poor expectations and limited opportunities to shape their care. They often report feeling 'invisible' or discriminated against. Furthermore, the homeless may have pressing 'survival' needs or for other reasons, including low self-esteem, do not recognise their health as a priority.

2.4.2 It is common for homeless people not to be registered with a GP and for there to be other barriers to accessing care, such as having previously experienced negative attitudes. It is estimated that this client group use around 4 times more acute hospital services than the general population. For inpatient costs, the figure rises to 8 times when the client group is compared to the general population aged 16-64. The most common reasons for admission include toxicity, alcohol or drugs, and mental health problems.

2.4.2 A 2002 report submitted to the Office of the Deputy Prime Minister detailed the access barriers to primary care for homeless people as: surgery opening times; appointment procedures; location; financial disincentives; and negative perceptions relating to violence, transience or antisocial behaviour.

2.4.3 Health professionals lacking awareness, skills and training compound this. Moreover the limited understanding of the health needs of homeless people inhibit the effective treatment of homeless patients. There is also a tendency to focus on presenting symptoms rather than underlying issues. Health promotion, prevention and recovery are often inadequately addressed.

2.4.4 Health services generally lack the flexibility to respond to the complex needs and chaotic lifestyles of homeless people. There are key gaps in and barriers to provision (e.g. access to mental health services for those with a dual diagnosis),
consequently it is easy for homeless people to fall between the gaps of different services.

2.4.5 Evidence suggests that homeless people may be more willing to engage with primary care services where relationships and trust can be built, dictating continuity of care. This is dually beneficial in terms of case management, particularly for long-term conditions and prescribing governance. Supporting continuity both in terms of longevity of care, and as people navigate between health (and other) services, is an essential feature of successful services.

2.4.6 Typically homeless people find it easier to access unplanned care settings than traditional primary care. Evidence from the literature suggests over utilisation of emergency and acute care. The most common reasons for admission include toxicity, alcohol or drugs and mental health problems. There is a lack of research evidence for improved primary care to reduce secondary care costs.

2.5 Models of provision

2.5.1 Research suggests that to be effective, and to address barriers to care, health service provision may need to be specialist in nature and located where it is needed most. The different arrangements for primary care provision for this client group have been loosely categorised into four models:

- **Model 1: Mainstream practices provide services for homeless**
  Example: A GP from a mainstream practice holds regular sessions for homeless people in a drop-in centre or sees them in his/her own surgery. May not register patients and no 24/7 provision. This model represents the least specialised and dedicated service.

- **Model 2: Outreach team of specialist homelessness nurses**
  Example: An outreach team of specialist nurses provide advocacy and support, dress wounds etc. and refer to other health services incl. dedicated GP clinics. Unlikely to register patients and no 24/7 provision.

- **Model 3: Full primary care specialist homelessness team**
  Example: A team of specialist GPs, nurses and other services (CPN, podiatry, substance misuse specialists) provide dedicated and specialist care. Co-located with a hostel / drop-in centre. Usually register patients and provide 24/7 cover. This is characterised as a full, specialist primary care homelessness service. This model has the potential to provide excellent primary care because it can tailor the service to meet their health needs and help overcome some of the access issues (such as to drug and alcohol dependency and mental health teams).

- **Model 4: Fully coordinated primary and secondary care**
  Example: A team of specialists spanning primary and secondary care provide an integrated service including: specialist primary care, out-reach services, intermediate care beds and in-reach services to acute beds. This model is the most specialist and dedicated model.

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2.5.2 Models 1 and 2 are recommended for PCTs with small homeless populations. Model 3 is suggested for major urban centres with larger homeless populations. Services that are suitable in areas with a very large population can include frequent walk in sessions or regular clinic sessions with Consultant Psychiatrists. It has be argued that the major urban centres such as London, Manchester, Birmingham have a sufficiently large homeless population for a fully integrated primary and secondary care service as per Model 4. Pilots are currently underway that seek to increase the integration of care for homeless patients. These include homelessness ward rounds in central London hospitals and care navigators: people with experience of homelessness, who can offer emotional support and assertive outreach for those most in need and link them up with services. This type of model could be achieved via a GM joint commissioning arrangement or through supra-district joint commissioning.

The Department of Health acknowledge that some PCTs may not have sufficient numbers of homeless people to justify a specialist homelessness service. In such cases, it is recommended that PCTs consider one of the less intensive models of provision (Model 1 or 2) or commission a more specialist service jointly with neighbouring PCTs.

2.5.3 Whilst the evidence base does not prescribe any specific model recommending a locally designed service solution based on the profile, and needs, of the local homeless population; the following are key features of successful service models:

- Joint and integrated provision, located where need is greatest.
- Outreach and co-located services to promote integration.
- Where services cannot be co-located, service users are supported in practical and hands-on ways to access and navigate services.
- Partners work together to address the observed pattern of tri morbidity commonly presented by homeless people. This may involve the development of specific protocols which reflect the complexity of health need and which reduce the number of people ‘falling’ between services. This is especially important if services are not located together.
- Multiple access and registration points including A&E, pharmacies, hostels and the local authority.
- All health providers have readily available and up to date information about primary care provision, including GP registration and access points, for homeless patients.
- Services managing long-term conditions are flexible and accessible for homeless people. Early identification, intervention and management of long and chronic conditions are also important to ensure long-term health benefits and to minimise costs.
- There are pathways, in and out of acute care, between hospital discharge teams, primary care providers and homelessness services to establish appropriate care, support and accommodation on discharge from hospital. More integrated pathways mitigate fragmented and crisis led use of service which incurs higher costs.
- There are support networks for clinical and non-clinical staff working with homeless service users to facilitate reflective practice, inform ongoing service provision and to provide training and education opportunities.
• Protocols are in place which facilitate information sharing amongst health service providers in order to ensure that care is co-ordinated. This is especially important in the case of homeless patients who often present with numerous chronic conditions and to ensure appropriate, and to mitigate against duplicate, prescribing.
• The number of ambulance call outs, A&E attendances, unscheduled hospital admissions and ‘revolving’ door patients are routinely monitored.
• Services use the Homeless Link Audit Tool to record and evidence the health needs of their clients. This then informs overall health need locally.

2.5.4 The chaotic nature of the homeless lifestyle means that traditional performance models may not be effective nor reflect performance adequately. Outcome measures therefore should seek to ensure continuous improvements with models of care that allow stabilisation of clients with complex needs and which avoid the deterioration of pre-existing long term conditions; alongside positive pathways to recovery.

2.5.4 It is important to recognise however that there is a lack of research evidence on the potential for improved primary care to reduce secondary care costs and improve health outcomes. It is likely however, that better primary care will improve health outcomes, producing valuable additional years of healthy life. It is also plausible that better primary care will reduce secondary care use and save money to PCTs, though improved primary care may also raise utilisation of secondary care via increased referrals for previously undiagnosed conditions. This should however improve outcomes and therefore give better value for money. The overall effect on costs and outcomes is not known.

3. OVERVIEW OF EXISTING SERVICES
3.1.1 The current service provided in Salford combines ‘outreach’ nurse triage at the Windsor Centre and ‘in-reach’, integrated primary care services delivered at Eccles Gateway.

3.1.2 The Windsor Centre provides services for homeless adults (18 years+) in Salford and, as a third sector provider, is collaboratively managed by Salford Loaves & Fishes Limited and Manchester City Mission. The Centre delivers a holistic range of services and facilities for homeless people, including night shelter accommodation. Approximately 60 – 70 people access the Centre everyday; around one third of these are rough sleepers and a further 10 – 15 are ‘sofa surfers’. The remaining clients, whilst functioning, remain vulnerable and are likely to be residing in temporary, or in transition to settled, accommodation. The Centre is used predominantly by males aged 30 – 50 years.

3.1.2 Up until 2007, and in keeping with evidence based models, the Service was provided outreach alongside a number of multi agency primary care providers. In 2007 NHS Salford established a LES contract with SHM for the provision of 20 hours of essential and enhanced primary care. The Service continued to provide outreach at the Windsor Centre with 3 – 4 GP sessions (2-2.5 hours per session) per week. Additional drug, alcohol and counselling services were also provided on site.
3.1.2 For the past 12 months the Service has undergone a number of changes, prior to and following the departure of the GP from SHM. Consequently, service provision has been sporadic and GP sessions erratic. As a result SHM informally reviewed the service and has, since 1st February 2011, provided an alternate service model.

3.1.3 The new model includes an outreach, nurse led triage service, supported by an Admin/Support Worker, at the Windsor Centre 4 days a week (Monday, Tuesday, Thursday & Friday). The SHM service outline indicates that this includes triage, registrations, health promotion, screening and health checks.

GP, drugs, alcohol and mental health services are provided on an appointment basis at Eccles Gateway on Thursday afternoon’s for 3.5 hours. On call GP services are available for emergency appointments on Monday, Tuesday and Friday at any of the SHM sites across Salford.

On Thursday’s patients are transported from the Windsor Centre, by Taxi, to Eccles Gateway for their appointment.

3.1.5 SHM report that the rationale for this change was:
- To provide more equitable services, engaging with a broader range of homeless people e.g. young people and families.
- To improve efficiency, in particular GP time.
- To facilitate access to the full range of primary care services, e.g. case management by the multidisciplinary team.
- To promote personal responsibility and define boundaries.
- To enable increased outreach for young people and families.

4. EMERGING FINDINGS

4.1 Homelessness and health in Salford

4.1.1 The majority of people who are homeless in Salford are those classified as officially homeless and for whom the local authority has a duty to provide suitable temporary and permanent accommodation. There is a smaller proportion (approx 4 – 30) of ‘hidden’ homeless people, who have not presented or are not classified as in priority need and therefore are ineligible for statutory settled accommodation.

4.1.2 Salford City Council is in the process of developing a homeless prevention action plan (Housing Options) which will include a health component, to improve health and reduce health inequalities. It will focus on people who are already housed or those in priority need. Salex Housing Limited is leading on this part of the plan.

4.1.3 There are 7 emergency accommodation and/or hostels across Salford and 1 night shelter. These each have specific eligibility criteria e.g. female or male only, young people etc. There are 5 which cater for single men over 18 years of age, 1 for single women, 1 for single young people aged 16 – 25 and 1 ‘wet’ hostel. Short stay emergency B & B accommodation is also available via Salford City Council and there are 2 female/family refuges available locally.
4.1.4 The evidence from this review suggests that whilst there is a spectrum of health need, reflecting the composition of the homeless population, the hidden homeless, particularly rough sleepers, are those most vulnerable; with complex physical and mental health needs. The health needs of rough sleepers are severe, neglected, complex and overlapping and, as a population, are hard to reach through mainstream services. Though small in number, this population account for the majority, recurrent and prolific group of urgent care services users locally. This group is also most vulnerable to serious morbidity and premature mortality. Addressing the health needs of chronically excluded adults, sleeping rough or living in the hostel system, is therefore a priority, rather than those who otherwise resolve their homelessness. This reflects national priorities which suggest work should be targeted towards:

- Rough sleepers
- Hostel and night shelter residents
- Squatters
- People staying temporarily with friends and relatives

4.1.5 It is however acknowledged that the homeless population is diverse and that there are a number of sub groups whose needs may not be adequately addressed, in particular young people and families.

4.1.6 The health needs of young homeless people are significant and, whilst not as chronic or complex as those experienced by rough sleepers and or excluded homeless adults, they have specific health needs in relation to sexual health and other communicable disease (particularly BBV).

4.1.7 Other people living in poor conditions (such as those in overcrowded or unfit homes) or those that are officially homeless, but resident in temporary or permanent accommodation, may also suffer from increased health problems linked to their housing situation. However they are not subject to the same barriers to accessing mainstream health care, and are not recognised to have health needs that are substantially different from the general population. This includes female led families, who typically remain with their existing GP or register with a new GP following relocation and whom are accustomed to accessing primary care services for general health needs. Dedicated primary care services, which address specific health needs, are also available for asylum seekers.

4.1.8 SHM have 79, predominantly male, homeless patients registered at the practice. Of those with a recorded status, 95% smoke and 30% are registered drug users. Only 5 patients registered with SHM are recorded as having a mental health issue. There is limited data available locally to indicate the number of alcohol dependent registered patients. However anecdotal evidence provided by both primary and secondary health professional stakeholders, consulted during this review, report alcohol and mental health as significantly prevalent and the reason for repeated attendance.

Patients, using the SHM Service, are typically signposted by the Windsor Centre and sometimes via A & E.
4.1.9 There is limited local data from which to assess the demand for acute and unscheduled care by homeless people in Salford. Last year however a homeless rough sleeper was recorded as the patient with the highest number of emergency admissions at SRFT, with a subsequent average length of stay of 4 days. The emergency admission costs for this patient totaled £22,000.

Anecdotal evidence suggests that emergency admissions for homeless patients predominantly relate to alcohol and mental health. Wound care and physical trauma conditions are also common. Demand is anecdotally recognised as being concentrated amongst a small number of prolific and chronic service users who are rough sleepers. It is also acknowledged that a number of alcohol related frequent fliers are homeless.

The health and social care needs of homeless patients are often significant and interrelated therefore complex care and case management is required. Whilst there is no active case management of homeless patients at SRFT, one of the ED Consultants has assumed informal responsibility for vulnerable and or violent patients including homeless people. This facilitates consistent acute care for recurrent service users and consequently informal monitoring of conditions and prescribing. The ED Consultant undertakes an informal care co-ordination role, liaising with a range of other agencies, in order to address the presenting and underlying health and social care needs of patients. However this is not formalised, is time consuming and frustrating as patients often ‘fall’ between services e.g. not fitting the service criteria particularly in the case of dual and or tri morbidity/diagnosis.

4.2 LES Performance

4.2.1 There are 79 homeless patients currently registered with SHM. These are predominantly male and have been referred and or registered via the Windsor Centre.

4.2.2 Appendix 2 illustrates LES performance data for 2011. Where the practice is performing well it relates to maintaining a register or recording numbers. Performance for key health issues such as BBV, screening, vaccinations, alcohol, mental health, smoking and sexual health is below target. To date there is no information available regarding the numbers of patients accessing wound management and the number of patients accessing drop-in services, health promotion and self care advice.

4.3 LES commissioning arrangements

4.3.1 The current LES needs to be redeveloped to reflect health need and evidence based models of care outlined in this report. Specifically:

- The LES should be informed by local health need therefore drugs, alcohol and mental health needs should be prioritised and target those with the poorest health outcomes.
- It should outline an appropriate primary care model, based on those described in section 2.5, to reflect the needs and challenges of the target population.
• The LES should include a core data set so that information on service user demographics is collected to inform commissioning and appropriate provision.
• The LES should ensure that there is routine performance management reporting. Performance indicators should reflect health priorities, focus on outcomes and should be developed to reflect the challenges of the target group. There should be no opportunity for providers to apply non-recurrent exclusions for screening and vaccinations for homeless patients.
• It is critical that the LES specifies the commissioners’ expectations in terms of the structural provision of services e.g. location (reflecting health need), consistent staff (e.g. the same practice nurse, GP etc) and the joint and integrated provision of key services such as mental health, drug and alcohol services. In particular the LES should clearly define what is meant and expected by ‘outreach’, co-location and integration. These are clearly defined in the Models outlined in section 2.5.
• There should also be flexibility within the LES to respond to changing health needs over time.

5. SERVICE USER CONSULTATION
5.1.1 To date there has been no consultation with the local homeless population regarding the design and or development of the existing service and or health services generally. Evidence suggests that engaging excluded people, such as homeless people, in the design of services is crucial to ensure it if fit for purpose.

5.1.2 As part of this review a series of consultation and engagement sessions are being held; targeting rough sleepers, young people and families. These are scheduled to take place in May and June 2011.

5.1.3 If resources and time are available consideration should be given to engaging, and consulting, with all 7 local emergency housing providers.

6. OUTSTANDING ISSUES/NEXT STEPS
6.1.1 The majority of the review has been completed; however there are some outstanding actions. These include:
- Meeting with drug, alcohol and mental health service providers to discuss arrangements for homeless patients.
- Service user consultation as described above. This will focus on those using/accessing the Windsor Centre but will also target other groups with specific health needs as described in this report, e.g. young people etc.
- Additional data from SRFT on the use of urgent care services.

7. CONCLUSIONS & RECOMMENDATIONS
7.1.1 This review has established that the current LES, and therefore existing Service, does not meet, or reflect, the health needs of the Salford homeless population.

7.1.2 It is evident that the health needs of rough sleepers, those using night shelters, common lodging houses and hostels should be prioritised. Services should also target young people, families and those in transition between temporary and settled accommodation to improve access and address health needs.
7.1.3 The LES should be redeveloped to reflect the health needs outlined, and based on the best practice models described in this report. The new LES should also be informed by the service user consultation to be conducted as part of this review.

In the interim consideration should be given to commissioning a temporary service solution from a neighbouring PCT. Both NHS Manchester and NHS Heywood, Middleton & Rochdale currently commission either mainstream or bespoke homeless primary care services.

GM level commissioning arrangements or supra-district commissioning may provide a longer term solution and also enable the provision of a specialist model as per Model 4. Furthermore this may be a more appropriate option given the size (small to medium) and nature (migration between Salford and Manchester) of the homeless population in Salford. This also represents a more cost efficient option in terms of economies of scale.
APPENDIX 1: Consulted Stakeholders

<table>
<thead>
<tr>
<th>Name</th>
<th>Designation/Organisation</th>
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<tbody>
<tr>
<td>Neil Turton</td>
<td>CEO, Salford Health Matters</td>
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<tr>
<td>Angela Trousdale</td>
<td>Practice Nurse for homeless service, Salford Health Matters</td>
</tr>
<tr>
<td>Karen Rogerson</td>
<td>Receptionist/Support Worker for the homeless service, Salford Health Matters</td>
</tr>
<tr>
<td>Dr Marek Zotkiewicz</td>
<td>GP, director and clinical lead for the service, Salford Health Matters</td>
</tr>
<tr>
<td>Dr Clare Gibbons</td>
<td>GP, clinical lead for Eccles, and GP for homeless service, Salford Health Matters</td>
</tr>
<tr>
<td>Nilli Williamson</td>
<td>Primary Care Commissioning Manager, NHS Salford</td>
</tr>
<tr>
<td>Jane Anderson</td>
<td>Service Manager - Housing Choice and Support, Salford City Council</td>
</tr>
<tr>
<td>Kate O’Sullivein</td>
<td>Windsor Centre Manager</td>
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<tr>
<td>Terry Durose</td>
<td>Director of Manchester City Mission</td>
</tr>
<tr>
<td>Dave Bullock</td>
<td>Windsor Centre Drop in Coordinator</td>
</tr>
<tr>
<td>Andrew MacDonald</td>
<td>DAAT Co-ordinator</td>
</tr>
<tr>
<td>Dr Neill Hughes</td>
<td>ED Consultant, SRFT</td>
</tr>
<tr>
<td>Melanie Walters</td>
<td>SRFT</td>
</tr>
<tr>
<td>Suzanne McDonald</td>
<td>SRFT</td>
</tr>
<tr>
<td>Dr Norohana</td>
<td>Retired GP responsible for setting up GP Service at the Windsor Centre</td>
</tr>
<tr>
<td>Tracy Williamson</td>
<td>Researcher, University of Salford</td>
</tr>
<tr>
<td>Julie Wray</td>
<td>User &amp; Carer Education Research, University of Salford</td>
</tr>
<tr>
<td>Christine Hogg</td>
<td>Researcher, University of Salford</td>
</tr>
<tr>
<td>Ruth Chadwick</td>
<td>University of Salford</td>
</tr>
</tbody>
</table>
APPENDIX 2: Homeless LES Clinical Indicator Performance 2010 & 2011

<table>
<thead>
<tr>
<th>Health Need</th>
<th>Description</th>
<th>Baseline Figures June 2010</th>
<th>Jan-11 (Actual Numbers)</th>
<th>Evidence</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>New Pt Checks</th>
<th>Homeless' patients on practice list</th>
<th>Practice List</th>
<th>82</th>
<th>79</th>
<th>Register</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drop-In Services</td>
<td>Names kept of pts accessing drop-in services, HP and self care advice</td>
<td>No. accessing drop in</td>
<td>No coding</td>
<td>No coding</td>
<td>Record</td>
</tr>
<tr>
<td></td>
<td>Target Group</td>
<td>8</td>
<td>8</td>
<td>Register</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Offered Screening</td>
<td>No coding</td>
<td>7</td>
<td>50% offered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SCREENED</td>
<td>3</td>
<td>3</td>
<td>50% screened</td>
<td></td>
</tr>
<tr>
<td>Cervical screening offered</td>
<td>Contraceptive Advice</td>
<td>0</td>
<td>1</td>
<td>Record</td>
<td></td>
</tr>
<tr>
<td>Core Contractual Services</td>
<td>Contraception</td>
<td>1</td>
<td>1</td>
<td>Record</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Flu Target Group</td>
<td>n/a</td>
<td>16</td>
<td>Record</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Offered Flu Vacccs</td>
<td>n/a</td>
<td>9</td>
<td>50% of registered patients</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Given Flu Vacccs</td>
<td>n/a</td>
<td>7</td>
<td>% given vacccs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pneumo Target Group</td>
<td>n/a</td>
<td>9</td>
<td>Record</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Offered Pneumo Vacccs</td>
<td>n/a</td>
<td>0</td>
<td>50% of registered patients</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Given Pneumo Vacccs</td>
<td>n/a</td>
<td>0</td>
<td>% given vacccs</td>
<td></td>
</tr>
<tr>
<td>Liver Disease</td>
<td>Register of patients with Liver disease</td>
<td>4</td>
<td>3</td>
<td>Register</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rx for Vit B Co &amp; thiamine</td>
<td>21</td>
<td>18</td>
<td>Record</td>
<td></td>
</tr>
<tr>
<td></td>
<td>FAST Scores</td>
<td>n/a</td>
<td>3</td>
<td>Record</td>
<td></td>
</tr>
<tr>
<td></td>
<td>AUDIT Scores</td>
<td>n/a</td>
<td>2</td>
<td>Record</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hep Screening Offered</td>
<td>No coding</td>
<td>12</td>
<td>Record</td>
<td></td>
</tr>
<tr>
<td></td>
<td>HEP B Imms</td>
<td>n/a</td>
<td>5</td>
<td>Record</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Referrals to SDAT</td>
<td>2</td>
<td>32</td>
<td>Record</td>
<td></td>
</tr>
<tr>
<td>Drug Misuse</td>
<td>Drug Misuse Register</td>
<td>30</td>
<td>24</td>
<td>Register</td>
<td></td>
</tr>
<tr>
<td>Alcohol Misuse</td>
<td>Target Group</td>
<td>82</td>
<td>79</td>
<td>Register</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Offered FAST</td>
<td>6</td>
<td>0</td>
<td>80% offered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Above 3 on FAST offered brief intervention/referral</td>
<td>3</td>
<td>0</td>
<td>100% offered</td>
<td></td>
</tr>
<tr>
<td>Module</td>
<td>Action</td>
<td>No. registered</td>
<td>% Offered Screened</td>
<td>% status recorded</td>
<td>% offered advice</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>------------</td>
<td>----------------</td>
<td>--------------------</td>
<td>-------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>BBV screening (on registration) for Hep, TB &amp; HIV to be offered</td>
<td>Audit</td>
<td></td>
<td>82</td>
<td>19</td>
<td>No info provided</td>
</tr>
<tr>
<td>Learning Difficulties LES</td>
<td>Register</td>
<td>0</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual Health</td>
<td>Audit</td>
<td></td>
<td>No coding</td>
<td>0</td>
<td>No info provided</td>
</tr>
<tr>
<td>MH QOF Register</td>
<td>Record</td>
<td>3</td>
<td>5</td>
<td></td>
<td></td>
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<tr>
<td>MH QOF Review</td>
<td>Record</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MH QOF Care Plan</td>
<td>Record</td>
<td>0</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MH QOF Review Follow up DNAs</td>
<td>Record</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bi-annual audit on use of A&amp;E &amp; crisis team in relation to mental health</td>
<td>Audit</td>
<td>tbc</td>
<td>tbc</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. smokers</td>
<td>Record</td>
<td>82</td>
<td>79</td>
<td>100% recorded</td>
<td>35</td>
</tr>
<tr>
<td>Smoking</td>
<td>Audit</td>
<td></td>
<td>No coding</td>
<td>No coding</td>
<td>No coding</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>Ethnicity Recorded</td>
<td>Preferred language recorded</td>
<td>100% of all patients recorded</td>
<td>60% of all patients recorded</td>
<td></td>
</tr>
<tr>
<td>----------------</td>
<td>--------------------</td>
<td>-----------------------------</td>
<td>------------------------------</td>
<td>-----------------------------</td>
<td></td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>0</td>
<td>26</td>
<td>17</td>
<td></td>
</tr>
</tbody>
</table>
## APPENDIX 2
### Homelessness, demographics and health needs by housing status

<table>
<thead>
<tr>
<th>Homeless Status</th>
<th>Accommodation Type</th>
<th>Accommodation Issue</th>
<th>Demographics</th>
<th>Health Needs</th>
</tr>
</thead>
</table>
| **Statutory Homeless** | Temporary | Households accepted by Local Authority | • Predominantly lone, female led families  
• Asylum Seekers | • Routine/general health  
• Mental health |
| **Non Statutory Homeless** | Insecure | • Squatters  
• Sofa Surfers  
• Temporary guests  
• Facing eviction | • Young people, often single | • Routine/general health  
• Mental health  
• Communicable disease (especially HIV, Hep A,B & C)  
• Substance misuse  
• Poor sexual health |
| | Unacceptable housing | • Overcrowding  
• Sub standard accommodation  
• Personal safety & wellbeing at risk | • Illegal migrants | • Routine/general health  
• Mental health  
• Violence |
| | Involuntary long term sharing | • Long term sharing against will | • Illegal migrants | • Routine/general health  
• Mental health  
• Violence |
| | Houseless | • Hostels  
• Shelters  
• Bed & Breakfast | • Single men and women | • Routine/general health  
• Mental health  
• Accidents (Burns, scalds & infection)  
• Behavioural disturbance (amongst children) |
| | Roofless | • Rough Sleepers | • Predominantly single males | • Substance misuse  
• Mental Health (psychiatric disorders)  
• Suicide & self harm  
• Violence  
• Accidents  
• Communicable disease  
• Musculo Skeletal Disorders  
• Dental/oral disorders  
• Neurological disorders  
• Gastrointestinal disease |
APPENDIX 3

Temporary Accommodation Providers in Salford (June 2011)

<table>
<thead>
<tr>
<th>Provider/Project Name</th>
<th>Address</th>
<th>Accommodation Type</th>
<th>Access Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive Lifestyles (Lancaster House)</td>
<td>7 – 11 Lancaster Road, Salford, M6 8AQ</td>
<td>Hostel</td>
<td>Single Males</td>
</tr>
<tr>
<td>Joan Lestor House</td>
<td>12 Ellesmere Street, Little Hulton, M38 9WJ</td>
<td>Hostel</td>
<td>Single women, 18+ only</td>
</tr>
<tr>
<td>Salford Foyer</td>
<td>1 Lower Seedley Road, Salford, M6 5WX</td>
<td>Hostel</td>
<td>Single, young people 16 – 25 years</td>
</tr>
<tr>
<td>SCC, Petrie Court</td>
<td>Cromwell Road, Pendleton, M6 6SX</td>
<td>Supported temporary accommodation</td>
<td>Young people 16 – 25 years</td>
</tr>
<tr>
<td>Positive Lifestyles (Eccles)</td>
<td>21 Cromwell Road, Eccles, M30 0QT</td>
<td>Hostel</td>
<td>Young people 16 – 25 years</td>
</tr>
<tr>
<td>Adullam Homes (Liberty House)</td>
<td>100 George Street South, Salford, M7 4PQ</td>
<td>Hostel</td>
<td>Young people 16 – 25 years</td>
</tr>
<tr>
<td>Project 34</td>
<td>32 – 34 Weaste Road, Salford, M5 5FW</td>
<td>Hostel</td>
<td>Single, 16+</td>
</tr>
<tr>
<td>Salvation Army</td>
<td>James Street Centre, 1 James Street, Salford, M3 5HP</td>
<td>Hostel</td>
<td>Single men 18+</td>
</tr>
<tr>
<td>ECHG SASH Project</td>
<td>Old Library House, Mandley Park, Leicester Road, Salford, M7 4DA</td>
<td>Hostel</td>
<td>Single men 18+</td>
</tr>
<tr>
<td>Positive Lifestyles (Royal Court)</td>
<td>66 -68 Parrin Lane, Monton, M30 8BD</td>
<td>‘Wet’ Hostel</td>
<td>Single men with alcohol dependence</td>
</tr>
<tr>
<td>Windsor Centre</td>
<td>Churchill Way, Pendleton, Salford, M6 5BU</td>
<td>Night Shelter</td>
<td>Single 18+</td>
</tr>
</tbody>
</table>
APPENDIX 4

The Faculty for Homeless Health (2011)
Standards for Commissioners, clinical health care and all services

Standards for Commissioners:
1. The accountable officer for homeless health care (whether in a GP Consortium or NHS Board regional office) should be at Director level or above.
2. Commissioners must publish evidence of partnership working with statutory and voluntary sectors and service user engagement at all levels.
3. Standard data sets concerning the numbers of homeless people, their health and associated expenditure in primary and community care and secondary care should be collated, reported and acted on by commissioners at least annually. Data should be collated in such a way that targets do not distort outcomes.
4. Means of enhanced/easy access to health care for homeless people should be described and publicised for each area – specialist services are not the only solution, enhanced access and outreach services from mainstream providers are also important. All primary care providers should be routinely tested for their willingness to register NFA patients.
5. Appropriate service responses to homeless patients - to these standards – must be commissioned and performance managed for community, specialist primary care, mainstream primary care, dental care and secondary care.
6. Commissioners should require proactive care planning, so encouraging a move away from gate keeping (spending time assessing and rationing entitlement) towards proactively planning to meet people’s needs.
7. Commissioners should require horizontal, patient-centred integration. By this we mean care planning and continuity across community settings and service provider boundaries, so that people can continue to receive continuity of care even if they lose the address that originally gave access to that care.
8. Commissioners should require vertical integration. By this we mean care planning and continuity of care into secondary care and back into the community. A clear expectation of compassion, communication and continuity of care between secondary, primary and community care.
9. Measures of success should be shared across multiple agencies, such as reductions in rough sleeping, anti-social behaviour, un-scheduled re-admission within 28 days, and unplanned A&E re-attendance within seven days.
10. There should be specific commissioning plans for homeless children and young people, as their care pathways and service requirements may differ.

Clinical standards in Homeless Health Care:
2. Multi-disciplinary collaborative care is central to effective care because many homeless people present with multiple healthcare needs.
3. Person centred care with service user involvement in planning and delivery. For example the Care Programme Approach used in mental health services.

4. The Recovery approach developed by users of psychiatric services should be incorporated into the design of all services. Summarised by the phrase – Hope, Agency and Opportunity for all14, this seeks to make shared decision making the norm. “No decision about me without me”16.

5. Where specialist services are provided they should act as a catalyst to improve care throughout the local health service.

6. Homeless services should provide the bridge linking hospitals and community care through hospital in-reach services.

7. Homeless services should work closely with public health departments particularly with important communicable diseases (e.g. TB or blood borne virus transmission).

8. Services should actively seek to offer treatment to refugees, asylum seekers, migrants and those with no recourse to public funds.

9. Homeless services should include the provision of “respite care” (now in 50 Cities in USA and Canada) – community based residential medical facilities for homeless people with significant and complex health care problems. This could be achieved cost-effectively through joint working with local hostels and the voluntary sector. These services improve outcomes and reduce subsequent unscheduled hospital admissions.

All Service Standards:

1. Regular involvement in, and where necessary leadership of, multi-agency planning for rough sleepers. Visible service user involvement in planning and evaluation of services.

2. Coordination of the health care of homeless people as they move between different organisations (hostels/drop-ins, shelters for homeless families, etc).

3. Child and family services to be linked to homeless family hostels with children treated and recorded as individuals, not nameless adjuncts to the parent.

4. Coordinated health care in hospital settings by collaboration with homeless ward rounds and attending multi-agency care planning meetings. Informative and timely discharge summaries should be standard even when the patient self discharges and should also contain information about any substitute opioid prescribing including date and quantity of last dose.

5. Plans for assertive outreach for non-engaged clients in each area; e.g. specialist clinicians with flexible hours, able to provide street outreach.

6. Recording of housing status with regular review.

7. Consideration of security, including the set up and location of clinical services, access to notes and alerts, and chaperones where necessary.

8. Participation in documenting, researching and publishing on the health hazards of homelessness, evaluations of service delivery models, continuous monitoring of longer term outcomes.

9. Education and involvement in undergraduate and postgraduate training of medical, nursing, dental, psychological therapies and social work students. Develop links with relevant professional bodies.
11. Promotion of homeless health care as a viable and attractive career choice for staff.
Patient Engagement Survey to assess the needs of homeless people in Salford
Author: Kris MacKay, July 2011

Purpose of report
As part of the current review of Primary Care Services for Homeless People we have conducted patient engagement survey to find out service user views on current provision.

The purpose of the engagement was to meet the following objectives:

1. To gain a better understanding of the community profile.
2. To understand the needs of the homeless community in relation to health.
3. To establish current awareness and use of health services.
4. To better understand access and experience of using health services.
5. To understand expectations/aspirations of health needs and services.
6. To identify priorities and preferences for healthcare provision

Methodology

Face to face interviews
We attended the Windsor drop in centre on two occasions to conduct face to face interviews with services users. These were recorded on questionnaires and then written up into Case Studies. These can be found at the end of the report.

Postal Questionnaire
Contact was made with service managers at the 7 hostels supporting homeless people across the city and sent out questionnaires for completion with their residents.

<table>
<thead>
<tr>
<th>Hostel</th>
<th>Client Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lancaster House</td>
<td>Single men 18+</td>
</tr>
<tr>
<td>Joan Leicester House</td>
<td>Single women 18+</td>
</tr>
<tr>
<td>Salford Foyer, Liberty House</td>
<td>Singles 16-24</td>
</tr>
<tr>
<td>Project 34</td>
<td>Single men 18+</td>
</tr>
<tr>
<td>Salvation Army</td>
<td>Single 18+</td>
</tr>
<tr>
<td>SASH</td>
<td>Single men / ex-offenders</td>
</tr>
<tr>
<td>Royal Court</td>
<td>wet' hostel</td>
</tr>
</tbody>
</table>

Of the 7 hostels contacted 5 were able to submit completed questionnaires and 51 completed forms were collected.

Unfortunately we did not receive any questionnaires from Joan Leicester House so the views of single women aged 18 and over are not represented in the findings of this report. Despite not receiving any questionnaires from the Salford Foyer which caters especially for singles age 16 – 24, we did manage to capture a significant number of this group from the other hostels.
1. Community Profile

Age
The majority of respondents were aged between 25 and 44. What is perhaps surprising is that 34% of respondents were in the younger age bracket but were not accessing the hostel specifically tailored to their age group. We did not get any responses from Salford Foyer which specifically works with this age group.

Gender
Only 2 of the 51 respondents were women and they were both accessing the Windsor centre. As mentioned above, we were unable to get any completed questionnaires from Joan Leicester House, the single women’s hostel.

Ethnicity
82% of respondents reported their ethnicity to be White British. 14% identified themselves as from BME communities. This represents a higher percentage than across the Salford population as a whole where people from BME populations make up 5.8%.

Respondents = 49

Main Spoken Language

Respondents = 50

Service accessing
In addition to the face to face interviews we also received 41 questionnaires from 5 hostels across the city. The breakdown is as follows:

<table>
<thead>
<tr>
<th>Service</th>
<th>N. of respondents</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Windsor Centre</td>
<td>10</td>
<td>19.6%</td>
</tr>
<tr>
<td>Lancaster House</td>
<td>7</td>
<td>13.7%</td>
</tr>
<tr>
<td>Project 34</td>
<td>11</td>
<td>21.6%</td>
</tr>
<tr>
<td>Royal Court</td>
<td>5</td>
<td>9.8%</td>
</tr>
<tr>
<td>Salvation Army</td>
<td>12</td>
<td>23.5%</td>
</tr>
<tr>
<td>SASH</td>
<td>6</td>
<td>11.8%</td>
</tr>
</tbody>
</table>
Respondents = 51

Currently residing
The majority of respondents were from hostels. Of those we spoke to at the Windsor Centre, only 1 gentleman was sleeping rough; 8 were already moved into their own privately rented accommodation and 1 was currently residing at Project 34.

<table>
<thead>
<tr>
<th>Place respondents sleep</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Rough sleeper, 1</td>
<td>1</td>
</tr>
<tr>
<td>Rented Flat, 9</td>
<td>9</td>
</tr>
<tr>
<td>Hostel, 41</td>
<td>41</td>
</tr>
</tbody>
</table>

Respondents = 51

Post code
The respondents were all living within 5 Post Codes:

<table>
<thead>
<tr>
<th>Post Code</th>
<th>N.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>M3</td>
<td>14</td>
<td>28.6%</td>
</tr>
<tr>
<td>M5</td>
<td>11</td>
<td>22.4%</td>
</tr>
<tr>
<td>M6</td>
<td>11</td>
<td>22.4%</td>
</tr>
<tr>
<td>M7</td>
<td>8</td>
<td>16.3%</td>
</tr>
<tr>
<td>M30</td>
<td>5</td>
<td>10.2%</td>
</tr>
</tbody>
</table>

Respondents = 49

Disability
The majority of respondents did not class themselves as having a disability; only 36%. For those accessing the Windsor Centre, this rose to 80%. Mental health was by far the most common disability specified.
Respondents = 49

Respondents = 50

Happy to take part in surveys
The majority were happy to take part in surveys and particularly those we interviewed at the Windsor Centre expressed their appreciation of having the chance to air their views on the services provided.

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>65.2%</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>8</td>
<td>17.4%</td>
</tr>
<tr>
<td>Unsure</td>
<td>8</td>
<td>17.4%</td>
</tr>
</tbody>
</table>

Respondents = 46
2. Current access to / use of health services

Registered with a GP
79% of respondents were permanently registered with a GP with an additional 4% registered as temporary patients. Most were registered with a local GP. 20% of respondents were registered with Salford Health Matters. For the 17% not registered the main reasons given were that they had either not had any need to visit the GP or that they have been put off by bad past experiences of services.

Respondents = 48

GP Practice

Service use in the past 12 months
The majority of respondents were registered with a GP and had seen them within the past 12 months. Use of GP Out of Hours and Walk in centres was less well utilised. A&E use was predominantly linked to alcohol, injury or mental health. For general inpatient / outpatient use of hospital services routine appointments, minor surgery, alcohol and mental health were given as reasons for treatment.
35% had seen a dentist in the past 12 months and 24% an optician.

The table below states the free text reasons given for use or non use of services.

**Service use in the past 12 months**

<table>
<thead>
<tr>
<th>Service</th>
<th>Use 0</th>
<th>Use 5</th>
<th>Use 10</th>
<th>Use 15</th>
<th>Use 20</th>
<th>Use 25</th>
<th>Use 30</th>
<th>Use 35</th>
<th>Use 40</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GP</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GP OOH</td>
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<tr>
<td>Walk in centre</td>
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<tr>
<td>A&amp;E</td>
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<tr>
<td>Dentist</td>
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<td>Optician</td>
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</table>

**Respondents = 49**

**Reasons for use of services**

<table>
<thead>
<tr>
<th>Service</th>
<th>Reason</th>
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</thead>
<tbody>
<tr>
<td>A&amp;E</td>
<td>Laceration to head</td>
</tr>
<tr>
<td></td>
<td>Broken hand/broken jaw</td>
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<tr>
<td></td>
<td>D&amp;D</td>
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<tr>
<td></td>
<td>Infection after operation on neck</td>
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<td></td>
<td>Alcohol</td>
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<td></td>
<td>Alcohol / TB</td>
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<tr>
<td></td>
<td>Stitches in left eye</td>
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<td></td>
<td>Shoulder injury</td>
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<tr>
<td></td>
<td>Suicide</td>
</tr>
<tr>
<td></td>
<td>Piece of glass in foot</td>
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<tr>
<td>OOH</td>
<td>Fits</td>
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<tr>
<td></td>
<td>Prescription</td>
</tr>
<tr>
<td>Walk in</td>
<td>Glass in foot</td>
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<td></td>
<td>Dressings</td>
</tr>
<tr>
<td>Hospital</td>
<td>Blood clot on lung</td>
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<tr>
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<td>Can’t remember</td>
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<tr>
<td></td>
<td>Alcoholism</td>
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<tr>
<td></td>
<td>Routine appointments</td>
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<tr>
<td></td>
<td>Crisis team</td>
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<td></td>
<td>Outpatients – Melanoma removed</td>
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<td></td>
<td>Physiotherapy</td>
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<tr>
<td></td>
<td>Liver problems</td>
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<tr>
<td></td>
<td>Operation on neck</td>
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<tr>
<td></td>
<td>Appointments</td>
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<td></td>
<td>Alcohol</td>
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<tr>
<td></td>
<td>Alcohol – T/B</td>
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<tr>
<td></td>
<td>Reasons for non-use of services</td>
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<tr>
<td>-------------</td>
<td>----------------------------------------------</td>
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<tr>
<td><strong>GP</strong></td>
<td>Haven’t needed it</td>
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<tr>
<td></td>
<td>Not ill</td>
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<tr>
<td></td>
<td>Doesn’t want to</td>
</tr>
<tr>
<td></td>
<td>Doesn’t want to</td>
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<tr>
<td><strong>Dentist</strong></td>
<td>Trying to get registered</td>
</tr>
<tr>
<td></td>
<td>Not thought about it</td>
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<tr>
<td></td>
<td>Not got one</td>
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<tr>
<td></td>
<td>Still registered in Stretford</td>
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<tr>
<td></td>
<td>Don’t need to</td>
</tr>
<tr>
<td></td>
<td>Not needed it</td>
</tr>
<tr>
<td></td>
<td>Lack of knowledge</td>
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<tr>
<td><strong>Optician</strong></td>
<td>Should visit</td>
</tr>
<tr>
<td></td>
<td>Cancelled appointment as not well</td>
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<tr>
<td></td>
<td>Good eye sight</td>
</tr>
<tr>
<td></td>
<td>Don’t need to</td>
</tr>
<tr>
<td></td>
<td>Can’t afford it</td>
</tr>
</tbody>
</table>
3. Treatment Preferences

Choice of venue to be seen
Respondents favoured being seen at a local GP practice on the whole (71%). Patients interviewed at the Windsor Centre were keen to comment how convenient they had found it when the GP was available at the centre.

Respondents = 35

Preference for appointment times
Overall there was an equal split of preference for morning and afternoon appointments. Evening appointments were less preferred. All respondents from the Windsor Centre indicated afternoon appointments as a preference although some were also happy with other appointment times.

Respondents = 41
4. Experience of using health services

Overall experience
Overall 76% of respondents were either satisfied or very satisfied with the primary care services they received. 19% were dissatisfied or very dissatisfied with the services.

Nb. This question was not directly asked through the questionnaire, but has been compiled from the free text responses given to the question asking respondents of their experiences of health services. A full list of these comments can be found below.

In addition, a more in depth description of service user experiences from the Windsor Centre can be found in the write ups from the face to face interviews at the end of the report.

![Satisfaction with services chart]

Respondents = 21

Barriers to access
Transport was seen as the biggest barrier to accessing services. Problems with actually getting through to the surgery and being able to get an appointment were also listed as challenges. Privacy and choice of doctors was also scored highly as a barrier.

Anecdotally in the face to face interviews a lack of understanding of the group and perceived prejudice against homeless people, those with mental health and addiction problems also came out as a theme which acted as a barrier to accessing services. Knowledge of services seemed to be most prominent around access to dentists and opticians with a number of respondents being unaware of how to access these services locally. These themes can be seen in more detail in the free comments below and also in the interview write ups at the end of this report.
General Comments
Experience of Using Health Services

- Tricky
- Overall it has been good
- I have been very satisfied with the services I have received from the health services
- So far so good
- Bad
- Generally good
- Fair services
- I think very good
- Overall good
- I suffer from anxiety and panic in crowded rooms
- Nerves
- Good
- Not used it
- Good
- Too many catastrophic health problems, think I’m just begging for dole money so won’t go
- Good
- Good
- All OK experiences
- Good
- OK
- Not good
- Hospital good, GP not so good
- Happy with service
- Never had a good experience
- Good, nothing to improve
5. Health needs

Self assessment of overall health
Most respondents assessed their health as ranging from fair to very good. Only 10% felt they had bad or very bad health. Despite nearly 80% of respondents declaring themselves to have a long term condition this did not seem to impact strongly on their assessment of their own levels of health.

Respondents = 50

Long term condition

Nature of Long term condition
The most common long term conditions reported were mental illness (57%) and back pain (39%). High blood pressure was the next most common, followed by other, COPD, Asthma and Arthritis.
Respondents = 44

Dependencies
83% of respondents reported dependencies of one kind or another. The most common was nicotine, with 49% or respondents recordings that they were smokers. Nearly 30% reported being dependant on alcohol.

Of those interviewed at the Windsor Centre, all reported either drug or alcohol dependency. All 3 respondents using methadone and diazepam were accessing this service.

Respondents = 41
6. Self Defined Health Priorities

Most important treatment areas
In answering this question, respondents were asked to prioritise from 1 – 5 what treatment areas were most important to them.

Mental health came out as their top priority followed by dental treatment, management of long term conditions, eye treatment and addiction.

![Most important treatment area graph]

Respondents = 45

What respondents are currently getting help with
25 respondents reported mental health problems, but only 16 said they were currently receiving treatment for this and 23 reported they would like more help in this area.

Again of the 34 who reported addiction or dependency only 15 were receiving support. Whilst some may not be seeking treatment, 13 respondents indicated they would like more help in this area.

Out of 35 reporting LTC only 13 claim to be receiving treatment for this and 9 state this is something they would like more help with.

Dental treatment is one of the key areas respondents would like more support with and tying into the theme mentioned above that there is a lack of awareness of how to access this provides a potential area for service improvement.
Currently receiving treatment for

- Dental treatment
- Addiction
- Mental Health
- Long term condition
- Eye treatment
- Podiatry
- Skin problem
- Chest complaint
- STI
- Other

Respondents = 47

What respondents would like more help with

Would like more help with

- Dental treatment
- Addiction
- Mental Health
- Long term condition
- Eye treatment
- Podiatry
- Skin problem
- Chest complaint
- STI
- Other

Respondents = 47
Care priorities
For this question respondents were asked to rank in order of importance from 1 – 6 the care priorities detailed in the table below. Confidentiality and understanding were rated highest and in free comments and findings from the interviews this was supported. Quality came in a close third, followed by shared decisions, dignity with access being rated as least important.

<table>
<thead>
<tr>
<th>Priority</th>
<th>Score</th>
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<tbody>
<tr>
<td>Confidentiality</td>
<td>100</td>
</tr>
<tr>
<td>Understanding</td>
<td>90</td>
</tr>
<tr>
<td>Quality</td>
<td>80</td>
</tr>
<tr>
<td>Shared decisions</td>
<td>70</td>
</tr>
<tr>
<td>Dignity</td>
<td>60</td>
</tr>
<tr>
<td>Access</td>
<td>50</td>
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</table>

Respondents = 38

One thing we could change
At the end of the questionnaire we allowed respondents the opportunity to tell us what one thing we could change to make the biggest impact on their health. These are listed below as free text.

- Understanding GP’s around homelessness and previous misuse of substances
- Equal treatment
- Putting point across with verbal sessions like this
- Support from services like Windsor
- Keep to appointment times / not running late
- Ensure current long term health problem is resolved ASAP
- Free gym
- Nothing
- Give me money to go private
- Alcohol
- Believe what I tell you
- Improving communication between liaising services in order to deal with issues promptly and correctly
- Help with getting a travel pass
- Better medication
- Sort my foot out
- All my ailments are being looked at
- More support workers
- More understanding for people with alcohol dependencies
- Stop drinking to eat more
- More options for people with drug problems
- I want to feel good, that is why I want to see a dentist as soon as possible
- Get help with Dental Treatment
- Help with mental health issue. Help with Cromwell House, Eccles and Ramsgate House, Salford, confirming mental health condition or mental health illness. I will be unable to understand a responding to financial position answer from either of above
- Find me a place that doesn't have stairs
- Getting appropriate accommodation, don't particularly want to speak to my health service ever again
- My teeth
- Psychiatric evaluation
- Stop smoking
- To have more down to earth doctors in the surgery
- Get me treatment for hepatitis C, Counselling over life getting back to my family in Glasgow, due to murder trial
- A full medical check up would be better for me
- More services like the Windsor
- More services like the Windsor centre
- Have more services where he could voice his opinions and verbally communicate his needs
- Having a doctor who understands people with addictions and treats everyone the equally even if they are homeless
- Appointments to be kept on time
- Speak to a GP to sort out his medication
- Speak to a GP to sort out his medication
Respondent interviews

Responses from one to one interviews held on 7th June 2011
11.45am – 2.15pm

Interview 1

This gentleman has used the beds in Windsor for some time in the past and has now moved on to Project 34, Weaste Lane, Salford. This is supported housing. The Windsor centre has been so good for him and he has moved on so much as a result of the services there.

Late last year (2010) this gentleman fell outside the Windsor Centre and hurt his foot. He carried on with usual daily routine and after a while got looked at hospital. He actually had got a piece of glass stuck in his foot which turned into cellulitis. His experience was ‘ok’ with the hospital service.

He described his overall health as bad.

He uses a crutch to walk every day as he broke his hip and now has problems with walking. His leg is almost mechanical as he has pins and metal plates in it, this was from an assault with a baseball bat.

He has metal plates in his forehead and also the back of his head.

Not really used any other services in the last twelve months other than a walk in centre and he said he was waiting 4 hours for them to say he was in the wrong place!

This gentleman has a dentist where he has just recently (within the last 12 months) had treatment over a 6 month period, he said it was so slow as they did 2 teeth at a time but this is now finished and he is happy with the result.

An afternoon appointment or early evening would be the preference for this man as he very rarely gets up early. It may have been different had he been sleeping in the night shelter at Windsor he said he was woken at 6am and then was walking the streets other than the services he accessed then until 10pm when the shelter was open to go to bed.

There is no preference where the health service is located for this gentleman as long as he is able to get there. He is currently happy using the service from the Windsor centre where he gets a taxi provided to go to Eccles gateway.

Area of ill health at the moment in order of most problematic are:

Addiction (alcohol)
Long term condition (asthma)
Skin problems
Foot Problems
Dental treatment

He is currently getting help with most of these but would like more support with addiction and his hay fever.

The service areas in order of importance which matter to this man are:

Being able to get there/access the service
Confidentiality/Privacy
Seeing someone who understands my needs
Being treated with dignity and respect
High quality care and treatment
Being involved in decisions with my treatment

The last question for this gentleman was if we could wave a magic wand to provide you with what you need in relation to health, what it be? He said to take me back to the way I was!

Also that there needs to be more support services like the Windsor centre and staff as without it he would not have made the steady progress he is making. There were definite signs of the uncertainty of the Windsor centre closing.

**Interview 2**

This gentleman numerous health conditions which he relies on support for. He is unable to go anywhere without someone, however has moved on from being homeless and now has his own flat on the Islington estate, Trinity Way. He has moved into Salford from another area.

He insisted on standing up during the interview as he could not sit for long he needed to keep moving due to his condition.

He appeared very agitated and uneasy at first however he stayed interested and engaged for the full interview which lasted over 30mins.

His experience of the doctors within the Windsor centre has not been good as the doctor has suggested he needs to come off his medication for his Schizophrenia after being on it for over 20 years. This would in his opinion make him have blackouts and become very poorly again. His doctor at the Windsor centre in his opinion seemed to dismiss all of his previous medical history and want to start a fresh which caused concern for this man as he relies heavily on medication he knows works and has been taking for long periods of time. He has since changed his GP as he now has a flat and is registered with the GP at the Angel Centre. He is extremely happy with both the doctors he now sees, he visits them once a month for regular check ups.

This gentleman has had 4 heart attacks, has arthritis, asthma, chronic back pain, heart disease, high cholesterol, COPD, chronic bronchitis, and numerous mental health conditions (manic depression, suicidal thoughts, schizophrenia)
He is a regular smoker and has dependencies with cannabis.

Over the last 12 months he is unable to remember if he has been in hospital, he has used the walk in centre at Pendleton but can’t remember why. He is currently having extensive dental work at the griffin practice. He has numerous teeth missing and is having a the rest extracted in phases.

He has recently cancelled an appointment with his optician as he was too ill on the day, he is going to make another one soon. In his words he has bad sight.

Afternoon appointments are very much preferred after 1pm as he doesn’t get up until late morning and would miss morning appointments. He is happy to go anywhere for a doctor as long as he is able to get there.

Area of ill health at the moment in order of most problematic are:

Chest complaints mainly bronchitis
Long term condition (asthma)
Dental treatment
Eye treatment
Addiction (cannabis)
Mental health

He is currently getting help with all of these but would contact his GP if he needed anything else.

The service areas in order of importance which matter to this man are:

Being involved in decisions with my treatment
Seeing someone who understands my needs
Being treated with dignity and respect
High quality care and treatment
Confidentiality/Privacy
Being able to get there/access the service

The last question for this gentleman was if we could wave a magic wand to provide you with what you need in relation to health, what it be? He said to have more services where he could voice his opinion and verbally communicate his needs. More interviews like this. He also said he wanted more services like Windsor centre as this is so helpful with support.

**Interview 3**

This gentleman had lots to tell us he split from his partner ten years ago and in his words it all went wrong from there. He ended up homeless living on the streets and became drug and alcohol dependant.

He has bad sight and has challenging mental health issues, he has severe depression and has been in Meadowbrook a few times.
He has blood clots in his legs and on his lung. He has flare up of these where his legs balloon and he has to access emergency treatment. Last time this happened he could not move and he was unable to get out of his flat. This episode built up over a month and he relied on his friend to bring him food. He ran out of gas and electric as he was on payment meters and did not have a phone after a week of living without the essentials he had to crawl out of his flat onto the street (he has a ground floor flat due to his condition) where two men found him and they phoned an ambulance. The gentleman was very vocal around the fact that his experience with emergency treatment such as in this case has been really good. However he feels he has been let down tremendously by all of the other services he has accessed or been referred into GP's. He feels he has been judged wherever he has gone.

He was given a prescription by one GP at the Pendleton gateway with the words try this as we are running out of options for this customer on it. The patient was told by the Pharmacist to keep it as this is bad practise, he has kept it. This is a clear example of his self worth being destroyed as he described people have treated him differently due to him having addictions and being homeless. This is why he found it essential to have a doctor at the Windsor centre who understood this type of client group.

He has stints of severe mental health issues such as suicidal thoughts, the advice he has been given by his last GP was to go to the mental health team within A&E when he feels like this. He said other than this he has never been offered support for his mental health.

He has Hepatitis C G type1, for this he is under North Manchester General Hospital and should attend once a month. This man is unable to afford the travel costs to get to this hospital therefore doesn’t bother going. There is a question around whether this service is provided within Salford somewhere. It is for injections.

In addition to this man should go to Salford Royal Hospital three times a week for anti-coag treatment for deep vein thrombosis (DVT), he said again financially he is unable to get to these appointments and often doesn’t bother.

He lives in his own flat after using the Windsor service. This is in Pendleton, M6.

He has Neuropathic Nerve Damage and three weeks ago was prescribed epilepsy tablets for this. They made him very ill. He isn’t happy about this and due to this now refuses to go to his GP. This is at Pendleton Gateway, the man said he has no trust in his knowledge and feels like he had been unfairly treated by him as mentioned previously in the interview.

He describes his overall health as very bad.

Cost is a huge barrier as being put on hold on the phone by trying to get an appointment for a GP is a lengthy and therefore costly process.

Over the last 12 months he has attended hospital through A&E with his blood clots, he has been to his GP where he has had bad experiences as mentioned. He uses the dentist at the Windsor centre and is extremely happy with this service and thinks there should be a GP in the same way.
He would definitely prefer afternoon appointments and would want a GP at Windsor as they seem to be more understanding and treat people equally.

This gentleman is a regular smoker.

Area of ill health at the moment in order of most problematic are:

Mental Health issues
An existing long term condition (Hep C)
Skin problems
Chest complaints mainly bronchitis
Dental treatment

He is currently getting help with his dental treatment and his chest complaints however really feels he needs more help with skin problems, Hep C and his mental health issues.

The service areas in order of importance which matter to this man are:

Confidentiality/Privacy
Seeing someone who understands my needs
Being treated with dignity and respect
Being involved in decisions with my treatment
High quality care and treatment
Being able to get there/access the service

The last question for this gentleman was if we could wave a magic wand to provide you with what you need in relation to health, what it be?

Having a doctor who understands people with addiction and treats everyone equally even if they are homeless.

**Interview 4**

This gentleman overall said he was happy with the health services he has had so far.

He mental health issues in the way of depression and anxiety. He has regular back pain when he walks and has a irregular heart beat.

Overall he would describe his health as fair.

He attends his GP once a month for regular check up and repeat prescriptions, this service is at the Windsor drop in centre. As mentioned he is very happy with this service and it has been great whilst he has been homeless. However he now has his own flat on Blackfriars M3 7ER. He would like to register with the Mocha Parade Practise for a GP as this is on his doorstep, unfortunately he has been told by the receptionist that it is not possible for him to register as he takes daily medication for his irregular heartbeat and the GP can not prescribe medication for the first three months for a new patient!!! I have brought this back to investigate as this does not sound right.
Each month he books an appointment to see his GP with the Windsor centre, he has to get to the Windsor centre, wait for a taxi to pick him up and get to Eccles gateway. He then gets a taxi back to the Windsor centre and then goes home. Although he is happy with this service he would like to be able to cut out all of the time it takes to get to his GP, it makes sense in his opinion to go to his most local practise. His partner is currently registered with the Mocha Parade Practise.

In the last 12 months he has been in hospital as an outpatient as he has had a melanoma removed. He has not been to the dentist as he never needs to as he now has dentures. He wears glasses and has to go regularly for check ups and new prescriptions if needed.

He has a dependency on cannabis, which he would like to stop. He is also a regular smoker.

He would definitely prefer afternoon appointments to see a GP.

Area of ill health at the moment in order of most problematic are:

- Addiction (Cannabis)
- Mental Health issues
- An existing long term condition (irregular heartbeat)
- Chest complaints mainly bronchitis
- Eye treatment
- Podiatry

He is currently getting help with his irregular heartbeat and his mental health issues however would like more help and support around his cannabis dependency.

The service areas in order of importance which matter to this man are:

- Confidentiality/Privacy
- Being able to get there/access the service
- Being treated with dignity and respect
- Seeing someone who understands my needs
- Being involved in decisions with my treatment
- High quality care and treatment

The last question for this gentleman was if we could wave a magic wand to provide you with what you need in relation to health, what it be?

When he has a doctors appointment he would appreciate it if they kept to the agreed appointment times as usually the are running late and he is waiting for long periods of time.
Responses from one to one interviews held on 16th June 2011
11.45am – 2.15pm

Interview 5
This lady was previously living in Hulme for four years but has moved over to Salford in the last 3 months,

Her main difficulty in accessing services was getting an appointment with a GP. If she rings for an appointment she is told she has to wait a week for a pre-booked appointment or can call back early the following morning which is not always easy to do.

She was previously very happy with the GP she had in Hulme on Boundary Lane as she could always get an appointment and felt that the GP understood her needs. She is generally in good health apart from addiction problems with Methadone and Diazepam. She does not currently have access to a Dentist but would like to register for treatment.

She stated that she does not want to use services inappropriately. For example she has not been to the dentist for years as she has not had toothache. Only likes to use services when she needs them.

She has no preference for times of appointments, but really liked it when she was able to access a GP at the Windsor Centre although she doesn't mind where services are delivered.

When she first moved to Salford she was registered with a different surgery and was taken off her Diazepam. She felt that this was done without any agreement from herself, she was just told that she did not need it any more and was put on a reduction programme which in her opinion was too fast and she felt she still needed the medication. She said that the GP accused her of selling the tablets on, which she denies and said it made her feel as though she was being judged unfairly. As a result of the prescriptions being used she began buying drugs on the street and this got her into more addiction with other substances such as methadone, although she did say later that she had been receiving treatment for addiction for several years.

She was not offered additional services such as a mental health worker to help her manage her mental illness. She sees Acton Square to get Methadone prescriptions and a help with her addiction problems.

One of the key difficulties she found with access was the lack of confidentiality and prejudice at reception. Some of the receptionists “have pretty big mouths” and will discuss medication loudly at the desk in front of other patients in the waiting room. She felt that receptionists judged you when they knew you had a history of addiction and this affected the help they would give you. Julie thought practices would benefit from having a confidential area such as they do in pharmacies to discuss things. She said she understood there might be issues around safety for the staff with this system but that something should be worked out. Once in with the doctor, confidentiality was not a problem, it was primarily an issue at reception. She also felt there was training needed around customer care and the attitude receptionists take to patients with addictions.

The one thing we could do to help her manage her health is to speak to the GP to help her sort her medication.
**Interview 6**

This gentleman is a Schizophrenic and hears voices continuously. He lives with his girlfriend in a rented flat. He has recently been discharged from prison in the last 2 weeks and has been having difficulty getting his medication. This is because he did not get an adequate discharge letter from prison. He is registered with a Salford GP. He finds it difficult to get to appointments as because of his mental health problems, and probably from being on long term medication, he has problems with his memory and being in the right place at the right time to get a taxi to the doctors. He relies on his girlfriend who is his carer to help him. He said it was much easier when the GP was based out of the Windsor Centre.

He says he was taking Olanzapine. He has been unable to get this from the doctors here. His medication has stopped because he has been unable to get to the doctors for review. He was previously on Chlorpromazine which he found much better for managing his condition. He claimed he has been on a downward spiral since he came out of prison and has not seen a GP for 6 months. This is in contradiction to him saying he only came out of prison in the last few weeks. Inconvenient hours are also a barrier for him in accessing GPs. He would prefer afternoon appointments.

He feels that he is not listened to during consultation with his doctor and that if he talks about his opinions on his medication this is ignored/dismissed and that it almost needs him to threaten violence to be listened to (he described a doctor ignoring what he said he needs were and him having to say to the doctor ‘would I need to smash up your consulting room for you to listen to me’)

He would like to get a dentist. He has no need of an optician and is not interested in seeing one. He has not used any urgent care services in the past 12 months.

The one thing we could do to help him manage his health is get him in touch with a ‘decent’ doctor to sort out his medication. The previous GP at the Windsor Centre Doctor Norahna was brilliant in his opinion and understood their needs.

**Interview 7**

This lady is a young Scottish woman who has been living in Salford for the last 4 years. She has her own flat and uses the Windsor Centre as a day centre. Her general health is good and she does not access Health Services instead she chooses to ‘self-medicate’.

She has a history of self harm and used to be in the hospital A&E services in Scotland weekly to be ‘stitched up’. She has previously spent time in psychiatric hospitals for self-harming.

She says she has never had a positive experience with doctors. She is registered with a Salford GP practice, but has never used it. She buys diazepam on the street which she says helps her control her mental health. She does not see addiction or mental health as a problem as she is managing these well on her own. She says she has accessed health services in the past and was always told she would be referred on to some other services and then was never contacted again. From this she has formed the opinion that doctors aren’t bothered to help and that they promise you services which don’t actually exist to get you out of the door. She would prefer to get her ‘medication’ from drug dealers because they just give you what you want and don’t ask personal questions.
She is not interested in getting medical/professional help for her mental health because she can manage it better by herself. She does not see taking Diazepam as an addiction, rather a necessary medication such as insulin for diabetes.

She has accessed the Walk in Centre last year to get sexual health advice as she had had a partner who was HIV positive. She is registered with a Dentist at Ordsall Health Centre and gets a taxi over from the Windsor centre on a Wednesday. She has no preference for times for appointments as she does not use services. She thought it was better when the GP was available at the Windsor centre as it is a place she feels comfortable attending.

When asked what we could do to help her with her health she states nothing as she has no need of health services.

**Interview 8**

This very articulate Scottish gentleman has been living in Salford for 4 years. He lives in his own flat but finds it hard to make ends meet. Money to pay bills are clearly a problem and he does not know how he is going to manage with his debts. His Incapacity benefit was recently cut by £120 a month. He received a letter saying he could appeal but does not want to as he is scared that they will reject his appeal and he will end up losing all of his benefits. He says he would never be able to get a good job as, now he is 38, what could he do. He says he might be able to get a cleaning job but this just depresses him, but he accepts that sitting on the couch watching TV every day is also no good for him. He was previously in Lancaster House Hostel which he found a good facility and it was then that he started attending the Windsor Centre.

He is addicted to Methadone and Diazepam. He has multiple health problems which he has not had addressed. He suffers from a knee problem, which he thinks may be arthritis as he has a family history, where his knee joint swells up and feels like it has clicked out of place, this is excruciatingly painful and he has to try and get it back in. He attended the optician recently and was offered a pair of glasses for £60, but was unable to get them as bills came in and he could not afford the money. He was not aware he should be able to get free glasses on benefits. He also suffers skin problems. On his face he gets psoriasis and he has been getting spots on his hands which itch that he has been told by a worker at Acton House may be Syphilis, he is waiting to hear back about this. He suffers from back pain which affects his mobility. He has breathing problems which have not been assessed but he states it is related to smoking.

He is registered with a Salford GP but has never been as he has been told by friends that this GP talks down to people who have addictions and does not help them, that he looks down his nose at drug users and takes them off their benzodiazepines. He says the GP just thinks they are all lying and he can see why he might think that but that it is not always the case. For this reason he will not go. He says he registered with this GP because he was in the building next door. He would like to find a new GP closer to where he lives but doesn’t know how to do it.

He has not used any urgent care services in the last 12 months. He has a dentist and goes to the one in Ordsall organised through he Windsor Centre.
If we could do one thing for him to improve his health it would be to organise for him to be able to get a proper health check to find out what the problem is with his chest, knee and hands.

**Interview 9**
This gentleman is a 40 year old man who is currently sleeping rough. He has Neuropathy and walks with a frame. He is heavy alcoholic and has mental health problems but has no will to address these.

He is registered with a GP surgery in another part of the city but finds it difficult to get there. He preferred it when the GP was available at the Windsor Centre. He has been to his GP by Taxi twice from the Windsor Centre, but it was difficult using the taxi with his walking frame. He has been in hospital several times over the past 12 months, usually for falling and 'smashing his head open' due to drink.

He does not currently want any medical treatment. He seems to have given up completely and is not willing to tackle his mental health or alcoholism. He is supported with these by a support worker at the Windsor Centre but this is the only help he receives.

**Interview 10**
This gentleman is 26 year old man living in Ordsall. He has recently moved on from Lancaster House and into his own accommodation that needs a lot of work. He drinks, smokes and doesn’t take much exercise. For this reason he feels his health is not good at the moment but also that it is not a priority for him. He has problem with his hip which he recently had an operation for and has broken his nose twice and is currently waiting for a scan on it to see if he needs further operations.

He has an addiction to codeine which he developed following the operation on his hip. Acton house are giving him help for this and he says he needs to tackle the addiction before they can help him with his mental health.

He is happy with his GP and can get there easily on foot or by public transport. He says all his experiences with his GP have been fine and there is nothing to improve. He says it is sometimes difficult to get an appointment as you have to phone at 8am and he would prefer afternoons as he does not often get up in the morning. He said that for routine appointments it is easy, if the doctor says they want you back in a week then you will get in.

He has not used walk in centres or A&E. When he has accessed the hospital it has been by referral from his GP. He has used GP OOH once for a prescription when he ran out of his medication. He is still registered with a dentist in Old Trafford where he used to live. He feels he is getting help with everything he needs help with.

If there was one thing we could do to make his health better, it would be to get him access to physiotherapist as he feels he was discharged to quickly with his hip and it still causes him pain.
## APPENDIX 6

### Health & Homelessness Working Group membership

<table>
<thead>
<tr>
<th>Services</th>
<th>Contact Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Health</td>
<td>Deputy Director of Public Health: David Herne</td>
</tr>
<tr>
<td>Primary care</td>
<td>Specialist Primary Care Provider, GP Commissioner (Hundreds Health), Primary Care Commissioner: SHM Rep (GP/CEO &amp; Practitioner), Tony Maher</td>
</tr>
<tr>
<td>Secondary medical and surgical services</td>
<td>ED Consultant, Service Reform Manager, Acute Commissioner: Dr Neil Hughes, Melanie Walters, ?</td>
</tr>
<tr>
<td>Hospital discharge planning services</td>
<td>SRFT Social Work: ?</td>
</tr>
<tr>
<td>Community services e.g. health visiting, podiatry, dentistry</td>
<td>Provider Commissioner: ?</td>
</tr>
<tr>
<td>Adult Mental Health Services</td>
<td>Head of Primary Care Psychology: Alison Harris</td>
</tr>
<tr>
<td>Child and Adolescent Mental Health Services</td>
<td>Provider Joint Commissioner: ?</td>
</tr>
<tr>
<td>Drug and alcohol services</td>
<td>DAAT: Colin Wisely, Andrew MacDonald</td>
</tr>
<tr>
<td>Supporting people services</td>
<td>SCC Housing Commissioner: Jane Anderson, ?</td>
</tr>
<tr>
<td>Voluntary sector services</td>
<td>Night Shelter, Other Hostel Providers: Windsor Centre Rep</td>
</tr>
<tr>
<td>Other</td>
<td>Salford Uni Rep</td>
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</tbody>
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