# HOMELESSNESS Fact Sheet

## Summary

The homeless population continues to be amongst the most vulnerable groups in our society with much of their health needs under-recognised or unmet. Poor physical and mental health are often both a cause and consequence of being homeless. The significant health inequality faced by this group is reflected by their substantially lower average life expectancy compared to the general population. For a homeless male, the average life expectancy is 47 years, whilst for a homeless female the age is just 43 years.

Homelessness can be broadly categorised into three main groups: rough sleepers, statutorily homeless and the hidden homeless. Rough sleeping counts in England have risen by 102% from 2010 to 2015, with latest figures suggesting that on any one night 3,569 individuals are sleeping rough in England.

Local Authorities have a statutory duty to help assist and secure accommodation for those deemed as being statutorily homeless. A 17% rise has been seen in the number of homelessness applications received by Local Authorities in England between 2010 and 2015. Sutton has also seen a significant rise of 51% in the number of homelessness applications made between this period. The main reasons identified for why applicants in Sutton become statutorily homeless include termination of short-hold tenancies, exposure to violent relationships and parents/friends no longer being able to accommodate them.

The health needs of the homeless population are substantial and often compounded by factors such as their living conditions, lifestyle factors and general perception of health. Reports by the Homeless Link, Health Needs Audit suggest that 78% of the homeless population suffer from at least one physical health problem. The most common complaints include chest/respiratory conditions and musculoskeletal problems. This is also reflective of Sutton's homeless population. Living and lifestyle factors make the homeless more vulnerable to infections such as tuberculosis, which is found to be 20 times more prevalent in this group.

Mental health conditions are recognised as a large health need amongst the homeless, with national data reporting that 72% of homeless individuals suffer from a mental health difficulty. Similarly, over half of Sutton's homeless respondents reported having a mental health diagnosis, with a large proportion having a dual diagnosis of both a mental health disorder and substance/alcohol problem.

Mortality data from national reports suggest that the main cause of death amongst the homeless is not due to intrinsic disease but a consequence of external and lifestyle factors. This includes alcohol and substance misuse, accidents and falls.

Homelessness can also have a great impact on the physical and psychological well-being of any children involved. The NSPCC estimate that 15,700 children aged 0-2 years live in families who are deemed as statutorily homeless. The potential health implications of homelessness can be demonstrated at different stages of a child's upbringing, from their foetal environment to the living conditions of temporary accommodations.

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Healthcare Services and the Homeless

The homeless population are identified as heavy users of hospital and A&E services, with A&E attendances being five times higher amongst the homeless. Reports suggest that some homeless individuals face difficulties when registering with GP surgeries. This is reflected in the Homeless Link, Health Needs Audit where 18% of homeless individuals reported being refused registration with a GP or dentist. Such perceived barriers may also account for just under half of Sutton's homeless respondents being registered with a GP.

Recommendations

The recommendations proposed are aimed at helping improve the level and access of health care provisions for Sutton's homeless population:

1. To make every contact count. It is recommended that all health care and service providers view each encounter as an opportunity to promote health and lifestyle advice.

2. To increase the level of GP registration amongst the homeless population. It is recommended collaborative work between Sutton CCG, GP practices and services including SPEAR could help improve levels.

3. For GP surgeries to allow greater flexibility with telephone and same-day appointments for homeless patients with greater social and medical needs.

4. For commissioners to consider the need for a dual diagnosis service within Sutton.

5. Commissioners to consider how podiatry services could be made more accessible for the homeless.

6. In view of the high rate of hospital admissions and A&E attendance by the homeless, consider the potential for a more proactive model involving primary care and community services.

## 1. Background

Homelessness continues to be a significant issue in the UK with numbers continuing to rise despite local, and national policies and strategies. Homelessness can be defined as a lack or a threatened lack of a safe, secure and adequate accommodation for a person. The social exclusion, living standards and vulnerability associated with being homeless can all greatly impact on an individual's physical, social and psychological wellbeing. The homeless population are amongst society's most vulnerable groups and often have significant health needs, many of which are under recognised or unmet. This health inequality is emphasised by the significantly lower average life expectancy observed amongst the homeless population. For a homeless male, the average life expectancy is 47 years, whilst for a homeless female the age is just 43 years.[1] This compares to the average life expectancy of 79.5 years for a male and 83.2 years for a female within the general population.[2] Reasons for the difference are multi-factorial with increased health needs and poor access to health care amongst the underlying causes.

## 2. Homelessness in Numbers

a) Rough Sleeping

### (i) National Picture

Those homeless who are rough sleeping represent the most extreme end of the spectrum and numbers can be difficult to estimate. Each year local authorities produce rough sleeping counts which can provide a snapshot estimate of the number of individuals sleeping rough on any one night. In 2015, 3,569 people were found to be sleeping rough on any one night in England, a 30% rise from 2014. The number of rough sleepers in London account for 26% of the national figure at 940, a 27% rise from 2014.[3] The total counts in England and London between 2010 and 2016 are shown in **Table 1** and **Figure 1**. The number of rough sleepers has significantly increased since 2010, with England seeing 102% rise in numbers.[4],[5]

### (ii) The Local Picture

In 2016, the estimated number of rough sleepers in Sutton on any one night was found to be 8. Reviewing data from 2010 there has been a general increasing trend in rough sleeping numbers **(Table 2)**. It is important to recognise the limitations to the accuracy of rough

[1] Crisis. Homelessness: A silent Killer. 2011.
[2] Public Health England. Public Health Outcomes Framework http://www.phoutcomes.info/
[3] Department for Communities and Local Government . Rough Sleeping Statistics England - Autumn 2015 Official Statistics. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/503015/Rough_Sleeping_Autumn_2015_statistical_release.pdf
[4] Department for Communities and Local Government. Homelessness statistics. https://www.gov.uk/government/collections/homelessness-statistics#rough-sleeping
[5] Homeless Link. Rough sleeping –explore the data. Cited on 20/4/16. Available on http://www.homeless.org.uk/facts/homelessness-in-numbers/rough-sleeping/rough-sleeping-explore-data

sleeping counts due to practicality reasons such as access to derelict areas and people bedding at different times.[6]

A comparison of the number of rough sleepers in Sutton to other London boroughs in 2016 is shown in **Figure 2**. The data suggests that crude counts of rough sleepers within Sutton are within the lower quarter of all London boroughs.[7]

b) Statutory Homelessness

**(i) National Picture**

The term 'homeless' goes beyond those individuals on the streets with no physical shelter or fixed abode. Statutory homelessness refers to those individuals or households who are faced with situations where living in their current residence is no longer feasible, and are faced with the threat of being homeless. Such individuals are able to apply to their local authorities (LA) for housing assistance and if deemed eligible their LA has a statutory duty to either secure their current accommodation or provide them with temporary residence.[8] [9]

The criteria for being deemed statutory homeless include:

- Being eligible for help – this relates to migration status
- Having a local connection to the borough
- Being unintentionally homeless
- Being within a priority needs group

Being in priority need includes households with dependent children, pregnant women and anyone classed as 'vulnerable'. The following includes a list of individuals who would be deemed as 'vulnerable':

- A person suffering with a mental health condition
- A person suffering with a physical disability
- A young person; aged 16-17 years or 18-20 years and vulnerable as a result of being in care previously
- A person who is suffering from violence or the threat of violence
- Old age
- Other emergencies, e.g. floods, fires [8, 9]

In 2015, local authorities in England received a total of 113,490 applications for homelessness assistance of which 56,510 were accepted.[9] This compares to 97,210 applications which were received in 2010, with 42,400 applications being accepted.[10] This displays a 17% rise in the total number of applications made and a 33% rise in the number of accepted applications.[10]

[6] Department for Communities and Local Government. Rough sleeping statistics England autumn 2015: table 1. February 2016

[7] Department for Communities and Local Government. Rough sleeping statistics England autumn 2015: table 1. February 2016.

[8] Source: Homeless prevention and housing needs team, Sutton.

[9] Department for Communities and Local Government. Homelessness statistics. https://www.gov.uk/government/collections/homelessness-statistics

[10] Homeless Link. Statutory homelessness. Cited on 22/03/2016. Available on: http://www.homeless.org.uk/facts/homelessness-in-numbers/statutory-homelessness

### (ii) The Local Picture

During 2015, Sutton received 445 applications for homelessness support of which 324 were accepted. This is a 51% rise in the number of applications made since 2010, and a 133% rise in the number of accepted applications.[10] This is shown in **Figure 3**.

When comparing the number of homelessness applications in Sutton in 2015 to other London boroughs it can be seen that the crude numbers received and subsequently accepted are within the lowest third for all boroughs.[10] This is shown in **Figure 4**.

Reasons why Sutton applicants lost their previous residence, thereby making them homeless, primary reasons include parents and/or other relatives/friends no longer willing or able to accommodate them, violent breakdown of relationships and termination of short hold tenancies.[11] The main reasons for applicants being eligible for housing assistance include households who have dependent children and those where the applicant is pregnant.[8,11] This highlights broader health issues such as the emotional and psychological affect that frequent moving and unfamiliar environments can have on children, or the stress and anxiety caused by the fear of being homeless for a pregnant woman.

### c) The Hidden Homeless

There is a large population of 'hidden homeless' who may not be captured and accounted for. They include those in hostels, those squatting in derelict buildings or those finding temporary refuge with friends and families. The charity Crisis estimates that there may be up to 380,000 hidden homeless people in the UK.[12] This again highlights the potential unmet health needs of a vast and vulnerable population.

## 3. The Health Needs of the Homeless Population: National Picture

The health needs of the homeless population are substantial with physical and mental health problems being both causes and consequences of the experience, adding to the complexity of the issue. Lifestyle factors including drug and alcohol misuse can compound the problem, adding to the significant health needs faced by this vast and heterogeneous group.

### a) Physical Health Needs

Health needs within the homeless population can vary in severity and form depending on whether the individual is a rough sleeper or statutorily homeless. Factors include the physical environment, circumstances which precipitated homelessness and the safety and security of accommodation and exposure to health risks.

Since 2011 the Homeless Link Audit has assessed parameters of health from 3,355 homeless individuals including rough sleepers, squatters and those in hostels and emergency accommodations. Of the respondents, 78% reported to having at least one or more physical health problem, with 44% stating this to be long-term of at least 12 months.[13] Musculoskeletal problems such as muscle, joint and bone pain are the commonest long-term health complaint reported by the homeless population, followed by respiratory/chest and

[11] Department for Communities and Local Government. Detailed local authority level homelessness figures: January to March 2015 https://www.gov.uk/government/statistical-data-sets/live-tables-on-homelessness.

[12] Crisis. Hidden Homelessness: Britain's Invisible City. 2004.

dental problems.[13,14] **Table 3** shows how the prevalence of physical health problems tends to be significantly higher amongst the homeless compared to the general population.[13]

Living conditions, lifestyle factors and poor immunity can make the homeless population vulnerable to conditions such as tuberculosis (TB). Rates of TB among the homeless population can be up to 20 times higher compared to the general population.[15] In addition reports suggest that drug-resistant strains of the organism are more common in those with social risk factors such as homelessness and alcohol and drug use.[16] Compliance with drug therapy can be an issue for the homeless. Chaotic lifestyles and frequent moving can make it difficult to adhere to the treatment plan which requires up to six months of drug therapy and frequent medical reviews. An important aspect of TB management includes contact tracing due to the infectious nature of pulmonary TB. This can prove challenging when index cases are those living on streets with no fixed abode.[15]

Although the health needs of the statutorily homeless is recognised to be less severe than those sleeping rough, living in temporary accommodation can expose and exacerbate different health problems. In a report by Shelter, 58% of families reported that their health or the health of their family had deteriorated as a result of living in temporary accommodation. Respiratory conditions including asthma and skin conditions such as eczema were reported to have become worse. In addition, just under half of respondents reported visiting their GP or hospital more frequently since moving. Factors contributing to changes in health are likely to be related to the physical conditions and standards of the accommodation, with respondents reporting 'dusty and damp' living conditions.[17,18]

b) Mental Health Needs

Mental health needs are often a contributing cause for homelessness as well as a consequence of the experience. The Homeless Link Audit found that 72% of respondents reported having a mental health difficulty. This compares to a recorded figure of 30% for the general population. Depression was the most common mental health condition reported and affected 49% of this group. This is substantially higher compared to data for the general population which is 10%. Other mental health diagnoses affecting the homeless population include drug and alcohol related problems, bipolar disorder and schizophrenia. **Table 4** profiles the prevalence of mental health diagnoses reported by this group with comparisons to the general population.[19]

[13] Homeless Link: Health Needs Audit – explore the data. Cited on 04/04/16. Available on http://www.homeless.org.uk/facts/homelessness-in-numbers/health-needs-audit-explore-data
[14] Jade Poyser. Public Health Nottinghamshire County . An assessment of the health needs of single homeless people in Nottinghamshire. July 2013.
[15] Jose I Figueroa-Munoz , Pilar Ramon-Pardo. Tuberculosis control in vulnerable groups. Bulletin of the World Health Organisation 2008. Volume 86, 657-736.
[16] Public Health England. Tuberculosis in the UK: 2014 report. 2014.
[17] Credland S and Lewis H. Shelter. Sick and tired - The impact of temporary accommodation on the health of homeless families. December 2004.
[18] Mitchell F et al., Shelter. Living in limbo: Survey of homeless households living in temporary accommodation. June 2004.
[19] Homeless Link. Mental Health and Wellbeing guide. 2011. http://www.homeless.org.uk/sites/default/files/site-attachments/Mental_Health_Guide.pdf

For the statutorily homeless the associated stress, insecurity and isolation of frequent moves and living in unfamiliar areas can impact on the psychological wellbeing of the individual. In a report by Shelter, 56% of respondents living in temporary accommodation reported suffering from depression. Factors related to their low mood included their current housing situation, uncertainty about the future and previous traumatic experiences.[18]

c) Alcohol and Substance Misuse

Alcohol and substance misuse remains a significant problem amongst the homeless population. Financial debt, physical health implications such as blood borne infections and exacerbation of mental health problems are amongst the issues facing those with substance addictions and dependencies.

Of the homeless population from the Health Needs Audit, 27% reported having an alcohol problem with 15% drinking daily and 35% drinking in excess of 10 units a day,[13] Compared to the general population the lifetime prevalence of drug misuse is substantially higher amongst the homeless population. One study reports that 95% of homeless respondents admitted to using some form of illicit drug in their lifetime. From this study 89% reported using in the last year and 73% using in the last week. This suggests ongoing and possibly habitual usage amongst the homeless rather than experimental use. Cannabis appears to be the most commonly used drug but also with a substantial proportion using heroin and crack cocaine.[20] The use of drugs and alcohol can often be a coping mechanism for mental health problems, thereby giving rise to a large proportion of dual diagnosis amongst the homeless population.[13,21]

d) Lifestyle Factors

Many factors associated with homelessness can create an environment where adopting and maintaining a healthy lifestyle can be difficult. This can have repercussions on general health and wellbeing.

Smoking, with its known associated health implications, is common amongst the homeless population with a reported prevalence of 78% compared to 18% for the general population.[13] Maintaining a balanced diet can also be a challenge for this group, with 29% reporting that on average they have less than two meals a day.[22] Factors likely to contribute include lack of money to buy good quality food, inadequate or shared kitchen and storage facilities and prioritising food which will cause satiety over nutritional value.

e) Mortality Data

As previously mentioned, the significant inequality in health between the homeless and general population is evident from the stark difference in reported life expectancies. In a report by Crisis, the cause of death amongst the homeless population was mainly due to external and lifestyle factors. In contrast, within the general population the main cause of

[20] Wincup E, Buckland G, Bayliss R .Youth homelessness and substance use: report to the drugs and alcohol research unit. Home Office Research, Development and Statistics Directorate. 2003.
[21] Data provided by SPEAR.
[22] Homeless Link. The unhealthy state of homelessness – health audit results 2014.

death is attributed to intrinsic diseases and systemic disorders.[1] **Figure 5** shows how drugs and alcohol account for over a third of deaths amongst the homeless population, which is 20 times that of the general population. Similarly deaths caused by falls and road traffic accidents are three times higher amongst the homeless.[1] Such data emphasises how the causes of deaths amongst the homeless population is predominately due to external factors which have the potential and scope to be avoided. Suicide is also disproportionately common.

## 4. Health Needs of Sutton's Homeless Population

The local charity SPEAR works to help address the social, housing and health needs of the homeless population in Sutton. Individuals are referred through several routes including self-referrals, by housing departments, hospitals and services including drug and alcohol teams. Data provided by SPEAR reflects the responses of 15 homeless individuals, predominately rough sleepers, identified in Sutton between 2015 and 2016. Although this number is low it still helps to gain a greater insight and understanding of the current health needs of Sutton's homeless population.

### a) Physical and Mental Health Needs

As with the national data, the predominant physical health problems faced by Sutton's homeless population include chest/breathing problems and musculoskeletal complaints. **Figure 6** profiles the prevalence of other physical health problems reported by this group. Many of the conditions were found to be long term and persisting for at least 12 months.[21]

Mental health problems are a significant health issue amongst Sutton's homeless population. This is reflected by the data which found that over half of respondents had a diagnosed mental health condition. Feelings of stress were a common finding in the group, affecting over three quarters of respondents. Similarly over half of the group reported symptoms of anxiety.

An area of mental health care identified by SPEAR as being a challenge was the effective management of dual diagnosis, which affects just over half of respondents. This is where an individual suffers from both a mental health condition and a substance/alcohol problem. One homeless worker voiced his concerns that "individuals can end up being bounced back and forth between the two teams when the condition is seen as two separate problems."[21] Consequently this can lead to potential delay in care and unmet needs.

The importance of addressing the social and mental health needs of this population is further emphasised by findings that over half of respondents reported to having suicidal thoughts. Moreover just under half of the group reported to self-harm, with one third of these individuals self-harming for more than 12 months. **Table 8** displays the prevalence of other mental health conditions reported by this group.

### b) Substance Misuse

With the association between substance misuse and homelessness, exploring hospital admission rates within Sutton can provide us with an insight of the health burden faced by this population.[23] **Figure 7** compares hospital admission rates for substance misuse between Sutton, London and England amongst the 15-24 age group. From 2011/12, admission rates

for Sutton appear to be rising although remaining statistically similar to those for England. However, compared to London, between 2008-2013 admission rates in Sutton for substance misuse have been significantly higher in most years. A similar profile is shown in **Figure 8**, which compares hospital admission rates for substance misuse within different London boroughs. It can be seen that boroughs south of central London have significantly higher admission rates, with Sutton having the third highest admission rate for substance misuse of the 32 London boroughs.[23]

Data for Sutton provided by SPEAR also emphasises the high prevalence of substance misuse amongst the homeless population, with over half of respondents either taking drugs or recovering from a drug problem. Cannabis is the most commonly used drug, with one third of the group using it in the last month. Moreover, just under a third reported taking crack/cocaine or heroin. When asked about level of support with regards to tackling drug use, one fifth felt they had no current help but would benefit from it. A similar proportion also felt their current level of support could be increased,[21] thereby identifying a possible under-met social and health need of this population.

c) Usage of Healthcare Services

Of the homeless population in Sutton, just under half of respondents were registered with a GP and just over a quarter with a dentist. With feet and skin disorders being a reported problem amongst the homeless, only one single respondent was accessing podiatry services. Importantly, none of the respondents reported being refused registration with a Sutton GP. However, one homeless worker felt that "some GP surgeries can still be reluctant to register homeless patients". As a result there have been occasions where escalation to Healthwatch Sutton has been needed to help facilitate the health care rights of homeless individuals when registering with a surgery.[21]

The perception and importance of health amongst homeless individuals can also act as a barrier to accessing health care services. One homeless worker felt that "health issues are typically superseded in importance by housing problems and alcohol and drug addictions."[21] This under-prioritisation of health needs can potentially result in late and more advanced presentation of conditions. Therefore it is important that such thoughts and perceptions of health are challenged whilst also understanding the greater impact of external and social factors.

## 5. The Effect of Homelessness on Children

The experience and journey for a homeless family will undoubtedly impact on the physical and psychological well-being of children involved. This may be the result of being uprooted from familiar environments, living conditions of temporary accommodations, the stress of frequent moves and stress and anxiety transferred from parents.

[23] Public Health England. Public Health Profiles. http://fingertips.phe.org.uk/search/homeless. Accessed on 20/03/16

The NSPCC estimate that around 15,700 0-to-2 year olds live in families deemed statutorily homeless, and that around 710 live in bed and breakfast accommodation.[24] The impact of homelessness can influence every stage of a child's upbringing, from foetal life through to early adulthood. A high proportion of those deemed statutorily homeless are pregnant women. The physical and emotional obstacles faced by a pregnant homeless woman can potentially influence the intrauterine environment and development of the foetus.[24] In a report by Family Housing Fund, service providers have found that one fifth of homeless women admit to misusing drugs and alcohol during pregnancy.[25] Depending on levels of usage this can have profound health implications during prenatal life which can manifest in physical and developmental abnormalities.

Homelessness can also create challenges for accessing and engaging with maternity services. Moving between different areas can make it difficult for a pregnant woman to develop and maintain a relationship with a healthcare provider, such as a GP or midwife. Consequently this may discourage her to seek help and support.[24]

Entering the neonatal and infancy period of a child's life, reports suggest that babies born to mothers living in temporary accommodation are at greater risk of being born pre-term and of low birth weight.[24,25] The environment that a child is brought up in can have great effect on physical and social development. Living in suboptimal conditions which may include overcrowding and damp can put children at greater risk of developing health problems including asthmatic wheeze and infectious diseases. Shelter have reported that children living in poor housing have up to a 25% higher risk of developing severe ill health and disability during their childhood and early adulthood.[26]

Homelessness can create a disruptive and chaotic living environment for a child. Many families, before being permanently placed, are moved between several different temporary accommodations and can often be out of their local area for up to 8 months.[8] In a survey by Shelter, 49% of parents living in temporary accommodation reported that their child's education had suffered as a consequence of their living situation. From this group 21% reported the reason being related to emotional instability or psychological problems. Moreover, 68% of parents reported that their child had experienced problems at school since being homeless, with 42% noticing their child often being unhappy or depressed.[18]

Mental health problems are more prevalent amongst homeless children compared to their peers. A child in temporary accommodation for more than a year is found to be three times more likely to display signs of mental health issues such as depression and anxiety.[25,26] The greater susceptibility to mental health problems is likely to be due to a number of risk factors, including the preceding reasons and environment that led to the family being homeless such as exposure to abuse and violence or breakdown of family relationships.

## 6. Use of Healthcare Services amongst the Homeless

Use of healthcare services by the homeless population is high. The Department of Health have estimated that the total cost of hospital use by this group is £85 million, four times

[24] Hogg S et al., NSPCC. All babies count: spotlight on homelessness. February 2015.
[25] Hart-Shegos E. Family Housing Fund. Homelessness and its effects on children. 1999.
[26] Harker L. Shelter. Chance of a lifetime. The impact of bad housing on children's lives. 2006.

greater than for the general population. Inpatient stays accounts for £76.2 million of this sum, which is likely to be contributed by the three times longer length of stay seen amongst homeless inpatients. High figures are also seen with A&E attendances, with the homeless population attending 5 times more frequently than the average population.[27]

This illustrates the substantial health needs of this group and the need to ensure that the most appropriate services and level of care are being both utilised and provided.

## 7. Barriers to Healthcare Services for the Homeless

The homeless population can face difficulties and barriers when accessing primary healthcare and specialist services. Registration with a general practice is not only vital for access to health care services but also acts as an integral link back into society. All individuals are entitled to primary care services regardless of their housing status. Therefore acceptable reasons for refusing registration of an individual are limited.[28] However despite this some homeless individuals still report challenges when trying to register with a GP practice. In the Health Needs Audit, 18% of respondents reported that they were refused registration with a GP or dentist.[13] Moreover, in a survey by Crisis, results estimated that homeless people are 40 times more likely not to be registered with a GP compared to the general population. In addition, they are three times more likely not to have had any contact with a GP in the last year.[29] There are similar findings for usage of specialist services. In a report by Shelter two thirds of those with mental health problems living in temporary accommodations were not accessing support services.[17]

The reason for the difficulty and lack of engagement with health care services is likely to be multifactorial. Lack of a permanent address can create practical and bureaucratic problems, and this was felt by 24% of respondents in the survey by Crisis.[29] Having to move between different accommodations and areas can disrupt the continuity of care, compliance with treatment regimes and rapports thereby possibly hindering the level of engagement. In addition, being when locating in a new area an individual may not be familiar with the services available and how to access them.[24] Previous experiences with healthcare services can also affect future contact. Some homeless individuals report experiencing prejudice and being stereotyped, thereby making them less likely to engage and approach primary care services.[29] From the perspective of the healthcare provider, the chaotic lifestyle of a homeless person and their complex health and social needs can create poor compliance with appointments and treatment regimes. In addition some GPs feel they do not have the appropriate resources or specialist knowledge to address the complex health and social needs of this population.[29] Such factors can result in a homeless individual neglecting or under-prioritising their health problems and only seeking medical attention in emergencies or acute settings.

[27] Department of Health & NHS. Healthcare for Single Homeless People. 2010
[28] BMA. Patient registration for GP practices. Available on: http://www.bma.org.uk/support-at-work/gp-practices/service-provision/patient-registration-for-gp-practices . Accessed on 11/04/2016.
[29] Crisis. Critical Condition Vulnerable single homeless people and access to GPs. 2002.

## 8. Recommendations

The following recommendations are based on potential gaps which have been identified through analysis of data and discussion with key members involved in the homelessness journey.

### (i) Making every contact count

Given the chaotic lifestyle and migratory status of the homeless population, it is recommended that health care workers and service providers view each encounter as a valuable opportunity to promote general health care advice. This may include addressing areas such as smoking cessation, diet and exercise, and recommendations of alcohol limits. For issues which require more specialist advice attempts can be made to direct the homeless individual to appropriate services. This can be extended to include key members of society such as ambulance staff, the police force and fire fighters.

### (ii) Maximise delivery of health care support at the level of primary care

An area requiring further review is the level of GP registration amongst Sutton's homeless population. Given the integral role of primary care the aim would be for all identified homeless individuals to be registered with a Sutton GP surgery. To fulfil and meet this aim collaboration between Sutton CCG, primary care practices and services like SPEAR would be encouraged. This could potentially help to identify non-registered homeless individuals and work towards bringing them into healthcare services. Areas likely to need further consideration to facilitate this movement would be issues around patient consent and sharing of data.

It is recognised that the homeless population often have poor compliance with services and clinical appointments. Therefore local GPs may consider identifying those known to have complicated health and social needs and allowing them to have priority phone appointments or flexible same day appointments. This patient-centred approached could help improve the level of engagement and accessibility whilst also developing good patient rapport.

### (iii) Maximising Service Provisions

A potential gap for review is the need for a dual diagnosis service within Sutton so that the individual's mental health and substance/alcohol problem is managed as one. Practically this could be easier for the homeless patient to attend appointments if both services are combined.

In addition Sutton may consider the provision of podiatry services which can be accessible for rough sleepers, as no such service currently exists in the area

**Links to further information**


1. Crisis. Homelessness: A silent Killer. 2011
2. Public Health England. Public Health Outcomes Framework http://www.phoutcomes.info/
3. Department for Communities and Local Government . Rough Sleeping Statistics England - Autumn 2016. https://www.gov.uk/government/statistics/rough-sleeping-in-england-autumn-2016
4. Department for Communities and Local Government. Homelessness statistics. https://www.gov.uk/government/collections/homelessness-statistics#rough-sleeping
5. Homeless Link. Rough sleeping – explore the data. Cited on 20/4/16. Available on http://www.homeless.org.uk/facts/homelessness-in-numbers/rough-sleeping/rough-sleeping-explore-data
6. Department for Communities and Local Government. Rough sleeping statistics England autumn 2015: table 1. February 2016.
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11. Department for Communities and Local Government. Detailed local authority level homelessness figures: January to March 2015 https://www.gov.uk/government/statistical-data-sets/live-tables-on-homelessness
12. Crisis. Hidden Homelessness: Britain's Invisible City. 2004
13. Homeless Link: Health Needs Audit – explore the data. Cited on 04/04/16. Available on http://www.homeless.org.uk/facts/homelessness-in-numbers/health-needs-audit-explore-data
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23. Public Health England. Public Health Profiles. Available on: http://fingertips.phe.org.uk/search/homeless. Accessed on 20/03/16
24. Hogg S et al., NSPCC. All babies count: spotlight on homelessness. February 2015.

25. Hart-Shegos E. Family Housing Fund. Homelessness and its effects on children. 1999
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