NHS
Bedfordshire

A Health Needs Assessment Report

HOMELESSNESS AND HEALTH

in the

Central Bedfordshire
Council Area

**They do not die through lack of housing.
They die from illness.**
(Aidan Halligan 2008)

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This report on *health and homelessness* in Central Bedfordshire seeks to provide an accurate representation of information from the agencies above and in so doing create a joint vision for the ongoing development of health services which meets the complex needs of homeless people in Bedfordshire.

Foreword

This Health Needs Assessment (HNA) report on *health and homelessness* in the Central Bedfordshire area completes a systematic review of how health services currently meet the health needs of homelessness people in Bedfordshire (excluding Luton). New knowledge can be gleaned from a wider geographical vista to inform commissioners and providers of health care as well as our multi agency partners about *health and homelessness*, which by its nature is cross cutting. Up until now knowledge has been largely Bedford-centric, partly because Bedford hosts health services with a county wide remit, but also because my own clinical and strategic role was based in Bedford, rather than Bedfordshire, until the formation of NHS Bedfordshire. Additionally, some homeless services for single homeless people in Bedford also have a county wide remit. Bedford hosts the only day centre (BECHAR) and night shelter (Kings Arms Project) in Bedfordshire, (excluding Luton). The two Bedford YMCA hostels cater for young homeless people from across the County. Such county town centricity generates its own productivity and focus with dynamic, well attended multi agency partnerships (MAP). The fora includes the Bedfordshire Supported Housing Forum (BSHF) which is a county wide group but tends to largely attract homeless agencies in the North of the county.

Central Bedfordshire consists of small towns and rural communities which may present difficulties to agencies in regard to service provision. Rural homelessness is likely to have a deeper personal impact because services are less easy to access largely due to transport issues (Shelter 2004, Bevan & Rugg 2006). The homeless charity Shelter stresses the particular importance of recognising the problem of rough sleeping in rural areas. Beyond the official street counts, they encourage the Department of Communities and Local Government (CLG) to engage local authorities in "rigorous assessments… and be prepared to carry out in-depth monitoring of the issues if anecdotal evidence suggests that people are rough sleeping in a district" (Shelter 2004 p 12). This HNA report seeks to reach beyond the *street count* in order to better understand the true nature of homelessness in Central Bedfordshire so that health services can effectively collaborate with our multi agency partners to meet the health needs of our homeless people.

The research on health and homelessness in the first HNA report (Bedford Borough report) is rigorous and robust. This NHS document should also be read with:

- Central Bedfordshire Homeless Strategies (SBDC and Mid Beds)
- NHS Bedfordshire (2009) Health Needs Assessment: Houghton Regis
- NHS Bedfordshire (2009) Health Needs Assessment: Offending
- NHS Bedfordshire (2008) Health Needs Assessment: Health and Homelessness in Bedford Borough Council
- NHS Bedfordshire (2008) Health Needs Assessment: Gypsies and Travellers
- NHS Bedfordshire (2008) Bedfordshire Teenage Parent Strategy
- NHS Bedfordshire/BLPT (2009) Suicide Strategy
- Supporting People Strategy 2008 - 2010

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Executive Summary

The new unitary authority in Central Bedfordshire positions NHS Bedfordshire at a providential juncture to effectively address an ongoing narrative of health and homelessness. It is a narrative increasingly characterised by partnership working between us, the local authority and the third sector agencies as we meet the complex needs of our homeless people coherently. Dovetailing with the Government's desire for zero rough sleeping in England by 2012 (*No one Left Out* SEU 2008) our starting point must surely be here for, quite clearly, NHS Bedfordshire has a duty to ensure that rough sleepers have equal access to primary health care as the rest of the population and must incorporate the needs of rough sleepers into planning strategies (SEU 2008). Yet, rough sleeping, where it exists, seems almost hidden amongst the rural expanse of Central Bedfordshire with its small towns dotted across an East-West landscape. This document seeks, therefore, to make homelessness in ***all*** its categories visible to health services and beyond.

Chapter One

In this chapter the document frames the interrelatedness between poor health and homelessness. The national, regional and local drivers that guide health and homelessness development are explored. Housing language is demystified to provide health professionals with improved understanding of housing and homelessness, leading towards more successful health interventions.

Chapter Two

The Central Bedfordshire overview of quantitative data shows that *statutory* homelessness has steadily decreased from 2007 to March 2009. Young homeless people form the majority of homeless applications. There were 342 new homeless applications in 2007. Street counts of rough sleepers are not required in Central Bedfordshire because the number is believed to be low but an estimated number came to 10 in 2007 (JSNA 2008). The number of families placed in temporary accommodation has decreased this year with most placed in Bedford Court – a communal building - or 12 temporary accommodation (TA) houses. Other local authorities place homeless families in central Bedfordshire - the reason for, and local impact of this should be explored further.

Chapter Three, Four and Five

These chapters outline the services available for homeless people. The issues of rough sleepers who *fall through the net* of services are identified and the need for improved partnership working is highlighted. Qualitative data from homeless agencies provide evidence of heath service development in regard to improved mental health working in some areas, although self harm remains an emotive and worrying issue for hostel staff. Alcohol services are also considered difficult to access in Central Bedfordshire but Healthlink do have satellite surgeries in Leighton Buzzard and Dunstable. Family homelessness requires coordination between agencies.

Chapter Six

Findings are discussed further in this chapter as I explore the health service dilemma of specialist homelessness services versus mainstream service core business block contract. Fordham's model (2009) illuminates the issues which need to be negotiated for effective health care delivery. The rural aspect of central Bedfordshire makes rough sleeping less visible yet homeless services knew of 9 people currently rough sleeping in Dunstable (3), Leighton Buzzard (2), and Biggleswade (4). Added to this are reports of 4 or 5 people who have slept rough in Sandy this year and the unknown picture of rough sleeping in other small towns. With the exception of Leighton Buzzard there is currently no humanitarian hub offering services such as food, shelter or general support in Central Bedfordshire. The expertise of key members of the Multi Agency Panel for rough sleepers in Bedford should be used in a Central Bedfordshire MAP[1] to coordinate movement into accommodation with a focus on support needs. The lack of homeless hostels for those over the age of 30 years, as well as the lack of medium to high level[2] support hostel accommodation in Central Bedfordshire may contribute to rough sleeping as well as particular key ill heath themes yet to be explored through focus groups. Agencies spoke of the fear that rough sleepers have expressed about finding homeless accommodation and support in Bedford; others do migrate towards Bedford for services.

Chapter Seven

The recommendations are fully explored in Chapter 7 and include:

Multi Agency Development

- Develop partnership work with the local authority and third sector agencies to tackle the hidden and complex issues around rough sleeping.
- Facilitate focus groups with rough sleepers to identify key health and housing themes
- Minimise eviction from hostels into rough sleeping by coordinating health support where needed
- Include key third sector support agencies in health care planning for those placed in accommodation following homelessness
- Complete and extend the multi agency admission and discharge protocol from Bedford Hospital to include: Luton & Dunstable Hospital, Stoke Mandeville and Royal Bucks. Streamline protocol with mental health unit protocols.
- Provide an array of multi agency protocols and working practices for Bedford Court, LA temporary accommodation, Houghton Regis
- Complete the notification system between housing and health services for all families moving in and out of temporary accommodation
- Sustain mental health, substance misuse and other health training/support for homeless services staff

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[1] i.e. Rough sleeping coordinator, rough sleeping outreach worker, NHS Bedfordshire Public Health nurse, Bedfordshire and Luton Mental Health Partnerships Trust – community mental health team, Healthlink dual diagnosis treatment services.

[2] Such as that needed for those with a history of mental health illness /dual diagnosis, self harm etc

- Develop self harm protocols in all homeless accommodation sites
- Explore the development of an independent housing advice centre in Central Bedfordshire
- Explore partnership work between public health and County Medical Officers employed by Housing
- Engage the Benefits Agency in local homelessness forums

Health Service Development

- Embed reflective practice[3] principles in all health services and provide robust training to all staff on homelessness and health
- Collect data and ethnic monitoring from all health disciplines and evaluate health outcomes
- Equip GP's to link into multi agency support networks in homelessness
- Provide a CPN specialising in homelessness or CMHT open clinics to improve engagement with mental health services and support homeless services in the prevention of mental health crisis. Consider CBT/IAPS floating support to hostels.
- Provide Health Improvement Programmes to hostels: Stop smoking, Chlamydia screening, Health Trainers
- Provide direct access to podiatry and dental services
- Provide hospital transport for homeless people so that appointments are not missed by people on low/no income. There is no direct bus route and taxi's cost £20 to the Luton and Dunstable Hospital from Leighton Buzzard
- Fund NHS Bedfordshire's DH award winning '*Ask About Medicines*' project with homeless people where pharmacists review medicines of homeless people on an annual basis

Joint/Commissioning

- Consider additional Tier 2, 3 and 4a alcohol treatment services in Central Bedfordshire. This should be undertaken specifically as a needs assessment for homeless people who are drug and alcohol dependent. It should evaluate pre and post contemplative accommodation including easier access to residential treatment units
- Jointly explore how homeless families with school aged children are identified and supported.
- Provide a Complex Needs Unit in Bedfordshire for those whose health and homelessness needs can not be supported by other accommodation providers.
- Provide mother and baby homeless units in Central Bedfordshire

[3] Reflective Practice (RP) embodies Evidence Based Practice (EBP).

PROPOSED NHS BEDFORDSHIRE HOMELESSNESS HEALTH *TEAM*				
Specialist Public Health Nurse - Homelessness/ Community Matron Model (already in post)	**Commissioner - Vulnerable Communities** (already in post)	**NES GP Services for homeless people** (already in post/ *new development in LB and Sandy*)	**Band 6/7 Practice/Specialist Nurse - Homelessness** ***(Pending/New post)***	**Community Psychiatric Nurse – Homelessness (CPN)** ***(New post)***
To continue developing the PH interface of multi agency working in homelessness with local authorities, health and homeless agencies. Educate all health staff and act as homelessness health consultant for health and housing staff. Manage complex/cases not picked up by other health professionals.	To commission services for homeless people in a cost effective manner, including the coordination of health service development through the Homeless Steering group and strategic multi agency forums	*To provide medical services at outreach clinics: Prebend day centre and nightshelter (Bedford)* Explore NES in Leighton Buzzard/Sandy	*To provide health care, immunisations and health screening at Prebend Day Centre, Nightshelter*. Explore the same in Leighton Buzzard Sandy/	To develop creative mental health crisis support /mental health programmes at day centres, night shelter and homeless accommodation sites in Bedfordshire. Work with A&E staff to manage recurring mental health issues in homelessness including Dual Diagnosis

Underpinned by
HOMELESS HEALTH CHAMPIONS IN:
A&E, Discharge Planning, District nursing, Physical Disability Team, Learning disability team, all mental health services, Shared Care, Healthlink, and 0-19 children's services.

1. Introduction and Context

To live somewhere involves the development of a special relationship to space, time, luminosity, self and others. A house, in its concrete reality, brings support to certain aspects of individual psychological structuring – it is the central reference point of human existence (World Health Organisation 2004 p6)

Loss of a home *is* loss on many fronts (FEANSTA 2007). Homelessness is increasingly recognised as a trigger arising from poor health (CLG 2008). Currently, in England the life expectancy of a rough sleeper is 40.2 years of age (Halligan 2008) and despite greater health needs compared to the general population (Crisis 2002, Bines 1994, Grenier 1996) including 'tri-morbidity'[4], (Dorney-Smith 2008) barriers in accessing health services are widely evident nationally in single homelessness (Wright et al 2004) and in family homelessness (Cook et al 2004,[5] Vostanis et al 1999). So, how is the commissioning of services by NHS Bedfordshire meeting the needs of such vulnerable communities and what are the gaps which should be addressed to meet those needs in the future design of health services? The aim of this Health Needs Assessment is to make strong recommendations for just such a purpose.

1.1 What is a Health Needs Assessment?

A Health Needs Assessment (HNA) is a systematic method of reviewing the health issues facing a population, leading to agreed priorities and resource allocation that will improve health and reduce inequalities. This HNA begins to explore where and how homeless people *fall through the net*[6] of health and other services leading to unmet or inappropriately met need which may be more costly to public services (Daiski 2007). It examines the way people who are experiencing homelessness are currently identified by health services in Central Bedfordshire, the health issues which affect them and how health and other services in Central Bedfordshire currently meet those needs, either individually or in partnership. Findings, therefore, will be considered in relation to partnership work, not just health services, reiterating Hegel's notion that society is compared to a living body which stands in relationship to other units and becomes 'much more than its parts' (Polkinghorne1983 p135-137).

[4] i.e. Concurrent existence of physical, mental and substance misuse health problems
[5] Access to GP services is difficult for homeless families (Cook et al 2004). Vostanis (1999) found access to mental health services difficult for homeless families.
[6] Examples include the premature physical ageing of rough sleepers (Cohen 2000); unless rough sleepers are assessed according to their *presenting age* their health need may be unmet (e.g. flexible criteria for 65+ services). Hospital discharge is often more complex because their identified need falls between physical disability teams, mental health teams and elderly care teams.

1.1.1 The aim of this HNA:

To raise awareness of the increased health needs of homeless people compared to the general population and identify how future joint commissioning of services can best meet the current gaps which will significantly reduce health inequalities in homelessness locally.

1.1.2 Objectives:

- To explore the extent of homelessness in Central Bedfordshire through qualitative and quantitative data
- To highlight the health needs of people including families experiencing homelessness through research studies undertaken in the UK
- To describe the healthcare services available to people experiencing homelessness in Central Bedfordshire
- To identify the gaps in health services provision for people experiencing homelessness
- To provide an overview of the strategic partnerships in homelessness
- To make recommendations for joint / NHS commissioning of services for homeless people in Central Bedfordshire.

1.1.3 Method

A range of methods were utilised in this HNA. Academic literature, along with national and local initiatives including government publications that were used in the first HNA (Bedford Borough Council area) were reviewed. Central Bedfordshire homelessness statistics provided knowledge about the extent of *statutory homelessness*. Additionally government documents on homelessness since 2006 have been included.

Qualitative evidence was sought in Central Bedfordshire from GP's and the health professional leads where health services are provided (GP services, Drug and alcohol services, mental health services, children's services). Not all of the health professionals responded to this report but where they have responded the data is included.

Focus group interviews were held in Central Bedfordshire in 2006-7 in Bedford Court in Houghton Regis; Kilgour Court in Leighton Buzzard and Signposts in Dunstable. The full report can be viewed in the Bedford Borough area report of Homelessness and Health (Fordham 2007).

1.2 Who are the stakeholders in Central Bedfordshire?

They include:

- Central Bedfordshire Council
- Aragon Housing
- Supporting People
- Homeless Accommodation Providers

Signposts Dunstable
Bedford Housing Link: Biggleswade and Sandy
Mayday Trust – Kilgour Court Leighton Buzzard
Leighton and Linslade Homeless Service
Aragon Housing, Sandy
Central Bedfordshire TA – Bedford Court Houghton Regis

- Bromford Floating Support Service
- Bedfordshire and Luton Mental Health and Social Care Partnership Trust
- Bedfordshire Drug Action Team
- Luton and Dunstable Hospital
- Bedford Hospital
- Practice Based Commissioners – Chiltern Vale, Ivel Valley, West Mid Beds and Leighton Buzzard
- Bedfordshire Community Health Services
- Bedfordshire Police Force
- Bedfordshire Connexions Service

1.3 Defining Health

> **Health is not only the absence of infirmity and disease but a state of physical, mental and social well-being (WHO 1948).**

Viewed through the WHO definition, single and family homelessness by their nature can be considered as states of ill health.

1.4 Defining Homelessness

> **Lacking secure accommodation, free from violence, or the threat of violence (Williams et al 2002:315).**

The most common definition of homelessness in the UK originates from the Housing (Homeless Persons) Act 1977. For the purposes of this document homeless people are those who are:

- Living in Local Authority temporary accommodation (TA)
- Living in hostels and refuges
- Rough sleeping, or living in squats
- Threatened with pending homelessness

1.4.1 Rough Sleeping Definition

> **Individuals sleeping rough' should include people sleeping, or bedded down, in the open air, or in buildings or other places not designed for habitation (ODPM 2006).**

Rough sleeping counts are supervised by the Department of Communities and Local Government (CLG) and generally undertaken when it is believed that there are three or more rough sleepers in a local authority area. The official count is performed for one hour (normally 23.00hrs to midnight) on one night of the year and only those rough sleepers who are "bedded down" are counted. As the numbers of rough sleepers are thought to be low in Central Bedfordshire, the local authority is not obliged to perform street counts. This study will reveal the number of people who are currently believed to be rough sleeping in Central Bedfordshire.

1.4.2 Definition of Family Homelessness

A guide prepared by the Community Practitioners' and Health Visitors' Association on family homelessness states,

The vast majority of homeless people are families living in temporary accommodation, or with relatives or friends. For some this means living in poor quality accommodation detrimental to their health and wellbeing. (CPHVA 2004 p2)

The health needs of family homelessness are discussed in the next chapter.

1.5 Categories in Homelessness

The *Housing (Homeless Persons) Act 1996* requires local authorities to categorise people who present as homeless into three areas:

1. Unintentionally homeless and in priority need (the majority)
2. Intentionally homeless and in priority need
3. Housed in temporary accommodation pending enquiries and a homelessness decision, or housed under discretionary power.

Local Authorities have an additional responsibility to identify statutory and non statutory homelessness in which there is a housing responsibility towards statutory homelessness. There is only a statutory obligation for Local Authorities to keep figures on those who are in *priority need* which relates mainly to families with children. People who are categorised as non statutory homeless are more likely to be unserved by statutory services and fall between housing, health and social services (Crane 2001). Non statutory homelessness affects mainly single homeless people who are then not registered as homeless with local authority housing departments and do not appear in homelessness statistics (Crane 2001).

Statutory homelessness:

- Those without the right to access secure accommodation for that night, are not legal tenants of any property, nor own property anywhere
- Those whom may lose their dwelling within 28 days
- Those with a local connection to the area
- Those in *priority need* i.e. with dependent children, older person household or vulnerable.
- Those who are not intentionally homeless i.e. in arrears from previous properties including mortgage arrears.

Non-statutory homelessness:

The local authority is not obliged to house people who they deem as *intentionally homeless* and *not in priority need* (Smith 2003)

1.5.1 The Legal Duty to House

To receive the full homelessness duty i.e. an offer of long term accommodation, an individual (or household) must pass five tests (Homeless Link 2006):

- Be legally homeless
- Be eligible for assistance
- Be in priority need
- Be unintentionally homeless rather than categorised as Intentionally homeless
- Have a local connection

1.6 Hidden Homelessness

In 2005 hidden homelessness was estimated to be around 380,000 people in the UK (Crisis 2006a), a size beyond the total population of Bristol. As well as 'sofa surfers'[7], these figures are generally believed to include hostel dwellers, squatters and rough sleepers who make up a large amount of the hidden population.

[7] *Sofa surfing* - a term used in homelessness to describe homeless people who sleep with family or friends because they have nowhere else to live.

1.7 What are the Health Needs of Single Homeless People?

Physical Health	Mental Health	Drug and alcohol	Dual Diagnosis /Tri-morbidity
Physical Health needs 2 to 3 times greater for rough sleepers (RS) than the general population (DETR 1999)	**Homelessness is a trigger to mental health problems** and exacerbates those that already exist (Bines 1994).	Rough sleepers: 15% non drinkers 36% had severe alcohol dependence 37 % were using drugs (Gill 1996)	**Dual diagnosis** of mentally ill health and substance dependence occurs in approx 20% of homeless people with mental illness
Life expectancy of RS is 40.2 years (Halligan 2008) compared with 79.5 years in general population (Health Inequalities profile 2006)	**Mental health - a leading cause of homelessness** In 1/3 of cases losing a home was associated with mental health problems (Craig et al 1995). More mental health problems than any other group in society (Stephens 2002)	**Drug overdose:** A study of Accident and Emergency departments found that rough sleepers were eight times more likely than the general population to attend with a drug overdose (North et al 1996).	**Tri morbidity** complex need of physical, mental illness and substance addiction in homeless populations (Sam Dorney Smith 2009)
Infectious diseases: Hepatitis and Sexually Transmitted Infections are two to three times higher than the rate within the general population (Connelly and Crown, 1994, Wood et al 1997, Wright 2002). **TB:** 25 times more prevalent than the national average (Citron 1997). In one London hostel the rate was 200 times more prevalent (SEU 1998)	**Suicide:** People who sleep rough are thirty five times more likely to commit suicide than the general population (Crisis 1996). In one study 43% of rough sleepers had attempted suicide and 25% had tried more than once (Griffiths 2001) The prevalence of serious mental illness (including major depression, schizophrenia and bipolar disorder) is reported as being present in at least 25-30% of street homeless and those in direct access hostels (Scott 1993, Craig 1995)]	Health risks amongst young homeless drug users: Main health problems linked to environment and isolation (Griffiths 2001) .	50% of admissions to a large London psychiatric hospital were 'revolving door' admissions with more than 3 admissions in the year. These people were more likely to have be discharged to homeless accommodation or live alone and have longer psychiatric histories and problems with substance use (Langsdon 2001)
There are higher rates of chronic conditions: epilepsy, diabetes, asthma, skin conditions, musculoskeletal problems, malnutrition (Pleace et al 1999, Connelly and Crown 1994).	**In hostels and B&B the incidence of mental health problems is higher**: 8 times higher in hostels and 11 times higher in B&B accommodation compared to the general population (Bines 1994)	Homeless alcohol dependent people are more likely to have had an alcoholic parent, had more children and have a lower level of education and job qualification than housed alcohol dependent people (Wright 2006)	St Mungo's(2004) survey of rough sleepers & those in hostels over 50 years of age: 56% are alcohol dependent 48% have mental health problems 47% have physical health problems 27% have challenging behaviour
ACCESS TO HEALTH SERVICES	Homeless people are 40% less likely than the general population to access GP services (Crisis 2002).	2 in 3 homeless people have physical health problems over 1 in 3 who need help are not receiving it (Gorton 2006)	**SINGLE PEOPLE**

Fordham 2009

1.7.1 What are the Health Needs of Homeless Families?

Health Needs of PARENTS	What the research says:	Health Needs of CHILDREN	What the research says:
Tischler (2002) **Adams (1996, Thompson et al 1995)**	Homeless parents had higher risk of depression and substance misuse with correlating higher need for mental health treatment	**Community Practitioners and Health Visitors Association (2004)** **Hutchinson (1999)** **Cook (2009)**	Higher accident rates for children living in TA due in part to: • Lack of safe play areas • Overcrowding • State of disrepair 1/3 of deaths in serious case reviews are homeless (London)
Vickers (1991)	Mothers felt tired, had sleep difficulties, often lost their temper and were irritated with their child.	**Vostanis et al (1999 pp 32 - 41)**	*Associated factors:* -Higher A&E attendance: infections, chronic illness, accident rates. -Behavioural/ mental health problems; -Physical health problems: chest infections, UTI malnourishment; -Developmental delay; -Immunisation delay; -Social exclusion -Lower educational achievement -Child in Need/of Protection.
Peckover (1989) **Sawtell (2002)**	-Women want quiet private environments to discuss experiences of DV with HV -Coping in adverse circumstances also brought families closer with mothers often drawing strength from their children	**Shatwell (2003)** **Stanley (2002)**	-Deterioration in children's health when living in hostels or B&B, caused by cramped or poor conditions. -Developmental milestones delayed.
Hodnicki and Horner (1993), Montgomery (1994), Smith and North (1994).	Many homeless mothers demonstrate significant strength and coping strategies, guarding their children from harm and seeking solutions to their difficulties	**Vostanis (1999 p32-41)**	Not all children are at higher risk because of homelessness
ACCESS TO HEALTH SERVICES	**Cook et al (2004)** **Vostanis et al (1999)**	Many families living in TA are not registered with a GP but Vostanis found homeless families were engaging with health services	**FAMILIES**
			Fordham 2009

1.7.2 Rural Homelessness

Studies show that homeless families in **rural areas** may spend longer in temporary accommodation than those in urban areas (Fitzpatrick, Pleace and Jones, 2005). Some of the health problems arising from such circumstances include an increased risk of dermatological problems, musculoskeletal problems, poor obstetric outcomes and a range of mental health problems. The importance of stigma, attitudes of frontline staff, the difficulties of sustaining anonymity or confidentiality, difficulties of public transport access to health services and a lack of choice in services, are all examples of how homeless people may find accessing services more difficult in **rural areas** (ibid).

1.8 Policy Context

1.8.1 NATIONAL DRIVERS

No-one Left Out Communities Ending Rough Sleeping (CLG 2008)

• **Improve access to health and social care services for people with multiple needs**
• **Assessment of needs and commissioning and delivery of services will continue to be driven at the local level but we need to ensure that focused integrated health and social care services are accessible to everyone on the streets *and* in hostels.** • **Doing more to support people to access effective health and care is a key priority in this strategy. Addressing physical and mental health needs is a vital step in helping people move towards greater stability and independence, achieving their potential and reducing the risk of returning to the street.**

In this document the Government states their belief that people should not have to sleep on the streets in the 21st century and plan to end rough sleeping by 2012. The key to successful delivery of the strategy is partnership working. Recognizing the complexity of need, they suggest two points: ***Focus on those most in need*** even when other initiatives have failed and ***never give up on the most vulnerable.*** The document outlines that the complex mental and physical health needs of those on the streets are not currently being met. Sometimes rough sleepers are either in dire situations or are extremely unwell and they require crisis intervention. It recommends that key day centres and the night have access to GPs and on site nursing facilities. Efforts must be targeted on those groups that we know are particularly vulnerable to homelessness and to rough sleeping:

- young people leaving care;
- people leaving prison;
- people who have experienced family breakdown;
- people leaving the armed forces.

Homeless Link 2008 – Response to the SEU strategy document

For the 2012 Government target of zero rough sleepers to be met, the national charity Homeless Link[8] recommends 10 steps

- *Access to shelter:* Give everyone an alternative to a night on the streets, without having to move out of their home area
- *Matrix commissioning:* Support people with a strong web of commissioned accommodation, employment, health and advice services personalised to their needs
- *A safety net for migrants*: Ensure everyone has an appropriate welfare safety net for shelter and food, regardless of their status
- *Close the routes to homelessness:* Work together across government to prevent homelessness among care leavers, prison leavers and ex-service personnel
- *Incentivise prevention:* Help public services and local authorities to work together to prevent homelessness and provide more responsive services, including reforms to housing benefit

The Homelessness Act 2002

The Act imposed a new statutory duty on Local Authorities to produce a Homelessness Strategy for addressing prevention and recurrence of homelessness. The strategy adopts a multi agency approach to provide a coherent service to homeless people so that the complex needs of this group are met.

Addressing the Health Needs of Homeless People (ODPM 2004)

In April 2004 the ODPM issued a Directory Advice Note to Local authorities, PCT's and other partners with the following targets:

- Improve the health care of families in temporary accommodation
- Improve access to primary care for homeless people
- Improve substance misuse treatment for homeless people
- Improve mental health treatment for homeless people

1.8.2 REGIONAL DRIVER

Public Service Agreements (PSA's)

Several indictors address the health needs of homeless people in the broader determinants of health:

- PSA 12 Improve the health and wellbeing of children and young people
- PSA 13 Improve children and young peoples' safety
- PSA16 Increase the number of socially excluded adults in settled accommodation, employment, education or training

[8] (http://www.homeless.org.uk/roughsleeping accessed 20 November 2009)

- PSA 18 Promote the health and well-being for all
- PSA19 Ensure better care for all
- PSA 25 Reduce the harm caused by alcohol or drugs
- NI 71 Missing from Home and Care

1.8.3 LOCAL DRIVERS

The NHS document *Improving Lives Saving Lives* has been regionally and locally developed into NHS Bedfordshire's eleven pledges.

A Healthier Bedfordshire (2008)
We will ensure health care is as available to marginalised groups and 'looked after children' as it is to the rest of us.
Pledge 9

Other pledges applicable to homelessness include:

- **Pledge 3** We will ensure GP practices improve access and become more responsive to the needs of all patients
- **Pledge 4** We will ensure dental services are available to all who need it
- **Pledge 8** We will work with partners to reduce the difference in life expectancy between the poorest 20% of our communities & the average in each PCT

Central Bedfordshire Homelessness Strategy
• **Strategic Priority 2** Improving multi agency links to prevent homelessness amongst people vulnerable to homelessness • **Strategic Priority 3** Continuing to develop a homelessness prevention framework for survivors of Domestic Violence
Mid Bedfordshire 2008-2013

The strategy recognises that homelessness impacts negatively on physical and mental health and that those with health needs are more vulnerable to homelessness. It recommends:

- The joint hospital discharge protocol for patients who are unable to return to their previous accommodation, with the aim of reducing unplanned and urgent discharges as much as possible.
- Joint working between NHS mental health services and Aragon for planned discharge from mental health services.
- Notification to health visitors of families placed into temporary accommodation so health service provision can be put in place.
- A resource pack for healthcare professionals to ensure clear signposting to available housing services.

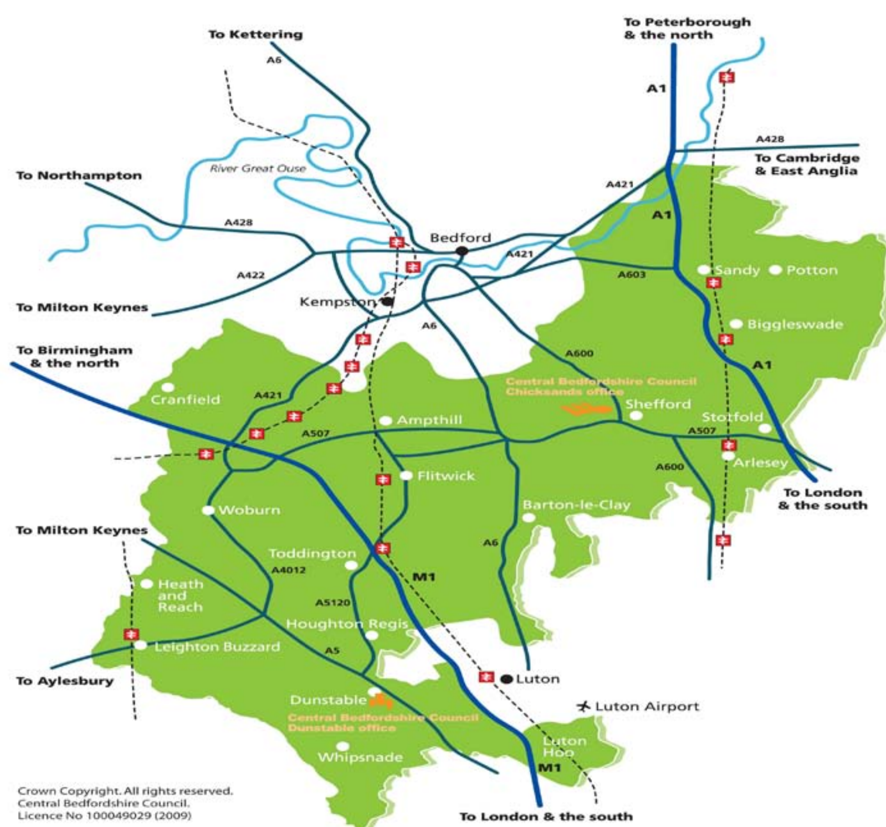
South Bedfordshire Community Plan also has homelessness as a priority and cites lack of suitable housing for a range of people with particular needs. It identifies the need to improve understanding of the diverse housing needs of communities in South Bedfordshire, including the need for affordable housing.

Joint Strategic Needs Assessment
The recommendations in this report will feed into the forthcoming JSNA (2010) Ensuring the engagement of particularly vulnerable and hard to reach groups, those with complex medical and social care needs and those experiencing exclusion will be one of the significant challenges of Joint Strategic Needs Assessment (JSNA). Their involvement is important, since they are more likely to suffer from poor health and wellbeing and from inequalities, and their engagement with JSNA will best shape services to meet their needs. Third sector and local user-led organisations often have considerable experience in identifying need within these groups.
Guidance on Joint Strategic Needs Assessment (CLG 2008 p 36)

2.0 Central Bedfordshire
Quantitative Data

2.1 Overview, Location and General Health in Central Bedfordshire

The Public Health Report (Bedford Primary Care Trust 2007) reads:
Central Bedfordshire lies in the East of England region, about 40 miles (55 kilometres) north of London. It is an area of mostly small towns and villages with little urbanisation. However, the towns of Dunstable and Houghton Regis form part of the Bedfordshire's largest conurbation with neighbours Luton. Central Bedfordshire Council was created on 1 April 2009 from the merger of Mid and South Bedfordshire. Central Bedfordshire is a relatively affluent area. The health of people in Central Bedfordshire is generally better than the England average. Nevertheless, inequalities do exist by gender, deprivation, location and ethnicity. For example, men living in the least deprived areas can expect to live over 5 years longer than men living in the most deprived areas in Central Bedfordshire. Over the past ten years, rates of deaths from all causes, early deaths from cancer and early deaths from heart disease and stroke have improved for men and women are now very similar to the England average. Obesity is higher in adulthood with over 1 in 5 adults being obese. In Central Bedfordshire around 1 adult in 5 binge drinks and smoking in pregnancy and breast feeding initiation are worse than the national average.



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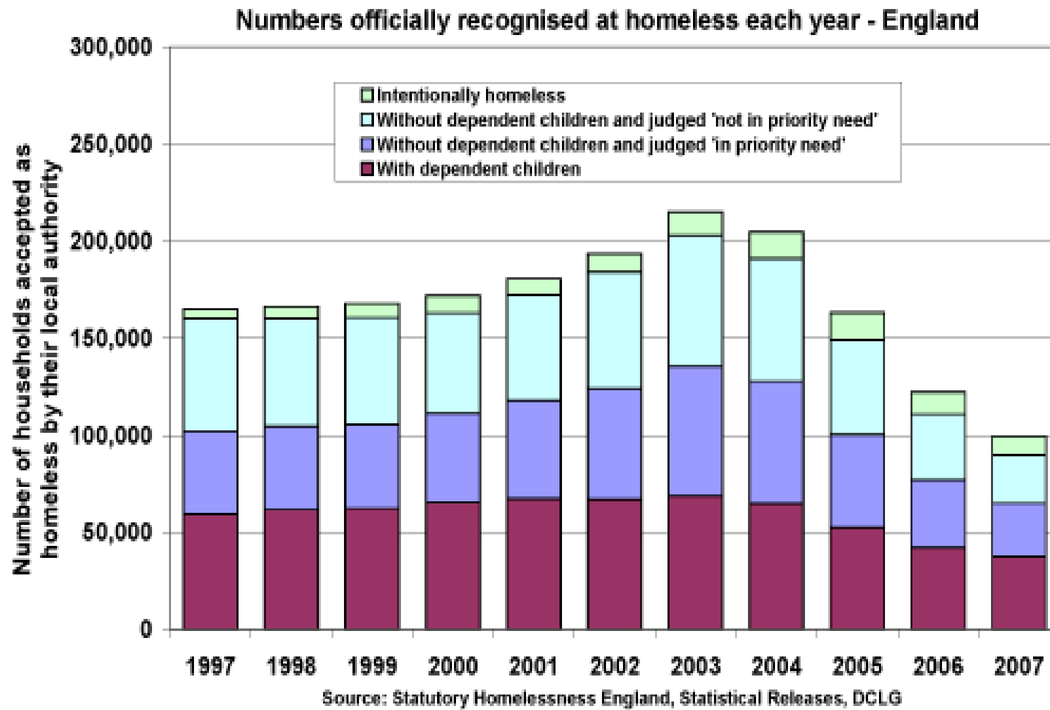
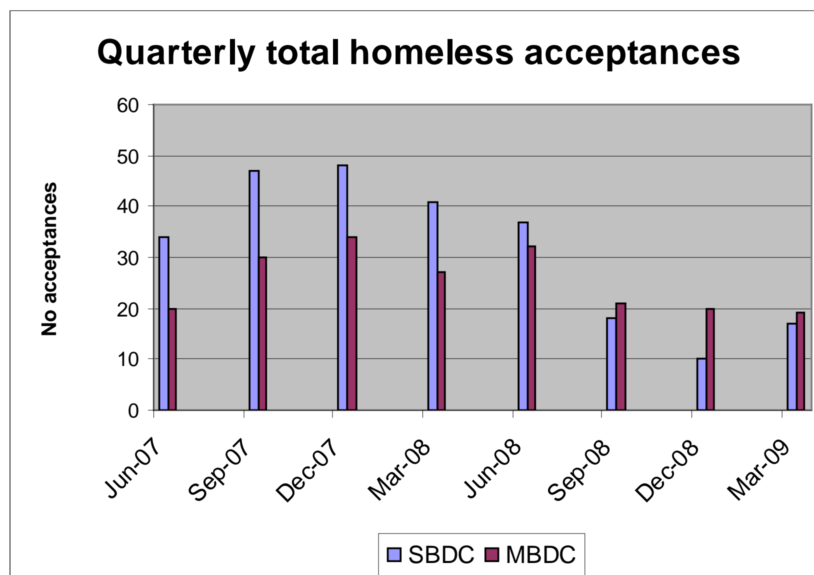
2.2.1 NATIONAL DATA: Officially Recognised Homelessness



Homelessness acceptances from 2003 to 2007 declined nationally. In the following graph homelessness acceptances in Central Bedfordshire also show a marked decline from December 07.

2.2.3 LOCAL DATA - Central Bedfordshire Council 2007-2008



2.2.4 A selection of comparative national and regional data from 2007:

Number of Households
Officially Recognised
as Newly Homeless in UK in 2007 (CLG)
Examples of homelessness ranked in England by Local Authorities

5 Peterborough (954) 1.40%

70 Bedford (363) 0.58%

95 City of London (20) 0.50%

96 East Northamptonshire (165) 0.50%

136 East Cambridgeshire (127) 0.40%

145 South Bedfordshire (180) 0.38%

164 Kings Lynn and West Norfolk (218) 0.36%

203 Mid Bedfordshire (145) 0.28%

299 South Cambridgeshire (80) 0.15%

Number of households in Bedfordshire **Total 688**

The above selection of neighbouring, regional and City of London data provides an overview of where the three Bedfordshire local authorities (prior to unitary status) are positioned. When South and Mid Bedfordshire data is amalgamated the figures of those recognised as newly homeless in 2007 remain slightly lower than those of Bedford.

2.2.5 Temporary Accommodation in Central Bedfordshire

The number of families placed in temporary accommodation has decreased in 2009 with most placed in Bedford Court – a communal building - or 12 temporary accommodation (TA) houses. Other local authorities place homeless families in central Bedfordshire - the reason for, and local impact of this should be explored further. Single homeless people are also placed in TA in a single block of flats in Sandy.

Bedfordshire County Council Joint Strategic Needs Assessment (2008 p7):

Rough Sleepers

According to figures For BVPI 202 from each of the District Councils, there are an estimated 20 rough sleepers in Bedfordshire, 10 in Bedford (actual, based on a count, Q1 07/08), 2 in Mid Beds (estimate for 06/07) and 8 in South Beds (estimate, November 06).

16 – 24 age group

In South Bedfordshire, the majority of accepted homeless applications are from the 16-24 age group, with the highest percentage across the three districts.

3 HOMELESSNESS, HOUSING AND HEALTH:

Central Bedfordshire
Dunstable, Houghton Regis, Leighton Buzzard

3.1 Dunstable

Pathways in homelessness: the role of Central Bedfordshire Council

People presenting as homeless in the South Central Bedfordshire are interviewed by the Housing Options Team based in the Central Bedfordshire Council (CBC) offices in Dunstable. The Housing Options Team offer a prevention scheme, advice and assistance to all homeless people and will help them decide whether they should make a homeless application. Higher care needs may also be identified and referrals to Social Services made - e.g. for those who those who:

- require immediate intervention from a social worker under the Mental Health Act
- have no recourse to public funds
- are under the age of 18
- have left care or about to do so
- are elderly
- are ill or have physical or mental health needs
- are intentionally homeless and have dependent children

Recently a Housing Forum has been established with Mental Health Services[9].The Council also have policies with Social Services in place for Leaving Care and Hospital Discharge. Proposed new protocols are planned for 16 and 17 year olds and Mental Health issues. A Sanctuary Scheme enabling people who have experienced domestic violence to remain at home with added security measures to protect them when the perpetrator no longer lives in the home.

The Central Bedfordshire Homelessness Advice Leaflet states that four areas are investigated to establish intentionality[10]:

- Did you deliberately do (or not do) something that caused you to leave accommodation which you could otherwise have stayed in, and it would have been reasonable for you to stay there.
- Did you agree to or know what happened?
- Why did you leave the accommodation you were in?
- Have you refused reasonable accommodation?

As in the rest of the United Kingdom, not everyone in Central Bedfordshire is owed a duty of care to be housed by the local authority; it depends on *intentionality* and

[9] MF to explore with mental health services whether this group could evolve into a larger coherent health and housing forum

[10] Under the Housing Act 1996, people are assessed to be intentionally or unintentionally homeless. A duty to house occurs for those people who are eligible, in priority need who are unintentionally homeless.

establishing *priority need*. It is therefore vital for health care professionals[11] with expert knowledge of health and homelessness to remain alert to how a health condition such as a Learning Difficulty[12] may contribute to the *intentionality*[13] debate and vital too that, where needed, evidence of priority need is offered, for as Bines (1994 p22) research shows,

> **Many single homeless people were suffering from multiple health problems…In many cases the combination of health problems such as fits, mental illness and alcohol posed a serious risk to their wellbeing and safety. None of those interviewed in the survey had, however, been accepted by a Local Authority as vulnerable and in priority need for housing despite their poor health.**[14]

3.1.2 Rough Sleeping in Dunstable

Example of people falling through the net of services
In Central Bedfordshire:

Two agencies cited one person who had been living in a builders skip in Dunstable. They were believed to have a mental health illness without an established diagnosis.

Health Related Questions for Consideration:
Were mental health services aware?
Was a GP, if registered, aware?
What housing and other support options were available?

Although there is untold personal suffering involved for just one person sleeping rough, Central Bedfordshire Council and the police do not generally consider rough sleeping to be a problem in the Dunstable area. At the time of writing this report three rough sleepers were known to Housing Options Team. Two of the three were a couple who used the Nightshelter and other services in Bedford regularly.

3.1.3 Connexions – identifying young homeless people in Dunstable

In Dunstable, young homeless people may initially be identified by Connexions who refer them into Central Bedfordshire Council or signpost them to the local hostel.

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[11] This should be a Public Health priority - i.e. captured in the specialism of the Public Health Nurse role.

[12] A case in clinical practice where Learning Disabled (LD) woman was not eligible for LD services as her IQ test was 71; 70 being the criteria for service provision. This created vulnerability leading to eviction for 'anti social behaviour' despite ensuing pregnancy.

[13] CLG (2009 p19 Statutory Homelessness statistics) advises that accommodation is available for those in priority need even where *intentionality* exists, for as long as is reasonable for the applicant to find a home.

[14] Pereira Test is applied to determine vulnerability i.e. the (homeless) person would be less able to fend for himself than an ordinary homeless person so that he would be likely to suffer injury or detriment, in circumstances where a less vulnerable person would be able to cope without harmful effects' (Brayen H.& Carr 2005 p 707 *Law for Social Workers*, Oxford UP)

The presenting health issues which Connexions have identified with young people are sexual health, mental health problems, general health issues, healthy eating and substance misuse. Connexions offer a counselling service. Support services such as Addaction are not always utilised by young people. Other young people, perhaps with a Learning Disability, seem unaware of their entitlement to benefits (Disability Living Allowance). Financial hardship contributes to, and triggers, homelessness. Furthermore, there are no mother and baby accommodation units in Dunstable. Even when living in the single homeless hostel, young pregnant girls have to move to another area for housing. Leaving supportive community networks at a vulnerable time for already vulnerable people was a concern held by all agencies.

3.1.4 Homeless Hostel Services - Dunstable

Signposts - homeless accommodation
For 16-30 year olds
129-133 High St North. Tel 01582 670676

Stage One - High Support Accommodation (Dunstable) for 12 people. Meals included.
Stage Two - Medium Support (Dunstable) for 12 people
Stage Three – Moving towards independent Living (Houghton Regis) for 8 people

Signposts use a 33 point plan towards independent living using the Supporting People Outcomes.

Skill 8 - assesses the skill of the resident to independently access health services.

Signposts residents' access local GPs without difficulty. Hostel staff also consider mental health partnerships to have developed well in recent years. Care plans are shared and psychiatrists include the hostel staff in key meetings. Self harm[15] is always an emotive and difficult issue as are other unidentified and emerging mental health problems. Support from health services for hostels across Bedfordshire should be developed in this respect. Addaction offices for those with substance misuse are within walking distance of the first stage hostel. During my visit to Signposts I met two young people who were in Phase Three accommodation. Both were enthusiastic about the support they had received from Signposts and were engaging successfully with college and employment. As with all hostels health pathways where eviction may occur through ill health are required.

3.1.5 Identified Health Gaps in Dunstable:

- Alcohol Services: Residents have to travel to Luton to access alcohol services. They and staff believe support should be available in Dunstable. For people with Dual Diagnosis which may include alcoholism, Healthlink hold a clinic on

[15] Self harm training for homeless service providers was facilitated by me in Summer 2008. This needs to continue annually. Self harm booklets published by the Mental Health Foundation are available on their web site – details from NHS Bedfordshire Resource Library.

Wednesday's and Friday's at the One Shop in Dunstable. Appointments are made through the Bedford Healthlink office. This facility should be advertised more widely.

- Build on the joint working partnerships with health services to minimise hostel evictions.
- Self harm and emerging mental health illness when the person is not known to services is a difficult issue for staff who need support and ongoing mental health training.
- Sexual Health Services - coordinate condoms and Chlamydia screening (Health Improvement Team subsequently arranged services)[16].
- Develop formal liaison protocols between floating support and mental health.

3.2 Houghton Regis

Bedford Court, Bedford Road Houghton Regis Central Bedfordshire Council Temporary Accommodation
Currently being refurbished and upgraded the TA will house homeless people including families who are vulnerable and in 'priority need'. The Project Manager visits daily but otherwise staff are not on site. The accommodation has 17 mixed units – some with two bedrooms and communal accommodation includes a large kitchen/lounge area suitable for health clinics or health information fairs.

3.2.1 Potential Gaps in Health, Housing and Social Care in Houghton Regis

Partnership working between housing and mental health services and between housing and social services could be developed further. For example, unlike Signposts in Dunstable, housing staff are hardly involved in mental health care plan meetings about vulnerable individuals living in TA. Similarly parental access rights following on from Child in Need of Protection proceedings are not routinely known to housing staff. Nor do housing staff know whether Health Visitors are aware of families or whether the child's/baby's progress is being monitored. This provides further evidence that an in and out Notification system[17] is required across NHS Bedfordshire for families in TA and should be developed in line with recommendations in the Bedford Borough HNA report. Exploring *information sharing* is highly recommended to jointly support vulnerable people.

3.2.2 Rough Sleeping in Houghton Regis

Police and other services in Houghton Regis were not aware of anyone rough sleeping in the Houghton Regis area.

[16] Condomania supply registered clients with condoms/dental dams (NHS Bedfordshire is invoiced for agencies registered in the scheme in this area)

[17] Notification Systems between Health and Housing are recommended by CPHVA (2004) and DoH in a joint document; also recommended by Queens Nursing Institute (to be published 2010) in a document on Family Homelessness which I have recently peer reviewed.

3.3 Leighton Buzzard

Leighton Buzzard hosts the only Refuge in Central Bedfordshire - but the 6 bedded unit will shortly be moving to two further sites out of the town.

The Leighton and Linslade Homeless Service
Chair: Alan Knowles; Co-ordinator Maggie Rice

Following local concern about the visibility of rough sleeping in the Leighton and Linslade area this homeless service became a registered charity in 2006. Since then the charity has successfully grown and supports around 16 people on a nightly license, for example:

2 people are currently rough sleeping on church floors awaiting accommodation
7 people in rooms which the charity rents from a local landlord
3 people are temporarily living at a variety of venues whilst awaiting accommodation (i.e. 'sofa surfing').
1 long term homeless person

Key workers have employment experience in housing and social services and the charity is well regarded by local agencies. However, it is not linked into Supporting People or Central Bedfordshire Council as it operates independently. Successful follow on housing options include referrals into hostels through the Supporting People Gateway system and homeless applications to housing departments. Health issues include supporting homeless people with medication, dealing with crisis mental health issues, discharge from hospital and hospital transport for appointments.

3.3.1 May Day Trust Homeless Accommodation Services

Kilgour Court
Bassett Road, Leighton Buzzard **Tel:** 01525 852996

Mayday Trust operates a 36-bedroom scheme in Leighton Buzzard, catering for a mixed client group. Referrals include: Care leavers, ex-offenders, victims of alcohol/substance abuse, victims of domestic violence, mental health referrals and those with moderate learning difficulties.

I'm pleased to say that in the twelve months I've been here my health has got better. I was in a bad way when I got here. I'm an awful lot better especially in terms of what's happening up here (head) … in terms of not having drink like I did, I'm a lot healthier….I'm able to think about things, think about where I go in my future and what I do next
(Focus Group 2007)

3.3.1 What should be addressed in health service development in Leighton Buzzard for homeless people?

Securing GP registration had previously been difficult for homeless people in Leighton Buzzard. Two particular surgeries in Leighton Buzzard were described by homeless services as providers of 'excellent' care to the homeless The GP's that I contacted for their views on homelessness responded by saying that there were very few homeless people in Leighton Buzzard and that homelessness was not perceived by them as a problem. One focus group respondent stated,

> **I believe that the majority of doctors – you've got to work a couple of times to get through to … I'm not after your methadone etc yeah. I'm epileptic – all I'm after, is my Epilim and occasionally things happen to me like verrucas and athlete's foot. I'm not after your drugs. But as soon as you say (your homeless)...with certain doctors the barriers come down. It's like you have to fight every step of the way.**
> **(Focus Group 2007)**

Homeless service providers identified the following improvements required in health services delivery for homeless people:

- Access to services and treatment of dual diagnosis[18] for homeless people
- Discharge co-ordination from hospitals/mental health units including follow up care by CMHT[19]. There was general concern about unplanned discharges at 4.00pm on Fridays
- Supporting homeless people with medications. This could develop in line with the proposals put forward by NHS Bedfordshire award winning 'Ask About Medicines' project where pharmacists review medicines of homeless people on an annual basis
- Easier access to podiatry and dental services
- The provision of hospital transport so that hospital appointments are not missed by people on low income. There is no direct bus route and taxi's cost £20 to the Luton and Dunstable Hospital
- Mental health training/support for homeless services staff
- Access to a homelessness nurse

[18] Dual Diagnosis has largely been replaced by 'tri-morbidity' of complex need in homelessness.
[19] Cited by a number of agencies in Central Bedfordshire

4 Central Bedfordshire
Sandy, Biggleswade, Ampthill, Shefford, Arlsey

4.1 Aragon Housing

When people are homeless present to Central Bedfordshire Council (the old Mid Beds area), they are directed to Aragon[20] Housing which has offices in Sandy and Ampthill. A decision on whether a homeless assessment[21] is required is made. Housing advice is always given. Temporary accommodation (TA) is provided across Mid Bedfordshire. There is one accommodation block in Sandy for single people. There are twelve premises to house homeless families. As in the rest of Bedfordshire a notification system between health services and housing services is not yet in place for homeless families with children but is currently being discussed. School aged children are not supported beyond Common Assessment Framework principles but education and school nursing should explore this further in line with the HHI (2010) *Family Homelessness* document (peer reviewed by author).

4.2 Sandy and Biggleswade

Bedford Housing Link
1 Church, St Biggleswade.

BHL offers low level support in 17 units in Sandy for 16 to 25 year olds: Winchester Road, College Road, Friar's Walk and Sandon Close. CAN offer outreach services. GP's are easily accessed. The hostel is not equipped to support people with medium to high level mental health needs.

BHL offers a successful low level support service where people learn to become independent. Although the offices are based in Biggleswade all residents are supported in houses in Sandy. The hostel uses the Lawns for GP and mental health support where diagnosed but developing mental health conditions can be a concern. Travel costs to access health and other services in major towns is also an issue.

Signposts highlighted how homeless people with medium to high level need and those over the age of 25, are unable to access accommodation in Central Mid Bedfordshire unless priority need for local authority housing is identified in homeless

[20] Aragon Housing Association was formed in 1994, following the transfer of homes from Mid Beds District Council.

[21] If a homeless person does not understand the homeless application process or sign to say they understand the homeless application then assessment and accommodation may be withheld until support/guidance is available - this could possibly hold implications for health services including LD services (interview with Aragon Housing manager).

assessments. Multi agency collaboration between health, housing and homeless services is required to establish priority need where vulnerability exists.

4.3 Rough Sleeping in Central (mid) Bedfordshire

At the time of writing this report the accumulation of known rough sleepers by different agencies in Central Bedfordshire came to around 9 people. Half of those who were known by services live in tents in the forest area around Sandy and Biggleswade. Others sleep in the car park in Sandy from time to time. Many are frightened about accessing support services in Bedford which they perceive as dangerous, busy, and fear of other homeless services users.

Significantly, there is no central hub to coordinate support for rough sleepers.

When Supporting People funding was reduced last year the informal support offered to rough sleepers by Bedford Housing Link in Biggleswade was withdrawn (hot drinks, shelter in the sitting room etc, charging mobile phones[22]). Consequently health service provision will always be difficult to assess *and* access unless homeless people are registered with a local GP. **This brings to light the importance of GP's knowing about local multi agency support networks to coordinate health and social care.** Responses from local police concurred that there was little evidence of rough sleeping in Flitwick, Shefford or Ampthill yet even where there is one person in each of these areas, a coordinated response is needed. Some agencies strongly felt that an independent housing advice centre is particularly needed in Central Bedfordshire. Crisis (2009) also recommends access and signposting homeless people to independent housing advices.

4.4 Floating Support Services in across Central Bedfordshire

BROMFORD FLOATING SUPPORT Supporting People
Bromford Support was set up in 2008 to provide support to vulnerable people with housing need. It is funded by Supporting People and monitored by QOF standard (Star quality outcomes framework). A maximum of 40 people are supported. Support is dependent on need (e.g. ex-offenders/families/mental health) and given for up to 10 hours p.w. There is a higher demand to support families than single homeless people. Multi agency reviews are held bi-monthly. Key workers need to be identified by health professionals in complex care planning for effective joint communication and safe working practices between agencies.

[22] Mobile phones are a life line for many rough sleepers.

5. The Provision of Health Services in Central Bedfordshire

Do they meet the need of homeless people?

NHS Bedfordshire: Public Health and Commissioning: The Merton Centre, St Peter's Street, Bedford MK40 2UB

- Public Health – Specialist Public Health Nurse – Homelessness
- Vulnerable Communities Commissioner

Practice Based Commissioners of Primary Care Services

- A Local Enhanced Service (LES) for Homelessness[23] at 2 Goldington Road surgery with clinics held at the night shelter and day centre – Horizon PBC.
- A nurse clinic be offered again in daily clinics at the Night Shelter or Day centre in Bedford
- ***There are no specialist GP/Nursing services for homeless people in Central Bedfordshire (excluding Luton)***

GP services

- Homeless people are eligible to access **all** GP services. An address is not required. GP's can use their own practice address to register rough sleepers.

Hospital Services

- Bedford Hospital NHS Trust Kempston Road, Bedford MK42 9DJ 01234 355122
- Luton and Dunstable Hospital NHS Foundation Trust Lewsey Road, Luton Beds LU4 ODZ 0845 1270127
- Midwife Luton 01582 497020
- Midwife Bedford 901234 497285 x 5577

Sexual Health Services

- Bridge House Bedford Hospital Ring for appointment or Walk in Clinics: Fri 8.30am, Mon and Wed 10.30am 01234 792146
- Luton & Dunstable Hospital Genito-Urinary Medicine Clinic Ring for appointment or Walk in Clinics from 8.30am:Mixed Mon and Fri am Male Thurs am Female Tues am Young people (Aged 22 and under) Tues from 3pm onwards 01582 497070
- Health Improvement Team: Condomania, Chlamydia screening and health education. Doolittle Mill, Ampthill, Bedfordshire

[23] Recently changed from an National Enhanced Service (NES)

- Brook Bedfordshire (Sexual Health Services for people under 25). Clinic times:

Monday	Flitwick Health Centre Dunstable College, Kingsway	3.30-6.30pm 12-2pm
Tuesday	Bedford, Broadway House Houghton Regis, Tithe Farm Neighbourhood Centre	3.45-6.45pm 3.30-6.30pm
Wednesday	Leighton Buzzard, Tactic Centre	4-6pm
Thursday	Biggleswade Health Centre, Saffron Road	3.30-6.30pm
Friday	Sandy Health Centre, Northcroft	4-6pm
Saturday	Bedford, Broadway House	1.30-4.30pm

- Terence Higgins Trust sexual health services for all ages. Clinic times:

Bedford First Floor, Broadway House, 4/6 The Broadway, Bedford MK40 2TE Mon 6pm-9pm, Thurs 5pm-8pm and Saturday 10am – 1pm
Flitwick Flitwick Health Centre The Highlands, Flitwick, Bedford, Bedfordshire, MK45 1DZ Mon 1pm-3pm
Biggleswade Biggleswade Health Centre Saffron Road, Biggleswade, Bedfordshire, SG18 8DJ Tues 6pm-9pm
Dunstable Dunstable Health Centre Priory Gardens, Dunstable, Bedfordshire, LU6 3SU Wed 6pm-9pm
Outreach clinics at venues across Bedford – Sat 1pm-5pm

Substance Misuse Services

- Shared Care South Substance misuse, drug treatment and advice. 67 High Street North, Dunstable, Beds LU6 1SJ 01582 501780
- Health Link. A treatment service for people with dual diagnosis. Referrals and appointments through Bedford office 01234 270123 – outreach clinics in Dunstable and Leighton Buzzard

Non NHS Drug and Alcohol Services:

- Bedfordshire Drug and Alcohol Team (B:Dat) Advice on drug and alcohol issues and local services across Bedfordshire Information Line 01234 332901
- Addaction Open access/needle exchange 67 High Street North, Dunstable, Beds LU6 1JFMon 8.30am – 8pm Tue to Fri 8.30am – 4.30pm 01582 501780
- Addaction Support and Advice Delta House, 34 Hockliffe Street, Leighton Buzzard, Beds LU7 1EZ Thur 12pm – 4.30pm
- CAN Drug and alcohol advice and services. 22 Grove Place, Bedford MK40 3JJ Tel 01234 354193 2nd Floor, Britannic House, 18 – 20 Dunstable Road, Luton Beds LU1 1DY 01582 400237
- James Kingham Project (jkp) Alcohol services. 32 St John's Street, Bedford MK42 ODH
  Open House Mon to Fri 12 noon – 4pm 01234 344133 Napier House, 17 -21 Napier Road, Luton, Beds LU1 1RF Open House Mon to Fri (Please call for times) 01582 723434

Mental Health and Well-being Services

- Contact GP in the first instance when registered unless it is an emergency.
- Bedfordshire and Luton Mental Health and Social Care Partnership NHS Trust (BLPT) 01582 700200
- Mental Health Weller Wing Bedford Hospital 01234 299900 (24 hours)
- Improving Access to Psychological Therapies (IAPT):Professional referral required Leighton Buzzard 01525 854576, Dunstable 01582 557316, Ampthill 01525 722560 Biggleswade 01525 722220 Mon to Fri 9am – 5pm

Adult Mental Health Services

- Acute and Crisis Services Mid and South Beds
  Houghton Regis
  Townsend Court
  Mayer Way Tel: 01582 707600
  Houghton Regis, Bedfordshire LU5 5BF
  Townsend Curt is a 25 bed acute admission unit for adults aged 16 - 65. 2 beds are for detox

- Crisis Resolution And Home Treatment Team
  The Crisis Teams offer an intensive assessment and treatment service at home for people with acute mental health problems who would otherwise require hospital admission. Their service includes an Accident & Emergency Liaison of the Luton and Dunstable Hospital and Bedford South Wing Hospital. Contact Phoenix Unit, Weller Wing Tel: 0124 315691

- Assertive Outreach Team
  Bedford Heights Tel: 01234 315835
  Manton Lane
  Bedford Bedfordshire
  MK41 7PA
  The Assertive Outreach Teams work with people who have complex mental health needs and have difficulty engaging with mainstream services inlcuding homeless people – but they must be registered with a GP. Both teams work flexibly 7 days a week. For the Bedford Team out of office hours, use their usual telephone number. For Luton use tel: 01582 700340 between 10am and 6pm week ends and bank holidays.

- Community Mental Health Teams – GP or Health professional referral needed
  Ampthill & District
  Meadow Lodge Tel: 01525 758400
  Steppingley Hospital
  Ampthill Road
  Steppingley, Bedfordshire
  MK45 1AB
  Biggleswade & District
  Spring House Tel: 01767 224922
  Biggleswade Hospital

Potton Road
Biggleswade, Bedfordshire
SG18 0EJ
Dunstable
Beacon House Tel: 01582 709200
5 Regent street
Dunstable, Bedfordshire
LU6 1LP
Leighton Buzzard
Crombie House
36 Hockliffe Street Tel: 01525 751133
Leighton Buzzard
Bedfordshire

- Community Mental Health Teams for Older People
  Mid Beds
  The Lawns resource centre Tel: 01767 224181
  The Baulk
  Biggleswade
  South Beds
  Poplars Unit Tel: 01582 657588
  Mayer way
  Houghton Regis, Dunstable. LU 5 5BF

  Residential
  Whichello's Wharf
  The Elms, off Stoke Road Tel: 01525 751170
  Linslade, Leighton Buzzard Bedfordshire LU7 2TD

  Whichello's Wharf provides a residential type setting for **adults of working age.** The emphasis is on Service user involvement in their care planning and rehabilitation programme. A safe therapeutic environment allows Service users opportunities to develop their personal, social and coping skills.

- Secure Services

  Robin Pinto Units 1 And 2
  Calnwood Road Tel Unit 1: 01582 657530
  Luton Bedfordshire
  LU4 0FB Tel Unit 2: 01582 657544
  The Robin Pinto unit is divided into one male and one female unit.

  Secure Services Community Team
  Orchard unit Tel: 01582 657500
  Calnwood road
  Luton LU4 0FB

Countywide service providing cover to the police cells and courts for the assessment/ referral on of mentally disordered offenders. Small caseloads held of Service users with a history of dangerous behaviour moving through the hierarchy of secure service provision. Active involvement with MAPPA.

Children and Young Persons Directorate (Cypd)

Dunstable

Child and Family Consultation Clinics
Dunstable Health Centre
Priory Gardens
Dunstable Bedfordshire LU6 3SU Tel: 01582 707634

Mid Beds and Bedford

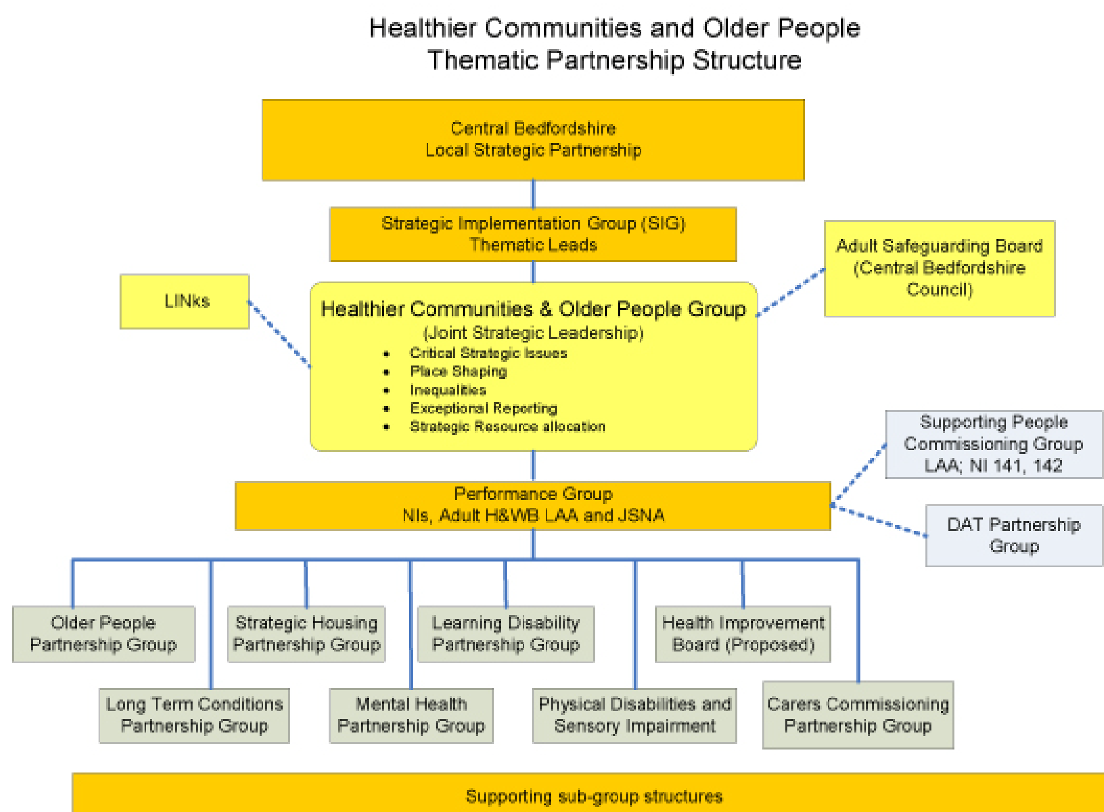
Child and Family consultation clinic Tel: 01234 310800
24 Grove place
Bedford MK40 3JT

Health Visitor, District Nurse, GP and other Primary Care service details will be reproduced in an information leaflet for homelessness and health in Central Bedfordshire

5.2 Strategic committees in health and homelessness in Bedfordshire

- Central Bedfordshire Strategic Housing Partnership Group
- Central Bedfordshire Council and Mental Health Forum
- Bedford Borough Council Multi Agency Panel for Rough Sleepers
- Bedford Borough Adult Health & Wellbeing Thematic Partnership
- Bedfordshire Supported Housing Executive Forum – Public Health representation
- Bedfordshire Supported Housing Forum – Public Health representation
- Bromford Floating Support (Central Beds) - Supporting People
- One Support floating support (Bedford) – Supporting People
- NHS Bedfordshire - Homeless Steering Group
- NHS Bedfordshire – Working party on Admission and Discharge policy
- NHS Bedfordshire – Task group Notifications for Family Homelessness

Strategic Flow Chart



The Homelessness Steering Group is a sub group of the Strategic Housing Partnership Group.

6 FINDINGS

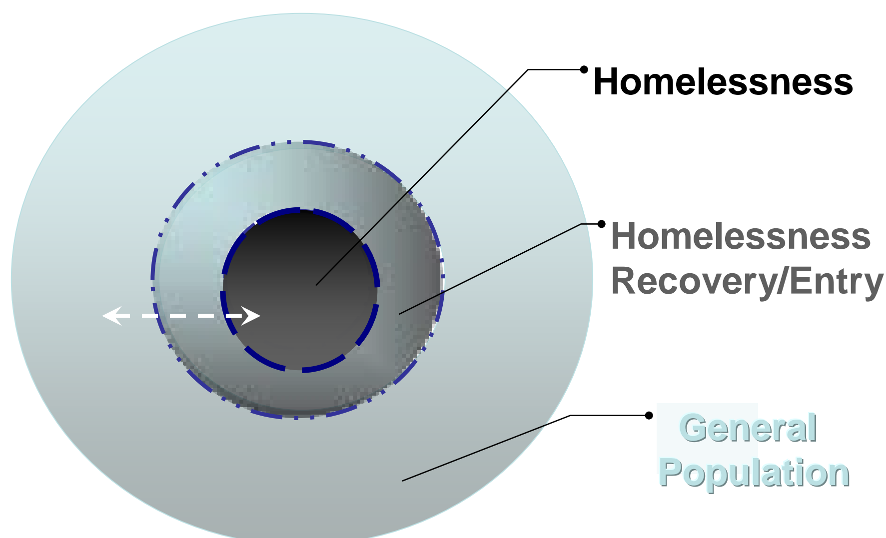
6.1 Do our health services currently meet the health needs of homeless people in Central Bedfordshire?

As we now know, to be homeless or vulnerably housed is a major health issue (Daiski 2006, Crisis 2003, Tischler 2002, Adams 1996, Thompson et al 1995). Ideally, mainstream health services would meet the need of our homeless residents in Central Bedfordshire. From the previous section, it would seem that NHS Bedfordshire provides sufficient health services to meet those needs but in the UK organisational barriers and issues including stigma makes engagement in health service (HHI 2008) difficult. Homeless people are generally considered ‘hard to engage’. It is at this point we enter the mainstream versus specialist care debate in the provision of health services to homeless people.

6.1.1 Specialist Homelessness Services versus Mainstream Services Core Business Block Contract

HOMELESSNESS – A BLIND SPOT IN MAINSTREAM HEALTH CARE?

Making the invisible visible in health care



Negotiating walls of resistance for equitable access to mainstream health services

Fordham 2009

Homeless people dwell invisibly or visibly, amidst the general population. Two levels of homelessness mark a deepening disengagement from mainstream health services. In Fordham’s model these are termed *walls of resistance* which are triggered not

only from the homeless person/ homeless family perspective but from health services (Fordham 2007, Fordham 2010, Poulton 2006, Daiski 2007).

Making the invisible visible in health care
Level One: Centre of the Eye – walls more resistant in meeting complex need
Rough sleepers, night shelter users and squatters
Barriers in mainstream health services include:

- Lack of partnership work and/or language barriers between housing and mainstream health professionals regarding rough sleepers[24] (Fordham 2008).
- Registration issues by GP practices [25]so that equitable access to primary and secondary care health services is prevented (NHS Bedfordshire Focus groups 2007).
- Professional fear as in '*Too frightened to Care?' an account of district nurses working with clients who misuse substances'* – in Peckover & Chidlow (2006) and Fordham (forthcoming).
- Stigma and discrimination - in Daiski (2007) *Perceptions of Homeless People on their Health needs and Priorities*[26] - also in NHS Bedfordshire focus groups (*in* Fordham 2007)
- Insufficient knowledge about homelessness and health to offer coherent care – **in** *The Role of the Public Health Nurse in meeting the primary health care needs of sing homeless people: a case study report* (Poulton et al 2006) and *Spaghetti Junction* (Fordham 2008)
- Not understanding the needs of homeless people – **in** *The Health of Single Homeless People in Nottingham* (Crocombe et al 2008) and *Falling through the Net* (Fordham 2010 – in print)
- Factors influencing nurses' judgement about self neglect cases – Lauder et al (2006)
- The homeless person's need to belong – rough sleepers resist hospitalisation even following TIA in order to be *at home* with their companions (Fordham forthcoming)
- Lack of complex needs accommodation leading to evictions due to complex need particularly alcohol addiction – ***in*** *Building Bridges in Homelessness* (Fordham 2007).

[24] Coherent, holistic support can only be offered through successful multi agency partnerships where health, housing and third sector professionals understand each others language and collaborate together to meet the complex needs of rough sleepers

[25] - The misconception that people without an address are not entitled to services[25] is a strong, initial barrier for homeless people to negotiate in accessing primary and secondary health services. Practices should use their own address to register patients. RCGP (2002) clearly stipulate that homeless people should not be discriminated against because of lack of an address.

[26] Illuminated the negative perception homeless people felt about health professionals response towards them.

Making the invisible visible
Level Two: The Iris – Initial specialist engagement facilitates mainstream access
Hostel residents, women's refuges, local authority accommodation and sofa surfers
Barriers to effective health care include:

- Refusal of hostel residents to re-engage with mental health services following previous section under the Mental Health Act. Hostel staff unsure how to manage devolving crisis and feel vulnerable (Fordham 2007, Fordham 2009, Fordham forthcoming)
- Reluctance to seek GP advice or a feeling of not being heard by GP fuels disengagement (Fordham 2008, Fordham 2010 *in print*)
- The need for therapeutic and holistic space to disclose traumatic events from childhood (Fordham 2007 and Fordham forthcoming)
- The need for therapeutic space to talk about recent traumatic incidents and the health needs of children (Fordham 2007 and NHS Bedfordshire Focus groups 2007)
- The line between being vulnerably housed and homeless is very fine, yet mainstream health clinicians do not appear to recognise or act on it (Fordham 2008)

When mainstream health services engage holistically and coherently with homeless people and homeless service providers then specialist health services for homeless people will not be required. Fordham (forthcoming) illuminates the need for existential advocacy into mainstream services and Crocombe et al (2008) suggest that specialist clinical services for homeless people should in time encourage them back into mainstream services.

6.2 Specific Findings in Central Bedfordshire

Central Bedfordshire homelessness acceptances show that young people make up the majority of applicants. Qualitative interviews with homeless agencies revealed that rough sleepers' needs were not coherently addressed. Research suggests that both these groups have an increased risk of mental health problems. One third of young homeless people have also attempted suicide (Craig et al 1996) and the life expectancy of a rough sleeper who has been on the streets since the age of 16 years is 40.2 years (Halligan 2008). Meeting the mental health needs of these groups as well as accessing primary care services is a main priority across Bedfordshire as well as in Central Bedfordshire. Additionally homeless services in Central Bedfordshire suggested that:

- Homeless people with dual diagnosis patients were cited by some agencies as falling through the net of health care as they were not being picked up by mental health or drug/alcohol services.
- Most agencies wanted additional easily accessible alcohol treatment services
- Several agencies cited discharge processes from mental health units as a cause for concern particularly at 4 pm on Fridays.

- Transport to and from hospital was costly. Discharge from the Luton and Dunstable Hospital was unstreamlined. One agency reported that homeless people were discharged to their home 17 miles away without discharge medications – and needed to return the following day despite not having the funds to do so.
- Although family homelessness was not viewed by Health Visitors or GP's in Central Bedfordshire as a particular issue this may arise from lack of understanding of homelessness need and lack of knowledge about families moving into temporary accommodation. Meeting the health needs of school children in family homelessness needs to be explored further as it is not part of core school nursing services.
- The newly refurbished accommodation at Bedford Court, Houghton Regis now requires support pathways into health, education, mental health, social services and Connexions
- Homeless pregnant women need to move out of area as Central Bedfordshire does not host mother and baby accommodation units. This is likely to increase their vulnerability.

2.2 EMERGING CENTRAL THEMES

- Homelessness in Central Bedfordshire does not appear to have the same critical edge as in Bedford.
- Rough sleeping remains almost invisible to health services despite individual agencies concerns about their knowledge of rough sleepers and the lack of support services to them. A multi agency forum should be convened as soon as rough sleepers are known about in Central Bedfordshire.
- GP's have a vital role in homeless people in Central Bedfordshire. They are likely to be the first health professional to meet the homeless person and need to be linked into local support networks and multi agency referral routes throughout Bedfordshire.
- Family homelessness needs to be co-ordinated with health and other services

Guidance on drug treatment and accommodation services for homeless people (Homeless Link 2009)

- There is a need for a range of drug treatment and accommodation services in every local area to accommodate people who are at different stages of the treatment pathway.
- Strategic reviews should be undertaken locally to establish: a pathway of services with clear routes between them; strong partnerships between housing and treatment services; and plans to remodel services where required.
- Clear referral routes to treatment and accommodation should support the pathway and allow flexibility in case of relapse. These referral routes should be well understood by all staff working with drug users, and make services accessible to those in need.
- Housing providers, commissioners and other agencies should work together in a mutually supportive way to deliver the flexible range of services needed by drug users.

7 Recommendations

7.1 Multi Agency Development

7.1.1 Dovetailing with the Government's desire for zero rough sleeping in England by 2012 (*No one Left Out* CLG 2008) the health priority for homeless people in Central Bedfordshire is the development of partnership work with the local authority and third sector agencies to tackle the complex issues around rough sleeping. The rural aspect of central Bedfordshire makes rough sleeping less visible. However, at the time of writing this report homeless services knew of 9 people currently rough sleeping in the towns of Dunstable (3), Leighton Buzzard (2), and Biggleswade (4). Added to this are reports of 4 or 5 people who have slept rough in Sandy this year and the unknown picture of rough sleeping in other small towns. With the exception of Leighton Buzzard there is currently no humanitarian hub offering services such as food, shelter or general support in Central Bedfordshire. The expertise of key members of the Multi Agency Panel for rough sleepers in Bedford could be used in a Central Bedfordshire MAP[27] to coordinate care.

7.1.2 The health needs/access to services of rough sleepers should be explored as soon as possible through a focus group to identify whether the lack of homeless hostels for those over the age of 30 years, as well as the lack of medium to high level[28] support hostel accommodation in Central Bedfordshire contributes to rough sleeping as well as particular key ill heath themes. Agencies spoke of the fear that rough sleepers have expressed to them about finding homeless accommodation and support in Bedford; others do migrate towards Bedford for services.

7.1.3 Providing support for people who are facing eviction from hostels, triggered at critical times by health problems which may lead to street homelessness should be addressed throughout Bedfordshire. Health interventions at these times enable residents and accommodation providers to move together towards successful residency (Fordham 2010, 2007). This problem could equally be addressed via a Multi Agency Panel for hostel residents (Benchmark Brighton) faced with eviction leading to street homelessness. This is a key recommendation in this document and is currently being explored by Bedfordshire Supported Housing Forum for the Bedford area. Ultimately a Complex Needs Unit should be commissioned for those with persistent complex needs.

7.1.4 The completion of the Bedford Hospital admission and discharge protocol should streamline with similar policies at the Luton & Dunstable Hospital, Stoke Mandeville, The Royal Bucks and mental health units this year. Commissioning gaps regarding homelessness assessments[29] as well as inappropriate discharge

[27] i.e. Rough sleeping coordinator, rough sleeping outreach worker, NHS Bedfordshire Public Health nurse, Bedfordshire and Luton Mental Health Partnerships Trust – community mental health team, Healthlink dual diagnosis treatment services.

[28] Such as that needed for those with a history of mental health illness /dual diagnosis, self harm etc

[29] This has not been identified as a particular problem within Central Bedfordshire

accommodation for rough sleepers needs to be addressed (Benchmark: Intermediate care beds[30] Lane 2005). Homeless people may have complex health and social needs which falls short of the criteria needed to access physical disability teams, mental health teams or elderly care teams. This requires a robust joint commissioning discussion via the Thematic Partnership[31].

7.1.5 To support the most vulnerable placed in Temporary Accommodation in Bedford Court, Houghton Regis multi agency protocols and working practices to jointly support vulnerable people towards independent living are a priority: Housing and Health, Housing and Social Services, Housing and Education.

7.1.6 A notification system between housing and health services for all families moving in and out of temporary accommodation in Central Bedfordshire requires completion (CPHVA/DoH 2004, CLG 2006, HHI 2010[32], Fordham 2008).

7.1.7 Some agencies strongly believe that an independent housing advice centre in Central Bedfordshire is required. Crisis (2009) homeless charity recommends such centres throughout the UK.

7.2 Health Service Development

7.2.1 Public Health: It is vital for health care professionals to be proficient in expert knowledge about health and homelessness[33] and remain alert to how health conditions such as Learning Difficulty[34] can contribute to the *intentionality*[35] debate. It is vital too that, where needed, evidence of vulnerability contributing to *priority need* is offered to the local authority by GP's and specialist homeless health professionals. This is a key role for the Public Health element of homelessness in two respects: firstly in training health professionals on homelessness issues and secondly by being politically effective in multi agency meetings in regard to health conditions which when not addressed may lead to evictions or not priority need. County medical officers employed by Housing together with Public Health professionals (homelessness) should work collaboratively in this respect.

7.2.2 In successive reports on homelessness in Bedfordshire (Crisis 2002, Broadbent 2006, Fordham 2007) mental health and primary care services have been identified as the two main areas required for service development. GP services in Central Bedfordshire now appear to meet the needs of homeless people in their practice populations, but proposed focus groups with rough sleepers in Central Bedfordshire

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[30] The Road to Recovery A Feasibility Study into Homeless Intermediate Care Lane (2005)
[31] Sub group of Bedfordshire Partnership Board
[32] Forthcoming publication by Queens Nursing Institute HHI - peer reviewed by author
[33] This should be a Public Health priority - i.e. captured in the specialism of the Public Health Nurse role?
[34] A case in clinical practice where LD (test IQ 71 – not eligible for LD support services as cut off is 70) created vulnerability - substance misuse/partner violence) led to eviction for 'anti social behaviour' despite ensuing pregnancy.
[35] CLG (2009 p19 Statutory Homelessness statistics) advises that accommodation is available for those in priority need even where *intentionality* exists, for as long as is reasonable for the applicant to find a home.

will throw more light on this aspect of their health care. Where homeless people are not linked in to mental health services, as for example, when hostel staff feel that a mental health illness is developing but the resident does not agree, where dual diagnosis is present or when self harm is occurring, then mental health issues in hostels remains a significant problem in Bedfordshire. A CPN specialising in homelessness is once more highlighted for commissioners as a top priority a) because of the high number of hostels in the county as well as the Prebend Day Centre/night shelter in Bedford and b) because engagement with mainstream health services including secondary care services can be persistently problematic for homeless people (Fordham 2007, 2008, 2010, Crocombe et al 2008, Poulton 2006).

RECOMMENDED NHS BEDFORDSHIRE HOMELESSNESS HEALTH *TEAM*				
Specialist Public Health Nurse - Homelessness or Community Matron model (already in post)	**Commissioner - Vulnerable Communities** (already in post)	**NES GP Services for homeless people** (already in post/ ***new development in LB/Sandy)***	**Band 6/7 Practice/Specialist Nurse - Homelessness** **(*New/Pending post*)**	**Community Psychiatric Nurse – Homelessness (CPN)** ***(New post)***
To continue developing the PH interface of multi agency working in homelessness with local authorities, health and homeless agencies. Monitor outcomes. Educate all health staff /continue as homelessness health consultant for all health and housing staff. Manage complex health cases.	To commission services for homeless people in a cost effective manner, including the coordination of health service development through the Homeless steering group and other multi agency forums	*To provide medical services at outreach clinics: Prebend day centre and nightshelter (Bedford)* Explore NES in Leighton Buzzard/Sandy	*To manage care for the health needs of homeless people including immunisations and screening at Prebend Day Centre, Nightshelter.* Explore same for Leighton Buzzard/ Sandy	To develop creative mental health and mental health crisis support programmes to homeless people and staff in all day centres, night shelter and accommodation sites in Bedfordshire. Work with A&E[36] staff to manage recurring mental health issues in homelessness including Dual Diagnosis

Underpinned by
HOMELESS HEALTH CHAMPIONS IN:
A&E, Discharge Planning, District nursing, Physical Disability Team, Learning disability team, all mental health services, Shared Care, Healthlink, and 0-19 children's services.

[36] Recommendation from the Mental Health task group 2009. See also homeless research by Fordham (2010 – forthcoming Jessica Kingsley)

- Collect data and ethnic monitoring from all health disciplines on homelessness to evaluate health outcomes
- Provide direct access to podiatry and dental services
- Provide hospital transport for homeless people so that appointments are not missed by people on low income. There is no direct bus route and taxi's cost £20 to the Luton and Dunstable Hospital from Leighton Buzzard
- Provide ongoing mental health training/support for homeless services staff
- Provide 'Health and homelessness' training to all health service staff in adult and Children's Services.
- Fund NHS Bedfordshire's DH award winning 'Ask About Medicines' project with homeless people where pharmacists review medicines of homeless people on an annual basis

Jackie Smith, Sajida Khatri, Maria Fordham and Margaret Stockham receive the award from Harry Cayton, Director for Patients and the Public at the Department of Health

Portcullis House, Westminster
JUNE 2007
National Recognition for Pharmaceutical Support to Hostels

7.3. Joint/Commissioning Priorities

In addition to the sections 7.1 and 7.2 above, the other commissioning priorities should include

- Consider additional Tier 2, 3 and 4a alcohol treatment services in Central Bedfordshire. This should be undertaken specifically as a needs assessment for homeless people who are drug and alcohol dependent. It should evaluate pre and post contemplative accommodation including easier access to residential treatment units
- Jointly explore how homeless families with school aged children are identified and supported.
- Provide a Complex Needs Unit in Bedfordshire for those whose health and homelessness needs can not be supported by other accommodation providers.

8 Concluding remarks

Since completing the first HNA on Health and Homelessness in 2007 the face of homelessness in Bedfordshire has moved onward quickly, in line with Government recommendations captured in the title of their latest publication *No-one Left out* (CLG) 2008. This report has similarly provided a framework for NHS Bedfordshire to work with partners in housing and third sector agencies to make sure that no one is left out of our health care service delivery. The vastly rural landscape of Central Bedfordshire presents its own challenges in homelessness – as it would for any area of health service delivery. But this report provides us with a new picture of homelessness in which to grasp and follow on with substantive work already honed in Bedford.

For me, the challenge given by one man in the Bedfordshire focus groups in 2006 has been passionately met. He said simply:

I'd like to look back in three or four years times and see a great difference because this discussion is being used.

Focus Group respondent 2006

The gauntlet is set for others to pick up as I conclude this HNA report with the same remark:

What can each one of you do to improve the health of homeless people in Central Bedfordshire over the next three or four years?

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LONLINESS AND SOCIAL EXCLUSION

There is strong evidence of an independent causal relationship between social isolation and coronary heart disease and an increased risk of suicide (Lauder 2006). Health risks associated with loneliness: Heart disease, depression, poor recovery after coronary heart surgery