Bridging the Gap – Health and Homelessness

Introduction

Our Health and Homelessness event took place on Wednesday 10 September at Central Hall in Manchester.

Over 70 people attended and came together to network, share their lived experiences and feedback in following discussions:

- How lived experiences are shared within organisations to influence and inform service delivery?
- How can we capture better data for children in temporary accommodation?

We showed the Groundswell film "Clarissa" and invited tables to discuss how practice and policy can be improved.

The final part of the event looked at improving the health and wellbeing for people experiencing homelessness and understanding health needs and unmet health needs.

Our Thanks

Amanda Croome, Caritas Cornerstone
https://www.caritassalford.org.uk/service/cornerstone-centre
Ped Durling and Debbie Cuthbert, Shelter -
https://england.shelter.org.uk/get_help/local_services/manchester
Sam Pratt and Maha Bryan, Shared Health Foundation - https://sharedhealthfoundation.org.uk
Peter Davey and Sarah Trelfa, Department of Public Health Manchester and Eleanor Smith, Manchester City Council, Homelessness Directorate - https://www.manchester.gov.uk
Cracking Good Food - https://crackinggoodfood.org
Central Hall Manchester staff and bookings team - https://centralhallmcr.org.uk
Groundswell - https://groundswell.org.uk

1. Table Discussion and Feedback with Shelter

What would those with Lived Experience say about what it is like to share their voice within your organisation/service?

Discussions took place amongst participants on the tables - with lived experiences and good practice being shared, and recognition of the importance and value of people's voices and lived experience to influence change and service delivery.

How it feels to share your lived experience

- Frustrating
- Don't get asked – need to be respected
- Need safe spaces
- Need to understand what co-production is
- Intimidating
- Empowering
- They feel supported and listened to, so that can bring about changes to the system
- Sometimes no action after stories are shared
- Intimidated to share in certain forums perhaps involving the council – feel this would impact on accommodation
- Not able to say what it would be like as not all organisations have the platforms to collect and use lived experience
- Adult social care – there are no formal mechanisms, could email feedback but not accessible
- It can be tokenistic when it comes to inclusive research. People with lived experience brought into give feedback at a point too late to make change
- People accessing foodbanks are regularly surveyed but may not be forthcoming to participate due to fear from being cut off. Setting up a steering group to overcome this.
- To give a voice is important and a framework is needed
- It can be tokenistic
- No specific processes in place
- Barrier – NHS and primary care – can be difficult to get the service user voice
- Tends to be more informal feedback captured
- Sometimes can act on feedback and sometimes cannot
- Insights can be lost in the day-to-day delivering the service
- Difficult for people with lived experiences to get their voice heard without an organisation
- Sometimes we just don't ask
- Charities needs hero journeys – whether they are the hero – if you self-advocate or point to a duty of care, you are met with silence
- It is complex and good to let people in
- If you mismatch the expectations the process can be laborious and scary

Examples of good practice

- We have employed someone with lived experience
- Need to feedback to people, so they know they're been listened to and had an impact
- People can get involved through volunteering
- Supported volunteering programmes are a great way of involving people in delivering services and everyone benefits
- Relatively easy – due to peer-based structure at Shelter
- They can talk to CEO but its organised

- Lots of opportunities to use their voice in a safe supported way
- Centrepoint and OAPA – They enjoy sharing their voices so others going through the same experience can see the support received and reach out to the charities for the same support.
- Mustard Tree – They would say it's easy to share their voice through focus groups for other service users.
- The Growth Company – The service users from sharing their voices allow them access to housing and employment services and enjoy sharing their experiences at events.
- Manchester City Council – When voices are shared it is usually through local groups and external organisations. They can see that their voices are heard a lot of the time but sometimes are disappointed.
- VoiceAbility – They know they get heard and are confident to stick up for themselves. The organisation is open to lived experience. They know they can influence commissioners, but more can be done.
- The Lab Project – They would find it positive and empowering. Giving something back. Know that it's going to make their lives more fulfilled.
- Versus Arthritis – People have good contacts to voice their experiences, if constructive the methods of communicating what actions are needed.
- Manchester University Foundation Hospitals NHS Trust – exceptionally difficult within the NHS, more lived experience needed. Calling ahead to Emergency Department before the patient arrives, can lead to improved outcomes.
- Shelter – My Health Matters peer programme and GROW Traineeships
- GMCA paid role in homelessness and migration team
- Ring-fenced roles in commissioning apps.
- CGL – Establishing community clinics to engage with the public, with drugs and alcohol service people will want to give back and volunteer, share lived experiences, pathways into employment.
- Culture set nationally about driving forward participatory employment pathways
- Participatory grant funding/making: Having people with lived experience on the panel to assess grant applications coming in to meet aims of reducing homelessness.
- Lived experience training – facilitated by people with lived experiences is powerful.

What we are going to do develop lived experience

- We want to be more intentional and structured with co-production
- Thinking of ways to have across the board input from people with lived experience
- We need to make sure people's input feeds through to real change
- They are the best to give insight into an issue
- Working out how to feed in voices to trustees without being tokenistic
- They can design service
- Opportunity to shape and lead on research
- Understand the mechanisms for lived experience involvement

Next Steps

The above information has been shared with the following Manchester Homelessness Partnership board and action groups to review and action next steps within their work.

- Manchester Homelessness Partnership board
- No Wrong Door Action Group – led by Shelter
- Co-Production Action Group – led by the Booth Centre

2. Table Discussion and Feedback with Shared Health Foundation

Sam Pratt, Policy and Communication Lead at the Shared Health Foundation presented on reducing the impact of poverty on health for children and families and shared a call to action for the participants to discuss.

Call to Action: How can we capture better data for children in Temporary Accommodation?

The key themes from the table discussions were:

- Whole systems approach to data
- Collaborative data sharing
- Improving trust in public services to increase consent and data collection
- Meaningful actions from data

In summary:
Participants recognised the lack of data sharing between services, such as local government, NHS, schools and voluntary sector organisations, leading to a deficit of information and limited connection of homeless families to additional support services.

Common themes amongst the groups highlighted that a more collaborative approach to data collection and sharing with a range of organisations will unify working across the sector, and provide the highest level of support for homeless children. One table also highlighted that housing is not coded for in data collection by the NHS, and that a whole system approach to data requires standardised coding for housing across all data collection by organisations. The collection and sharing of data is met with regulations (such as GDPR), and the need for consent. Groups recognised that mistrust in public services, and stigma or concern about social services can be a barrier to consent and limit data collection. To address this, participants suggested applying holistic approaches to housing and temporary accommodation, and creating supportive environments for families to disclose housing circumstances through understanding language and clear communication.

Frontline workers also need to undertake trauma-informed training to engage with families and build rapport, and be trained about privacy legislation. Capturing children's voices directly was highlighted as equally important.

Finally, people discussed the need for action as a result of better data collection and sharing. This includes tracking accountability across agencies, sharing lessons from data (such as child mortality), and using insights to direct resources.

Next steps:

- Better data collection and sharing needs to be actioned across services in the sector
- Schools must be urged to record numbers of students in temporary accommodation, track attendance and academic attainment of these pupils
- A range of organisations across the sector will look into collecting housing and family data about their clients: foodbanks, Shelter and Change Grow Live (CGL). The Growth Company will look into collecting client data about risk of homelessness and refer families to their in-house benefits team.
- Manchester City Council highlighted that data collection is a requirement for commissioned services, and will look into actioning a targeted project on temporary accommodation with a view to make system change.
- All organisations across the sector to action asking families what school their child(ren) attends and for their consent to share this information.

Thank you to Maha Bryan, Shared Health Foundation for summarising the feedback and providing the above information.

3. Table Discussion and Feedback on the Groundswell Film "Clarissa"

The Groundswell film "Clarissa" was shared and discussions took place on tables. The feedback has been themed into three areas – Practice, Access and Information as well as what works well in Manchester and what needs to change in policy and practice.

Practice

- Key part was that one stable person who didn't give up on her and builds up that trust
- Worker was resilient/professional and trauma informed
- Clarissa felt judged by others – all services should be non-judgemental
- Service providers / GPs etc need to maybe meet with people before they have health issues or at a crisis point so that they build trust and have better interactions once someone has a health issues or issue they need support with
- The GP should have offered Clarissa to have a female member of staff present. GPs and practice staff should be trauma informed
- It was effective having the worker meet Clarissa in her own space and territory
- Maybe having services/GPs that are specialist in treating people with specific issues eg a GP service where staff are trained in working with people with autism and neurodiversity
- Male or female practitioner preference on forms
- Need to work with people using time and flexibility – not focusing on hard KPIs
- Requires a lot of advocating for yourself, so where possible ask those probing questions so people don't have to ask, for example, do you require a male or female doctor
- Psychologically, trauma informed environments in services, for example, doctors waiting room
- Confidentiality considerations
- Building trust is crucial
- Being able to support at the moment when people are ready
- More outreach from healthcare professionals
- Reducing stigma to changing people's perception

Access

- Showed importance of consistency in the welcome/first encounter in a service – all staff need to be welcoming and trauma informed
- We need trauma-informed environments across Manchester
- Lack of phone signal or Wi-Fi in crisis centres is a problem – building must be fit for purpose
- Should be a pathway for patients who experience distress and have notes on file about behaviour to come back and still access treatment
- Environment of GP – looking posh might put people off attending and if they don't belong. Lack of privacy when registering or filling forms

- Have a navigator in each service who can work with people who are vulnerable more flexibly – create a single point of contact
- Interpreting services needs to improve especially more rare dialects so people can access translation/interpreters
- Waiting room very bright, too formal and she was on her own
- Peer advocates to support people to access healthcare

Information

- Makes us consider do services need to ask all of the questions they do (relating to form filling part) – look at using a condensed form for relevant information only
- Clarissa felt very overwhelmed by the form and it was an extra barrier when she had already taken a big step going to the GP
- A note on forms saying you don't need to answer any questions you don't want to – would be helpful
- Streamline form filling, maximise accessibility, link records and record sharing so patients don't have to repeat themselves
- Can address be asked for in a more trauma informed way and not making an assumption they have one
- Systems need to be more linked – all systems are separate from each other – needs to be more joined up
- Assumed literacy when completing forms
- Trauma-informed data gathering – look at what is needed versus what does the service want to collect and why
- Balance of data collection – so what?

What do we do well in Manchester?

- Better collaboration
- Better networks
- More focused/action groups – health and employment for example
- Great trauma informed frontline workers – group practice and trauma informed places and services
- Better at lived experience but need to improve
- Key services in city centre are accessible
- Choice – Street Engagement Hub – multi-agency approach

What needs to change in policy and practice?

- Lack of consistency in health settings on being trauma informed spaces
- Same for registration – lack of education
- Consider a local enhanced payment for registering no fixed abode patients
- More education for people about rights – access to a chaperone – this should be built into a policy
- People with lived experience not feeding into policy decisions
- Consideration about people's literacy and comprehension when completing forms
- Does the information you provide impact your care?

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4. Wellbeing isn't just about being "happy", it is about how we feel, cope and stay strong in our daily lives.

Please reflect on what wellbeing means to you, recognise small positive actions that support your wellbeing and identify barriers you face.

How do we empower individuals experiencing homelessness to connect, be active, give, take notice and keep learning?

What works well, what needs to improve and where are the gaps?

All participants moved around five tables and contributed to the above questions and provided feedback.

Connect – what works well?

- Encouraging group activity – sports or walking to encourage a variety of activities to people who may not access things easily
- Going out into communities instead of always expecting them to come to you

Connect – what can we improve on?

- Being a provider – offering a welcoming and safe space
- Connecting with people where they are
- Have conversations rather than doing assessments
- Ensure we move back to relational practice in social work, we used to do that well
- Creating events and regular spaces or activities that bring different backgrounds together and activity engaging people from marginalised majority groups
- Ensure service practitioners are based in community spaces that are designed around what people want and need
- Creating welcoming and inclusive environments where people can be themselves and where everyone is respected

Keep Learning – what works well?

- Learning through doing – opportunities to be involved in community groups, volunteering, and being involved in experts by experience events or sessions
- Offering adult education classes from schools and community venues
- Attending a range of events/networking to learn from them and their experiences and share

Keep Learning – what can we improve on?

- Being person centred and have flexible opportunity to learn and get involved
- Valuing lived experience as much as learned experience
- How to engage people who wouldn't usually access opportunities – use community champions to tap into communities
- Multi-agency learning – learn together and understand what each other can offer
- Understanding of learning styles
- Being open to constructive criticism and being open about what happens when people suggest improvement
- Shift the power imbalance in interactions with people – must be strengths based conversations and hope, what does this look like?

Be Active – what works well?

- A range of activities and sports, gardening and walking – providing access to services this way
- Community walking groups

- Recovery organisations in drugs and alcohol have physical health focused groups for people in recovery, including homelessness
- MCR Active – PARS offer includes individual plan health and low level mental health
- Simplicity – small person centred steps mean a lot

Be Active – what can we improve on?

- Be more creative with appointments – a walk and talk rather than a clinical room
- Swimming lessons – free or low cost for asylum seekers
- People/groups are unaware of what is available
- Not always at the top of the priority list in commissioning – KPIs in drugs and alcohol
- Awareness across communities who are not accessing services
- Having capacity and time to exercise when facing multiple disadvantages and issues
- Affordability of classes and activities
- Providing money or subsidies for people on low income to go to exercise activities

Give – what works well?

- Volunteering and use of lived experience
- Community
- Giving opportunity for people to have a sense of control
- Connecting people into a purposeful community around volunteering / getting involved in a project – even whilst they are still in crisis

Give – what can we improve on?

- More flexibility in types of volunteering
- Flexible systems
- More of what works well
- Person-centred opportunities
- Research/data collection

Take Notice – what works well?

- Awareness of triggers
- Exercises and techniques
- Taking a break
- Deflecting from inwards concentration
- Reflective practice
- Supporting each other

Take Notice – what can we improve on?

- Building in space and time
- Validation of people's feelings and experience
- Not assuming that you understand
- Be trauma informed

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5. Health Needs

To explore unmet health and care needs by letting participants express what needs are being met across different areas and what needs are unmet.

"Everyone has needs – a safe place to stay, food, feeling part of something. Today we want to understand which needs are being met for you, your beneficiaries and which needs are not being met"

Examples of what works well

- Tuberculosis – Public health awareness sessions with BHA for Equality
- Public Health Protection Team – work on TB in people experiencing homelessness
- Respiratory health and smoking – can develop into long-term condition if not checked
- Dual diagnosis – mainstreamed for access but not specialist services
- Shelter – My Health Matters
- Urban Village Medical Practice outreach at day centres – vaccines, basic wound care and testing
- Basic needs being met, for example, food and shelter
- Being supported by a key worker or charity organisation
- Food most of the time and travel costs covered
- Interview and clothing available
- Crisis intervention through Shelter
- Access to support services – housing, food and a GP
- Using the right language/tone in health campaigns – trauma informed communication
- Access to fresh fruit and vegetables thanks to the various foodbanks, pantries and community grocers
- Blood Borne Viruses – place based services and CQC registered (Barnabus
- Safe drug services – methadone etc, harm reduction and needle exchange

Unmet Health Needs

NHS Primary Care

- Access to a dentist, lack of dental services and prevention work
- Dental health – cannot get to see a dentist
- Walk-in Centre for rough sleepers – trauma informed, Live Well, gateway to health
- Access to a GP
- So difficult to get a GP appointment for non-urgent and preventative appointments
- Resources to give people around choice at GP practice and services
- Women's needs – mental health, sanitary products and smear tests
- Women's health – menopause and periods
- Seeing an optician and cannot afford glasses

NHS Community Health

- Access to a podiatrist/chiropodist and lack of prevention work taking place
- Nutrition provision and advice – no access to healthy foods
- Oral health prevention, advice and support

NHS Mental Health

- Talking Therapies (in accommodation) – more capacity, CBT not appropriate, safe spaces e.g crisis cafes, more informal options available
- Transition from CAMHS to adult mental health
- 18 month wait to see CAMHS
- Neurodiversity awareness and support
- Mental health provision

- More dual diagnosis services
- Mental health needs and wellbeing needs are not being met
- Lack of timely response for mental health support

Public Health

- Blood Borne Viruses – lack of education and fear
- Trauma in children
- Safe sleeping for babies
- Families and vaccinations that are being missed out – needs to be more specialist provision

NHS Secondary Care

- Long waiting lists for secondary care
- Families in temporary accommodation have access to less services and hard to access specialist services
- When there are accessible/specialist services they become overwhelmed – mainstream services need to become more accessible

Access to health and care services

- Interpreters and accessible services for people
- Digital exclusion
- Stopping the revolving door of crisis and rebuilding
- Progress towards autonomy and independence – not being met
- Also web-based – digital exclusion
- Cost saving to health by meeting or reducing needs by providing accessible quality housing vs cost of meeting escalating complex health needs in homeless environment
- Need to be registered to access some drop-in services – this is a barrier to people accessing services, also criteria can be too high or requires self-diagnosis

Education and Learning

- Access to learning
- Access to opportunities to share their knowledge with others

Emotional Health and Wellbeing

- Emotional needs not being met
- Food and medication
- Confidence to socialise, find work and meet new people
- Security of having control over their circumstances and their future
- Not having a set person/caseworker to hand hold and take people through the necessary steps they need to overcome barriers

Physical Health and Activities

- Accessible social and physical activities

Dietary needs and Nutrition

- Can be difficult to get access to food suitable for their dietary needs – if relying on day centres for food or street food organisations
- In temporary accommodation there is no access to cooking facilities to cook nutritious meals

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- The No Wrong Door Action Group – led by Shelter
- Employment Action Group
- Health and Homelessness Task Group – led by Department of Public Health, Manchester City Council
- Accommodation Action Group – led by Justlife, Barnabus and the Booth Centre
- Manchester University Hospitals NHS Foundation Trust – Homelessness Working Group

**The No Wrong Door approach is a strategy for working with individuals experiencing multiple disadvantages. It provides a one-stop access point for long-term services and support. The approach is integrated and person-centred, combining a range of services and support options. It aims to ensure that individuals are not turned away when seeking help. Effectively they can go to any organisation in Manchester that supports people experiencing multiple disadvantage, and that organisation will help them find the right service for their specific needs. Currently organisations in Manchester are in the first phase of completing a self-assessment tool and the feedback from this report will inform the development of the No Wrong Door approach and its implementation.*