Health & Wellbeing Overview & Scrutiny Committee

Title:	**Health & Wellbeing Overview & Scrutiny Committee**
Date:	**4 February 2014**
Time:	**4.00pm**
Venue	**Council Chamber, Hove Town Hall**
Members:	**Councillors:** Rufus (Chair)C Theobald (Deputy Chair), Buckley, Cox, Marsh, Robins, Sykes and Wealls **Co-optees:** Jack Hazelgrove (OPC), Amanda Mortensen (Parent Governor Representative), Marie Ryan, Youth Council and Healthwatch
Contact:	**Kath Vlcek** 01273 290450 kath.vlcek@brighton-hove.gov.uk

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Ward Affected: *All Wards*

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Contact Officer: *Kath Vlcek, Scrutiny Support Officer* *Tel: 01273 290450*

Ward Affected: *All Wards*

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Contact Officer: *Kath Vlcek, Scrutiny Support Officer* *Tel: 01273 290450*

Ward Affected: *All Wards*

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For further details and general enquiries about this meeting email scrutiny@brighton-hove.gov.uk

Date of Publication 28 January 2014

Agenda Item 1

To consider the following Procedural Business:

A. Declaration of Substitutes

Where a Member of the Committee is unable to attend a meeting for whatever reason, a substitute Member (who is not a Cabinet Member) may attend and speak and vote in their place for that meeting. Substitutes are not allowed on Scrutiny Select Committees or Scrutiny Panels.

The substitute Member shall be a Member of the Council drawn from the same political group as the Member who is unable to attend the meeting, and must not already be a Member of the Committee. The substitute Member must declare themselves as a substitute, and be minuted as such, at the beginning of the meeting or as soon as they arrive.

B. Declarations of Interest

(1) To seek declarations of any personal or personal & prejudicial interests under Part 2 of the Code of Conduct for Members in relation to matters on the Agenda. Members who do declare such interests are required to clearly describe the nature of the interest.

(2) A Member of the Overview and Scrutiny Commission, an Overview and Scrutiny Committee or a Select Committee has a prejudicial interest in any business at a meeting of that Committee where –
(a) that business relates to a decision made (whether implemented or not) or action taken by the Executive or another of the Council's committees, sub-committees, joint committees or joint sub-committees; and
(b) at the time the decision was made or action was taken the Member was
(i) a Member of the Executive or that committee, sub-committee, joint committee or joint sub-committee and
(ii) was present when the decision was made or action taken.

(3) If the interest is a prejudicial interest, the Code requires the Member concerned:
(a) to leave the room or chamber where the meeting takes place while the item in respect of which the declaration is made is under consideration. [There are three exceptions to this rule which are set out at paragraph (4) below].
(b) not to exercise executive functions in relation to that business and

(c) not to seek improperly to influence a decision about that business.

(4) The circumstances in which a Member who has declared a prejudicial interest is permitted to remain while the item in respect of which the interest has been declared is under consideration are:

(a) for the purpose of making representations, answering questions or giving evidence relating to the item, provided that the public are also allowed to attend the meeting for the same purpose, whether under a statutory right or otherwise, BUT the Member must leave immediately after he/she has made the representations, answered the questions, or given the evidence;

(b) if the Member has obtained a dispensation from the Standards Committee; or

(c) if the Member is the Leader or a Cabinet Member and has been required to attend before an Overview and Scrutiny Committee or Sub-Committee to answer questions.

C. Declaration of Party Whip

To seek declarations of the existence and nature of any party whip in relation to any matter on the Agenda as set out at paragraph 8 of the Overview and Scrutiny Ways of Working.

D. Exclusion of Press and Public

To consider whether, in view of the nature of the business to be transacted, or the nature of the proceedings, the press and public should be excluded from the meeting when any of the following items are under consideration.

NOTE: Any item appearing in Part 2 of the Agenda states in its heading the category under which the information disclosed in the report is confidential and therefore not available to the public.

A list and description of the exempt categories is available for public inspection at Brighton and Hove Town Halls.

BRIGHTON & HOVE CITY COUNCIL

HEALTH & WELLBEING OVERVIEW & SCRUTINY COMMITTEE

4.00pm 5 NOVEMBER 2013

COUNCIL CHAMBER, HOVE TOWN HALL

MINUTES

Present: Councillor Rufus (Chair)

Also in attendance: Councillor Buckley, Cox, Marsh, Robins, Wealls, Barnett and Phillips

Other Members present: Jane Viner, Healthwatch co-optee; Thomas Soud, Youth Council representative

PART ONE

97. PROCEDURAL BUSINESS

97.1 Councillor Dawn Barnett was substituting for Councillor Carol Theobald; Councillor Alex Phillips for Councillor Ollie Sykes.

Apologies from cooptees Jack Hazelgrove OPC; Amanda Mortensen Parent Governor; Marie Ryan

97.2 Declarations of Party Whip

There were none

97.3 Declarations of Interest

There were none

97.4 Exclusion of Press and Public

As per the agenda

98. MINUTES OF PREVIOUS MEETING

98.1 The minutes were agreed. They have been updated to show the public question from 10 September 2013 and response from Healthwatch Brighton and Hove.

99. CHAIR'S COMMUNICATIONS

99.1 There were no Chairs Communications other than drawing members' attention to the email inviting them to take part in the next PLACE assessment.

100. MENTAL HEALTH BEDS UPDATE - FINAL REPORT

100.1 This item was presented by Anne Foster, CCG, Samantha Allen, SPFT, Dr Becky Jarvis, CCG Clinical Lead for Mental Health, and Dr Mandy Assin, Consultant Psychiatrist, SPFT Divisional Clinical Lead.

100.2 Ms Foster began by giving a brief update on the history behind the decision to permanently close the mental health beds in question, reducing the total in city from 95 to 76. In November 2011, it was agreed to temporarily close a ward of 19 beds, closely monitoring the situation from a clinical basis. Since the ward has been temporarily closed, it has allowed some of the variable costs to be reinvested into community services including additional care co-ordinator posts and nursing posts in the crisis resolution home treatment team. In addition the CCG and SPFT had undertaken some additional redesign of community mental health services including the development a new personality disorder clinic, which had not been available in the city before.

100.3 Dr Jarvis, Chair of the Clinical Review Group (CRG), summarised the role of the CRG. They have met regularly over the two years, monitoring key metrics relating to the temporary closure of the beds.

Amongst the metrics being monitored, the CRG found that there was on average, two people per day needing admission to hospital, and that although there may be a shortage of beds, there was no one type of bed that was in shortfall, eg it was not always male beds or female beds in shortfall.

They also found that the re-admission rate stayed fairly stable over the period that the ward was closed. The CRG also took complaints and other soft data into account.

100.4 Since January 2012, 9 out of every 10 residents needing admission have been able to access beds locally. Although there has been a higher demand than this at times, there has never been the demand for a further nineteen beds at any one time.

100.5 The CRG carried out an options appraisal, considering three options – keeping the status quo, reopening the entire ward, or permanently closing the ward but allowing for flexible capacity from the Priory. This third option was found to be the preferred option, as this allows for a much more cost effective way of meeting the actual demand in the city. The funds released from the closure of the ward will be ring fenced for further investment in mental health services, with the cost of the Priory beds receiving priority.

100.6 The CRG will now review its membership, to include representatives from Adult Care & Health and from Healthwatch.

100.7 Denise D'Souza, Executive Director, Adult Services, was asked to comment on the preferred third option. She said that she had held separate conversations with the CCG and she was satisfied with the third proposal from a social care perspective. The

increase in local beds will help to ease the pressure on services and on social care staff, including Approved Social Workers.

100.8 Members then asked questions.

100.9 Members asked for more detail about the proposed service delivery from the Priory.

- They heard that the Priory offered single ensuite rooms, and could accommodate a mixture of male and female customers. There were 16 beds in total, provided over two different floors with ensuite bedrooms for men and women, which is something that could not be offered within the current arrangements at Mill View Hospital. It was envisaged that SPFT would spot-buy five or six of the beds at any one time.

- SPFT would only pay for the bed days that they needed, rather than all of the associated fixed costs of running a ward. Local provision at the Priory also means that there will be reduced costs in terms of patient transport etc.

- If the Priory happens to be full, the client would be taken to other SPFT hospitals in Sussex, or if that were unavailable, to other NHS or independent sector provision further afield. Brighton and Hove residents will have priority for Priory bed availability.

- The empty ward at the Nevill hospital will be used, first as a temporary home for the Brunswick ward residents whilst that is being refurbished, and then to use as a nursing home for people with dementia.

- There was no other similar provision available in Brighton and Hove.

100.10 Members asked for clarification of the ‘care coordinator’ role. They heard that this role used to be known as a Community Psychiatric Nurse, and their role is to help the client and coordinate care for a particular customer. .Care Co-ordinators can also be other health professionals such as Occupational Therapists and Social Workers and they are all trained mental health professionals.

100.11 Members asked how the released money would be spent. They heard that approximately half of the £1.8 million had already been used for the additional Care Co-ordinator and Crisis Resolution Home Treatment posts, and the other half held by SPFT due to the fixed costs associated with the empty ward.

100.12 Members asked how the quality of patient care would be monitored in the contract. They heard that there will be a Mill View clinician liaising with the Priory, carrying out regular clinical reviews.

100.13 Several members queried the £800,000 fixed costs that had been quoted for keeping the ward empty and how this had been calculated. They heard that this was the share of the fixed costs associated with the space, including the opportunity cost of not using that space for another reason. Members asked for a more detailed breakdown to be circulated following the meeting. They would also like this to include the ongoing costs of a Discharge Coordinator attending the Priory, and the costs of different types of beds, eg in NHS or private provision.

This was all agreed. [NB This has now been provided and attached to the agenda document pack.]

100.14 Members asked whether there was any financial saving to SPFT if option 3 were taken up. They heard that if the released funds were totally invested in mental health as proposed, there would be no financial saving but it would mean a much stronger community mental health service.

100.15 Had the clinical impact on the patients been assessed? Dr Assin said that this had been carefully considered. The Priory would not be used for anyone in acute need, but would be more likely to be used for people coming to the end of their treatment. It was hoped that this meant that people would not be moved from the Priory back to inpatient treatment at Mill View.

100.16 Some members said that they were very supportive of the proposals, feeling that this was the way forward for service provision across a number of areas. They considered that the £800,000 fixed costs which had been lost so far were in effect an expensive insurance policy. Were there any lessons that could be learnt from this so that costs would be minimised in future? There were many lessons for the future which the CCG and SPFT were reviewing and the learning could be shared with HWOSC members.

100.17 Members asked whether the two year monitoring period was at least in part caused by the fact that politicians were overseeing the process. Geraldine Hoban, Chief Operating Officer of the CCG said that it was true that this might have had an impact although this was not necessarily a negative thing. If the beds had been closed too prematurely, this might have introduced risk into the system. Although the process had taken a long time this has allowed community services to be developed as real alternatives to inpatient care. The Chair of HWOSC commented that HWOSC's approach had been to take a cautious view of the proposals and monitor it closely and therefore there was a shared responsibility for the time it had taken so far.

100.18 The Chair concluded that there still was still a sense of anxiety about the financial and some of the clinical aspects of patient care, but he had not picked up a huge sense of concern about the general direction of the approach. He hoped that the SPFT and the CCG had noted the committee's concerns – they would be sent more formally too. The Chair also hoped that there would be learning to go forward to other schemes. The Committee notes the proposal and the CRG decision to proceed with Option 3.

100.19 HWOSC noted the report, with a formal follow up to share concerns, and with an update report in approximately six months' time.

101. MUSCULOSKELETAL & DERMATOLOGY SERVICES IN SUSSEX

101.1 Alison Dean and Kathy Felton from the CCG presented a joint report on the reprocurement of two key services for Brighton & Hove, musculo-skeletal services (MSK) and dermatology. They were presented together as they were going through similar procurement processes, although the size of the contracts differed greatly.

The MSK contract will cover services across the areas of Brighton and Hove CCG, Horsham and Mid Sussex CCG and Crawley CCG, covering much of the general catchment area for RSCH. It is a multi million pound contract and will need a provider with clinical expertise, due to the size of the service being procured.

101.2 Ms Dean and Ms Felton outlined the current situation for each service, including the engagement and consultation process, which had helped to shape the service being procured. The procurement process will include social value considerations and all commissioners will be expected to show how their approach adds social value to the city.

The CCG is looking to embed social value in all of its commissioning services, and will monitor this closely.

101.3 Members asked for more information about the providers who had expressed an interest. They heard that there was a variety of providers including private companies, third sector groups and some local NHS providers.

101.4 HWOSC members noted the procurement processes, and asked for more information about the new provider and other services to be procured in the future.

102. MATERNITY SERVICES

102.1 Kathy Felton and BSUH colleagues, Heather Brown, Consultant Obstetrician & Gynaecologist, Chief of Women and Children's Division, Tosin Ajala, Consultant Obstetrician & Gynaecologist and Jenny Davidson, Acting Deputy Head of Midwifery & Gynaecology presented a summary of maternity services in the city. This had been prepared in response to a question from HWOSC about what had happened with regard to services at Eastbourne and the impact on RSCH.

102.2 Ms Felton mentioned that there was a very active Maternity Services Liaison Committee (MSLC) made up of parents who had used the service, they were a key factor in providing valuable feedback on services. IT was CCG funded and the CCG provided a crèche for members. They had hoped to come to the HWOSC but had not been able to provide a representative due to the timing of the meeting.

102.3 Maternity services were closely monitored through a number of metrics; the report to HWOSC included some of the more challenging indicators or those which had changed recently. This included the increase in staffing numbers to meet national targets, and a renewed uptake in homebirth rates, following a decline.

102.4 There had been queries about the c-section rate, and RSCH was above the national average. There is a difference between elective c-section rate and maternal request c-section rate. Locally there is not much demand for maternal request c-sections.

102.5 With regard to the temporary closure of the obstetric led service at Eastbourne, arrangements had been put into place in RSCH to accommodate the extra parents. There had not been as great a take up as had been anticipated so far. There were

regular monitoring conversations across Brighton and Hove and East Sussex to check that arrangements were adequate.

102.6 Councillors asked questions and commented on the report

102.7 There was a lack of continuity with community midwives, which might be one of the reasons that women did not opt for home births; how was this being addressed?

Ms Davidson said that this had been addressed through an increased number of staff working an increased number of hours including overnight care, to offer a more complete service. They were also trying to increase the number of support workers in the community including breast feeding support

102.8 How is the MSLC promoted?

The MSLC is a very healthy group but work is underway to try and promote diversity. The main BSUH website links to the MSLC website (http://brightonandhovemslc.com/). The group participates in all relevant clinical audits and developing protocols.

102.9 What is the position on Bounty reps working in the maternity ward?

The Bounty representatives give new mothers goody bags including samples of different products, health information and Child Benefit forms. The idea is to help new mothers. The company pay the hospital a small amount of money to be on the wards. Mothers have reported a wide range of experiences, some positive and others less so.

BSUH has talked to Bounty about the training that their staff receive and are happy with the response received. They have also carried out spot checks and MSLC have monitored the situation too. BSUH is happy to go forward with Bounty as things are, but will monitor this.

102.10 What were the factors that allowed the homebirth rate to reach a high of 9% and why did it drop so dramatically?

Ms Davidson said that in the past community midwives offered the homebirth service and could provide more continuity of care as they provided antenatal, labour and birth and postnatal care, and this led to a higher take up. The system was then changed where labour and birth cover for homebirths was covered the majority of the time by hospital midwives who were not as familiar with the parents which could have accounted for the drop. Since earlier this year the service has been re-configured and is similar to the original model where community midwives offer the homebirth service and provide antenatal, labour and birth and postnatal care, leading to better continuity of service and care.

102.11 The Chair thanked the CCG and BSUH staff for attending; the report was noted.

103. PLACE ASSESSMENT RESULTS FOR BSUH

103.1 Nikki Luffingham, Chief Operating Officer, BSUH and Steve Gallagher, Operational Director, Facilities and Estates, Brighton and Sussex University Hospitals NHS Trust, gave a presentation on the PLACE assessment results and answered questions.

103.2 The Healthwatch representative commented that she was very pleased that the menus would be reviewed; Healthwatch had heard that the menus were not able to address simple dietary requirements such as low-fat menus. Councillors added that they had experienced a lack of awareness about diabetic dietary needs which was worrying.

Ms Luffingham said that it was disappointing that this had been the case and that they would feed back the information to the Chief Dietician.

103.3 Members asked for clarification of how the scores had been calculated. Mr Gallagher said that the categories were predefined by central Government and the percentages were worked out centrally, by the Department of Health. They were not explicit about how they had arrived at the exact percentages. BSUH is due to meet with the Department of Health in December so will feed this back and ask for more information.

103.4 Members were invited to take part in the next PLACE assessment; details had been emailed to everyone.

104. HOMELESSNESS SCRUTINY PANEL: VERBAL UPDATE

104.1 Councillor Wealls gave a brief update, explaining that the panel members had met different groups of homeless people, service providers and third sector organisations. There was one more meeting due, and the report and recommendations would come to HWOSC in February 2014.

The meeting concluded at 6.30pm

Signed Chair

Dated this day of

HEALTH & WELLBEING OVERVIEW & SCRUTINY COMMITTEE	Agenda Item 109 Brighton & Hove City Council

Subject:		**BSUH Major Trauma Centre & Hospital Site Reconfiguration**		
Date of Meeting:		**4 February 2014**		
Report of:		**Monitoring Officer**		
Contact Officer:	**Name:**	**Kath Vlcek**	**Tel:**	**29-0450**
	Email:	**Kath.vlcek@brighton-hove.gov.uk**		
Ward(s) affected:		**All**		

FOR GENERAL RELEASE

1. PURPOSE OF REPORT AND POLICY CONTEXT

1.1 To update HWOSC members on the Major Trauma Centre at Royal Sussex County Hospital

2. RECOMMENDATIONS:

2.1 That HWOSC members note and comment on the report.

3. CONTEXT/ BACKGROUND INFORMATION

3.1 From 2 April 2012, following a comprehensive major trauma designation process led by NHS South of England, the Royal Sussex County Hospital (RSCH) in Brighton was designated as the regional major trauma centre (MTC) for Sussex providing 24/7 enhanced specialist care for the most seriously injured patients within the Sussex Trauma Network.

BSUH made significant financial investment in the MTC, with the support of local and specialist commissioners, equating to £6m revenue and £3m capital; this included the provision of 24/7 consultant presence in the Emergency Department, access to a designated 24/7 major trauma theatre, a new CT scanner, a dedicated major trauma ward and a multi-disciplinary major trauma workforce.

3.2 Following a self-assessment process and discussions with the Surrey and Sussex Local Area team, in February 2013 BSUH entered into a derogation process for major trauma as there is currently no co-located neuro-trauma service at the MTC, i.e. physically located at the RSCH.

Derogation is a time limited agreement whereby one or more contractual standards or requirements within the national service specification will not be in place during the contractual period.

3.3 Until such time as a full neuro-trauma service is implemented at the MTC in Brighton, the pre-existing head injury pathways to Hurstwood Park Neurosciences Centre (HPNC) will be maintained and, for certain injury patterns, pre-hospital providers (South East Coast Ambulance and Kent, Surrey and Sussex Air Ambulance) have agreed protocols to transport the small number of patients affected to other MTC's at the discretion of their senior clinical controllers.

3.4 In December 2013 following detailed work by clinical and managerial leads across the organisation, the BSUH Board of Directors approved plans to move the elective and emergency neurosurgery service HPNC to RSCH and considerable planning is underway to enable the move to RSCH to be completed by August 2014.

3.5 A programme of work has been established to move planned trauma and orthopaedics and the urology service from the RSCH site to the Princess Royal Hospital site in the summer of 2014. It is proposed to maintain a daily urology outpatient service at RSCH for Brighton & Hove patients. These service moves to PRH will release beds and theatre capacity on the RSCH site to accommodate neurosurgery as well as creating other benefits and efficiencies for these services.

Performance

3.6 During the first twenty months the MTC has provided an enhanced service to seriously injured patients across Sussex and beyond. This has been demonstrated in the Major Trauma Performance Dashboard published nationally each quarter by the national trauma and Audit Research Network (TARN). TARN clinical reports have demonstrated that better clinical outcomes have been achieved since go-live in April 2012, with more survivors of major trauma than expected

3.7 The development of the MTC is significant strategic initiative for the Trust and considerable work is underway to ensure that the MTC achieves compliance against the national service specification for major trauma within the prescribed timescale

4. COMMUNITY ENGAGEMENT & CONSULTATION

4.1 Public consultation has already been undertaken on the relocation of neurosurgery to RSCH as part of the development of the 3Ts outline business case. As a relatively low number of patients are affected by the urology and trauma and orthopaedic service moves and as only parts of the service are moving further discussions on the proposed changes will take place with HOSC and local commissioners

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

None to this cover report.

Legal Implications:

None to this cover report.

Equalities Implications:

None to this cover report.

Sustainability Implications:

None to this cover report.

SUPPORTING DOCUMENTATION

Appendices:

1. Brighton and Sussex University Hospitals Briefing Note for Health Overview and Scrutiny Committee - Major Trauma Centre & Hospital Site Reconfiguration

Brighton and Sussex University Hospitals

Briefing Note for Health Overview and Scrutiny Committee

Major Trauma Centre & Hospital Site Reconfiguration

From 2 April 2012, following a comprehensive major trauma designation process led by NHS South of England, the Royal Sussex County Hospital (RSCH) in Brighton was designated as the regional major trauma centre (MTC) for Sussex providing 24/7 enhanced specialist care for the most seriously injured patients within the Sussex Trauma Network.

BSUH made significant financial investment in the MTC, with the support of local and specialist commissioners, equating to £6m revenue and £3m capital; this included the provision of 24/7 consultant presence in the Emergency Department, access to a designated 24/7 major trauma theatre, a new CT scanner, a dedicated major trauma ward and a multi-disciplinary major trauma workforce.

National service specification for major trauma

In 2013 the national specialised service specification for major trauma was published by the NHS Commissioning Board. Following a self-assessment process and discussions with the Surrey and Sussex Local Area team, in February 2013 BSUH entered into a derogation process for major trauma as there is currently no co-located neuro-trauma service at the MTC, i.e. physically located at the RSCH.

Derogation is a time limited agreement whereby one or more contractual standards or requirements within the national service specification will not be in place during the contractual period.

Derogation will only be agreed when assurance has been provided that alternative service arrangements are in place that will ensure patient safety and acceptable quality standards of care. Derogation is a time limited process and will only be agreed if it can be demonstrated that there is a plan to achieve compliance within an agreed period of time. The MTC is compliant with all other aspects of the national service specification and has demonstrated it has robust plans in place for implementing interventional radiology and burns and plastics services at the MTC.

Until such time as a full neuro-trauma service is implemented at the MTC in Brighton, the pre-existing head injury pathways to Hurstwood Park Neurosciences Centre (HPNC) will be maintained and, for certain injury patterns, pre-hospital providers (South East Coast Ambulance and Kent, Surrey and Sussex Air Ambulance) have agreed protocols to transport the small number of patients affected to other MTC's at the discretion of their senior clinical controllers. As recommended following the MTC designation process an audit of patients with moderate and severe head injuries attending the MTC, HPNC and other Trauma Units is being undertaken whilst interim bypass arrangements are in place.

Traumatic Head Injury Service

In August 2013 the Clinical Director (Specialised Services) for NHS England was invited to visit to the hospital to help identify a way forward to ensure compliance and in his subsequent report recommended the immediate transfer of all emergency and elective neurosurgery from Hurstwood Park Neurological Centre (HPNC) to RSCH and the development of an integrated spinal service for the Trust.

In December 2013 following detailed work by clinical and managerial leads across the organisation, the BSUH Board of Directors approved plans to move the elective and

emergency neurosurgery service HPNC to RSCH and considerable planning is underway to enable the move to RSCH to be completed by August 2014. This will include capital investment to convert the former day surgery unit at RSCH into a neurosurgery unit with co-location of key clinical services including bi planar angiography, CT scanning, MRI, neurosurgery theatres and a dedicated neurosurgery ward. Additional critical care beds will also be created at both RSCH and the Princess Royal Hospital.

The neurology department, neurosurgery outpatients and other support services including neuropsychology and neurophysiology will continue to be based at HPNC and will provided outreach services as required.

The new location for neurosurgery and its support services are interim until such time as a fully integrated new neurosciences unit is established within the 3Ts hospital re-development.

Site Reconfiguration Programme

A programme of work has been established ("the Site Reconfiguration Programme") to move planned trauma and orthopaedics and the urology service from the RSCH site to the Princess Royal Hospital site in the summer of 2014. It is proposed to maintain a daily urology outpatient service at RSCH for Brighton & Hove patients.

These service moves to PRH will release beds and theatre capacity on the RSCH site to accommodate neurosurgery as well as creating other benefits and efficiencies for these services.

An options appraisal is to be undertaken in early 2014 by clinical and managerial leads on the implementation of a single pathway for fractured neck of femur patients; discussions have also taken place with local commissioners and the local area team and the emerging preferred location for a single site service is PRH.

Workforce consultation

A number of staff within neurosurgery, urology, and trauma and orthopaedics will be affected by the site reconfiguration programme including medical staff, nursing and theatre staff, allied health professionals and administrative staff. An informal consultation process with staff commenced in November 2013 and a formal consultation process will start early in 2014.

Public consultation has already been undertaken on the relocation of neurosurgery to RSCH as part of the development of the 3Ts outline business case. As a relatively low number of patients are affected by the urology and trauma and orthopaedic service moves and as only parts of the service are moving further discussions on the proposed changes will take place with HOSC and local commissioners.

Sussex Operational Delivery Network for Major Trauma

New management arrangements have been put in place to support the development of the MTC including the appointment of a new Clinical Lead for major trauma.

In November 2013 funding was agreed by the Surrey and Sussex Local Area Team to enable the MTC at Brighton to host the Sussex Operational Delivery Network (ODN) for Major Trauma. The ODN will focus on coordinating patient pathways between trauma providers across Sussex to ensure access to specialist support and expertise. The major trauma ODN for Sussex will include representation from senior clinicians and managers from all the providers of major trauma services across Sussex including trauma units

(Hastings Hospital, Worthing Hospital and Chichester Hospital), South East Coast Ambulance Service and the Air Ambulance Service.

Appointments are being made to new clinical and management/administration positions to support the new Sussex Major Trauma ODN and the inaugural meeting has been scheduled for 4 February 2014.

MTC External Peer Review

Regional Trauma Networks (RTNs) went live across England in April 2012. A peer review process has been established to monitor implementation of trauma networks and MTCs, to demonstrate where further work is required, and to share areas of best practice and learning. The process is led by trauma clinicians from across the trauma networks and reviews are based on submission of evidence and a panel visit.

The last external peer review of the MTC and Sussex Trauma Network was undertaken in March 2013 and the key recommendations focussed on the head injury pathway, interventional radiology (IR), plastic surgery presence and cover, and development of the helipad. Progress has been made in developing an IR service for major trauma and a new hybrid IR theatre is due to be ready by June 2104; a new consultant in ortho-plastics appointment, in conjunction with Queen Victoria Hospital, East Grinstead, is due to be advertised in early 2014. The move of neurosurgery from HPNC to RSCH by August 2014 will address the head injury pathway issue.

The next external peer review of the MTC and Trauma ODN has been scheduled for 6 March 2014.

MTC performance

During the first twenty months the MTC has provided an enhanced service to seriously injured patients across Sussex and beyond. This has been demonstrated in the Major Trauma Performance Dashboard published nationally each quarter by the national trauma and Audit Research Network (TARN). TARN clinical reports have demonstrated that better clinical outcomes have been achieved since go-live in April 2012, with more survivors of major trauma than expected.

In November 2013 TARN published the MTC performance dashboard for 2013/14 Q2 which shows that across the 13 measures the MTC is performing well, for example:

§ The proportion of patients who meet NICE head injury guidelines and receive a CT scan within 60 minutes of arrival is 100%
§ 100% of patients are administered Tranexamic acid within 3 hours of incident (new performance measure)

The development of the MTC is significant strategic initiative for the Trust and considerable work is underway to ensure that the MTC achieves compliance against the national service specification for major trauma within the prescribed timescale.

The Trust is committed to working with commissioners, providers and patients to ensure the delivery of safe and effective major trauma services across the whole patient pathway and help secure the best outcome for patients.

Authors:-

Nikki Luffingham, Chief Operating Officer
Simon Maurice, Programme Director for Major Trauma
3 January 2014

HEALTH & WELLBEING OVERVIEW & SCRUTINY COMMITTEE	Agenda Item 110 Brighton & Hove City Council

Subject:		**NHS 111 Update**	
Date of Meeting:		**Health & Wellbeing Overview & Scrutiny Committee**	
Report of:		**Monitoring Officer**	
Contact Officer:	**Name:**	**Kath Vlcek**	**Tel: 29-0450**
	Email:	**Kath.vlcek@brighton-hove.gov.uk**	
Ward(s) affected:		**All**	

FOR GENERAL RELEASE

1. PURPOSE OF REPORT AND POLICY CONTEXT

1.1 To update the Health & Wellbeing Overview & Scrutiny Committee on the 111 service locally

2. RECOMMENDATIONS:

2.1 That HWOSC members note the update and comment on the

3. CONTEXT/ BACKGROUND INFORMATION

3.1 The 111 service was introduced in March 2013 and had a number of problems from the start which resulted in an improvement plan being introduced. Following implementation of the improvement plan, performance of the NHS 111 service improved significantly on the majority of key performance standards i.e. calls abandonment rate and calls answered within 60 seconds.

3.2 The service then went fully live on 13 August 2013, with all remaining activity from North Hants Urgent Care OOH (Surrey Heath CCG), MedOCC OOH (Medway CCG) and NHS Direct being transferred into the service.

3.3 The NHS 111 service is now consistently responding to calls with more than 95% being answered within 60 seconds and abandoned calls are predominantly less than 1% even at peak weekend periods. Activity is generally around 80% of planned/expected and the majority of service standards are improving as the service develops.

3.4 Although the majority of performance standards are being met on a daily basis (calls abandonment rate and calls answered within 60 seconds), there are still ongoing issues with the clinical call back times (within 10 minutes) and warm transfers (transfer of call to clinician). As a result, the provider was issued with a contractual performance notice in December and commissioners are currently working with the provider to put effective plans in place to improve this aspect of the service.

3.5 Since the launch of NHS 111, there have been various anecdotal reports from acute providers and other stakeholders suggesting that NHS 111 was the cause of the pressure on A&E. However, there is no data or evidence to back up these reports and the number of patients being referred to A&E is approximately the same as previously referred by NHS Direct.

4. ANALYSIS & CONSIDERATION OF ANY ALTERNATIVE OPTIONS

4.1 As part of the National Review of Urgent and Emergency Care, NHS 111 has been identified as the service that will ensure patients with urgent care needs get to the right service in the right place, first time. NHS 111 will be significantly enhanced so that it becomes the 'smart call to make', creating a 24 hour, personalised priority contact service. The enhanced service will provide

- Relevant access to patient records
- More appropriate use of clinicians – direct access where required
- Direct appointment booking into referral services

Commissioners will work with the provider to ensure that the service is able to put these enhancements in place.

5. COMMUNITY ENGAGEMENT & CONSULTATION

5.1 Healthwatch has reported on NHS 111 and made a number of recommendations around staff training, promotion of service and the triage service. Many of the recommendations have already been addressed via a Healthwatch article. This will be developed for future use.

6. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

6.1 None to this cover report for information.

Legal Implications:

6.2 None to this cover report for information.

Equalities Implications:

6.3 None to this cover report.

Sustainability Implications:

6.4 None to this cover report.

SUPPORTING DOCUMENTATION

Appendices:

1. Update from the CCG Programme Lead for NHS 111

NHS 111 Update for HWOSC

Background

NHS 111 was identified in the White Paper, *Liberating the NHS* as a new national NHS service, providing a telephone advice line for patients with urgent health problems which require assessment but which are not so serious as to require a 999 call. The service is free to callers, 24 hours a day, 7 days a week, 365 days a year and makes it easier for people to access local NHS healthcare services. NHS 111 has incorporated services previously offered by NHS Direct and the telephony components of the GP Out of Hours (OOH) services.

The public should call NHS 111 when they:

- Need medical help fast but it's not a 999 emergency
- Don't have a GP or know how to access healthcare
- Think you need A&E or other urgent care service
- Need health information, reassurance or advice on what to do next

NHS 111 will provide each caller with:

- A clinical assessment without the need for a call back
- Ambulance dispatch without delay (if emergency)
- Referral to services with appropriate skills and capacity to meet their needs
- Self-care advice when appropriate
- Transfer of clinical assessment data to other services for onward care

Benefits of NHS 111:

- Improved access to urgent care services
- Improved efficiency of NHS services
- Increasing public satisfaction and confidence in using NHS services
- Enable the design and commissioning of more effective and efficient services

Implementation across Kent, Medway, Surrey and Sussex

The NHS 111 service went live on 13 March, with calls from South East Health (now IC24), MedOCC OOH and the NHS Direct 0845 number. During the first week of go live, the service was significantly challenged due to a major technical issue where clinical information could not be sent electronically to the OOH GP service. This was despite significant system testing by the Department of Health in the 2 weeks lead up to go live. Clinical information then had to be faxed by call handlers to the OOH providers, taking them away from the phones and causing a backlog of calls. In addition, from go live, the service was significantly challenged and unable to manage the volume of calls due to both insufficient call handling capacity and provider senior management capacity. As a result, the provider was issued with a contractual performance notice and an improvement plan was implemented.

Following implementation of the improvement plan, performance of the NHS 111 service improved significantly on the majority of key performance standards i.e. calls abandonment rate and calls answered within 60 seconds.

The service then went 'full' go-live on 13th August, with all remaining activity from North Hants Urgent Care OOH (Surrey Heath CCG), MedOCC OOH (Medway CCG) and NHS Direct being transferred into the service.

Although the majority of performance standards are being met on a daily basis (calls abandonment rate and calls answered within 60 seconds), there are still ongoing issues with warm transfers (transfer of call to clinician) and the clinical call back times (within 10 minutes). Part of this issue is the lack of clinical resource within the service – unable to put through a warm transfer which causes

extended call back times. As a result, the provider was issued with a contractual performance notice in December and commissioners are currently working with the provider to put effective plans in place to improve this aspect of the service.

Current situation

The NHS 111 service is now consistently responding to calls with more than 95% being answered within 60 seconds and abandoned calls are predominantly less than 1% even at peak weekend periods. Activity is generally around 80% of planned/expected and the majority of service standards are improving as the service develops.

It was expected that the service would be significantly challenged over the Christmas/New Year period and commissioners worked with the provider to ensure that effective and resilient plans were in place to manage the surge in activity. As a result, the service managed the increase in demand, utilising national contingency during peak hours (calls diverted to other 111 providers with available call capacity) and there have been no reports to show that there were any significant increases in activity elsewhere in the local healthcare economy.

Since the launch of NHS 111, there have been various anecdotal reports from acute providers and other stakeholders suggesting that NHS 111 was the cause of the 'continued' pressure on A&E. However, there is no data or evidence to back up these reports and the number of patients being referred to A&E is approximately the same as previously referred by NHS Direct. We are now working closely with providers from across the local healthcare economy to ensure that the correct pathways are in place for NHS 111 to direct patients into the most appropriate services, first time.

Governance

Operational

The Sussex Collaborative Delivery Team (SCDT) in conjunction with commissioner project leads are now leading for Sussex and working together with the other commissioners across Kent Surrey and Sussex. The programme is moving into a sustainable structure where regular clinical and management meetings will audit and review all the soft intelligence and available data to ensure a safe, responsive, effective service is provided within Sussex.

The SCDT hold monthly NHS 111 Business/Operational meetings with representation from all Sussex CCG's and respective clinical and quality leads. The group look to resolve any local operational issues and are now starting to develop a benefits realisation strategy.

Clinical and Quality

Sussex has a monthly NHS 111 Clinical Governance meeting with representation from CCG,s and stakeholders across the local healthcare economy. The meeting is chaired by Dr Grant Kelly (NHS 111 Sussex Clinical Lead) where local issues are discussed and a selection of NHS 111 calls are monitored for the purposes of end to end testing of the patient pathway.

Communication and Public Awareness

Initially, we only did some low key marketing of the NHS 111 service i.e. posters and leaflets in GP practices and healthcare providers. More recently, the service has been highlighted as part of the 'we could be heroes' campaign in Brighton and Hove which aims to provide the public with information on the available services in the city and when they are appropriate.

NHS England have put a hold on any national or local mass media campaigns as there are still areas in England that have not yet went live.

If a member of public calls NHS Direct (not in service) or their GP when they are closed, then voicemail messages will direct them to the NHS 111 service.

Local News

NHS 111 was highlighted in the recent Brighton and Hove Healthwatch report on 'Urgent Health Care Services' and a number of conclusions were drawn up and recommendations made. It should be noted that of the small number of people surveyed (169), only 16 of those had actually used the service.

Many of the recommendations in the report i.e. concerns around staff training, promotion of service and the triage questions had already been addressed in the August addition of the Healthwatch Newsletter via an FAQ style article. We are currently in the process of developing this FAQ article further to answer all he questions raised.

The future of NHS 111

As part of the National Review of Urgent and Emergency Care, NHS 111 has been identified as the service that will ensure patients with urgent care needs get to the right service in the right place at the first time. NHS 111 will be significantly enhanced so that it becomes the 'smart call to make', creating a 24 hour, personalised priority contact service. The enhanced service will provide:

- Relevant access to patient records
- More appropriate use of clinicians – direct access where required
- Direct appointment booking into referral services including GP's

Commissioners will work with the provider to ensure that the service is able to put these enhancements in place.

HEALTH & WELLBEING OVERVIEW & SCRUTINY COMMITTEE	Agenda Item 111 Brighton & Hove City Council

Subject:	**Diabetes Service Provision in Brighton and Hove – Consultation Results**		
Date of Meeting:	**4 February 2014**		
Report of:	**Monitoring Officer**		
Contact Officer: Name:	**Kath Vlcek**	**Tel:**	**29-0450**
Email:	**Kath.vlcek@brighton-hove.gov.uk**		
Ward(s) affected:	**All**		

FOR GENERAL RELEASE

1. PURPOSE OF REPORT AND POLICY CONTEXT

1.1 To update the HWOSC on the results and outcomes of the Diabetes stakeholder consultation held in autumn/ winter 2013.

2. RECOMMENDATIONS:

2.1 That the HWOSC notes the outcome of the consultation and comments on the proposals to address the feedback received.

3. CONTEXT/ BACKGROUND INFORMATION

3.1 Brighton and Hove CCG has identified improving the diabetes care pathway as a key strategic priority for 2013-2014. The increasing number of people diagnosed with diabetes each year is expected to continue. Public Health estimates suggest that one in two people who currently have diabetes, have not been diagnosed.

3.2 As a result of changes in risk factors (in particular overweight & obesity) and the population age structure, by 2030 there will be 17,842 people in the city with diabetes, compared with 9,936 people diagnosed with diabetes in 2011/12. This is a 56% increase.

3.3 The current pathway is fragmented, with services delivered by separate organisations (hospital, community, GP practices) with no over-arching care planning across the system. There is scope to deliver more holistic care for patients and to develop a more 'joined-up' pathway, between hospital, GP practices, community and mental health support.

The successful management of patients with diabetes requires a whole system approach, with support for self-care and care in the community as key elements that can have a major impact on outcomes across all care settings. Through delivering more integrated care, Brighton and Hove CCG anticipates that it will improve both the quality of care and also make better use of resources

3.4 In September 2013, the CCG Local Member Group approved the strategic proposal to develop an Integrated Diabetes Care model, which would deliver a seamless diabetes care pathway led by multidisciplinary teams delivering integrated, patient focussed care, delivering national evidence-based and cost-effective standards to deliver improved outcomes

4. COMMUNITY ENGAGEMENT & CONSULTATION

4.1 The CCG invited stakeholders, patients, service users and the public to participate in the diabetes services consultation through either attending a city-wide stakeholder event, or through completing a web-based/paper-based survey.

4.2 Brighton and Hove CCG held the diabetes stakeholder engagement event in November 2013, with 53 attendees including 11 service users. There were presentations and facilitated round-table discussions. The outcomes and themes were reported back to the Diabetes Clinical Referral Group.

4.3 Clinical surveys were carried out amongst GPs, practice nurses and clinical leads and user surveys carried out amongst patients and carers.

4.4 There were a number of consistent messages from the consultation response. Many areas of good practice were identified, as well as areas that should be improved in the future. Key requests in consultation responses were around the gaps in current service pathway, with insufficient access to some services and the need for the new service model to be an integrated multidisciplinary specialist service.

4.5 Delivering coordinated diabetes care requires the CCG to commission a model which delivers the following:-

- Care needs to be integrated - a ‘one-stop shop’ approach, including psychological support, dietetics and podiatry support services
- Equitable services for all patients
- To have a named care coordinator role for patients
- To ensure all patients receive NICE diabetes care processes and care-planning
- To ensure services are more holistic, and are wrapped around the patients’ needs
- Support integration of care through good information sharing across the system
- Promote and support patient empowerment, through with access to education and information
- Improve knowledge and skill across primary care in diabetes management
- Deliver care in clinically appropriate care-setting, ensuring access to specialist advice and support as needed

4.6 The planned start date for the new service will be 1st April 2015. This would allow a full year to develop the service specification and to competitively procure the integrated service, subject to consideration by the Governing Body in March.

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

None to this cover report.

Legal Implications:

None to this cover report.

Equalities Implications:

There are significant health inequalities related to diabetes. It is more common in people living in the more socially deprived areas of the city.The level of diabetes is increasing because of increased levels of obesity, an aging population and a growing number of people of South Asian ethnicity.

The main fixed risk factors relate to age, gender and ethnic group: The rate of onset of Type 2 diabetes increases with age, diabetes is more common in men and in certain ethnic groups: it is up to six times more common people of South Asian ethnicity, and up to three times more common in those of African and African-Caribbean descent. [2]

There are public health interventions to address the risk factors of obesity, diet and exercise but these need to be better integrated into care pathways and there needs to be more public awareness for the risk factors of diabetes.

Sustainability Implications:

A Sustainability and Social Needs Assessment is being carried out by the CCG.

SUPPORTING DOCUMENTATION

Appendices:

1. Diabetes service provision in Brighton and Hove – Consultation Results; CCG report.

[1] Joint Strategic Needs Assessment for adults with diabetes in Brighton and Hove http://www.bhlis.org/needsassessments [Accessed on 26/08/2012].

[2] Department of Health. Who gets diabetes - Health Inequalities http://www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/browsable/DH_4899972

Brighton and Hove
Clinical Commissioning Group

Report to Brighton and Hove HWOSC
Tuesday 4th February 2014
Author: Charlotte D'Alessandro – CCG Commissioning Support Manager for Community Care

Diabetes service provision in Brighton and Hove – Consultation Results

Introduction

1. Throughout the Autumn/Winter 2013/14, Brighton and Hove Clinical Commissioning Group (the CCG) has led a city-wide stakeholder consultation, to seek views on improvements to diabetes care.

   The purpose of this paper is to update the HWOSC on the results and outcomes of the Diabetes stakeholder consultation.

Background

2. As part of the priority planning process in 2012, Diabetes services and care was identified as a key priority. Consequently, Brighton and Hove CCG identified improving the Diabetes care pathway as a key strategic priority for 2013-2014.

3. The current pathway is fragmented, with services delivered by separate organisations (hospital, community, GP practices) with no over-arching care planning across the system. There is scope to deliver more holistic care for patients and to develop a more 'joined-up' pathway, between hospital, GP practices, community and mental health support. The successful management of patients with diabetes requires a whole system approach, with support for self-care and care in the community as key elements that can have a major impact on outcomes across all care settings. Through delivering more integrated care, Brighton and Hove CCG anticipates that it will improve both the quality of care and also make better use of resources.

   Clinical best practice
   The Department of Health "Best practice for commissioning diabetes services" guidance (2013) states through commissioning integrated diabetes services, CCGs would achieve the following benefits:-
   - Improved patient experience
   - Ensuring that all healthcare organisations involved in providing diabetes care, through partnership, clearly own the responsibility for delivering excellent care to their local population
   - Providing clearly defined terms of accountability and responsibility for each health care professional / provider
   - Reducing duplication of time, tests and information

The NHS England South East Coast Cardiovascular Strategic Clinical Network (2013) has identified the following key strategic priorities as recommendations to support CCGs to deliver best practice:

- Commission Integrated models of diabetes care
- Raising awareness of foot care, and integrate Foot care into diabetes care pathways
- Support Patient empowerment to self-manage their diabetes (care plan, structured education programmes and self-management programmes)
- That all patients diagnosed with diabetes received all NICE care processes
- Improving knowledge and up-skilling primary care through commissioning education programmes
- Raising awareness and Early diagnosis (including NHS Health Checks programme)

The CCG hopes to achieve the following outcomes through improving the diabetes care pathway:-

- To deliver a seamless Diabetes pathway for patients in Brighton and Hove which in accordance with clinical best practice
- To ensure care pathway is integrated, seamless and delivers more holistic care for patients
- To ensure patients receive coordinated care
- To commission a pathway which delivers improved patient outcomes
- To ensure patients are empowered and better supported to self-manage their diabetes
- To ensure the whole system joins in partnership to own the health outcomes of patients
- To improve skills and knowledge across primary care

The Joint Strategic Needs Assessment for Brighton and Hove recommends that every person with diabetes should have a care plan every year, which includes the health checks as recommended by National Institute for Clinical Excellence (NICE).

4. In September 2013, the CCG Local Member Group approved the strategic proposal to develop an Integrated Diabetes Care model, which would deliver a seamless diabetes care pathway led by multidisciplinary teams delivering integrated, patient focussed care, delivering national evidence-based and cost-effective standards to deliver improved outcomes.

5. The Brighton and Hove ‘Commissioning Intentions 2014-2016’ document, approved by the Governing Body on 26th November 2013, outlined the proposal to commission an integrated community based model of care based on a multi-disciplinary team approach, which we anticipate will be in place from April 2015.

Local inequalities in Brighton and Hove

6. There are significant health inequalities related to diabetes. It is more common in people living in the more socially deprived areas of the city.[1]

The level of diabetes is increasing because of increased levels of obesity, an aging population and a growing number of people of South Asian ethnicity.

7. The main fixed risk factors relate to age, gender and ethnic group: The rate of onset of Type 2 diabetes increases with age, diabetes is more common in men and in certain ethnic groups: it is up to six times more common people of South Asian ethnicity, and up to three times more common in those of African and African-Caribbean descent. [2]

8. There are public health interventions to address the risk factors of obesity, diet and exercise but these need to be better integrated into care pathways and there needs to be more public awareness for the risk factors of diabetes.[1]

Predicted levels of local future need

9. The increasing number of people diagnosed with diabetes each year is expected to continue. Public Health estimates suggest that one in two people who currently have diabetes, have not been diagnosed.

10. As a result of changes in risk factors (in particular overweight & obesity) and the population age structure, by 2030 there will be 17,842 people in the city with diabetes, compared with 9,936 people diagnosed with diabetes in 2011/12. This is a 56% increase.

11. Diabetes is projected to account for 17% of total national NHS expenditure by 2037.[3]

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[1] Joint Strategic Needs Assessment for adults with diabetes in Brighton and Hove http://www.bhlis.org/needsassessments [Accessed on 26/08/2012].

[2] Department of Health. Who gets diabetes - Health Inequalities http://www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/browsable/DH_4899972

[3] Hex, N., Bartlett, C., Wright, D., Taylor, M., Varley, D. Estimating the current and future costs of Type 1 and Type 2 diabetes in the United Kingdom, including direct health costs and indirect societal and productivity costs. *Diabetic Medicine.* In press.

Consultation

12. Patient and public involvement

The CCG invited stakeholders, patients, service users and the public to participate in the diabetes services consultation through either attending a city-wide stakeholder event, or through completing an web-based/paper-based survey (which asked the same discussion questions as at the stakeholder event to ensure consistency).

The invitation to stakeholders was circulated to healthcare professionals across Brighton and Hove including GPs and practice nurses, Specialist Diabetes Teams across community provider (SCT) and the acute trust (BSUH), care homes and nursing homes, patients, carers, public and other stakeholders, including Community and Voluntary Sector Forum, Ambulance Service (SECAMB), mental health trust Sussex Partnership Foundation Trust, Carers Centre, Amaze, FED, Diabetes UK, primary care Patient Groups in GP practices, LINKs and Health-watch.
Information about the event and also the links to the surveys were also publicised on the CCG website, on the Diabetes Consultation page.

13.1 Stakeholder Event

Brighton and Hove CCG held a Diabetes stakeholder engagement event on 5th November 2013.

This event was widely advertised, as outlined above. Fifty-three stakeholders attended the city-wide diabetes engagement event. Eleven (21%) attendees who attended the event were service users/carers.

The event was designed to be an informal but focussed atmosphere, to raise awareness, generate discussion about current services, identify gaps/duplication, and create ideas about the ways in which diabetes care can be improved in order to deliver coordinated care, improve patient experience and improve health outcomes for people living with diabetes in Brighton and Hove.

The diabetes stakeholder event involved a presentation from CCG outlining the aims for the event, the strategic context for diabetes care as a key priority for Brighton and Hove, and the outcomes that the CCG hopes to achieve through improving the diabetes care.

There was a presentation from Public Health which outlined the expected prevalence level of diabetes within Brighton and Hove, the impact of diabetes, and recommendations for improving care. The presentation also outlined the current service model and summarised the financial cost of delivering the current model.

There were facilitated round-table group discussions where all tables/participants discussed the same two questions, which allowed patients, service users and stakeholders to discuss and suggest ways that diabetes care needs to improve, so that patients receive coordinated care. The Full Summary Report detailing outcomes and themes from the discussions, at the event has been reported back to both those who attended the event, and also to those who were unable to attend.

A summary of outcomes and themes from the event was presented to the Brighton and Hove CCG Local Member Group at the meeting on the 19th November 2013.

The Full Summary report was circulated to the Diabetes Clinical Reference Group (CRG) and was discussed at the CRG meeting on 3rd December 2013. There are patient/service user representatives on the Brighton and Hove Diabetes CRG.

13.2 Surveys for Healthcare Professionals, patients/carers, public and other stakeholders

Brighton and Hove CCG prepared a survey (for clinicians, healthcare professionals patients, stakeholders across the city) which was circulated via email to all GPs, Practice nurses, Clinical Leads, in order to gain as much feedback as possible from clinicians and stakeholders who were unable to attend the stakeholder event, so that they can also contribute their views into the consultation on how we can improve diabetes care pathway.
A link to this electronic survey was also placed on the CCG Diabetes Consultation website page.

The outcomes from the healthcare professional survey are consistent with the emerging themes from stakeholder discussions at the city-wide stakeholder event on 5th November.

13.3 Patient/carer Surveys

Brighton and Hove CCG also prepared a patient survey which was circulated to patients and carers.

This survey was designed by the CCG to gather information from patients on how and where they currently receive their care, what care/support they have accessed, and how they would like their diabetes care services to improve in future, and what additional services they would like to access in order to support them in living with their diabetes.

The survey was available to patients, service users and carers both electronically, and in hard-copy.

A link to the survey was placed on the CCG Diabetes Consultation website page. Hard-copies of the patient survey were given to all GP Practices in November 2013, and further hard-copies were provided to the SCT Community Diabetes Service, SCT Community Podiatry Service, the Psychological Diabetes Service at BSUH, and the Diabetes Out-Patients department at BSUH within Brighton and Hove asking them if they could also ask if any patients would like to participate in the consultation. Also, at the Diabetes Stakeholder Event, there were patient surveys and also cards with the web-link for stakeholders and patients to take away.

The electronic link to the patient/carer survey was circulated out with the Health-watch newsletter, and both the electronic link and some hard copies of the survey with the Brighton and Hove Neighbourhood Care Scheme Newsletter, which reached over 1200 people across Brighton and Hove. Brighton and Hove CCG also asked GP Practices across the city to ask their patients, when they attended for an annual review throughout November and December, if they would be interested in completing the survey.

Results and Outcomes of the Stakeholder and Patient Consultation

Discussion and comments from all stakeholder, public and patient feedback all highlighted similar themed. The feedback has been clustered into the following themes below:-

14.1 *What works well within the current pathway/service provision:-*

- Overall, health care professionals across the whole pathway are good, but there is not sufficient capacity across the pathway to deliver a high quality service that is equitable and accessible to all patients living with diabetes
- The Community Diabetes Team (provided by Sussex Community NHS Trust) is very good, (welcomed by patients and clinicians). Service provides very quick & easy access, helpful advice, and there is good access to the service
- Patient Education programmes provided by the Community Diabetes Team (‘DESMOND’, ’Walking Away’) are good and well received by patients, but there is a high non-attendance rate. The education programmes need a review/refresh to ensure they better suit patient needs and convenience to attend the course i.e. to provide the programmes in the evenings,.
- The Intensive Education for Type1 (BHITE) programme (currently provided by Brighton and Sussex University Hospitals NHS Trust) is well received by patients
- Care-planning works well where it is carried out. However, care planning is not carried out for all patients, and not all patients bring their care-plan to their appointments.
- Retinal Screening Service (provided by Brighton and Sussex University Hospitals NHS Trust) is very good and recall system works well
- Annual reviews completed in general practice are well received by patients, and patients have told us this is the most convenient place for them to receive further aspects of diabetes care in future

14.2 *Gaps/issues with current service provision / pathway:-*

- The current pathway is disjointed and not joined up
- Insufficient access to specialist dietetics and podiatry services
- Need an integrated multidisciplinary specialist service, with psychological/wellbeing support, podiatry, dieticians, with sufficient capacity
- Inequity of access to quality care (Recommended NICE Care Processes are not currently received by all patients)
- Inequitable access to some current services (i.e. lack of access to exercise for people with mobility problems)
- Need more patient support and information to empower patients to self-manage their diabetes

- Adolescent transition support needs to be more targeted to addressing the needs of this group, to support management of diabetes into adulthood
- Need to deliver rolling education programme to primary care clinicians to increase knowledge and skill in diabetes management
- Need better provision to support transition phase moving from children's into adult diabetes services
- Need a standardised and consistent approach to care planning and sharing of information across the pathway
- Primary care clinicians needs access to timely advice from specialists

***14.3** Delivering coordinated diabetes care requires the CCG to commission a model which delivers the following:-*

- **Care needs to be integrated - a 'one-stop shop' approach, including psychological support, dietetics and podiatry support services**
- **Equitable services for all patients**
- **To have a named care coordinator role for patients**
- **To ensure all patients receive NICE diabetes care processes and care-planning**
- **To ensure services are more holistic, and are wrapped around the patients' needs**
- **Support integration of care through good information sharing across the system**
- **Promote and support patient empowerment, through with access to education and information**
- **Improve knowledge and skill across primary care in diabetes management**
- **Deliver care in clinically appropriate care-setting, ensuring access to specialist advice and support as needed**

15. Feeding back to stakeholders, patients and the public

The full summary report detailing all of the feedback and findings from the full consultation has been fed back to attendees of the stakeholder event, has been saved onto the CCG website page, circulated to the project team and discussed by the Diabetes CRG (December 2013).

All of the feedback gathered from throughout the full diabetes consultation process will be used to shape the new model and define the service specification, to deliver an improved care pathway for people living with diabetes within Brighton and Hove.

The CCG will also be inviting stakeholders to attend a Diabetes Feedback Event, (date to be confirmed). At the event, the CCG will summarise the emerging themes & outcomes from the full city-wide stakeholder and patient consultation and based on this feedback, and we will be presenting the proposed integrated diabetes service for Brighton and Hove.
There will be regular updates throughout service development and implementation on the CCG website.

Further Detail and Next steps

Developing the service model and service specification

16. An Equality Analysis is being carried out. Given the increased risk factors associated with ethnicity, this will be reflected, and targeted work on increasing awareness of diabetes within those groups will be detailed.

17. A Sustainability and Social Needs Assessment is being carried out.

18. The CCG is in the process of finalising the details of the integrated service model. Based on current financial spend, the cost for the model will be approximately £1million.

19. The CCG is in the process of gaining procurement advice and further detail.

There may need a need to competitively procure. Competitively procuring the service would optimise the efficiency of a new model, reduce duplication across the system, and would deliver a seamless pathway which could be linked to improved patient outcome measures.

20. The Diabetes Clinical Reference Group meeting in January has approved in principle, the proposal for an Integrated Community-based Diabetes Service.

21. The Clinical Strategy Group meeting in February will consider the business case for the clinical model.

22. At the Governing Body meeting in March, the Governing Body will consider the business case for a new integrated model and will consider procurement.

23. Once the proposed service model has been approved by the CCG Governing Body, the service specification will be prepared for approval by the CCG.

24. The planned start date for the new service will be 1st April 2015. This would allow a full year to develop the service specification and to competitively procure the integrated service, subject to consideration by the Governing Body in March.

HEALTH & WELLBEING OVERVIEW & SCRUTINY COMMITTEE	Agenda Item 112 Brighton & Hove City Council

Subject:		**End of Life Pathways**	
Date of Meeting:		**4 February 2014**	
Report of:		**Monitoring Officer**	
Contact Officer:	**Name:**	**Kath Vlcek**	**Tel: 29-0450**
	Email:	**Kath.vlcek@brighton-hove.gov.uk**	
Ward(s) affected:		**All**	

FOR GENERAL RELEASE

1. PURPOSE OF REPORT AND POLICY CONTEXT

1.1 The purpose of the report is to provide HWOSC with an update on developments in Palliative Care and End of Life services and pathways in Brighton and Hove.

2. RECOMMENDATIONS:

2.1 That HWOSC members note the content of the report and comment on it.

3. CONTEXT/ BACKGROUND INFORMATION

3.1 End of life care helps all those with advanced, progressive, incurable illness to live as well as possible until they die. It enables the supportive and palliative care needs of patients, their carers and family to be identified and met throughout the last phase of life and into bereavement.

3.2 In July 2008, the Department of Health published a national strategy to improve provision of end of life care. The aim of this strategy is to bring about a step change in access to high quality care for all people approaching the end of life. High quality care should be available wherever the person may be: at home, in a care home, in hospital, in a hospice or elsewhere. Implementation of this strategy should enhance choice, quality, equality and value for money.

3.3 In Brighton and Hove there is a joint palliative and care group (the Palliative Care and End of Life Steering Group), that has representative from primary, secondary, social and community care services as well as the voluntary sector. This group strives to promote and deliver high quality care for patients approaching the end of life. This group and is responsible for forming a joint action plan to deliver the national strategy on end of life care locally.

3.4 Main work streams for the group include the Sussex End of Life Care and Dementia Project, the Palliative care partnership, work with primary care providers and the interim guidance in place of the Liverpool Care Pathway.

4. COMMUNITY ENGAGEMENT & CONSULTATION

4.1 There was a stakeholder event in December 2013, to provide a collective response to the proposed advice to health and care professionals, about care in the last days to hours of life.

The event was attended by: Representatives from B&H CCG; three local service users: Age UK; The Trust for Developing Communities; staff from Brighton & Hove City Council, and Brighton Older Peoples Council; representatives from Brighton & Sussex University Hospitals including palliative care consultants, clinical nurse specialists and the trusts chaplain and rabbi; Brighton Carers Centre; two local GPs, three members of Healthwatch; a GP from the out of hour's service (IC24). Living Well/Dying Well a local charity with specialist interest in dying; the Martlets Hospice, including clinicians, nurses and chaplain; Macmillan Cancer; Sussex Community Trust staff ,; a clinician from Sussex Partnership Foundation Trust; the homeless co-ordinator for the St Johns Ambulance; a local Nursing Home Manager

4.2 This event will be followed by a further stakeholder consultation in April 2014 to discuss the content and implementation of a local end of life care plan, when the final advice from the Leadership Alliance for the Care of Dying People has been received.

7. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

None to this cover report.

Legal Implications:

7.1 None to this cover report.

Equalities Implications:

7.2 None to this cover report.

Sustainability Implications:

7.3 None to this cover report.

SUPPORTING DOCUMENTATION

Appendices:

1. CCG Report on End of Life Pathways

Brighton and Hove
Clinical Commissioning Group

Report to Brighton and Hove HWOSC
Tuesday 4th February 2014
Author: Simone Lane– CCG Commissioning Manager for Community Care

Purpose of the Report

The purpose of the report is to provide HWOSC with an update on developments in Palliative Care and End of Life services and pathways in Brighton and Hove.

End of Life Definition

End of life care: Helps all those with advanced, progressive, incurable illness to live as well as possible until they die. It enables the supportive and palliative care needs of patients, their carers and family to be identified and met throughout the last phase of life and into bereavement. It includes management of pain and other symptoms and provision of psychological, social, spiritual and practical support. Source: National Council for Palliative Care 2006 from National End of Life Care Strategy, 2008.

Background

Just over 1% of people die each year and around 455,000 people died in England in 2010 .There are changing trends in the age of death, with increasing numbers of deaths in people aged 85 and over and a decreasing trend in people aged 65 to 84. The older age group has a greater likelihood of frailty and multi-morbidities. The majority of deaths occur in an acute hospital and do so following a period of chronic illness such as heart failure, cancer, stroke, chronic respiratory disease, neurological disease or dementia. Deaths in England and Wales are expected to rise by 17% from 2012 to 2030. A large proportion of deaths are foreseeable, and a recent estimate suggests that approximately 355,000 people need good palliative care services every year but around 92,000 people are not being reached. Although 63% of people surveyed stated that home is their preferred place of death, in 2010 most deaths occurred in hospitals (53%) and only 21% occurred in the home with an additional 18% in care homes. Traditionally, end of life care services have been orientated towards cancer care. In 2010 non-cancer related deaths accounted for over 70% of deaths. The percentage and number of people with non-cancer diagnoses accessing specialist palliative care services has increased overall in the past 12 years. However -The proportions of people with conditions other than cancer who access these services still remains very low. In Brighton and Hove we have seen an increase in deaths in usual place of residence, in Brighton and Hove in 2011/12 42.8% of people died in their usual place of residence, compared to 44.7% in 2012/13, (nationally the figure was 43.9% in 2012/13)

National Strategy

In July 2008, the Department of Health published a national strategy to improve provision of end of life care. The aim of this strategy is to bring about a step change in access to high quality care for all people approaching the end of life. High quality care should be available wherever the person may be: at home, in a care home, in hospital, in a hospice or elsewhere. Implementation of this strategy should enhance choice, quality, equality and value for money.

Local Delivery of the National Strategy

In Brighton and Hove there is a joint palliative and care group (the Palliative Care and End of Life Steering Group), that has representative from primary, secondary, social and community care services as well as the voluntary sector. This group strives to promote and deliver high quality care for patients approaching the end of life. This group and is responsible for forming a joint action plan to deliver the national strategy on end of life care locally.

End of Life 2013-14 - Main Work streams

1. Sussex End of Life Care and Dementia Project

This project aims to improve end of life care for people with Dementia across Sussex, so that more people with dementia die in their preferred place of death, with dignity, without undue pain and with their advance wishes respected. The specific project objectives were:

- To increase advance care planning with/for people with dementia
- To develop a comprehensive integrated end of life and dementia care pathway
- To develop practitioners understanding, knowledge & skills enabling them to deliver safe, high quality end of life care to people with dementia.

Achievements to date are:

- Establishing a multi-agency stakeholder groups
- Development of the Sussex Integrated End of Life and Dementia Care Pathway.
- Increased co-operation between end of life care and dementia specialist practitioners
- Providing 'Conversations for Life' education and training events to promote Advance Care Planning.
- Providing two Namaste Care workshops to promote compassionate, sensory based end of life care.
- Distribution of 10,000 'This is Me' Bags across Sussex the dissemination and promotion of examples of good practice in end of life and dementia care.
- Providing organisations with support so they can 'dementia and end of life proof' their existing education and training opportunities and integrate these into their workforce development plans.

2. Palliative Care Partnership

In 12/13 after a pathway review and stakeholder consultation, a major redesign of End of Life and Palliative Care pathway was carried out. In April 2013 the Palliative Care Partnership (PCP) service was commissioned and is provided by Sussex Community Trust and the Martlets Hospice.

The Palliative Care Partnership provides expert support and advice for palliative and end of life care patients and their families, as well as the professionals caring for them. The service is working to improve patients' experiences of community palliative and end of life care health service. It is also contributing towards achieving reductions in unscheduled admissions into secondary care and A&E, and an increase in the number of patients dying in their preferred place of care.

3. **Primary Care**

The Gold Standard in Palliative Care supports primary health care teams in providing the highest standards of generalist palliative care, to enable patients in the last year of their life to achieve the best possible physical, spiritual, and social care in the place of their choice. The GSF was first introduced in Brighton & Hove in 2001 in 2013/14 there are 41 practices out of 47 signed up for the Palliative Care Local enhanced service

The key to improving access to services, is to identify all patients, regardless of diagnosis, in their last year of life (aiming for 1% of the practice population), add them to a GSF register and for their care to be discussed and reviewed monthly in a multi-disciplinary team meeting. Early identification allows time for Advance Care Planning. Patients, relatives, carers and health care professionals can discuss and ascertain the patient's choices and preferences whilst they still have capacity and anticipate their needs. The appropriate care and support can then be accessed for the patient and their carer in their preferred place of care.

There have been improvements year on year in the numbers of patients having their Preferred Place of Care documented and achieved. In 2011/12 90% of patients on practice GSF registers had their PPC documented. GP training about anticipatory medications has seen an improvement in practice.

In 2013/14 there has been a requirement for GPs to attend training on Dementia and end of life care. This included the importance of giving patients with Dementia the opportunity to discuss and document their wishes and preferences (whilst they still have capacity) by completing an Advance Care Plan and also making GPs aware of prognostic tools which will assist them in identifying when patients with dementia are in their last year of life.

4. The Liverpool Care Pathway (LCP)

The Liverpool Care Pathway for the Dying Patient (LCP) is a model of care which enables healthcare professionals to focus on care in the last hours or days of life when a death is expected.

The LCP is tailored to the person's individual needs and includes consideration of their physical, social, spiritual and psychological needs. It requires senior clinical decision making, communication, a management plan and regular reassessment. The LCP is not a treatment in itself but a framework for good practice – it aims to support, but does not replace, clinical judgement. The LCP guides and enables healthcare professionals to focus on care in the last hours or days of life, when a death is expected.

Good, comprehensive, clear communication is essential to the LCP and all decisions leading to a change in care delivery should be communicated to the patient where possible and deemed appropriate, but always to the relative or carer. This is in accordance with GMC best practice guidance (GMC 2010). The views of all concerned must be listened to, considered and documented.

Following a series of instances nationally of poor care, the Department of Health announced in January 2013 that an independent review into the use of the LCP would be undertaken, chaired by Baroness Julia Neuberger. In July 2013 the independent review of the Liverpool Care Pathway (LCP) published its report 'More Care Less Pathway'.

In the report Baroness Neuberger said: "There is no doubt that, in the right hands, the Liverpool Care Pathway supports people to experience high quality and compassionate care in the last hours and days of their life. But evidence given to the review has revealed too many serious cases of unacceptable care where the LCP has been incorrectly implemented."

This national document therefore makes a number of recommendations about how people at the end of their life should be cared for, and specifically recommends that 'the use of the Liverpool Care Pathway should be replaced within the next six to 12 months by an end of life care plan for each patient".

The CCG, as part of the work of the Palliative Care and End of Life Steering Group, held a meeting with key stakeholders in primary, community and secondary care in September 2013, to ensure that interim arrangements were in place during this transition period. It was agreed that services would follow the NHS England interim guidance for Doctors and Nurses regarding how to care for the dying patient (NHS England July 2013), and will continue to follow this until further guidance is available. This interim guidance recommends that the principles of good palliative care, on which the LCP was originally based are continued to be upheld. These are regular assessment and management of symptom control and comfort measures, effective communication with patients and their families, provision of psychological, social and spiritual support. These principles hold true, whether or not the LCP or any integrated care pathway or plan for dying is used.

In response to the recommendations in the 'More Care Less Pathway report, the Leadership Alliance for the Care of Dying People (LACDP) was set up, to lead and provide a focus for improving the care for these people and their families in response to the recommendations made in the report. As part of this work, the alliance is now running an engagement process to hear the views of clinicians, patients, families and carers around the proposed advice to health and care professionals, about care in the last days to hours of life.
(https://www.engage.england.nhs.uk/consultation/care-dying-ppl-engage)

The CCG as part of the work of the Palliative Care and End of Life Steering Group is now leading an engagement process, to ensure that there is thorough local consultation on what a local end of life care plan to replace the LCP should look like. As a first step in this process a stakeholder event was held on December 17th 2013 to provide a collective response to the proposed advice to health and care professionals, about care in the last days to hours of life.

The event was attended by: Representatives from B&H CCG; three local service users: Age UK; The Trust for Developing Communities; staff from Brighton & Hove City Council, and Brighton Older Peoples Council; representatives from Brighton & Sussex University Hospitals including palliative care consultants, clinical nurse specialists and the trusts chaplain and rabbi; Brighton Carers Centre; two local GPs, three members of Healthwatch; a GP from the out of hour's service (IC24). Living Well/Dying Well a local charity with specialist interest in dying; the Martlets Hospice, including clinicians, nurses and chaplain; Macmillan Cancer; Sussex Community Trust staff , including clinicians, service director and chaplain; a clinician from Sussex Partnership Foundation Trust; the homeless co-ordinator for the St Johns Ambulance; a local Nursing Home Manager

This event will be followed by a further stakeholder consultation in April 2014 to discuss the content and implementation of a local end of life care plan, when the final advice from the Leadership Alliance for the Care of Dying People has been received.

Priorities for Palliative Care and End of Life 2014 -15

Priorities for 2014/15 will be agreed by the Palliative Care and End of Life Steering Group in March 2014 but will include:-

- Rolling out and embedding the work of the Sussex End of Life Care and Dementia Project and developing a training strategy and forum to develop this work.
- Developing a shared care plan as an alternative to the LCP agreed by all providers, and ensure this is disseminated and staff receive training across the whole pathway.
- Working to ensure an appropriate shared palliative care and end of life electronic record is developed.
- Ensuring Advanced Care Planning is incorporated to the new frailty model
- Ensuring all GP practices in Brighton and Hove are utilising the Gold Standards Framework (GSF) and appropriately trained, especially on an alternative to LCP.
- Increasing the number of identified palliative care patients with a non-malignant diagnosis, where the trajectory of their disease is more complex, who are added to the practices GSF register.

HEALTH & WELLBEING OVERVIEW & SCRUTINY COMMITTEE	Agenda Item 113 Brighton & Hove City Council

Subject:		**Homelessness Scrutiny Panel Report**	
Date of Meeting:		**04 February 2014**	
Report of:		**The Monitoring Officer**	
Contact Officer:	**Name:**	**Giles Rossington**	**Tel: 29-1038**
	Email:	**Giles.rossington@brighton-hove.gov.uk**	
Ward(s) affected:		**All**	

FOR GENERAL RELEASE

Note: The special circumstances for non-compliance with Council Procedure Rule 3, Access to Information Procedure Rule 5 and Section 100B(4) of the Local Government Act 1972 (as amended), (items not considered unless the agenda is open to inspection at least five days in advance of the meeting) were that the scrutiny panel wanted to take the opportunity to take evidence from Brighton Housing Trust, which necessitated the late publication of this report.

1. PURPOSE OF REPORT AND POLICY CONTEXT

1.1 In 2012 HWOSC agreed to establish a scrutiny panel to look at issues relating to homelessness. The panel was chaired by Cllr Andrew Wealls, and also included Cllrs Alan Robins and Ollie Sykes.

1.2 The scrutiny panel report is attached as **Appendix 1** to this report. Minutes of the panel meetings and additional information will be published on the council's website in due course.

2. RECOMMENDATIONS:

2.1 That HWOSC endorse the scrutiny panel report on homelessness (**Appendix 1**) and refer it on for consideration by the appropriate policy committee(s)

3. CONTEXT/ BACKGROUND INFORMATION

3.1 In 2012 Cllr Wealls requested that a scrutiny panel be established to examine issue relating to homelessness in the city.

3.2 HWOSC agreed the request and a panel consisting of Cllrs Wealls, Robins and Sykes was established, with Cllr Wealls agreeing to chair. The panel held several evidence gathering meetings in the Spring of 2013 interviewing a wide range of witnesses. Panel members also took part in the annual rough sleeper street count and visited a number of accommodation and support services for homeless people.

3.3 This panel report was due to be published in Winter 2013. However, staffing changes to the Scrutiny team meant that it was not in fact possible to complete the report until early 2014.

4. ANALYSIS & CONSIDERATION OF ANY ALTERNATIVE OPTIONS

4.1 The HWOSC has the option to decline to endorse the homelessness scrutiny panel report.

5. COMMUNITY ENGAGEMENT & CONSULTATION

5.1 The homeless scrutiny panel spoke with a wide range of community and voluntary sector organisations responsible for supporting homeless people and preventing homelessness, as well as with rough sleepers and other homeless people.

6. CONCLUSION

6.1 In line with normal procedure, we are asking that the HWOSC endorses this report and refers it on to the appropriate BHCC Policy Committee(s) for consideration.

7. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

7.1 The financial implications of the recommendations from the scrutiny panel will be assessed in the context of the Council's budget strategy when the recommendations are considered by the policy committees.

Finance Officer Consulted: Anne Silley Date: 29/01/14

Legal Implications:

7.2 Once HWOSC has agreed its recommendations based on the work of the scrutiny panel , it must prepare a formal report and submit it to the council's Chief Executive for consideration at the relevant decision-making body.

7.3 If HWOSC cannot agree on one single final report, up to one minority report may be prepared and submitted for consideration by the relevant policy committee with the majority report.

Lawyer Consulted: Oliver Dixon Date: 29/01/14

Equalities Implications:

7.4 The scrutiny panel report (Appendix 1) includes detailed assessments of the problems of homelessness as they impact upon a range of 'equalities' groups, including LGBT people, and those who have experienced Domestic Violence.

Sustainability Implications:

7.5 None identified

Any Other Significant Implications:

7.6 None identified.

SUPPORTING DOCUMENTATION

Appendices:

1. The Homelessness Scrutiny Panel Report

Documents in Members' Rooms

None

Background Documents

None

Report of the Homelessness Scrutiny Panel

February 2014

Panel members: Cllrs Andrew Wealls (Chair), Alan Robins and Ollie Sykes

Introduction

1 What is homelessness?

Homelessness can be defined in several ways. In its widest sense, being homeless means not having access to safe, secure accommodation. People might be staying temporarily with friends or family, or living in accommodation which is unsafe or from which they will shortly be evicted. The majority of homeless people are able to resolve their housing problems without involving outside agencies, except perhaps for some advice services.

However, many other homeless people require much more support, and it is also possible to speak of homelessness in the narrower sense of those who apply for help and who meet the criteria set out in Homelessness legislation. Local authorities have a statutory responsibility to help these eligible homeless people access secure accommodation.

In a narrower sense still, a relatively small group of homeless people cannot find, or for various reasons decline to accept, shelter, and end up sleeping rough. Even when temporarily housed in a hostel or similar accommodation, people in this group are very vulnerable and are likely to find themselves homeless again in the future. Many of the people in this group have physical or mental health problems or substance misuse issues.

2 Local Authority Duties (Homelessness)

Local authorities have clearly defined duties under homeless legislation. Someone is classified as homeless only when they have satisfied five criteria:

- They are a UK citizen
- They are actually (or will imminently be) homeless
- They are not ‘intentionally’ homeless (e.g. they have not become homeless due to a deliberate act or omission)
- They have a local connection (e.g. they have lived in the area for six of the past twelve months or three of the past five years, or are working in the area, or have close family living in the area)
- They are in a ‘priority need’ category (i.e. they have a vulnerability which means that they are in greater need of secure housing than the average person)[1]

People who meet all five of these criteria are eligible for help from their local authority. This may include housing advice, assistance with references or a deposit, the offer of temporary accommodation, or even of a secure tenancy – basically whatever support is required to enable an individual to access safe and secure accommodation. In past years, people accepted as homeless would probably have been offered a secure tenancy in a council-owned property; but this is generally no longer the case, and nowadays the offer will typically be of temporary accommodation. The previous model had the

[1] Evidence from Sylvia Peckham, BHCC Head of Temporary Accommodation and Allocations, 25 January 2013: point 3.2.

perverse effect of encouraging people to become homeless in order to get rapid access to social housing tenancies. It also had the effect of placing relatively large numbers of highly vulnerable people together in housing estates, with a potentially detrimental impact upon the cohesiveness of those communities. Placing vulnerable homeless people in temporary accommodation gives housing services the opportunity to provide the necessary training and support to help them manage future tenancies successfully, hopefully avoiding the situation where people who have become homeless after failing to maintain a tenancy are granted another tenancy which they will then fail to maintain.[2]

3 Other Local Authority Duties

Even when people do not meet all of the statutory homelessness criteria, the local authority may still have a duty to house them under adult social care or children's legislation – e.g. for families with dependant children, or people who have particularly acute vulnerabilities in terms of old age, mental or physical health, substance misuse or learning disabilities.[3] People who have been in care as children, those experiencing domestic violence, former members of the armed services, and people leaving custody may also be deemed to have particular vulnerabilities which mean that there is a duty to house them.

This division is important in terms of two-tier local authorities, where responsibilities for homelessness are split between district councils (housing) and county councils (social care). However, for unitary authorities such as Brighton & Hove the same organisation is responsible for both housing and social care. There are obvious advantages in having one department discharge all these responsibilities – and this is what happens locally, with the city council's housing team commissioning accommodation on behalf of adult social care and children's services as well as for its own clients.[4]

Even where there is no local authority duty to house an individual, councils are not legally barred from offering housing support to those who do not meet the eligibility criteria, and may choose to house some very vulnerable people such as rough sleepers.[5]

4 Rough Sleepers

Anyone who becomes homeless could potentially find themselves sleeping rough, and some rough sleeping services are designed to address this general need. However, a significant proportion of those sleeping rough at any time will be people who have refused to be properly housed, or whose issues and behaviour make it very difficult to house them securely for any length of time. This group of rough sleepers often have severe mental health

[2] Evidence from Sylvia Peckham, 25 January 2013: point 3.4.
[3] Nationally, more than 70% of households accepted as statutorily homeless are accepted because they include dependant children/pregnant women. See DCLG Statutory Homelessness Statistics Release 2013 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/205221/Statutory_Homelessness_Q1_2013_and_2012-13.pdf
[4] Evidence from Sylvia Peckham, 25 January 2013: point 3.3.
[5] Evidence from Sylvia Peckham, 25 January 2013: point 3.6.

problems, learning disabilities, physical disabilities, substance and/or alcohol misuse and dependence issues, a history of anti-social or criminal behaviour, or traumatic personal histories (and often a combination of these issues). Although we are talking about small numbers of people here, their impact is quite disproportionate to their size, and many rough sleepers have very complex needs requiring specialist support.

5 What's the trend?

Homelessness has been a serious local and national problem for many years, with rates of rough sleepers, people accepted as statutorily homeless, people living in temporary accommodation, and people 'sofa-surfing' fluctuating from year to year. However, recent years do seem to have shown consistent increases in several of the measures of homelessness. For example:

- There was a 6% increase in successful homeless applications across England between 2011-12 and 2012-13.[6]
- Between 2012 and 2013 the number of people in temporary accommodation across England also increased by 10%.[7]
- Between 2010 and 2012 rough sleeping rates across England by around 30%[8]
- In Sussex between 2011 and 2012 there was a 40% increase in rough sleepers.

There are several reasons to think that homelessness may well increase in the next few years. In the first place, it is widely accepted that homelessness rises in times of economic hardship – people who lose their jobs struggle to pay rent; young people without jobs can't get tenancies; people leave secure accommodation in search of work in less depressed areas. There is obviously a good deal of uncertainty here, both in terms of the speed and the extent of economic recovery locally and nationally (with the potential for internal migration of job-seekers into more economically buoyant areas).

This general pressure can be exacerbated by particular local pressures – obviously by how well the local economy is doing; but also by local house prices (high prices tend to mean higher rents in the private market as a wider range of people are obliged to rent); by supply and demand in the private rented sector (where demand exceeds supply landlords can afford to be more selective in their choice of tenants); by the presence of large numbers of students etc. Clearly all of these pressures apply in Brighton & Hove.

[6] See DCLG Statutory Homelessness: Statistical Release 2013, p3. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/205221/Statutory_Homelessness_Q1_2013_and_2012-13.pdf
[7] See DCLG Statutory Homelessness: Statistical Release 2013, p8.
[8] See DCLG Rough Sleeping Autumn 2012: Statistical Release, p2. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/73200/Rough_Sleeping_Statistics_England_-_Autumn_2012.pdf

6 Welfare reform

An additional pressure is the ongoing reform of the benefits system which includes significant changes to Housing Benefit (HB), involving reducing the amount that can be claimed and restricting the types of accommodation that some groups of people can claim – e.g. changing the rules so that under 35s can now only claim for the cost of a room in a shared house or making changes to under-occupancy rules in social housing (the so-called 'bedroom tax'). They also include changes to Council Tax benefits; the reassessment of various disability-related benefits, and some other measures.

A major issue is likely to be the move from paying HB to landlords to making direct payments to tenants. This poses particular problems for those clients who struggle to manage their own finances, a group which includes many people in temporary accommodation. It is not currently clear whether people in temporary accommodation will be exempted from direct payments (as those in supported housing have been), but if they are not there may be a precipitous drop in rent collection rates for this type of property – pilot areas have seen collection rates fall from 98% to 60%, which would equate to around £4 million per year across Brighton & Hove.[9]

It is not yet apparent what impact these benefit reforms will have, although it is clearly the Government's intention that they will reduce welfare costs and encourage a more rational use of housing stock rather than increasing the numbers of homeless people. In some instances, welfare reforms have not yet produced the predicted detrimental impact.[10] However, even if there is a limited national impact upon homelessness, there may be a much higher impact in some areas – where, for example, private landlords housing HB claimants may prefer to look to other markets (students/professionals) rather than reducing rents to reflect lower HB payments. Again, given its large student population and high number of professional private renters, Brighton & Hove is as likely as anywhere to experience these pressures.

It is also the case that some areas may act as magnets to homeless people, attracting people from other areas. Again, this is likely to be a particular problem for Brighton & Hove, with its reputation as a diverse, tolerant and fun city.

7 Who is becoming homeless?

Clearly, anyone can become homeless, but services have reported significant increases in two groups of people: people with very low support needs (e.g. people who are work-ready or actually in work but who cannot access secure housing because they don't have money for deposits or can't provide references etc), and also people with very complex needs. The first group is relatively easy to support via help with deposits etc. as long as they are swiftly identified.[11] Supporting the second group is much more challenging.

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[9] Evidence from Sylvia Peckham, 25 January 2013: point 3.15.
[10] Evidence from Sylvia Peckham, 25 January 2013: point 3.16.
[11] Evidence from Bec Davison, CRI, 07.02.13: 8.2.

There are particular problems with young people – given the very high levels of youth unemployment it can be very difficult for young people to get private tenancies without deposits, references or a steady wage.

8 Social Capital

There are various definitions of social capital, but in essence it represents the informal support networks that individuals have which allow them to cope with crises. In terms of homelessness, your social capital is what keeps you off the streets if you find yourself without a home, whether it's family members lending you the money for a deposit or friends letting you sleep on their sofa.

Social capital is crucial in keeping the numbers of homeless people who seek statutory support at a manageable level. However, there are a number of factors that can impact upon social capital. These include recessionary pressures – people who are themselves struggling to make ends meet are less likely to be able to help others out, so the more general an economic downturn the more it is likely to reduce social capital. Similarly, the length of a downturn is important as a willingness to help people temporarily will not necessarily translate into long term support.

Other factors may include how settled and 'local' a population is – areas where lots of people are non-local are likely to have lower social capital than areas in which most of the residents are locals.

Another factor may be the availability of spare living space – in areas where housing is relatively cheap, lots of people may have spare rooms, meaning that they may be able to offer friends a temporary place to stay. In areas where it is expensive, spare rooms are an unaffordable luxury for most people.

It does seem as if there may have been a recent reduction in the availability of social capital in Brighton & Hove, and this may make itself felt in increasing numbers of homeless people seeking support. Bec Davison of CRI told the panel that it had been calculated that in recent years it had typically taken someone who found themselves homeless seven years to exhaust their social capital and become a rough sleeper, but that this was currently taking more like a year – it is unclear why the situation has changed so much recently. This is a national trend, but as noted above it may be a particularly serious issue locally. Ms Davison recommended that more work be done locally to investigate this phenomenon and to plot what might be done to increase social capital.[12]

9 Services

The range of services offered to homeless people is very wide. It includes Housing advice and assessment; council-commissioned temporary (B&B) and emergency (hostel) accommodation; a range of council-commissioned support and outreach services delivered by community sector organisations; mental health, substance misuse and learning disability services; general

[12] Evidence from Bec Davison, CRI, 07.02.13: 8.3.

healthcare; police and probation services; community safety, and benefits advice. As well as services commissioned or provided by the statutory agencies, there are a wide range of voluntary and community sector-funded and provided services available across the city. Some of these services may be dovetailed with statutory support, but others are not, and some voluntary sector services might seem to work against the thrust of statutory sector strategies (supporting homeless people with no local connection to stay in Brighton & Hove, when statutory services will be trying to relocate them, for example). In consequence, the map of homeless services is complex, and is something that, to some extent, has grown organically rather than as the result of strategic planning.

10 BHCC Services

The city council runs a range of homelessness services. The Housing Options team offers advice on finding a home and also processes homelessness claims. For people deemed officially homeless, or homeless and awaiting assessment, there are two basic types of accommodation: B&B or temporary housing and hostel or emergency housing. Some of this accommodation is directly owned and managed by the council, but most is contracted from a range of providers. In theory homeless people will be offered the most appropriate type of accommodation, with those with relatively low support needs going into B&H and those with higher support needs (e.g. many rough sleepers) into the hostels system. However, this does not always quite work this way in practice, as sometimes one type of accommodation may be full or for some reason unsuitable for a particular client.

In many instances the council will seek to support people in accessing private-rented accommodation rather than providing them with council accommodation – e.g. by helping them with deposit or references or putting them in touch with landlords willing to house a wide range of people.

The council also commissions a range of outreach and support services for rough sleepers, largely from CRI, a national voluntary sector organisation, and from Brighton Housing Trust (BHT).

The council also provides or commissions other services such as extreme weather shelters for rough sleepers[13].

Councils have a variety of responsibilities for adults who have particular vulnerabilities, such as significant mental health, learning disability or physical health problems, and these responsibilities apply whether someone is securely housed or homeless.

[13] Evidence from Jenny Knight, BHCC Commissioning Officer for Rough Sleepers: 25.01.13, point 3.7.

Recommendations

Health
It is difficult to estimate the health impact of being insecurely housed or of 'sofa surfing' – in large part because we have no ready way of identifying the 'hidden homeless' who do not seek help from services. It seems likely however that this group of people is particularly vulnerable in terms of emotional wellbeing and mental health: being homeless is hardly conducive to happiness. There may well be other health impacts also – of living in damp or unsanitary housing, of having limited facilities for preparing fresh meals and so on.

We know much more about rough sleeping and health, which is reported as part of our local Joint Strategic Needs Assessment (JSNA). Rough sleepers typically have much higher than average health needs, particularly in terms of mental health, drug & alcohol dependency, physical trauma (especially foot trauma), skin problems, respiratory illnesses and infections.

Brighton Homeless Healthcare (Morley Street GP practice) provides a specialist primary (GP) care service to homeless people in the city. In terms of the practice population:

- Life expectancy is 70.3 years (the city average is 81.7)
- Mortality rates from coronary heart disease are *twelve* times greater than for the GP practice with the second highest rate
- A&E attendance rates are five times higher than the local average
- Emergency hospital admissions are four times higher than the local average
- Planned in-patient hospital admissions are a third lower than the local average
- Hospital re-admission rates are twice the local average[14]

Health, other than mental health, is not an area that the panel investigated in any depth. However, support officers to the panel were given the opportunity to attend a conference organised by SHORE (Sussex Homeless Outreach, Reconnection & Engagement), where together with Public Health colleagues they presented a workshop on homelessness and health needs to a range of homelessness professionals from across Sussex.

Several themes emerged from this workshop and from more general conversations with public health experts. These include:

[14] See Brighton & Hove Joint Strategic Needs Assessment Summary 2012: Rough Sleeping.

Identifying rough sleeper health needs. Rough sleeper numbers are relatively small, even in somewhere like Brighton & Hove. This can mean that the health needs of this group can easily get overlooked, with the focus of attention being big, population-wide issues such as smoking or obesity or on high prevalence/high impact conditions like cancer and dementia. However, the health needs of rough sleepers are so extreme that they can have a really disproportionate impact on services – e.g. in terms of requiring emergency admissions – and on health inequalities across the population. There is therefore a case, both in financial and in equalities terms, for services to think much more carefully about the needs of rough sleepers than their numbers alone might seem to justify.

Outreach services for rough sleepers. Rough sleepers typically live very chaotic lives and may struggle to make or keep appointments etc. This presents an obvious problem in terms of accessing health services, where patients are generally required to make an appointment days or weeks in advance or at the very least to spend several hours waiting in A&E or at a GP walk-in service. For many rough sleepers this simply isn't going to happen, meaning that they will only come into contact with health services when they have a crisis requiring emergency admission. Such admissions are very expensive, with outcomes much worse than for people whose conditions are properly supported via primary, community and secondary healthcare. What is required, therefore, is a range of 'outreach' services that meet the needs of rough sleepers, rather than expecting rough sleepers to negotiate the normal NHS access pathways.

In fact, there is a good deal being done already in Brighton & Hove in terms of homeless health. Homelessness is already needs assessed, and there is a dedicated homeless needs section in the city Joint Strategic Needs Assessment (JSNA). There is also a dedicated primary care service for homeless people run from the Morley Street surgery. Recent initiatives by Housing have included outreach work, with clinicians going into hostels and assessing and treating problems in situ. The city public health team is also fully involved in strategic housing partnerships.

Brighton Housing Trust also told the panel about a project they have been involved with, providing a 'Hostels Alcohol Nurse' who works intensively with the most alcohol dependant hostel residents in the city (particularly those who are currently not accessing medical treatment). This project has been very successful to date, with significant reductions in emergency call-outs, presentation at A&E, and hospital admissions saving an estimated £240,000 over 12 months.[15]

Another recent initiative is the Hostels Hospital Discharge Project. This is a partnership project between BHT, CRI, Riverside ECHG and Sussex Community NHS Trust. The project will target hostel residents who have

[15] More information on this initiative is included in **Section 2** of this report.

recently been discharged from hospital, seeking to provide high quality support which will reduce re-admission rates.[16]

In addition the Brighton & Hove Health & Wellbeing Board (HWB) recently agreed that the coming year's JSNA programme of specialist needs assessments should include additional work on homelessness – using the Homeless Link Health Needs Audit toolkit to better identify health needs across the local homeless community.

The HWB also recently agreed to establish a city multi-agency Programme Board to drive better integration of health and social care services for vulnerable 'homeless' people – a group including rough sleepers, but also people sofa-surfing or living in temporary accommodation, hostels, squats etc.

It is clear from the work mentioned above that the health and care needs of 'homeless' people are increasingly being recognised as an issue across services, and that active steps are being taken to accurately assess the scale of the problem and to develop effective joint working approaches. This is to be warmly welcomed.

The panel also welcomes the fact that the HWB has taken ownership of the issue of homeless health by establishing a Programme Board. We trust that the Programme Board will report regularly to the HWB.

RECOMMENDATION 1 Given the significance of homeless people in terms of city health inequalities, we welcome the fact that the Health & Wellbeing Board is taking an active interest in the health and social care needs of this group. We are very interested in the progression of this work, and request that the HWB's plans for homeless healthcare be presented to the HWOSC for comment within the next 12 months.

Targeted Support

Many homeless people have relatively few additional support needs. However, some people have very complex needs, including severe mental illness, learning disability, physical disability, problems with drugs & alcohol, a history of offending, traumatic personal histories, and so on. Often, the most complex clients may have a combination of these and other problems.

This relatively small group of people with very complex needs makes up a significant part of our local population of rough sleepers. This is unsurprising, as all of the above problems are potential risk factors in being unable to keep up a tenancy. Not only are people with complex needs much more at risk of becoming homeless than the general population, but they are typically much harder to help. Even if people engage with services it can be very difficult to support them properly – as they can be very challenging and may not be able to cope with the rules of support services, hostels etc.

[16] Information provided by BHT, Nikki Homewood and Andy Winter, informal meeting Jan 14.

In addition, people with complex needs are likely to need support from a number of services – housing obviously, but potentially also social care, NHS mental and physical health services, the police, probation and so on. There are obvious risks involved in having a number of agencies provide support to an individual, particularly in terms of duplication or of clients falling 'through the gaps'. This is particularly so since people with the most complex needs are unlikely to cope well with complexity – having to deal with a number of agencies can be confusing and may worsen rather than help some conditions.

Traditional means of supporting people with very complex needs have also been found to be too focused on the short-term – providing support for the here and now which may provide some topical assistance, but which does little to change people's behaviour significantly, and therefore little that is likely to reduce support needs going forward.

Where people with complex needs have to negotiate set support and care pathways there can be problems too. Rigid pathways for specific issues are unlikely to be suitable for people with cross-cutting needs; but if the only way to access appropriate levels of support is to follow a particular pathway, then people may end up going around in circles.

For example, Ellie Reed, a Complex Needs Social Worker with CRI, told the panel about a client of hers who has been evicted from city hostels more than 30 times. It was clear, and had been for a considerable time, that this client could not cope with a hostel environment – the rules, the business and noise and the presence of active drugs users were all factors making effective support via a hostel placement a practical impossibility. What was needed for this client was private, self-contained accommodation, where, with lots of appropriate support, there was at least a chance that he could settle.[17]

However, the pathway for homeless people requires users to cope successfully with living in Band 2 (hostel) accommodation before 'stepping-down' to Band 3 independent supported living. In general this pathway makes perfect sense – someone who has shown that they can cope with the rules-based approach of hostel living may well be more likely to succeed in an independent environment than someone who has gone straight from rough sleeping to independent living. But for certain people, the pathway through hostels is never going to be appropriate.

Following a long process of negotiation CRI have been able to circumvent the pathway in this instance and have placed their client directly into a 'training flat' normally used to support Band 2 to Band 3 transfers. This is a welcome outcome, but with a less rigid pathway this might have been achieved much more easily and at a point prior to many of the person's 30 plus evictions, avoiding a lot of stress to the user and saving services a very significant amount of money – because although the current arrangements require a high degree of support, this is likely to be insignificant compared to the costs

[17] Evidence from Ellie Reed, CRI, 07.02.13: point 8.6.

of repeatedly evicting someone, supporting them as a rough sleeper, finding them new hostel accommodation and so on.

There is a general point here as well as a specific one about over-rigid pathways: a great deal of money is spent 'supporting' people with complex needs through crises. This can include eviction and re-housing, but also in-patient admissions to hospital, anti-social behaviour of many kinds, and even prison. Given the extraordinary level of costs associated with some of these issues, it would seem to make obvious sense to target preventative support at those people most likely to cost the system large amounts in the long term. It is clearly also the case that, once people become habitual offenders, or rough sleepers etc. it is much more difficult and much more expensive to change their behaviour than if the intervention came at an earlier point.

Of course, services do work together to try to provide holistic support for their clients, and there are really good examples of innovative co-working. However, within traditional organisational restrictions there is only so much that can be done.

There is an interesting model for a more integrated way of working to support the most vulnerable currently being trialled. In recent years, some very vulnerable families across the city have been receiving targeted support – initially as part of the 'Troubled Families' initiative, latterly as part of an expanded nationally-driven programme, locally known as 'Stronger Families, Stronger Communities'. This initiative sees several hundred of the most vulnerable local households receiving targeted support and intervention from a multi-disciplinary team. Each family works with a single 'coach' who helps them manage their interactions with different support services, and ensures that support is appropriate to the client's needs, that it works towards achieving clear outcomes, and that the demands placed upon clients are realistic.

In combination with a better integration and focusing of existing support channels, the initiative also provides additional support, particularly in the form of general help with living: paying bills, making benefits claims, keeping the home clean, keeping appointments etc. The additional expense of this type of targeted help is recouped down the line, as effectively supported clients are less likely to make much more expensive demands on services at a later date – e.g. a family that pays the rent or claims the appropriate level of Housing Benefit will avoid rent arrears and therefore avoid the cost of debt collection or eviction. Since some of these long term costs are very expensive indeed, and since the households being supported are very likely to end up in serious trouble without early support, the cost of this additional support is likely to be considerably less than the cost of no additional support. And clearly, what is true in terms of funding is likely to be true in terms of the welfare of the people involved also.[18]

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[18] However, the notion that front-loaded investment in services will deliver a down-line savings has relatively little really high-quality evidence-base. Bec Davison of CRI suggested that it would be worthwhile to do some detailed mapping of the costs and benefits of this type of

The cost-benefit analysis of this type of intervention is clearest when the people being supported have problems which a) are very likely to escalate if not effectively treated, and b) are likely to cost a great deal to treat in the longer term. Whilst there are arguments for providing additional support to very broad populations, the cost benefit is less obvious here, as many of the people receiving additional support may not have developed bigger problems down the line. If there is a financial argument for targeted support therefore, it is likely to be strongest for clients with the most complex needs.

The panel believes that there are real opportunities in using the Stronger Families, Stronger Communities model of front-loaded, integrated support to target those rough sleepers with the most complex needs who are currently not well served by the existing homelessness and allied pathways. (To be clear the panel is not proposing that the Stronger Families programme be expanded to include vulnerable homeless people; merely that homeless people are supported via an integrated programme of practical support with a significant focus on making financial savings as well as improving the lives of services users – and Stronger Families is an obvious model of this type of scheme.)

In the first place, we propose that a cost-benefit analysis is undertaken, identifying the costs of providing additional targeted support to those rough sleepers with the most complex needs versus the likely future costs of continuing with current support methods. Such an analysis needs to reach beyond the local authority to include other services directly impacted by rough sleeping. This will potentially include the NHS, both in terms of mental health services, where there is a laudable recent history of successful integration and cost-sharing, but also in terms of physical health – rough sleepers are many times more likely to present for A&E treatment and to require unplanned hospital admissions than the general population, so there is a potential benefit to NHS acute providers and the commissioners of unplanned/emergency care here.[19] It may also include the police and fire services, probation and potentially the prison system – the costs of imprisoning people are very high and there is a strong correlation between rough sleeping and incarceration. Community and voluntary sector organisations in the city must also be involved in this calculation.

In some instances it may be the case that, even if it is possible to show that targeted support would result in a longer term saving, it is not feasible to persuade national agencies etc. to contribute to local initiatives. It would be very useful to have an idea of the absolute savings that could potentially be achieved across the board even if some of these savings cannot readily be realised, not least so as to be able to plan for lobbying of national agencies.

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model against the costs/benefits of the models currently in place. Evidence from Bec Davison, 07.02.13: point 8.10.

[19] As noted elsewhere in the report, there are current initiatives providing support for hostel residents with alcohol problems and for those recently discharged from hospital which might provide a useful source of data.

However, in the short term, the focus should be on those organisations where there is a realistic chance of partnership working and cost sharing.

One of the biggest difficulties encountered in supporting homeless people with very complex needs can be that this group is very likely to be wary of authority – for obvious reasons with individuals who feel they have been failed by services in the past or for people who have been in and out of prison. This issue is becoming better recognised, with one obvious solution being to increasingly rely on trusted, expert community sector organisations to do much of the direct interfacing with clients. In the type of targeted support approach outlined above, an absolutely key element is that of the 'care coordinator' who forms a relationship with and acts on behalf of the client. It may well be that this is a role that is be best carried out by non-statutory sector organisations, although equally there may be instances (e.g. where someone has a very complicated mental health problem) when it is better to have that role filled by a suitably qualified professional from a statutory agency.[20]

The panel were very interested to hear about the Big Lottery Bid application: this multi-partner application seeks funding to deliver more holistic services to homeless people with complex needs. Panel members were delighted to hear that the application was approved just before Christmas 2013.

This project is to be commended, but we need to go further: not just seeking external funding to deliver better targeted services to clients with complex needs, but actively reconsidering how the council and its key city partners use existing homelessness funding. There seems to be real potential to use resources more wisely: front-loading support for some clients may save money in the longer term as well as giving homeless people the best possible chance of getting some stability into their lives. In consequence, we hope that the Big Lottery work is viewed as a springboard to more intelligent co-working rather than as an end in itself.

It has also recently been announced that the council will establish a multi-agency board to oversee services focused on homeless people and community safety. This initiative is very much to be welcomed and it is heartening to see that city agencies are beginning to make real practical moves towards proper integration of services.

If this report had been written a few years ago, the panel might well have been calling for more integration of services across a landscape where different agencies worked largely within their own silos, even though many homeless professionals recognised and were lobbying for greater integration. At the present time, however, it is clear that much has changed, and that agencies have taken significant practical steps towards better integration.

This is good news for vulnerable homeless people and for the city as a whole. However, we are still a long way from truly integrated services, and there is a

[20] Evidence from Bec Davison, CRI, 07.02.13: point 8.5.

real danger that some of the current initiatives will fizzle out without having really advanced things, particularly in instances where a project is dependent upon lottery or other uncertain external funding. (In this context it is good to hear that partners are committed to continuing the project to provide integrated health and social care to vulnerable homeless people despite failing to win Department of Health Pioneer funding for the scheme.)

There is also a risk that we end up with a number of schemes to better integrate services for homeless and insecurely housed people, but that there is little or no effective integration of the schemes at a strategic planning level. While the various initiatives would still be valuable in themselves this would seem to risk missing some obvious opportunities. However, it also needs to be recognised that services are complex and that there may therefore be very good reasons for approaching better integration of, say, healthcare separately from community safety services.

In order to ameliorate these risks the panel proposes that the city council nominates a senior officer to act as a champion for homelessness service integration.

- The homelessness integration champion should have a brief to encourage the better integration of services across the city, in terms of both statutory agencies and other sectors.

- The homelessness integration champion should submit a report to both Housing Committee and the Overview & Scrutiny Committee (within 12 months of these panel recommendations being agreed by the relevant council decision-making committee). The report should detail the practical steps taken towards better integration over the past 12 months by the various schemes in operation, as well as plans for further development across the next year.

- The homeless integration champion will also be responsible for ensuring that the various projects for better integration of homelessness services are aware of each other's work programmes and are working symbiotically where there are advantages in so doing. Actions towards co-ordinating the move to better integration across the wide range of services to homeless people should also be detailed in the report to Housing Committee/OSC.

- The homelessness integration champion will also be responsible for collating information on the cost savings (or otherwise) achieved by better integration of services, both to include in the report to Housing Committee/OSC, and in terms potentially of establishing a more general business case for the value of service integration.

RECOMMENDATION 2 A senior BHCC officer should be appointed as 'homelessness services integration champion' across statutory services and other sectors.

Hostels
Traditionally, in Brighton & Hove and elsewhere, most single homeless people eligible for local housing support would be offered a place in a hostel. Hostels typically house a number of people in individual bedrooms, but with other areas communal. Hostels provide various levels of support, depending on the types of clients housed there. They are intended to be a relatively short term resource, with residents moving on to independent living or to lower support housing. However, progress on this pathway will depend on a client's ability to live independently: whilst some hostel residents are perfectly capable of managing a tenancy, others, particularly those from rough sleeping backgrounds are not, and require intensive support to develop these skills.

There is little doubt that hostels can be a very useful housing resource: for instance, it is generally more straightforward and more cost-effective to provide support to a number of people living together than to smaller groups or individuals. Nikki Homewood of BHT told the panel that city hostels could be extremely effective, delivering really good outcomes in terms of supporting people to move on to independent living. Hostels are not just shelters, but places from which a wide range of support services can potentially be delivered efficiently.[21]

However, there are also some quite significant problems associated with hostels. Firstly, the hostel environment may simply be unsuitable for some clients. This may be particularly the case for people with particular mental or physical health problems or learning disabilities who cannot cope with group living. For others, particularly for those trying to recover from drug or alcohol misuse, hostels are a difficult environment because some residents may be using such substances. Other people may simply be unable to obey the rule-based system that hostels need to employ to deal safely with high-needs residents.[22] It seems perverse to attempt to house people genuinely unable to cope with group accommodation in an environment that may serve to exacerbate rather than reduce their support needs.

Secondly, the fact that hostels bring together a number of people who may tend to have problems with offending, anti-social behaviour, mental health problems and drug or alcohol misuse can create significant problems for local communities. It is evident that the size of hostels is a factor here: the more people with high support needs who are housed together, the more likely it is that they will interact badly.[23] Although a good deal can be done to reduce the impact of anti-social behaviour associated with hostels, particularly in terms of the support provided to hostel residents, the presence of hostels in residential areas remains problematic.

Thirdly is the issue of location. For historical reasons our hostels tend either to be located in central Brighton near the seafront, or close to London Road or

[21] Evidence from Nikki Homewood, BHT, informal meeting Jan 14.
[22] Evidence from Narinder Sundar, Commissioning Manager, BHCC Housing, 07.02.13: point 8.6.
[23] Evidence from Sylvia Peckham, 25.01.13: point 3.10.

St James Street. This concentration of accommodation means that there is a disproportionate impact on some communities. It is also unfortunate that so many of our hostels are close to areas associated with anti-social behaviour, drug-dealing and street drinking.[24] For people who are trying to be abstinent such environments pose obvious challenges. (It's evidently not just coincidence that the areas with most hostels are the places where there are problems with street-drinking etc – part of the problem is the behaviour of some hostel residents. However it's also clear that somewhere like Brighton sea-front is going to be a hot spot for substance misuse and anti-social behaviour whether or not hostels are clustered there.)[25]

The panel heard from housing officers that a pilot initiative had seen a small hostel opened at a location a little out of the city centre, and that results had so far been positive, with a reduced level of drink and drugs-related anti-social behaviour from residents, and relatively few problems caused for the local community.[26] However, it should be noted that this hostel houses people with relatively low support needs.[27]

It does seem as if there is some potential to make hostel provision more diffuse, with less reliance upon large central Brighton hostels in favour of smaller units in slightly less central areas. If effective, this would help to reduce anti-social behaviour from hostel residents and reduce the impact upon local communities, particularly those in city centre wards.

RECOMMENDATION 3 the council needs to take action to diversify its 'stock' of hostel accommodation, seeking to spread hostels more evenly across the city, and to offer a range of accommodation options in terms of hostel size and the level of support on offer.

This still leaves the problem of people for whom hostel accommodation is never going to be a feasible option. At the moment there is no realistic alternative for these clients. This seems unacceptable, since people with the type of complex needs that make it impossible to effectively place them in hostels are not going to magically find a housing solution without intensive support. Instead they are likely to end up in a 'revolving door' – rough sleeping until they are placed in a hostel, evicted from the hostel and then rough sleeping again until they are placed in another hostel. This is clearly a poor way to support highly vulnerable people and a potential waste of money.

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[24] Evidence from Sylvia Peckham, BHCC Head of Temporary Accommodation and Allocations, 25 January 2013: point 3.11.

[25] BHT told the panel that a recent local count of street drinkers run by Equinox had shown that, perhaps contrary to received opinion, the majority of persistent street drinkers are not hostel residents, and that a relatively small percentage of city hostel residents are in fact street drinkers. Of 93 people identified as street drinkers, 35 were hostel residents. Of the 35 people identified as high profile regular street drinkers, 16 were hostel residents. This is under 6% of the city's hostel population (288). This suggests that hostels work effectively to minimise the problematic street presence of their residents (evidence provided by BHT: included in **Section 2** to this report).

[26] Evidence from Sylvia Peckham, BHCC Head of Temporary Accommodation and Allocations, 25 January 2013: point 3.11.

[27] Evidence from BHT: informal meeting Jan 14.

Some witnesses to the panel suggested that we should move away from the hostel model entirely, seeking instead to focus on much smaller units, or on housing people individually with support.[28] In the short term it seems highly unlikely that we would or could abandon the hostel model, but it is important there should be alternatives for those clients for whom hostels are an ineffective housing option. This should include smaller scale supported housing as well as supported independent housing. Although this type of supported housing may seem considerably more expensive than accommodating someone in a hostel, it is unlikely to be more expensive than *failing* to accommodate someone in a hostel.[29] This is an option that has been successfully explored by local authorities in Westminster and Oxford,[30] although housing officers did point out that, whilst offering alternatives to hostel accommodation may initially appear an attractive option, it does depend on there being appropriate housing stock available, which may pose a problem locally given the high demand for social housing.[31]

RECOMMENDATION 4 we need a more diverse range of supported accommodation available to house single homeless people, particularly those with very complex needs. Whilst this is clearly not going to happen overnight, we would welcome a commitment to move to a model of greater diversity coupled with at least some practical action in the short term.

Service Mapping and Member Engagement

Everyone knows that homelessness is a major issue in Brighton & Hove. However, beyond this general perception of there being a problem, there is relatively little detailed public understanding of homelessness as an issue. Indeed, the panel members were struck by how little *they* actually knew about homelessness services, and just how wide-ranging services actually are. As part of the scrutiny review process, members talked widely to officers in the council's housing service and other homelessness support providers. They also visited several services for homeless people, including hostels, drop-in centres and B&B accommodation, talking with staff and service-users.[32]

It quickly became apparent that services for homelessness are a complex mosaic, involving at least two council housing teams, NHS commissioners and providers, Community Safety, Public Health, the police and probation services, and a wide range of community and voluntary sector providers – some commissioned by the city council or the NHS, others independently funded and operating to their own agenda.

[28] Evidence from Bec Davison, CRI, 07.02.13: point 8.7, and from Ellie Reed and Sarah Gorton: point 8.15.
[29] Evidence from Bec Davison, CRI, 07.02.13: point 8.7.
[30] Evidence from Sarah Gorton, Homeless Link, 07.02.13: point 8.7.
[31] Evidence from Narinder Sundar, 07.02.13: point 8.8.
[32] Panel members visited First Base Day Centre, Phase 1 Hostel, New Steine Mews Hostel, Glenwood Lodge Hostel and the West Pier Project. Members also took part in the annual rough sleeper street count and attended a service-user event where they interacted with Business Action on Homelessness. As part of the panel process, support officers met with BHT and co-ran a workshop session at the SHORE conference.

Complexity is not necessarily a bad thing. In some instances very complex service arrangements may work superbly well. It may also be that there is an irreducible complexity inherent in homelessness services – because the problems cut across so many services and concern so large a number of partners, and because there is so much long-standing public and charitable concern around homelessness. It may well be that there is very limited potential in terms of further integrating or streamlining this map, and indeed there may be major benefits from having multiple approaches and solutions to the problem of homelessness.

However, whilst the local map of homelessness services is doubtless fully understood by the relevant housing professionals, and makes perfect sense to those whose core job is homelessness, from the point of view of potential service users, or even of people working in the police or the NHS, the complexity threatens to be bewildering.[33] If the people who need to use a service are unclear as to what services are actually available and how to access them, they are unlikely to have a positive experience.

Whatever the actual organisational and partnership complexity of homelessness services therefore, there is a clear need for a readily comprehensible map of services – something that offers a simple picture of the services on offer across the city.

RECOMMENDATION 5 the council needs to produce a clear map of statutory and non-statutory homelessness services across the city and make it available via the its website.

In a similar vein, the Council's elected members have ultimate decision-making powers in relation to homelessness services (at least in terms of services commissioned or provided by the city council), but members' understanding of homelessness as an issue and of the types of services on offer is often very limited (excepting of course Housing Committee members). The panel members were very impressed by the services they visited or were told about, and by the obvious competence and dedication of the people working in them. We think that there would be value in the housing team doing more with elected members, both in terms of homelessness as a strategic concern and in terms of the practical services on offer and how they can be a resource to ward Councillors. Improving the information available to elected members is likely to lead to a better understanding of the importance of homelessness services. This is particularly important as homelessness cuts across services, meaning that decision-makers in areas other than housing would benefit from greater knowledge of the issue.

This was reinforced by evidence from Sarah Gorton, the South East Regional Manager for Homeless Link, a national membership organisation for organisations working in the field of homelessness. Ms Gorton highlighted the

[33] Evidence from John Child, Deputy Service Director, Sussex Partnership NHS Foundation Trust, 07.02.03, point 8.19.

importance of involving elected members in homelessness services, and commented:

"It was really good to see members from all parties interested enough to come on the rough sleeper count and impressive to attend the scrutiny panel meeting and witness the genuine desire from Councillors to engage in the issues and to think about what needs to change."[34]

Other witnesses, including Central Sussex YMCA, reiterated the importance of elected member involvement in homelessness issues.[35]

As Brighton & Hove City Council operates a committee system, we already have a relatively high degree of cross-party member involvement in homelessness issues via the BHCC Housing Committee. There is also direct elected member involvement in the local Strategic Housing Partnership. In addition the city Health & Wellbeing Board will be involved in monitoring the soon to be established Programme Board for integrated homeless health and social care.

There is therefore already a good base of relatively expert members to build on. This should be reinforced via the member training programme. The panel is pleased to note that the member seminar programme already includes training on homelessness issues, and trusts that there will be further training scheduled.

Pathways

Service pathways set out how service-users access and progress through a system and are an important tool for professionals. Homelessness pathways need to be simple enough for service users and non-housing professionals to understand and they need to be flexible enough to avoid bottlenecks and perverse outcomes. It is not necessarily an easy task to devise a pathway through services that is easily understood and appropriately flexible, and even the most robustly designed pathways need periodic tweaks.

The panel heard evidence that aspects of homelessness pathways were not working as well as they should. For instance, CRI told us that homeless pathways demand that homeless people accessing band 3 unsupported accommodation must first have progresses through band 2 supported accommodation (i.e. hostels). For most clients this may make perfect sense, as people who have successfully lived in group accommodation are well placed to take on the additional responsibilities associated with independent living – many rough sleepers would not cope well if immediately moved into unsupported accommodation. However, for a small group of people with complex needs, progress through band 2 is much more problematic, and a better alternative might be to house them directly in band 3 housing with appropriate levels of support.[36] In this particular instance it seems likely that a

[34] Email from Sarah Gorton, SE Regional Manager, Homeless Link
[35] Evidence from Central Sussex YMCA, 19.02.13: point 13.35.
[36] Evidence from Ellie Reed, CRI, 07.02.13: point 8.6.

generally sensible policy has had perverse consequences, and some relaxation of the pathway rules would be desirable.

Other witnesses suggested that the homeless pathways be amended to provide more robust learning and work support[37], or that a dedicated young people homeless pathway be established.[38] The panel is pleased to note that the city council is actively seeking to develop a young person housing pathway.[39]

RECOMMENDATION 6 – homeless pathways should be revised to allow clients to progress directly into band 3 support when it is clear that there is no realistic possibility of them progressing successfully through band 2 support.

Setting local levels of support

Homeless is not a localised issue. Whilst the majority of homeless people in an area are likely to be from that area, by no means every homeless person will be. Some destinations are inherently more appealing than others for rough sleepers. Factors which make a particular area attractive include: climate, levels of street violence, the presence of an established rough sleeping 'community', access to drugs, the availability of non-statutory support (food, sleeping bags etc), and the relative generosity of statutory sector support.

A number of these factors apply to Brighton & Hove and it is therefore no surprise that the city has to deal with a disproportionate number of rough sleepers. Of course, there's not much we can do about the weather, and some of the things that make Brighton & Hove attractive to rough sleepers are also the things that make the city attractive to tourists or businesses, so we'd be unlikely to want to change them even if we could.

However, there is more opportunity to influence some of these factors, most obviously in terms of statutory services. Every upper-tier local authority is required to provide a legal minimum level of homelessness services, but providing additional levels of service is optional. In practice this can mean that neighbouring authorities may offer significantly different levels of service, and if this is the case there is an obvious danger that homeless people will migrate from areas of low to areas of higher support, increasing pressure on those areas that have already done the most to address homelessness problems.

One solution to this issue would be to recommend that local support was provided at the legal minimum level. However, there are a couple of potential problems here. Firstly, there is an ethical dimension to be considered with regard to any decision about providing services to vulnerable people: we may not feel that the legal minimum is sufficient. Secondly, not all rough sleepers will necessarily go elsewhere if support services are cut. It is likely that we

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[37] Evidence from Rob Liddiard, Friends First, 19.02.13: point 13.35.
[38] Evidence from Stuart Kitchenside, Sanctuary, 19.02.13: point 13.35.
[39] BHCC Draft Joint Commissioning Strategy: Housing & Support for Young People aged 16-25 (presented at BHCC Children & Young People Committee 14.10.13).

would continue to have significant numbers of people sleeping rough in the city irrespective of the level of support offered. But without support it is also likely that these remaining rough sleepers would be at greater risk and present greater risks to the local community. There is therefore a pragmatic balance to be struck in terms of setting a level of support that does not needlessly attract out-of-area rough sleepers, but which ensures that the impact of those rough sleepers who are bound to remain is minimised.

Whilst it may never be possible to guarantee that a local area's approach to homelessness will exactly tally with those of its neighbours, it is obvious that all practical steps should be taken to synchronise approaches in order to minimise the migration of homeless people from one area to another. The panel heard evidence from John Routledge of SHORE (Sussex Homeless Outreach, Reconnection and Engagement). SHORE seeks to bring statutory and non-statutory providers of homelessness services across Sussex together to share best practice and plan more effectively.[40] We are pleased to note that the council's housing service is actively engaged with the SHORE initiative: it clearly makes sense to share as much information and expertise as possible with our neighbours, even if we may have differing views on how to deal with homelessness.

In very practical terms, it is difficult to not provide some sort of support to homeless people living locally even if they have no local connection. In theory such people should return to wherever they do have a local connection and receive support there. However, recent years have seen many local authorities becoming more reluctant to accept their duty to house such people, and Brighton & Hove will not relocate homeless people unless there is appropriate support in place for them, so in practice we do provide services to a number of people who have no local connection.[41]

It seems to us that there is really good work already going on across local authority boundaries here, and we therefore have no specific recommendation to make.

Domestic Violence

There are many reasons for people becoming homeless, and although all homeless people are potentially vulnerable, some are especially so. People fleeing their homes because of domestic violence are obviously homeless. However, in order to be eligible for local authority help under housing legislation, applicants have to meet five criteria, including whether they are 'intentionally homeless' and whether they have a 'local connection'. Both of these can cause problems for people who have experienced domestic violence.

In terms of 'intentionality', people who simply abandon a tenancy for no good reason are likely to be deemed 'intentionally homeless' and therefore

[40] See evidence from John Routledge, SHORE, 07.02.13: point 8.13.
[41] Evidence from Bec Davison, CRI, 07.02.13: point 8.4.

ineligible for housing support. Whilst experiencing domestic violence would probably be considered a valid reason for abandoning one's home, it may be no simple matter to prove this, particularly in instances where people are too scared to involve the police, or where long term abuse has never been reported to the authorities, meaning that there is no documented history to refer to. It is frequently the case that people suffering from domestic violence do not report their abuse

In terms of local connection, it is evident that people forced to flee their homes may not feel safe in their local areas. Whilst some people may have family or friends in other parts of the country, others will not, and may well have little choice but to move to an area where they have no connections – indeed such an area may be the safest place for them. However, having a local connection is one of the criteria by which homeless applications are judged. Again, there should already be enough flexibility in the system to ensure that someone genuinely fleeing domestic violence is able to access housing support wherever they have settled. Housing legislation effectives waives the requirement to have a local connection if you can show that you have no connection to any locality (for example if you've been serving with the armed forces for a length of time), or if you can prove that the places where you have an established connection are unsafe. However, the problem is again that it may not necessarily be easy for someone to prove that they are at risk, particularly if they do not have a well-documented history of domestic violence.

The city council is committed to supporting the victims of domestic violence, and this should clearly include helping people access housing services to which they are statutorily entitled. However, the council cannot simply take people who claim to be the survivors of domestic violence at their word. Even if the overwhelming majority of such applicants are genuine, this would leave a loophole for fraudulent applications, and a loophole that would probably get larger over time. This does not mean that the local authority should not continue to adopt as sensitive an attitude to domestic violence as possible, recognising that the great majority of people who claim to be fleeing abuse are indeed doing so, and that a necessarily robust system of checking must be designed not to deter genuine cases.

The panel recommends that future housing strategy reviews should specifically address the needs of people fleeing domestic violence. We also recommend that staff induction and training should ensure that those assessing eligibility for housing are aware of the common issues relating to intentionality and local connection outlined above, and that guidance to assessment teams should make it clear that the city council is committed to supporting survivors of domestic violence in accessing all services to which they are entitled.

Where the council knows that people have been affected by domestic violence, it could also explore using more flexible forms of tenancy. People suffering domestic violence may, regrettably, have to move at short notice for their own safety. It seems perverse to hold people in these circumstances

responsible for breaching a tenancy agreement or to make them forfeit their deposits.[42]

RECOMMENDATION 8 New and refreshed BHCC housing strategies must explicitly address the housing needs of victims of domestic violence.

RECOMMENDATION 9 Training for housing staff dealing with homeless applications must explicitly include information on domestic violence.

LGBT people

Jess Taylor of RISE told the panel that there was a real issue with LGBT people being made homeless because of their sexual orientation or gender identification - especially in terms of young people 'coming out' and being rejected by their families. The consequence of this is that LGBT people are typically over-represented amongst rough sleepers (up to 30% of rough sleepers in urban areas identify as LGBT, whereas the general LGBT population is rarely more than 10-15%).[43]

Facing being ostracised or harassed at home, many LGBT people gravitate to urban areas with a reputation for being inclusive, as do lots of people who simply want to live in an LGBT-friendly environment. Brighton & Hove is obviously a popular choice as an LGBT-friendly destination, and there are significant economic and cultural benefits for the city here.

Jess Taylor told the panel that domestic violence is typically under-reported, and this is likely to be even more so across the LGBT community, with many people reluctant to divulge details of the sexual or gender identity to the police or other authorities. Locally, the level of formally reported LGBT domestic violence is very low, but this is totally at odds with all qualitative data, such as the Count Me In Too survey, and is likely to indicate that there is an endemic problem of under-reporting in the city.[44] Peter Castleton of the council's Community Safety team echoed this point, telling members that official crime figures tended to under report both domestic violence and crimes against the LGBT community.[45] Homeless LGBT people, particularly younger people, may also be particularly vulnerable to domestic violence and to being coerced into providing sex in return for shelter, although this is not a problem unique to LGBT communities.[46] There is currently no local refuge provision or other safe space for men or trans men affected by domestic violence, although there is some provision for trans women. [47]

[42] Evidence from Jess Taylor, 19.02.13: point 13.12.
[43] Evidence from Jess Taylor, RISE, 19.02.13: point 13.2.
[44] Evidence from Jess Taylor, 19.02.13: point 13.5.
[45] Evidence from Peter Castleton, BHCC Community Safety, 19.02.13: point 13.5.
[46] Evidence from Jess Taylor and from Peter Castleton, 19.02.13: point 13.7.
[47] Evidence from Jess Taylor, 19.02.13: point 13.8.

Recent changes to Housing Benefit have capped payments to under 35s, meaning that people can only claim for the cost of a room in a shared house rather than for independent accommodation. For some LGBT people, particularly those who have already suffered domestic violence, this can be problematic, as people may not feel safe living with relative strangers who may target them for their gender orientation or sexual identity.[48]

Jess Taylor noted that LGBT people who do become estranged from their friends and family after coming out are much more likely than the general population to lack 'social capital' – the types of informal support that typically prevent homeless people from becoming rough sleepers.[49]

Ms Taylor told members that some LGBT people report encountering problems when attempting to access housing services – e.g. difficulties with staff who are unsympathetic or who do not understand LGBT issues. This is something that was also noted in the Count Me In Too survey of local LGBT communities and has been widely reported anecdotally. Ms Taylor suggested that this problem should be dealt with by ensuring that housing staff receive proper training in dealing with and signposting for LGBT customers (e.g. the type of training provided by Allsorts).[50]

Older LGBT people can feel very isolated, perhaps particularly those who are living in sheltered housing schemes where LGBT identities are not always well understood or accepted. Jess Taylor pointed out that there is no dedicated LGBT sheltered housing in the city and little acknowledgement of LGBT concerns across existing sites.[51]

The panel recommends that future homelessness strategies should explicitly address the needs of LGBT people, recognising that Brighton & Hove is particularly likely to attract those who have been unable to live free of harassment in other areas. We also recommend that staff induction and training should ensure that those assessing eligibility for housing are aware of the common issues relating to intentionality and local connection outlined above, and that guidance to assessment teams should make it clear that the city council is committed to supporting LGBT people in accessing all services to which they are entitled.

RECOMMENDATION 10 New and refreshed BHCC housing strategies must explicitly address the housing needs of LGBT people.

RECOMMENDATION 11 Training for housing staff dealing with homeless applications must explicitly include information on LGBT needs.

[48] Evidence from Jess Taylor, 19.02.13: point 13.9.
[49] Evidence from Jess Taylor, RISE, 19.02.13: point 13.6.
[50] Evidence from Jess Taylor, 19.02.13: point 13.10.
[51] Evidence from Jess Taylor, 19.02.13: point 13.11.

Young people

There are specific problems associated with young homeless people. In the first place, homelessness is a growing problem for young people as it is for other demographic groups. But there are also changes within the group of young people presenting as homeless. Stuart Kitchenside from Sanctuary told members that the profile of young people being supported by Sanctuary had changed significantly in the past five years, with a rise in younger applicants (16-17 rather than 20-25) coupled with increasingly complex support needs. This has a resulted in a changed emphasis for support services, moving from a focus on preparing young people for further/higher education to teaching basic coping skills.[52]

Sussex Central YMCA agreed, but noted that the need to concentrate on young people with complex support needs shouldn't distract people from the fact that demand for services was increasing across the whole of the demographic – the YMCA has seen client numbers increase six-fold in the last six years (from 100 to 600). By no means all of these young people have high support needs, but young people (i.e. 18-21) with no job, no employment history, credit history, guarantors or references, and with limited independent living skills, are competing for properties against students and young professionals and are unsurprisingly losing out. There is an obvious need for a focus on this issue: supporting young people to stay in the family home for longer, teaching living skills, and providing sufficient supported accommodation for those who cannot realistically find or maintain private sector tenancies.[53]

Supporting younger homeless people with high needs is a specialist job: when young people have had bad experiences with families and school they may not thrive in a rules-based environment. It is therefore important that service providers are able, and are enabled by commissioners, to work flexibly and appropriately with young people, delivering against outcomes rather than process targets. This work is necessarily long term, and typically does not fit the 2 year support plans that Supporting People funding requires. Mr Kitchenside noted that housing commissioners had been very progressive in these respects, recognising how complex and delicate work with young people has become and relaxing their rules to accommodate this – although there was always more that could be done.[54]

It is not totally clear why the profile of young homeless people has changed so much recently. Stuart Kitchenside suggested that it may reflect the increasing lack of jobs for low-achieving young people – a problem exacerbated in Brighton & Hove by the large student and graduate populations competing with local people for low-skills jobs. This lack of available jobs may discourage young people from trying to gain the skills that might make them employable.[55] Sussex Central YMCA agreed, but added that there was also a

[52] Evidence from Stuart Kitchenside, 19.02.13: point 13.13.
[53] Evidence from Sussex Central YMCA, 19.02.13: point 13.33.
[54] Evidence from Stuart Kitchenside, 19.02.13: point 13.14.
[55] Evidence from Stuart Kitchenside, 19.02.13: point 13.18.

general issue of 'extended adolescence' with young people taking on 'adult' attitudes and responsibilities much later in life. This could be seen across the social spectrum and was not necessarily a problem for privileged/high achieving young people, but could be a significant issue for young people who cannot rely upon parental support, and especially for those with other vulnerabilities such as mental health problems, learning disabilities, or experience of unstable childhoods.[56]

Support services are sensibly focused on getting their young clients into work. However, in practice this can be complicated by the claw-back of benefits and Supporting People funding from people who do find work. This may leave them no better off than before and could act as a further disincentive. Moreover there is a risk that vulnerable young people who are successful in finding work could be deemed as no longer in need of Supporting People funding and be therefore required to find private sector housing. Whilst this move-on might sometimes be appropriate, if applied indiscriminately it could end up ruining the progress of young people who have responded really well to support by moving them into unsuitable accommodation before they are truly ready to be moved.[57]

Indeed it may not be wise to assume that young people can easily access private sector housing. Stuart Kitchenside noted that it can be almost impossible for young people to get private tenancies as landlords are reluctant to house them, preferring 'easier' and more remunerative student or young professional tenants. Encouraging private landlords to take a more positive view of young tenants would therefore be valuable.[58]

Mr Kitchenside also told members that there is currently no dedicated service pathway for young homeless people, meaning that younger clients are expected to use the adult homelessness pathways. There is a real danger here in exposing vulnerable and easily-influenced young people to entrenched homeless adults and indeed to professionals whose main point of reference is that of entrenched service users. The risk is that young people will effectively be encouraged to view homelessness as a norm, as well as being exposed to resources which are really not appropriate for young people.[59] Sometimes there may be an advantage in accommodating some young people in adult schemes, particularly for those people who cannot settle in age-appropriate hostels, but this should be determined by the support needs of the individual not because pathways are too rigid or because there is a lack of age-appropriate places.[60]

Sussex Central YMCA noted that there is not enough supported accommodation for young people, with long waiting lists for hostels meaning that too many young people are housed in inappropriate B&B accommodation. There is a particular frustration here as B&Bs are both

[56] Evidence from Central Sussex YMCA, 19.02.13: point 13.18
[57] Evidence from Central Sussex YMCA, 19.02.13: point 13.19.
[58] Evidence from Stuart Kitchenside, 19.02.13: point 13.20.
[59] Evidence from Stuart Kitchenside, 19.02.13: point 13.16.
[60] Evidence from Stuart Kitchenside, 19.02.13: point 13.17.

expensive and typically poor environments for vulnerable people – providing sufficient hostel capacity would potentially be cheaper in the short term and would deliver even bigger long term benefits as it would provide a living environment designed to reduce people's vulnerabilities rather than one likely to exacerbate them. There are particular capacity issues in terms of supported accommodation for young people with mental health, substance misuse or learning disability issues.[61]

When addressing the housing needs of younger people it is also important to think holistically. If young people are not work ready, lack the types of skills or qualifications needed to enter the job market or the skills necessary to live independently, then finding them housing is likely to offer only a very partial solution to their difficulties. Rather, housing support needs to be delivered alongside other types of support, and any strategy aimed at younger homeless people needs to recognise that solutions will need to be much broader than the provision of shelter.

The recently published BHCC Draft Joint Commissioning Strategy: Housing & Support for Young People aged 16-25 addresses a number of the points raised above. In general the draft strategy should be warmly welcomed. However, it is unclear whether the strategy will seek specifically to address issues concerning the growing number of young people with high/complex support needs, the supply of specialist supported housing for young people, and 'holistic' support which focuses on work-skills as well as housing support. We feel that these are important areas and should form part of future service planning for young people at risk of homelessness, potentially as part of the Joint Commissioning Strategy.

RECOMMENDATION 12 Relevant new and refreshed homelessness strategies (e.g. the Joint Commissioning Strategy for Young people) should explicitly address need with regard to:

- **services for young people with high support needs;**
- **ensuring that there is sufficient specialised housing to support young people;**
- **the need to deliver 'holistic' support to young people (i.e. helping make young people work ready at the same time as housing them)**

Community Safety/Policing

Peter Castleton of the BHCC Community Safety Team told members that local services for rough sleepers involved the council working in partnership with the police, with BHT and CRI, and with a number of community and voluntary sector organisations, both to discourage rough sleeping and to provide outreach support to those who nonetheless rough sleep.[62] The

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[61] Evidence from Sussex Central YMCA, 19.02.13: point 13.34.

[62] Also important in this context is the Co-ordinated Agency Intervention to End Rough Sleeping Approach (CAIERS). This new multi-agency project, led by BHT and CRI seeks to plan and co-ordinate support to end rough sleeping on a case-by-case basis, prioritising the most entrenched and vulnerable service-users. To date this project has been very successful. More information, supplied by BHT, as included in **Section 2** to this report.

intention is to protect rough sleepers – from other rough sleepers and from 'external' threats - and to minimise the impact that rough sleeping has on settled communities. In general services are very good, as demonstrated by the fact that the number of rough sleepers locally has increased significantly in recent years without a similar increase in complaints about them.

However, there are still some major problems. These include a very high homicide rate within the rough sleeping community; very high levels of harassment and abuse of rough sleepers - particularly by drunk people in the centre of town - poor reporting of harassment by rough sleepers; and rough sleepers being used for forced employment. There is also a considerable cross-over between the rough sleeping community and other groups – most notably street drinkers. This means that rough sleeper problems can spread to other areas – as when housed street drinkers invite rough-sleeping street drinkers back to their flats.[63] Brian Doughty, Head of BHCC Adult Assessment, added that a significant problem for adult social care was 'cuckooing', where vulnerable tenants were targeted by homeless people who would 'befriend' them before moving in with them and exploiting them. Again this is a cross-agency problem and a joint protocol is being established to help deal with it.[64]

Mr Castleton told members that support for rough sleepers needed to be carefully targeted. Some rough sleepers are actually incredibly resilient and do not need (or want) high levels of support.[65]

Bec Davison of CRI agreed that the police and community safety teams had made great strides in recent years to understand and develop links with homeless people (e.g. via the Street Community Policing Team), and this was to be commended. However, there was a risk that a focus on building relationships with the homeless community meant that anti-social behaviour committed by rough sleepers might be ignored for fear that enforcement would alienate those with whom the police were trying to build bridges.[66] John Child noted that Sussex Partnership NHS Foundation Trust (SPFT) had experienced parallel problems, with the police reluctant to use appropriate enforcement measures when dealing with mental health service users.[67]

Employment support

Many homeless people lack qualifications, job experience or even the most basic work skills, either because they have never had them or because the trauma they have experienced has effectively de-skilled them. If people are to eventually live normal, settled lives it is clearly vital that they have the necessary skills to live and work independently. It is therefore important that, in addition to providing shelter, services for homeless people enable their clients to develop work and learning skills.

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[63] Evidence from Peter Castleton, BHCC Community Safety, 19.02.13: point 13.25.
[64] Evidence from Brian Doughty, 19.02.13: point 13.23.
[65] Evidence from Peter Castleton, 19.02.13: point 13.28.
[66] Evidence from Bec Davison, CRI, 07.02.13: point 8.16.
[67] Evidence from John Child, Sussex Partnership NHS Foundation Trust, 07.02.13: point 8.7.

The panel heard from Rob Liddiard and Adrian Willard of Friends First. Friends First is a small voluntary organisation that provides a range of services for homeless people, including drop-in provision, supported accommodation, a move-on house and a working farm. Friends First aims to support homeless people to develop work skills by giving them experience of working – either in building or market-gardening. The intention is to teach general work-related skills, such as being punctual and reliable, rather than very specific skills. Mr Liddiard noted that this was a relatively undeveloped idea in terms of local homeless provision, but that there was considerable merit in the concept of a 'working hostel' environment as becoming work-ready was an important part of reintegrating homeless people into the community.[68] The use of a rural setting for some of these services has advantages in terms of avoiding some of the distractions of a city centre environment, although few Brighton & Hove homeless people would choose or be well-adapted to living permanently in a rural environment.[69]

The panel heard that there was a significant practical problem with running the Friends First market garden: Jobcentre+ refuses to accept that clients being trained via the market garden are undertaking genuine job-training and requires them to sign-on as usual. It can easily take claimants half a day's travel to do so, and this is unsettling for the service users as well as being a waste of time that could have been spent on work training. What seems particularly nonsensical is that the people training at the market garden are by definition lacking in the kind of skills that would make them employable, so they are being made to 'sign-on' to show that they are actively seeking jobs they cannot hope to obtain rather than spending the time learning skills that might make them employable.[70]

We are aware that this type of problem is not limited to Friends First, but has been encountered by a range of groups supporting homeless or formerly homeless people. It seems to be the case that Jobcentre+ has limited room for manoeuvre here, being obliged to act in accordance with central Government guidance. After lobbying by local third sector organisations Jobcentre+ has agreed to classify some schemes in such a way as to minimise the need for service-users to sign-on. Voluntary organisations have also agreed to seek the relaxation of sign-on rules only in situations where they are providing core employability skills, not in situations where they are teaching more generic skills like IT literacy.

We welcome this compromise brokered by local voluntary sector organisations and by Jobcentre+. However, although the situation is better than it was, only a partial solution has been achieved – what is really needed is more constructive central Government guidance which actively encourages the up-skilling of homeless and insecurely housed people as an essential part of re-integrating them into society.

[68] Evidence from Rob Liddiard, Friends First, 19.02.13: point 13.30.
[69] Evidence from Adrian Willard, Friends First, 19.02.13: point 13.31.
[70] Evidence from Rob Liddiard, 19.02.13: point 13.32.

RECOMMENDATION 13 the Council should consider lobbying central Government (on the issue of people who are receiving employability training being required to attend the Job Centre to sign-on), reflecting the concerns of local voluntary sector providers that the rules dictating the ability of Jobcentre + to relax its signing-on requirements are still too inflexible.

Private landlords

With little or no space available in social housing in Brighton & Hove and local property prices unaffordable for many people, the private rented sector has assumed increasing importance in recent years. However, to access private sector housing, homeless people have to compete against several other groups, including professionals (some of whom might previously have bought property, but are now unable to find deposits or a mortgage) and students, whose numbers have increased in recent years.

With demand effectively outpacing supply in the local housing market, landlords and letting agents have become increasingly choosy about the tenants they take on, seeking to minimise their exposure to risk by demanding hefty deposits, references, undertaking credit checks and only renting to those in steady employment. (Letting agents typically insist on these checks being carried out *and* charge large sums to process them.) These checks and charges can present a formidable barrier to people trying to access housing, particularly for those with limited financial resources, and can mean that people are in a position where they are in employment and able to pay a commercial rent, but still can't get a tenancy.

The situation is likely to be much worse for people with a chequered housing history – for instance people with mental health or learning disability problems that have meant they have struggled to pay rent on time, or to keep their properties clean etc. Vulnerable people like these are obviously unlikely to be able to compete effectively against professionals in an open housing market. One way of dealing with this is to try and ensure that vulnerable people currently in tenancies are not evicted (there is a particular urgency here for local authorities which are likely to have to provide long term support for vulnerable people if they can't live successfully in the private rented sector).

There is therefore a clear need for local authorities and other agencies involved in homelessness to work closely with private landlords to try and support vulnerable tenants in their private sector tenancies and avoid evictions which are likely to be bad news for the individuals affected and for statutory support services. The council's housing teams already do a good deal of work in this respect, both at an operational level and at a more strategic level via the city Strategic Housing Partnership, and this work is to be commended.[71]

[71] Evidence from Narinder Sundar, 07.02.13: point 8.28.

Brian Doughty, Head of Adult Assessment for the city council, told the panel that there was a particular problem with clients who are 'neglectful' – people who may have mental health problems, but who retain the capacity to make decisions about their own welfare, and who 'choose' to neglect themselves, living in unsanitary conditions, hoarding etc. Clearly, few private landlords would actively choose to have this type of tenant, so there is a need for services to offer as much support as necessary to landlords if they want to keep such people in their tenancies.

This is true for public landlords too – i.e. the council or housing associations – taking a firm stance on un-neighbourly or anti-social behaviour needs to be balanced against the need to support vulnerable people, and an understanding that eviction may simply just shift the burden and costs of supporting people down the line.[72]

The council's housing teams are already very active in their engagement with private landlords, both at an operational and a strategic level, through the city Strategic Housing Partnership. The panel recognises the worthwhile work being undertaken here, and notes that it is likely to grow in importance in coming years as the city becomes more rather than less reliant upon the private rented sector to house vulnerable people.

A local resident, Mr Richard Scott, suggested that services might look to do more in terms of intervening in private sector landlord/tenant disputes – e.g. in certain circumstances offering to guarantee the payment of a tenant's debts providing they were allowed to remain in their tenancy, and then working with the tenant to recover these debts gradually.[73]

RECOMMENDATION 14 New or refreshed homelessness strategies should explicitly address the issue of working with private landlords to maximise the supply of private rented accommodation accessible to homeless people.

Prison

Offending is prevalent amongst rough sleepers: usually for matters such as street drinking, begging, shop-lifting and drugs offences, but frequently for more violent crimes also. Many rough sleepers have a significant criminal history, including imprisonment.

Being imprisoned is itself likely to cause or contribute to homelessness: people who are in prison may be at risk of losing tenancies, or of being estranged from their families and homes.

This is a particular local issue, given the proximity of Lewes prison. People released from Lewes may gravitate to Brighton & Hove on release, whether or not they have a local connection, and some of these people (particularly the

[72] Evidence from Brian Doughty, Head of BHCC ASC Assessment, 19.02.13: point 13.21.
[73] Evidence from Richard Scott, 07.02.13: point 8.29.

ones who are not locals) may end up rough sleeping.[74] There are good services available in Brighton & Hove for ex-convicts with a local connection, including an in-reach service provided at Lewes Prison by the council's Housing Options team and by BHT, but fewer such services for those who are not locals.[75]

Clearly rough sleeping is unlikely to provide a stable background to enable ex-offenders to reintegrate successfully into society and to reduce the risk of re-offending. People who end up rough sleeping after being released from prison have a relatively poor chance of avoiding re-offending – which is bad news for them and has obvious system costs in terms of the impact of future crimes on the criminal justice system.

It seems obvious therefore that every step should be taken to ensure that people leaving prison do not end up on the streets. However, things are not necessarily this simple: offering housing support to released offenders who did not meet the local eligibility criteria would certainly cost the city council money in the short term; and although it might well save the public sector considerable sums in the long term, there is no obvious way of getting the agencies who are likely to make most of the long term savings (the police, the courts, probation, prisons) to contribute. In addition, there would be an obvious risk here in offering a higher level of support than neighbouring areas – the city is presumably not eager to be a preferred destination for people leaving prison. It may therefore be that this is the kind of issue that is best progressed jointly with neighbouring local areas, and with the agencies that stand to gain most from reductions in re-offending.

An allied issue is that of the imprisonment of local people who have social housing or council tenancies. We are unclear whether people who are in prison for only a brief period are able to resume their tenancies when they are released. If not, this would seem to make their reintegration into the community much harder and substantially increase their risk of becoming homeless – with obvious financial impacts. We would hope therefore that a sensible solution could be found to sustain tenancies across short periods of incarceration.

RECOMMENDATION 15 – the council should explore what can be done to maintain people's tenancies should they be imprisoned for a short period of time. The aim should be to minimise the number of people with a local housing connection being made homeless as a result of imprisonment.

[74] Evidence from Sara Emerson, 07.02.13: point 8.18.
[75] Evidence from Narinder Sundar, 07.02.13: point 8.18

Housing and Social Care co-working

Brighton & Hove is a unitary authority, which means that the city council is responsible for supporting homeless people under housing legislation *and* vulnerable adults and families under social care legislation. The latter include people who do not meet the statutory homeless criteria but who have very significant vulnerabilities in terms of mental health, substance misuse, physical or learning disabilities. A similar arrangement is in place with council children's services for families who are eligible for housing under children's legislation. In recent years, the city council has increasingly moved to a model where all people eligible for housing by the council are dealt with by housing services rather than being housed directly by adult or children's social care.

In general, such arrangements should be welcomed – there is obvious logic in having a local authority housing team responsible for delivering all the housing support which the authority is required to provide. The alternative would be to have a situation where adult social care, children's services and housing all commissioned their own services, with an obvious risk of duplication and increased costs.

However, some of the clients whom social care is responsible for housing have particular vulnerabilities which mean that they require high levels of expert support to live independently. For example, a minority of people with learning disabilities may act in ways which endanger themselves or others – by being neglectful etc. It is important that agreements between social care and housing ensure that appropriate levels of support are provided for very vulnerable people, particularly because if serious problems do develop it can be prove very difficult to take enforcement action against people with such high levels of vulnerability.[76] At the same time it is crucial that already vulnerable people are not made more so by being evicted from their homes. Social care, housing and environmental health services need to work closely together to manage this group of clients and a joint protocol is being developed to this end.[77]

The panel heard that operational partnerships between adult social care and housing had improved markedly in recent years and were now fairly effective. However, it is evident that there is still work to do in terms of strategic co-working. This is an important issue, not least because it seems possible that we are going to see an increase in people with high levels of vulnerability presenting as homeless in the coming years. If departmental boundaries mean that this co-working is only ever going to be partially effective, then this seems to us to be an argument for looking to see whether the boundaries between ASC and housing need to be redrawn to more accurately reflect the degree to which the services are required to work in an integrated manner.

[76] Evidence from Sylvia Peckham, 25.01.13: point 3.13.
[77] Evidence from Brian Doughty, Head of BHCC ASC Assessment, 19.02.13: point 13.21.

RECOMMENDATION 16 New and refreshed homelessness strategies must explicitly recognise that social care and housing increasingly need to work in an integrated manner, and should establish structures to enable this.

Partnership Working

Effective partnership working to support people with complex needs is predicated upon information-sharing. However there are some major difficulties here, particularly in relation to health and mental health records.[78] This is a really tricky area as there are genuine issues of patient confidentiality to be balanced against the advantages of information-sharing. Good work has been done in this respect already, but it is obvious that more needs to be done.

Eligibility

Local authorities are only *required* to offer housing support to those applicants who meet all the statutory eligibility criteria. However, councils may volunteer to support people who do not meet all the criteria, and some do so, particularly in terms of the ‘local connection’ and ‘intentionality’ tests.[79]

There are a couple of good reasons for relaxing the eligibility criteria. In the first place, having very strict criteria in place will catch those who have no real connection to a locality or who have acted irresponsibly in past tenancies, but it may also catch people who are quite genuine applicants. There is therefore an argument in terms of equity here. This is particularly so for groups such as people fleeing domestic violence or LGBT people escaping from harassment in their home towns, where there is evidence that some types of applicant may, through no fault of their own, struggle to prove that they are genuinely eligible.

Secondly, people who are deemed ineligible for housing assistance will not necessarily go elsewhere – many will stay in the local area, and some of them may end up rough sleeping etc, with the potential for major down-stream costs. It may therefore make sense to relax eligibility criteria in circumstances where the up-front costs are likely to be dwarfed by the costs of not effectively supporting people who will nonetheless remain as a local problem.

However, whilst relaxing the eligibility criteria might be a possibility somewhere with a surfeit of empty social housing, it’s unlikely to be a realistic option in Brighton & Hove where demand for social housing already far exceeds supply and which is already a ‘destination’ for homeless applicants. It is important though to recognise that not every unsuccessful homeless applicant is necessarily unworthy of support – many people who do have a real connection to the city and who haven’t lost tenancies through any fault of their own will nonetheless fail to meet the homeless eligibility criteria.[80] The

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[78] Evidence from Peter Castleton, 19.02.13: point 13.29.
[79] Evidence from Sarah Gorton, 07.02.13: point 8.20.
[80] Evidence from David Richards, a local homeless person: 07.02.13, point 8.22.

local authority needs to be sensitive in dealing with applicants like these, and where possible, to provide them with, or perhaps more realistically direct them to, support and advice.

RECOMMENDATION 17 New and refreshed homelessness strategies should specifically address the support/advice needs of those who have been deemed ineligible for statutory housing support, recognising that this is a significant group of people, many of whom have genuine support needs.

Dual Diagnosis

People who have *both* severe and enduring mental health problems and major substance misuse issues are often referred to as having a 'dual diagnosis'. (The term is also sometimes used for other co-morbidities, such as learning disability and substance misuse problems.) People with a dual diagnosis can be amongst the most vulnerable people in the community *and* amongst the most disruptive, presenting major challenges to support services, including housing. People with a dual diagnosis are over-represented in temporary and emergency housing, and particularly so amongst rough sleepers.

Brighton & Hove has long had problems with dual diagnosis, unsurprisingly given the city's well documented issues with drugs and alcohol and the local level of mental health problems. There has been a good deal of work in recent years, including a strategic needs assessment, the work of a scrutiny panel on dual diagnosis and Sussex Partnership NHS Foundation Trust's development of a dual diagnosis strategy. However, problems persist, and will doubtless continue to do so however good services become at dealing with this issue.[81]

The panel has no specific recommendations to make in respect of dual diagnosis, but notes that our recommendations around providing multi-agency, front-loaded and targeted support to those homeless people with the most complex needs would obviously apply to people with a dual diagnosis.

Dealing with homeless applications

The panel heard evidence that the system for processing homelessness applications was dysfunctional, with applications regularly being lost and staff being unsympathetic to applicants.[82] We also heard that LGBT people had experienced particular problems with staff who failed to understand their circumstances.[83]

This is anecdotal evidence, and it may well be that people who have had a negative experience of the system are in a minority – we have certainly not conducted a systematic review of services. However, it should clearly be the

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[81] Evidence from John Child, Deputy Service Director, Sussex Partnership NHS Foundation Trust, 07.02.13: point 8.26.
[82] Evidence from David Richards, 07.02.13, point 8.23.
[83] Evidence from Jess Taylor, 19.02.13: point 13.10.

case that all service users are treated courteously, and that an assessment system should be designed to *support* people in claiming services to which they are eligible, not to deter claimants. At the same time, it is important to remember that statutory homelessness services are meant to be a last resort for people who are unable to otherwise find shelter. They are not intended as an alternative to finding one's own accommodation, and people need to be discouraged from viewing them as such.

There is clearly a balance to be struck here: homelessness services need to be accessible, but they also have to manage demand effectively, ensuring that they are used as a last rather than a first resort.[84] However, managing demand ought not to mean that assessment is less than optimally efficient, nor that applicants should receive anything other than courteous and professional treatment.

Local Connection/Intentionality

The panel heard experts argue that it might make sense to apply the 'local connection' or 'intentionally homeless' criteria more flexibly for certain groups of people – for example those affected by domestic violence, or young LGBT people. However, there is a strong counter-argument here: that Brighton & Hove is already a destination for homeless people and that we simply could not cope with a greatly increased influx of applicants if the eligibility criteria were relaxed.[85] There is obviously a balance to be struck between an ethical homelessness policy (and one which accords with statutory equalities duties) and the need to manage an already major problem (with the danger that accepting more applicants will mean that there are fewer resources to help homeless people).

Housing Supply

Clearly, one of the most obvious ways to reduce levels of homelessness would be to build additional local housing. Equally clearly this is not an easy task, particularly in somewhere like Brighton & Hove with limited available sites and high costs. The panel recognises that the council is working hard to develop the supply of permanent housing, but that this is a challenging long-term project.

In this context it is worth mentioning innovative shorter term 'fixes' such as the BHT scheme to provide temporary housing for homeless people in 'container homes' in Hollingdean. This project has provided a significant number of much-needed homes quickly and at a low cost. There is a potential opportunity to develop similar schemes using other temporarily vacant sites across the city – for example sites such as Preston barracks.

[84] Evidence from Bec Davison, 07.02.13: point 8.27.
[85] Evidence from Peter Castleton, 19.02.13: point 13.27.

Monitoring the Panel Recommendations

This scrutiny panel will initially seek endorsement of this report at the Health & Wellbeing Overview & Scrutiny Committee (HWOSC). Should this be forthcoming, the panel report will be presented for decision at one or more of the Council's policy committees. The policy committee(s) will decide which recommendations to accept and implement.

Scrutiny typically monitors the implementation of agreed panel recommendations. We therefore propose that the agreed panel recommendations relevant to this report be monitored annually by the Overview & Scrutiny Committee. In addition officers may choose to report progress in implementation periodically to policy committee(s).

RECOMMENDATION 18 – The OSC should monitor the implementation of agreed panel recommendations on an annual basis until the committee is satisfied that all recommendations have been implemented.

Appendix 1

List of Panel Recommendations

RECOMMENDATION 1 Given the significance of homeless people in terms of city health inequalities, we welcome the fact that the Health & Wellbeing Board is taking an active interest in the health and social care needs of this group. We are very interested in the progression of this work, and request that the HWB's plans for homeless healthcare be presented to the HWOSC for comment within the next 12 months.

RECOMMENDATION 2 A senior BHCC officer should be appointed as 'homelessness services integration champion' across statutory services and other sectors.

RECOMMENDATION 3 the council needs to take action to diversify its 'stock' of hostel accommodation, seeking to spread hostels more evenly across the city, and to offer a range of accommodation options in terms of hostel size and the level of support on offer.

RECOMMENDATION 4 we need a more diverse range of supported accommodation available to house single homeless people, particularly those with very complex needs. Whilst this is clearly not going to happen overnight, we would welcome a commitment to move to a model of greater diversity coupled with at least some practical action in the short term.

RECOMMENDATION 5 the council needs to produce a clear map of statutory and non-statutory homelessness services across the city and make it available via the its website.

RECOMMENDATION 6 – homeless pathways should be revised to allow clients to move directly into band 3 support when it is clear that there is no realistic possibility of them progressing successfully through band 2 support.

RECOMMENDATION 8 New and refreshed BHCC housing strategies must explicitly address the housing needs of victims of domestic violence.

RECOMMENDATION 9 Training for housing staff dealing with homeless applications must explicitly include information on domestic violence.

RECOMMENDATION 10 New and refreshed BHCC housing strategies must explicitly address the housing needs of LGBT people.

RECOMMENDATION 11 Training for housing staff dealing with homeless applications must explicitly include information on LGBT needs.

RECOMMENDATION 12 Relevant new and refreshed homelessness strategies (e.g. the Joint Commissioning Strategy for Young people) should explicitly address need with regard to:

- **services for young people with high support needs;**
- **ensuring that there is sufficient specialised housing to support young people;**
- **the need to deliver 'holistic' support to young people (i.e. helping make young people work-ready at the same time as housing them)**

RECOMMENDATION 13 the Council should consider lobbying central Government (on the issue of people who are receiving employability training being required to attend the Job Centre to sign-on), reflecting the concerns of local voluntary sector providers that the rules dictating the ability of Jobcentre + to relax its signing-on requirements are still too inflexible.

RECOMMENDATION 14 New or refreshed homelessness strategies should explicitly address the issue of working with private landlords to maximise the supply of private rented accommodation accessible to homeless people.

RECOMMENDATION 15 – the council should explore what can be done to maintain people's tenancies should they be imprisoned for a short period of time. The aim should be to minimise the number of people with a local housing connection being made homeless as a result of imprisonment.

RECOMMENDATION 16 New and refreshed homelessness strategies must explicitly recognise that social care and housing increasingly need to work in an integrated manner, and should establish structures to enable this.

RECOMMENDATION 17 New and refreshed homelessness strategies should specifically address the support/advice needs of those who have been deemed ineligible for statutory housing support, recognising that this is a significant group of people, many of whom have genuine support needs.

RECOMMENDATION 18 – The OSC should monitor the implementation of agreed panel recommendations on an annual basis until the committee is satisfied that all recommendations have been implemented.

HEALTH & WELLBEING OVERVIEW & SCRUTINY COMMITTEE	Agenda Item 113a Brighton & Hove City Council

Subject:		**Alcohol Scrutiny Panel Report**	
Date of Meeting:		**04 February 2014**	
Report of:		**The Monitoring Officer**	
Contact Officer:	**Name:**	**Kath Vlcek**	**Tel: 29-0450**
	Email:	**Kath.vlcek@brighton-hove.gov.uk**	
Ward(s) affected:		**All**	

FOR GENERAL RELEASE

Note: The special circumstances for non-compliance with Council Procedure Rule 3, Access to Information Procedure Rule 5 and Section 100B(4) of the Local Government Act 1972 (as amended), (items not considered unless the agenda is open to inspection at least five days in advance of the meeting) were that the scrutiny panel wanted to take the opportunity to take evidence from the Director of Public Health, which necessitated the late publication of this report.

1. PURPOSE OF REPORT AND POLICY CONTEXT

1.1 In 2013 HWOSC agreed to establish a scrutiny panel to look at issues relating to alcohol. The panel was chaired by Councillor Lizzie Deane, and also included Councillors Mo Marsh and Dee Simson.

1.2 The scrutiny panel report is attached as **Appendix 1** to this report.

2. RECOMMENDATIONS:

2.1 That HWOSC endorse the scrutiny panel report on alcohol (**Appendix 1**) and refer it on for consideration by the appropriate policy committee(s)

3. CONTEXT/ BACKGROUND INFORMATION

3.1 In February 2013, the Health & Wellbeing Overview & Scrutiny Committee (HWOSC) received a report from Dr Tom Scanlon, Director of Public Health updating the committee on the work of the Alcohol Programme Board and suggesting priority areas for potential scrutiny panels looking at the area.

These areas were:

- Development of alcohol free events
- Development of best practice retailers
- Improving the environment by encouraging responsible drinking

3.2 HWOSC agreed the request and a panel consisting of Councillors Deane, Marsh and Simson was established, with Councillor Deane agreeing to chair. The panel held several evidence gathering meetings in autumn 2013. It took the decision not to hold these meetings in public due to the amount of public involvement

which had already taken place around alcohol policy development including the Big Alcohol Debate.

3.3 The panel members did involve a wide range of partners however, including members of the Alcohol Programme Board, trade associations, both of the local universities, retailers, the police, tourism representatives and others

4. ANALYSIS & CONSIDERATION OF ANY ALTERNATIVE OPTIONS

4.1 The HWOSC has the option to decline to endorse the scrutiny panel report.

5. COMMUNITY ENGAGEMENT & CONSULTATION

5.1 The panel members spoke to a wide range of partners including members of the Alcohol Programme Board, trade associations, both of the local universities, retailers, the police, tourism representatives and others.

6. CONCLUSION

6.1 In line with normal procedure, we are asking that the HWOSC endorses this report and refers it on to the appropriate BHCC Policy Committee(s) for consideration.

7. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

7.1 The financial implications of the recommendations from the scrutiny panel will be assessed in the context of the Council’s budget strategy when the recommendations are considered by the policy committees.

Finance Officer Consulted: Anne Silley Date: 29/01/14

Legal Implications:

7.2 Once HWOSC has agreed its recommendations based on the work of the scrutiny panel, it must prepare a formal report and submit it to the council’s Chief Executive for consideration at the relevant decision-making body.

7.3 If HWOSC cannot agree on one single final report, up to one minority report may be prepared and submitted for consideration by the relevant policy committee with the majority report.

Lawyer Consulted: Oliver Dixon Date: 29/01/14

Equalities Implications:

7.4 None identified

Sustainability Implications:

7.5 None identified

Any Other Significant Implications:

7.6 Public Health issues are covered in the body of the report.

SUPPORTING DOCUMENTATION

Appendices:

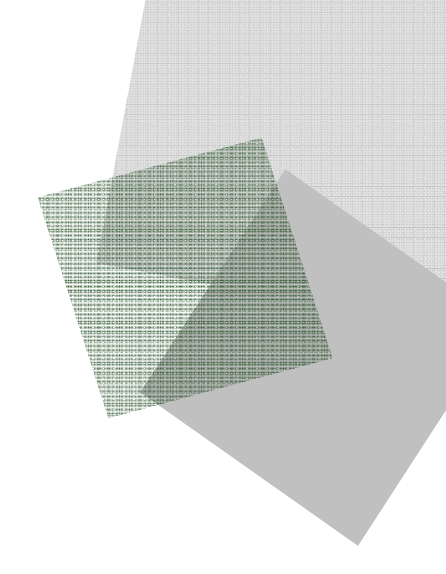
1. The Alcohol Scrutiny Panel Report

Documents in Members' Rooms

None

Background Documents

None



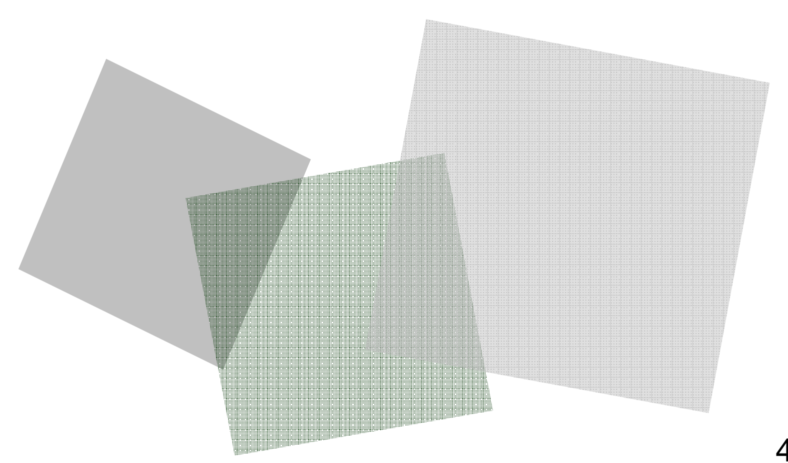
**Report of the Health & Wellbeing
Overview & Scrutiny Panel**

February 2014

Scrutiny Panel on Alcohol

Panel Members

**Councillors Lizzie Deane (Chair)
Mo Marsh
Dee Simson**



Chair's Introduction

When you think of going out in Brighton and Hove, chances are you'll think of events involving alcohol. There's no doubt that alcohol contributes a lot economically and socially to the city with alcohol-related business worth an estimated £329M to the local economy every year[1]. However there are a number of well recognised downsides to the ubiquity of alcohol in Brighton & Hove, including anti social behaviour, alcohol related crime and health impacts, with the cost to the city estimated at £107 million[2] annually. Councillors wanted to ensure that they had been involved in shaping the role of alcohol in the city on behalf of residents, without duplicating the valuable and extensive work that has already taken place elsewhere.

There's been a lot of discussion about alcohol in Brighton & Hove already including the Intelligent Commissioning work and the Big Alcohol Debate, both of which involved members of the public sharing their views on alcohol with the council and health partners. The Alcohol Programme Board meets regularly to bring together key public and private sector colleagues in the city on a range of alcohol related issues including addressing the city's drinking culture, the availability of alcohol, the night time economy and treatment for people with drinking problems.

The Alcohol Programme Board has already looked at these issues in depth and has come up with a range of action plans and recommendations for further development. However a number of areas had not been fully explored, and it was suggested that these were areas that a scrutiny panel could usefully look at.

There were three panel meetings, which looked at alcohol-free events; responsible retailing and promoting responsible drinking.

The first panel meeting looked at the role of alcohol-free events and led into a discussion with members of the Alcohol Programme Board about responsible retailing. The second scrutiny meeting was an opportunity to review the Statement of Licensing Policy. In the third meeting, panel members met with both universities to talk about responsible drinking and how this is promoted amongst the student population.

Given that members of the public have already commented on alcohol in the city fairly recently, the scrutiny panel took the decision not to actively invite members of the public to take part in this set of meetings. We have involved a wide range of partners though including members of the Alcohol Programme Board, trade associations, both of the local universities, retailers, the police, tourism representatives and others.

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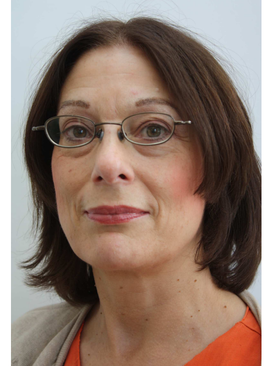
[1] Public Health Report to Health and Wellbeing Overview & Scrutiny Committee, February 2013
[2] Public Health Report to Health and Wellbeing Overview & Scrutiny Committee, February 2013

The panel would like to thank everyone who has taken part in the set of alcohol panel meetings for the invaluable information and advice that they have given.

I was joined on the panel by councillors Mo Marsh and Dee Simson. I would like to thank them for their time and effort in addressing this huge issue.

We would also like to thank the council's Scrutiny Team for the help that they have given to the panel during this scrutiny review process, from organising the meetings and attendees to drafting this report.

There is a glossary of terms at the end of the report.



EXECUTIVE SUMMARY OF RECOMMENDATIONS

1. Brighton & Hove City Council needs to lead by example in the case of operating low alcohol or alcohol-free events. We recommend that our own events, such as the Mayor's Christmas Party or in-house events are not automatically alcohol based and would like to see more consideration given to a wider range of non/ low-alcohol drinks being provided to encourage people to explore alternatives to alcohol.

   This should extend to people wishing to rent council-managed land for an event, eg a park or the seafront. We recommend that the Events team highlight alcohol awareness in their events information or ask that people increase their food offer rather than relying on alcohol.

   We also recommend that Brighton & Hove City Council reconsiders the clause included in certain commercial leases that promotes the need for an alcohol licence. (**page 7)**

2 The council should seek to encourage a range of day and night time events which might involve alcohol but don't rely on it. The panel recommends continuing the work between responsible trade partners such as Brighton and Hove Licensees' Association and the statutory bodies to ensure that this is managed well.

   In line with this we recommend that the council cuts down on the proportion of large events that are alcohol sponsored. We recommend that the Alcohol Programme Board continues to work with the Events Team to address this, seeking a measureable reduction in large events that are currently sponsored by alcohol. **(page 9)**

3 The panel commends the level and range of work in place at both universities to raise alcohol awareness issues and address the drinking culture. We recommend that this is used as an exemplar for other organisations working with students and young people.

   We would like to endorse the continued use of innovative methods of promoting the alcohol awareness message including the CRI unit measure glasses and scratchcards, and would encourage all organisations working with young people to use the tools available. This will help young people understand the impact of alcohol on their health and wellbeing. **(page 11)**

4 We recommend that the planned work of the Alcohol Programme Board in addressing older people's drinking behaviour should include information on the cumulative impact of alcohol on a number of health and wellbeing issues including physical and mental health. **(page 12)**

5 We recommend that the council's Licensing Team continue with their proactive work to encourage retailers to sell alcohol in a responsible way during large events**. (page 13)**

6 The panel is mindful that 'Inncredible', the local Best Bar None scheme in Brighton has not progressed due to lack of funding. We are not in a position to recommend that the council funds this but we recommend that the Alcohol Programme Board work with local trade bodies, council officers and police staff explore what assistance could be given to enable this scheme to become live. **(page 14)**

7. The panel recognises the strengths of the Statement of Licensing Policy but would suggest that the policy and Matrix be reviewed by the Licensing Committee, in particular

(a) the geographical scope of the Cumulative Impact Zone
(b) that café bars are given their own categorisation in the Matrix to recognise that they are not restaurants or pubs and that different guidance may apply
(c) review the definition of residential or commercial areas
(d) review the statement on hours of alcohol sale
(e) review the policy on food and alcohol retailers outside the CIZ **(page 16)**

The Overview and Scrutiny Committee will monitor the implementation of the agreed recommendations.

1. What is the council's role in promoting responsible drinking?

1.1 The Big Alcohol Debate ran in Brighton and Hove from October 2011 to January 2012. It asked contributors a number of open questions including '*What would you do about alcohol in Brighton and Hove if you were in charge?*'

1.2 One of the key messages that came back from contributors was that the city needs to promote more alternatives to alcohol including late-night solutions to encourage a broader mix of people into the city centre. For example, alcohol-free venues such as cafes, tea houses and other attractions should be encouraged to stay open late and there should be more city sponsored activities that aren't alcohol-driven. Many residents are discouraged from coming into the city in the evening because of alcohol-fuelled disruptive behaviour.[3]

1.3 With this in mind, we as panel members met with representatives of the Alcohol Programme Board including members of trade associations, events organisers, police, health representatives and anti social behaviour staff and with representatives from the local universities to look at alcohol-free events and responsible drinking.

1.4 There are a number of daytime alcohol-free events throughout the annual programme of events, including sports and family events; these operate successfully. We were asked to consider whether there was a place for more of a focus on alcohol-free events in the night-time. We also considered the council's role in leading by example, for instance, by making some council-led functions alcohol-free.

1.5 As panel members, we are all concerned that alcohol has become too central to everyday life, and that it is in danger of taking over events that do not necessarily need to have alcohol present. Alcohol is slowly creeping into a wider range of events including school fetes, parents' evenings, church functions and community events, which has led to people expecting that alcohol should be available at all events as a norm. The council is not 'anti-fun' but it is important to provide a range of options so that alcohol does not always become the default.

<u>The council's role in alcohol-free events</u>

1.6 With this in mind, we felt that Brighton and Hove City Council should lead by example, and more actively consider the drinks offer at its own social events such as the Mayor's Christmas party or council-organised awards ceremonies. We would like to see more positive consideration given to the range of low/ non-alcoholic drinks offered at these events,

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[3] [3] Public Health Report to Health and Wellbeing Overview & Scrutiny Committee, February 2013

and for a positive public statement to be made explaining the council's position.

1.7 We feel that this positive consideration of low/ non-alcoholic drinks ought to be extended to events held on council-owned land, such as those events held in parks or on the seafront. We understand that these are privately organised events and the council cannot control every element of what is being provided but we would like events organisers to at least consider an alternative offer.

1.8 We would like the Events Team to include information about alcohol awareness in the information that they give to events organisers, asking them to actively consider non- or low-alcoholic drinks options. We would also encourage more food-led events being organised rather than alcohol-led events.

1.9 We are concerned that Brighton & Hove City Council often includes a clause within certain commercial leases that stipulates the need for the prospective licensee to have an alcohol licence. We feel that this is not always necessary and tends to promote a culture where alcohol is expected as a norm. We would like the leases to be reviewed so that this is not always the case with future leases.

1.10 Recommendation 1 -Brighton & Hove City Council needs to lead by example in the case of operating low alcohol or alcohol-free events. We recommend that our own events, such as the Mayor's Christmas Party or in-house events are not automatically alcohol based and would like to see more consideration given to a wider range of non/ low-alcohol drinks being provided to encourage people to explore alternatives to alcohol.

This should extend to people wishing to rent council-managed land for an event, eg a park or the seafront. We recommend that the Events team highlight alcohol awareness in their events information or ask that people increase their food offer rather than relying on alcohol.

We also recommend that Brighton & Hove City Council reconsiders the clause included in certain commercial leases that promotes the need for an alcohol licence.

2 External Events

2.1 Over the past few years, Brighton & Hove Arts Commission and the city council have held a White Night event, a free all night art festival, aiming to open up different venues within the city for arts and cultural events.

2.2 Regrettably, the event has attracted some people who did not want to attend the events but were using it as a reason to drink excessively

resulting in anti-social behaviour. The most recent White Night also clashed with a high-drinking event, Zombie Night, which led to some excessive drinking. The resulting anti-social behaviour has led to the event being cancelled for the foreseeable future. It should be noted that the problems did not occur within the festival events themselves, but by people drinking after the events had taken place.

2.3 This was a similar outcome to Pride, in that the arranged events were well managed and relatively problem free. Problems were caused by mainly young people drinking near the events, often in open spaces, not in a managed venue. At this year's Pride for example, the police were called to manage approximately 150 young people drinking near Preston Park and causing anti-social behaviour. We heard that the police dealt with these matters robustly but that the problem has escalated year on year.

2.4 We considered whether theoretically the anti social behaviour would be curtailed if the events were removed but all parties agreed that it was not the event that was causing the excessive drinking and subsequent behaviour. The events are a valued part of Brighton and Hove's event calendar, bringing many social and economic benefits but they can act as a catalyst for further drinking beyond the event itself.

2.5 Alcohol sales within events tended to be well managed and alcohol was responsibly sold, but problems occurred with people drinking outside the event in an unmanaged capacity. The anti social behaviour problems are caused by spontaneous drinking in unlicensed spaces, not by the events themselves.

2.6 We concluded that it was not the case that events ought to be cancelled or even that more alcohol free events were necessarily needed but that there was a need to work with licensed premises and retailers to sell alcohol in a responsible way, as well as offering more alternative and affordable low and non-alcoholic drink options.

2.7 The Chair of Brighton and Hove Licensees' Association said that, by trying to restrict alcohol and run events without involving the local trade, it made unlicensed events a free for all in terms of bringing your own alcohol. This was endorsed by all parties; we need to turn the idea of alcohol-free events on its head, and involve trade as a partner rather than blaming them for how people choose to drink.

2.8 We would like to thank the local business representatives for coming to the panel meeting and for all of their input. Their comments were invaluable and challenged some of the assumptions that we had made prior to meeting as a panel.

By utilising local companies as responsible partners, this could increase business for local companies, adding social value and building on the positive relationships between the public sector and

responsible businesses. As part of this positive relationship we would like to encourage responsible traders to increase their low and non-alcoholic drink offer. We believe that there is a good business case to be made; we heard about the increasing amounts of overseas students who do not drink alcohol and who would prefer to attend venues with a variety of drinks alternatives.

2.9 As a passing comment, we note that two new alcohol-free venues are interested in opening in Brighton and Hove. The plans were not advanced enough for us to consider them as part of the panel process but we look forward to hearing how the proposals develop in due course.

2.10 We also wanted to note that we did not wish to discourage young people from attending and taking part in the cultural events on offer; events are there for all to enjoy.

2.11 As a panel, we recognised that there are a wide range of events and social occasions where excessive alcohol can be consumed, including stag and hen parties. We decided not to focus on these type of events as they are being addressed by another scrutiny panel, looking at 'party houses'.

2.12 Recommendation 2 - The council should seek to encourage a range of day and night time events which might involve alcohol but don't rely on it. The panel recommends continuing the work between responsible trade partners such as Brighton and Hove Licensees' Association and the statutory bodies to ensure that this is managed well.

In line with this, we recommend that the council cuts down on the proportion of large events that are alcohol sponsored. We recommend that the Alcohol Programme Board continues to work with the Events Team to address this, seeking a measureable reduction in large events that are currently sponsored by alcohol.

3 Students

3.1 As a city with two universities, we have a lot of young people, often living away from home from the first time, who often feel pressured into drinking excessively. We spoke to both university student unions about their approaches to alcohol, the advice given to students, the role of alcohol-free events and so on. We also spoke to the member of staff at Sussex who is responsible for Wellbeing, including alcohol related issues.

3.2 We were pleased to hear that both universities are very aware of the problems that alcohol can cause, and are taking positive steps to address the alcohol culture.

3.3 Sussex University has made a conscious effort to increase the number of alcohol-free events as part of the Freshers' Week entertainments, this year making 65% of events alcohol-free. This has grown year on year, and reflects the make-up of the university's student demographic, with a growing number of overseas students. One of the events offered this year was a day time cultural tour of Brighton, rather than being taken to pubs. This was organised in conjunction with Brighton & Hove City Council's Licensing Team. The event was very successful and will be replicated in future years.

Sussex University's bar manager told us that their alcohol sales on campus had decreased over the last few years, and that sales tended to be food-based or non-alcoholic options. They actively promoted responsible drinking behaviours, for example ensuring alcohol awareness information was available in their bars, and including information about the number of alcohol units on their menus. As a panel we very much welcome this approach and hope that the trend towards alcohol awareness will continue.

3.4 The University of Brighton reported some similar trends including the low rates of alcohol consumption in campus bars. They told us that there had been demand for alcohol to be sold in campus cafes but since it had been introduced this year, there had been very low sales. The positive health benefits may be offset by students pre-loading on alcohol in their rooms before going out socially. The university works with health groups to promote responsible drinking and alcohol awareness and will make sure that information is available in fresher information packs. We were also very pleased to hear about the steps that the University of Brighton was taking to address excessive drinking behaviour during sports club initiations, with a range of sanctions that can be applied if it is felt necessary.

3.5 The University of Brighton does not have an equivalent member of staff responsible for Wellbeing. Instead, their alcohol work is coordinated by the Student Union's Vice President, Wellbeing, who also has to address other wellbeing issues and is only in post for a limited time. This year, the postholder is very keen to address some of the alcohol awareness issues that have already been identified, but this might not always be the case, depending on who is in post and the priorities that they may have.

As panel members we felt that it would be beneficial if this could be formalised into a more permanent officer post to ensure continuity of policy development, although we recognise that there are funding implications for this. We encourage the University of Brighton to consider providing funding for such a position; we will pursue this further.

3.6 As local councillors, we have had concerns about the Carnage events that operate in the city centre. These are pub crawls organised by an

external company, which have a reputation for promoting excessive drinking, anti-social behaviour and other negative repercussions. We were very glad to note that neither university endorsed the event and did not support or promote it on their campuses. However we heard that the organisers utilise a range of marketing techniques including social media and personal ticket sales and the universities could not stop their students from attending the events individually.

3.7 We heard about an alternative pub night called “Brightonian Nights” where students are stewarded around the pubs of Brighton. For the past three years council licensing officers have worked with police colleagues and the student union events organisers to ensure that a safer environment is in place including extra policing for the event; stewarding, drink-pricing contracts to ensure no irresponsible promotions, water angels giving out water to the students; medical staff, and other safety measures. We would encourage more positive partnership working of this type in the future.

3.8 We asked both universities for their views on whether there was a demand for a late night coffee shop or soft drinks/ chill out spaces provided in clubs. The universities agreed that this would be worth exploring further and would help extend the offer of entertainment available for students who do not want to drink as much as others. We hope that the universities will work together to explore this further.

3.9 Recommendation 3 – The panel commends the level and range of work in place at both universities to raise alcohol awareness issues and address the drinking culture. We recommend that this is used as an exemplar for other organisations working with students and young people.

We would like to endorse the continued use of innovative methods of promoting the alcohol awareness message including the CRI unit measure glasses and scratchcards, and would encourage all organisations working with young people to use the tools available. This will help young people understand the impact of alcohol on their health and wellbeing.

4 Health

4.1 We were aware that there is a range of work already underway to address young people’s drinking behaviours. We are also mindful that people of all age ranges can experience problems with excessive drinking and that more support and help ought to be given to older people, particularly to those who might drink at home and are not known to service providers.

4.2 We were pleased to hear that the Alcohol Programme Board had already identified this as a gap and will be working over the next year to address this. We fully support the Alcohol Programme Board in this.

We would like the information provided to include details on the cumulative impact of alcohol on both physical and mental health so that people are fully aware of the impact that excessive drinking may have.

4.3 As a panel, we heard about the alcohol awareness work that has taken place throughout the city, promoting the sensible drinking level message and raising general awareness about alcohol. We were told about a campaign called 'Dry January' which aims to encourage people to give up alcohol entirely for January. We considered whether this was something that we as a panel wanted to promote but on balance felt that this might have the unintended consequence of encouraging binge drinking before and after January. We were also concerned about the negative financial impact on local businesses if we encouraged residents not to drink at all in January.

4.4 We felt much more comfortable promoting the message of moderate drinking, and are delighted to see that alcohol awareness messages are being repeated across Brighton & Hove in January 2014. We would like to thank colleagues who work in Health Promotion in CRI for their prompt assistance.

4.5 Recommendation 4 - We recommend that the planned work of the Alcohol Programme Board in addressing older people's drinking behaviour should include information on the cumulative impact of alcohol on a number of health and wellbeing issues including physical and mental health.

5 Licensed Trade

5.1 As we have already seen, retailers and licensed premises are a key partner when it comes to looking at responsible retailing and promoting responsible drinking. We were mindful of the health impacts of drinking alcohol excessively, and the effect on people's behaviour. We would like to see licensed premises being encouraged to positively promote alcohol-free or low alcohol drink options.

5.2 The Chair of Brighton & Hove Licensees' Association said that publicans are business people and they would sell any drinks that would make a profit, whether this contained alcohol or not. However the profit margin on all types of drinks was largely tied to the premises type, and if the landlord was tied to one company this could mean that their pricing structure was restricted.

5.3 The business representative on the Alcohol Programme Board said that part of their business plan was to introduce own brand lighter alcohol products into stores. As a panel, we welcome this and hope that it can be introduced in other supermarkets too.

5.4 We are very pleased with the success of the recent Sensible on Strength campaign[4] which has encouraged off-licences to voluntarily agree not to sell higher strength beer, lager and cider. The aim is to limit the availability of super-strength drinks. Over 70 retailers have already signed up, with the aim that this would have a positive impact on the level of street drinking and associated anti-social behaviour. The campaign message is not anti alcohol but emphasises that super-strength drinks are causing damage to many people and communities and that if people with drink problems move off the super-strength drinks then their health and life chances will improve. We would like to commend the officers who have worked on the campaign.

5.5 We noted that the siting of alcohol in a premises could affect people's decision to buy it. For instance, during Pride or other festivals you often see crates of beer piled near the check outs, encouraging people to buy more than they perhaps otherwise might.

5.6 We would like to see enquiries made into the feasibility of a similar voluntary scheme for retailers, encouraging them to re-locate alcohol to a less obvious or accessible place which might limit some of the spontaneous purchases. This scheme could also be extended to encourage retailers not to sell alcohol on days which are known to be associated with excessive drinking, eg Pride.

5.7 As a member of the Alcohol Programme Board, a major retailer has indicated that there is scope to work with Brighton and Hove to limit the availability of alcohol during high profile events. This could include a temporary suspension of alcohol sales during Pride from premises close to potential hotspots.[5]

5.8 Recommendation 5 – we recommend that the council's Licensing Team continue with their proactive work to encourage retailers to sell alcohol in a responsible way during large events.

6 Responsible Retailers

6.1 One of the key aims of the Alcohol Programme Board was to strengthen the partnership between the licensed trade and the public sector. We as councillors along with our police colleagues are very grateful to the trade representatives for their robust input into discussions and we are keen that we can work positively together in the future. The Alcohol Programme Board's remit includes creating a positive and sustainable night time economy, and we hope that this panel helps towards that aim.

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[4] http://www.brighton-hove.gov.uk/content/licensing/sensible-strength

[5] Public Health Report to Health and Wellbeing Overview & Scrutiny Committee, February 2013

6.2 We as panel members queried what the best way was to deal with traders who may not be as responsible or considerate as those represented on the Alcohol Programme Board. The Chair of the Licensees' Association said that a few years ago, there had been a lot of work to get Inncredible, a local scheme similar to Best Bar None off the ground. The scheme would give positive recognition to responsible retailers and licensed premises, which is recognised as a good way to bring other premises up to scratch. It has Best Bar None endorsement and is based on the specific needs of Brighton and Hove. The Licensees' Association predict that there would be approximately 200 members; it is proposed that the scheme is free to join otherwise it would restrict the number of potential members.

6.3 However although the council, the police and members of the licensed trade have all backed the scheme, no one has been willing to date to fund the administration costs. The Licensees' Association is willing to run the scheme but does not have the available funds or resources, which is estimated to cost approximately £20,000 per annum.

Police representatives and councillors feel that Inncredible is a positive move forward and every effort should be found to help run the scheme. Brighton and Hove lags behind other authorities in not operating a Best Bar None scheme, and this ought to be addressed. We agree that the Licensees' Association should be supported to operate the scheme and do not feel it is fair to expect the Licensees' Association to fund the work by itself. We heard that it is not practical to ask licensed premises to pay, as this will restrict the number of members.

6.5 Due to the financial pressures that the council is facing, we do not feel able to recommend that the council covers all of the costs but we recommend that council officers and police work with the Licensees' Association to explore ways of taking this forward imminently.

6.6 Recommendation 6 -The panel is mindful that 'Inncredible', the local Best Bar None scheme in Brighton has not progressed due to lack of funding. We are not in a position to recommend that the council funds this but we recommend that the Alcohol Programme Board work with local trade bodies, council officers and police staff explore what assistance could be given to enable this scheme to become live.

7 Revising the Statement of Licensing Policy

7.1 The purpose of the Statement of Licensing Policy is to promote the licensing objectives and set out a general approach to making licensing decisions for Brighton & Hove City Council. Licensing is about regulating licensable activities on licensed premises, by qualifying clubs and at temporary events. The licensing objectives are: the

prevention of crime and disorder; public safety; the prevention of public nuisance; and the protection of children from harm.[6]

7.2 The three panel members are also members of the Licensing Committee so we decided to look at the Statement of Licensing Policy (SOLP) as a panel. We have extensive first hand experience of applying the SOLP to current licence applications. The current SOLP was last revised in December 2011.

7.3 We already have a great deal of good practice in the city, much of which is being emulated across the country including the Cumulative Impact Zone (CIZ) and the Matrix approach.

7.4 The Cumulative Impact Zone is an area in the centre of Brighton and Hove where the concentration of licensed premises causes problems of crime and disorder and public nuisance; therefore an approach to 'Cumulative Impact' is necessary as part of the council's Statement of Licensing Policy. There are stricter guidelines on opening licensed premises in the CIZ with the majority of new licence applications being refused.

7.5 The Matrix defines licence application types (eg, restaurant, pub, night club) and gives a general indication as to whether the licence would be granted in certain area types, eg the cumulative impact area, or mixed residential and commercial streets. It does not list particular streets by name, other than the Marina and London Road.

These are robust and creative policy responses to the many different demands that have to be balanced when considering licensing applications, not least the tension between protecting public health and licensing objectives.

7.7 The SOLP is the only tool that the council has to control licensing in the city. Whilst it may not be perfect, it is a very good attempt at controlling how the council wants to see alcohol being traded in the city. The council sees the Matrix as central to its vision, and has kept areas of classification deliberately vague to help members with flexibility in decision making.

7.8 The Matrix is a real strength of the current SOLP. When it was introduced in 2011 it was a great leap forward, and it is very useful when considering applications, although there are sometimes queries over whether it is prescriptive or for guidance.

7.9 As committee members we are often faced with having to make decisions over what is currently an undefined grey area of residential mixed area applications. We discussed whether it would be better to

[6] http://www.brighton-hove.gov.uk/sites/brighton-hove.gov.uk/files/downloads/licence_applications/3994_Statement_of_Licensing_Policy_2012_AW.pdf

list every street in Brighton & Hove and assign it a category, or whether to leave it as a more flexible policy. We felt that although there would be some benefits to defining each street, licensing panel members need the opportunity to make real decisions; the problem with defining rules too much is that panel members lose the opportunity to deviate from it with a more appropriate response. We therefore felt that the current approach was the right one.

7.10 We also felt that the Cumulative Impact Zone approach was a very beneficial one for the city as a way of assessing the combined impact of licensed premises in an area. We wondered whether other areas with multiple licensed premises and related problem behaviour could be considered to be included.

7.11 The Head of Regulatory Services, which covers Licensing amongst other functions, said that any decision to include or exclude an area would be based on the evidence available about current negative impacts including noise nuisance complaints, crime rates etc. Anecdotally we have heard that London Road/ Preston Road up to Preston Park, Lewes Road and George St in Hove have all experienced problems and we would like to recommend that these areas are reviewed for inclusion.

Café bars

7.12 Licensing Committee members often have to make decisions on applications from cafés requesting alcohol licences. It seems that all cafes will want to sell alcohol soon, which we note is already causing concern in the community.

7.13 We asked whether there was a way of addressing this. The Head of Regulatory Services said that from a licensing point of view, there was no simple way to address this, as café bars currently fall into the same category as restaurants and bars and the same guidance would apply.

7.14 We asked whether this classification could be reviewed with a view to giving café bars their own categorisation and relevant guidance in the Matrix to recognise that they are not restaurants or pubs. We think that this would strengthen the position statement, whilst recognising the licensing limitations.

7.15 We also had concerns about the food and alcohol retailers such as mini-supermarkets which are outside the CIZ as we feel that the policy addressing such establishments could be more stringent.

7.16 Recommendation 7 - The panel recognises the strengths of the Statement of Licensing Policy but would suggest that the policy and the Matrix be reviewed by the Licensing Committee, in particular

a)the geographical scope of the Cumulative Impact Zone
b) that café bars are given their own categorisation and in the Matrix to recognise that they are not restaurants or pubs and that different guidance may apply
c)review the definition of residential or commercial areas
d) review the statement on hours of alcohol sale
e) review the policy on food and alcohol retailers outside the CIZ

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GLOSSARY

APB - Alcohol Programme Board – the APB[7] has a programme of work to tackle the adverse consequences of alcohol consumption in Brighton and Hove. There are four 'domains' of work within the Programme Board Action Plan:

- The drinking culture
- Availability of alcohol
- The night time economy
- Early identification, treatment and aftercare

The APB has very senior input from across the city's statutory partners including health, the city council and police, and from representatives for the alcohol industry.

Best Bar None- Best Bar None is a national award scheme supported by the Home Office aimed at promoting responsible management and operation of alcohol licensed premises. Since 2003, it has been adopted by over 100 towns and cities across the UK.[8]

Carnage - Carnage UK is a company that organises drinking events for an estimated 350,000 undergraduates in 45 towns and cities[9] including Brighton and Hove. The events organisers have faced criticism that they encourage binge drinking and anti-social behaviour.

CIZ/ CIA – Cumulative Impact Zone/ Area - This is an area where the concentration of licensed premises in a small area of the city centre is causing problems of crime and disorder and public nuisance, and that therefore an approach to 'Cumulative Impact' is necessary as part of the council's Statement of Licensing Policy. The CIA is based on evidence of crime, anti-social behaviour, noise nuisance etc. It currently covers 1.5% of Brighton & Hove City Council's administrative area.[10]

Inncredible – this is Brighton and Hove's suggested own Best Bar None (see above) scheme, devised by Brighton & Hove Licensees Association and supported by Best Bar None. It is based upon the specific needs of Brighton & Hove.

Matrix – this is part of the Statement of Licensing Policy. It defines licence application types (eg, restaurant, pub, night club) and gives a general indication as to whether the licence would be granted in certain area types, eg

[7] Public Health Report to Health and Wellbeing Overview & Scrutiny Committee, February 2013
[8] http://www.bbnuk.com/
[9] http://www.theguardian.com/education/2009/nov/08/philip-laing-carnage-binge-drinking
[10] http://www.brighton-hove.gov.uk/sites/brighton-hove.gov.uk/files/downloads/licence_applications/3994_Statement_of_Licensing_Policy_2012_AW.pdf

the cumulative impact area, or mixed residential and commercial streets. It does not list particular streets by name, other than the Marina.[11]

SOLP – Statement of Licensing Policy - The purpose of the Statement of Licensing Policy is to promote the licensing objectives and set out a general approach to making licensing decisions for Brighton & Hove City Council. Licensing is about regulating licensable activities on licensed premises, by qualifying clubs and at temporary events. The licensing objectives are: the prevention of crime and disorder; public safety; the prevention of public nuisance; and the protection of children from harm.[12]

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[11] http://www.brighton-hove.gov.uk/sites/brighton-hove.gov.uk/files/downloads/licence_applications/3994_Statement_of_Licensing_Policy_2012_AW.pdf

[12] http://www.brighton-hove.gov.uk/sites/brighton-hove.gov.uk/files/downloads/licence_applications/3994_Statement_of_Licensing_Policy_2012_AW.pdf

Special Care Dentistry
Head Office
Haywards Heath Health Centre
Heath Road
Haywards Heath
West Sussex
RH16 3BB

23rd January 2014

Cllr Sven Rufus
Chair, HWOSC
Room 128 King's House
Brighton & Hove City Council
Grand Avenue
Hove BN3 2LS

Date Cllr Rufus

Proposal to relocate Special Care Dentistry from Moulsecoomb to Morley Street

We are writing to you with regard to our proposal to relocate the Special Care Dental Service currently provided at Moulsecoomb Dental Clinic, Brighton to Morley Street Dental Clinic, Brighton.

Please see the briefing note enclosed. This shows the level of activity at the clinic and how this has reduced by half over recent years. It explains why the relocation will allow us to offer our patients safer, higher quality care and a better experience. Subject to feedback, we would like to complete the relocation by 31 March 2014.

We welcome your response and would ask you to note that the NHS England Surrey & Sussex Area Team, which commissions our Special Care Dental Service, has agreed to the change in principle but has asked for confirmation from the HWOSC.

We look forward to hearing from you. Please feel free to contact us as below with any queries.

Yours sincerely

Sarah Crosbie

Sarah Crosbie, Clinical/Managing Director, Dental Services
01444 884106

John Forrester, Senior Business Manager, Dental Services
01444 884101

Proposal to relocate Special Care Dentistry from Moulsecoomb Dental Clinic to Morley Street Dental Clinic

Introduction

The purpose of this paper is to advise you about proposed changes with regard to the relocation of the Special Care Dental Service currently provided at Moulsecoomb Dental Clinic, Brighton to Morley Street Dental Clinic, Brighton, and to explain why we think this will allow us to offer the patients using the service a safer, better quality experience.

About the Special Care Dental service (SCD)

The SCD accepts referrals to provide special care dentistry to adults and children with special health and social care needs and/or people who have difficulty accessing general dental services.

The service cares for a range of patients including people with learning and/or physical disabilities and/or medical problems; people with a mental health diagnosis; children with challenging behaviour; looked after children; people with dental phobias; people from the traveller community and homeless people. The service also provides domiciliary dental care for housebound people.

The service is commissioned by NHS England, which assumed responsibility in April 2013 from primary care trusts for commissioning all primary, community and secondary NHS dental services in England, including dental out of hours and urgent care.

The proposed change

Moulsecoomb Dental Clinic was established in Moulsecoomb Health Centre many years ago to meet local demand. Patients with special needs that cannot be placed in the care of a high street dental practice are retained and Moulsecoomb has around three hundred patients in this category. However, the number of patients being referred has declined as shown below and patients are now referred to Morley Street Dental Clinic.

Moulsecoomb Dental Clinic only operates one day each week and in order to provide comprehensive, higher quality care with better options for appointments and a better patient experience, we propose to relocate the service to Morley Street Dental Clinic. This operates each weekday Monday to Friday and, with five surgeries, gives patients more options regarding their treatment and appointments. This will reduce waiting times and overcome the problem of providing emergency appointments at Moulsecoomb.

Being a larger clinic, there is a better mix of skills at Morley Street which means we can offer all treatment options in one location. We have Senior Dental Officers with the most experience, supported by Dental Officers. Both can create treatment plans which can be undertaken by Dental Therapists. This means that the dentists can concentrate their skills on the more complex patients. An example would be Dental Therapists providing confidence building for phobic patients and spending more time on Oral Health instruction to improve prevention.

Engagement

With regard to the relocation we are engaging with:

- The NHS England Surrey & Sussex Area Team.
- Patients with regard to recall appointments.
- Referrers including GPs, general dental practitioners, school nurses and health visitors.
- Brighton & Hove Health & Wellbeing Overview and Scrutiny Committee HWOSC).
- Brighton & Hove Healthwatch.

The NHS England Surrey & Sussex Area Team has been informed about this change and has agreed in principle but requires confirmation from the HWOSC.

Patients will be informed in writing and the relocation discussed when follow-up and/or recall appointments are arranged. The experience of referrals seen at Morley Street Dental Clinic has not given rise to any adverse comment.

Reasons for the relocation

There are four key reasons: safety, patient experience, operational and financial.

Safety: Moulsecoomb Dental Clinic operates one day a week from one room. There is no reception support and the room serves as a combined office, dental surgery and decontamination/sterilisation room. Moulsecoomb Health Centre cannot provide additional space. This situation is not compliant with national infection control and decontamination standards. In contrast, Morley Street Dental Clinic has recently undergone substantial refurbishment designed to overcome such safety issues, therefore providing the required level of compliance and a safer environment for patients and staff

The Moulsecoomb service is provided by a single registered dental practitioner who is unable to call immediately for appropriate peer support if faced with a challenging clinical decision. This presents a clinical risk in general, and an additional risk given the special and sometimes challenging needs of our patients. As said above, there is a better mix of skills at Morley Street, because it is a larger clinic with five surgeries. This

means we can offer all treatment options in one location, and appropriate peer support.

Patient experience: We will be able to offer a considerably better service at Morley Street and so improve our patients' experience of care.

We provide a reception service each weekday at Morley Street, offering better access and communication. Patients can discuss appointment times/changes face-to-face, and we will be less reliant on telephone answerphone messages. Patients who are anxious and distressed will additionally benefit from the interaction with receptionists who understand their special needs.

Because of the range of services at Morley Street, we can provide a full range of treatment options at one location. A good example is conscious sedation which is only available at Morley Street. We can also take both standard and pan oral radiographs using digital imaging thus reducing exposure time to radiation. Patients can choose to see a female or male clinician, as available.

We have access to a wheelchair platform which eliminates the need for wheelchair patients to transfer to the dental chair.

Morley Street is in the centre of Brighton just 2.8 miles from Moulsecoomb and is well served by public transport. On-street parking is available close by.

Operational: Patients are referred into the service by GPs, general dental practitioners, school nurses, health visitors, and managers of nursing and residential homes. We have seen a steady decline in the number of referrals going to the clinic, and there is no prospect of a significant increase in referrals.

The number of referrals over recent years is:

- 2009/10 – 114.
- 2010/11 – 85.
- 2011/12 – 94.
- 2012/13 – 56.

The number of retained patients is 304: 96 adults and 208 children. All will be reviewed to determine those that can be returned to the care of a general dental practitioner. Those who are appropriate for retention and undergoing a course of treatment will be transferred to Morley Street under the care of their existing dentist.

Financial: The cost of providing care at Moulsecoomb is disproportionately high given the relatively small number of patients using the centre and the occupancy costs associated with providing the service.

Operating only one day each week, the clinic is not fully utilised, the equipment is underused. We have specialist medical devices due for replacement. Relocating the

service will help us achieve maximum value for money from the resources available, and enable us to better maintain and develop the special care dental service for the population of Brighton & Hove as a whole going forward.

Considering the options

In reaching this decision we have taken account of a number of factors including:

- The impact on patients, carers and staff.
- Our commitment and responsibility to deliver safe and effective patient care of a high quality and to improve the patients' experience of care.
- The availability and suitability of other services.
- The availability of other accommodation and capacity.
- The cost of providing services and the financial context in which we work, including the requirement to secure sustainable financial efficiencies.

Conclusion

This proposal provides assurance that the decision to relocate the Moulsecoomb Special Care Dental Service to Morley Street is reasonable. Subject to feedback from other parties, it is intended that the relocation be completed by 31 March 2014.

Sarah Crosbie, Clinical/Managing Director, Dental Services
John Forrester, Senior Business Manager, Dental Services

HEALTH & WELLBEING OVERVIEW & SCRUTINY COMMITTEE	Agenda Item 113 Brighton & Hove City Council

Subject:		**Homelessness Scrutiny Panel Report**	
Date of Meeting:		**04 February 2014**	
Report of:		**The Monitoring Officer**	
Contact Officer:	**Name:**	**Giles Rossington**	**Tel: 29-1038**
	Email:	**Giles.rossington@brighton-hove.gov.uk**	
Ward(s) affected:		**All**	

FOR GENERAL RELEASE

Note: The special circumstances for non-compliance with Council Procedure Rule 3, Access to Information Procedure Rule 5 and Section 100B(4) of the Local Government Act 1972 (as amended), (items not considered unless the agenda is open to inspection at least five days in advance of the meeting) were that the scrutiny panel wanted to take the opportunity to take evidence from Brighton Housing Trust, which necessitated the late publication of this report.

1. PURPOSE OF REPORT AND POLICY CONTEXT

1.1 In 2012 HWOSC agreed to establish a scrutiny panel to look at issues relating to homelessness. The panel was chaired by Cllr Andrew Wealls, and also included Cllrs Alan Robins and Ollie Sykes.

1.2 The scrutiny panel report is attached as **Appendix 1** to this report. Minutes of the panel meetings and additional information will be published on the council's website in due course.

2. RECOMMENDATIONS:

2.1 That HWOSC endorse the scrutiny panel report on homelessness (**Appendix 1**) and refer it on for consideration by the appropriate policy committee(s)

3. CONTEXT/ BACKGROUND INFORMATION

3.1 In 2012 Cllr Wealls requested that a scrutiny panel be established to examine issue relating to homelessness in the city.

3.2 HWOSC agreed the request and a panel consisting of Cllrs Wealls, Robins and Sykes was established, with Cllr Wealls agreeing to chair. The panel held several evidence gathering meetings in the Spring of 2013 interviewing a wide range of witnesses. Panel members also took part in the annual rough sleeper street count and visited a number of accommodation and support services for homeless people.

3.3 This panel report was due to be published in Winter 2013. However, staffing changes to the Scrutiny team meant that it was not in fact possible to complete the report until early 2014.

4. ANALYSIS & CONSIDERATION OF ANY ALTERNATIVE OPTIONS

4.1 The HWOSC has the option to decline to endorse the homelessness scrutiny panel report.

5. COMMUNITY ENGAGEMENT & CONSULTATION

5.1 The homeless scrutiny panel spoke with a wide range of community and voluntary sector organisations responsible for supporting homeless people and preventing homelessness, as well as with rough sleepers and other homeless people.

6. CONCLUSION

6.1 In line with normal procedure, we are asking that the HWOSC endorses this report and refers it on to the appropriate BHCC Policy Committee(s) for consideration.

7. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

7.1 The financial implications of the recommendations from the scrutiny panel will be assessed in the context of the Council's budget strategy when the recommendations are considered by the policy committees.

Finance Officer Consulted: Anne Silley Date: 29/01/14

Legal Implications:

7.2 Once HWOSC has agreed its recommendations based on the work of the scrutiny panel , it must prepare a formal report and submit it to the council's Chief Executive for consideration at the relevant decision-making body.

7.3 If HWOSC cannot agree on one single final report, up to one minority report may be prepared and submitted for consideration by the relevant policy committee with the majority report.

Lawyer Consulted: Oliver Dixon Date: 29/01/14

Equalities Implications:

7.4 The scrutiny panel report (Appendix 1) includes detailed assessments of the problems of homelessness as they impact upon a range of 'equalities' groups, including LGBT people, and those who have experienced Domestic Violence.

Sustainability Implications:

7.5 None identified

Any Other Significant Implications:

7.6 None identified.

SUPPORTING DOCUMENTATION

Appendices:

1. The Homelessness Scrutiny Panel Report

Documents in Members' Rooms

None

Background Documents

None

Report of the Homelessness Scrutiny Panel

February 2014

Panel members: Cllrs Andrew Wealls (Chair), Alan Robins and Ollie Sykes

Introduction

1 What is homelessness?

Homelessness can be defined in several ways. In its widest sense, being homeless means not having access to safe, secure accommodation. People might be staying temporarily with friends or family, or living in accommodation which is unsafe or from which they will shortly be evicted. The majority of homeless people are able to resolve their housing problems without involving outside agencies, except perhaps for some advice services.

However, many other homeless people require much more support, and it is also possible to speak of homelessness in the narrower sense of those who apply for help and who meet the criteria set out in Homelessness legislation. Local authorities have a statutory responsibility to help these eligible homeless people access secure accommodation.

In a narrower sense still, a relatively small group of homeless people cannot find, or for various reasons decline to accept, shelter, and end up sleeping rough. Even when temporarily housed in a hostel or similar accommodation, people in this group are very vulnerable and are likely to find themselves homeless again in the future. Many of the people in this group have physical or mental health problems or substance misuse issues.

2 Local Authority Duties (Homelessness)

Local authorities have clearly defined duties under homeless legislation. Someone is classified as homeless only when they have satisfied five criteria:

- They are a UK citizen
- They are actually (or will imminently be) homeless
- They are not 'intentionally' homeless (e.g. they have not become homeless due to a deliberate act or omission)
- They have a local connection (e.g. they have lived in the area for six of the past twelve months or three of the past five years, or are working in the area, or have close family living in the area)
- They are in a 'priority need' category (i.e. they have a vulnerability which means that they are in greater need of secure housing than the average person)[1]

People who meet all five of these criteria are eligible for help from their local authority. This may include housing advice, assistance with references or a deposit, the offer of temporary accommodation, or even of a secure tenancy – basically whatever support is required to enable an individual to access safe and secure accommodation. In past years, people accepted as homeless would probably have been offered a secure tenancy in a council-owned property; but this is generally no longer the case, and nowadays the offer will typically be of temporary accommodation. The previous model had the

[1] Evidence from Sylvia Peckham, BHCC Head of Temporary Accommodation and Allocations, 25 January 2013: point 3.2.

perverse effect of encouraging people to become homeless in order to get rapid access to social housing tenancies. It also had the effect of placing relatively large numbers of highly vulnerable people together in housing estates, with a potentially detrimental impact upon the cohesiveness of those communities. Placing vulnerable homeless people in temporary accommodation gives housing services the opportunity to provide the necessary training and support to help them manage future tenancies successfully, hopefully avoiding the situation where people who have become homeless after failing to maintain a tenancy are granted another tenancy which they will then fail to maintain.[2]

3 Other Local Authority Duties

Even when people do not meet all of the statutory homelessness criteria, the local authority may still have a duty to house them under adult social care or children's legislation – e.g. for families with dependant children, or people who have particularly acute vulnerabilities in terms of old age, mental or physical health, substance misuse or learning disabilities.[3] People who have been in care as children, those experiencing domestic violence, former members of the armed services, and people leaving custody may also be deemed to have particular vulnerabilities which mean that there is a duty to house them.

This division is important in terms of two-tier local authorities, where responsibilities for homelessness are split between district councils (housing) and county councils (social care). However, for unitary authorities such as Brighton & Hove the same organisation is responsible for both housing and social care. There are obvious advantages in having one department discharge all these responsibilities – and this is what happens locally, with the city council's housing team commissioning accommodation on behalf of adult social care and children's services as well as for its own clients.[4]

Even where there is no local authority duty to house an individual, councils are not legally barred from offering housing support to those who do not meet the eligibility criteria, and may choose to house some very vulnerable people such as rough sleepers.[5]

4 Rough Sleepers

Anyone who becomes homeless could potentially find themselves sleeping rough, and some rough sleeping services are designed to address this general need. However, a significant proportion of those sleeping rough at any time will be people who have refused to be properly housed, or whose issues and behaviour make it very difficult to house them securely for any length of time. This group of rough sleepers often have severe mental health

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[2] Evidence from Sylvia Peckham, 25 January 2013: point 3.4.

[3] Nationally, more than 70% of households accepted as statutorily homeless are accepted because they include dependant children/pregnant women. See DCLG Statutory Homelessness Statistics Release 2013 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/205221/Statutory_Homelessness_Q1_2013_and_2012-13.pdf

[4] Evidence from Sylvia Peckham, 25 January 2013: point 3.3.

[5] Evidence from Sylvia Peckham, 25 January 2013: point 3.6.

problems, learning disabilities, physical disabilities, substance and/or alcohol misuse and dependence issues, a history of anti-social or criminal behaviour, or traumatic personal histories (and often a combination of these issues). Although we are talking about small numbers of people here, their impact is quite disproportionate to their size, and many rough sleepers have very complex needs requiring specialist support.

5 What's the trend?

Homelessness has been a serious local and national problem for many years, with rates of rough sleepers, people accepted as statutorily homeless, people living in temporary accommodation, and people 'sofa-surfing' fluctuating from year to year. However, recent years do seem to have shown consistent increases in several of the measures of homelessness. For example:

- There was a 6% increase in successful homeless applications across England between 2011-12 and 2012-13.[6]
- Between 2012 and 2013 the number of people in temporary accommodation across England also increased by 10%.[7]
- Between 2010 and 2012 rough sleeping rates across England by around 30%[8]
- In Sussex between 2011 and 2012 there was a 40% increase in rough sleepers.

There are several reasons to think that homelessness may well increase in the next few years. In the first place, it is widely accepted that homelessness rises in times of economic hardship – people who lose their jobs struggle to pay rent; young people without jobs can't get tenancies; people leave secure accommodation in search of work in less depressed areas. There is obviously a good deal of uncertainty here, both in terms of the speed and the extent of economic recovery locally and nationally (with the potential for internal migration of job-seekers into more economically buoyant areas).

This general pressure can be exacerbated by particular local pressures – obviously by how well the local economy is doing; but also by local house prices (high prices tend to mean higher rents in the private market as a wider range of people are obliged to rent); by supply and demand in the private rented sector (where demand exceeds supply landlords can afford to be more selective in their choice of tenants); by the presence of large numbers of students etc. Clearly all of these pressures apply in Brighton & Hove.

[6] See DCLG Statutory Homelessness: Statistical Release 2013, p3. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/205221/Statutory_Homelessness_Q1_2013_and_2012-13.pdf
[7] See DCLG Statutory Homelessness: Statistical Release 2013, p8.
[8] See DCLG Rough Sleeping Autumn 2012: Statistical Release, p2. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/73200/Rough_Sleeping_Statistics_England_-_Autumn_2012.pdf

6 Welfare reform

An additional pressure is the ongoing reform of the benefits system which includes significant changes to Housing Benefit (HB), involving reducing the amount that can be claimed and restricting the types of accommodation that some groups of people can claim – e.g. changing the rules so that under 35s can now only claim for the cost of a room in a shared house or making changes to under-occupancy rules in social housing (the so-called 'bedroom tax'). They also include changes to Council Tax benefits; the reassessment of various disability-related benefits, and some other measures.

A major issue is likely to be the move from paying HB to landlords to making direct payments to tenants. This poses particular problems for those clients who struggle to manage their own finances, a group which includes many people in temporary accommodation. It is not currently clear whether people in temporary accommodation will be exempted from direct payments (as those in supported housing have been), but if they are not there may be a precipitous drop in rent collection rates for this type of property – pilot areas have seen collection rates fall from 98% to 60%, which would equate to around £4 million per year across Brighton & Hove.[9]

It is not yet apparent what impact these benefit reforms will have, although it is clearly the Government's intention that they will reduce welfare costs and encourage a more rational use of housing stock rather than increasing the numbers of homeless people. In some instances, welfare reforms have not yet produced the predicted detrimental impact.[10] However, even if there is a limited national impact upon homelessness, there may be a much higher impact in some areas – where, for example, private landlords housing HB claimants may prefer to look to other markets (students/professionals) rather than reducing rents to reflect lower HB payments. Again, given its large student population and high number of professional private renters, Brighton & Hove is as likely as anywhere to experience these pressures.

It is also the case that some areas may act as magnets to homeless people, attracting people from other areas. Again, this is likely to be a particular problem for Brighton & Hove, with its reputation as a diverse, tolerant and fun city.

7 Who is becoming homeless?

Clearly, anyone can become homeless, but services have reported significant increases in two groups of people: people with very low support needs (e.g. people who are work-ready or actually in work but who cannot access secure housing because they don't have money for deposits or can't provide references etc), and also people with very complex needs. The first group is relatively easy to support via help with deposits etc. as long as they are swiftly identified.[11] Supporting the second group is much more challenging.

[9] Evidence from Sylvia Peckham, 25 January 2013: point 3.15.
[10] Evidence from Sylvia Peckham, 25 January 2013: point 3.16.
[11] Evidence from Bec Davison, CRI, 07.02.13: 8.2.

There are particular problems with young people – given the very high levels of youth unemployment it can be very difficult for young people to get private tenancies without deposits, references or a steady wage.

8 Social Capital

There are various definitions of social capital, but in essence it represents the informal support networks that individuals have which allow them to cope with crises. In terms of homelessness, your social capital is what keeps you off the streets if you find yourself without a home, whether it's family members lending you the money for a deposit or friends letting you sleep on their sofa.

Social capital is crucial in keeping the numbers of homeless people who seek statutory support at a manageable level. However, there are a number of factors that can impact upon social capital. These include recessionary pressures – people who are themselves struggling to make ends meet are less likely to be able to help others out, so the more general an economic downturn the more it is likely to reduce social capital. Similarly, the length of a downturn is important as a willingness to help people temporarily will not necessarily translate into long term support.

Other factors may include how settled and 'local' a population is – areas where lots of people are non-local are likely to have lower social capital than areas in which most of the residents are locals.

Another factor may be the availability of spare living space – in areas where housing is relatively cheap, lots of people may have spare rooms, meaning that they may be able to offer friends a temporary place to stay. In areas where it is expensive, spare rooms are an unaffordable luxury for most people.

It does seem as if there may have been a recent reduction in the availability of social capital in Brighton & Hove, and this may make itself felt in increasing numbers of homeless people seeking support. Bec Davison of CRI told the panel that it had been calculated that in recent years it had typically taken someone who found themselves homeless seven years to exhaust their social capital and become a rough sleeper, but that this was currently taking more like a year – it is unclear why the situation has changed so much recently. This is a national trend, but as noted above it may be a particularly serious issue locally. Ms Davison recommended that more work be done locally to investigate this phenomenon and to plot what might be done to increase social capital.[12]

9 Services

The range of services offered to homeless people is very wide. It includes Housing advice and assessment; council-commissioned temporary (B&B) and emergency (hostel) accommodation; a range of council-commissioned support and outreach services delivered by community sector organisations; mental health, substance misuse and learning disability services; general

[12] Evidence from Bec Davison, CRI, 07.02.13: 8.3.

healthcare; police and probation services; community safety, and benefits advice. As well as services commissioned or provided by the statutory agencies, there are a wide range of voluntary and community sector-funded and provided services available across the city. Some of these services may be dovetailed with statutory support, but others are not, and some voluntary sector services might seem to work against the thrust of statutory sector strategies (supporting homeless people with no local connection to stay in Brighton & Hove, when statutory services will be trying to relocate them, for example). In consequence, the map of homeless services is complex, and is something that, to some extent, has grown organically rather than as the result of strategic planning.

10 BHCC Services

The city council runs a range of homelessness services. The Housing Options team offers advice on finding a home and also processes homelessness claims. For people deemed officially homeless, or homeless and awaiting assessment, there are two basic types of accommodation: B&B or temporary housing and hostel or emergency housing. Some of this accommodation is directly owned and managed by the council, but most is contracted from a range of providers. In theory homeless people will be offered the most appropriate type of accommodation, with those with relatively low support needs going into B&H and those with higher support needs (e.g. many rough sleepers) into the hostels system. However, this does not always quite work this way in practice, as sometimes one type of accommodation may be full or for some reason unsuitable for a particular client.

In many instances the council will seek to support people in accessing private-rented accommodation rather than providing them with council accommodation – e.g. by helping them with deposit or references or putting them in touch with landlords willing to house a wide range of people.

The council also commissions a range of outreach and support services for rough sleepers, largely from CRI, a national voluntary sector organisation, and from Brighton Housing Trust (BHT).

The council also provides or commissions other services such as extreme weather shelters for rough sleepers[13].

Councils have a variety of responsibilities for adults who have particular vulnerabilities, such as significant mental health, learning disability or physical health problems, and these responsibilities apply whether someone is securely housed or homeless.

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[13] Evidence from Jenny Knight, BHCC Commissioning Officer for Rough Sleepers: 25.01.13, point 3.7.

Recommendations

Health
It is difficult to estimate the health impact of being insecurely housed or of 'sofa surfing' – in large part because we have no ready way of identifying the 'hidden homeless' who do not seek help from services. It seems likely however that this group of people is particularly vulnerable in terms of emotional wellbeing and mental health: being homeless is hardly conducive to happiness. There may well be other health impacts also – of living in damp or unsanitary housing, of having limited facilities for preparing fresh meals and so on.

We know much more about rough sleeping and health, which is reported as part of our local Joint Strategic Needs Assessment (JSNA). Rough sleepers typically have much higher than average health needs, particularly in terms of mental health, drug & alcohol dependency, physical trauma (especially foot trauma), skin problems, respiratory illnesses and infections.

Brighton Homeless Healthcare (Morley Street GP practice) provides a specialist primary (GP) care service to homeless people in the city. In terms of the practice population:

- Life expectancy is 70.3 years (the city average is 81.7)
- Mortality rates from coronary heart disease are *twelve* times greater than for the GP practice with the second highest rate
- A&E attendance rates are five times higher than the local average
- Emergency hospital admissions are four times higher than the local average
- Planned in-patient hospital admissions are a third lower than the local average
- Hospital re-admission rates are twice the local average[14]

Health, other than mental health, is not an area that the panel investigated in any depth. However, support officers to the panel were given the opportunity to attend a conference organised by SHORE (Sussex Homeless Outreach, Reconnection & Engagement), where together with Public Health colleagues they presented a workshop on homelessness and health needs to a range of homelessness professionals from across Sussex.

Several themes emerged from this workshop and from more general conversations with public health experts. These include:

[14] See Brighton & Hove Joint Strategic Needs Assessment Summary 2012: Rough Sleeping.

Identifying rough sleeper health needs. Rough sleeper numbers are relatively small, even in somewhere like Brighton & Hove. This can mean that the health needs of this group can easily get overlooked, with the focus of attention being big, population-wide issues such as smoking or obesity or on high prevalence/high impact conditions like cancer and dementia. However, the health needs of rough sleepers are so extreme that they can have a really disproportionate impact on services – e.g. in terms of requiring emergency admissions – and on health inequalities across the population. There is therefore a case, both in financial and in equalities terms, for services to think much more carefully about the needs of rough sleepers than their numbers alone might seem to justify.

Outreach services for rough sleepers. Rough sleepers typically live very chaotic lives and may struggle to make or keep appointments etc. This presents an obvious problem in terms of accessing health services, where patients are generally required to make an appointment days or weeks in advance or at the very least to spend several hours waiting in A&E or at a GP walk-in service. For many rough sleepers this simply isn't going to happen, meaning that they will only come into contact with health services when they have a crisis requiring emergency admission. Such admissions are very expensive, with outcomes much worse than for people whose conditions are properly supported via primary, community and secondary healthcare. What is required, therefore, is a range of 'outreach' services that meet the needs of rough sleepers, rather than expecting rough sleepers to negotiate the normal NHS access pathways.

In fact, there is a good deal being done already in Brighton & Hove in terms of homeless health. Homelessness is already needs assessed, and there is a dedicated homeless needs section in the city Joint Strategic Needs Assessment (JSNA). There is also a dedicated primary care service for homeless people run from the Morley Street surgery. Recent initiatives by Housing have included outreach work, with clinicians going into hostels and assessing and treating problems in situ. The city public health team is also fully involved in strategic housing partnerships.

Brighton Housing Trust also told the panel about a project they have been involved with, providing a 'Hostels Alcohol Nurse' who works intensively with the most alcohol dependant hostel residents in the city (particularly those who are currently not accessing medical treatment). This project has been very successful to date, with significant reductions in emergency call-outs, presentation at A&E, and hospital admissions saving an estimated £240,000 over 12 months.[15]

Another recent initiative is the Hostels Hospital Discharge Project. This is a partnership project between BHT, CRI, Riverside ECHG and Sussex Community NHS Trust. The project will target hostel residents who have

[15] More information on this initiative is included in **Section 2** of this report.

recently been discharged from hospital, seeking to provide high quality support which will reduce re-admission rates.[16]

In addition the Brighton & Hove Health & Wellbeing Board (HWB) recently agreed that the coming year's JSNA programme of specialist needs assessments should include additional work on homelessness – using the Homeless Link Health Needs Audit toolkit to better identify health needs across the local homeless community.

The HWB also recently agreed to establish a city multi-agency Programme Board to drive better integration of health and social care services for vulnerable 'homeless' people – a group including rough sleepers, but also people sofa-surfing or living in temporary accommodation, hostels, squats etc.

It is clear from the work mentioned above that the health and care needs of 'homeless' people are increasingly being recognised as an issue across services, and that active steps are being taken to accurately assess the scale of the problem and to develop effective joint working approaches. This is to be warmly welcomed.

The panel also welcomes the fact that the HWB has taken ownership of the issue of homeless health by establishing a Programme Board. We trust that the Programme Board will report regularly to the HWB.

RECOMMENDATION 1 Given the significance of homeless people in terms of city health inequalities, we welcome the fact that the Health & Wellbeing Board is taking an active interest in the health and social care needs of this group. We are very interested in the progression of this work, and request that the HWB's plans for homeless healthcare be presented to the HWOSC for comment within the next 12 months.

Targeted Support

Many homeless people have relatively few additional support needs. However, some people have very complex needs, including severe mental illness, learning disability, physical disability, problems with drugs & alcohol, a history of offending, traumatic personal histories, and so on. Often, the most complex clients may have a combination of these and other problems.

This relatively small group of people with very complex needs makes up a significant part of our local population of rough sleepers. This is unsurprising, as all of the above problems are potential risk factors in being unable to keep up a tenancy. Not only are people with complex needs much more at risk of becoming homeless than the general population, but they are typically much harder to help. Even if people engage with services it can be very difficult to support them properly – as they can be very challenging and may not be able to cope with the rules of support services, hostels etc.

[16] Information provided by BHT, Nikki Homewood and Andy Winter, informal meeting Jan 14.

In addition, people with complex needs are likely to need support from a number of services – housing obviously, but potentially also social care, NHS mental and physical health services, the police, probation and so on. There are obvious risks involved in having a number of agencies provide support to an individual, particularly in terms of duplication or of clients falling 'through the gaps'. This is particularly so since people with the most complex needs are unlikely to cope well with complexity – having to deal with a number of agencies can be confusing and may worsen rather than help some conditions.

Traditional means of supporting people with very complex needs have also been found to be too focused on the short-term – providing support for the here and now which may provide some topical assistance, but which does little to change people's behaviour significantly, and therefore little that is likely to reduce support needs going forward.

Where people with complex needs have to negotiate set support and care pathways there can be problems too. Rigid pathways for specific issues are unlikely to be suitable for people with cross-cutting needs; but if the only way to access appropriate levels of support is to follow a particular pathway, then people may end up going around in circles.

For example, Ellie Reed, a Complex Needs Social Worker with CRI, told the panel about a client of hers who has been evicted from city hostels more than 30 times. It was clear, and had been for a considerable time, that this client could not cope with a hostel environment – the rules, the business and noise and the presence of active drugs users were all factors making effective support via a hostel placement a practical impossibility. What was needed for this client was private, self-contained accommodation, where, with lots of appropriate support, there was at least a chance that he could settle.[17]

However, the pathway for homeless people requires users to cope successfully with living in Band 2 (hostel) accommodation before 'stepping-down' to Band 3 independent supported living. In general this pathway makes perfect sense – someone who has shown that they can cope with the rules-based approach of hostel living may well be more likely to succeed in an independent environment than someone who has gone straight from rough sleeping to independent living. But for certain people, the pathway through hostels is never going to be appropriate.

Following a long process of negotiation CRI have been able to circumvent the pathway in this instance and have placed their client directly into a 'training flat' normally used to support Band 2 to Band 3 transfers. This is a welcome outcome, but with a less rigid pathway this might have been achieved much more easily and at a point prior to many of the person's 30 plus evictions, avoiding a lot of stress to the user and saving services a very significant amount of money – because although the current arrangements require a high degree of support, this is likely to be insignificant compared to the costs

[17] Evidence from Ellie Reed, CRI, 07.02.13: point 8.6.

of repeatedly evicting someone, supporting them as a rough sleeper, finding them new hostel accommodation and so on.

There is a general point here as well as a specific one about over-rigid pathways: a great deal of money is spent 'supporting' people with complex needs through crises. This can include eviction and re-housing, but also in-patient admissions to hospital, anti-social behaviour of many kinds, and even prison. Given the extraordinary level of costs associated with some of these issues, it would seem to make obvious sense to target preventative support at those people most likely to cost the system large amounts in the long term. It is clearly also the case that, once people become habitual offenders, or rough sleepers etc. it is much more difficult and much more expensive to change their behaviour than if the intervention came at an earlier point.

Of course, services do work together to try to provide holistic support for their clients, and there are really good examples of innovative co-working. However, within traditional organisational restrictions there is only so much that can be done.

There is an interesting model for a more integrated way of working to support the most vulnerable currently being trialled. In recent years, some very vulnerable families across the city have been receiving targeted support – initially as part of the 'Troubled Families' initiative, latterly as part of an expanded nationally-driven programme, locally known as 'Stronger Families, Stronger Communities'. This initiative sees several hundred of the most vulnerable local households receiving targeted support and intervention from a multi-disciplinary team. Each family works with a single 'coach' who helps them manage their interactions with different support services, and ensures that support is appropriate to the client's needs, that it works towards achieving clear outcomes, and that the demands placed upon clients are realistic.

In combination with a better integration and focusing of existing support channels, the initiative also provides additional support, particularly in the form of general help with living: paying bills, making benefits claims, keeping the home clean, keeping appointments etc. The additional expense of this type of targeted help is recouped down the line, as effectively supported clients are less likely to make much more expensive demands on services at a later date – e.g. a family that pays the rent or claims the appropriate level of Housing Benefit will avoid rent arrears and therefore avoid the cost of debt collection or eviction. Since some of these long term costs are very expensive indeed, and since the households being supported are very likely to end up in serious trouble without early support, the cost of this additional support is likely to be considerably less than the cost of no additional support. And clearly, what is true in terms of funding is likely to be true in terms of the welfare of the people involved also.[18]

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[18] However, the notion that front-loaded investment in services will deliver a down-line savings has relatively little really high-quality evidence-base. Bec Davison of CRI suggested that it would be worthwhile to do some detailed mapping of the costs and benefits of this type of

The cost-benefit analysis of this type of intervention is clearest when the people being supported have problems which a) are very likely to escalate if not effectively treated, and b) are likely to cost a great deal to treat in the longer term. Whilst there are arguments for providing additional support to very broad populations, the cost benefit is less obvious here, as many of the people receiving additional support may not have developed bigger problems down the line. If there is a financial argument for targeted support therefore, it is likely to be strongest for clients with the most complex needs.

The panel believes that there are real opportunities in using the Stronger Families, Stronger Communities model of front-loaded, integrated support to target those rough sleepers with the most complex needs who are currently not well served by the existing homelessness and allied pathways. (To be clear the panel is not proposing that the Stronger Families programme be expanded to include vulnerable homeless people; merely that homeless people are supported via an integrated programme of practical support with a significant focus on making financial savings as well as improving the lives of services users – and Stronger Families is an obvious model of this type of scheme.)

In the first place, we propose that a cost-benefit analysis is undertaken, identifying the costs of providing additional targeted support to those rough sleepers with the most complex needs versus the likely future costs of continuing with current support methods. Such an analysis needs to reach beyond the local authority to include other services directly impacted by rough sleeping. This will potentially include the NHS, both in terms of mental health services, where there is a laudable recent history of successful integration and cost-sharing, but also in terms of physical health – rough sleepers are many times more likely to present for A&E treatment and to require unplanned hospital admissions than the general population, so there is a potential benefit to NHS acute providers and the commissioners of unplanned/emergency care here.[19] It may also include the police and fire services, probation and potentially the prison system – the costs of imprisoning people are very high and there is a strong correlation between rough sleeping and incarceration. Community and voluntary sector organisations in the city must also be involved in this calculation.

In some instances it may be the case that, even if it is possible to show that targeted support would result in a longer term saving, it is not feasible to persuade national agencies etc. to contribute to local initiatives. It would be very useful to have an idea of the absolute savings that could potentially be achieved across the board even if some of these savings cannot readily be realised, not least so as to be able to plan for lobbying of national agencies.

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model against the costs/benefits of the models currently in place. Evidence from Bec Davison, 07.02.13: point 8.10.

[19] As noted elsewhere in the report, there are current initiatives providing support for hostel residents with alcohol problems and for those recently discharged from hospital which might provide a useful source of data.

However, in the short term, the focus should be on those organisations where there is a realistic chance of partnership working and cost sharing.

One of the biggest difficulties encountered in supporting homeless people with very complex needs can be that this group is very likely to be wary of authority – for obvious reasons with individuals who feel they have been failed by services in the past or for people who have been in and out of prison. This issue is becoming better recognised, with one obvious solution being to increasingly rely on trusted, expert community sector organisations to do much of the direct interfacing with clients. In the type of targeted support approach outlined above, an absolutely key element is that of the 'care coordinator' who forms a relationship with and acts on behalf of the client. It may well be that this is a role that is be best carried out by non-statutory sector organisations, although equally there may be instances (e.g. where someone has a very complicated mental health problem) when it is better to have that role filled by a suitably qualified professional from a statutory agency.[20]

The panel were very interested to hear about the Big Lottery Bid application: this multi-partner application seeks funding to deliver more holistic services to homeless people with complex needs. Panel members were delighted to hear that the application was approved just before Christmas 2013.

This project is to be commended, but we need to go further: not just seeking external funding to deliver better targeted services to clients with complex needs, but actively reconsidering how the council and its key city partners use existing homelessness funding. There seems to be real potential to use resources more wisely: front-loading support for some clients may save money in the longer term as well as giving homeless people the best possible chance of getting some stability into their lives. In consequence, we hope that the Big Lottery work is viewed as a springboard to more intelligent co-working rather than as an end in itself.

It has also recently been announced that the council will establish a multi-agency board to oversee services focused on homeless people and community safety. This initiative is very much to be welcomed and it is heartening to see that city agencies are beginning to make real practical moves towards proper integration of services.

If this report had been written a few years ago, the panel might well have been calling for more integration of services across a landscape where different agencies worked largely within their own silos, even though many homeless professionals recognised and were lobbying for greater integration. At the present time, however, it is clear that much has changed, and that agencies have taken significant practical steps towards better integration.

This is good news for vulnerable homeless people and for the city as a whole. However, we are still a long way from truly integrated services, and there is a

[20] Evidence from Bec Davison, CRI, 07.02.13: point 8.5.

real danger that some of the current initiatives will fizzle out without having really advanced things, particularly in instances where a project is dependent upon lottery or other uncertain external funding. (In this context it is good to hear that partners are committed to continuing the project to provide integrated health and social care to vulnerable homeless people despite failing to win Department of Health Pioneer funding for the scheme.)

There is also a risk that we end up with a number of schemes to better integrate services for homeless and insecurely housed people, but that there is little or no effective integration of the schemes at a strategic planning level. While the various initiatives would still be valuable in themselves this would seem to risk missing some obvious opportunities. However, it also needs to be recognised that services are complex and that there may therefore be very good reasons for approaching better integration of, say, healthcare separately from community safety services.

In order to ameliorate these risks the panel proposes that the city council nominates a senior officer to act as a champion for homelessness service integration.

- The homelessness integration champion should have a brief to encourage the better integration of services across the city, in terms of both statutory agencies and other sectors.

- The homelessness integration champion should submit a report to both Housing Committee and the Overview & Scrutiny Committee (within 12 months of these panel recommendations being agreed by the relevant council decision-making committee). The report should detail the practical steps taken towards better integration over the past 12 months by the various schemes in operation, as well as plans for further development across the next year.

- The homeless integration champion will also be responsible for ensuring that the various projects for better integration of homelessness services are aware of each other's work programmes and are working symbiotically where there are advantages in so doing. Actions towards co-ordinating the move to better integration across the wide range of services to homeless people should also be detailed in the report to Housing Committee/OSC.

- The homelessness integration champion will also be responsible for collating information on the cost savings (or otherwise) achieved by better integration of services, both to include in the report to Housing Committee/OSC, and in terms potentially of establishing a more general business case for the value of service integration.

RECOMMENDATION 2 A senior BHCC officer should be appointed as 'homelessness services integration champion' across statutory services and other sectors.

Hostels
Traditionally, in Brighton & Hove and elsewhere, most single homeless people eligible for local housing support would be offered a place in a hostel. Hostels typically house a number of people in individual bedrooms, but with other areas communal. Hostels provide various levels of support, depending on the types of clients housed there. They are intended to be a relatively short term resource, with residents moving on to independent living or to lower support housing. However, progress on this pathway will depend on a client's ability to live independently: whilst some hostel residents are perfectly capable of managing a tenancy, others, particularly those from rough sleeping backgrounds are not, and require intensive support to develop these skills.

There is little doubt that hostels can be a very useful housing resource: for instance, it is generally more straightforward and more cost-effective to provide support to a number of people living together than to smaller groups or individuals. Nikki Homewood of BHT told the panel that city hostels could be extremely effective, delivering really good outcomes in terms of supporting people to move on to independent living. Hostels are not just shelters, but places from which a wide range of support services can potentially be delivered efficiently.[21]

However, there are also some quite significant problems associated with hostels. Firstly, the hostel environment may simply be unsuitable for some clients. This may be particularly the case for people with particular mental or physical health problems or learning disabilities who cannot cope with group living. For others, particularly for those trying to recover from drug or alcohol misuse, hostels are a difficult environment because some residents may be using such substances. Other people may simply be unable to obey the rule-based system that hostels need to employ to deal safely with high-needs residents.[22] It seems perverse to attempt to house people genuinely unable to cope with group accommodation in an environment that may serve to exacerbate rather than reduce their support needs.

Secondly, the fact that hostels bring together a number of people who may tend to have problems with offending, anti-social behaviour, mental health problems and drug or alcohol misuse can create significant problems for local communities. It is evident that the size of hostels is a factor here: the more people with high support needs who are housed together, the more likely it is that they will interact badly.[23] Although a good deal can be done to reduce the impact of anti-social behaviour associated with hostels, particularly in terms of the support provided to hostel residents, the presence of hostels in residential areas remains problematic.

Thirdly is the issue of location. For historical reasons our hostels tend either to be located in central Brighton near the seafront, or close to London Road or

[21] Evidence from Nikki Homewood, BHT, informal meeting Jan 14.
[22] Evidence from Narinder Sundar, Commissioning Manager, BHCC Housing, 07.02.13: point 8.6.
[23] Evidence from Sylvia Peckham, 25.01.13: point 3.10.

St James Street. This concentration of accommodation means that there is a disproportionate impact on some communities. It is also unfortunate that so many of our hostels are close to areas associated with anti-social behaviour, drug-dealing and street drinking.[24] For people who are trying to be abstinent such environments pose obvious challenges. (It's evidently not just coincidence that the areas with most hostels are the places where there are problems with street-drinking etc – part of the problem is the behaviour of some hostel residents. However it's also clear that somewhere like Brighton sea-front is going to be a hot spot for substance misuse and anti-social behaviour whether or not hostels are clustered there.)[25]

The panel heard from housing officers that a pilot initiative had seen a small hostel opened at a location a little out of the city centre, and that results had so far been positive, with a reduced level of drink and drugs-related anti-social behaviour from residents, and relatively few problems caused for the local community.[26] However, it should be noted that this hostel houses people with relatively low support needs.[27]

It does seem as if there is some potential to make hostel provision more diffuse, with less reliance upon large central Brighton hostels in favour of smaller units in slightly less central areas. If effective, this would help to reduce anti-social behaviour from hostel residents and reduce the impact upon local communities, particularly those in city centre wards.

RECOMMENDATION 3 the council needs to take action to diversify its 'stock' of hostel accommodation, seeking to spread hostels more evenly across the city, and to offer a range of accommodation options in terms of hostel size and the level of support on offer.

This still leaves the problem of people for whom hostel accommodation is never going to be a feasible option. At the moment there is no realistic alternative for these clients. This seems unacceptable, since people with the type of complex needs that make it impossible to effectively place them in hostels are not going to magically find a housing solution without intensive support. Instead they are likely to end up in a 'revolving door' – rough sleeping until they are placed in a hostel, evicted from the hostel and then rough sleeping again until they are placed in another hostel. This is clearly a poor way to support highly vulnerable people and a potential waste of money.

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[24] Evidence from Sylvia Peckham, BHCC Head of Temporary Accommodation and Allocations, 25 January 2013: point 3.11.

[25] BHT told the panel that a recent local count of street drinkers run by Equinox had shown that, perhaps contrary to received opinion, the majority of persistent street drinkers are not hostel residents, and that a relatively small percentage of city hostel residents are in fact street drinkers. Of 93 people identified as street drinkers, 35 were hostel residents. Of the 35 people identified as high profile regular street drinkers, 16 were hostel residents. This is under 6% of the city's hostel population (288). This suggests that hostels work effectively to minimise the problematic street presence of their residents (evidence provided by BHT: included in **Section 2** to this report).

[26] Evidence from Sylvia Peckham, BHCC Head of Temporary Accommodation and Allocations, 25 January 2013: point 3.11.

[27] Evidence from BHT: informal meeting Jan 14.

Some witnesses to the panel suggested that we should move away from the hostel model entirely, seeking instead to focus on much smaller units, or on housing people individually with support.[28] In the short term it seems highly unlikely that we would or could abandon the hostel model, but it is important there should be alternatives for those clients for whom hostels are an ineffective housing option. This should include smaller scale supported housing as well as supported independent housing. Although this type of supported housing may seem considerably more expensive than accommodating someone in a hostel, it is unlikely to be more expensive than *failing* to accommodate someone in a hostel.[29] This is an option that has been successfully explored by local authorities in Westminster and Oxford,[30] although housing officers did point out that, whilst offering alternatives to hostel accommodation may initially appear an attractive option, it does depend on there being appropriate housing stock available, which may pose a problem locally given the high demand for social housing.[31]

RECOMMENDATION 4 we need a more diverse range of supported accommodation available to house single homeless people, particularly those with very complex needs. Whilst this is clearly not going to happen overnight, we would welcome a commitment to move to a model of greater diversity coupled with at least some practical action in the short term.

Service Mapping and Member Engagement

Everyone knows that homelessness is a major issue in Brighton & Hove. However, beyond this general perception of there being a problem, there is relatively little detailed public understanding of homelessness as an issue. Indeed, the panel members were struck by how little *they* actually knew about homelessness services, and just how wide-ranging services actually are. As part of the scrutiny review process, members talked widely to officers in the council's housing service and other homelessness support providers. They also visited several services for homeless people, including hostels, drop-in centres and B&B accommodation, talking with staff and service-users.[32]

It quickly became apparent that services for homelessness are a complex mosaic, involving at least two council housing teams, NHS commissioners and providers, Community Safety, Public Health, the police and probation services, and a wide range of community and voluntary sector providers – some commissioned by the city council or the NHS, others independently funded and operating to their own agenda.

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[28] Evidence from Bec Davison, CRI, 07.02.13: point 8.7, and from Ellie Reed and Sarah Gorton: point 8.15.

[29] Evidence from Bec Davison, CRI, 07.02.13: point 8.7.

[30] Evidence from Sarah Gorton, Homeless Link, 07.02.13: point 8.7.

[31] Evidence from Narinder Sundar, 07.02.13: point 8.8.

[32] Panel members visited First Base Day Centre, Phase 1 Hostel, New Steine Mews Hostel, Glenwood Lodge Hostel and the West Pier Project. Members also took part in the annual rough sleeper street count and attended a service-user event where they interacted with Business Action on Homelessness. As part of the panel process, support officers met with BHT and co-ran a workshop session at the SHORE conference.

Complexity is not necessarily a bad thing. In some instances very complex service arrangements may work superbly well. It may also be that there is an irreducible complexity inherent in homelessness services – because the problems cut across so many services and concern so large a number of partners, and because there is so much long-standing public and charitable concern around homelessness. It may well be that there is very limited potential in terms of further integrating or streamlining this map, and indeed there may be major benefits from having multiple approaches and solutions to the problem of homelessness.

However, whilst the local map of homelessness services is doubtless fully understood by the relevant housing professionals, and makes perfect sense to those whose core job is homelessness, from the point of view of potential service users, or even of people working in the police or the NHS, the complexity threatens to be bewildering.[33] If the people who need to use a service are unclear as to what services are actually available and how to access them, they are unlikely to have a positive experience.

Whatever the actual organisational and partnership complexity of homelessness services therefore, there is a clear need for a readily comprehensible map of services – something that offers a simple picture of the services on offer across the city.

RECOMMENDATION 5 the council needs to produce a clear map of statutory and non-statutory homelessness services across the city and make it available via the its website.

In a similar vein, the Council's elected members have ultimate decision-making powers in relation to homelessness services (at least in terms of services commissioned or provided by the city council), but members' understanding of homelessness as an issue and of the types of services on offer is often very limited (excepting of course Housing Committee members). The panel members were very impressed by the services they visited or were told about, and by the obvious competence and dedication of the people working in them. We think that there would be value in the housing team doing more with elected members, both in terms of homelessness as a strategic concern and in terms of the practical services on offer and how they can be a resource to ward Councillors. Improving the information available to elected members is likely to lead to a better understanding of the importance of homelessness services. This is particularly important as homelessness cuts across services, meaning that decision-makers in areas other than housing would benefit from greater knowledge of the issue.

This was reinforced by evidence from Sarah Gorton, the South East Regional Manager for Homeless Link, a national membership organisation for organisations working in the field of homelessness. Ms Gorton highlighted the

[33] Evidence from John Child, Deputy Service Director, Sussex Partnership NHS Foundation Trust, 07.02.03, point 8.19.

importance of involving elected members in homelessness services, and commented:

"It was really good to see members from all parties interested enough to come on the rough sleeper count and impressive to attend the scrutiny panel meeting and witness the genuine desire from Councillors to engage in the issues and to think about what needs to change."[34]

Other witnesses, including Central Sussex YMCA, reiterated the importance of elected member involvement in homelessness issues.[35]

As Brighton & Hove City Council operates a committee system, we already have a relatively high degree of cross-party member involvement in homelessness issues via the BHCC Housing Committee. There is also direct elected member involvement in the local Strategic Housing Partnership. In addition the city Health & Wellbeing Board will be involved in monitoring the soon to be established Programme Board for integrated homeless health and social care.

There is therefore already a good base of relatively expert members to build on. This should be reinforced via the member training programme. The panel is pleased to note that the member seminar programme already includes training on homelessness issues, and trusts that there will be further training scheduled.

Pathways

Service pathways set out how service-users access and progress through a system and are an important tool for professionals. Homelessness pathways need to be simple enough for service users and non-housing professionals to understand and they need to be flexible enough to avoid bottlenecks and perverse outcomes. It is not necessarily an easy task to devise a pathway through services that is easily understood and appropriately flexible, and even the most robustly designed pathways need periodic tweaks.

The panel heard evidence that aspects of homelessness pathways were not working as well as they should. For instance, CRI told us that homeless pathways demand that homeless people accessing band 3 unsupported accommodation must first have progresses through band 2 supported accommodation (i.e. hostels). For most clients this may make perfect sense, as people who have successfully lived in group accommodation are well placed to take on the additional responsibilities associated with independent living – many rough sleepers would not cope well if immediately moved into unsupported accommodation. However, for a small group of people with complex needs, progress through band 2 is much more problematic, and a better alternative might be to house them directly in band 3 housing with appropriate levels of support.[36] In this particular instance it seems likely that a

[34] Email from Sarah Gorton, SE Regional Manager, Homeless Link
[35] Evidence from Central Sussex YMCA, 19.02.13: point 13.35.
[36] Evidence from Ellie Reed, CRI, 07.02.13: point 8.6.

generally sensible policy has had perverse consequences, and some relaxation of the pathway rules would be desirable.

Other witnesses suggested that the homeless pathways be amended to provide more robust learning and work support[37], or that a dedicated young people homeless pathway be established.[38] The panel is pleased to note that the city council is actively seeking to develop a young person housing pathway.[39]

RECOMMENDATION 6 – homeless pathways should be revised to allow clients to progress directly into band 3 support when it is clear that there is no realistic possibility of them progressing successfully through band 2 support.

Setting local levels of support

Homeless is not a localised issue. Whilst the majority of homeless people in an area are likely to be from that area, by no means every homeless person will be. Some destinations are inherently more appealing than others for rough sleepers. Factors which make a particular area attractive include: climate, levels of street violence, the presence of an established rough sleeping 'community', access to drugs, the availability of non-statutory support (food, sleeping bags etc), and the relative generosity of statutory sector support.

A number of these factors apply to Brighton & Hove and it is therefore no surprise that the city has to deal with a disproportionate number of rough sleepers. Of course, there's not much we can do about the weather, and some of the things that make Brighton & Hove attractive to rough sleepers are also the things that make the city attractive to tourists or businesses, so we'd be unlikely to want to change them even if we could.

However, there is more opportunity to influence some of these factors, most obviously in terms of statutory services. Every upper-tier local authority is required to provide a legal minimum level of homelessness services, but providing additional levels of service is optional. In practice this can mean that neighbouring authorities may offer significantly different levels of service, and if this is the case there is an obvious danger that homeless people will migrate from areas of low to areas of higher support, increasing pressure on those areas that have already done the most to address homelessness problems.

One solution to this issue would be to recommend that local support was provided at the legal minimum level. However, there are a couple of potential problems here. Firstly, there is an ethical dimension to be considered with regard to any decision about providing services to vulnerable people: we may not feel that the legal minimum is sufficient. Secondly, not all rough sleepers will necessarily go elsewhere if support services are cut. It is likely that we

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[37] Evidence from Rob Liddiard, Friends First, 19.02.13: point 13.35.
[38] Evidence from Stuart Kitchenside, Sanctuary, 19.02.13: point 13.35.
[39] BHCC Draft Joint Commissioning Strategy: Housing & Support for Young People aged 16-25 (presented at BHCC Children & Young People Committee 14.10.13).

would continue to have significant numbers of people sleeping rough in the city irrespective of the level of support offered. But without support it is also likely that these remaining rough sleepers would be at greater risk and present greater risks to the local community. There is therefore a pragmatic balance to be struck in terms of setting a level of support that does not needlessly attract out-of-area rough sleepers, but which ensures that the impact of those rough sleepers who are bound to remain is minimised.

Whilst it may never be possible to guarantee that a local area's approach to homelessness will exactly tally with those of its neighbours, it is obvious that all practical steps should be taken to synchronise approaches in order to minimise the migration of homeless people from one area to another. The panel heard evidence from John Routledge of SHORE (Sussex Homeless Outreach, Reconnection and Engagement). SHORE seeks to bring statutory and non-statutory providers of homelessness services across Sussex together to share best practice and plan more effectively.[40] We are pleased to note that the council's housing service is actively engaged with the SHORE initiative: it clearly makes sense to share as much information and expertise as possible with our neighbours, even if we may have differing views on how to deal with homelessness.

In very practical terms, it is difficult to not provide some sort of support to homeless people living locally even if they have no local connection. In theory such people should return to wherever they do have a local connection and receive support there. However, recent years have seen many local authorities becoming more reluctant to accept their duty to house such people, and Brighton & Hove will not relocate homeless people unless there is appropriate support in place for them, so in practice we do provide services to a number of people who have no local connection.[41]

It seems to us that there is really good work already going on across local authority boundaries here, and we therefore have no specific recommendation to make.

Domestic Violence

There are many reasons for people becoming homeless, and although all homeless people are potentially vulnerable, some are especially so. People fleeing their homes because of domestic violence are obviously homeless. However, in order to be eligible for local authority help under housing legislation, applicants have to meet five criteria, including whether they are 'intentionally homeless' and whether they have a 'local connection'. Both of these can cause problems for people who have experienced domestic violence.

In terms of 'intentionality', people who simply abandon a tenancy for no good reason are likely to be deemed 'intentionally homeless' and therefore

[40] See evidence from John Routledge, SHORE, 07.02.13: point 8.13.
[41] Evidence from Bec Davison, CRI, 07.02.13: point 8.4.

ineligible for housing support. Whilst experiencing domestic violence would probably be considered a valid reason for abandoning one's home, it may be no simple matter to prove this, particularly in instances where people are too scared to involve the police, or where long term abuse has never been reported to the authorities, meaning that there is no documented history to refer to. It is frequently the case that people suffering from domestic violence do not report their abuse

In terms of local connection, it is evident that people forced to flee their homes may not feel safe in their local areas. Whilst some people may have family or friends in other parts of the country, others will not, and may well have little choice but to move to an area where they have no connections – indeed such an area may be the safest place for them. However, having a local connection is one of the criteria by which homeless applications are judged. Again, there should already be enough flexibility in the system to ensure that someone genuinely fleeing domestic violence is able to access housing support wherever they have settled. Housing legislation effectives waives the requirement to have a local connection if you can show that you have no connection to any locality (for example if you've been serving with the armed forces for a length of time), or if you can prove that the places where you have an established connection are unsafe. However, the problem is again that it may not necessarily be easy for someone to prove that they are at risk, particularly if they do not have a well-documented history of domestic violence.

The city council is committed to supporting the victims of domestic violence, and this should clearly include helping people access housing services to which they are statutorily entitled. However, the council cannot simply take people who claim to be the survivors of domestic violence at their word. Even if the overwhelming majority of such applicants are genuine, this would leave a loophole for fraudulent applications, and a loophole that would probably get larger over time. This does not mean that the local authority should not continue to adopt as sensitive an attitude to domestic violence as possible, recognising that the great majority of people who claim to be fleeing abuse are indeed doing so, and that a necessarily robust system of checking must be designed not to deter genuine cases.

The panel recommends that future housing strategy reviews should specifically address the needs of people fleeing domestic violence. We also recommend that staff induction and training should ensure that those assessing eligibility for housing are aware of the common issues relating to intentionality and local connection outlined above, and that guidance to assessment teams should make it clear that the city council is committed to supporting survivors of domestic violence in accessing all services to which they are entitled.

Where the council knows that people have been affected by domestic violence, it could also explore using more flexible forms of tenancy. People suffering domestic violence may, regrettably, have to move at short notice for their own safety. It seems perverse to hold people in these circumstances

responsible for breaching a tenancy agreement or to make them forfeit their deposits.[42]

RECOMMENDATION 8 New and refreshed BHCC housing strategies must explicitly address the housing needs of victims of domestic violence.

RECOMMENDATION 9 Training for housing staff dealing with homeless applications must explicitly include information on domestic violence.

LGBT people

Jess Taylor of RISE told the panel that there was a real issue with LGBT people being made homeless because of their sexual orientation or gender identification - especially in terms of young people 'coming out' and being rejected by their families. The consequence of this is that LGBT people are typically over-represented amongst rough sleepers (up to 30% of rough sleepers in urban areas identify as LGBT, whereas the general LGBT population is rarely more than 10-15%).[43]

Facing being ostracised or harassed at home, many LGBT people gravitate to urban areas with a reputation for being inclusive, as do lots of people who simply want to live in an LGBT-friendly environment. Brighton & Hove is obviously a popular choice as an LGBT-friendly destination, and there are significant economic and cultural benefits for the city here.

Jess Taylor told the panel that domestic violence is typically under-reported, and this is likely to be even more so across the LGBT community, with many people reluctant to divulge details of the sexual or gender identity to the police or other authorities. Locally, the level of formally reported LGBT domestic violence is very low, but this is totally at odds with all qualitative data, such as the Count Me In Too survey, and is likely to indicate that there is an endemic problem of under-reporting in the city.[44] Peter Castleton of the council's Community Safety team echoed this point, telling members that official crime figures tended to under report both domestic violence and crimes against the LGBT community.[45] Homeless LGBT people, particularly younger people, may also be particularly vulnerable to domestic violence and to being coerced into providing sex in return for shelter, although this is not a problem unique to LGBT communities.[46] There is currently no local refuge provision or other safe space for men or trans men affected by domestic violence, although there is some provision for trans women. [47]

[42] Evidence from Jess Taylor, 19.02.13: point 13.12.
[43] Evidence from Jess Taylor, RISE, 19.02.13: point 13.2.
[44] Evidence from Jess Taylor, 19.02.13: point 13.5.
[45] Evidence from Peter Castleton, BHCC Community Safety, 19.02.13: point 13.5.
[46] Evidence from Jess Taylor and from Peter Castleton, 19.02.13: point 13.7.
[47] Evidence from Jess Taylor, 19.02.13: point 13.8.

Recent changes to Housing Benefit have capped payments to under 35s, meaning that people can only claim for the cost of a room in a shared house rather than for independent accommodation. For some LGBT people, particularly those who have already suffered domestic violence, this can be problematic, as people may not feel safe living with relative strangers who may target them for their gender orientation or sexual identity.[48]

Jess Taylor noted that LGBT people who do become estranged from their friends and family after coming out are much more likely than the general population to lack 'social capital' – the types of informal support that typically prevent homeless people from becoming rough sleepers.[49]

Ms Taylor told members that some LGBT people report encountering problems when attempting to access housing services – e.g. difficulties with staff who are unsympathetic or who do not understand LGBT issues. This is something that was also noted in the Count Me In Too survey of local LGBT communities and has been widely reported anecdotally. Ms Taylor suggested that this problem should be dealt with by ensuring that housing staff receive proper training in dealing with and signposting for LGBT customers (e.g. the type of training provided by Allsorts).[50]

Older LGBT people can feel very isolated, perhaps particularly those who are living in sheltered housing schemes where LGBT identities are not always well understood or accepted. Jess Taylor pointed out that there is no dedicated LGBT sheltered housing in the city and little acknowledgement of LGBT concerns across existing sites.[51]

The panel recommends that future homelessness strategies should explicitly address the needs of LGBT people, recognising that Brighton & Hove is particularly likely to attract those who have been unable to live free of harassment in other areas. We also recommend that staff induction and training should ensure that those assessing eligibility for housing are aware of the common issues relating to intentionality and local connection outlined above, and that guidance to assessment teams should make it clear that the city council is committed to supporting LGBT people in accessing all services to which they are entitled.

RECOMMENDATION 10 New and refreshed BHCC housing strategies must explicitly address the housing needs of LGBT people.

RECOMMENDATION 11 Training for housing staff dealing with homeless applications must explicitly include information on LGBT needs.

[48] Evidence from Jess Taylor, 19.02.13: point 13.9.
[49] Evidence from Jess Taylor, RISE, 19.02.13: point 13.6.
[50] Evidence from Jess Taylor, 19.02.13: point 13.10.
[51] Evidence from Jess Taylor, 19.02.13: point 13.11.

Young people

There are specific problems associated with young homeless people. In the first place, homelessness is a growing problem for young people as it is for other demographic groups. But there are also changes within the group of young people presenting as homeless. Stuart Kitchenside from Sanctuary told members that the profile of young people being supported by Sanctuary had changed significantly in the past five years, with a rise in younger applicants (16-17 rather than 20-25) coupled with increasingly complex support needs. This has a resulted in a changed emphasis for support services, moving from a focus on preparing young people for further/higher education to teaching basic coping skills.[52]

Sussex Central YMCA agreed, but noted that the need to concentrate on young people with complex support needs shouldn't distract people from the fact that demand for services was increasing across the whole of the demographic – the YMCA has seen client numbers increase six-fold in the last six years (from 100 to 600). By no means all of these young people have high support needs, but young people (i.e. 18-21) with no job, no employment history, credit history, guarantors or references, and with limited independent living skills, are competing for properties against students and young professionals and are unsurprisingly losing out. There is an obvious need for a focus on this issue: supporting young people to stay in the family home for longer, teaching living skills, and providing sufficient supported accommodation for those who cannot realistically find or maintain private sector tenancies.[53]

Supporting younger homeless people with high needs is a specialist job: when young people have had bad experiences with families and school they may not thrive in a rules-based environment. It is therefore important that service providers are able, and are enabled by commissioners, to work flexibly and appropriately with young people, delivering against outcomes rather than process targets. This work is necessarily long term, and typically does not fit the 2 year support plans that Supporting People funding requires. Mr Kitchenside noted that housing commissioners had been very progressive in these respects, recognising how complex and delicate work with young people has become and relaxing their rules to accommodate this – although there was always more that could be done.[54]

It is not totally clear why the profile of young homeless people has changed so much recently. Stuart Kitchenside suggested that it may reflect the increasing lack of jobs for low-achieving young people – a problem exacerbated in Brighton & Hove by the large student and graduate populations competing with local people for low-skills jobs. This lack of available jobs may discourage young people from trying to gain the skills that might make them employable.[55] Sussex Central YMCA agreed, but added that there was also a

[52] Evidence from Stuart Kitchenside, 19.02.13: point 13.13.
[53] Evidence from Sussex Central YMCA, 19.02.13: point 13.33.
[54] Evidence from Stuart Kitchenside, 19.02.13: point 13.14.
[55] Evidence from Stuart Kitchenside, 19.02.13: point 13.18.

general issue of 'extended adolescence' with young people taking on 'adult' attitudes and responsibilities much later in life. This could be seen across the social spectrum and was not necessarily a problem for privileged/high achieving young people, but could be a significant issue for young people who cannot rely upon parental support, and especially for those with other vulnerabilities such as mental health problems, learning disabilities, or experience of unstable childhoods.[56]

Support services are sensibly focused on getting their young clients into work. However, in practice this can be complicated by the claw-back of benefits and Supporting People funding from people who do find work. This may leave them no better off than before and could act as a further disincentive. Moreover there is a risk that vulnerable young people who are successful in finding work could be deemed as no longer in need of Supporting People funding and be therefore required to find private sector housing. Whilst this move-on might sometimes be appropriate, if applied indiscriminately it could end up ruining the progress of young people who have responded really well to support by moving them into unsuitable accommodation before they are truly ready to be moved.[57]

Indeed it may not be wise to assume that young people can easily access private sector housing. Stuart Kitchenside noted that it can be almost impossible for young people to get private tenancies as landlords are reluctant to house them, preferring 'easier' and more remunerative student or young professional tenants. Encouraging private landlords to take a more positive view of young tenants would therefore be valuable.[58]

Mr Kitchenside also told members that there is currently no dedicated service pathway for young homeless people, meaning that younger clients are expected to use the adult homelessness pathways. There is a real danger here in exposing vulnerable and easily-influenced young people to entrenched homeless adults and indeed to professionals whose main point of reference is that of entrenched service users. The risk is that young people will effectively be encouraged to view homelessness as a norm, as well as being exposed to resources which are really not appropriate for young people.[59] Sometimes there may be an advantage in accommodating some young people in adult schemes, particularly for those people who cannot settle in age-appropriate hostels, but this should be determined by the support needs of the individual not because pathways are too rigid or because there is a lack of age-appropriate places.[60]

Sussex Central YMCA noted that there is not enough supported accommodation for young people, with long waiting lists for hostels meaning that too many young people are housed in inappropriate B&B accommodation. There is a particular frustration here as B&Bs are both

[56] Evidence from Central Sussex YMCA, 19.02.13: point 13.18
[57] Evidence from Central Sussex YMCA, 19.02.13: point 13.19.
[58] Evidence from Stuart Kitchenside, 19.02.13: point 13.20.
[59] Evidence from Stuart Kitchenside, 19.02.13: point 13.16.
[60] Evidence from Stuart Kitchenside, 19.02.13: point 13.17.

expensive and typically poor environments for vulnerable people – providing sufficient hostel capacity would potentially be cheaper in the short term and would deliver even bigger long term benefits as it would provide a living environment designed to reduce people's vulnerabilities rather than one likely to exacerbate them. There are particular capacity issues in terms of supported accommodation for young people with mental health, substance misuse or learning disability issues.[61]

When addressing the housing needs of younger people it is also important to think holistically. If young people are not work ready, lack the types of skills or qualifications needed to enter the job market or the skills necessary to live independently, then finding them housing is likely to offer only a very partial solution to their difficulties. Rather, housing support needs to be delivered alongside other types of support, and any strategy aimed at younger homeless people needs to recognise that solutions will need to be much broader than the provision of shelter.

The recently published BHCC Draft Joint Commissioning Strategy: Housing & Support for Young People aged 16-25 addresses a number of the points raised above. In general the draft strategy should be warmly welcomed. However, it is unclear whether the strategy will seek specifically to address issues concerning the growing number of young people with high/complex support needs, the supply of specialist supported housing for young people, and 'holistic' support which focuses on work-skills as well as housing support. We feel that these are important areas and should form part of future service planning for young people at risk of homelessness, potentially as part of the Joint Commissioning Strategy.

RECOMMENDATION 12 Relevant new and refreshed homelessness strategies (e.g. the Joint Commissioning Strategy for Young people) should explicitly address need with regard to:

- **services for young people with high support needs;**
- **ensuring that there is sufficient specialised housing to support young people;**
- **the need to deliver 'holistic' support to young people (i.e. helping make young people work ready at the same time as housing them)**

Community Safety/Policing

Peter Castleton of the BHCC Community Safety Team told members that local services for rough sleepers involved the council working in partnership with the police, with BHT and CRI, and with a number of community and voluntary sector organisations, both to discourage rough sleeping and to provide outreach support to those who nonetheless rough sleep.[62] The

[61] Evidence from Sussex Central YMCA, 19.02.13: point 13.34.

[62] Also important in this context is the Co-ordinated Agency Intervention to End Rough Sleeping Approach (CAIERS). This new multi-agency project, led by BHT and CRI seeks to plan and co-ordinate support to end rough sleeping on a case-by-case basis, prioritising the most entrenched and vulnerable service-users. To date this project has been very successful. More information, supplied by BHT, as included in **Section 2** to this report.

intention is to protect rough sleepers – from other rough sleepers and from 'external' threats - and to minimise the impact that rough sleeping has on settled communities. In general services are very good, as demonstrated by the fact that the number of rough sleepers locally has increased significantly in recent years without a similar increase in complaints about them.

However, there are still some major problems. These include a very high homicide rate within the rough sleeping community; very high levels of harassment and abuse of rough sleepers - particularly by drunk people in the centre of town - poor reporting of harassment by rough sleepers; and rough sleepers being used for forced employment. There is also a considerable cross-over between the rough sleeping community and other groups – most notably street drinkers. This means that rough sleeper problems can spread to other areas – as when housed street drinkers invite rough-sleeping street drinkers back to their flats.[63] Brian Doughty, Head of BHCC Adult Assessment, added that a significant problem for adult social care was 'cuckooing', where vulnerable tenants were targeted by homeless people who would 'befriend' them before moving in with them and exploiting them. Again this is a cross-agency problem and a joint protocol is being established to help deal with it.[64]

Mr Castleton told members that support for rough sleepers needed to be carefully targeted. Some rough sleepers are actually incredibly resilient and do not need (or want) high levels of support.[65]

Bec Davison of CRI agreed that the police and community safety teams had made great strides in recent years to understand and develop links with homeless people (e.g. via the Street Community Policing Team), and this was to be commended. However, there was a risk that a focus on building relationships with the homeless community meant that anti-social behaviour committed by rough sleepers might be ignored for fear that enforcement would alienate those with whom the police were trying to build bridges.[66] John Child noted that Sussex Partnership NHS Foundation Trust (SPFT) had experienced parallel problems, with the police reluctant to use appropriate enforcement measures when dealing with mental health service users.[67]

Employment support

Many homeless people lack qualifications, job experience or even the most basic work skills, either because they have never had them or because the trauma they have experienced has effectively de-skilled them. If people are to eventually live normal, settled lives it is clearly vital that they have the necessary skills to live and work independently. It is therefore important that, in addition to providing shelter, services for homeless people enable their clients to develop work and learning skills.

[63] Evidence from Peter Castleton, BHCC Community Safety, 19.02.13: point 13.25.
[64] Evidence from Brian Doughty, 19.02.13: point 13.23.
[65] Evidence from Peter Castleton, 19.02.13: point 13.28.
[66] Evidence from Bec Davison, CRI, 07.02.13: point 8.16.
[67] Evidence from John Child, Sussex Partnership NHS Foundation Trust, 07.02.13: point 8.7.

The panel heard from Rob Liddiard and Adrian Willard of Friends First. Friends First is a small voluntary organisation that provides a range of services for homeless people, including drop-in provision, supported accommodation, a move-on house and a working farm. Friends First aims to support homeless people to develop work skills by giving them experience of working – either in building or market-gardening. The intention is to teach general work-related skills, such as being punctual and reliable, rather than very specific skills. Mr Liddiard noted that this was a relatively undeveloped idea in terms of local homeless provision, but that there was considerable merit in the concept of a 'working hostel' environment as becoming work-ready was an important part of reintegrating homeless people into the community.[68] The use of a rural setting for some of these services has advantages in terms of avoiding some of the distractions of a city centre environment, although few Brighton & Hove homeless people would choose or be well-adapted to living permanently in a rural environment.[69]

The panel heard that there was a significant practical problem with running the Friends First market garden: Jobcentre+ refuses to accept that clients being trained via the market garden are undertaking genuine job-training and requires them to sign-on as usual. It can easily take claimants half a day's travel to do so, and this is unsettling for the service users as well as being a waste of time that could have been spent on work training. What seems particularly nonsensical is that the people training at the market garden are by definition lacking in the kind of skills that would make them employable, so they are being made to 'sign-on' to show that they are actively seeking jobs they cannot hope to obtain rather than spending the time learning skills that might make them employable.[70]

We are aware that this type of problem is not limited to Friends First, but has been encountered by a range of groups supporting homeless or formerly homeless people. It seems to be the case that Jobcentre+ has limited room for manoeuvre here, being obliged to act in accordance with central Government guidance. After lobbying by local third sector organisations Jobcentre+ has agreed to classify some schemes in such a way as to minimise the need for service-users to sign-on. Voluntary organisations have also agreed to seek the relaxation of sign-on rules only in situations where they are providing core employability skills, not in situations where they are teaching more generic skills like IT literacy.

We welcome this compromise brokered by local voluntary sector organisations and by Jobcentre+. However, although the situation is better than it was, only a partial solution has been achieved – what is really needed is more constructive central Government guidance which actively encourages the up-skilling of homeless and insecurely housed people as an essential part of re-integrating them into society.

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[68] Evidence from Rob Liddiard, Friends First, 19.02.13: point 13.30.
[69] Evidence from Adrian Willard, Friends First, 19.02.13: point 13.31.
[70] Evidence from Rob Liddiard, 19.02.13: point 13.32.

RECOMMENDATION 13 the Council should consider lobbying central Government (on the issue of people who are receiving employability training being required to attend the Job Centre to sign-on), reflecting the concerns of local voluntary sector providers that the rules dictating the ability of Jobcentre + to relax its signing-on requirements are still too inflexible.

Private landlords

With little or no space available in social housing in Brighton & Hove and local property prices unaffordable for many people, the private rented sector has assumed increasing importance in recent years. However, to access private sector housing, homeless people have to compete against several other groups, including professionals (some of whom might previously have bought property, but are now unable to find deposits or a mortgage) and students, whose numbers have increased in recent years.

With demand effectively outpacing supply in the local housing market, landlords and letting agents have become increasingly choosy about the tenants they take on, seeking to minimise their exposure to risk by demanding hefty deposits, references, undertaking credit checks and only renting to those in steady employment. (Letting agents typically insist on these checks being carried out *and* charge large sums to process them.) These checks and charges can present a formidable barrier to people trying to access housing, particularly for those with limited financial resources, and can mean that people are in a position where they are in employment and able to pay a commercial rent, but still can't get a tenancy.

The situation is likely to be much worse for people with a chequered housing history – for instance people with mental health or learning disability problems that have meant they have struggled to pay rent on time, or to keep their properties clean etc. Vulnerable people like these are obviously unlikely to be able to compete effectively against professionals in an open housing market. One way of dealing with this is to try and ensure that vulnerable people currently in tenancies are not evicted (there is a particular urgency here for local authorities which are likely to have to provide long term support for vulnerable people if they can't live successfully in the private rented sector).

There is therefore a clear need for local authorities and other agencies involved in homelessness to work closely with private landlords to try and support vulnerable tenants in their private sector tenancies and avoid evictions which are likely to be bad news for the individuals affected and for statutory support services. The council's housing teams already do a good deal of work in this respect, both at an operational level and at a more strategic level via the city Strategic Housing Partnership, and this work is to be commended.[71]

[71] Evidence from Narinder Sundar, 07.02.13: point 8.28.

Brian Doughty, Head of Adult Assessment for the city council, told the panel that there was a particular problem with clients who are 'neglectful' – people who may have mental health problems, but who retain the capacity to make decisions about their own welfare, and who 'choose' to neglect themselves, living in unsanitary conditions, hoarding etc. Clearly, few private landlords would actively choose to have this type of tenant, so there is a need for services to offer as much support as necessary to landlords if they want to keep such people in their tenancies.

This is true for public landlords too – i.e. the council or housing associations – taking a firm stance on un-neighbourly or anti-social behaviour needs to be balanced against the need to support vulnerable people, and an understanding that eviction may simply just shift the burden and costs of supporting people down the line.[72]

The council's housing teams are already very active in their engagement with private landlords, both at an operational and a strategic level, through the city Strategic Housing Partnership. The panel recognises the worthwhile work being undertaken here, and notes that it is likely to grow in importance in coming years as the city becomes more rather than less reliant upon the private rented sector to house vulnerable people.

A local resident, Mr Richard Scott, suggested that services might look to do more in terms of intervening in private sector landlord/tenant disputes – e.g. in certain circumstances offering to guarantee the payment of a tenant's debts providing they were allowed to remain in their tenancy, and then working with the tenant to recover these debts gradually.[73]

RECOMMENDATION 14 New or refreshed homelessness strategies should explicitly address the issue of working with private landlords to maximise the supply of private rented accommodation accessible to homeless people.

Prison

Offending is prevalent amongst rough sleepers: usually for matters such as street drinking, begging, shop-lifting and drugs offences, but frequently for more violent crimes also. Many rough sleepers have a significant criminal history, including imprisonment.

Being imprisoned is itself likely to cause or contribute to homelessness: people who are in prison may be at risk of losing tenancies, or of being estranged from their families and homes.

This is a particular local issue, given the proximity of Lewes prison. People released from Lewes may gravitate to Brighton & Hove on release, whether or not they have a local connection, and some of these people (particularly the

[72] Evidence from Brian Doughty, Head of BHCC ASC Assessment, 19.02.13: point 13.21.
[73] Evidence from Richard Scott, 07.02.13: point 8.29.

ones who are not locals) may end up rough sleeping.[74] There are good services available in Brighton & Hove for ex-convicts with a local connection, including an in-reach service provided at Lewes Prison by the council's Housing Options team and by BHT, but fewer such services for those who are not locals.[75]

Clearly rough sleeping is unlikely to provide a stable background to enable ex-offenders to reintegrate successfully into society and to reduce the risk of re-offending. People who end up rough sleeping after being released from prison have a relatively poor chance of avoiding re-offending – which is bad news for them and has obvious system costs in terms of the impact of future crimes on the criminal justice system.

It seems obvious therefore that every step should be taken to ensure that people leaving prison do not end up on the streets. However, things are not necessarily this simple: offering housing support to released offenders who did not meet the local eligibility criteria would certainly cost the city council money in the short term; and although it might well save the public sector considerable sums in the long term, there is no obvious way of getting the agencies who are likely to make most of the long term savings (the police, the courts, probation, prisons) to contribute. In addition, there would be an obvious risk here in offering a higher level of support than neighbouring areas – the city is presumably not eager to be a preferred destination for people leaving prison. It may therefore be that this is the kind of issue that is best progressed jointly with neighbouring local areas, and with the agencies that stand to gain most from reductions in re-offending.

An allied issue is that of the imprisonment of local people who have social housing or council tenancies. We are unclear whether people who are in prison for only a brief period are able to resume their tenancies when they are released. If not, this would seem to make their reintegration into the community much harder and substantially increase their risk of becoming homeless – with obvious financial impacts. We would hope therefore that a sensible solution could be found to sustain tenancies across short periods of incarceration.

RECOMMENDATION 15 – the council should explore what can be done to maintain people's tenancies should they be imprisoned for a short period of time. The aim should be to minimise the number of people with a local housing connection being made homeless as a result of imprisonment.

[74] Evidence from Sara Emerson, 07.02.13: point 8.18.
[75] Evidence from Narinder Sundar, 07.02.13: point 8.18

Housing and Social Care co-working

Brighton & Hove is a unitary authority, which means that the city council is responsible for supporting homeless people under housing legislation *and* vulnerable adults and families under social care legislation. The latter include people who do not meet the statutory homeless criteria but who have very significant vulnerabilities in terms of mental health, substance misuse, physical or learning disabilities. A similar arrangement is in place with council children's services for families who are eligible for housing under children's legislation. In recent years, the city council has increasingly moved to a model where all people eligible for housing by the council are dealt with by housing services rather than being housed directly by adult or children's social care.

In general, such arrangements should be welcomed – there is obvious logic in having a local authority housing team responsible for delivering all the housing support which the authority is required to provide. The alternative would be to have a situation where adult social care, children's services and housing all commissioned their own services, with an obvious risk of duplication and increased costs.

However, some of the clients whom social care is responsible for housing have particular vulnerabilities which mean that they require high levels of expert support to live independently. For example, a minority of people with learning disabilities may act in ways which endanger themselves or others – by being neglectful etc. It is important that agreements between social care and housing ensure that appropriate levels of support are provided for very vulnerable people, particularly because if serious problems do develop it can be prove very difficult to take enforcement action against people with such high levels of vulnerability.[76] At the same time it is crucial that already vulnerable people are not made more so by being evicted from their homes. Social care, housing and environmental health services need to work closely together to manage this group of clients and a joint protocol is being developed to this end.[77]

The panel heard that operational partnerships between adult social care and housing had improved markedly in recent years and were now fairly effective. However, it is evident that there is still work to do in terms of strategic co-working. This is an important issue, not least because it seems possible that we are going to see an increase in people with high levels of vulnerability presenting as homeless in the coming years. If departmental boundaries mean that this co-working is only ever going to be partially effective, then this seems to us to be an argument for looking to see whether the boundaries between ASC and housing need to be redrawn to more accurately reflect the degree to which the services are required to work in an integrated manner.

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[76] Evidence from Sylvia Peckham, 25.01.13: point 3.13.
[77] Evidence from Brian Doughty, Head of BHCC ASC Assessment, 19.02.13: point 13.21.

RECOMMENDATION 16 New and refreshed homelessness strategies must explicitly recognise that social care and housing increasingly need to work in an integrated manner, and should establish structures to enable this.

Partnership Working

Effective partnership working to support people with complex needs is predicated upon information-sharing. However there are some major difficulties here, particularly in relation to health and mental health records.[78] This is a really tricky area as there are genuine issues of patient confidentiality to be balanced against the advantages of information-sharing. Good work has been done in this respect already, but it is obvious that more needs to be done.

Eligibility

Local authorities are only *required* to offer housing support to those applicants who meet all the statutory eligibility criteria. However, councils may volunteer to support people who do not meet all the criteria, and some do so, particularly in terms of the 'local connection' and 'intentionality' tests.[79]

There are a couple of good reasons for relaxing the eligibility criteria. In the first place, having very strict criteria in place will catch those who have no real connection to a locality or who have acted irresponsibly in past tenancies, but it may also catch people who are quite genuine applicants. There is therefore an argument in terms of equity here. This is particularly so for groups such as people fleeing domestic violence or LGBT people escaping from harassment in their home towns, where there is evidence that some types of applicant may, through no fault of their own, struggle to prove that they are genuinely eligible.

Secondly, people who are deemed ineligible for housing assistance will not necessarily go elsewhere – many will stay in the local area, and some of them may end up rough sleeping etc, with the potential for major down-stream costs. It may therefore make sense to relax eligibility criteria in circumstances where the up-front costs are likely to be dwarfed by the costs of not effectively supporting people who will nonetheless remain as a local problem.

However, whilst relaxing the eligibility criteria might be a possibility somewhere with a surfeit of empty social housing, it's unlikely to be a realistic option in Brighton & Hove where demand for social housing already far exceeds supply and which is already a 'destination' for homeless applicants. It is important though to recognise that not every unsuccessful homeless applicant is necessarily unworthy of support – many people who do have a real connection to the city and who haven't lost tenancies through any fault of their own will nonetheless fail to meet the homeless eligibility criteria.[80] The

[78] Evidence from Peter Castleton, 19.02.13: point 13.29.
[79] Evidence from Sarah Gorton, 07.02.13: point 8.20.
[80] Evidence from David Richards, a local homeless person: 07.02.13, point 8.22.

local authority needs to be sensitive in dealing with applicants like these, and where possible, to provide them with, or perhaps more realistically direct them to, support and advice.

RECOMMENDATION 17 New and refreshed homelessness strategies should specifically address the support/advice needs of those who have been deemed ineligible for statutory housing support, recognising that this is a significant group of people, many of whom have genuine support needs.

Dual Diagnosis

People who have *both* severe and enduring mental health problems and major substance misuse issues are often referred to as having a 'dual diagnosis'. (The term is also sometimes used for other co-morbidities, such as learning disability and substance misuse problems.) People with a dual diagnosis can be amongst the most vulnerable people in the community *and* amongst the most disruptive, presenting major challenges to support services, including housing. People with a dual diagnosis are over-represented in temporary and emergency housing, and particularly so amongst rough sleepers.

Brighton & Hove has long had problems with dual diagnosis, unsurprisingly given the city's well documented issues with drugs and alcohol and the local level of mental health problems. There has been a good deal of work in recent years, including a strategic needs assessment, the work of a scrutiny panel on dual diagnosis and Sussex Partnership NHS Foundation Trust's development of a dual diagnosis strategy. However, problems persist, and will doubtless continue to do so however good services become at dealing with this issue.[81]

The panel has no specific recommendations to make in respect of dual diagnosis, but notes that our recommendations around providing multi-agency, front-loaded and targeted support to those homeless people with the most complex needs would obviously apply to people with a dual diagnosis.

Dealing with homeless applications

The panel heard evidence that the system for processing homelessness applications was dysfunctional, with applications regularly being lost and staff being unsympathetic to applicants.[82] We also heard that LGBT people had experienced particular problems with staff who failed to understand their circumstances.[83]

This is anecdotal evidence, and it may well be that people who have had a negative experience of the system are in a minority – we have certainly not conducted a systematic review of services. However, it should clearly be the

[81] Evidence from John Child, Deputy Service Director, Sussex Partnership NHS Foundation Trust, 07.02.13: point 8.26.
[82] Evidence from David Richards, 07.02.13, point 8.23.
[83] Evidence from Jess Taylor, 19.02.13: point 13.10.

case that all service users are treated courteously, and that an assessment system should be designed to *support* people in claiming services to which they are eligible, not to deter claimants. At the same time, it is important to remember that statutory homelessness services are meant to be a last resort for people who are unable to otherwise find shelter. They are not intended as an alternative to finding one's own accommodation, and people need to be discouraged from viewing them as such.

There is clearly a balance to be struck here: homelessness services need to be accessible, but they also have to manage demand effectively, ensuring that they are used as a last rather than a first resort.[84] However, managing demand ought not to mean that assessment is less than optimally efficient, nor that applicants should receive anything other than courteous and professional treatment.

Local Connection/Intentionality

The panel heard experts argue that it might make sense to apply the 'local connection' or 'intentionally homeless' criteria more flexibly for certain groups of people – for example those affected by domestic violence, or young LGBT people. However, there is a strong counter-argument here: that Brighton & Hove is already a destination for homeless people and that we simply could not cope with a greatly increased influx of applicants if the eligibility criteria were relaxed.[85] There is obviously a balance to be struck between an ethical homelessness policy (and one which accords with statutory equalities duties) and the need to manage an already major problem (with the danger that accepting more applicants will mean that there are fewer resources to help homeless people).

Housing Supply

Clearly, one of the most obvious ways to reduce levels of homelessness would be to build additional local housing. Equally clearly this is not an easy task, particularly in somewhere like Brighton & Hove with limited available sites and high costs. The panel recognises that the council is working hard to develop the supply of permanent housing, but that this is a challenging long-term project.

In this context it is worth mentioning innovative shorter term 'fixes' such as the BHT scheme to provide temporary housing for homeless people in 'container homes' in Hollingdean. This project has provided a significant number of much-needed homes quickly and at a low cost. There is a potential opportunity to develop similar schemes using other temporarily vacant sites across the city – for example sites such as Preston barracks.

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[84] Evidence from Bec Davison, 07.02.13: point 8.27.
[85] Evidence from Peter Castleton, 19.02.13: point 13.27.

Monitoring the Panel Recommendations

This scrutiny panel will initially seek endorsement of this report at the Health & Wellbeing Overview & Scrutiny Committee (HWOSC). Should this be forthcoming, the panel report will be presented for decision at one or more of the Council's policy committees. The policy committee(s) will decide which recommendations to accept and implement.

Scrutiny typically monitors the implementation of agreed panel recommendations. We therefore propose that the agreed panel recommendations relevant to this report be monitored annually by the Overview & Scrutiny Committee. In addition officers may choose to report progress in implementation periodically to policy committee(s).

RECOMMENDATION 18 – The OSC should monitor the implementation of agreed panel recommendations on an annual basis until the committee is satisfied that all recommendations have been implemented.

Appendix 1

List of Panel Recommendations

RECOMMENDATION 1 Given the significance of homeless people in terms of city health inequalities, we welcome the fact that the Health & Wellbeing Board is taking an active interest in the health and social care needs of this group. We are very interested in the progression of this work, and request that the HWB's plans for homeless healthcare be presented to the HWOSC for comment within the next 12 months.

RECOMMENDATION 2 A senior BHCC officer should be appointed as 'homelessness services integration champion' across statutory services and other sectors.

RECOMMENDATION 3 the council needs to take action to diversify its 'stock' of hostel accommodation, seeking to spread hostels more evenly across the city, and to offer a range of accommodation options in terms of hostel size and the level of support on offer.

RECOMMENDATION 4 we need a more diverse range of supported accommodation available to house single homeless people, particularly those with very complex needs. Whilst this is clearly not going to happen overnight, we would welcome a commitment to move to a model of greater diversity coupled with at least some practical action in the short term.

RECOMMENDATION 5 the council needs to produce a clear map of statutory and non-statutory homelessness services across the city and make it available via the its website.

RECOMMENDATION 6 – homeless pathways should be revised to allow clients to move directly into band 3 support when it is clear that there is no realistic possibility of them progressing successfully through band 2 support.

RECOMMENDATION 8 New and refreshed BHCC housing strategies must explicitly address the housing needs of victims of domestic violence.

RECOMMENDATION 9 Training for housing staff dealing with homeless applications must explicitly include information on domestic violence.

RECOMMENDATION 10 New and refreshed BHCC housing strategies must explicitly address the housing needs of LGBT people.

RECOMMENDATION 11 Training for housing staff dealing with homeless applications must explicitly include information on LGBT needs.

RECOMMENDATION 12 Relevant new and refreshed homelessness strategies (e.g. the Joint Commissioning Strategy for Young people) should explicitly address need with regard to:

- **services for young people with high support needs;**
- **ensuring that there is sufficient specialised housing to support young people;**
- **the need to deliver 'holistic' support to young people (i.e. helping make young people work-ready at the same time as housing them)**

RECOMMENDATION 13 the Council should consider lobbying central Government (on the issue of people who are receiving employability training being required to attend the Job Centre to sign-on), reflecting the concerns of local voluntary sector providers that the rules dictating the ability of Jobcentre + to relax its signing-on requirements are still too inflexible.

RECOMMENDATION 14 New or refreshed homelessness strategies should explicitly address the issue of working with private landlords to maximise the supply of private rented accommodation accessible to homeless people.

RECOMMENDATION 15 – the council should explore what can be done to maintain people's tenancies should they be imprisoned for a short period of time. The aim should be to minimise the number of people with a local housing connection being made homeless as a result of imprisonment.

RECOMMENDATION 16 New and refreshed homelessness strategies must explicitly recognise that social care and housing increasingly need to work in an integrated manner, and should establish structures to enable this.

RECOMMENDATION 17 New and refreshed homelessness strategies should specifically address the support/advice needs of those who have been deemed ineligible for statutory housing support, recognising that this is a significant group of people, many of whom have genuine support needs.

RECOMMENDATION 18 – The OSC should monitor the implementation of agreed panel recommendations on an annual basis until the committee is satisfied that all recommendations have been implemented.

Report of the Homelessness Scrutiny Panel

February 2014

Panel members: Cllrs Andrew Wealls (Chair), Alan Robins and Ollie Sykes

Homelessness is a crisis which can impact people from all backgrounds and walks of life. For some it is temporary; friends and family help out, and they return to life in safe secure accommodation. For those hardest hit, who may also be suffering mental health problems or alcohol or substance misuse, homelessness can be debilitating. And, of course, there is a broad spectrum of challenges in between.

This Scrutiny Report on Homelessness considers all of those who experience homelessness in our city, and reflects the enormous complexity of the issue it tackles. My councillor colleagues, Alan Robins and Ollie Sykes and I were incredibly moved by some of the personal experiences of some of those who contributed, impressed by the dedication and hard work of those who help them and often challenged by the complexity of the issues homelessness presents.

This complexity, particularly when presented most often with co-morbidities, presents the key challenge faced by all of those who support homeless people. It is a familiar problem; how do we improve co-working between the NHS, the Council's many services and departments, landlords (private and local authority), employment services and not-for profit entities and charities? It was clear to the panel that there is much excellent practice in the city, but it would be fair to say there are also opportunities for better working together, and improved, tailored service provision.

The Panel consulted widely across public sector, Council and charity and not-for profit organisations who support homeless people in our city. We would like to thank them not only for their contributions to our research but also for their hard work and dedication to helping people, often in very difficult circumstances.

We also thank all of those who have been directly affected by homelessness who contributed to this report. Without their input it would not have been possible to deliver this work. It is now up to all of us to deliver the recommendations of the report to improve the lives of those who may be some of the most vulnerable people in our city.

Introduction

1 What is homelessness?
Homelessness can be defined in several ways. In its widest sense, being homeless means not having access to safe, secure accommodation. People might be staying temporarily with friends or family, or living in accommodation which is unsafe or from which they will shortly be evicted. The majority of homeless people are able to resolve their housing problems without involving outside agencies, except perhaps for some advice services.

However, many other homeless people require much more support, and it is also possible to speak of homelessness in the narrower sense of those who apply for help and who meet the criteria set out in Homelessness legislation. Local authorities have a statutory responsibility to help these eligible homeless people access secure accommodation.

In a narrower sense still, a relatively small group of homeless people cannot find, or for various reasons decline to accept, shelter, and end up sleeping rough. Even when temporarily housed in a hostel or similar accommodation, people in this group are very vulnerable and are likely to find themselves homeless again in the future. Many of the people in this group have physical or mental health problems or substance misuse issues.

2 Local Authority Duties (Homelessness)
Local authorities have clearly defined duties under homeless legislation. Someone is classified as homeless only when they have satisfied five criteria:

- They are a UK citizen
- They are actually (or will imminently be) homeless
- They are not 'intentionally' homeless (e.g. they have not become homeless due to a deliberate act or omission)
- They have a local connection (e.g. they have lived in the area for six of the past twelve months or three of the past five years, or are working in the area, or have close family living in the area)
- They are in a 'priority need' category (i.e. they have a vulnerability which means that they are in greater need of secure housing than the average person)[1]

People who meet all five of these criteria are eligible for help from their local authority. This may include housing advice, assistance with references or a deposit, the offer of temporary accommodation, or even of a secure tenancy – basically whatever support is required to enable an individual to access safe and secure accommodation. In past years, people accepted as homeless would probably have been offered a secure tenancy in a council-owned

[1] Evidence from Sylvia Peckham, BHCC Head of Temporary Accommodation and Allocations, 25 January 2013: point 3.2.

property; but this is generally no longer the case, and nowadays the offer will typically be of temporary accommodation. The previous model had the perverse effect of encouraging people to become homeless in order to get rapid access to social housing tenancies. It also had the effect of placing relatively large numbers of highly vulnerable people together in housing estates, with a potentially detrimental impact upon the cohesiveness of those communities. Placing vulnerable homeless people in temporary accommodation gives housing services the opportunity to provide the necessary training and support to help them manage future tenancies successfully, hopefully avoiding the situation where people who have become homeless after failing to maintain a tenancy are granted another tenancy which they will then fail to maintain.[2]

3 Other Local Authority Duties

Even when people do not meet all of the statutory homelessness criteria, the local authority may still have a duty to house them under adult social care or children's legislation – e.g. for families with dependant children, or people who have particularly acute vulnerabilities in terms of old age, mental or physical health, substance misuse or learning disabilities.[3] People who have been in care as children, those experiencing domestic violence, former members of the armed services, and people leaving custody may also be deemed to have particular vulnerabilities which mean that there is a duty to house them.

This division is important in terms of two-tier local authorities, where responsibilities for homelessness are split between district councils (housing) and county councils (social care). However, for unitary authorities such as Brighton & Hove the same organisation is responsible for both housing and social care. There are obvious advantages in having one department discharge all these responsibilities – and this is what happens locally, with the city council's housing team commissioning accommodation on behalf of adult social care and children's services as well as for its own clients.[4]

Even where there is no local authority duty to house an individual, councils are not legally barred from offering housing support to those who do not meet the eligibility criteria, and may choose to house some very vulnerable people such as rough sleepers.[5]

4 Rough Sleepers

Anyone who becomes homeless could potentially find themselves sleeping rough, and some rough sleeping services are designed to address this general need. However, a significant proportion of those sleeping rough at any time will be people who have refused to be properly housed, or whose

[2] Evidence from Sylvia Peckham, 25 January 2013: point 3.4.
[3] Nationally, more than 70% of households accepted as statutorily homeless are accepted because they include dependant children/pregnant women. See DCLG Statutory Homelessness Statistics Release 2013 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/205221/Statutory_Homelessness_Q1_2013_and_2012-13.pdf
[4] Evidence from Sylvia Peckham, 25 January 2013: point 3.3.
[5] Evidence from Sylvia Peckham, 25 January 2013: point 3.6.

issues and behaviour make it very difficult to house them securely for any length of time. This group of rough sleepers often have severe mental health problems, learning disabilities, physical disabilities, substance and/or alcohol misuse and dependence issues, a history of anti-social or criminal behaviour, or traumatic personal histories (and often a combination of these issues). Although we are talking about small numbers of people here, their impact is quite disproportionate to their size, and many rough sleepers have very complex needs requiring specialist support.

5 What's the trend?

Homelessness has been a serious local and national problem for many years, with rates of rough sleepers, people accepted as statutorily homeless, people living in temporary accommodation, and people 'sofa-surfing' fluctuating from year to year. However, recent years do seem to have shown consistent increases in several of the measures of homelessness. For example:

- There was a 6% increase in successful homeless applications across England between 2011-12 and 2012-13.[6]
- Between 2012 and 2013 the number of people in temporary accommodation across England also increased by 10%.[7]
- Between 2010 and 2012 rough sleeping rates across England increased by around 30%[8]
- In Sussex between 2011 and 2012 there was a 40% increase in rough sleepers.

There are several reasons to think that homelessness may well increase in the next few years. In the first place, it is widely accepted that homelessness rises in times of economic hardship – people who lose their jobs struggle to pay rent; young people without jobs can't get tenancies; people leave secure accommodation in search of work in less depressed areas. There is obviously a good deal of uncertainty here, both in terms of the speed and the extent of economic recovery locally and nationally (with the potential for internal migration of job-seekers into more economically buoyant areas).

This general pressure can be exacerbated by particular local pressures – obviously by how well the local economy is doing; but also by local house prices (high prices tend to mean higher rents in the private market as a wider range of people are obliged to rent); by supply and demand in the private rented sector (where demand exceeds supply landlords can afford to be more selective in their choice of tenants); by the presence of large numbers of students etc. Clearly all of these pressures apply in Brighton & Hove.

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[6] See DCLG Statutory Homelessness: Statistical Release 2013, p3. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/205221/Statutory_Homelessness_Q1_2013_and_2012-13.pdf

[7] See DCLG Statutory Homelessness: Statistical Release 2013, p8.

[8] See DCLG Rough Sleeping Autumn 2012: Statistical Release, p2. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/73200/Rough_Sleeping_Statistics_England_-_Autumn_2012.pdf

6 Welfare reform

An additional pressure is the ongoing reform of the benefits system which includes significant changes to Housing Benefit (HB), involving reducing the amount that can be claimed and restricting the types of accommodation that some groups of people can claim – e.g. changing the rules so that under 35s can now only claim for the cost of a room in a shared house or making changes to under-occupancy rules in social housing (the so-called 'bedroom tax'). They also include changes to Council Tax benefits; the reassessment of various disability-related benefits, and some other measures.

A major issue is likely to be the move from paying HB to landlords to making direct payments to tenants. This poses particular problems for those clients who struggle to manage their own finances, a group which includes many people in temporary accommodation. It is not currently clear whether people in temporary accommodation will be exempted from direct payments (as those in supported housing have been), but if they are not there may be a large drop in rent collection rates for this type of property – pilot areas have seen collection rates fall from 98% to 60%, which would equate to around £4 million per year across Brighton & Hove.[9]

It is not yet apparent what impact these benefit reforms will have, although it is clearly the Government's intention that they will reduce welfare costs and encourage a more rational use of housing stock rather than increasing the numbers of homeless people. In some instances, welfare reforms have not yet produced the predicted detrimental impact.[10] However, even if there is a limited national impact upon homelessness, there may be a much higher impact in some areas – where, for example, private landlords housing HB claimants may prefer to look to other markets (students/professionals) rather than reducing rents to reflect lower HB payments. Again, given its large student population and high number of professional private renters, Brighton & Hove is as likely as anywhere to experience these pressures.

It is also the case that some areas may act as magnets to homeless people, attracting people from other areas. Again, this is likely to be a particular problem for Brighton & Hove, with its reputation as a diverse, tolerant and fun city.

7 Who is becoming homeless?

Clearly, anyone can become homeless, but services have reported significant increases in two groups of people: people with very low support needs (e.g. people who are work-ready or actually in work but who cannot access secure housing because they don't have money for deposits or can't provide references etc), and also people with very complex needs. The first group is relatively easy to support via help with deposits etc. as long as they are swiftly identified.[11] Supporting the second group is much more challenging.

[9] Evidence from Sylvia Peckham, 25 January 2013: point 3.15.
[10] Evidence from Sylvia Peckham, 25 January 2013: point 3.16.
[11] Evidence from Bec Davison, CRI, 07.02.13: 8.2.

There are particular problems with young people – given the very high levels of youth unemployment it can be very difficult for young people to get private tenancies without deposits, references or a steady wage.

8 Social Capital

There are various definitions of social capital, but in essence it represents the informal support networks that individuals have which allow them to cope with crises. In terms of homelessness, your social capital is what keeps you off the streets if you find yourself without a home, whether it's family members lending you the money for a deposit or friends letting you sleep on their sofa.

Social capital is crucial in keeping the numbers of homeless people who seek statutory support at a manageable level. However, there are a number of factors that can impact upon social capital. These include recessionary pressures – people who are themselves struggling to make ends meet are less likely to be able to help others out, so the more general an economic downturn the more it is likely to reduce social capital. Similarly, the length of a downturn is important as a willingness to help people temporarily will not necessarily translate into long term support.

Other factors may include how settled and 'local' a population is – areas where lots of people are non-local are likely to have lower social capital than areas in which most of the residents are locals.

Another factor may be the availability of spare living space – in areas where housing is relatively cheap, lots of people may have spare rooms, meaning that they may be able to offer friends a temporary place to stay. In areas where it is expensive, spare rooms are an unaffordable luxury for most people.

It does seem as if there may have been a recent reduction in the availability of social capital in Brighton & Hove, and this may make itself felt in increasing numbers of homeless people seeking support. Bec Davison of CRI told the panel that it had been calculated that in recent years it had typically taken someone who found themselves homeless seven years to exhaust their social capital and become a rough sleeper, but that this was currently taking more like a year – it is unclear why the situation has changed so much recently. This is a national trend, but as noted above it may be a particularly serious issue locally. Ms Davison recommended that more work be done locally to investigate this phenomenon and to plot what might be done to increase social capital.[12]

9 Services

The range of services offered to homeless people is very wide. It includes Housing advice and assessment; council-commissioned temporary (B&B) and emergency (hostel) accommodation; a range of council-commissioned support and outreach services delivered by community sector organisations;

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[12] Evidence from Bec Davison, CRI, 07.02.13: 8.3.

mental health, substance misuse and learning disability services; general healthcare; police and probation services; community safety, and benefits advice. As well as services commissioned or provided by the statutory agencies, there are a wide range of voluntary and community sector-funded and provided services available across the city. Some of these services may be dovetailed with statutory support, but others are not, and some voluntary sector services might seem to work against the thrust of statutory sector strategies (supporting homeless people with no local connection to stay in Brighton & Hove, when statutory services will be trying to relocate them, for example). In consequence, the map of homeless services is complex, and is something that, to some extent, has grown organically rather than as the result of strategic planning.

10 BHCC Services

The city council runs a range of homelessness services. The Housing Options team offers advice on finding a home and also processes homelessness claims. For people deemed officially homeless, or homeless and awaiting assessment, there are two basic types of accommodation: B&B or temporary housing and hostel or emergency housing. Some of this accommodation is directly owned and managed by the council, but most is contracted from a range of providers. In theory homeless people will be offered the most appropriate type of accommodation, with those with relatively low support needs going into B&H and those with higher support needs (e.g. many rough sleepers) into the hostels system. However, this does not always quite work this way in practice, as sometimes one type of accommodation may be full or for some reason unsuitable for a particular client.

In many instances the council will seek to support people in accessing private-rented accommodation rather than providing them with council accommodation – e.g. by helping them with deposit or references or putting them in touch with landlords willing to house a wide range of people.

The council also commissions a range of outreach and support services for rough sleepers, largely from CRI, a national voluntary sector organisation, and from Brighton Housing Trust (BHT).

The council also provides or commissions other services such as extreme weather shelters for rough sleepers[13].

Councils have a variety of responsibilities for adults who have particular vulnerabilities, such as significant mental health, learning disability or physical health problems, and these responsibilities apply whether someone is securely housed or homeless.

[13] Evidence from Jenny Knight, BHCC Commissioning Officer for Rough Sleepers: 25.01.13, point 3.7.

Recommendations

Health
It is difficult to estimate the health impact of being insecurely housed or of 'sofa surfing' – in large part because we have no ready way of identifying the 'hidden homeless' who do not seek help from services. It seems likely however that this group of people is particularly vulnerable in terms of emotional wellbeing and mental health: being homeless is hardly conducive to happiness. There may well be other health impacts also – of living in damp or unsanitary housing, of having limited facilities for preparing fresh meals and so on.

We know much more about rough sleeping and health, which is reported as part of our local Joint Strategic Needs Assessment (JSNA). Rough sleepers typically have much higher than average health needs, particularly in terms of mental health, drug & alcohol dependency, physical trauma (especially foot trauma), skin problems, respiratory illnesses and infections.

Brighton Homeless Healthcare (Morley Street GP practice) provides a specialist primary (GP) care service to homeless people in the city. In terms of the practice population:

- Life expectancy is 70.3 years (the city average is 81.7)
- Mortality rates from coronary heart disease are *twelve* times greater than for the GP practice with the second highest rate
- A&E attendance rates are five times higher than the local average
- Emergency hospital admissions are four times higher than the local average
- Planned in-patient hospital admissions are a third lower than the local average
- Hospital re-admission rates are twice the local average[14]

Health, other than mental health, is not an area that the panel investigated in any depth. However, support officers to the panel were given the opportunity to attend a conference organised by SHORE (Sussex Homeless Outreach, Reconnection & Engagement), where together with Public Health colleagues they presented a workshop on homelessness and health needs to a range of homelessness professionals from across Sussex.

Several themes emerged from this workshop and from more general conversations with public health experts. These include:

[14] See Brighton & Hove Joint Strategic Needs Assessment Summary 2012: Rough Sleeping.

Identifying rough sleeper health needs. Rough sleeper numbers are relatively small, even in somewhere like Brighton & Hove. This can mean that the health needs of this group can easily get overlooked, with the focus of attention being big, population-wide issues such as smoking or obesity or on high prevalence/high impact conditions like cancer and dementia. However, the health needs of rough sleepers are so extreme that they can have a really disproportionate impact on services – e.g. in terms of requiring emergency admissions – and on health inequalities across the population. There is therefore a case, both in financial and in equalities terms, for services to think much more carefully about the needs of rough sleepers than their numbers alone might seem to justify.

Outreach services for rough sleepers. Rough sleepers typically live very chaotic lives and may struggle to make or keep appointments etc. This presents an obvious problem in terms of accessing health services, where patients are generally required to make an appointment days or weeks in advance or at the very least to spend several hours waiting in A&E or at a GP walk-in service. For many rough sleepers this simply isn't going to happen, meaning that they will only come into contact with health services when they have a crisis requiring emergency admission. Such admissions are very expensive, with outcomes much worse than for people whose conditions are properly supported via primary, community and secondary healthcare. What is required, therefore, is a range of 'outreach' services that meet the needs of rough sleepers, rather than expecting rough sleepers to negotiate the normal NHS access pathways.

In fact, there is a good deal being done already in Brighton & Hove in terms of homeless health. Homelessness is already needs assessed, and there is a dedicated homeless needs section in the city Joint Strategic Needs Assessment (JSNA). There is also a dedicated primary care service for homeless people run from the Morley Street surgery. Recent initiatives by Housing have included outreach work, with clinicians going into hostels and assessing and treating problems in situ. The city public health team is also fully involved in strategic housing partnerships.

Brighton Housing Trust also told the panel about a project they have been involved with, providing a 'Hostels Alcohol Nurse' who works intensively with the most alcohol dependant hostel residents in the city (particularly those who are currently not accessing medical treatment). This project has been very successful to date, with significant reductions in emergency call-outs, presentation at A&E, and hospital admissions saving an estimated £240,000 over 12 months.[15]

Another recent initiative is the Hostels Hospital Discharge Project. This is a partnership project between BHT, CRI, Riverside ECHG and Sussex Community NHS Trust. The project will target hostel residents who have

[15] More information on this initiative is included in **Section 2** of this report.

recently been discharged from hospital, seeking to provide high quality support which will reduce re-admission rates.[16]

In addition the Brighton & Hove Health & Wellbeing Board (HWB) recently agreed that the coming year's JSNA programme of specialist needs assessments should include additional work on homelessness – using the Homeless Link Health Needs Audit toolkit to better identify health needs across the local homeless community.

The HWB also recently agreed to establish a city multi-agency Programme Board to drive better integration of health and social care services for vulnerable 'homeless' people – a group including rough sleepers, but also people sofa-surfing or living in temporary accommodation, hostels, squats etc.

It is clear from the work mentioned above that the health and care needs of 'homeless' people are increasingly being recognised as an issue across services, and that active steps are being taken to accurately assess the scale of the problem and to develop effective joint working approaches. This is to be warmly welcomed.

The panel also welcomes the fact that the HWB has taken ownership of the issue of homeless health by establishing a Programme Board. We trust that the Programme Board will report regularly to the HWB.

RECOMMENDATION 1 Given the significance of homeless people in terms of city health inequalities, we welcome the fact that the Health & Wellbeing Board is taking an active interest in the health and social care needs of this group. We are very interested in the progression of this work, and request that the HWB's plans for homeless healthcare be presented to the HWOSC for comment within the next 12 months.

Targeted Support

Many homeless people have relatively few additional support needs. However, some people have very complex needs, including severe mental illness, learning disability, physical disability, problems with drugs & alcohol, a history of offending, traumatic personal histories, and so on. Often, the most complex clients may have a combination of these and other problems.

This relatively small group of people with very complex needs makes up a significant part of our local population of rough sleepers. This is unsurprising, as all of the above problems are potential risk factors in being unable to keep up a tenancy. Not only are people with complex needs much more at risk of becoming homeless than the general population, but they are typically much harder to help. Even if people engage with services it can be very difficult to support them properly – as they can be very challenging and may not be able to cope with the rules of support services, hostels etc.

[16] Information provided by BHT, Nikki Homewood and Andy Winter, informal meeting Jan 14.

In addition, people with complex needs are likely to need support from a number of services – housing obviously, but potentially also social care, NHS mental and physical health services, the police, probation and so on. There are obvious risks involved in having a number of agencies provide support to an individual, particularly in terms of duplication or of clients falling 'through the gaps'. This is particularly so since people with the most complex needs are unlikely to cope well with complexity – having to deal with a number of agencies can be confusing and may worsen rather than help some conditions.

Traditional means of supporting people with very complex needs have also been found to be too focused on the short-term – providing support for the here and now which may provide some topical assistance, but which does little to change people's behaviour significantly, and therefore little that is likely to reduce support needs going forward.

Where people with complex needs have to negotiate set support and care pathways there can be problems too. Rigid pathways for specific issues are unlikely to be suitable for people with cross-cutting needs; but if the only way to access appropriate levels of support is to follow a particular pathway, then people may end up going around in circles.

For example, Ellie Reed, a Complex Needs Social Worker with CRI, told the panel about a client of hers who has been evicted from city hostels more than 30 times. It was clear, and had been for a considerable time, that this client could not cope with a hostel environment – the rules, the business and noise and the presence of active drugs users were all factors making effective support via a hostel placement a practical impossibility. What was needed for this client was private, self-contained accommodation, where, with lots of appropriate support, there was at least a chance that he could settle.[17]

However, the pathway for homeless people requires users to cope successfully with living in Band 2 (hostel) accommodation before 'stepping-down' to Band 3 independent supported living. In general this pathway makes perfect sense – someone who has shown that they can cope with the rules-based approach of hostel living may well be more likely to succeed in an independent environment than someone who has gone straight from rough sleeping to independent living. But for certain people, the pathway through hostels is never going to be appropriate.

Following a long process of negotiation CRI have been able to circumvent the pathway in this instance and have placed their client directly into a 'training flat' normally used to support Band 2 to Band 3 transfers. This is a welcome outcome, but with a less rigid pathway this might have been achieved much more easily and at a point prior to many of the person's 30 plus evictions, avoiding a lot of stress to the user and saving services a very significant amount of money – because although the current arrangements require a high degree of support, this is likely to be insignificant compared to the costs

[17] Evidence from Ellie Reed, CRI, 07.02.13: point 8.6.

of repeatedly evicting someone, supporting them as a rough sleeper, finding them new hostel accommodation and so on.

There is a general point here as well as a specific one about over-rigid pathways: a great deal of money is spent 'supporting' people with complex needs through crises. This can include eviction and re-housing, but also in-patient admissions to hospital, anti-social behaviour of many kinds, and even prison. Given the extraordinary level of costs associated with some of these issues, it would seem to make obvious sense to target preventative support at those people most likely to cost the system large amounts in the long term. It is clearly also the case that, once people become habitual offenders, or rough sleepers etc. it is much more difficult and much more expensive to change their behaviour than if the intervention came at an earlier point.

Of course, services do work together to try to provide holistic support for their clients, and there are really good examples of innovative co-working. However, within traditional organisational restrictions there is only so much that can be done.

There is an interesting model for a more integrated way of working to support the most vulnerable currently being trialled. In recent years, some very vulnerable families across the city have been receiving targeted support – initially as part of the 'Troubled Families' initiative, latterly as part of an expanded nationally-driven programme, locally known as 'Stronger Families, Stronger Communities'. This initiative sees several hundred of the most vulnerable local households receiving targeted support and intervention from a multi-disciplinary team. Each family works with a single 'coach' who helps them manage their interactions with different support services, and ensures that support is appropriate to the client's needs, that it works towards achieving clear outcomes, and that the demands placed upon clients are realistic.

In combination with a better integration and focusing of existing support channels, the initiative also provides additional support, particularly in the form of general help with living: paying bills, making benefits claims, keeping the home clean, keeping appointments etc. The additional expense of this type of targeted help is recouped down the line, as effectively supported clients are less likely to make much more expensive demands on services at a later date – e.g. a family that pays the rent or claims the appropriate level of Housing Benefit will avoid rent arrears and therefore avoid the cost of debt collection or eviction. Since some of these long term costs are very expensive indeed, and since the households being supported are very likely to end up in serious trouble without early support, the cost of this additional support is likely to be considerably less than the cost of no additional support. And clearly, what is true in terms of funding is likely to be true in terms of the welfare of the people involved also.[18]

[18] However, the notion that front-loaded investment in services will deliver a down-line savings has relatively little really high-quality evidence-base. Bec Davison of CRI suggested that it would be worthwhile to do some detailed mapping of the costs and benefits of this type of

The cost-benefit analysis of this type of intervention is clearest when the people being supported have problems which a) are very likely to escalate if not effectively treated, and b) are likely to cost a great deal to treat in the longer term. Whilst there are arguments for providing additional support to very broad populations, the cost benefit is less obvious here, as many of the people receiving additional support may not have developed bigger problems down the line. If there is a financial argument for targeted support therefore, it is likely to be strongest for clients with the most complex needs.

The panel believes that there are real opportunities in using the Stronger Families, Stronger Communities model of front-loaded, integrated support to target those rough sleepers with the most complex needs who are currently not well served by the existing homelessness and allied pathways. (To be clear the panel is not proposing that the Stronger Families programme be expanded to include vulnerable homeless people; merely that homeless people are supported via an integrated programme of practical support with a significant focus on making financial savings as well as improving the lives of services users – and Stronger Families is an obvious model of this type of scheme.)

In the first place, we propose that a cost-benefit analysis is undertaken, identifying the costs of providing additional targeted support to those rough sleepers with the most complex needs versus the likely future costs of continuing with current support methods. Such an analysis needs to reach beyond the local authority to include other services directly impacted by rough sleeping. This will potentially include the NHS, both in terms of mental health services, where there is a laudable recent history of successful integration and cost-sharing, but also in terms of physical health – rough sleepers are many times more likely to present for A&E treatment and to require unplanned hospital admissions than the general population, so there is a potential benefit to NHS acute providers and the commissioners of unplanned/emergency care here.[19] It may also include the police and fire services, probation and potentially the prison system – the costs of imprisoning people are very high and there is a strong correlation between rough sleeping and incarceration. Community and voluntary sector organisations in the city must also be involved in this calculation.

In some instances it may be the case that, even if it is possible to show that targeted support would result in a longer term saving, it is not feasible to persuade national agencies etc. to contribute to local initiatives. It would be very useful to have an idea of the absolute savings that could potentially be achieved across the board even if some of these savings cannot readily be realised, not least so as to be able to plan for lobbying of national agencies.

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model against the costs/benefits of the models currently in place. Evidence from Bec Davison, 07.02.13: point 8.10.

[19] As noted elsewhere in the report, there are current initiatives providing support for hostel residents with alcohol problems and for those recently discharged from hospital which might provide a useful source of data.

However, in the short term, the focus should be on those organisations where there is a realistic chance of partnership working and cost sharing.

One of the biggest difficulties encountered in supporting homeless people with very complex needs can be that this group is very likely to be wary of authority – for obvious reasons with individuals who feel they have been failed by services in the past or for people who have been in and out of prison. This issue is becoming better recognised, with one obvious solution being to increasingly rely on trusted, expert community sector organisations to do much of the direct interfacing with clients. In the type of targeted support approach outlined above, an absolutely key element is that of the 'care coordinator' who forms a relationship with and acts on behalf of the client. It may well be that this is a role that is be best carried out by non-statutory sector organisations, although equally there may be instances (e.g. where someone has a very complicated mental health problem) when it is better to have that role filled by a suitably qualified professional from a statutory agency.[20]

The panel were very interested to hear about the Big Lottery Bid application: this multi-partner application seeks funding to deliver more holistic services to homeless people with complex needs. Panel members were delighted to hear that the application was approved just before Christmas 2013.

This project is to be commended, but we need to go further: not just seeking external funding to deliver better targeted services to clients with complex needs, but actively reconsidering how the council and its key city partners use existing homelessness funding. There seems to be real potential to use resources more wisely: front-loading support for some clients may save money in the longer term as well as giving homeless people the best possible chance of getting some stability into their lives. In consequence, we hope that the Big Lottery work is viewed as a springboard to more intelligent co-working rather than as an end in itself.

It has also recently been announced that the council will establish a multi-agency board to oversee services focused on homeless people and community safety. This initiative is very much to be welcomed and it is heartening to see that city agencies are beginning to make real practical moves towards proper integration of services.

If this report had been written a few years ago, the panel might well have been calling for more integration of services across a landscape where different agencies worked largely within their own silos, even though many homeless professionals recognised and were lobbying for greater integration. At the present time, however, it is clear that much has changed, and that agencies have taken significant practical steps towards better integration.

This is good news for vulnerable homeless people and for the city as a whole. However, we are still a long way from truly integrated services, and there is a

[20] Evidence from Bec Davison, CRI, 07.02.13: point 8.5.

real danger that some of the current initiatives will fizzle out without having really advanced things, particularly in instances where a project is dependent upon lottery or other uncertain external funding. (In this context it is good to hear that partners are committed to continuing the project to provide integrated health and social care to vulnerable homeless people despite failing to win Department of Health Pioneer funding for the scheme.)

There is also a risk that we end up with a number of schemes to better integrate services for homeless and insecurely housed people, but that there is little or no effective integration of the schemes at a strategic planning level. While the various initiatives would still be valuable in themselves this would seem to risk missing some obvious opportunities. However, it also needs to be recognised that services are complex and that there may therefore be very good reasons for approaching better integration of, say, healthcare separately from community safety services.

In order to ameliorate these risks the panel proposes that the city council nominates a senior officer to act as a champion for homelessness service integration.

- The homelessness integration champion should have a brief to encourage the better integration of services across the city, in terms of both statutory agencies and other sectors.

- The homelessness integration champion should submit a report to both Housing Committee and the Overview & Scrutiny Committee (within 12 months of these panel recommendations being agreed by the relevant council decision-making committee). The report should detail the practical steps taken towards better integration over the past 12 months by the various schemes in operation, as well as plans for further development across the next year.

- The homeless integration champion will also be responsible for ensuring that the various projects for better integration of homelessness services are kept aware of each other's work programmes and work jointly when it is advantageous to do so.

- The homelessness integration champion will be responsible for collating information on the cost savings (or otherwise) achieved by better integration of services, both to include in the report to Housing Committee/OSC, and in terms potentially of establishing a more general business case for the value of service integration.

RECOMMENDATION 2 A senior BHCC officer should be appointed as 'homelessness services integration champion' across statutory services and other sectors.

Hostels
Traditionally, in Brighton & Hove and elsewhere, most single homeless people eligible for local housing support would be offered a place in a hostel. Hostels typically house a number of people in individual bedrooms, but with other areas communal. Hostels provide various levels of support, depending on the types of clients housed there. They are intended to be a relatively short term resource, with residents moving on to independent living or to lower support housing. However, progress on this pathway will depend on a client's ability to live independently: whilst some hostel residents are perfectly capable of managing a tenancy, others, particularly those from rough sleeping backgrounds are not, and require intensive support to develop these skills.

There is little doubt that hostels can be a very useful housing resource: for instance, it is generally more straightforward and more cost-effective to provide support to a number of people living together than to smaller groups or individuals. Nikki Homewood of BHT told the panel that city hostels could be extremely effective, delivering really good outcomes in terms of supporting people to move on to independent living. Hostels are not just shelters, but places from which a wide range of support services can potentially be delivered efficiently.[21]

However, there are also some quite significant problems associated with hostels. Firstly, the hostel environment may simply be unsuitable for some clients. This may include people on the autistic spectrum for whom group living can be very challenging. For others, particularly for those trying to recover from drug or alcohol misuse, hostels are a difficult environment because some residents may be using such substances. Other people may simply be unable to obey the rule-based system that hostels need to employ to deal safely with high-needs residents.[22] It seems perverse to attempt to house people genuinely unable to cope with group accommodation in an environment that may serve to exacerbate rather than reduce their support needs.

Secondly, the fact that hostels bring together a number of people who may tend to have problems with offending, anti-social behaviour, mental health problems and drug or alcohol misuse can create significant problems for local communities. It is evident that the size of hostels is a factor here: the more people with high support needs who are housed together, the more likely it is that they will interact badly.[23] Although a good deal can be done to reduce the impact of anti-social behaviour associated with hostels, particularly in terms of the support provided to hostel residents, the presence of hostels in residential areas remains problematic.

Thirdly is the issue of location. For historical reasons our hostels tend either to be located in central Brighton near the seafront, or close to London Road or St James Street. This concentration of accommodation means that there is a

[21] Evidence from Nikki Homewood, BHT, informal meeting Jan 14.
[22] Evidence from Narinder Sundar, Commissioning Manager, BHCC Housing, 07.02.13: point 8.6.
[23] Evidence from Sylvia Peckham, 25.01.13: point 3.10.

disproportionate impact on some communities. It is also unfortunate that so many of our hostels are close to areas associated with anti-social behaviour, drug-dealing and street drinking.[24] For people who are trying to be abstinent such environments pose obvious challenges. (It's evidently not just coincidence that the areas with most hostels are the places where there are problems with street-drinking etc – part of the problem is the behaviour of some hostel residents. However it's also clear that somewhere like Brighton sea-front is going to be a hot spot for substance misuse and anti-social behaviour whether or not hostels are clustered there.)[25]

The panel heard from housing officers that a pilot initiative had seen a small hostel opened at a location a little out of the city centre, and that results had so far been positive, with a reduced level of drink and drugs-related anti-social behaviour from residents, and relatively few problems caused for the local community.[26] However, it should be noted that this hostel houses people with relatively low support needs.[27]

It does seem as if there is some potential to make hostel provision more diffuse, with less reliance upon large central Brighton hostels in favour of smaller units in slightly less central areas. If effective, this would help to reduce anti-social behaviour from hostel residents and reduce the impact upon local communities, particularly those in city centre wards.

RECOMMENDATION 3 the council needs to take action to diversify its 'stock' of hostel accommodation, seeking to spread hostels more evenly across the city, and to offer a range of accommodation options in terms of hostel size and the level of support on offer.

This still leaves the problem of people for whom hostel accommodation is never going to be a feasible option. At the moment there is no realistic alternative for these clients. This seems unacceptable, since people with the type of complex needs that make it impossible to effectively place them in hostels are not going to magically find a housing solution without intensive support. Instead they are likely to end up in a 'revolving door' – rough sleeping until they are placed in a hostel, evicted from the hostel and then rough sleeping again until they are placed in another hostel. This is clearly a poor way to support highly vulnerable people and a potential waste of money.

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[24] Evidence from Sylvia Peckham, BHCC Head of Temporary Accommodation and Allocations, 25 January 2013: point 3.11.

[25] BHT told the panel that a recent local count of street drinkers run by Equinox had shown that, perhaps contrary to received opinion, the majority of persistent street drinkers are not hostel residents, and that a relatively small percentage of city hostel residents are in fact street drinkers. Of 93 people identified as street drinkers, 35 were hostel residents. Of the 35 people identified as high profile regular street drinkers, 16 were hostel residents. This is under 6% of the city's hostel population (288). This suggests that hostels work effectively to minimise the problematic street presence of their residents (evidence provided by BHT: included in **Section 2** to this report).

[26] Evidence from Sylvia Peckham, BHCC Head of Temporary Accommodation and Allocations, 25 January 2013: point 3.11.

[27] Evidence from BHT: informal meeting Jan 14.

Some witnesses to the panel suggested that we should move away from the hostel model entirely, seeking instead to focus on much smaller units, or on housing people individually with support.[28] In the short term it seems highly unlikely that we would or could abandon the hostel model, but it is important there should be alternatives for those clients for whom hostels are an ineffective housing option. This should include smaller scale supported housing as well as supported independent housing. Although this type of supported housing may seem considerably more expensive than accommodating someone in a hostel, it is unlikely to be more expensive than *failing* to accommodate someone in a hostel.[29] This is an option that has been successfully explored by local authorities in Westminster and Oxford,[30] although housing officers did point out that, whilst offering alternatives to hostel accommodation may initially appear an attractive option, it does depend on there being appropriate housing stock available, which may pose a problem locally given the high demand for social housing.[31]

RECOMMENDATION 4 we need a more diverse range of supported accommodation available to house single homeless people, particularly those with very complex needs. Whilst this is clearly not going to happen overnight, we would welcome a commitment to move to a model of greater diversity coupled with at least some practical action in the short term.

Service Mapping and Member Engagement

Everyone knows that homelessness is a major issue in Brighton & Hove. However, beyond this general perception of there being a problem, there is relatively little detailed public understanding of homelessness as an issue. Indeed, the panel members were struck by how little *they* actually knew about homelessness services, and just how wide-ranging services actually are. As part of the scrutiny review process, members talked widely to officers in the council's housing service and other homelessness support providers. They also visited several services for homeless people, including hostels, drop-in centres and B&B accommodation, talking with staff and service-users.[32]

It quickly became apparent that services for homelessness are a complex mosaic, involving at least two council housing teams, NHS commissioners and providers, Community Safety, Public Health, the police and probation services, and a wide range of community and voluntary sector providers – some commissioned by the city council or the NHS, others independently funded and operating to their own agenda.

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[28] Evidence from Bec Davison, CRI, 07.02.13: point 8.7, and from Ellie Reed and Sarah Gorton: point 8.15.
[29] Evidence from Bec Davison, CRI, 07.02.13: point 8.7.
[30] Evidence from Sarah Gorton, Homeless Link, 07.02.13: point 8.7.
[31] Evidence from Narinder Sundar, 07.02.13: point 8.8.
[32] Panel members visited First Base Day Centre, Phase 1 Hostel, New Steine Mews Hostel, Glenwood Lodge Hostel and the West Pier Project. Members also took part in the annual rough sleeper street count and attended a service-user event where they interacted with Business Action on Homelessness. As part of the panel process, support officers met with BHT and co-ran a workshop session at the SHORE conference.

Complexity is not necessarily a bad thing. In some instances very complex service arrangements may work superbly well. It may also be that there is an irreducible complexity inherent in homelessness services – because the problems cut across so many services and concern so large a number of partners, and because there is so much long-standing public and charitable concern around homelessness. It may well be that there is very limited potential in terms of further integrating or streamlining this map, and indeed there may be major benefits from having multiple approaches and solutions to the problem of homelessness.

However, whilst the local map of homelessness services is doubtless fully understood by the relevant housing professionals, and makes perfect sense to those whose core job is homelessness, from the point of view of potential service users, or even of people working in the police or the NHS, the complexity threatens to be bewildering.[33] If the people who need to use a service are unclear as to what services are actually available and how to access them, they are unlikely to have a positive experience.

Whatever the actual organisational and partnership complexity of homelessness services therefore, there is a clear need for a readily comprehensible map of services – something that offers a simple picture of the services on offer across the city.

RECOMMENDATION 5 the council needs to produce a clear map of statutory and non-statutory homelessness services across the city and make it available via the its website.

In a similar vein, the Council's elected members have ultimate decision-making powers in relation to homelessness services (at least in terms of services commissioned or provided by the city council), but members' understanding of homelessness as an issue and of the types of services on offer is often very limited (excepting of course Housing Committee members). The panel members were very impressed by the services they visited or were told about, and by the obvious competence and dedication of the people working in them. We think that there would be value in the housing team doing more with elected members, both in terms of homelessness as a strategic concern and in terms of the practical services on offer and how they can be a resource to ward Councillors. Improving the information available to elected members is likely to lead to a better understanding of the importance of homelessness services. This is particularly important as homelessness cuts across services, meaning that decision-makers in areas other than housing would benefit from greater knowledge of the issue.

This was reinforced by evidence from Sarah Gorton, the South East Regional Manager for Homeless Link, a national membership organisation for organisations working in the field of homelessness. Ms Gorton highlighted the

[33] Evidence from John Child, Deputy Service Director, Sussex Partnership NHS Foundation Trust, 07.02.03, point 8.19.

importance of involving elected members in homelessness services, and commented:

"It was really good to see members from all parties interested enough to come on the rough sleeper count and impressive to attend the scrutiny panel meeting and witness the genuine desire from Councillors to engage in the issues and to think about what needs to change."[34]

Other witnesses, including Central Sussex YMCA, reiterated the importance of elected member involvement in homelessness issues.[35]

As Brighton & Hove City Council operates a committee system, we already have a relatively high degree of cross-party member involvement in homelessness issues via the BHCC Housing Committee. There is also direct elected member involvement in the local Strategic Housing Partnership. In addition the city Health & Wellbeing Board will be involved in monitoring the soon to be established Programme Board for integrated homeless health and social care.

There is therefore already a good base of relatively expert members to build on. This should be reinforced via the member training programme. The panel is pleased to note that the member seminar programme already includes training on homelessness issues, and trusts that there will be further training scheduled.

Pathways

Service pathways set out how service-users access and progress through a system and are an important tool for professionals. Homelessness pathways need to be simple enough for service users and non-housing professionals to understand and they need to be flexible enough to avoid bottlenecks and perverse outcomes. It is not necessarily an easy task to devise a pathway through services that is easily understood and appropriately flexible, and even the most robustly designed pathways need periodic tweaks.

The panel heard evidence that aspects of homelessness pathways were not working as well as they should. For instance, CRI told us that homeless pathways demand that homeless people accessing band 3 unsupported accommodation must first have progresses through band 2 supported accommodation (i.e. hostels). For most clients this may make perfect sense, as people who have successfully lived in group accommodation are well placed to take on the additional responsibilities associated with independent living – many rough sleepers would not cope well if immediately moved into unsupported accommodation. However, for a small group of people with complex needs, progress through band 2 is much more problematic, and a better alternative might be to house them directly in band 3 housing with appropriate levels of support.[36] In this particular instance it seems likely that a

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[34] Email from Sarah Gorton, SE Regional Manager, Homeless Link
[35] Evidence from Central Sussex YMCA, 19.02.13: point 13.35.
[36] Evidence from Ellie Reed, CRI, 07.02.13: point 8.6.

generally sensible policy has had perverse consequences, and some relaxation of the pathway rules would be desirable.

Other witnesses suggested that the homeless pathways be amended to provide more robust learning and work support[37], or that a dedicated young people homeless pathway be established.[38] The panel is pleased to note that the city council is actively seeking to develop a young person housing pathway.[39]

RECOMMENDATION 6 – homeless pathways should be revised to allow clients to progress directly into band 3 support when it is clear that there is no realistic possibility of them progressing successfully through band 2 support.

Setting local levels of support

Homeless is not a localised issue. Whilst the majority of homeless people in an area are likely to be from that area, by no means every homeless person will be. Some destinations are inherently more appealing than others for rough sleepers. Factors which make a particular area attractive include: climate, levels of street violence, the presence of an established rough sleeping 'community', access to drugs, the availability of non-statutory support (food, sleeping bags etc), and the relative generosity of statutory sector support.

A number of these factors apply to Brighton & Hove and it is therefore no surprise that the city has to deal with a disproportionate number of rough sleepers. Of course, there's not much we can do about the weather, and some of the things that make Brighton & Hove attractive to rough sleepers are also the things that make the city attractive to tourists or businesses, so we'd be unlikely to want to change them even if we could.

However, there is more opportunity to influence some of these factors, most obviously in terms of statutory services. Every upper-tier local authority is required to provide a legal minimum level of homelessness services, but providing additional levels of service is optional. In practice this can mean that neighbouring authorities may offer significantly different levels of service, and if this is the case there is an obvious danger that homeless people will migrate from areas of low to areas of higher support, increasing pressure on those areas that have already done the most to address homelessness problems.

One solution to this issue would be to recommend that local support was provided at the legal minimum level. However, there are a couple of potential problems here. Firstly, there is an ethical dimension to be considered with regard to any decision about providing services to vulnerable people: we may not feel that the legal minimum is sufficient. Secondly, not all rough sleepers will necessarily go elsewhere if support services are cut. It is likely that we

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[37] Evidence from Rob Liddiard, Friends First, 19.02.13: point 13.35.
[38] Evidence from Stuart Kitchenside, Sanctuary, 19.02.13: point 13.35.
[39] BHCC Draft Joint Commissioning Strategy: Housing & Support for Young People aged 16-25 (presented at BHCC Children & Young People Committee 14.10.13).

would continue to have significant numbers of people sleeping rough in the city irrespective of the level of support offered. But without support it is also likely that these remaining rough sleepers would be at greater risk and present greater risks to the local community. There is therefore a pragmatic balance to be struck in terms of setting a level of support that does not needlessly attract out-of-area rough sleepers, but which ensures that the impact of those rough sleepers who are bound to remain is minimised.

Whilst it may never be possible to guarantee that a local area's approach to homelessness will exactly tally with those of its neighbours, it is obvious that all practical steps should be taken to synchronise approaches in order to minimise the migration of homeless people from one area to another. The panel heard evidence from John Routledge of SHORE (Sussex Homeless Outreach, Reconnection and Engagement). SHORE seeks to bring statutory and non-statutory providers of homelessness services across Sussex together to share best practice and plan more effectively.[40] We are pleased to note that the council's housing service is actively engaged with the SHORE initiative: it clearly makes sense to share as much information and expertise as possible with our neighbours, even if we may have differing views on how to deal with homelessness.

In very practical terms, it is difficult to not provide some sort of support to homeless people living locally even if they have no local connection. In theory such people should return to wherever they do have a local connection and receive support there. However, recent years have seen many local authorities becoming more reluctant to accept their duty to house such people, and Brighton & Hove will not relocate homeless people unless there is appropriate support in place for them, so in practice we do provide services to a number of people who have no local connection.[41]

It seems to us that there is really good work already going on across local authority boundaries here, and we therefore have no specific recommendation to make.

Domestic Violence

There are many reasons for people becoming homeless, and although all homeless people are potentially vulnerable, some are especially so. People fleeing their homes because of domestic violence are obviously homeless. However, in order to be eligible for local authority help under housing legislation, applicants have to meet five criteria, including whether they are 'intentionally homeless' and whether they have a 'local connection'. Both of these can cause problems for people who have experienced domestic violence.

In terms of 'intentionality', people who simply abandon a tenancy for no good reason are likely to be deemed 'intentionally homeless' and therefore

[40] See evidence from John Routledge, SHORE, 07.02.13: point 8.13.
[41] Evidence from Bec Davison, CRI, 07.02.13: point 8.4.

ineligible for housing support. Whilst experiencing domestic violence would probably be considered a valid reason for abandoning one's home, it may be no simple matter to prove this, particularly in instances where people are too scared to involve the police, or where long term abuse has never been reported to the authorities, meaning that there is no documented history to refer to. It is frequently the case that people suffering from domestic violence do not report their abuse

In terms of local connection, it is evident that people forced to flee their homes may not feel safe in their local areas. Whilst some people may have family or friends in other parts of the country, others will not, and may well have little choice but to move to an area where they have no connections – indeed such an area may be the safest place for them. However, having a local connection is one of the criteria by which homeless applications are judged. Again, there should already be enough flexibility in the system to ensure that someone genuinely fleeing domestic violence is able to access housing support wherever they have settled. Housing legislation effectives waives the requirement to have a local connection if you can show that you have no connection to any locality (for example if you've been serving with the armed forces for a length of time), or if you can prove that the places where you have an established connection are unsafe. However, the problem is again that it may not necessarily be easy for someone to prove that they are at risk, particularly if they do not have a well-documented history of domestic violence.

The city council is committed to supporting the victims of domestic violence, and this should clearly include helping people access housing services to which they are statutorily entitled. However, the council cannot simply take people who claim to be the survivors of domestic violence at their word. Even if the overwhelming majority of such applicants are genuine, this would leave a loophole for fraudulent applications, and a loophole that would probably get larger over time. This does not mean that the local authority should not continue to adopt as sensitive an attitude to domestic violence as possible, recognising that the great majority of people who claim to be fleeing abuse are indeed doing so, and that a necessarily robust system of checking must be designed not to deter genuine cases.

The panel recommends that future housing strategy reviews should specifically address the needs of people fleeing domestic violence. We also recommend that staff induction and training should ensure that those assessing eligibility for housing are aware of the common issues relating to intentionality and local connection outlined above, and that guidance to assessment teams should make it clear that the city council is committed to supporting survivors of domestic violence in accessing all services to which they are entitled.

Where the council knows that people have been affected by domestic violence, it could also explore using more flexible forms of tenancy. People suffering domestic violence may, regrettably, have to move at short notice for their own safety. It seems perverse to hold people in these circumstances

responsible for breaching a tenancy agreement or to make them forfeit their deposits.[42]

RECOMMENDATION 8 New and refreshed BHCC housing strategies must explicitly address the housing needs of victims of domestic violence.

RECOMMENDATION 9 Training for housing staff dealing with homeless applications must explicitly include information on domestic violence.

LGBT people

Jess Taylor of RISE told the panel that there was a real issue with LGBT people being made homeless because of their sexual orientation or gender identification - especially in terms of young people 'coming out' and being rejected by their families. The consequence of this is that LGBT people are typically over-represented amongst rough sleepers (up to 30% of rough sleepers in urban areas identify as LGBT, whereas the general LGBT population is rarely more than 10-15%).[43]

Facing being ostracised or harassed at home, many LGBT people gravitate to urban areas with a reputation for being inclusive, as do lots of people who simply want to live in an LGBT-friendly environment. Brighton & Hove is obviously a popular choice as an LGBT-friendly destination, and there are significant economic and cultural benefits for the city here.

Jess Taylor told the panel that domestic violence is typically under-reported, and this is likely to be even more so across the LGBT community, with many people reluctant to divulge details of the sexual or gender identity to the police or other authorities. Locally, the level of formally reported LGBT domestic violence is very low, but this is totally at odds with all qualitative data, such as the Count Me In Too survey, and is likely to indicate that there is an endemic problem of under-reporting in the city.[44] Peter Castleton of the council's Community Safety team echoed this point, telling members that official crime figures tended to under report both domestic violence and crimes against the LGBT community.[45] Homeless LGBT people, particularly younger people, may also be particularly vulnerable to domestic violence and to being coerced into providing sex in return for shelter, although this is not a problem unique to LGBT communities.[46] There is currently no local refuge provision or other safe space for men or trans men affected by domestic violence, although there is some provision for trans women. [47]

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[42] Evidence from Jess Taylor, 19.02.13: point 13.12.
[43] Evidence from Jess Taylor, RISE, 19.02.13: point 13.2.
[44] Evidence from Jess Taylor, 19.02.13: point 13.5.
[45] Evidence from Peter Castleton, BHCC Community Safety, 19.02.13: point 13.5.
[46] Evidence from Jess Taylor and from Peter Castleton, 19.02.13: point 13.7.
[47] Evidence from Jess Taylor, 19.02.13: point 13.8.

Recent changes to Housing Benefit have capped payments to under 35s, meaning that people can only claim for the cost of a room in a shared house rather than for independent accommodation. For some LGBT people, particularly those who have already suffered domestic violence, this can be problematic, as people may not feel safe living with relative strangers who may target them for their gender orientation or sexual identity.[48]

Jess Taylor noted that LGBT people who do become estranged from their friends and family after coming out are much more likely than the general population to lack 'social capital' – the types of informal support that typically prevent homeless people from becoming rough sleepers.[49]

Ms Taylor told members that some LGBT people report encountering problems when attempting to access housing services – e.g. difficulties with staff who are unsympathetic or who do not understand LGBT issues. This is something that was also noted in the Count Me In Too survey of local LGBT communities and has been widely reported anecdotally. Ms Taylor suggested that this problem should be dealt with by ensuring that housing staff receive proper training in dealing with and signposting for LGBT customers (e.g. the type of training provided by Allsorts).[50]

Older LGBT people can feel very isolated, perhaps particularly those who are living in sheltered housing schemes where LGBT identities are not always well understood or accepted. Jess Taylor pointed out that there is no dedicated LGBT sheltered housing in the city and little acknowledgement of LGBT concerns across existing sites.[51]

The panel recommends that future homelessness strategies should explicitly address the needs of LGBT people, recognising that Brighton & Hove is particularly likely to attract those who have been unable to live free of harassment in other areas. We also recommend that staff induction and training should ensure that those assessing eligibility for housing are aware of the common issues relating to intentionality and local connection outlined above, and that guidance to assessment teams should make it clear that the city council is committed to supporting LGBT people in accessing all services to which they are entitled.

RECOMMENDATION 10 New and refreshed BHCC housing strategies must explicitly address the housing needs of LGBT people.

RECOMMENDATION 11 Training for housing staff dealing with homeless applications must explicitly include information on LGBT needs.

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[48] Evidence from Jess Taylor, 19.02.13: point 13.9.
[49] Evidence from Jess Taylor, RISE, 19.02.13: point 13.6.
[50] Evidence from Jess Taylor, 19.02.13: point 13.10.
[51] Evidence from Jess Taylor, 19.02.13: point 13.11.

Young people

There are specific problems associated with young homeless people. In the first place, homelessness is a growing problem for young people as it is for other demographic groups. But there are also changes within the group of young people presenting as homeless. Stuart Kitchenside from Sanctuary told members that the profile of young people being supported by Sanctuary had changed significantly in the past five years, with a rise in younger applicants (16-17 rather than 20-25) coupled with increasingly complex support needs. This has a resulted in a changed emphasis for support services, moving from a focus on preparing young people for further/higher education to teaching basic coping skills.[52]

Sussex Central YMCA agreed, but noted that the need to concentrate on young people with complex support needs shouldn't distract people from the fact that demand for services was increasing across the whole of the demographic – the YMCA has seen client numbers increase six-fold in the last six years (from 100 to 600). By no means all of these young people have high support needs, but young people (i.e. 18-21) with no job, no employment history, credit history, guarantors or references, and with limited independent living skills, are competing for properties against students and young professionals and are unsurprisingly losing out. There is an obvious need for a focus on this issue: supporting young people to stay in the family home for longer, teaching living skills, and providing sufficient supported accommodation for those who cannot realistically find or maintain private sector tenancies.[53]

Supporting younger homeless people with high needs is a specialist job: when young people have had bad experiences with families and school they may not thrive in a rules-based environment. It is therefore important that service providers are able, and are enabled by commissioners, to work flexibly and appropriately with young people, delivering against outcomes rather than process targets. This work is necessarily long term, and typically does not fit the 2 year support plans that Supporting People funding requires. Mr Kitchenside noted that housing commissioners had been very progressive in these respects, recognising how complex and delicate work with young people has become and relaxing their rules to accommodate this – although there was always more that could be done.[54]

It is not totally clear why the profile of young homeless people has changed so much recently. Stuart Kitchenside suggested that it may reflect the increasing lack of jobs for low-achieving young people – a problem exacerbated in Brighton & Hove by the large student and graduate populations competing with local people for low-skills jobs. This lack of available jobs may discourage young people from trying to gain the skills that might make them employable.[55] Sussex Central YMCA agreed, but added that there was also a

[52] Evidence from Stuart Kitchenside, 19.02.13: point 13.13.
[53] Evidence from Sussex Central YMCA, 19.02.13: point 13.33.
[54] Evidence from Stuart Kitchenside, 19.02.13: point 13.14.
[55] Evidence from Stuart Kitchenside, 19.02.13: point 13.18.

general issue of ‘extended adolescence’ with young people taking on ‘adult’ attitudes and responsibilities much later in life. This could be seen across the social spectrum and was not necessarily a problem for privileged/high achieving young people, but could be a significant issue for young people who cannot rely upon parental support, and especially for those with other vulnerabilities such as mental health problems, learning disabilities, or experience of unstable childhoods.[56]

Support services are sensibly focused on getting their young clients into work. However, in practice this can be complicated by the claw-back of benefits and Supporting People funding from people who do find work. This may leave them no better off than before and could act as a further disincentive. Moreover there is a risk that vulnerable young people who are successful in finding work could be deemed as no longer in need of Supporting People funding and be therefore required to find private sector housing. Whilst this move-on might sometimes be appropriate, if applied indiscriminately it could end up ruining the progress of young people who have responded really well to support by moving them into unsuitable accommodation before they are truly ready to be moved.[57]

Indeed it may not be wise to assume that young people can easily access private sector housing. Stuart Kitchenside noted that it can be almost impossible for young people to get private tenancies as landlords are reluctant to house them, preferring ‘easier’ and more remunerative student or young professional tenants. Encouraging private landlords to take a more positive view of young tenants would therefore be valuable.[58]

Mr Kitchenside also told members that there is currently no dedicated service pathway for young homeless people, meaning that younger clients are expected to use the adult homelessness pathways. There is a real danger here in exposing vulnerable and easily-influenced young people to entrenched homeless adults and indeed to professionals whose main point of reference is that of entrenched service users. The risk is that young people will effectively be encouraged to view homelessness as a norm, as well as being exposed to resources which are really not appropriate for young people.[59] Sometimes there may be an advantage in accommodating some young people in adult schemes, particularly for those people who cannot settle in age-appropriate hostels, but this should be determined by the support needs of the individual not because pathways are too rigid or because there is a lack of age-appropriate places.[60]

Sussex Central YMCA noted that there is not enough supported accommodation for young people, with long waiting lists for hostels meaning that too many young people are housed in inappropriate B&B accommodation. There is a particular frustration here as B&Bs are both

[56] Evidence from Central Sussex YMCA, 19.02.13: point 13.18
[57] Evidence from Central Sussex YMCA, 19.02.13: point 13.19.
[58] Evidence from Stuart Kitchenside, 19.02.13: point 13.20.
[59] Evidence from Stuart Kitchenside, 19.02.13: point 13.16.
[60] Evidence from Stuart Kitchenside, 19.02.13: point 13.17.

expensive and typically poor environments for vulnerable people – providing sufficient hostel capacity would potentially be cheaper in the short term and would deliver even bigger long term benefits as it would provide a living environment designed to reduce people's vulnerabilities rather than one likely to exacerbate them. There are particular capacity issues in terms of supported accommodation for young people with mental health, substance misuse or learning disability issues.[61]

When addressing the housing needs of younger people it is also important to think holistically. If young people are not work ready, lack the types of skills or qualifications needed to enter the job market or the skills necessary to live independently, then finding them housing is likely to offer only a very partial solution to their difficulties. Rather, housing support needs to be delivered alongside other types of support, and any strategy aimed at younger homeless people needs to recognise that solutions will need to be much broader than the provision of shelter.

The recently published BHCC Draft Joint Commissioning Strategy: Housing & Support for Young People aged 16-25 addresses a number of the points raised above. In general the draft strategy should be warmly welcomed. However, it is unclear whether the strategy will seek specifically to address issues concerning the growing number of young people with high/complex support needs, the supply of specialist supported housing for young people, and 'holistic' support which focuses on work-skills as well as housing support. We feel that these are important areas and should form part of future service planning for young people at risk of homelessness, potentially as part of the Joint Commissioning Strategy.

RECOMMENDATION 12 Relevant new and refreshed homelessness strategies (e.g. the Joint Commissioning Strategy for Young people) should explicitly address need with regard to:

- **services for young people with high support needs;**
- **ensuring that there is sufficient specialised housing to support young people;**
- **the need to deliver 'holistic' support to young people (i.e. helping make young people work ready at the same time as housing them)**

Community Safety/Policing

Peter Castleton of the BHCC Community Safety Team told members that local services for rough sleepers involved the council working in partnership with the police, with BHT and CRI, and with a number of community and voluntary sector organisations, both to discourage rough sleeping and to provide outreach support to those who nonetheless rough sleep.[62] The

[61] Evidence from Sussex Central YMCA, 19.02.13: point 13.34.
[62] Also important in this context is the Co-ordinated Agency Intervention to End Rough Sleeping Approach (CAIERS). This new multi-agency project, led by BHT and CRI seeks to plan and co-ordinate support to end rough sleeping on a case-by-case basis, prioritising the most entrenched and vulnerable service-users. To date this project has been very successful. More information, supplied by BHT, as included in **Section 2** to this report.

intention is to protect rough sleepers – from other rough sleepers and from 'external' threats - and to minimise the impact that rough sleeping has on settled communities. In general services are very good, as demonstrated by the fact that the number of rough sleepers locally has increased significantly in recent years without a similar increase in complaints about them.

However, there are still some major problems. These include a very high homicide rate within the rough sleeping community; very high levels of harassment and abuse of rough sleepers - particularly by drunk people in the centre of town - poor reporting of harassment by rough sleepers; and rough sleepers being used for forced employment. There is also a considerable cross-over between the rough sleeping community and other groups – most notably street drinkers. This means that rough sleeper problems can spread to other areas – as when housed street drinkers invite rough-sleeping street drinkers back to their flats.[63] Brian Doughty, Head of BHCC Adult Assessment, added that a significant problem for adult social care was 'cuckooing', where vulnerable tenants were targeted by homeless people who would 'befriend' them before moving in with them and exploiting them. Again this is a cross-agency problem and a joint protocol is being established to help deal with it.[64]

Mr Castleton told members that support for rough sleepers needed to be carefully targeted. Some rough sleepers are actually incredibly resilient and do not need (or want) high levels of support.[65]

Bec Davison of CRI agreed that the police and community safety teams had made great strides in recent years to understand and develop links with homeless people (e.g. via the Street Community Policing Team), and this was to be commended. However, there was a risk that a focus on building relationships with the homeless community meant that anti-social behaviour committed by rough sleepers might be ignored for fear that enforcement would alienate those with whom the police were trying to build bridges.[66] John Child noted that Sussex Partnership NHS Foundation Trust (SPFT) had experienced parallel problems, with the police reluctant to use appropriate enforcement measures when dealing with mental health service users.[67]

Employment support

Many homeless people lack qualifications, job experience or even the most basic work skills, either because they have never had them or because the trauma they have experienced has effectively de-skilled them. If people are to eventually live normal, settled lives it is clearly vital that they have the necessary skills to live and work independently. It is therefore important that, in addition to providing shelter, services for homeless people enable their clients to develop work and learning skills.

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[63] Evidence from Peter Castleton, BHCC Community Safety, 19.02.13: point 13.25.
[64] Evidence from Brian Doughty, 19.02.13: point 13.23.
[65] Evidence from Peter Castleton, 19.02.13: point 13.28.
[66] Evidence from Bec Davison, CRI, 07.02.13: point 8.16.
[67] Evidence from John Child, Sussex Partnership NHS Foundation Trust, 07.02.13: point 8.7.

The panel heard from Rob Liddiard and Adrian Willard of Friends First. Friends First is a small voluntary organisation that provides a range of services for homeless people, including drop-in provision, supported accommodation, a move-on house and a working farm. Friends First aims to support homeless people to develop work skills by giving them experience of working – either in building or market-gardening. The intention is to teach general work-related skills, such as being punctual and reliable, rather than very specific skills. Mr Liddiard noted that this was a relatively undeveloped idea in terms of local homeless provision, but that there was considerable merit in the concept of a 'working hostel' environment as becoming work-ready was an important part of reintegrating homeless people into the community.[68] The use of a rural setting for some of these services has advantages in terms of avoiding some of the distractions of a city centre environment, although few Brighton & Hove homeless people would choose or be well-adapted to living permanently in a rural environment.[69]

The panel heard that there was a significant practical problem with running the Friends First market garden: Jobcentre+ refuses to accept that clients being trained via the market garden are undertaking genuine job-training and requires them to sign-on as usual. It can easily take claimants half a day's travel to do so, and this is unsettling for the service users as well as being a waste of time that could have been spent on work training. What seems particularly nonsensical is that the people training at the market garden are by definition lacking in the kind of skills that would make them employable, so they are being made to 'sign-on' to show that they are actively seeking jobs they cannot hope to obtain rather than spending the time learning skills that might make them employable.[70]

We are aware that this type of problem is not limited to Friends First, but has been encountered by a range of groups supporting homeless or formerly homeless people. It seems to be the case that Jobcentre+ has limited room for manoeuvre here, being obliged to act in accordance with central Government guidance. After lobbying by local third sector organisations Jobcentre+ has agreed to classify some schemes in such a way as to minimise the need for service-users to sign-on. Voluntary organisations have also agreed to seek the relaxation of sign-on rules only in situations where they are providing core employability skills, not in situations where they are teaching more generic skills like IT literacy.

We welcome this compromise brokered by local voluntary sector organisations and by Jobcentre+. However, although the situation is better than it was, only a partial solution has been achieved – what is really needed is more constructive central Government guidance which actively encourages the up-skilling of homeless and insecurely housed people as an essential part of re-integrating them into society.

[68] Evidence from Rob Liddiard, Friends First, 19.02.13: point 13.30.
[69] Evidence from Adrian Willard, Friends First, 19.02.13: point 13.31.
[70] Evidence from Rob Liddiard, 19.02.13: point 13.32.

RECOMMENDATION 13 the Council should consider lobbying central Government (on the issue of people who are receiving employability training being required to attend the Job Centre to sign-on), reflecting the concerns of local voluntary sector providers that the rules dictating the ability of Jobcentre + to relax its signing-on requirements are still too inflexible – although it should be recognised that only people undertaking genuine employability-focused training should be exempted from signing-on.

Private landlords

With little or no space available in social housing in Brighton & Hove and local property prices unaffordable for many people, the private rented sector has assumed increasing importance in recent years. However, to access private sector housing, homeless people have to compete against several other groups, including professionals (some of whom might previously have bought property, but are now unable to find deposits or a mortgage) and students, whose numbers have increased in recent years.

With demand effectively outpacing supply in the local housing market, landlords and letting agents have become increasingly choosy about the tenants they take on, seeking to minimise their exposure to risk by demanding hefty deposits, references, undertaking credit checks and only renting to those in steady employment. (Letting agents typically insist on these checks being carried out *and* charge large sums to process them.) These checks and charges can present a formidable barrier to people trying to access housing, particularly for those with limited financial resources, and can mean that people are in a position where they are in employment and able to pay a commercial rent, but still can't get a tenancy.

The situation is likely to be much worse for people with a chequered housing history – for instance people with mental health or learning disability problems that have meant they have struggled to pay rent on time, or to keep their properties clean etc. Vulnerable people like these are obviously unlikely to be able to compete effectively against professionals in an open housing market. One way of dealing with this is to try and ensure that vulnerable people currently in tenancies are not evicted (there is a particular urgency here for local authorities which are likely to have to provide long term support for vulnerable people if they can't live successfully in the private rented sector).

There is therefore a clear need for local authorities and other agencies involved in homelessness to work closely with private landlords to try and support vulnerable tenants in their private sector tenancies and avoid evictions which are likely to be bad news for the individuals affected and for statutory support services. The council's housing teams already do a good deal of work in this respect, both at an operational level and at a more

strategic level via the city Strategic Housing Partnership, and this work is to be commended.[71]

Brian Doughty, Head of Adult Assessment for the city council, told the panel that there was a particular problem with clients who are 'neglectful' – people who may have mental health problems, but who retain the capacity to make decisions about their own welfare, and who 'choose' to neglect themselves, living in unsanitary conditions, hoarding etc. Clearly, few private landlords would actively choose to have this type of tenant, so there is a need for services to offer as much support as necessary to landlords if they want to keep such people in their tenancies.

This is true for public landlords too – i.e. the council or housing associations – taking a firm stance on un-neighbourly or anti-social behaviour needs to be balanced against the need to support vulnerable people, and an understanding that eviction may simply just shift the burden and costs of supporting people down the line.[72]

The council's housing teams are already very active in their engagement with private landlords, both at an operational and a strategic level, through the city Strategic Housing Partnership. The panel recognises the worthwhile work being undertaken here, and notes that it is likely to grow in importance in coming years as the city becomes more rather than less reliant upon the private rented sector to house vulnerable people.

A local resident, Mr Richard Scott, suggested that services might look to do more in terms of intervening in private sector landlord/tenant disputes – e.g. in certain circumstances offering to guarantee the payment of a tenant's debts providing they were allowed to remain in their tenancy, and then working with the tenant to recover these debts gradually.[73]

RECOMMENDATION 14 New or refreshed homelessness strategies should explicitly address the issue of working with private landlords to maximise the supply of private rented accommodation accessible to homeless people.

Prison

Offending is prevalent amongst rough sleepers: usually for matters such as street drinking, begging, shop-lifting and drugs offences, but frequently for more violent crimes also. Many rough sleepers have a significant criminal history, including imprisonment.

Being imprisoned is itself likely to cause or contribute to homelessness: people who are in prison may be at risk of losing tenancies, or of being estranged from their families and homes.

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[71] Evidence from Narinder Sundar, 07.02.13: point 8.28.
[72] Evidence from Brian Doughty, Head of BHCC ASC Assessment, 19.02.13: point 13.21.
[73] Evidence from Richard Scott, 07.02.13: point 8.29.

This is a particular local issue, given the proximity of Lewes prison. People released from Lewes may gravitate to Brighton & Hove on release, whether or not they have a local connection, and some of these people (particularly the ones who are not locals) may end up rough sleeping.[74] There are good services available in Brighton & Hove for ex-convicts with a local connection, including an in-reach service provided at Lewes Prison by the council's Housing Options team and by BHT, but fewer such services for those who are not locals.[75]

Clearly rough sleeping is unlikely to provide a stable background to enable ex-offenders to reintegrate successfully into society and to reduce the risk of re-offending. People who end up rough sleeping after being released from prison have a relatively poor chance of avoiding re-offending – which is bad news for them and has obvious system costs in terms of the impact of future crimes on the criminal justice system.

It seems obvious therefore that every step should be taken to ensure that people leaving prison do not end up on the streets. However, things are not necessarily this simple: offering housing support to released offenders who did not meet the local eligibility criteria would certainly cost the city council money in the short term; and although it might well save the public sector considerable sums in the long term, there is no obvious way of getting the agencies who are likely to make most of the long term savings (the police, the courts, probation, prisons) to contribute. In addition, there would be an obvious risk here in offering a higher level of support than neighbouring areas – the city is presumably not eager to be a preferred destination for people leaving prison. It may therefore be that this is the kind of issue that is best progressed jointly with neighbouring local areas, and with the agencies that stand to gain most from reductions in re-offending.

An allied issue is that of the imprisonment of local people who have social housing or council tenancies. We are unclear whether people who are in prison for only a brief period are able to resume their tenancies when they are released. If not, this would seem to make their reintegration into the community much harder and substantially increase their risk of becoming homeless – with obvious financial impacts. We would hope therefore that a sensible solution could be found to sustain tenancies across short periods of incarceration.

RECOMMENDATION 15 – the council should explore what can be done to maintain people's tenancies should they be imprisoned for a short period of time. The aim should be to minimise the number of people with a local housing connection being made homeless as a result of imprisonment.

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[74] Evidence from Sara Emerson, 07.02.13: point 8.18.
[75] Evidence from Narinder Sundar, 07.02.13: point 8.18

Housing and Social Care co-working

Brighton & Hove is a unitary authority, which means that the city council is responsible for supporting homeless people under housing legislation *and* vulnerable adults and families under social care legislation. The latter include people who do not meet the statutory homeless criteria but who have very significant vulnerabilities in terms of mental health, substance misuse, physical or learning disabilities. A similar arrangement is in place with council children's services for families who are eligible for housing under children's legislation. In recent years, the city council has increasingly moved to a model where all people eligible for housing by the council are dealt with by housing services rather than being housed directly by adult or children's social care.

In general, such arrangements should be welcomed – there is obvious logic in having a local authority housing team responsible for delivering all the housing support which the authority is required to provide. The alternative would be to have a situation where adult social care, children's services and housing all commissioned their own services, with an obvious risk of duplication and increased costs.

However, some of the clients whom social care is responsible for housing have particular vulnerabilities which mean that they require high levels of expert support to live independently. For example, a minority of people with learning disabilities may act in ways which endanger themselves or others – by being neglectful etc. It is important that agreements between social care and housing ensure that appropriate levels of support are provided for very vulnerable people, particularly because if serious problems do develop it can be prove very difficult to take enforcement action against people with such high levels of vulnerability.[76] At the same time it is crucial that already vulnerable people are not made more so by being evicted from their homes. Social care, housing and environmental health services need to work closely together to manage this group of clients and a joint protocol is being developed to this end.[77]

The panel heard that operational partnerships between adult social care and housing had improved markedly in recent years and were now fairly effective. However, it is evident that there is still work to do in terms of strategic co-working. This is an important issue, not least because it seems possible that we are going to see an increase in people with high levels of vulnerability presenting as homeless in the coming years. If departmental boundaries mean that this co-working is only ever going to be partially effective, then this seems to us to be an argument for looking to see whether the boundaries

[76] Evidence from Sylvia Peckham, 25.01.13: point 3.13.
[77] Evidence from Brian Doughty, Head of BHCC ASC Assessment, 19.02.13: point 13.21.

between ASC and housing need to be redrawn to more accurately reflect the degree to which the services are required to work in an integrated manner.

RECOMMENDATION 16 New and refreshed homelessness strategies must explicitly recognise that social care and housing increasingly need to work in an integrated manner, and should establish structures to enable this.

Partnership Working

Effective partnership working to support people with complex needs is predicated upon information-sharing. However there are some major difficulties here, particularly in relation to health and mental health records.[78] This is a really tricky area as there are genuine issues of patient confidentiality to be balanced against the advantages of information-sharing. Good work has been done in this respect already, but it is obvious that more needs to be done.

Eligibility

Local authorities are only *required* to offer housing support to those applicants who meet all the statutory eligibility criteria. However, councils may volunteer to support people who do not meet all the criteria, and some do so, particularly in terms of the 'local connection' and 'intentionality' tests.[79]

There are a couple of good reasons for relaxing the eligibility criteria. In the first place, having very strict criteria in place will catch those who have no real connection to a locality or who have acted irresponsibly in past tenancies, but it may also catch people who are quite genuine applicants. There is therefore an argument in terms of equity here. This is particularly so for groups such as people fleeing domestic violence or LGBT people escaping from harassment in their home towns, where there is evidence that some types of applicant may, through no fault of their own, struggle to prove that they are genuinely eligible.

Secondly, people who are deemed ineligible for housing assistance will not necessarily go elsewhere – many will stay in the local area, and some of them may end up rough sleeping etc, with the potential for major down-stream costs. It may therefore make sense to relax eligibility criteria in circumstances where the up-front costs are likely to be dwarfed by the costs of not effectively supporting people who will nonetheless remain as a local problem.

However, whilst relaxing the eligibility criteria might be a possibility somewhere with a surfeit of empty social housing, it's unlikely to be a realistic option in Brighton & Hove where demand for social housing already far exceeds supply and which is already a 'destination' for homeless applicants. It is important though to recognise that not every unsuccessful homeless

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[78] Evidence from Peter Castleton, 19.02.13: point 13.29.
[79] Evidence from Sarah Gorton, 07.02.13: point 8.20.

applicant is necessarily unworthy of support – many people who do have a real connection to the city and who haven't lost tenancies through any fault of their own will nonetheless fail to meet the homeless eligibility criteria.[80] The local authority needs to be sensitive in dealing with applicants like these, and where possible, to provide them with, or perhaps more realistically direct them to, support and advice.

RECOMMENDATION 17 New and refreshed homelessness strategies should specifically address the support/advice needs of those who have been deemed ineligible for statutory housing support, recognising that this is a significant group of people, many of whom have genuine support needs.

Dual Diagnosis

People who have *both* severe and enduring mental health problems and major substance misuse issues are often referred to as having a 'dual diagnosis'. (The term is also sometimes used for other co-morbidities, such as learning disability and substance misuse problems.) People with a dual diagnosis can be amongst the most vulnerable people in the community *and* amongst the most disruptive, presenting major challenges to support services, including housing. People with a dual diagnosis are over-represented in temporary and emergency housing, and particularly so amongst rough sleepers.

Brighton & Hove has long had problems with dual diagnosis, unsurprisingly given the city's well documented issues with drugs and alcohol and the local level of mental health problems. There has been a good deal of work in recent years, including a strategic needs assessment, the work of a scrutiny panel on dual diagnosis and Sussex Partnership NHS Foundation Trust's development of a dual diagnosis strategy. However, problems persist, and will doubtless continue to do so however good services become at dealing with this issue.[81]

The panel has no specific recommendations to make in respect of dual diagnosis, but notes that our recommendations around providing multi-agency, front-loaded and targeted support to those homeless people with the most complex needs would obviously apply to people with a dual diagnosis.

Dealing with homeless applications

The panel heard evidence that the system for processing homelessness applications was dysfunctional, with applications regularly being lost and staff being unsympathetic to applicants.[82] We also heard that LGBT people had experienced particular problems with staff who failed to understand their circumstances.[83]

[80] Evidence from David Richards, a local homeless person: 07.02.13, point 8.22.
[81] Evidence from John Child, Deputy Service Director, Sussex Partnership NHS Foundation Trust, 07.02.13: point 8.26.
[82] Evidence from David Richards, 07.02.13, point 8.23.
[83] Evidence from Jess Taylor, 19.02.13: point 13.10.

This is anecdotal evidence, and it may well be that people who have had a negative experience of the system are in a minority – we have certainly not conducted a systematic review of services. However, it should clearly be the case that all service users are treated courteously, and that an assessment system should be designed to *support* people in claiming services to which they are eligible, not to deter claimants. At the same time, it is important to remember that statutory homelessness services are meant to be a last resort for people who are unable to otherwise find shelter. They are not intended as an alternative to finding one's own accommodation, and people need to be discouraged from viewing them as such.

There is clearly a balance to be struck here: homelessness services need to be accessible, but they also have to manage demand effectively, ensuring that they are used as a last rather than a first resort.[84] However, managing demand ought not to mean that assessment is less than optimally efficient, nor that applicants should receive anything other than courteous and professional treatment.

Local Connection/Intentionality

The panel heard experts argue that it might make sense to apply the 'local connection' or 'intentionally homeless' criteria more flexibly for certain groups of people – for example those affected by domestic violence, or young LGBT people. However, there is a strong counter-argument here: that Brighton & Hove is already a destination for homeless people and that we simply could not cope with a greatly increased influx of applicants if the eligibility criteria were relaxed.[85] There is obviously a balance to be struck between an ethical homelessness policy (and one which accords with statutory equalities duties) and the need to manage an already major problem (with the danger that accepting more applicants will mean that there are fewer resources to help homeless people).

Housing Supply

Clearly, one of the most obvious ways to reduce levels of homelessness would be to build additional local housing. Equally clearly this is not an easy task, particularly in somewhere like Brighton & Hove with limited available sites and high costs. The panel recognises that the council is working hard to develop the supply of permanent housing, but that this is a challenging long-term project.

In this context it is worth mentioning innovative shorter term 'fixes' such as the BHT scheme to provide temporary housing for homeless people in 'container homes' in Hollingdean. This project has provided a significant number of much-needed homes quickly and at a low cost. There is a potential

[84] Evidence from Bec Davison, 07.02.13: point 8.27.
[85] Evidence from Peter Castleton, 19.02.13: point 13.27.

opportunity to develop similar schemes using other temporarily vacant sites across the city.

Monitoring the Panel Recommendations

This scrutiny panel will initially seek endorsement of this report at the Health & Wellbeing Overview & Scrutiny Committee (HWOSC). Should this be forthcoming, the panel report will be presented for decision at one or more of the Council's policy committees. The policy committee(s) will decide which recommendations to accept and implement.

Scrutiny typically monitors the implementation of agreed panel recommendations. We therefore propose that the agreed panel recommendations relevant to this report be monitored annually by the Overview & Scrutiny Committee. In addition officers may choose to report progress in implementation periodically to policy committee(s).

RECOMMENDATION 18 – The OSC should monitor the implementation of agreed panel recommendations on an annual basis until the committee is satisfied that all recommendations have been implemented.

Appendix 1

List of Panel Recommendations

RECOMMENDATION 1 Given the significance of homeless people in terms of city health inequalities, we welcome the fact that the Health & Wellbeing Board is taking an active interest in the health and social care needs of this group. We are very interested in the progression of this work, and request that the HWB's plans for homeless healthcare be presented to the HWOSC for comment within the next 12 months.

RECOMMENDATION 2 A senior BHCC officer should be appointed as 'homelessness services integration champion' across statutory services and other sectors.

RECOMMENDATION 3 the council needs to take action to diversify its 'stock' of hostel accommodation, seeking to spread hostels more evenly across the city, and to offer a range of accommodation options in terms of hostel size and the level of support on offer.

RECOMMENDATION 4 we need a more diverse range of supported accommodation available to house single homeless people, particularly those with very complex needs. Whilst this is clearly not going to happen overnight, we would welcome a commitment to move to a model of greater diversity coupled with at least some practical action in the short term.

RECOMMENDATION 5 the council needs to produce a clear map of statutory and non-statutory homelessness services across the city and make it available via the its website.

RECOMMENDATION 6 – homeless pathways should be revised to allow clients to move directly into band 3 support when it is clear that there is no realistic possibility of them progressing successfully through band 2 support.

RECOMMENDATION 8 New and refreshed BHCC housing strategies must explicitly address the housing needs of victims of domestic violence.

RECOMMENDATION 9 Training for housing staff dealing with homeless applications must explicitly include information on domestic violence.

RECOMMENDATION 10 New and refreshed BHCC housing strategies must explicitly address the housing needs of LGBT people.

RECOMMENDATION 11 Training for housing staff dealing with homeless applications must explicitly include information on LGBT needs.

RECOMMENDATION 12 Relevant new and refreshed homelessness strategies (e.g. the Joint Commissioning Strategy for Young people) should explicitly address need with regard to:

- **services for young people with high support needs;**
- **ensuring that there is sufficient specialised housing to support young people;**
- **the need to deliver 'holistic' support to young people (i.e. helping make young people work-ready at the same time as housing them)**

RECOMMENDATION 13 the Council should consider lobbying central Government (on the issue of people who are receiving employability training being required to attend the Job Centre to sign-on), reflecting the concerns of local voluntary sector providers that the rules dictating the ability of Jobcentre + to relax its signing-on requirements are still too inflexible.

RECOMMENDATION 14 New or refreshed homelessness strategies should explicitly address the issue of working with private landlords to maximise the supply of private rented accommodation accessible to homeless people.

RECOMMENDATION 15 – the council should explore what can be done to maintain people's tenancies should they be imprisoned for a short period of time. The aim should be to minimise the number of people with a local housing connection being made homeless as a result of imprisonment.

RECOMMENDATION 16 New and refreshed homelessness strategies must explicitly recognise that social care and housing increasingly need to work in an integrated manner, and should establish structures to enable this.

RECOMMENDATION 17 New and refreshed homelessness strategies should specifically address the support/advice needs of those who have been deemed ineligible for statutory housing support, recognising that this is a significant group of people, many of whom have genuine support needs.

RECOMMENDATION 18 – The OSC should monitor the implementation of agreed panel recommendations on an annual basis until the committee is satisfied that all recommendations have been implemented.