# Healthy Living, Healthy Lives

# Mid Term Evaluation of the Homelessness to Health project

Hanover Consultancy Limited February 2018

## Acknowledgements

The evaluation team would like to thank the staff at Healthy Living, Healthy Lives CIC, in particular, Stephanie O' Leary, for the time spent providing information to help support this independent mid-term evaluation report. In addition, special thanks to the users who access the service provided by Healthy Living, Healthy Lives, who, despite their difficult individual circumstances gave their time to feedback on how they felt the project was being delivered and the impact it made in their day to day lives.

Finally, thanks to the staff at the Welcome Centre and the stakeholders who also provided valuable feedback

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## 1. Context of homelessness.

Rough sleeping has increased in Redbridge by 39% in the last year, with 60 rough sleepers counted on the snapshot single typical night in November 2016 making it the 3rd highest in London.

In Redbridge, 1,044 households applied as homeless in 2016/17.

Redbridge had the 10th highest number of households living in temporary accommodation London (13.5 per 1,000 households).

392 households were placed in bed and breakfast accommodation at the end of 2016/17.

*London Borough of Redbridge Housing Strategy 2017 –2022.*

Homelessness often results from a combination of events such as relationship breakdown, debt, adverse experiences in childhood and through ill health. Homelessness and ill health are intrinsically linked and professionals in public service sectors have a role to play in tackling the issues together.

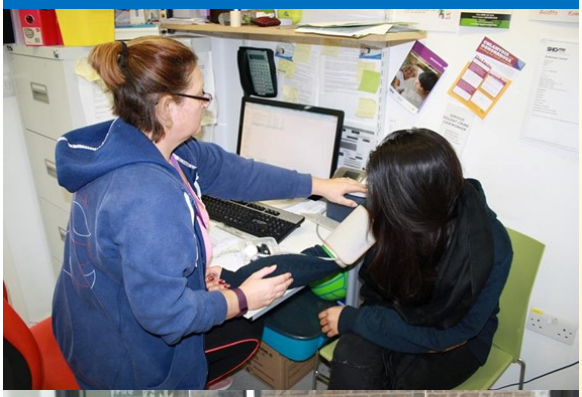
Evidence tells us that the health of people experiencing homelessness is significantly worse than that of the general population, and the cost of homelessness experienced by single people to the National Health Service, (NHS) and social care is considerable.

A recent audit by the Housing Charity, Shelter, found that 41 per cent of homeless people reported a long term physical health problem and 45 per cent had a diagnosed mental health problem, compared with 28 per cent and 25 per cent, respectively, in the general population.

Homelessness is complex and often reflects other vulnerabilities or circumstances related to health, justice or social services. Successful homelessness strategies require all public services as well as the voluntary sector to work together as a system to think about what effective strategies can be put in place to successful outcomes in reducing homelessness and rough sleeping. To understand the position better, evidence of the problem tells that:

- homelessness is often the consequence of a combination and culmination of structural and individual factors: ill health can be a contributory factor;
- homelessness, and the fear of becoming homeless, can also result in ill health or exacerbate existing health conditions;
- people who are homeless report much poorer health than the general population;
- homelessness in early life can impact on life chances and the longer a person experiences homelessness the more likely their health and wellbeing will be at risk;
- homelessness is more likely amongst populations who also experience wider inequalities e.g., care leavers and people with experience of the criminal justice system;
- co-morbidity amongst the longer-term homeless population is not unusual; the average age of death of a homeless person is 47 (lower for women – 43), compared to 77 years amongst the general population;
- you should be considered homeless if you have no home in the UK or anywhere else in the world available for you to occupy, or are in temporary accommodation. Rough sleepers are defined as people sleeping or bedding down in the open air. This includes the streets, doorways, parks, bus shelters, buildings and any place not designed for habitation.

## 2. The Project



**Homeless Healthcare** – This is a long running project which has been delivering health care services to the homeless population in the London Borough of Redbridge (LBR) since 2006.

Initially this was supported by the local council along with some short term funding to deliver different aspects of the work. However, since 2015 the offer has been substantially increased due to a five year grant from BIG Lottery Reaching Community Fund. This has allowed for the recruitment of additional resources including a counsellor, chiropodist, massage therapist, junior nurse, mental health nurse as well as two sports coaches. Further resource is available for an art therapist volunteer. The service is managed by the CEO , Stephanie O'Leary who is also the senior nurse. The project works in partnership with many other health organisations and is based at the Welcome Centre which is a day centre for people experiencing homelessness and is owned and managed by HLP Ltd.

**Project mission**

- to reduce inequality in health and healthcare for people experiencing homelessness:
- to improve the physical and mental health of the homeless community in LBR.

This will be achieved by working either directly or indirectly with a multi disciplinary team and increasing awareness of homeless health issues

**Project outcomes;**

- people who are homeless in LBR will have improved mental and emotional health;
- there will be reduced inequality and barriers to health in the homeless population in LBR;
- people who are homeless in LBR will have improved physical health

## 3. Project activities.


**Project activities:**

The project holder and the funder agreed that at the mid-point stage of the project that the following activities would be delivered.

| Year one | Activities |
|---|---|
| | Initial health check identifies health needs, addressing these including onward appropriate referral, GP registration and ongoing liaison to support needs |
| | Chiropodist will attend monthly and undertake foot health assessment and treat appropriately. Up to 20 clients will benefit monthly |
| | Aerobic exercise offered weekly; 15 - 20 clients will be involved each week |
| | Health Promotion activities will be organised and established |

| Year two | Activities |
|---|---|
| | NE London Homeless Nurse Network will be established more awareness |
| | Build on year 1; continue health checks, ongoing care, GP registration and referral |
| | Chiropody, counselling/alternative therapies and exercise group will continue |
| | Health promotion talks/displays will continue |

The vast majority of targets agreed with the Big Lottery have been achieved. Data returns provide the evidence to support delivery.

In the case where targets have not been progressed, Healthy Living, Healthy Lives CIC has negotiated with the Big Lottery alternative outcomes and revised its delivery plan.

## 4. The evaluation process


**The mid-term evaluation began October 2017 and completed in December 2017.**

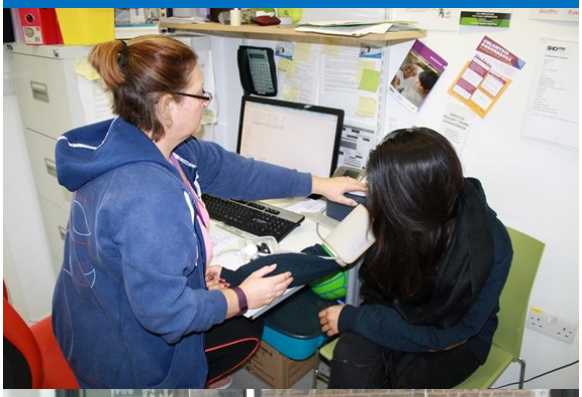
The scope of the mid term evaluation was agreed with Healthy Living, Healthy Lives CIC in October 2017. The outcome of this mid-term evaluation will be a report detailing the progress made from conceptual planning stage to the mid-term point. This will include evidencing progress against the activities agreed by the funder and project holder at the start of the project as well as making comment on the following;

- the voice of the user and what difference the project has made in their lives;
- are there any unintended outcomes because of this project;
- is the project sustainable;
- how can the project be improved
- what are the key learning points and recommendations for the remaining project term.

The process involved the following;

- face to face interviews with service users to ascertain what difference the service has made in their lives and what more could be offered to help improve users mental, emotional and physical health which if improved will in turn positively impact their economic wellbeing. The results will provide evidence to help understand what changes can be made to the project from the conceptual planning stage to the later years of the project.
- interviews were conducted with key staff from Healthy Living, Healthy Lives Community Interest Company and the multi-agency team involved in the wider delivery of the project to ascertain what impact has been in terms of improving professional practice as well as multi agency working. Conclusions and key learning points from this part of the evaluation will assist with the planning and delivery of the project for years 4 and 5 and reported at the end of the project
- interviews with key stakeholders also take place to ascertain what added value has been achieved by the project as well as help understand what improvements can be made to the local eco system for supporting the homeless. Key staff from the LBR strategic housing team, local GP surgery, King George Hospital, local drugs and alcohol teams, the dual diagnosis nurse, local night shelters, local rehabilitation services, local mental health teams, mobile TB X-ray unit/ chest clinic were contacted for feedback.

## 5. Summary of findings



- Progress has been made from the conceptual planning stage to the mid-term point with the delivery of the project well imbedded as part of an integrated offer of services for the homeless across the London Borough of Redbridge.

- Clients attend the centre on a regular basis and interventions take place such as administering short term medical relief (through nursing interventions) as well as preventative services, such as health screening, advice on diabetes, chiropody services, haircuts for homeless and other health matters including counselling support. Other screening services such as mobile x ray services attend the centre because of this project.

- Hospital appointments are made as well as urgent referrals to other parts of the local health system to ensure clients receive the best available service in the shortest time by using partnership links established because of the project.

- All clients interviewed spoke highly of the project, they understood what was available and when it could be accessed.

- All clients interviewed rated the service highly. A 99% satisfaction rate is high with several clients commenting on how the service has made a clear difference in their troubled lives. For example, six clients commented that the service, nursing intervention and health checks had “saved their lives” one stated that “without the immediate support of Stephanie, I did not expect to survive”.

- During the evaluation, one client was immediately referred and seen by the local hospital for life saving treatment. This was evidence to support the fact that the project had found ways to improve referral and shorten waiting times.

- Stakeholders interviewed recognised and applauded Healthy Living, Healthy Lives for the project as it levered in valuable specific, targeted services that would not be available through the existing statutory network of providers in the area.

- Stakeholders interviewed also commented and provided evidence that because of the project the process for referring clients was much quicker due to direct contact with specialists within the health system. This was an example of a client referred to a TB nurse at King George Hospital.

- An analysis of the data returns to the Big Lottery Fund indicate that the project is on track at the mid-point stage.

## 6. Case study A

### Haircuts

We started working with Haircuts4Homeless in July 2016 and the charity visit monthly to provide a haircut for any client wishing to access this service.

Having a haircut helps us to feel neater and provides dignity. This is something we all take for granted.

G accessed this service. She had been trying hard to get work, was making use of the shower and clothes washing service provided by the centre. Due to lack of finance she had exhausted her benefits so had no money. She was unable to afford a haircut and felt scruffy. She stated that having the opportunity to have a haircut made a real difference to the way she felt. Her demeanour changed and she gained confidence. She felt she could go for an interview and that she could look her best. She did and she was rewarded with a part time job. Since then we have seen her confidence return.

She has been able to relocate to the Midlands where her employment has continued with a well known chain, is now employed full time and has accommodation.

As an organisation we work to an holistic model of care where we consider the physical, mental, emotional, social, financial and spiritual well-being of a person and in supporting a part, we are helping the whole person (Gestalt Theory).

(photo used with permission of the client)

## 6. Case study B

Tim (pseudonym) has a history of substance misuse including crack cocaine, alcohol and marijuana. Following the breakdown of his marriage he became mentally disorientated when he could no longer see his children. He became severely depressed to the extent that he could not reasonably perform his job and was suspended for a period of time then asked to leave.

When Tim started coming to the Welcome Centre he presented as very angry and severely depressed. He was street homeless, unwashed and unkempt which he found difficult to deal with, especially as he always took such pride in his appearance. Tim had approached the Housing Advice Centre for help with his accommodation and he received support from the nurse and the centres support worker in terms of advocacy and assistance to gather evidence to satisfy his application. On the strength of his deteriorating Mental Health (MH) he was placed in temporary accommodation on the proviso that he attend a MH assessment.

The nurse supported the whole process of his mental health assessments by speaking to his GP, the Immediate Access to Psychological Therapies Team (IAPT) and regularly meeting with him to provide ongoing support during the process of him receiving an appointment. An assessment of his needs were taken by the IAPT team including his circumstances, his life story and the detail of his mental health condition which at this time included hearing voices and paranoia. The practitioner did not think that Tim was schizophrenic rather that his symptoms were as a result of the extreme levels of stress, anxiety, chaos and multiple traumas. Tim was offered Cognitive behavioural therapy (CBT) sessions. Initially it was anticipated that Tim's depression stemmed from his substance misuse and the chaos and distressing issues concerning his family. It transpired from his IAPT assessment that while his current problems are a significant contributory factor, his very emotional story revealed that he had suffered mental, physical and emotional abuse since childhood.

Tim wept as he told his story as he had never opened up before in his entire life or divulged his fears, anxiety and pain. For the first time he could hear himself speaking about the things he always felt he had to carry and could never share.

Tim explained he has been unable to hold back his tears but admitted that he felt a sense of peace. Tim has completely given up alcohol and drugs and has maintained his sobriety. Walking around in dirty clothes every day which made him feel helpless, depressed, and ashamed and out of control, not being able to satisfy his most basic human needs.

*"Being able to have regular showers and take care of himself with the help of R3, one to one sessions, the encouragement of the nurse, staff and volunteers, has really raised my self-esteem."*

*Tim is on a positive journey and says he now has 'renewed hope'.*

## 6. Case study C

**Counselling support**

PL, a 36 year old accessed the counselling service. He states:

'At the start I had no self confidence, low self esteem, low motivation; I was depressed. I had been homeless for some time. I had started work but was exploited. Over a period of time I started to see the counsellor and made sure I saw him most weeks. As I was able to talk through the things that had been going on in my life, I found that my confidence and motivation are up and self esteem is better.'

Through this he felt empowered to set up self employment as a ballroom dance teacher and gradually became 'too busy' for counselling, which was seen as a positive step

## 6. Case study D

**Counselling support.**

RC has been accessing the counselling service for many months. He has stated that this lifeline has been beneficial in helping him to deal with past insecurities and lack of self esteem and self worth.

He continues to access the service, dipping in and out and feels that this helps him to remain calm and well. He was offered temporary accommodation and has started a new relationship. After a period of time and continued counselling progress, through dealing with his issues in particular anger, and gaining confidence, he has recently been offered and has accepted a one bedroomed flat in the borough and is coping very well.

He continues to access the counselling service and improvement in his mental and emotional health is maintained.

## 6. Case study E

**Table Tennis**

MP has been an alcoholic for a number of years. He has been supported into housing, but this has not been maintained due to his excessive drinking.

Since we purchased the Table Tennis table and employed coach, it has been very noticeable that he has stopped drinking and comes to the centre sober in order to play. The table is taken out daily, even when the coach is not available, and he, with a number of other clients, engage in the sport for some considerable time.

It is quite often difficult to find a point at which the clients will engage with services and start to take responsibility for lifestyle and work toward change. At times, it takes a number of initiatives before the client will engage.

Whilst we started the Table Tennis coaching to support improved physical health, it has had other positive outcomes.

This gentleman has not yet been rehoused – there are a number of issues which will need to be sorted out – but he is on the road to recovery and input from the health team has been the catalyst.

## 5. Case study F

Name: RA

Medical history : Type 2 diabetic.

Gender : Male

Activity: RA was at first reluctant to take part in the table tennis program. He was very insular, and he would often just sit at the table looking at the papers and talking to himself. After 2 weeks of watching others play R came to the table and asked to play. I could see that he had never played table tennis before and his ball/eye co-ordination was very limited. Over the last few months R has been very keen on participating in every session where possible and he is the first to want to play when I have set the table in position.

Outcome: I believe that R has become more engaged in activities and has grown more sociable due to participating in the table tennis program. His movement is now much improved and he is far less sedentary due to this activity. I will now be looking at ways of how he can take more ownership of his health and wellbeing through showing how this will improve his table tennis performance.

## 7. Areas for development.

Respondents interviewed as part of the evaluation noted the following:

- Resources. Whilst funding is always cited, feedback from stakeholders as well as clients noted that there was an opportunity for more resource aimed at tackling mental health issues experienced by users. Feedback suggested that statutory services often miss the homeless and rough sleeping cohort when deploying services. The unique integrated offer delivered by Healthy Living, Healthy Lives could be developed further in area in this respect.

- The project is delivered at the Welcome Centre in Ilford, Essex. The centre is funded via different partners and reports on its activity. The offer delivered through the Healthy Living, Healthy Lives project is not separated and therefore it is difficult for broader stakeholders in the network to recognise the unique and distinct delivery/contribution by Healthy Living, Healthy Lives as opposed to that of the Welcome Centre. It is recommended that a Service Level Agreement is put in place that identifies the different strands of delivery.

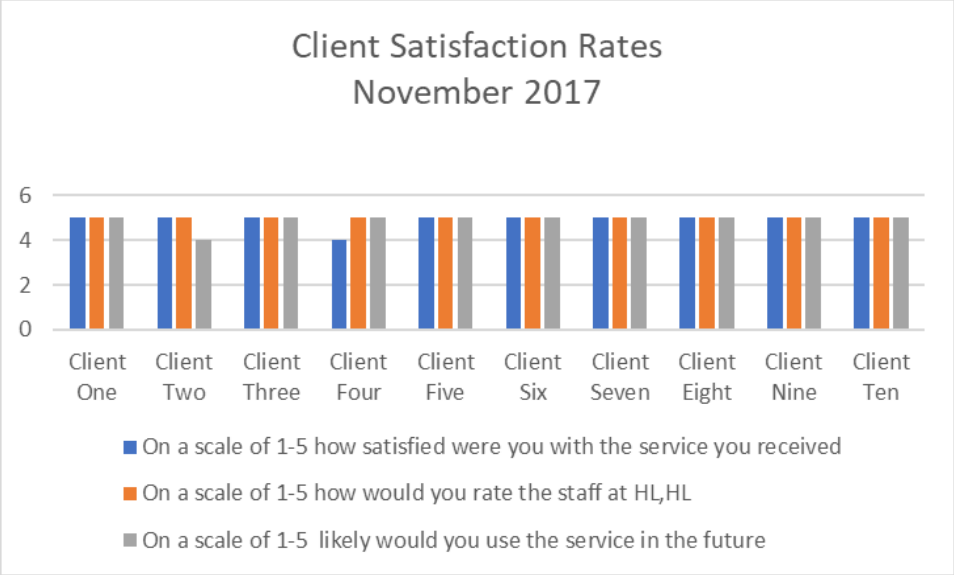
- Further work on marketing Healthy Living, Healthy Lives as an entity is required so that there is more awareness of the organisation, who it serves and what it does. A newsletter is planned as well as a regular update to partners.

- Stakeholders as well as clients were clear that if there was more physical space available for the project to expand its existing activities, further outcomes such as increased health awareness activity could be delivered. This could be achieved through mobile office accommodation at the Welcome Centre. A discussion should be initiated with the management of the Welcome Centre to establish what scope is available.

## 8. Client satisfaction & access

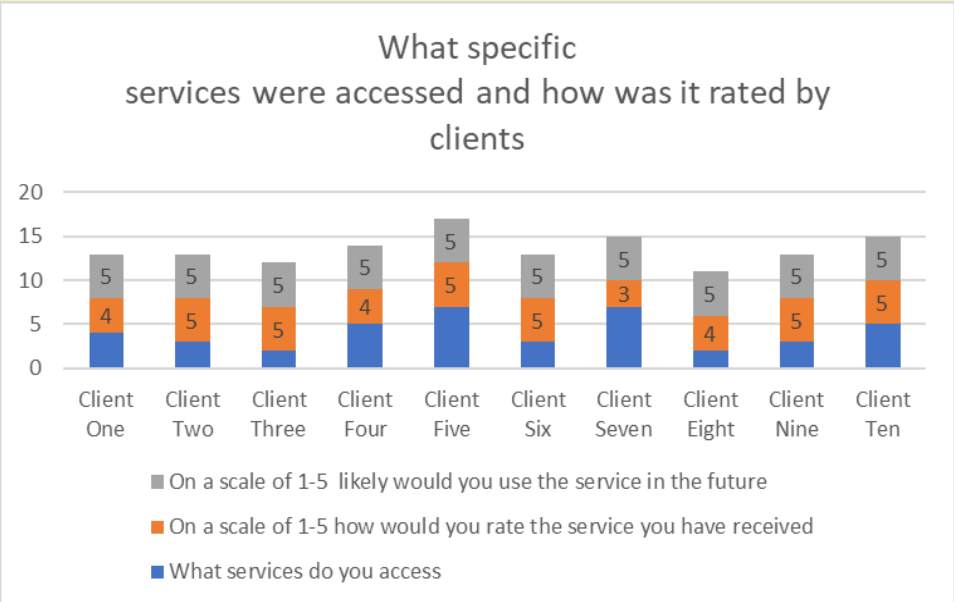
### Client satisfaction rates

Clients interviewed on the day were overall, highly satisfied with the services that they accessed and felt that their needs were satisfied.




The project delivered by Healthy Living, Healthy Lives provides a range of services for clients. These are co-ordinated effectively by Stephanie O' Leary and are delivered by a range of experienced and qualified personnel.

Access is clear and available to all clients. Take up is varied with the most popular services being, health check-ups, chiropody, fitness activity and haircuts.



## 9. Stakeholder feedback

Stakeholders interviewed were impressed by the range of services that are available via Healthy Living, Healthy Lives. The Welcome Centre benefits greatly from the project and receives good publicity. The Director and Centre Manager spoke highly of the way in which Stephanie O'Leary co-ordinates the service offer and ensures that they are available quickly if needed. They recognised the fact that there is added value gained from having the project delivered at the centre.

Two Support Workers employed through the Welcome Centre were also interviewed. Both were able to evidence examples of improved multi agency working with local health agencies such as local surgeries and the NHS hospital, King Georges. They also noted the on going monitoring of clients by Healthy Living, Healthy Lives to ensure that they were observing dietary advice as well as intake of medication where appropriate.

The TB Nurse at the local NHS hospital, King Georges, evidenced improved referral times because of the project and the communication with Healthy Living, Healthy Lives. It was clear that if the project was not available, the clients would not receive nursing and medical services as they would not engage with the routine NHS system for appointments.

Providers delivering Haircuts and Chiropody services were also interviewed and were clear about the purpose of the project, the outcomes sought and were clear about their own role as part of a small system helping vulnerable clients and the difference it was making to them in terms of higher self-esteem and confidence.

Stakeholders recognised that more could be achieved if the Welcome Centre were able to provide more accommodation for the project to expand its existing service offer.

## 10. Conclusions

- At the mid-point stage, the project is making good progress in relation to improving health outcomes for the homeless as evidenced in this mid-term evaluation.
- The project is on track in relation to its plan with the Big Lottery
- The project is making a real difference to the health and well being of homeless clients across the Borough through the range of services it delivers. There is clear evidence of client involvement in the project, this covers both user experience and feedback to target support where needed. As detailed in the summary of findings, clients were able to articulate the difference the project is making in their lives.
- There is clear evidence of quick and prompt referrals from the project to other parts of the NHS system that allows vulnerable homeless clients to obtain the treatment they require.
- There is an opportunity for increasing activity if the Welcome Centre can look at better space utilisation.
- The mid-term evaluation did not uncover any unintended outcomes. However, what was heard time and again through staff and stakeholder interviews was the intense and rapid response to client needs and a shortening of waiting times given that the cohort would not access services through existing routes.
- The project is sustainable as it is currently delivered. However, given the popularity any expansion of existing services would need to be costed and funded. This would include accommodation.

The areas for improvement detailed in this report will need to be tracked through the remaining term of the project. The final project evaluation will assess the extent to which development has been made as well as addressing key learning points