Bristol City Council

Reducing Rough Sleeping

Needs Analysis

December 2020

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Section A – Introduction

The current Rough Sleeper Service was commissioned during 2013/14 and began on the 1st October 2014. At that time the number of people who were sleeping on the streets in Bristol – although increasing – was far less than the level of people who currently end up on the streets today. St Mungo's were successful in being awarded the tender. The original service based at the Compass Centre (Jamaica St) and 1 New St, St Jude's consisted of the following elements:

- Outreach and engagement with rough sleepers;
- Lease and management of the ground floor of the Jamaica Street hostel;
- Education, training and employment activities (ETE), including volunteering;
- Direct access and additional support to clients in 16 Extra Support Beds (OABs);
- Coordination of the Severe Weather Emergency Protocol (SWEP);
- Lease and management of 1 New Street premises in St Jude's;
- Delivering a No Second Night Out service;
- Delivering a pre-employment support programme.

As the number of people rough sleeping in the city has increased and new funding streams from the Ministry for Housing Communities and Local Government have been introduced the service has reduced ETE resources and shifted to provide more street outreach and engagement.

Since the COVID-19 pandemic Bristol's services for rough sleepers, the clients accessing those services and the needs of those clients have shifted. COVID-19 represents a particular threat for people with underlying health conditions which includes a significant proportion of people who are street homeless. COVID-19 is also a significant driver of new rough sleeping due to the impact on local businesses and jobs; higher rates of relationship breakdown and domestic violence and in addition, the impact that lockdown restrictions has had in impacting on the ability of individuals to sofa surf and other short-term accommodation options.

The pandemic has also had a significant impact on how services are delivered, with social distancing rules meaning that shelters and dormitory accommodation are no longer a safe way to temporarily accommodate people whilst longer term options are found. The Everyone In programme, formally launched on 26th of March 2020, called for the provision of emergency accommodation for people sleeping rough during the pandemic. In Bristol, over 1,000 people were accommodated in hotels, youth hotels and temporary emergency accommodation between March and November 2020 and significant efforts have been made to prevent these clients from returning to the streets wherever possible by helping them to maintain the emergency accommodation and identifying suitable move on accommodation. The crisis has been an opportunity to engage with those longer-term rough sleepers who had previously resisted engaging.

Together with insights from service providers, the evidence presented in Section C suggests that the first two quarters of 2020-21 have seen a large, new cohort of people who are rough sleeping for reasons connected to the COVID-19 pandemic and who may have less complex and overlapping needs. This group are new to the streets, have moved from sofa-surfing or living in unsafe conditions and many have had recent experience of employment and maintaining accommodation. During the pandemic we have also housed people who are more likely to have no recourse to public funds (NRPF) due to their asylum status or being EEA nationals who are deemed not to be exercising their treaty rights as a result of the abrogation of legislation relating to public funding. A flow of these groups of people on to the streets is expected to continue whilst the impact or COVID-19 continues and as the economic impact of the crisis is felt further.

At the time of writing, the continuation of the pandemic, a third national lockdown, the introduction of the tiered system of restrictions and anticipated need for accommodation during winter pressures provide the context for short term commissioning while the needs of rough sleepers during an ongoing pandemic will need to be considered for longer-term commissioning.

Section B – Service user profile

a. Context Bristol population

The majority of the information contained in this section is from the Bristol Joint Strategic Needs Analysis.[1]

Life expectancy

Summary Points

- In Bristol people are living longer: men living 1.4 years longer and women 0.8 years.
- Life expectancy for both men and women is below the England average.
- There is significant variation in life expectancy across the city.

Life Expectancy Overview

Despite life expectancy levels increasing for both men and women in the city for the last 10 years, rates are still behind the England average. Life expectancy for men in Bristol (78.4 years) is just below the England average of 79.6 years. For women life expectancy in Bristol (82.6 years) is also slightly lower than and broadly similar to the England average (83.2 years) [2]. There is significant variance for life expectancy rates in different areas of the city reflecting lower life expectancy in the most deprived areas of the city. Bristol's worst male life expectancy is in Inner City (77.3 years). Male life expectancy in Inner City is unexpectedly low compared to female life expectancy in that area. Further investigation is needed to identify the reason for the low male life expectancy in Inner City.

There are large differences in life expectancy between the wards of Bristol. For women the highest life expectancy is in Clifton (92.3 years) and for men - in Hotwells & Harbourside (84.8 years). However, the female life expectancy for Hotwells & Harbourside has a great deal of uncertainty and is not significantly different to any other wards in Bristol. Lawrence Hill (73.9 years) has the lowest life expectancy in Bristol for men and St George Central (77.6 years) is lowest for women.

Deaths of homeless people

There has been an increase of deaths of homeless people as the level of people sleeping rough has increased. This was noted in the governments Rough Sleeping Strategy[3]. As a result, the government has published information on the deaths of people who are homeless showing a nationwide increase between 2013-18[4].

[1] https://www.bristol.gov.uk/policies-plans-strategies/joint-strategic-needs-assessment
[2] Life expectancy trends. Source: JSNA Data Profiles, August 2020
[3] https://www.gov.uk/government/publications/the-rough-sleeping-strategy
[4] Office for National Statistics (Gov.uk)

Deaths due to COVID-19

There have been a total of 261 COVID-19 deaths (12% of all deaths in that period) in Bristol since the beginning of March 2020. Up to 01/11/2020, the number of deaths represents 3% of all 7,555 confirmed cases of COVID-19 in Bristol. This is 1.3% lower than the rate nationally in England and 1% lower than the UK rate. In Bristol there have been no COVID deaths within the rough sleeping population and cases have been limited to 11 at the time of writing by the coordination of socially distanced accommodation and the implementation of outbreak prevention measures.

Population

Summary Points

- The population of Bristol has grown considerably over the last decade (2009-19) by 10.6% compared to the growth rate of 7.6% nationally.
- The population grew up to mid-2018 but in the 12 months to mid-2019 the population remained unchanged – this is in-line with the UK population which grew at its slowest rate for 15 years.

The population of Bristol local authority is estimated to be 463,400 people[5], the 8th largest city in England and Wales. Bristol has a relatively young age profile; the median age of people living in Bristol in 2019 was 32.4 years old, compared to the England and Wales median of 40.2 years.

The number of residents living in each ward differs substantially across the city. The largest ward in Bristol is Avonmouth & Lawrence Weston with an estimated population of 21,400 people and the smallest is St George Troopers Hill with 5,800 usual residents.

Although internal population moves to and from other parts of the UK result in a small loss to the overall number of people living in Bristol, these population flows are large. In the 12 months to mid-2019 36,400 people moved into Bristol from other areas of the UK, whilst 37,100 moved out of Bristol to other areas of the UK. In contrast, 7,100[6] people moved into Bristol from outside the UK and 8,600 people moved out of Bristol to go abroad.

Deprivation

There were 17,200[7] children (21%) and 13,600 older people (17%) in Bristol living in income deprived households. A slightly lower proportion of Bristol's population lived in the most deprived areas in England in 2019 than in 2015 – 15% of residents compared to 16% in 2015 – this is 70,400 people including 18,900 children and 7,900 older people.

Income Deprivation

63,600[8] people in Bristol (14% of the total population) suffer from income deprivation, down from 17% in 2015. However, the proportion of people who are income deprived varies greatly across the city from as high as 44% of people living in 'Whitchurch Lane' in Hartcliffe and Withywood ward to 1% of people living in 'University Halls' in Stoke Bishop. There are 34 Lower Super Output Areas (LSOAs) in Bristol in the most

[6] ONS Mid-Year Population Estimates;
[7] ONS Mid-Year Population Estimates;
[8] ONS Mid-Year Population Estimates;

income deprived 10% nationally; of these 17 are in Bristol South, 11 are in Inner City, 4 in Bristol North and West (Outer) and 2 in Bristol East. In all these areas more than a quarter of residents are income deprived.

Health

According to the 2011 Census, there are 71,700 people in Bristol with a "limiting long-term illness or disability". As a proportion this is 16.7% which is lower than the 17.9% national average. This contrasts with a 2010 Health Needs Audit of 152 people in homelessness services or supported housing, whereby 59% said they experienced a long term physical health need or problem. Some of these health conditions increase the risk of both infection and ill health as a result of COVID-19The health needs of Bristol's rough sleeping population are discussed in Sections C and E.

Wider determinants (not covered above)

Housing

House prices in Bristol are rising faster than nationally and faster than average incomes. There is a serious shortage of affordable housing in the city and rising homelessness. There has been a significant increase in the private rented sector, with rents also rising. According to a 2017[9] study:

- 53% of Bristol housing is owner occupied,
- 29% privately rented, and
- 18% social rented.

The private rented sector increased significantly from 12% in 2001 to 29%, overtaking the social rented sector.

Housing Need

Bristol's Housing Delivery Plan 2017 - 2020 notes that the emerging West of England (WoE) Joint Spatial Plan will provide the framework for 105,000 net additional homes, and identifies a need for 32,200 affordable homes between 2016 and 2036 (across WoE). The emerging target for Bristol is around 33,000 homes and the need for affordable homes in Bristol is projected to be an additional 18,800 between 2016 and 2036.

House prices and affordability

House prices in Bristol are rising. The average house price in Bristol in September 2019 was £290,100, almost £40,000 higher than the England average of £250,700. Over the last decade, average house prices in Bristol increased by almost 80% (+£127,800), compared to a 46% (+£79,500) increase in England.

In 2002 this ratio was 5.45 in Bristol rising to 9.01 in 2016 (i.e. the cost of the cheapest homes in Bristol

were over 9 times the annual earnings of lower income households). This is higher than the England ratio of 7.16 and the highest of the English Core Cities. As the affordability ratio rises, more people who may have bought houses in the past are now seeking to rent in the private sector.

[9] BRE Integrated Dwelling Level Housing Stock Modelling and Database for Bristol City Council

The Private Sector and affordability

As noted above, the Bristol private rental sector (PRS) is growing in size, and also in unaffordability. Between 2015/16 and 2018/19 the average rent for a 1 bed property in Bristol rent had risen to £798 a month from £717 (an 18% increase).

Table 1: Comparison between Bristol and England Average (Mean) Private Sector Rents 2015/16 to 2018/19

Property Type	Bristol 2015/16	England 2015/16	Bristol 2018/19	England 2018/19	Bristol % rental increase	England % rental increase
Room	£394	£382	£459	£411	14.2%	7.1%
Studio	£567	£641	£636	£668	10.9%	4.1%
1 bedroom	£717	£694	£798	£731	10.2%	5.1%

Source: Valuation Office Agency: private rental market statistics

The PRS is becoming particularly unaffordable to those on benefits or on low incomes, exacerbated by the impact of the Government's Welfare Benefit reforms and the introduction of the Local Housing Allowance (LHA) rates in 2008, and the subsequent capping and then 4-year freeze of these rates until 2020.

Despite LHA rates rising by 3% for one and three bedroom properties in April 2018, there remains a growing disparity between housing benefit rates and actual market rents across the city.

Table 2: Bristol Local Housing Allowance (LHA) and Average Bristol Private Sector Rent

Property Type	LHA Monthly Rates (2019/20) Pre-Covid-19	Revised LHA Monthly Rates (2020-21) due to Covid-19	Average Monthly Private Sector Rent 2019/20
Shared room (single under 35 rate)	£310.55	£391.51	£400
1 Bedroom	£575.44	£695.02	£625

Private renting will is now the default option for younger households and the shortage of housing supply means that high or even higher prices to rent or buy are likely to continue. A report from Zoopla[10]published in October 2019 lists Bristol rental prices rising 4.5% in the last year, compared to 2% for the UK average and is the fifth highest city with regards to average earnings spent on private sector rents.

Affordable Housing Need

The four local authorities of the West of England - Bath and North East Somerset Council, Bristol City Council, North Somerset Council and South Gloucestershire Council - have collectively prepared the Joint

[10] https://advantage.zpg.co.uk/wp-content/uploads/2019/10/Rental-Market-Report-—-Q3-2019.pdf

Spatial Plan (JSP). The JSP is a statutory Development Plan Document that will provide the strategic overarching development framework for the West of England to 2036. The JSP plans to meet the needs arising from both the Bristol and the Bath housing market areas to 2036.

The Strategic Housing Market Assessments for the Wider Bristol and Bath Housing Market Areas (2015 and updates in 2016 and 2018) carried out by Opinion Research Services (ORS) demonstrate that there is a need for 30,065 Affordable Homes in the West of England in the period 2016-2036. The table below illustrates how this figure is broken down in each of the four West of England local authority areas:

Table 6: Breakdown of Affordable Housing Need by West of England Unitary Authority

Local Authority	**Affordable Housing Need**
Bath and North East Somerset	3,212
Bristol	16,228
North Somerset	4,639
South Gloucestershire	5,987
Total	**30,065**

Social housing lets have reduced in the city to 1,800 per year, down from 3,000 per year 10 years ago. This has had a two-fold impact in:

- reducing accessibility to social housing whilst demand is rising;
- Reduced availability of move-on accommodation from supported housing for single adults and young people.

b. Client Profiles – current service

The Rough Sleeper Service has been running since October 2014. The data in the graphs below relates to the last three calendar years (2017-18, 2018-19 and 2019-20). We have also included information relation to (2019-20) separately to illustrate the most up to date information we have for a complete year. The charts for 2020-21 show the data for the year to date, covering the majority of the period since the national lockdown was called on 16th March and since the Everyone In programme was launched on the 26th of March 2020.

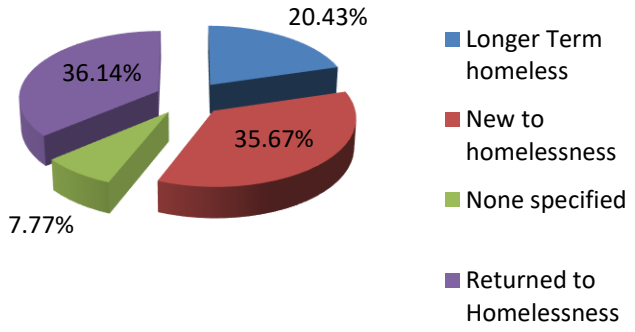
Between 2017-20, 1,941 individuals are recorded as having slept rough in Bristol. This is a 0.2% reduction to the 1,975 reported for 2016-19 suggesting rates of total rough sleeping are consistent. The 857 individuals recorded in the first two quarters of 2020-21 during the COVID-19 pandemic is a significant rise. Although these two quarters are the ones with warmer weather when higher numbers may sleep rough, this figure equates to 98% of the total of 2019-20.

Homelessness category

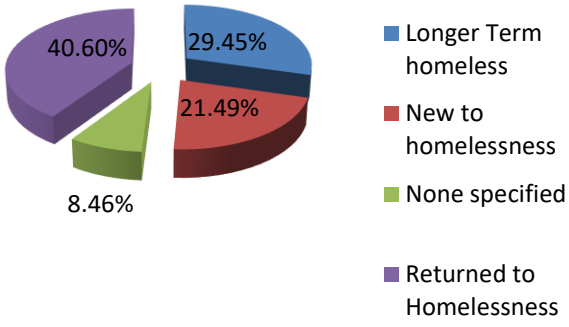
The graphs below illustrate the profile of people in contact with the service and have been divided into the following categories and definitions:

i. Those new to the streets (i.e. new rough sleepers seen within the last 12 months);
ii. Those who have slept rough before but returned to the streets (i.e. after a gap of at least 12 months);
iii. Longer term rough sleepers, often with complex needs (who have been rough sleeping in consecutive years).

Homelessness Categories 2017-2020: 1941 individuals

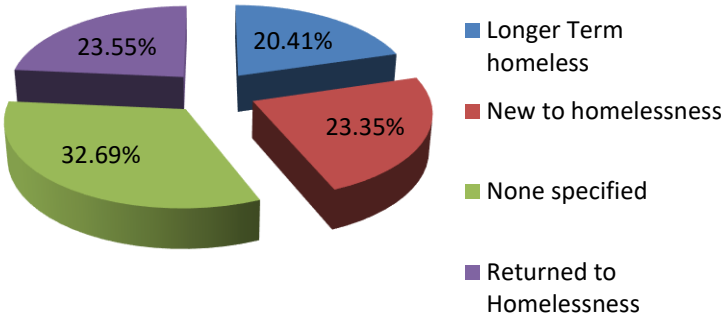


Homelessness Categories 2019-2020: 873 individuals



The reduced proportion of people who were new to homelessness is likely attributable to the additional No First Night Out/No Second Night Out service funded by MHCLG. In 2018-19, the service worked with 128 people who had slept rough but were new to the streets (some of whom would have worked with the Rough Sleeper Service and 146 people who were No First Night Out who were on the verge of rough sleeping). In 2019-20 the service evolved into the Somewhere Safe to Stay service (SStS), this service worked with 596 people who were referred as being new to the streets or on the cusp of rough sleeping.

Homelessness categories Q1,Q2 2020-2021: 857 individuals

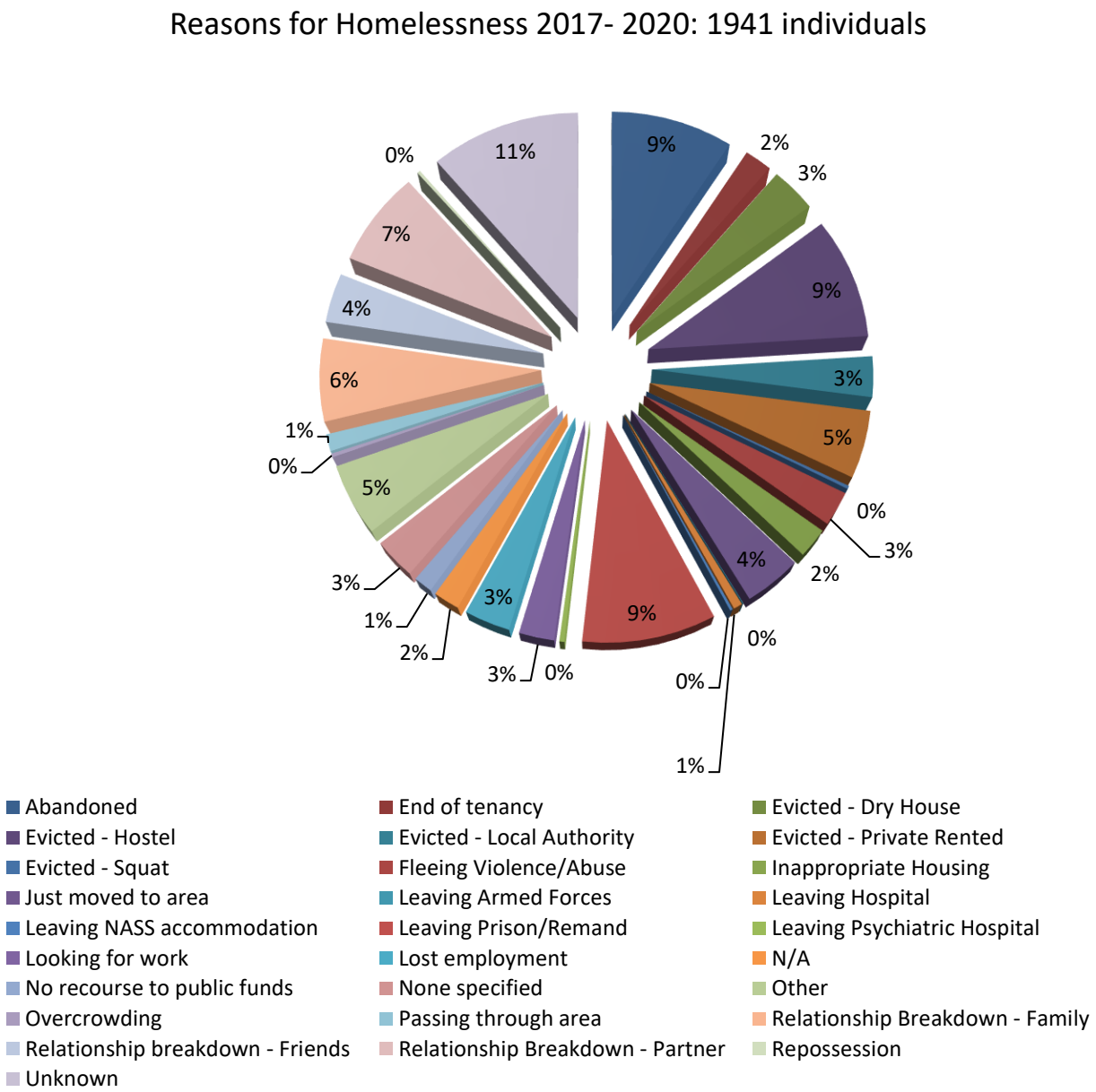


In the first two quarters of 2020-21, more than three times the proportion of individuals were recorded as 'none specified' for their homeless category, whilst there was a drop in those returning to homelessness (-17%) and longer term homeless (-9%). This probably reflects the change in the profile of those coming

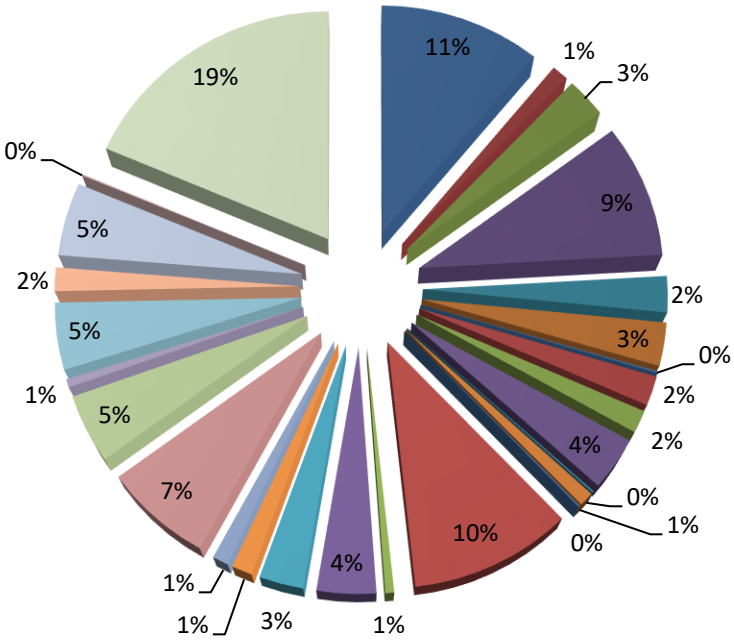
onto the streets during Everyone in and the nature of housing people and getting them off the streets as quickly as possible.

Reason for homelessness

The reasons for homelessness for the 1,941 people recorded from the current service are set out in the graph below. The top 3 reasons for the three years 2017-20 were Eviction (from Dry house, hostel, local authority, private rented or squat), abandoned accommodation and leaving prison/remand. This is also reflected in the figures for 2019-20.

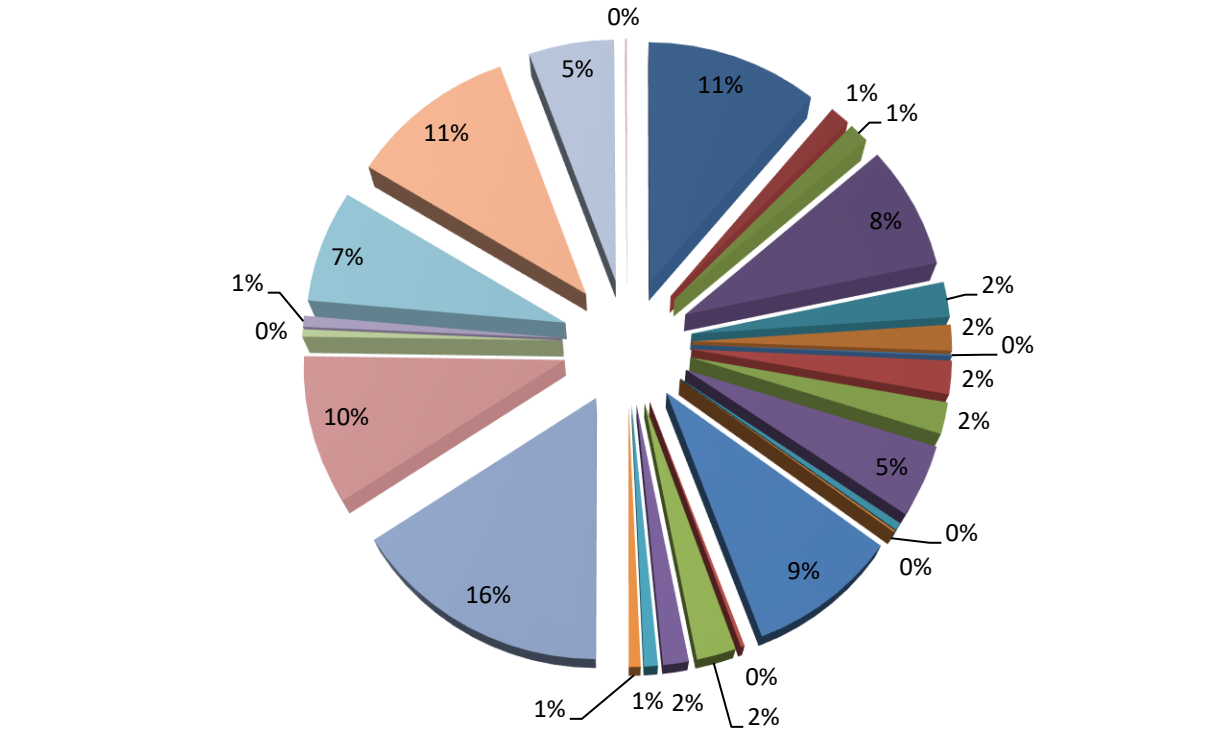


Reasons for Homelessness 2019-2020: 873 individuals



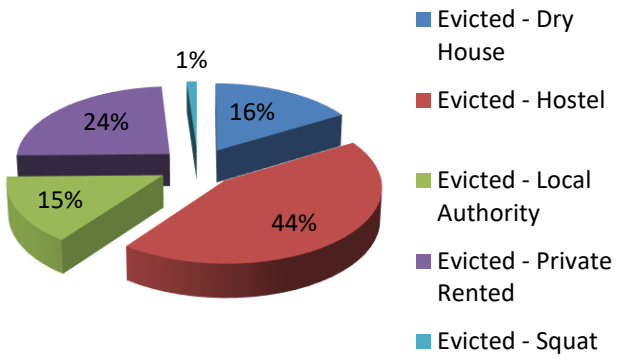
- Abandoned
- End of tenancy
- Evicted - Dry House
- Evicted - Hostel
- Evicted - Local Authority
- Evicted - Private Rented
- Evicted - Squat
- Fleeing Violence/Abuse
- Inappropriate Housing
- Just moved to area
- Leaving Armed Forces
- Leaving Hospital
- Leaving NASS accommodation
- Leaving Prison/Remand
- Leaving Psychiatric Hospital
- Looking for work
- Lost employment
- N/A
- No recourse to public funds
- None specified
- Other
- Passing through area
- Relationship Breakdown - Family
- Relationship breakdown - Friends
- Relationship Breakdown - Partner
- Repossession
- Unknown

Reasons for homelessness Q1,Q2 2020-2021: 857 individuals

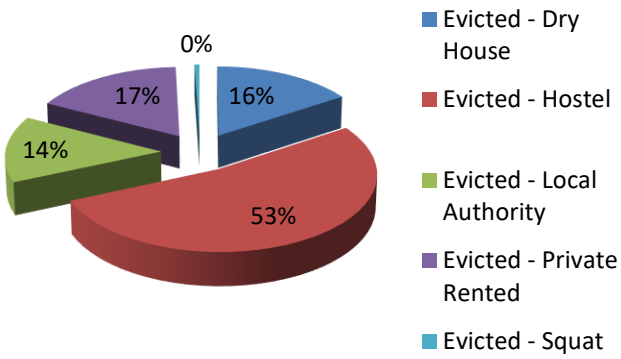


In recent years the top 3 reasons given by clients as the reason for rough sleeping have been Eviction, then relationship breakdown followed by leaving prison/remand. This shifted in the first two quarters of 2020-21, with relationship breakdown, overtaking Eviction and followed by Prison. 'Relationship breakdown, friends' was the highest category for within the relationship category subset, increasing from the average for the previous three years. Following reports of increased domestic violence during lockdown, the number reporting this reason is high for a six month period (18), but the proportion is roughly consistent with past years.

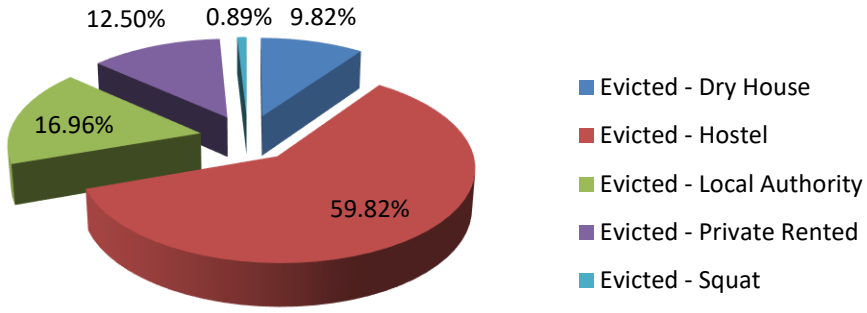
The graphs below this give a breakdown of where people have been evicted from and the type of relationship breakdown.



Breakdown of 530 evictions 2017-2020



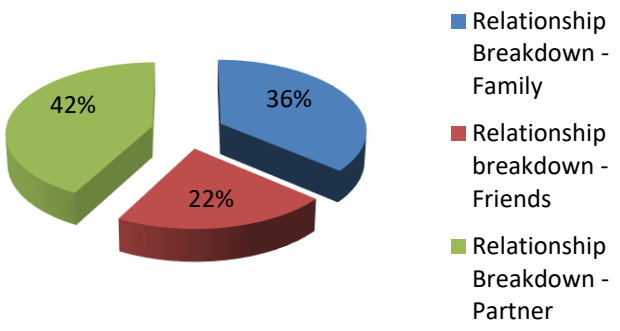
Breakdown of 184 evictions 2019-2020



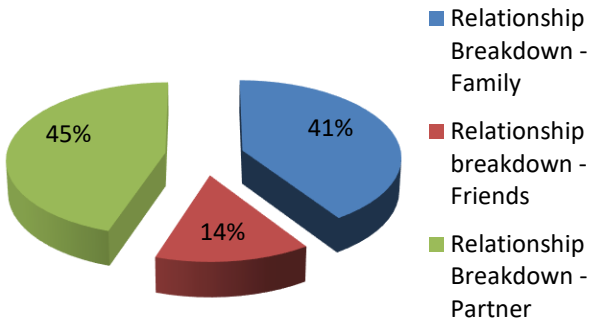
Breakdown of 112 evictions 2020-2021 (Q1,Q2)

The number of evictions in 2020-21 so far (112) is also high for a six month period, representing 605 of the total for the previous year. This is notable considering the ban on evictions from 23rd of March 2020 and the extension of notice periods from 29th August 2020.[11] The proportion evicted from hostels shows a marked increase, with 67 (59.8%) in the first two quarters, equivalent to 69% of the total for 2019-20. However, when compared with information for the four homelessness pathways, there were 50% fewer evictions from all pathways accomodation, including hostels in these two quarters (35) than in the equivalent period for the previous year (70). This suggests that the 67 people listed above who gave their homelessness reason as 'evicted – hostel' during quarters one and two of 2020-21 is not based on an increase in evictions. Possible explanations for the increase in this reason for homelessness include: a rise in eviction from non-commissioned hostel; people abandoning hostel accomodation and reporting it as an eviction; people being evicted from hostels outside Bristol and moving to Bristol to sleep rough; or people being evicted from settings that aren't hostels (e.g. emergency accommodation) and giving the wrong response to this question when asked.

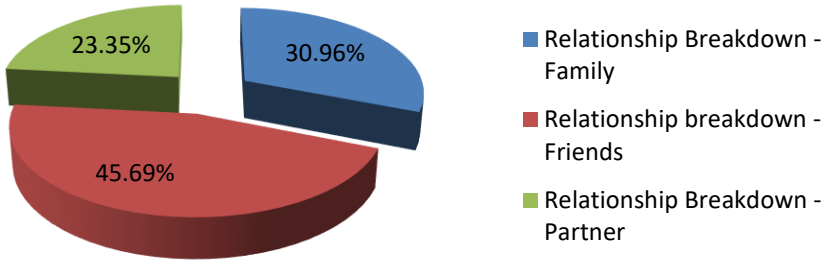
[11] https://england.shelter.org.uk/housing_advice/coronavirus



434 relationship breakdown 2017-2020



118 relationship breakdown 2019-20



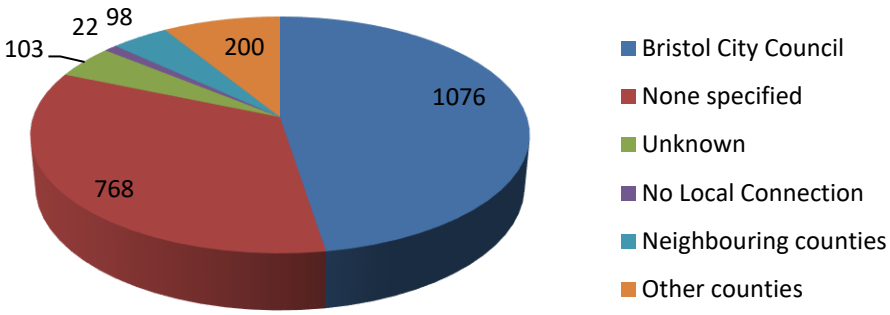
197 relationship breakdown 2020-2021 (Q1,Q2)

The number of people giving relationship breakdown as a reason for rough sleeping rose 67% during the first two quarters of 2020-21 (197 people) as compared with all four quarters of 2019-20 (118 people). These relationship breakdowns were far more likely to be from a relationship with friends (46%), rather than with a partner (23%), as compared with either the previous year or the three year trend from 2017-2020. We suspect that the increase in this area is due to people being asked to leave by friends as a result of the impact of the Pandemic, lockdown and the need to self-isolate.

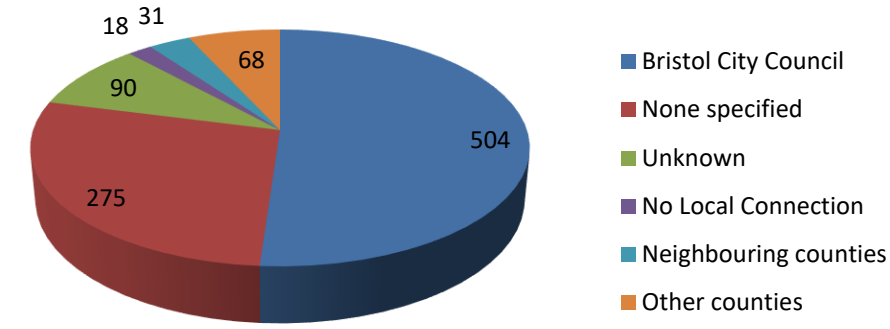
Local connection

The charts below show the local connections of the clients accessing the Rough Sleeper Service for 2017-20, 2019-20 and for the first two quarters of 2020-21. Percentages are not shown because multiple entries for one client are possible where their local connection is unknown or not specified and this later changes. Clients with unknown or not specified local connection fell from 45% in 2017-19, to 42% in 2019-20 and 36% in 2020-21. There were no clients with a local connection to any London Borough in 2020-21 or 2020-21 but 11 (1%) for 2017-20.

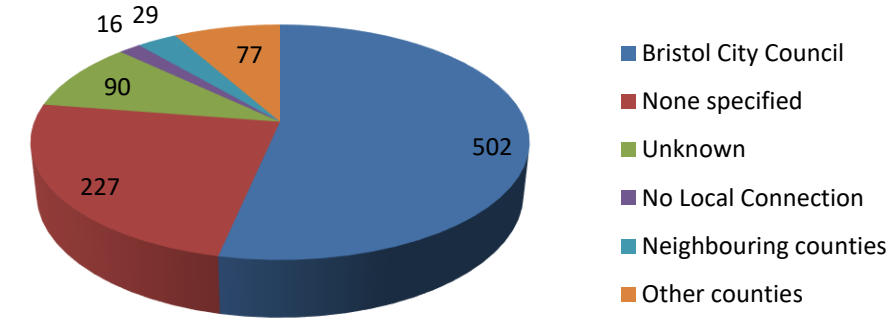
Clients by local connection 2017-20



Clients by local connection 2019-20

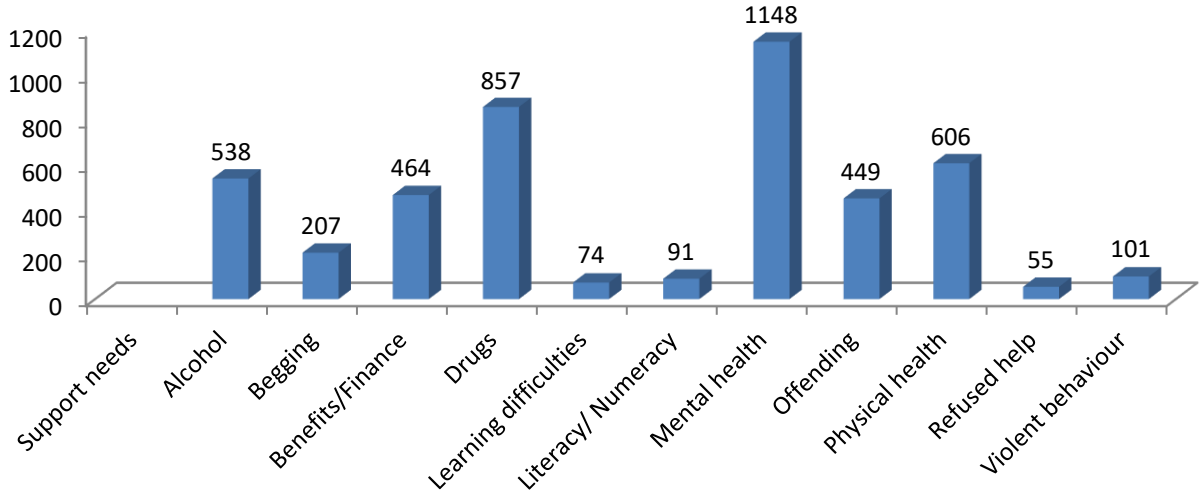


Clients by local connection Q1, Q2 2020-21

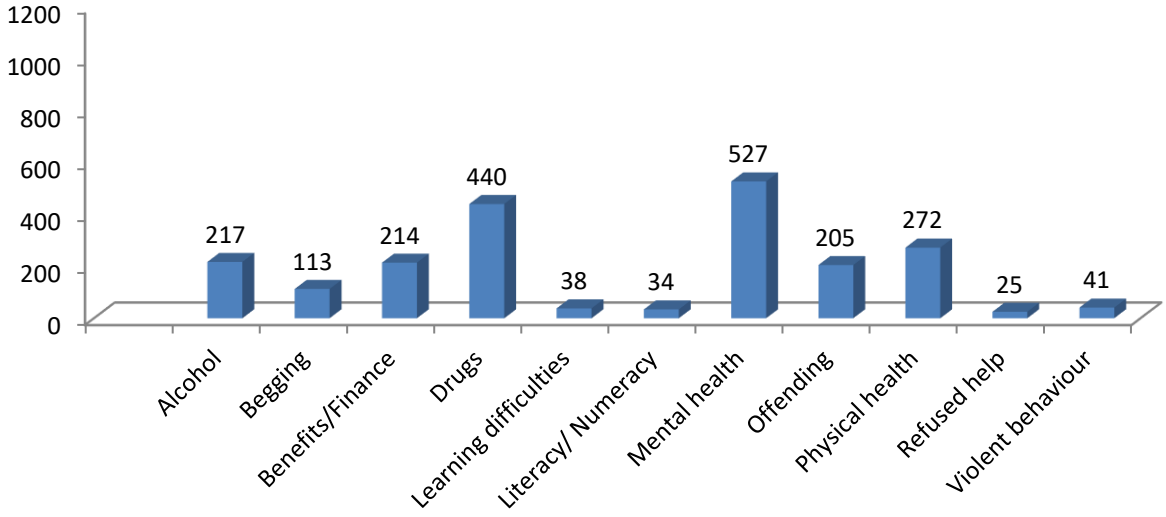


Support needs

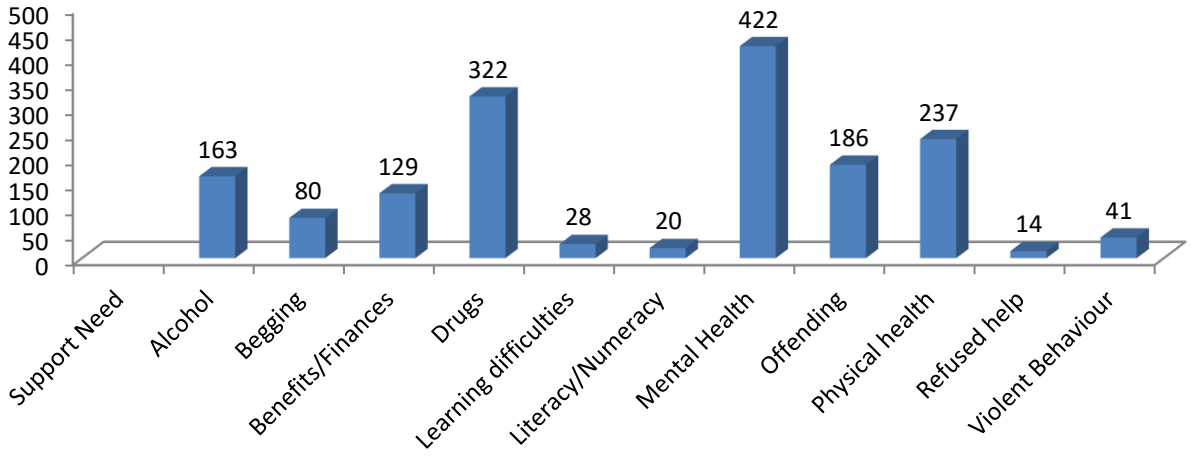
Client support needs are collated in the graph below. Clearly some people had more than one or multiple support needs. The results for 2019-20 broadly follows the three year trend with mental health, drugs, alcohol, physical health and benefits/finance as the top five areas that people identified as needing support around. On this list, benefits finance overtook offending from the three year trend 2016-2019 as reported in the previous version of this needs analysis from November 2019. It must be acknowledged that some of the categories are under-reported or not recorded as the principal support needs are recorded. This would explain the higher levels recorded for alcohol, drugs, mental health, physical health and offending, whereas other areas such as learning difficulties and literacy/numeracy have very low numbers recorded against them.



Support needs 2017-2020 1941 clients



Support needs 2019-2020 873 clients

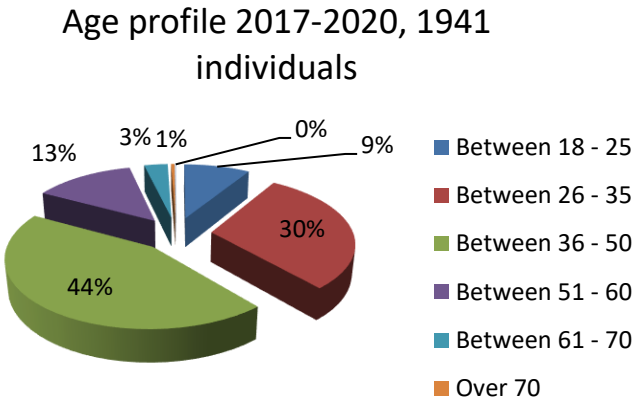


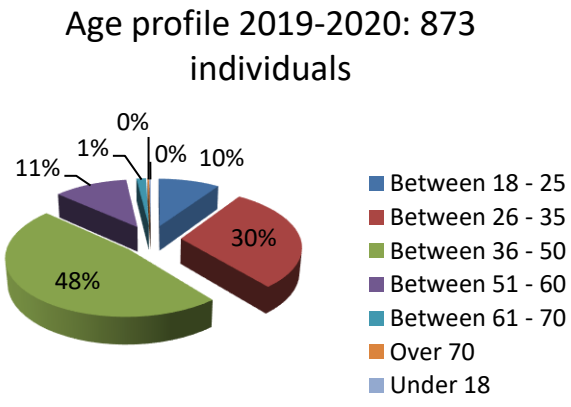
Support needs 2020-2021 (Q1,Q2) 857 clients

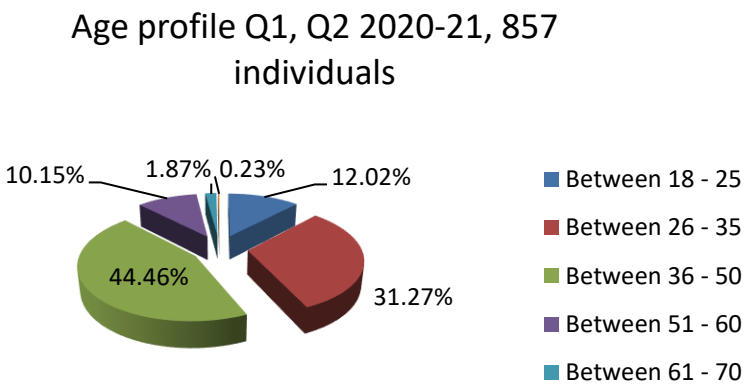
The clients' needs identified during the first two quarters of 2020-21 had a similar top five most common needs with offending overtaking benefits/finances. However, people reported lower levels of needs around alcohol (-6%), drugs (-12%) and mental health (11%) as compared with the previous year. This is likely to be a reflection of the new cohort of people who are rough sleeping for reasons connected to the COVID-19 pandemic.

Age of clients

For all three time periods, the majority of people (over 70%) who were sleeping on the streets and had contact with the Rough Sleeper Service were between the ages of 26-50. There have been very few people who are under 18 who have accessed the service. Anyone under 18 would be immediately referred into social services and accommodation via the Emergency Duty Team service. The proportions of individuals in these age categories was roughly equivalent during the three time periods, however, the proportion aged 18-25 rose by a fifth (2 percentage points) during quarters one and two of 2020-21.

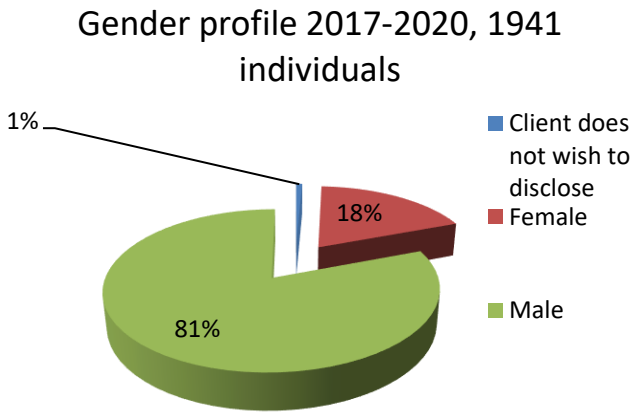


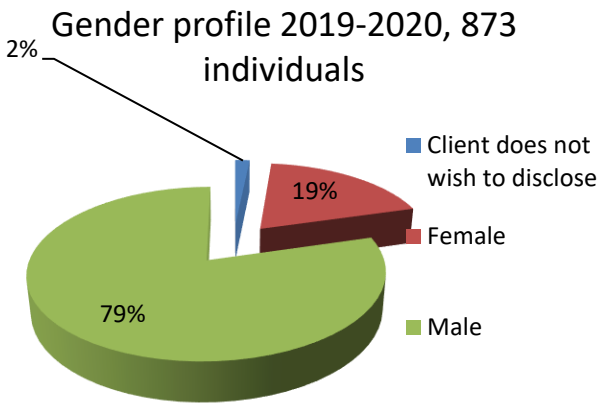


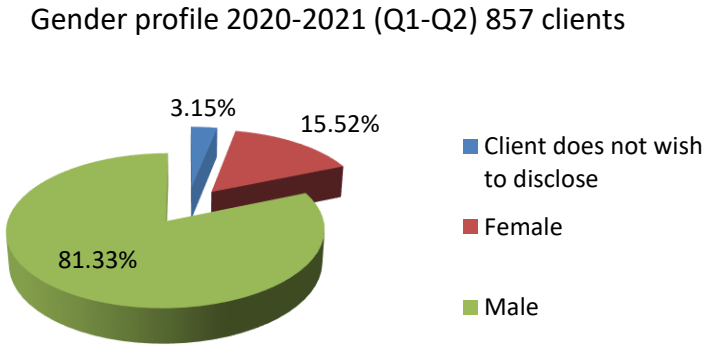


Gender

In the last full year (2019-20) – compared to the average for the last three years (2017-20) - there has been a slight shift in the gender of people accessing the service with the number of female clients increasing to 19% of the total client group, although this reduced again during the two quarters of 2020-21 during the COVID-19 pandemic, with the lower rate of 15.5%. There has also been a steady increase in the proportion of people preferring not to disclose their gender, reaching 3% during the first half of 2020-21.





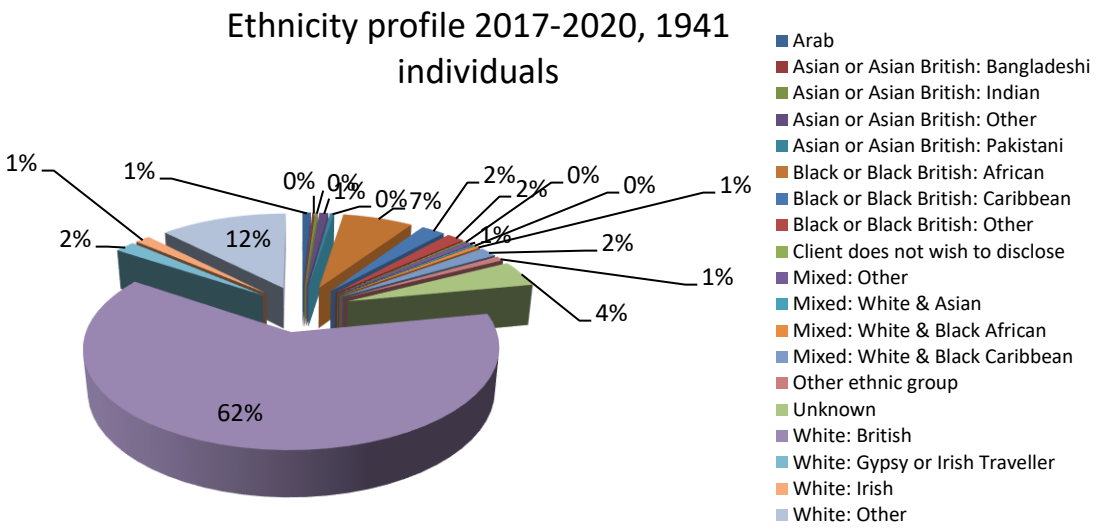


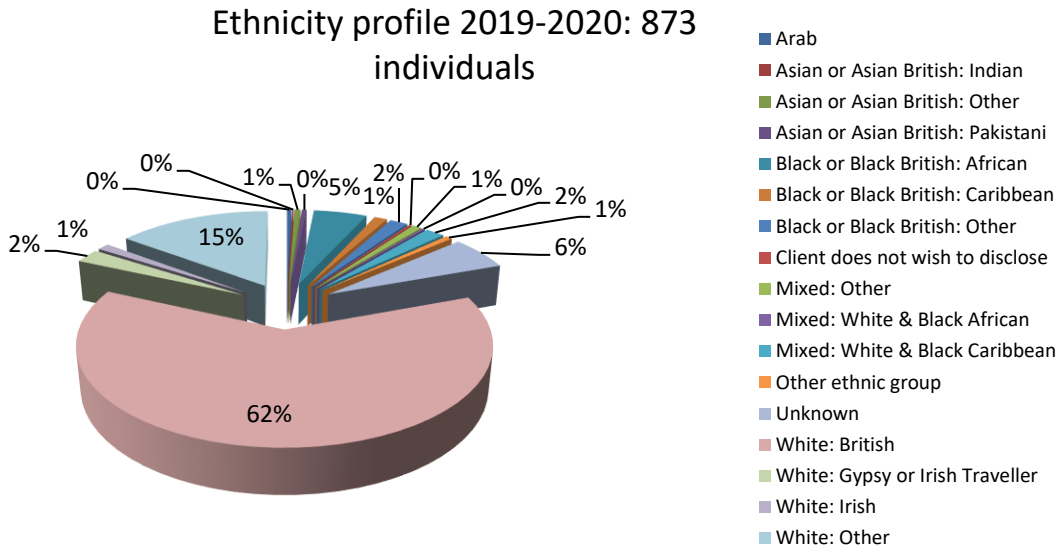
Ethnicity

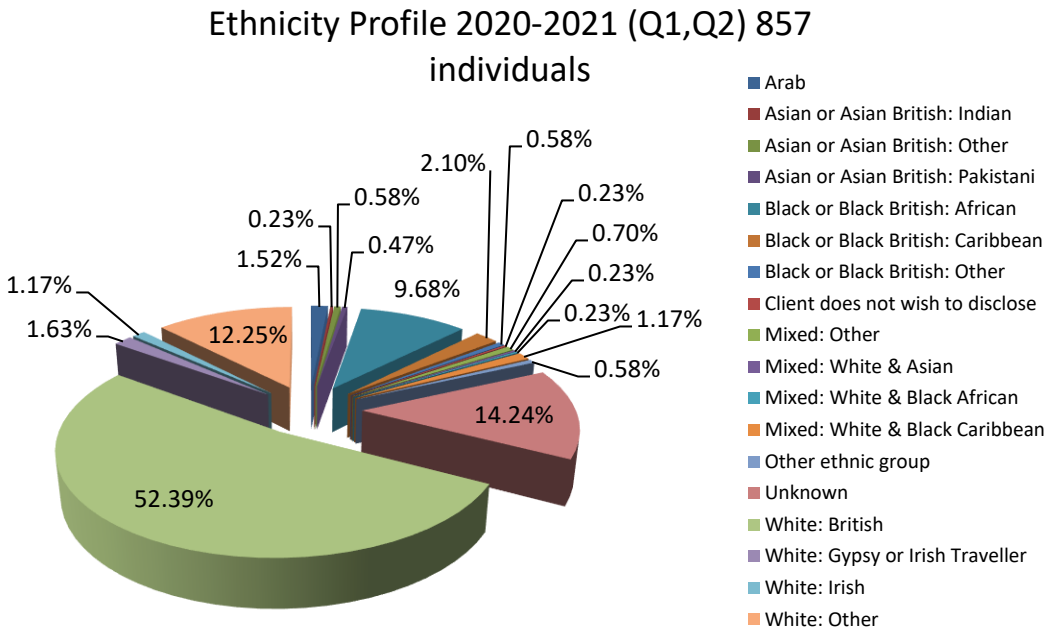
Data on the recorded ethnicity for those people entering the service is set out in the graphs below for 2017-2020 and 2019-20, and the first two quarts of 2020-21. Beneath this is a further graph showing the Bristol population profile from the 2011 census. The graphs show that there are higher levels of Black/African/Caribbean/Black British people, white other and lower levels of Asian/Asian British people

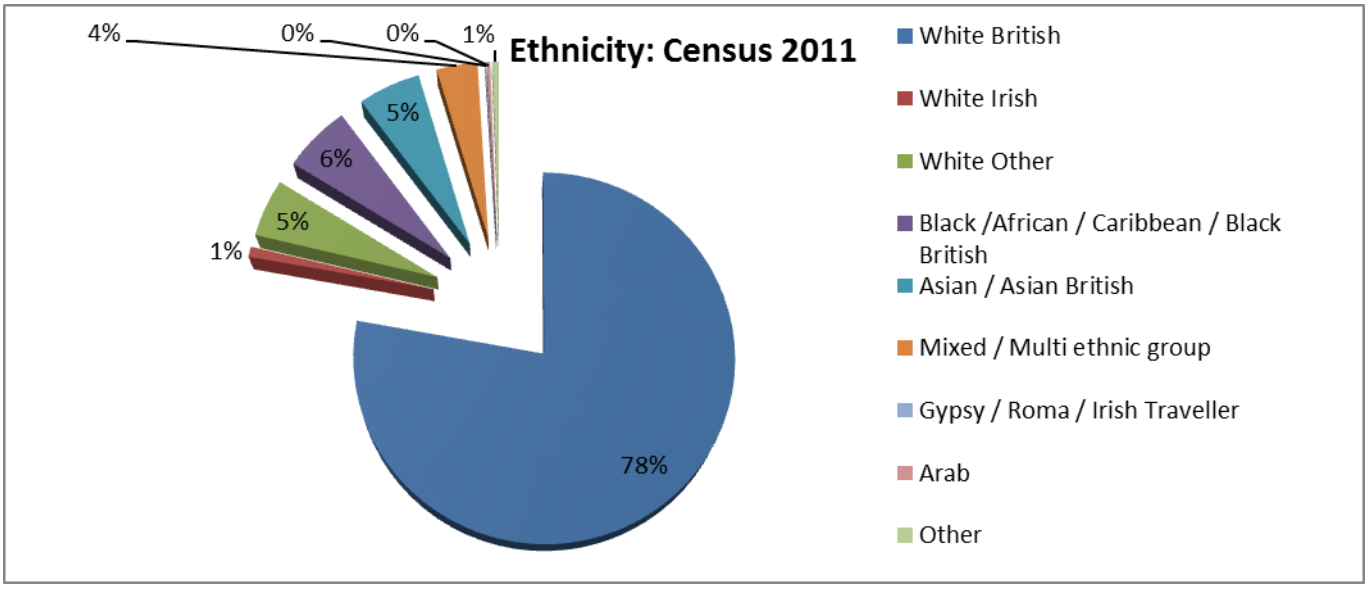
engaging with the service compared to the Bristol population in 2011. However, this census data is now out of date and is no longer thought to correspond with averages in Bristol.

The chart showing the first two quarters of 2020-21 during the COVID-19 period show a reduction in those identifying as white British, from 62% in both previous time periods to 52%. This drop is explained by slight increases in most other ethnicities - in particular double the number of individuals identifying as Black or Black British: African or where the ethnicity is unknown. This suggests that the COVID-19 pandemic has had more of an impact on people of ethnicities other than 'White British' who are disproportionately likely to enter the rough sleeping service. During 'Everyone in' the government suspended legislation around people who had no recourse to public funding which is likely to have had an impact in the reduction of white British clients in comparison to previous years.









Nationality

Appendix 1 shows the nationality of clients when entering the service.

For the first two quarters of 2020-21 the proportion of individuals reporting as British reduced to 67%, from 72% in 2019-20 and 74% on average for 2017-20. There was also a rise in certain nationalities which are countries of origin for asylum seekers, in particular Sudan (24) and Somalia (16) but also Eritrea (6), the Syrian Arab Republic (6) and Afghanistan (3). There was also a reduction in the number of individuals from certain countries in Europe, including Poland, Portugal, Slovakia, Spain and Latvia which may connect to pending legislation changes around rough sleeping and EU nationals. Conversely, in 2020-21 there were 11 people entering the service from the Netherlands and 4 from Germany – these individuals may have been asylum seekers who have registered Dutch or German nationalities since arriving in Europe. A cross all three time periods there remain high numbers from Poland and Romania.

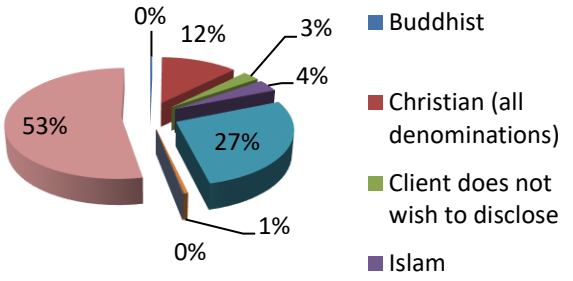
The rise in non-British nationalities in 2020-21 likely connects to high levels of individuals who have no recourse to public funds (NRPF) engaging with services following the breakdown of sofa surfing

arrangements, and to higher numbers of EEA nationals who may have lost informal accommodation options or who may have lost cash-in-hand employment.

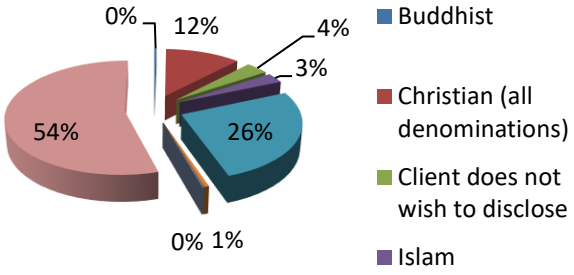
Religion

A significant number of people stated they had no religion, other or did not wish to disclose. In the first two periods, 12% of people said they were Christian with 4% of people said they were Muslim. For the first two quarters of 2020-21 an increased proportion (68%) were of unknown religion, likely due to the speed with which many people engaging with the service were accommodated in Emergency Accommodation.

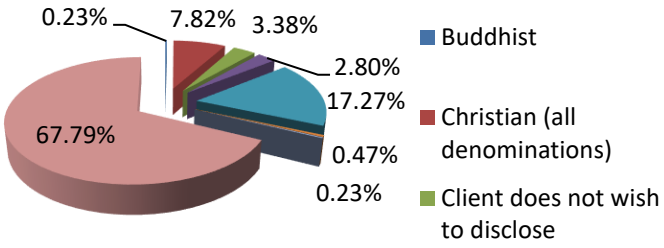
Religion profile 2017-2020, 1941 individuals



Religion profile 2019-2020: 873 individuals

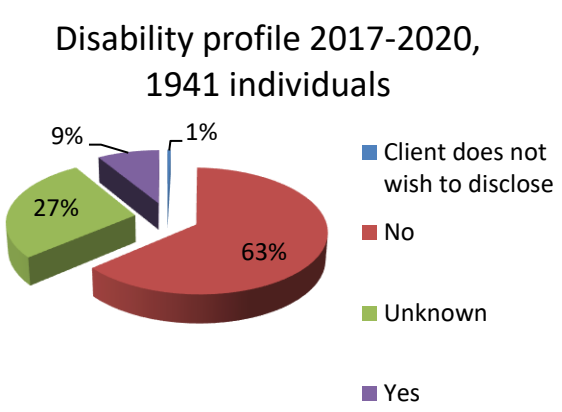


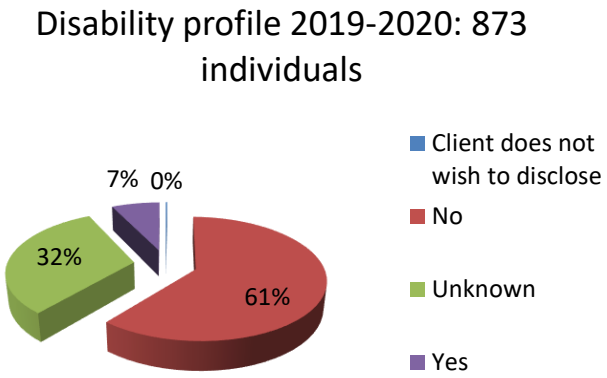
Religion profile 2020-2021 (Q1,Q2) 857 individuals

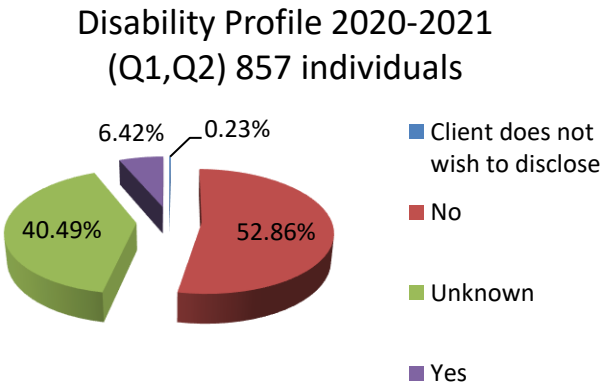


Disability

The majority of people on entry to the service responded to say that they did not have a disability; indeed only 9% in 2017-2020 and 7% in 2019-20 stated that they did have a disability. As noted above, this contrasts with a 2010 Health Needs Audit of 152 people in homelessness services or supported housing, whereby 59% said they experienced a long term physical health need or problem. This low rate may be partially explained by stigma in acknowledging a disability but could also be related to people perceiving that mental health and learning disabilities are not disabilities. The first two quarters of 2020-21 there was an increase in those where their disability status was unknown, again possibly reflecting people who moved from rough sleeping before fuller details were collected.

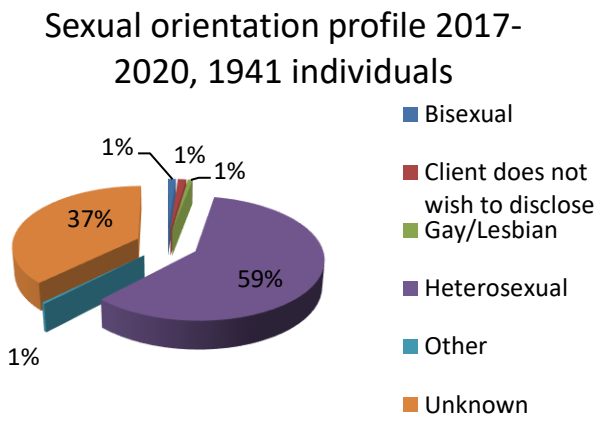


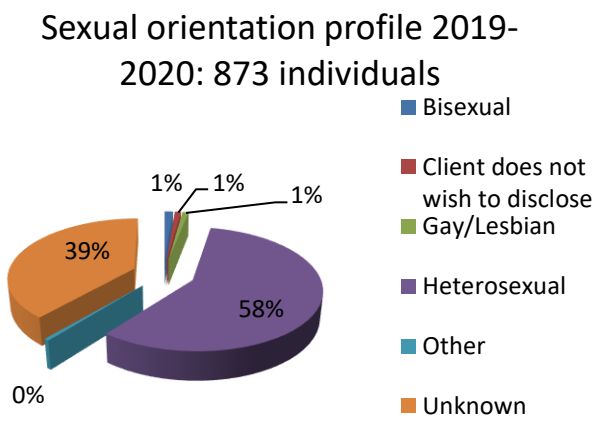




Sexual orientation

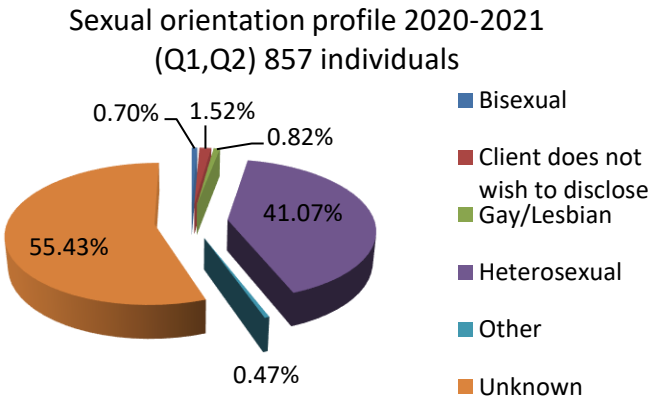
Lower rates of people identifying as bisexual and gay and lesbian for all three time periods than are identified in the Bristol Quality of life Survey 2016[12] may indicate a need to assimilate recommendations from Stonewall's *Finding Safe Spaces* so that people feel safer in services in the city to feel confident to be open about their sexuality[13].





[12] Sexual Orientation and gender - 2015/16 Bristol Quality of Life Survey adult population

[13] https://stonewallhousing.org/wp-content/uploads/2018/09/FindingSafeSpaces_StonewallHousing_LaptopVersion.pdf



Summary – continuation of trends with new scenario during COVID-19 pandemic

The data shared above suggests the broad continuation of trends around the needs and personal characteristics, including in comparison with the data for 2016-18 included in the Rough Sleepers Needs Analysis completed in October 2019. However, comparison with the data for the first two quarters of 2020-21, during the COVID-19 Pandemic and following the accommodation of a large number of rough sleepers in emergency accommodation, suggests a shift in need, personal characteristics and data availability that fits with our expectations about the cohort of people sleeping rough during this time period.

The evidence above shows:

- A large total increase, with around double the number of individuals for a six month average.
- A large increase in 'not known' homelessness category many of whom may have moved off the streets quickly but actually been 'new to the streets', and who were easier to find options for – likely due to COVID-led first-time homelessness.
- Lower rates of Mental Health, drug and alcohol needs due (as some of those with those needs may have been maintaining emergency accommodation successfully – see below) – likely due to COVID-led first-time homelessness.
- A large increase in reason for homelessness being 'relationship breakdown with friends' - likely linked to fear of COVID and people staying in during lockdown using space otherwise used for sofa surfing, or to breakdown of shared rented accommodation.
- A rise in the proportion of non-white British people sleeping rough and a rise in non-British nationalities, thought to be linked to the suspension of No Recourse to Public Funds (NRPF) condition for Asylum Seekers and EEA Nationals by government during 'Everyone in'.

Together with insights from service providers, this evidence suggests there may be a large, new cohort of people who are rough sleeping for reasons connected to the COVID-19 pandemic and who:

- may have less complex needs, are new to the streets;
- have moved from sofa-surfing;
- have recent experience of employment and maintaining accommodation;
- who are more likely to have no recourse to public funds (NRPF) or be an EEA national, and
- who may have been quickly moved off of the streets.

A flow of these people on to the streets is expected to continue whilst the impact or COVID-19 continues and as the economic impact of the crisis is felt further.

Alongside this large rise in numbers and the new characteristics of this cohort, it is important to consider the large cohort of former-rough sleepers who may not appear in these statistics, having been housed in emergency accommodation prior to the beginning of April 2020. Some of these individuals are now in emergency or private rented accommodation, and who meet the need and personal characteristics profile highlighted in the 2017-20, including more complex needs and longer-term and repeat rough sleeping. A higher rate of repeat homelessness for this group may occur where these new accommodation options are not sustained.

Overlapping these cohorts are those in the MHCLG 'Protect programme' category who have experience of longer-term or repeat rough sleeping or who have physical vulnerabilities, who may or may not have used emergency accommodation during 2019-20 and who will now be monitored and identified for targeted interventions and accommodation options using targeted funding from MHCLG.

Section C – Rough sleeping and single homelessness

Rough Sleeping During COVID-19 Pandemic

The chart below shows the levels of rough sleeping in Bristol during the pandemic since 4th May 2020[14]. Between May and August, during the Everyone In programme rough sleeping remained consistently low, with a low of 25 people on the 5th of August. In September, following reduction of emergency hotel accommodation saw this figure rose to 95 on the 30th of September, more in line with annual counts from recent years. Throughout the reporting period, an average of 71% of people sleeping rough had either refused or been evicted from or abandoned emergency accommodation.

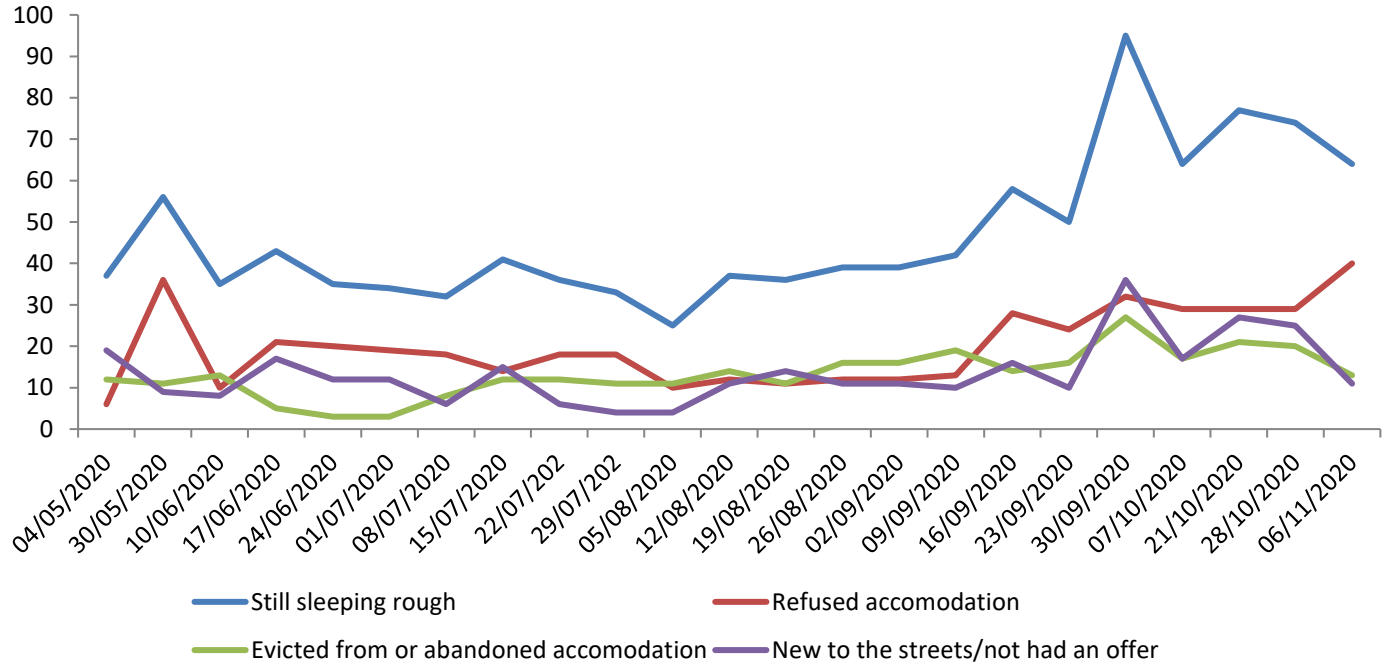
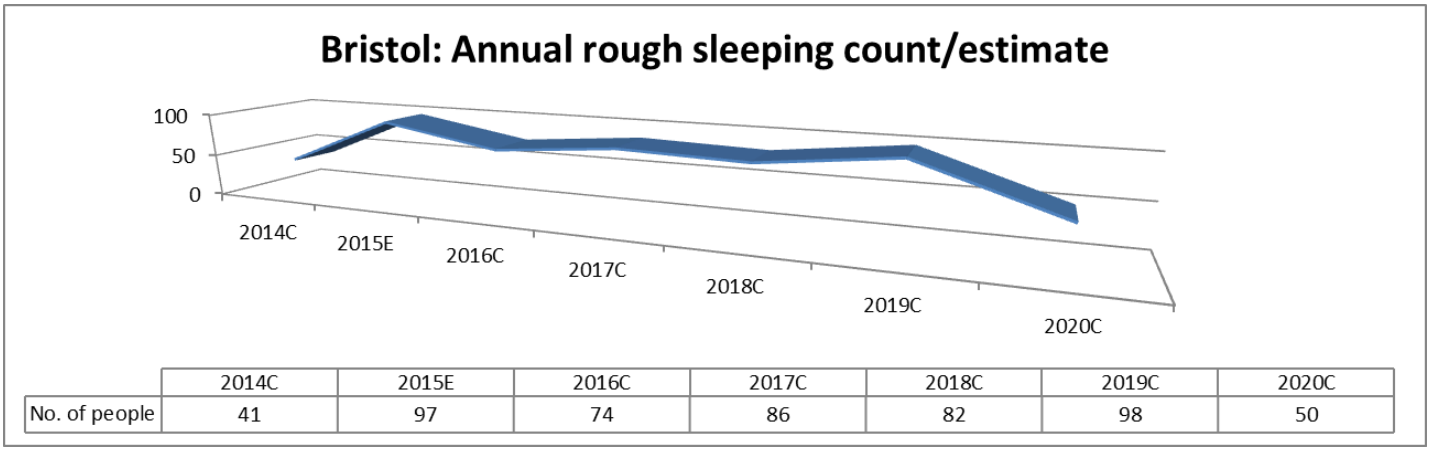


Chart above: Rough sleeping counts and reasons since 4th May 2020, based on weekly count and return to MHCLG

[14] Based on numbers agreed between Rough Sleeper Service and the Homelessness Prevention Team at weekly meetings.

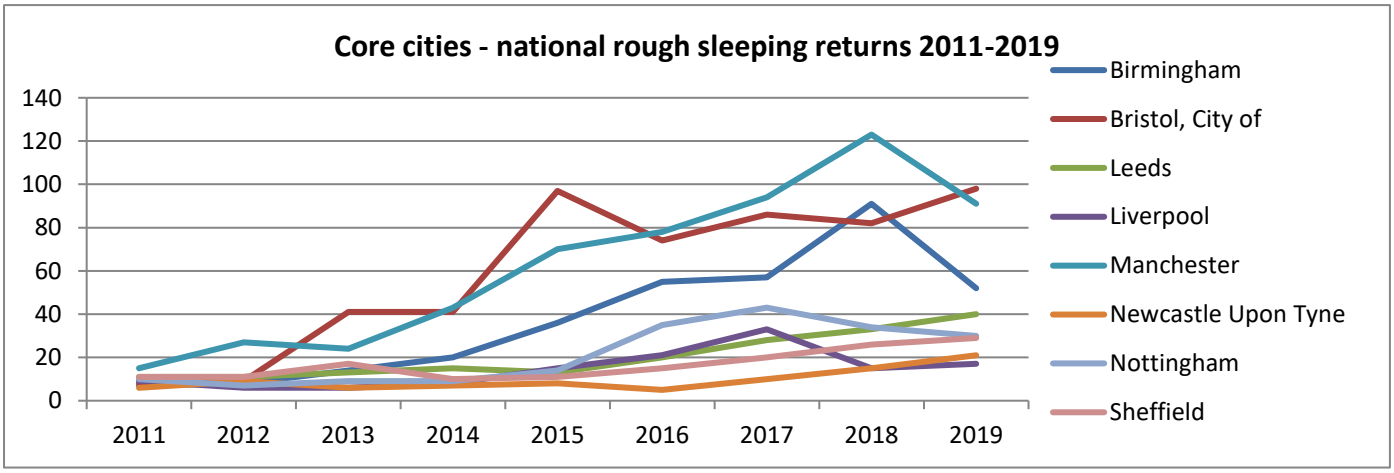
Annual rough sleeping counts/estimates



	2014C	2015E	2016C	2017C	2018C	2019C	2020C
No. of people	41	97	74	86	82	98	50

The number of people sleeping on the streets has risen significantly in Bristol since 2013. The government has adopted annual 'snapshot' counts or estimates on any one given night in the autumn prior to December as their preferred methodology for quantifying the levels of people sleeping rough in geographical areas. By this measure the number of people sleeping rough in Bristol has increased by 811% since 2010 and has risen by 165% nationally[15].

When we look at the Core City returns from 2011-19 we see that both Manchester and Newcastle Upon Tyne have continued to report increased returns throughout this period whilst Bristol is reporting a similar figure to that of 2015, having been relatively static between 2016 – 2018.

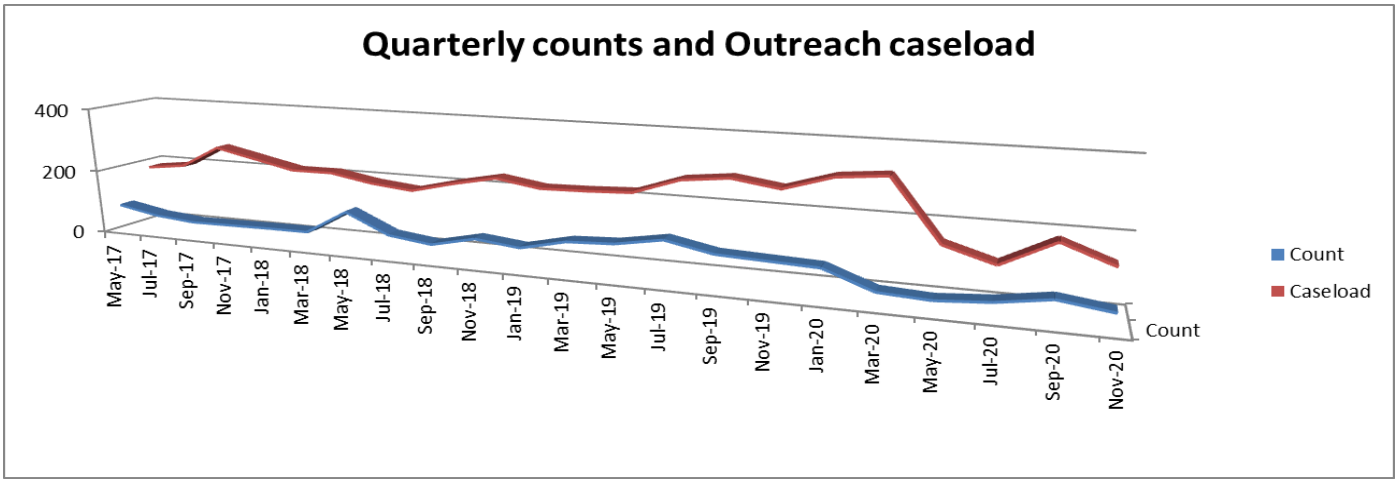


However, snapshot counts do not show the real levels of the number of people who end up street homeless. Other data gives us a more accurate picture of the true scale of the number of people who end up rough sleeping in Bristol. Since May 2016, the Outreach team (Rough Sleeper Service) have conducted regular counts on a quarterly basis using the govt. count methodology.

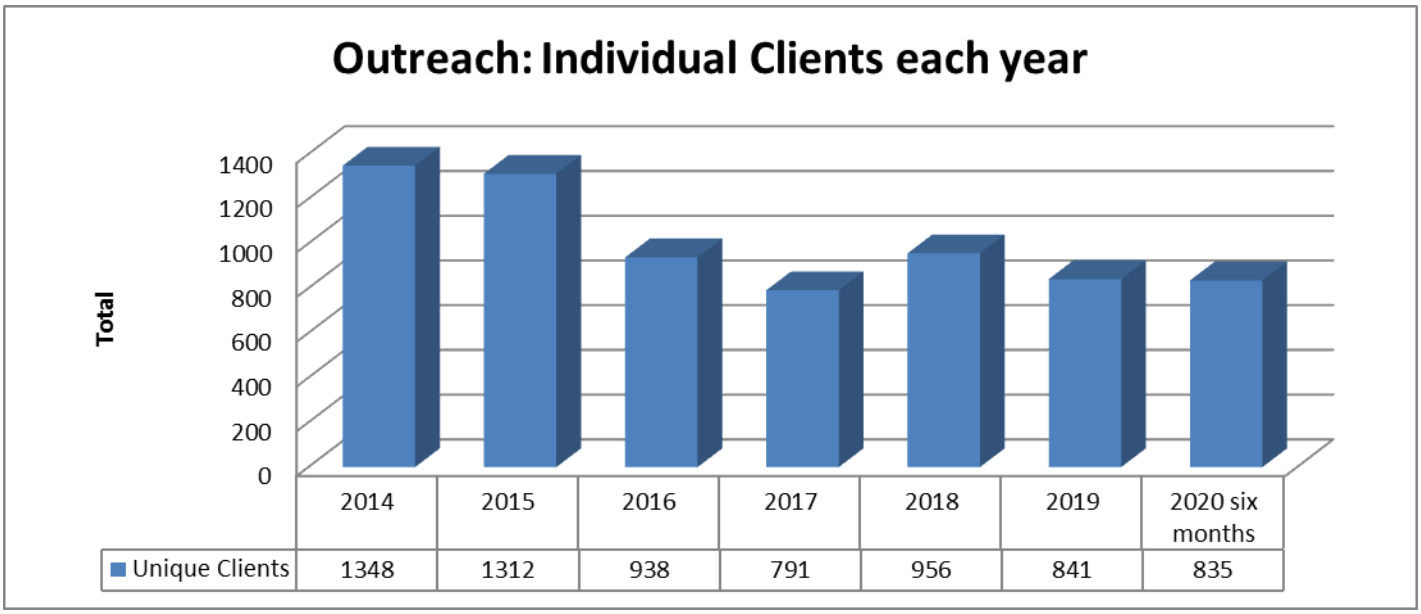
The data gives a more accurate picture of the more recent increase in the number of people who are street homeless in the city, particularly when it is combined with the overall caseload of people that the Outreach team are working with.[16] The increase in the number of people seen on the quarterly counts clearly correlates with increased Outreach caseload as seen in the chart below up until March 2020, after which the impact of Everyone in is evident.

[15] https://www.gov.uk/government/statistics/rough-sleeping-snapshot-in-england-autumn-2019

[16] Outreach caseload includes people in squats, night shelters or sporadically rough sleeping (when insecurely housed).

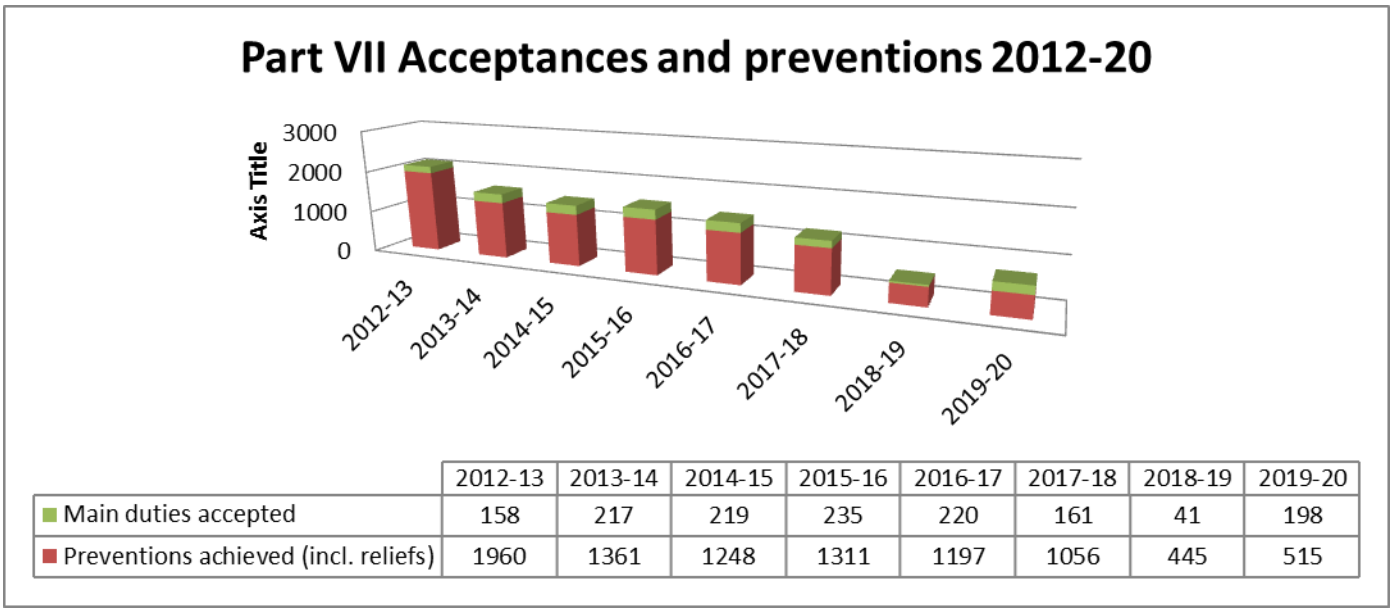


The information in the graph below shows the number of individual people that have been clients of the Outreach team during the calendar year since 2014. The levels of individual rough sleepers surged in 2014 and 2015, reducing in 2016 and 2017, before increasing again. In 2019 the figure dropped slightly, but following Everyone in in March 2020 the figure in 2020 and 2021 is likely to reach the high levels experienced in 2014 and 2015.



Single people: Part VII duty and preventions

The table below shows the level of single people where there was a part VII duty accepted by Bristol City Council or where homelessness has been prevented (and recorded as a Relief duty from 3rd April 2018 when the Homelessness Reduction Act came into force). Since 2012-13 it has been increasingly hard to secure alternative private sector accommodation to prevent homelessness due to the unaffordability of this sector to people on benefits and low wages.



	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20
Main duties accepted	158	217	219	235	220	161	41	198
Preventions achieved (incl. reliefs)	1960	1361	1248	1311	1197	1056	445	515

Please note that the main duty acceptance figures for singles (i.e. all households which did not include a dependent child or expectant mother) was 41 during 2018/19 and 198 during 2019/20. The relatively low figure during 2018/19 was largely due to the implementation of the Homelessness Reduction Act (HRA) on 3rd April 2018, which had the effect of delaying the acceptance of the main duty in most cases. This had less of an impact the following year.

The prevention figures for singles were 445 during 2018/19 and 515 during 2019/20. They are lower than previous years because for 2018/19 onwards, these figures only include those applicants towards whom a prevention or relief duty had been accepted following the implementation of the Homelessness Reduction Act on 3rd April 2018 and does not include prevention and relief stats from external organisations'.

Section D – Current service performance

Please note this section is as it appeared in the previous Needs Analysis that was produced in February 2020 up until the **COVID-19 Everyone In Emergency Accommodation** section.

Rough Sleeper service

Since the current Rough Sleeper Service began in October 2014, the number of people who have ended up street homeless in the city has increased massively. This has obviously had an impact on the performance of the service as the KPIs were set in early 2014 when the rough sleeping had begun increasing but the true level of the increase in rough sleeping was at that time unknown.

In response to this there have been a number of additional funding streams that Bristol City Council has successfully bid for funding streams from the Ministry for Housing Communities and Local Government (MHCLG):

Rough Sleeper Grant 2017-19 (No First Night Out/No Second Night Out)

The rough sleeping grant provided additional funding resources to help those new to the streets, or at imminent risk of sleeping rough, to the rapid support they need. The funding paid for a coordinator and two staff, operating mainly in Bristol with some resource operating in North Somerset.

The target for the Rough Sleepers Grant was to help over 600 individuals avoid a night on the streets (and associated risks associated with sleeping rough). This was to be achieved through:

- securing accommodation with friends or family.
- help to access the private rented sector;
- reconnection to where people have accommodation
- securing supported accommodation

'Entrenched' Rough Sleeping – Social Impact Bond 2017-21 (3.5 years)

Through the Entrenched Rough Sleeping Social Impact Bond funding, we aim to commission a service specifically targeted at a named cohort of 125 rough sleepers who the current system is failing - providing personalised support to these individuals who are currently entrenched within the homelessness system. The outcome payments criteria and rates are already set up – with a 100% payment by results contract fully funded by the DCLG. The payments are linked to achieving better outcomes in three domains: accommodation, better managed health needs and entry into employment.

MRSP 2017-19

Funding was granted from the Home Office to St Mungo's and Bristol City Council for a service which worked with people from the EEA who were ineligible for public funding. The service sought to assist people into employment and help them find private rental accommodation or if they were unable to achieve that if their needs were too complex, to assist them to voluntarily return to their country to occupy accommodation with friends or family.

MAESP 2018-19

Funding from the BCC Employment & Skills service for specific work with EEA nationals. The funding helped provide temporary accommodation, whilst at the same time improving their confidence and skills in order to assist people to find employment and private rental sector accommodation to move off the streets.

Rough Sleeper Initiative Funding 2018-20

Funding from MHCLG to fund the following projects:

- 24 hour Winter Shelter in St Anne's House;
- Move-on team Supported Housing Pathways;
- Psychological support to assist move-on from Supported Housing Pathways;
- Extending the Golden Key Housing First programme (24 units);
- Working with prison leavers to prevent rough sleeping;
- Strategic coordination of prison release.

Rapid Rehousing Pathway 2019-20

Bristol City Council was successful in applying to be one of 11 'early adopters' to provide a Rapid Rehousing Pathway, for people at risk of rough sleeping building on the No First Night Out model in London, rapidly assessing the needs of people who are sleeping rough or those who are at risk of sleeping rough and supporting them to get the right help.

The service incorporated Somewhere Safe to Stay (SStS) service working alongside three other separate funding streams to source private sector accommodation, provide floating support for those people and to provide additional support to people who have slept rough with more complex needs to maintain supported accommodation.

Performance of current service and linked services

Monitoring against outcomes

Outcome 1: Reduce Rough Sleeping (Positive Move-On)

Indicator	Target	Performance
Minimised monthly average number of rough sleepers in Bristol.	Y1≤20 Y2≤15 Y3≤10	This has not been achieved. The service was commissioned when there was a massive increase in rough sleeping (see Annual Rough Sleeping Counts/estimates above)
a) Percentage of positive move-on by client group	90%	93%
Those who have left the service but are back on the street count within 6 / 12 / 18 months	≤5%	3.65%

Outcome 2: Develop Confidence, Self Esteem and Skills

Indicator	Target	Performance
Percentage of clients at case closed, 6 and 12 months reporting they are: • Increasing/maintaining their confidence in sustaining independent living • Increasing/maintaining their self confidence • Increasing/maintaining their sense of belonging • Increasing/maintaining their agreement that people from different backgrounds get on well together • Engaging in additional training / education / volunteering • Securing/maintaining employment	90%	n.b. This target was dropped earlier in the contract (2016-17) as the service was remodelled to maximise resources for engaging with and assisting people sleeping rough to move off the streets.

Percentage of volunteers at 6 and 12 months after training/induction, reporting they are: • Increasing/maintaining their confidence in sustaining independent living • Increasing/maintaining their self confidence • Increasing/maintaining their sense of belonging • Increasing/maintaining their agreement that people from different backgrounds get on well together • Engaging in additional training / education / volunteering • Securing/maintaining employment	90%	n.b. This target was dropped earlier in the contract (2016-17) as the service was remodelled to maximise resources for engaging with and assisting people sleeping rough to move off the streets.

Outcome 3: Organisational learning

<table>
<tr><th>Indicator</th><th>Target</th><th>Performance</th></tr>
<tr><td>Percentage of clients, volunteers, partners and community groups reporting their respective satisfaction with:
• Services meeting their needs
• Accessibility of services
Welcoming environment</td><td>n.a.</td><td>From last survey, conducted October 2018
<table>
<tr><th rowspan="2">Feedback Source</th><th rowspan="2">Timescale</th><th colspan="3">Percentage reporting satisfaction with:</th></tr>
<tr><th>Services meeting their needs</th><th>Accessibility of services</th><th>Welcoming environment</th></tr>
<tr><td rowspan="2">Clients</td><td>Target</td><td></td><td></td><td></td></tr>
<tr><td>Since Contract Start</td><td>82%</td><td>83%</td><td>94%</td></tr>
<tr><td rowspan="2">Partners</td><td>Target</td><td></td><td></td><td></td></tr>
<tr><td>Since Contract Start</td><td>89%</td><td>89%</td><td>89%</td></tr>
<tr><td rowspan="2">Community Groups</td><td>Target</td><td></td><td></td><td></td></tr>
<tr><td>Since Contract Start</td><td>100%</td><td>100%</td><td>100%</td></tr>
<tr><td rowspan="2">Volunteers</td><td>Target</td><td></td><td></td><td></td></tr>
<tr><td>Since Contract Start</td><td>100%</td><td>100%</td><td>94%</td></tr>
</table></td></tr>
</table>

Outcome 4: Improve Health & Wellbeing

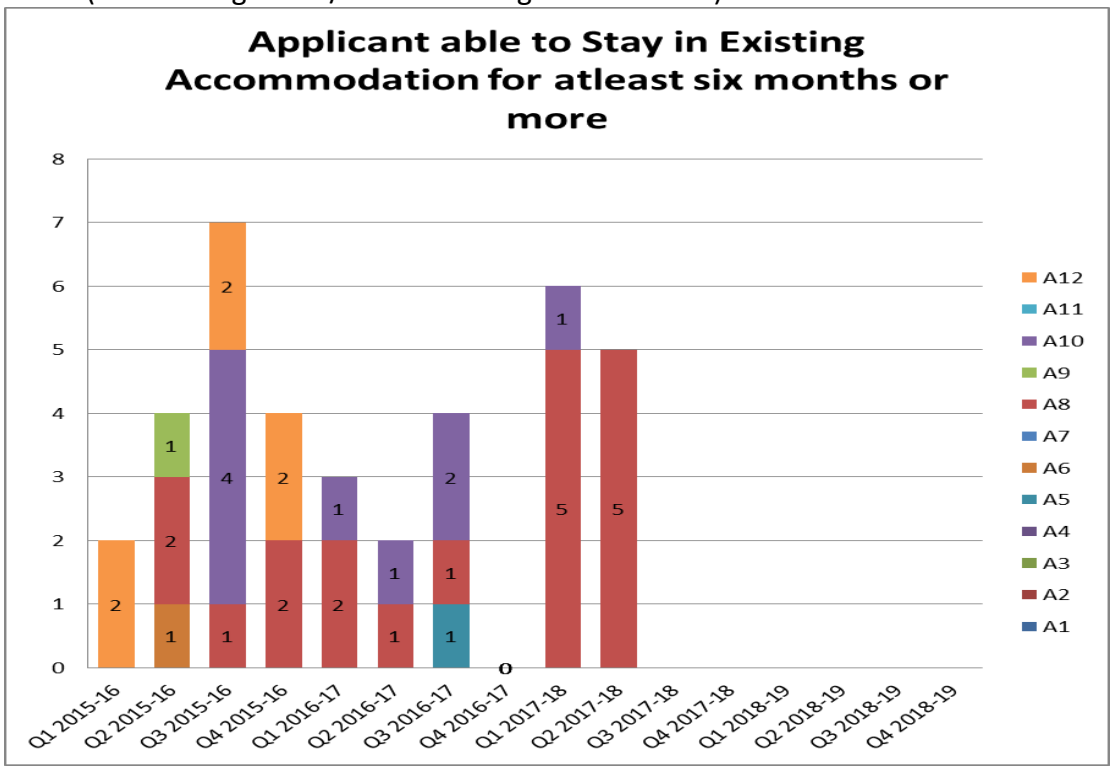
<table>
<tr><th>Indicator</th><th>Target</th><th>Performance</th></tr>
<tr><td>Ensure that all rough sleepers in the city are offered / have access to a place to sleep in the warm when the SWEP is activated. 100%</td><td>100%</td><td>100%</td></tr>
<tr><td>Where identified in client support plans, as appropriate:
a) Facilitate client access and engagement with primary and physical health services as appropriate
b) Facilitate client access and engagement with psychological support and/or mental health services as appropriate
c) Facilitate client access and engagement with appropriate drug and alcohol treatment services as appropriate</td><td>100%</td><td>
<table>
<tr><th></th><th></th><th>Timescale</th></tr>
<tr><td rowspan="3">Primary and physical health services</td><td>GP / nurse</td><td>> 149</td></tr>
<tr><td>Hospital</td><td>> 272</td></tr>
<tr><td>Other</td><td>> 4</td></tr>
<tr><td rowspan="3">Psychological support and/or mental health services</td><td>MH Act Assessment</td><td>> 10</td></tr>
<tr><td>ACE</td><td>> 14</td></tr>
<tr><td>Other</td><td>> 108</td></tr>
<tr><td rowspan="4">Drug and alcohol treatment services</td><td>SMART</td><td>> 13</td></tr>
<tr><td>ROADS</td><td>> 21</td></tr>
<tr><td>Wet Session</td><td>> 67</td></tr>
<tr><td>Other</td><td></td></tr>
</table>
</td></tr>
</table>

Rough Sleeper Service Relief & Prevention

The information in this section is taken from the prevention statistics in the P1E Homeless returns to govt. From October 2018 the P1E returns were ended and the government began collecting relief and prevention information through HCLIC prevention returns in relation to the duties under the Homelessness Reduction Act.

Relief

There have been relatively few reliefs achieved by the service and by the graph below you can see that this drops off completely when the Rough Sleeper Grant (No First Night Out/No Second Night Out service) is introduced:

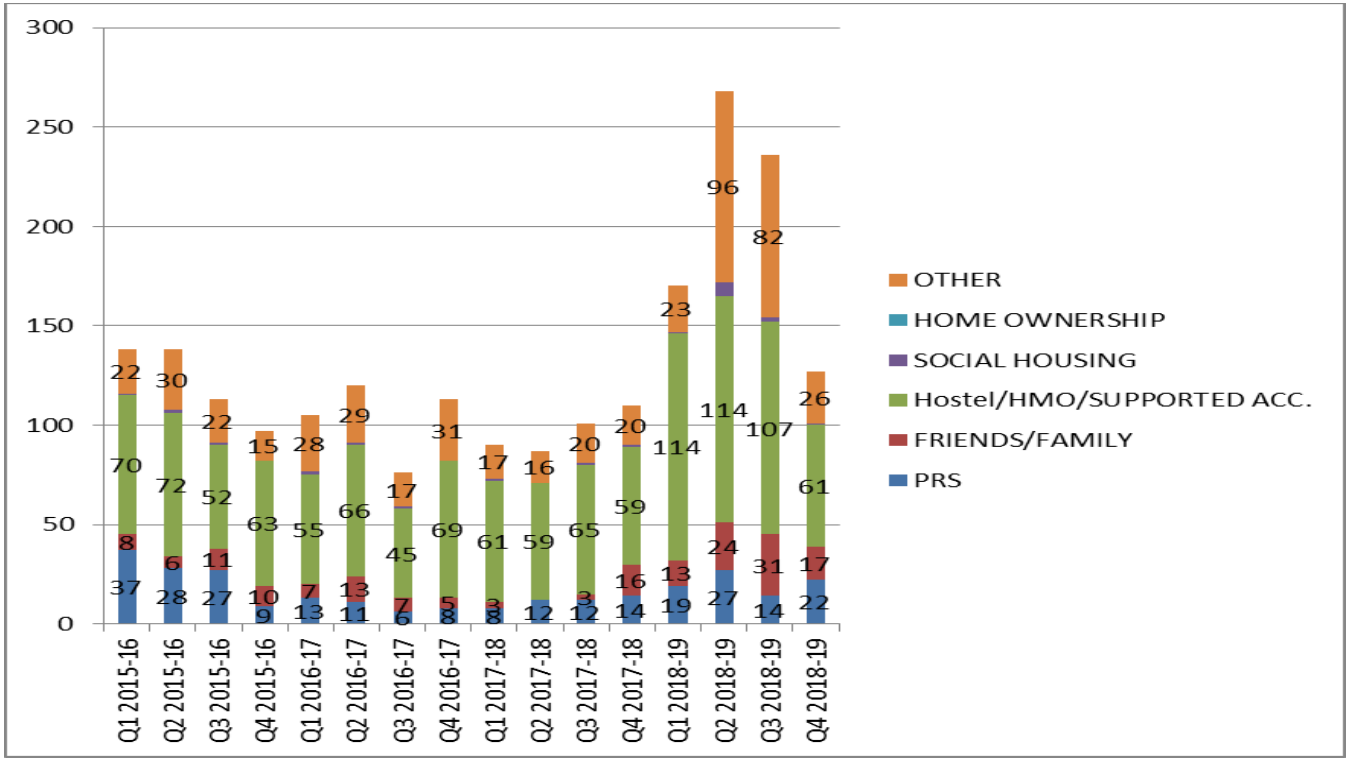


A1	Mediation using external or internal trained family mediators
A2	Conciliation including home visits for threatened evictions by friends or family
A3	Financial payments from a homelessness prevention fund
A4	Debt advice
A5	Resolving housing benefit problems
A6	Resolving rent or service charge arrears in privately or socially rented sector
A7	Sanctuary scheme measures for domestic violence
A8	Crisis intervention - providing emergency support
A9	Negotiation or legal advocacy to keep accommodation in privately rented sector
A10	Other assistance to keep existing accommodation in privately or socially rented sectors
A11	Mortgage arrears intervention/mortgage rescue
A12	Other (please specify)

Prevention

The prevention statistics in the graph below have been amalgamated into 5 categories to simplify overlapping categories for social housing, private rental sector and hotels/supported housing. Access to hostels/supported housing has remained broadly consistent throughout the period although there was a large increase in Q1 to 3 2018-19 and subsequently reduced markedly in Q4. Waiting times to access supported accommodation for people sleeping rough has increased recently to around six months reflecting increasing demand for supported accommodation from single homeless households. This is exacerbated by slower move on from supported housing due to less availability of social housing and affordability issues with the private rental sector.

Access to the PRS had reduced significantly in 2016-17, however the introduction of the Rough Sleeper Grant increased the focus on accessing the private rental sector and this focus has been assimilated into the Rapid Rehousing Pathway. There has also been a renewed focus on assisting people to return to friends and family during this period. It is not entirely clear as to why there was an increase in the other categories in this period, in looking at the returns some cases have been recorded as in B&B (presumably under a duty from Bristol City Council, so should not be recorded here) and a significant number of reconnections to other areas in the UK and Europe (linking to the MRSP and MAESP funding).



Rough Sleeper Grant 2017-19 (No First Night Out/No Second Night Out)

The table below shows the outputs and outcomes for the project and 296 outcomes were achieved for individuals (against an estimated target of 600). This client group was separate from those people worked with through the Rough Sleeper Service. In Bristol 389 people were worked with of which 100 people had accommodation outcomes (relief) and 124 had homelessness prevented for a period of at least 6 months giving a success rate of achieving 58% of clients worked with who had homelessness prevented or relieved.

	Outputs and Outcomes			Cumulative figures - people can be worked with during more than one quarter						
	2016/17	2017/18				2018/19				2019-20
	Q4	Q1	Q2	Q3	*Q4*	*Q1*	*Q2*	*Q3*	*Q4*	*Q1 - projection*
COMBINED - BRISTOL AND NORTH SOMERSET										
People worked with who had already slept rough	0	18	35	61	104	166	229	259	296	296
People worked with who had not already slept rough	0	1	6	19	58	93	127	195	242	242
Accommodation outcomes (rough sleepers only)	0	3	13	29	56	73	99	112	127	127
Preventions - 6 months	n/a	n/a	n/a	1	9	19	58	91	125	167
SUBSET - BRISTOL										
People worked with who had already slept rough	0	0	8	23	58	96	133	163	186	no projection
People worked with who had not already slept rough	0	0	5	18	57	90	124	166	203	no projection
Accommodation outcomes (rough sleepers only)	0	0	3	14	33	52	73	86	100	no projection
Preventions - 6 months	n/a	n/a	n/a	n/a	5	18	57	90	124	no projection
SUBSET - NORTH SOMERSET										
People worked with who had already slept rough	0	18	27	38	46	70	96	96	110	no projection
People worked with who had not already slept rough	0	1	1	1	1	3	3	29	39	no projection
Accommodation outcomes (rough sleepers only)	0	3	10	15	17	21	26	26	27	no projection
Preventions - 6 months	n/a	n/a	n/a	1	1	1	1	1	1	no projection

Entrenched Rough Sleeping – Social Impact Bond 2017-21

The table below represents the outcomes achieved after 18 months of the 42 month SIB service. PIP means the percentage target set for investors to recoup their payments (this is a payment by results service for which Social Investors receive a return on their investment). The service is on track to meet the predicted outcomes.

Outcome	Total Target Case	PIP (80% of target case)	Actual Total Claim against outcome	Difference Actual PIP	% of PIP outcomes achieved
Entering Accommodation	125	100	100	0	100%
3 Months in Accommodation	106	85	81	-4	96%
6 Months in Accommodation	96	77	60	-17	78%
12 Months in Accommodation	88	70	24	-46	34%
18 Months in Accommodation	69	55	4	-51	0%
24 Months in Accommodation	56	45	0	-45	0%
General Weilbeing Assessment X3	372	298	249	-49	84%
MH entry into engagement with services	40	32	19	-13	59%
MH sustained engagement with services	35	28	7	-21	25%
Alcohol misuse entry into alcohol treatment	31	25	3	-22	12%
Alcohol misuse sustained engagement with alcohol treatment	27	22	1	-21	5%
Drug misuse entry into drug t reatment	61	49	35	-14	72%
Drug misuse sustained engagement with drug treatment	67	54	36	-18	67%
Improved education/ training	16	13	1	-12	8%
Volunteering 13 weeks	6	5	1	-4	21%
Volunteering 26 weeks	6	5	0	-5	0%
Part time work 13 weeks	0	0	0	0	0%
Parttime work 26 weeks	0	0	0	0	0%
Full time work 13 weeks	3	2	0	-2	0%
Full time work 26 weeks	3	2	0	-2	0%

MAESP & MRSP

Monitoring net held by Contracts & Commissioning Team

Rough Sleeper Initiative Funding 2018-20

The information below shows the outcomes for the Rough Sleeper Initiative Funding to reduce the levels of people who end up rough sleeping in the city made available from the Ministry for Housing Communities.

2018/19	Aug-18		Sep-18		Oct-18		Nov-18		Dec-18		Jan-19		Feb-19		Mar-19		Totals results	
Intervention	**Prevention**	**Relief**	**Prevention**	**Relief**	**Prevention**	**Relief**	**Prevention**	**Relief**	**Prevention**	**Relief**	**Prevention**	**Relief**	**Prevention**	**Relief**	**Prevention**	**Relief**	**Prevention**	**Relief**
Move On - Navigator Team Second step	0	0	0	0	0	0	0	0	0	**1**	**0**	**1**	**0**	**3**	0	**2**	**0**	**7**
Psychological Support Second Step	0	0	0	0	0	0	0	0	0	0	**0**	**0**	**0**	**0**	0	0	**0**	**0**
Housing First Second Step	0	0	0	0	0	0	0	0	0	0	**0**	**2**	**0**	**0**	0	1	**0**	**3**
Winter Shelter St Mungos	0	0	0	0	0	0	0	**0**	0	**5**	**0**	**12**	**0**	**8**	0	**20**	**0**	**45**
NFNO Prison release	**1**	0	**0**	0	**3**	0	**2**	0	**3**	0	**3**	**0**	**0**	**0**	**6**	0	**18**	**0**
															Total for year		**18**	**55**

	Apr-19		May-19		Jun-19		Jul-19										Totals results	
Intervention	**Prevention**	**Relief**	**Prevention**	**Relief**	**Prevention**	**Relief**	**Prevention**	**Relief**									**Prevention**	**Relief**
Move On - Navigator Team	0	**1**	0	**6**	0	**1**	0	**5**									**0**	**13**
Psychological Support	0	**1**	0	0	0	0	0	0									**0**	**1**
Housing First	0	0	0	0	0	0	0	0									**0**	**0**
Winter Shelter	0	0	0	0	0	0	0	**0**									**0**	**0**
NFNO Prison release	**3**	0	**10**	0	**5**	1	**7**	**0**									**25**	**1**
															Total for year		**25**	**15**

COVID-19 Everyone In Emergency Accommodation

Everyone In - March 2020

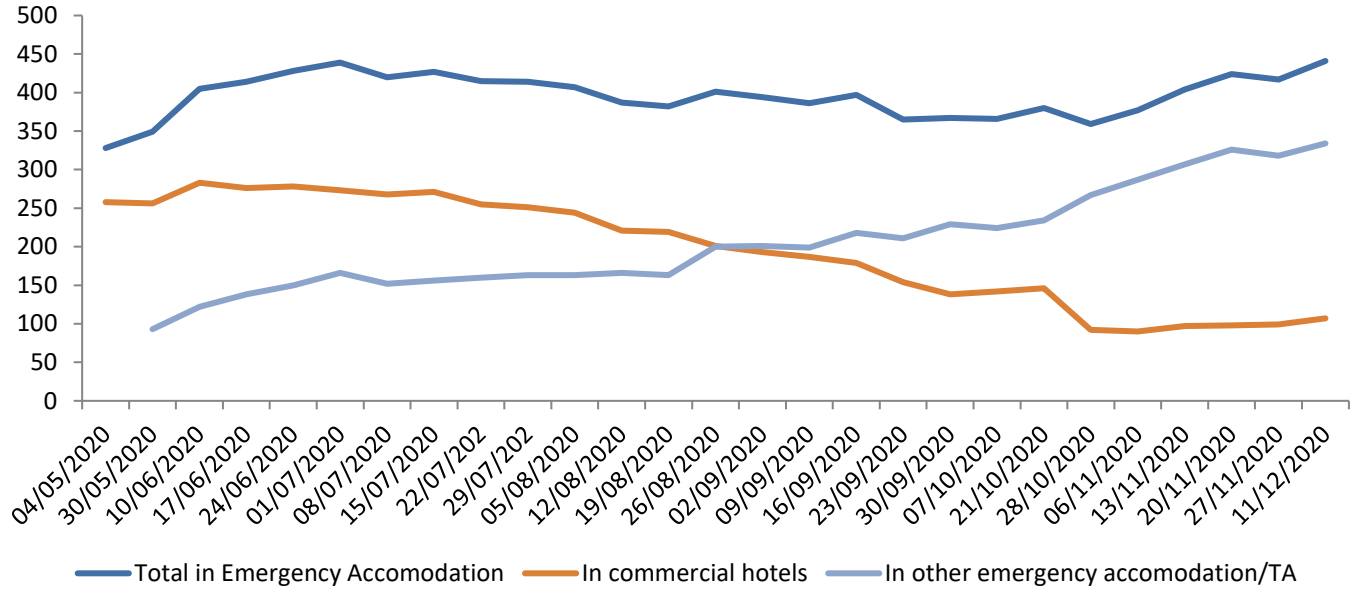
During the COVID-19 pandemic the numbers of individuals in emergency accommodation rose dramatically during the first lockdown following the launch of Everyone In on the 27th of March. There was a reduction in the use of emergency accommodation following the end of the lockdown and the easing of national restrictions.

In Bristol emergency accommodation with support was provided via:

- The YMCA / the Wing
- The YHA
- The Holiday Inn, Bond St
- Arnos Manor Hotel
- Travelodge, Mitchel Lane
- Dispersed Temporary Accommodation

Numbers in emergency accommodation (hotels and emergency TA) reached a high of 439 on 1st of July, reducing to 359 as of 6th November before rising again to 441 on the 11th of December. Over this period more than 1,000 individuals have been accommodated to date. Clients in hotels and hostels peaked at 283 on 10th of June, reducing steadily as the use of these settings was phased out over July, with some use intended to continue until at least April 2021.

Number of individuals in emergency accommodation[17]



Interim NSAP Fund – October 2020

The Next Steps Accommodation Programme (NSAP) makes available the financial resources needed to support local authorities and their partners to prevent these people from returning to the streets.[18] BCC's proposal was designed to meet the challenge for placing 2,218 clients anticipated to need emergency accommodation in Bristol in 2020-21, including 387 in emergency provision and 37 sleeping rough.

[17] Note: Figures for the 14th October and 4th December 2020 were not available.

[18] https://www.gov.uk/government/publications/next-steps-accommodation-programme-guidance-and-proposal-templates

The initial interim fund is to support emergency accommodation provision for the remainder of 2020-2021. In Bristol the funding will be used for:

- Hotels costs to autumn 2020
- Hotel costs into 2021
- Block contract for shared housing (120 bed spaces)
- Temporary Accommodation provision for NRPF clients (47 bed spaces)

Bristol City Council's proposals for the main included capital funding for 51 bed spaces[19] via acquisition, repurposing, a nominations agreement and revenue funding:

- St Mungo's properties (44 bed spaces)
- BCC Supported Move On Accommodation (30 bed spaces)
- Solon and Elim properties (9 bed spaces)
- Imperial Apartments (120 bed spaces)
- The supported Move On team
- Housing First support for 28 clients
- HMO block contract

Unfortunately, funding for Imperial Apartments (2021-24), the HMO Block contract (2021-22) and Housing First Support was not agreed in the first round of funding for NSAP.

Cold weather Fund

All councils will receive a share of the £10 million Cold Weather Fund to protect people from life-threatening cold weather and the risks posed by coronavirus.[20] Planning is underway to explore options for socially-distanced Severe Winter Weather Emergency Provision (SWEP) in the city in place of the usual use of dormitories and shared sleeping settings. Bristol City council has been awarded £140,000 against this fund in conjunction with the Protect programme below.

Protect Programme Fund

Following the second national lockdown and under the new national restrictions of the tiered system, numbers of rough sleepers are rising at the time of writing and use of emergency accommodation is expected to rise again throughout the winter months. The Protect programme, announced on 6th November, offers a share of £15 million funding focused on the most vulnerable, repeat and long-term rough sleepers.[21] The award, combined with the Cold Weather Fund award can be found in Appendix 2.

Section E – Health Needs

Introduction

People who end up sleeping rough often experience barriers in accessing both health and care services and it is well documented that they experience poor health outcomes in comparison to the rest of society. Crisis have found that Homeless people are more likely to die young, with an average age of death of 47 years old and even lower for homeless women at 43, compared to 77 for the general population, 74 for men and 80 for women[22].

People who become street homeless often have high and complex support and treatment needs as a result of trauma experienced in their childhood.

[19] Subject to final confirmation.
[20] https://www.gov.uk/government/news/rough-sleepers-to-be-helped-to-keep-safe-this-winter
[21] https://www.gov.uk/government/news/jenrick-launches-protect-programme-the-next-step-in-winter-rough-sleeping-plan
[22] https://www.crisis.org.uk/media/236799/crisis_homelessness_kills_es2012.pdf

Health Needs Assessment

Other areas in England have produced recent health needs assessments. In Bristol, Public Health in collaboration with partner organisations will be completing a similar needs assessment for Bristol in early 2021. Below are the summary recommendations from Brighton and Manchester, two cities that like Bristol have experienced high numbers of people sleeping rough and there will be overlapping issues for people who end up rough sleeping in Bristol.

Brighton

Summary of recommendations:

Section 2: Access to health services

1. Target interventions to increase rates of registration with GPs and dentists at services with the lowest levels.
2. Increase rates of dental registration and consider evidence and recommendations from recent Pathway research in addition to this audit to improve access to dental services for the homeless population.
3. NHS commissioners to provide advice to GPs to ensure that homeless people have equitable access to primary care (including advice on photo ID).
4. NHS commissioners to consider the evidence that discharge planning is working relatively effectively (probably as a result of the Pathway service) in the development of future services. Consider how this can be improved further.
5. NHS commissioners and Brighton & Sussex University Hospitals NHS Trust to consider the proportion of A&E visits by homeless people that are genuinely required and whether service redesign could reduce inappropriate use of hospital services.

Section 3: Health behaviours

1. Review provision of Stop Smoking Services for the homeless population in Brighton & Hove. All smokers should be encouraged and offered support to quit.
2. Ensure homeless people are included in healthy eating and physical activity programmes and that they are meeting their needs.
3. Target these health promotion programmes at services identified with the highest levels of need to achieve maximum impact.
4. Providers and commissioners to note the findings of low levels of exercise and poor diet relating to fruit and vegetable consumption and eating two meals a day, and ensure these are prioritised.

Section 4: Health and wellbeing

1. Work with homeless health services in the City to ensure they are meeting the physical and mental health needs of the homeless population.
2. Ensure training for staff in hostels and other homeless services in identifying mental and physical health needs and signposting to appropriate services.
3. Investigate whether current projects are addressing the high levels of physical and mental health needs in the LGB homeless population.

Section 5: Substance misuse

1. Share audit findings with the local Drug and Alcohol service commissioners and the Drug and Alcohol Action Team (DAAT) for their consideration to support re-commissioning.
2. Ensure provision of stop smoking services for the homeless population adequately incorporates cannabis use in addition to regular cigarettes.

3. There was a good level of awareness of local needle exchange services among injecting drug users (IDUs) and relevant services should ensure this is maintained.

Section 6: Screening and immunisations

1. Ensure all homeless people in risk groups are offered the appropriate vaccinations and screening tests. Consider providing these at drop-in sessions where health assessments are conducted. This is particularly
2. important for TB which all rough sleepers and open access hostel dwellers should be offered testing for.
3. Ensure that local pathways for TB, HIV and hepatitis C are working effectively.

Manchester

Summary of recommendations:

Recommendation 1: A strategy for integrated commissioning of services:

There is currently no integrated commissioning response to the homeless population involving the health service, social care and accommodation services.

To achieve improved outcomes for the population health and social care commissioners need to acknowledge that homelessness must feature as a mainstream area in all commissioning strategies, and develop an integrated commissioning framework that supports the effective delivery of this. The emerging Greater Manchester Health and Social Care Partnership commissioning strategy provides an excellent opportunity to ensure a response to homelessness is firmly embedded within the design and implementation of this to improve the health inequalities experienced by the homeless population of Manchester.

Recommendation 2: Integrated services for substance misuse and mental health

Extremely high proportions of homeless people experience physical health problems, mental health problems and substance misuse but crucially 60% of individuals experience all three together, more commonly referred to as tri-morbidity, which is associated with very poor outcomes and excess morbidity and mortality. The audit clearly demonstrated very poor access to services to help them to address these health problems which in turn results in high impact on acute services and the associated high economic burden.

In Manchester the strategy for these areas of healthcare for many years has resulted in the commissioning of separate services for substance misuse and mental health which is an ineffective response for the homeless population. We recommend a strategic review of this area of healthcare with consideration given to integrated models of care and the commissioning support required to test and deliver these. Analysis of the economic benefits of these models should be central to the commissioning strategy.

Recommendation 3: Optimal access to Healthcare

It is an accepted basic principle of healthcare in the UK that people should be registered with a GP in order to give them access to primary healthcare and optimise access to other areas of the health service.

The audit shows that whilst Urban Village Medical Practice is very effective in enabling access to primary care for many homeless people in the city, there is still not optimal access for the whole population, particularly in areas outside the city centre, which continues to impact on acute services and result in poor health outcomes for this population. As part of the transformation of health and social care, steps should be taken to ensure that access to primary healthcare is equitable for all homeless people across the city, and should include work with all GP practices to offer effective registration for homeless people in line with NHS England guidance. GPs should be encouraged and supported to promote flexible access to

appointments and assertive services which aim to not only address health inequalities but also reduce impact on secondary care services. An analysis of the economic benefits of these models of care should be central to the commissioning strategy.

Public Health Complex Needs and rough sleeping needs assessment

Secondary and Complex Needs

Understanding secondary and complex support needs for service users with mental ill health is important for mapping interdependencies with other services including other Adult Social Care provision, homelessness pathways and drug and alcohol services. This analysis also supports an understanding of how service users' complex needs and associated risks can impact their journeys through referral pathways. A recent internal review of 30 admissions to Acute and Psychiatric Intensive Care Unit (PICU) wards in Bristol found:

- 37% had experienced deterioration in mental health due to non-compliance with prescribed mental health medication
- 31% of those not currently within Recovery services at the time of admission (13 people) were discharged due to engagement issues.[23]

Whilst these characteristics are not exclusive to people with complex needs, homelessness, substance misuse and secondary Care Act-eligible needs can also impact on access to the community - including to mental health services – and provide challenges to medication use.

In addition, mental health needs can provide a barrier to engaging with support for other needs, including engagement with homelessness, substance issues and Adult Social Care services.

Bristol Homeless Health Service

The Homeless Health Service situated in the Compass Centre was recommissioned in 2016. The aims of the service were based on national guidance produced by the Office of the Deputy Prime Minister and the Department of Health "Achieving positive shared outcomes in health and homelessness" They are:-

- To improve access to primary health care for homeless people, and in particular to continue to increase the proportion of homeless people who are registered with a GP, and to ensure that all but the most transient people are registered within an agreed timescale.
- To achieve improvements in the physical health of homeless people.
- To achieve improvements in the mental health of homeless people including the provision of appropriate services in primary care and where appropriate rapid access to secondary care.
- To ensure that all service users who misuse drugs and alcohol are supported in accessing harm minimisation services and that those who wish to do so are able to access treatment.
- To provide a full range of high quality, responsive, safe Primary Medical Services to high need patients identified as requiring registration including:
    a) Comprehensive health assessment, appropriate treatment and stabilisation for patients, including case management for people with long term conditions.
    b) A specific range of additional and enhanced services

We don't have up to date information on the health needs of clients using the service and information from a health needs survey conducted in Bristol in 2010 is considered to be too long ago to illustrate health

[23] This review is not currently publically available but was conducted to inform planning inform ally in lieu of a formal study.

issues amongst people currently rough sleeping in Bristol. However, we are able to draw information from the Health Needs Assessment used in the recommissioning process and information from a Homeless Link Health Needs Audit[24] that states, "Homelessness is a social determinant of health. Poor health is both a cause and a result of homelessness, and there is increasing evidence to show that people who are or have been homeless experience multiple and chronic health problems at a rate significantly higher than the general population….. Those who are homeless on a longer term basis are particularly vulnerable to health problems, and rough sleeping is the form of homelessness most associated with health problems".

The study goes on to illustrate these differences with the general population:

Unhealthy lifestyles

Homeless people tend to lead unhealthier lifestyles compared with the general population. The health audit results from Homeless Link in 2014 found that 77% of homeless people said they smoke, compared to 21% of the general population. 35% did not eat at least two meals a day.

Physical health problems

Homeless people suffer the same health conditions as the general population but theirs are more regular and severe, and they are more likely to die from external causes (Crisis 2011). Of 2500 homeless people surveyed by Homeless Link (2014) 73% reported at least one health problem. 41% said that this was a long term problem compared with 28% for the general population. The most common longstanding physical health problems were musculoskeletal in nature, followed by respiratory and dental. (See table 1) All health problems were more common in homeless people except those affecting the heart and circulation; this may be because these conditions predominantly affect older people and the homeless die young.

Table 1: Longstanding health problems in homeless people compared to the general population

Health issue	Homeless population (%)	General population (%)
Joints and muscular	22.1	13.9
Chest and breathing	15.2	5.8
Dental	15	Unknown
Eyes	14.2	1.4
Stomach	10.4	2.6
Heart and circulation	7.7	10.1
Skin	7.6	0.8
Urinary	4.7	1.5

Source: Homeless Link. The unhealthy state of homelessness: Health audit results 2014. Accessed: http://www.homeless.org.uk/sites/default/files/site-attachments/The%20unhealthy%20state%20of%20homelessness%20FINAL.pdf

Sexually transmitted infections (STIs) and blood borne viruses (BBVs)

There is little data regarding the rate of STIs in the homeless population. The research that is available suggests that this patient group is at increased risk of acquiring STIs and BBVs compared to the general population(Noell et al. 2001)(Beijer et al. 2012), which is often linked to increased risk behaviour (John & Law 2011).(Beijer et al. 2012) There are unmet sexual health needs in the homeless population in terms of supply of information, testing, condom supply and use, contraceptive advice, cervical cytology. (Collins 2003)

[24] https://www.homeless.org.uk/sites/default/files/site-attachments/The%20unhealthy%20state%20of%20homelessness%20FINAL.pdf

Substance misuse

Drug and alcohol addiction represent a significant health problem amongst homeless people, and it accounts for just over a third of deaths.(Crisis 2011) It may lead to homelessness or develop as a means to cope with the difficulties of homeless life and past trauma. Two thirds of homeless people cite drug and alcohol use as a reason for first becoming homeless and those who use drugs are seven times more likely to become homeless than the general population.(Kemp et al. 2006)

The effects of drug and alcohol misuse have a strong destructive force on the physical and mental health of homeless people. The Homeless health link audit in 2014 found that 39% of homeless people said they take drugs or are recovering from a drug problem. 36% had taken drugs in the last month. This is much higher than the general population (0.5%). Cannabis was the most commonly used drug (64%), followed by heroin (27%), prescription drugs (29%) and amphetamines (17%).

27% said they have or are recovering from an alcohol problem. 15.6% drank every day, and two thirds of participants drank more than the recommended amount each time they drank (compared to one third of general population).**Mental health problems**
Mental health problems cannot be considered in isolation from the wider personal and social situation; they can lead to and be caused by breakdown of social relationship, unemployment and eventual homelessness. They are also closely linked with alcohol and drug dependence.

80% of homeless people report some form of mental health issue and 45% have a diagnosed mental health condition – compared with 25% for the general population.(Homeless Link 2014) Homeless people are over nine times more likely to commit suicide, and a report by the Salvation Army found that 53% of homeless women and 34% of homeless men had attempted suicide at least once.(Bonner et al. 2009)

Table 2 shows the prevalence of mental health conditions in the homeless, which is higher than in the general population for all conditions where figures are available. The prevalence of depression is particularly high.

Table 2: Diagnosed mental health conditions in the homeless population compared to the general population

Mental health condition	Homeless population (%)	General population (%)
Depression	36	3
Dual diagnosis	12	No figure available
Personality disorder	7	3-5
Post-traumatic stress disorder	7	No figure available
Schizophrenia	6	1-3
Bipolar disorder	6	1-3

Source: Homeless Link. The unhealthy state of homelessness: Health audit results 2014. Accessed: http://www.homeless.org.uk/sites/default/files/site-attachments/The%20unhealthy%20state%20of%20homelessness%20FINAL.pdf

Barriers to Healthcare

The homeless population face many barriers to accessing mainstream primary healthcare services. Although there have been improvements in the number of homeless people registering with a GP practice (an estimated 90% are registered) (Homeless Link 2014) many still struggle to join. This is often due to

being unable to provide a permanent address or the documentation required to register.(St Mungo's Broadway 2014) Homeless link (2014) report that 7% of homeless people had been refused access to a GP or dentist within the past 12 months.

Homeless people may be stigmatized, and often face negative reactions or difficulty dealing with staff when trying to access healthcare services.(Gorton et al. 2003) Many homeless people report experiencing discrimination, which may make them unwilling to seek help or even result in them being refused treatment. Particularly those with complex needs can find it difficult to manage their emotions and to respond to situations of perceived adversity; their behaviour can be challenging for mainstream services to deal with and this can result in them being excluded from care.

Chaotic lifestyles can affect engagement with healthcare services and homeless people might delay seeking healthcare until their problem is critical, as their health needs are superseded by other, more immediate needs.(Office of the Chief Analyst -Department of Health 2010) A lack of routine makes it difficult to adhere to appointment times,(Griffiths 2002) and contributes towards poor compliance with treatments; missed appointments may in turn lead to exclusion from services. Long waiting times can present an additional challenge, particularly for those with mental health problems or substance misuse who frequently find it difficult to sit in waiting rooms for prolonged periods, or be in close proximity to other people. (Homeless Link 2003)

A lack of language or literacy skills can present an additional barrier to accessing healthcare; for instance there may be difficulty understanding written information relating to appointments or prescriptions. Problems with language or literacy may also deter people from seeking help. Research by St Mungo's found that 51% of homeless people lack the basic English skills needed for everyday life.(Dunmoulin & Jones 2014)

Service provider flexibility is essential in meeting the specific needs of the homeless population, and lack of integration between services and a fragmented or disjointed approach to the delivery of primary care is unhelpful. The multiple health problems frequently encountered by homeless people often mean that support must be accessed from different parts of the health system. This can be difficult to navigate particularly when people are leading chaotic lifestyles and managing issues related to mental health and substance misuse(St Mungo's Broadway 2014)

Use of Health Services

Homeless people are heavy users of health services. A&E visits and hospital admissions are four to eight times higher than for the general public at a cost of an estimated £85 million per year.(Office of the Chief Analyst -Department of Health 2010) Homeless people see a GP 1.5-2.5 more often than then general public. This is proportionately lower than their use of services in secondary care, which suggests that hospital treatment is being preferentially accessed – at increased cost to the NHS.(Homeless Link 2014) National cost data show that the average cost of a GP consultation is £45 and a community nurse £48 per hour, whilst an A&E attendance costs around £113 and an average inpatient stay £1779. (Homeless Link 2014).

HealthLink

HealthLink undertook work with Compass Health to survey the health needs of Compass Health (Health the service in place prior to 2016 at the Compass Centre); the results were included in the Health Needs Analysis for the recommissioning in 2015-16:

Service user profile

Of the 24 clients that Health Link worked with from 1st Jan 2015 – 31st March 2015, the majority (22, 92%) were male and most were of White British ethnicity. This is representative of the patients registered with Compass Health.

Health issues

Table 6 shows the health issues of clients seen. The most common conditions were related to drug and alcohol misuse and to mental health problems. There were also significant numbers of chronic health conditions and a fifth of individuals supported during the reporting period were deemed to be at end of life (assessed using the question: "would the health link team be surprised if an individual we are supporting would die within the next 12 months?") Most clients have multiple and complex health needs, which accounts for the totals adding up to more than 100%.

Table 6: Health issues of patients seen by HealthLink
(January - March 2015)

Health Issues	**No**	**%**
Drug Dependency	18	75%
*Mental Health	18	75%
Alcohol Dependency	14	58%
Asthma or other Respiratory (including COPD)	13	54%
Circulation Issues (including DVT)	12	50%
Hepatitis, HIV, BBVs	10	42%
Acute Infection	9	38%
Cognitive Impairment (any cause)	9	38%
Liver disease	6	25%
Renal failure	5	21%
End of Life	5	21%

*Mental Health includes service users who have symptoms that may be related to alcohol/drug dependency.

Admission and A&E Data

The Health Needs assessment used in the commissioning process for the Homeless Health service also covered admissions to A&E:

Analysis of admission and A&E data from the Bristol Royal Infirmary from April 2011 to March 2014 shows 6618 A&E attendances from 973 people, and 3477 admissions from 650 patients. The data count people in hostels or with no fixed abode and do not include people with a blank postcode or those who are sofa surfing, so it is likely to be a significant underestimate of the true numbers.

Alcohol related problems or mental health issues were the most common reasons for A&E attendance and admission. The average number of hospital stay was 11 nights. The average annual A&E attendance was four times in a year, and the average re-attending rate within 28 days was 267, and 1087 within a year. The total cost of re-attendances over three years was £329,442 (annual cost £109,807). For admissions over the 3 years the extra cost for exceeding trim points was £246,921 with an average extra cost per year of £82,307.

Out of the 973 people attending A and E 190 (19.5%) were not registered with a GP. For people admitted the figure was 6.6% (43/650). For A&E attendance data high GP Practice use was seen from Bedminster Family Practice, Broadmead Medical Centre, Lawrence Hill Health Centre and Montpelier Health Centre. For admission data the practices with the most patients were Bedminster Family Practice, Broadmead Medical Centre, Lawrence Hill Health Centre and The Old School Surgery.

References in this section from the Health Needs Assessment using in the recommissioning process for the Homeless Health Service can be found in Appendix 3.

Impact of COVID-19 and lockdown on homeless health

Some people with long-term health conditions are particularly at risk from COVID-19, including those who have diabetes, who are obese or those with kidney or liver disease.[25] In the general population, people with higher risk will have been contacted by letter to advise them of the risk. For rough sleepers, higher rates of poor physical health and long-term conditions compared with the general population, lower rates of GP registration and the lack of a regular postal address mean that many will be at increased risk from COVID-19 but may not have received any support or notification. Despite this, confirmed cases in the homeless population in emergency accommodation and other settings are extremely low, with 11 cases since the onset of the pandemic and no registered deaths. However, these cases have largely come during November 2020 and correlates with a higher infection rate in Bristol leading up to and during the second lockdown. Compliance with social distancing and infection prevention guidance in these settings has been largely good.

Infection by COVID-19 and social circumstances relating to the crisis, lockdown and economic downturn can impact mental health. According to the WHO, bereavement, isolation, loss of income and fear can trigger mental health conditions or exacerbate existing ones.[26] People may face increased levels of alcohol and drug use, insomnia and anxiety. COVID-19 itself can lead to neurological and mental complications, such as delirium, agitation, and stroke. These challenges have particular significance for the rough sleeping population whose higher rates of mental health need, serious mental illness and substance misuse make them especially vulnerable.

In addition, there are new barriers to accessing services including where services are offering reduced face-to-face support during some periods. A lack of face to face support work, as well as therapeutic treatment has the potential to contribute to increased social isolation. Where sessions are conducted online to comply with social distancing restrictions e.g. group therapy sessions, this presents a barrier to clients who are rough sleeping who may also face digital exclusion and be unable to access remote support online. People with pre-existing mental, neurological or substance use disorders are also more vulnerable to COVID-19 infection and may face a higher risk of severe outcomes and even death.[27]

Challenges around accessing substance use treatment have also been amplified by COVID-19. On average, 40% of people in emergency COVID-19 accommodation have needs around substance use. Alcohol dependent clients who relied on begging and shoplifting to fund their intake are now at risk of withdrawal. Alcohol detox and other treatments are also suspended. As with mental health, group sessions are either not running or available only online, making them inaccessible for most rough sleepers. This scenario has also led to an opportunity around the increased use of Opiate Replacement Therapy, with a significant rise

[25] NHS Guidance accessed 9/11/20 are https://www.nhs.uk/conditions/coronavirus-covid-19/people-at-higher-risk/whos-at-higher-risk-from-coronavirus/

[26] https://www.who.int/news/item/05-10-2020-covid-19-disrupting-mental-health-services-in-most-countries-who-survey

[27] https://www.who.int/news/item/05-10-2020-covid-19-disrupting-mental-health-services-in-most-countries-who-survey

in those clients offered scripts during the first lockdown as clients sought to cope with the loss of income. This presents a potential opportunity for these clients making progress around their substance use.

Client & Staff Voice

As part of the review of our current services we sought to hear directly from existing and former service users in order to understand, in their voice, the needs and experiences of those people using our services. We wanted to hear what people using services for rough sleeping felt is working for them and what is not. What does or could make a real difference to them.

We also wanted to hear from those staff working "on the ground" and directly with the clients in our services, recognising that it is often managers and senior managers that feed into the formal consultation process.

We put together a list of six questions for clients/peers and eight questions for staff (see table below) which we will be asking using a variety of methods including:

- An online survey
- A number of focus groups
- 1-2-1 informal interviews

This pre-consultation took place in October 2019, as an initial step in the wider consultation and recommissioning process which will include formal consultation with senior management teams of our existing providers and other linked homelessness, health and support services.

Analysis of the responses is included in the Commissioning Plan and will be used as a basis for shaping services in the future.

Client Questions:

Sleeping on the streets		**Why are we asking?**
Q1	What led to you to sleep on the streets and do you think there is anything that could have been done either by you, support services or anyone else to Prevent you from rough sleeping?	How can we better help prevent people from rough sleeping?
Q2	When you are housed or in accommodation what do you think would help prevent you from returning to sleeping on the streets?	What helps or hinders people sustaining housing?
Q3	What prevents you or other people you know who are sleeping rough from wanting to or being able to leave the streets?	How can we better help prevent people from rough sleeping/leave the streets?
What has worked well/not so well?		
Q4	Are there any particular people or services that stand out for you in being a really important to you right now?	What is working in the clients view? What services have most impact?

	Who/what are they and why?	
Q5	What didn't work so well for you?	What is not working in the clients view?
Q6	What's most important to you right now? Or what matters most to you right now? (this may not relate to housing)	What matters most to Service Users at different stages of their journey?

Staff Questions:

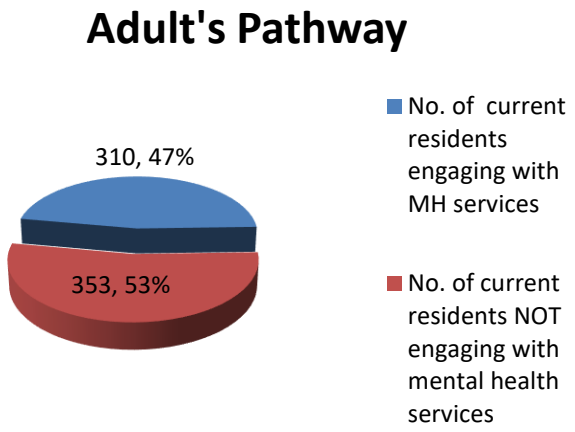
Client work		**What do we want to know?**
Q1	What is working that enables you to do the right thing for the person you are trying to help?	What's working?
Q2	What are the barriers and challenges that prevent you?	What's not working?
Q3	Thinking about our range of services for people who are rough sleeping -which do you think are having the most positive impact?	Where are we getting it right?
Q4	Where do you think we currently have gaps in the services we provide?	Gaps in provision
Q5	What one change in our services do you think would help to reduce rough sleeping?	Creative ideas – 'right placement and support first time' ethos
Staff efficiency, wellbeing and morale		
Q6	What could be changed to enable you to spend more time on the things you feel are important and valuable to your role and your clients?	Valuable work versus non-valuable work
Q7	What motivates and demotivates you in your role?	Staff motivations and morale
Q8	How would you rate your wellbeing at work? (rate 1-5, 1 being low, 5 being high). Why?	Staff resilience and wellbeing to deliver our services.

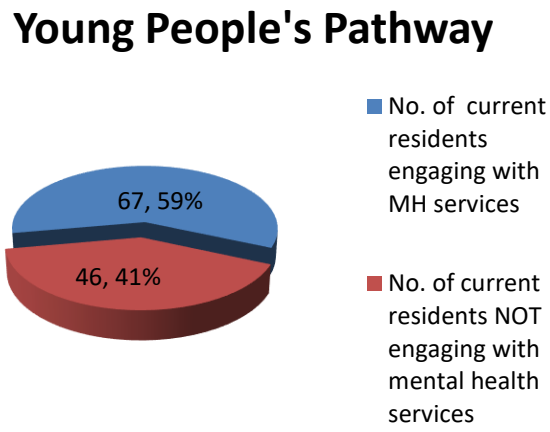
Section F – Profiles of clients in Pathways

Support needs of clients in pathways for adults and young people

The information below sets out a summary of needs from adult and young people's pathways collated from Q4 returns in 2019/20. Not all clients in the Pathways have slept rough but all will have been homeless or been threatened with Homelessness.

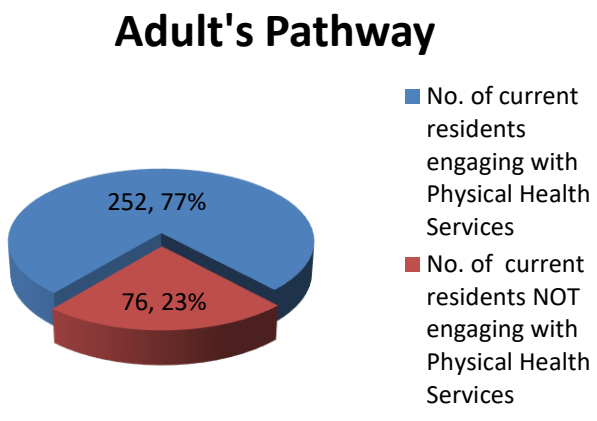
Mental health needs

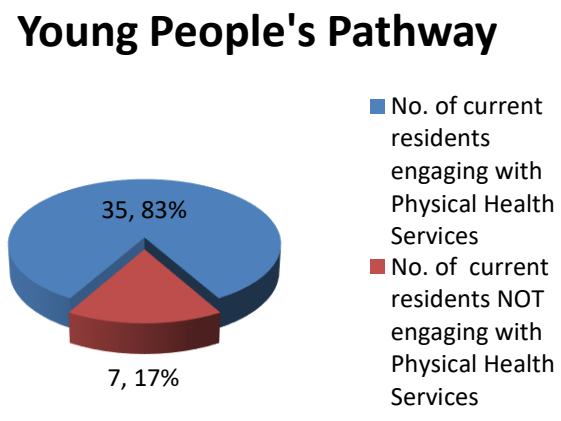




There are 835 residents in the adult pathways of which 663 (79%) have been identified as having support around mental health needs.
There are 261 residents in the young people's pathway of which 113 (43%) have been identified as having mental health needs.

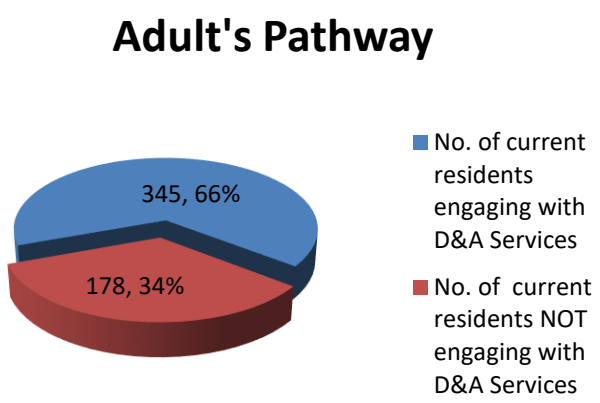
Physical health needs

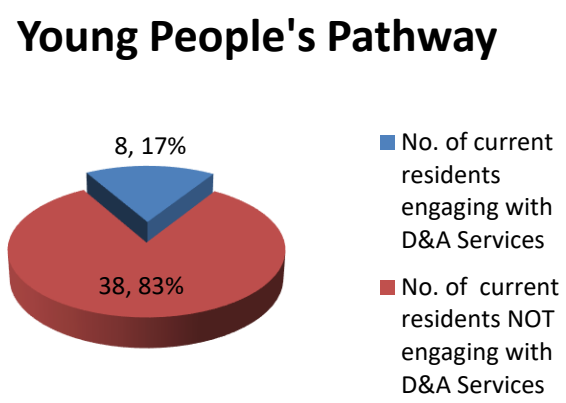




From the 835 total adult residents, 328 (39%) have physical health needs, whilst out of the 261 young people 42 (16%) have
physical health needs.

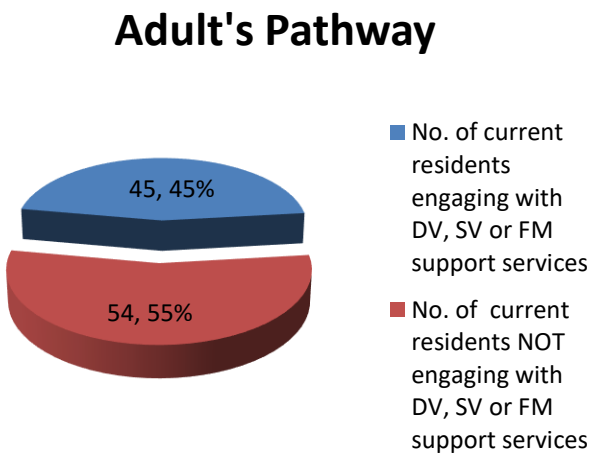
Drugs and alcohol

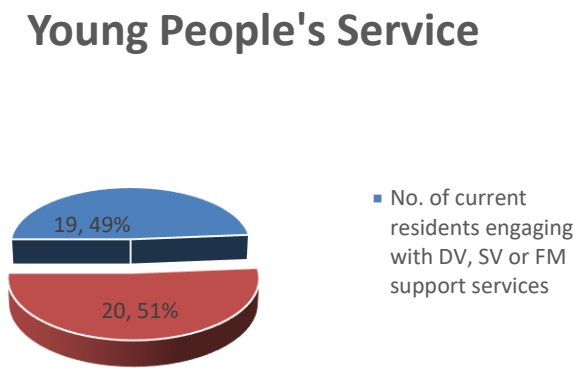




From the 835 adult residents 523 (63%) have identified an issue with drugs or alcohol use. Out of the 261 young people 46(18%) have identified an issue with drugs or alcohol use.

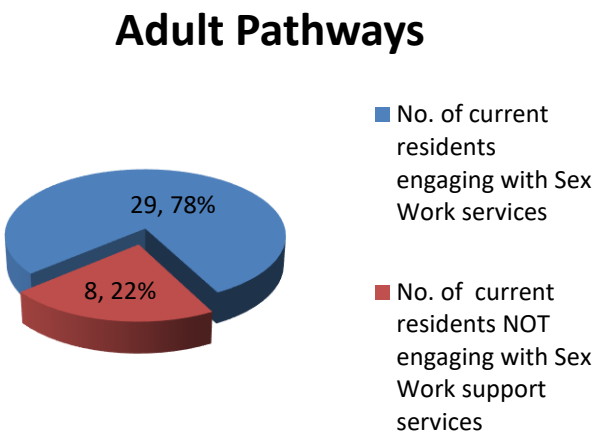
Violence and exploitation

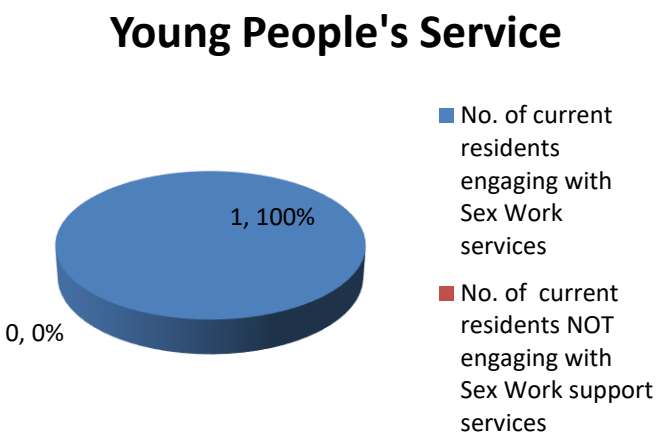




Out of the 835 adult residents, 99 (12%) have support needs relating to domestic violence, sexual violence, child sexual exploitation, trafficking and forced marriage. From the 261 young people, 39 (15%) have support needs in these areas.

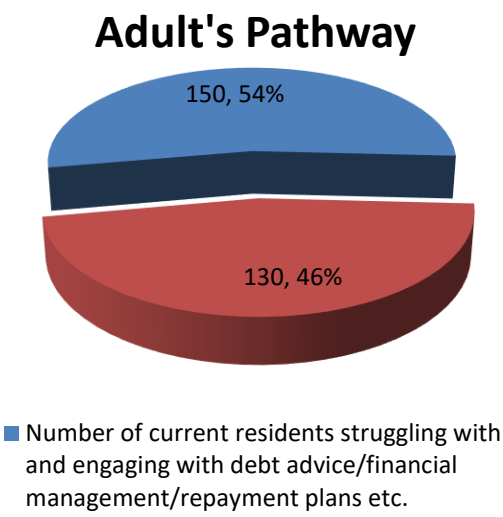
Sex work

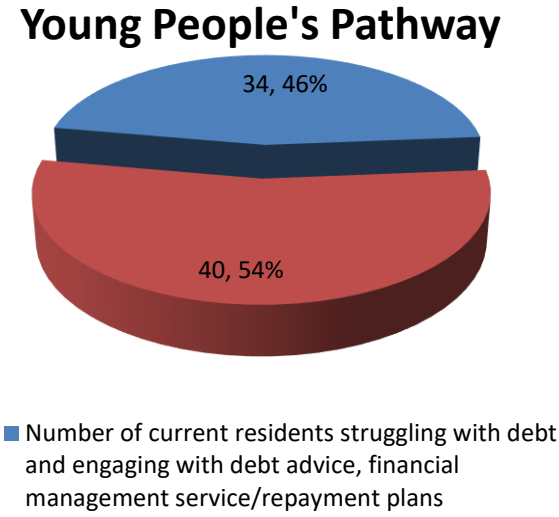




From the 835 residents in the adult's pathway, 37 (4%) of adults have support needs relating to sex work, whilst 1 (1%) of the 261 young people have support needs relating to sex work.

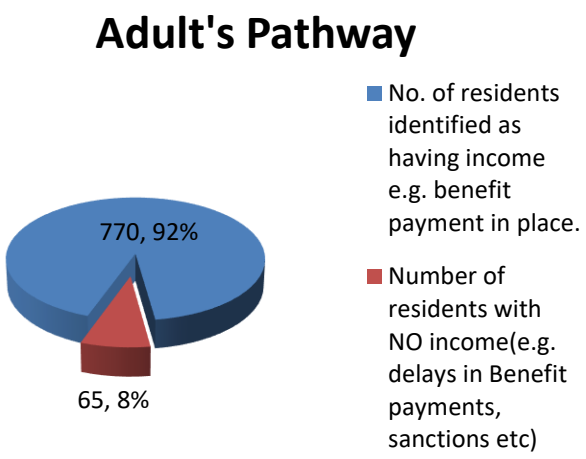
Debt

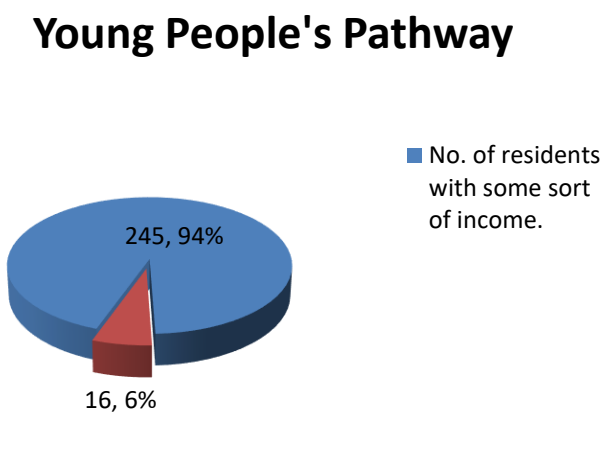




Out of the 835 adults, 280 (34%) are struggling with debts; whilst out of the 261 young people 74 (28%) are struggling with debt.

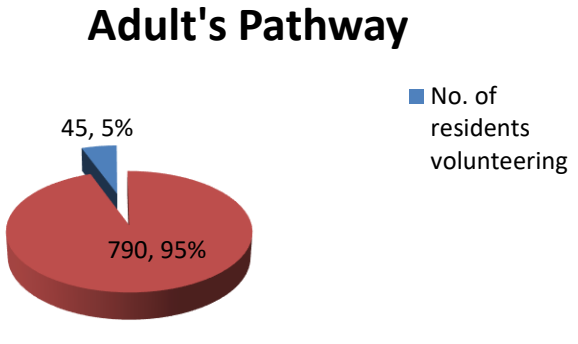
No income

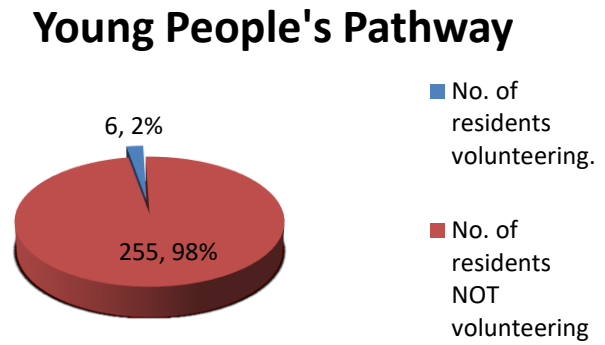




From the 835 adult residents 65 (8%) have no income (e.g. delays in benefit payments and sanctions), whilst out of the 261 young people 16 (6%) have no income.

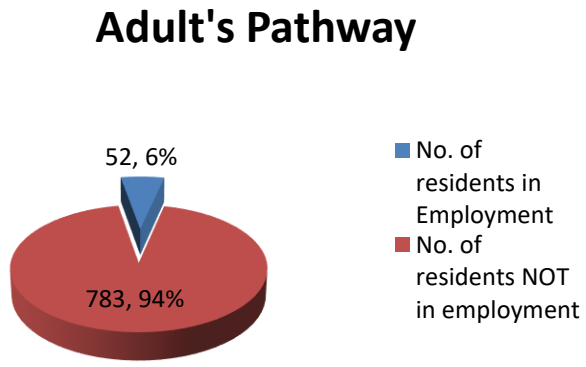
Volunteering

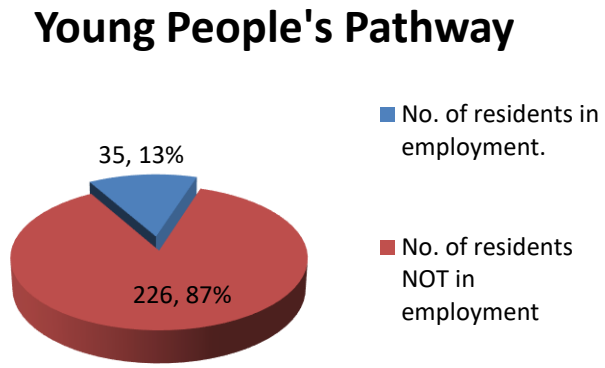




Of the 835 adult residents, 45 (5%) are volunteering and of the 261 young people, 6 (2%) are volunteering.

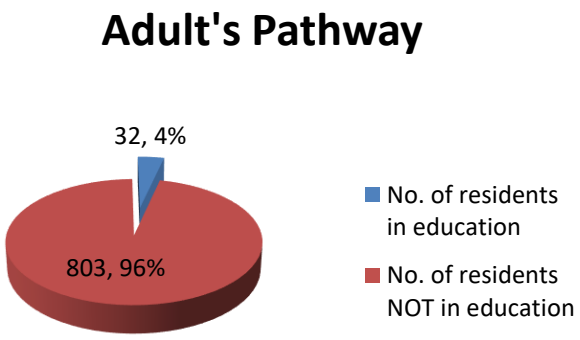
Employment

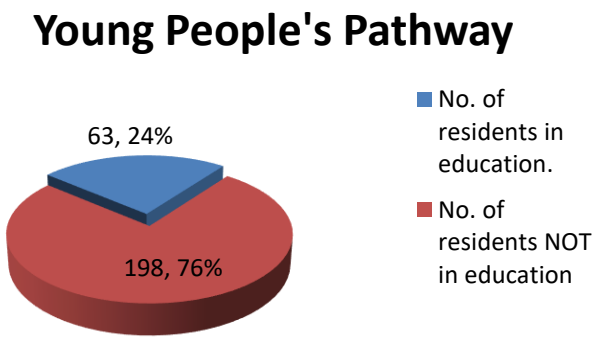




Of the 835 adult residents, 52 (6%) are in employment, whilst out of the 261 young people, 35 (13%) are in employment.

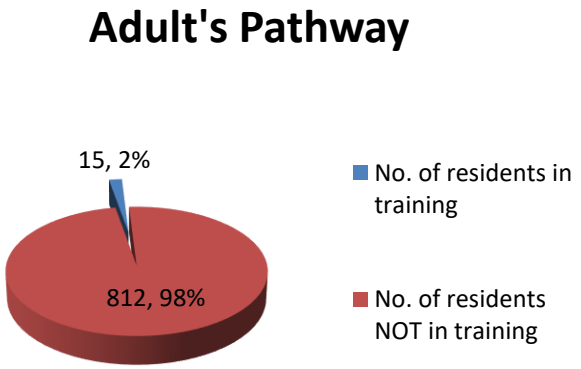
Education

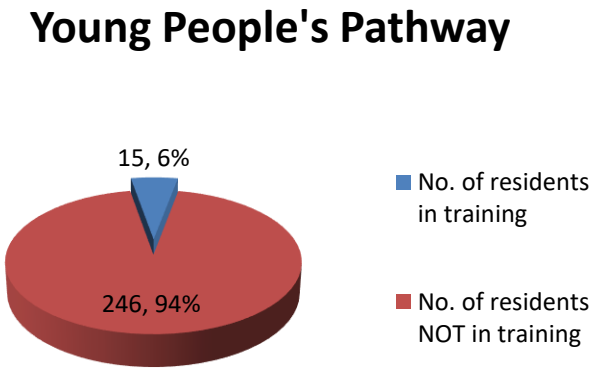




32 people (4%) of adult residents are in education and 63 (24%) of young people.

Training





15 (2%) of adults are on some sort of training and 15 (6%) of young people.

Section G – Rough sleeping & Future Demand

Short-term Rough Sleeping demand during COVID-19

At the time of writing in mid-December, 441 people remain in emergency COVID-19 accommodation. Of these, 107 are in commercial hotels and 334 are in other temporary accommodation. 57 people are known to be sleeping rough in Bristol who have either refused accommodation, been evicted from or abandoned accommodation or have yet to have an offer of accommodation.

Since the announcement of new national restrictions, there has been an increase in homelessness presentations and it is anticipated that the demand for services will increase from these levels during the winter months. At the national level, new homelessness is reported to be rising among young people as a

result of loss of employment, including in sectors such as hospitality and retail, and due to people leaving overcrowded shared accommodation or being served eviction notices despite the evictions ban.[28] Bristol has higher numbers of young people compared with national averages, high levels of people living in shared housing and hospitality and retail are among the top sectors for employment. As a result, the continued disruption to these sectors is likely to drive higher levels of new rough sleeping, including those who may be able to maintain their accommodation with the right support.

Structural Factors behind levels of rough sleeping

In March 2019 Alma Economics produced three reports[29] commissioned by the Ministry of Housing, Communities and Local Government and the Department for Work and Pensions, reviewing evidence on the causes of homelessness and rough sleeping and to provide options for modelling to understand future trends. The findings are divided into:
Personal (personal circumstances of individuals) that include:

- Relationship breakdown (including domestic abuse and violence)
- Mental illness
- Addiction
- Discharge from prison
- Leaving the care system
- Financial problems

And Structural factors (defined as wider societal and economic issues that affect the social environment for individuals) that include:

- Lack of affordable housing
- Decline of social sector housing as a proportion of all housing
- Tighter mortgage regulation and higher costs for first time buyers
- Unfavourable labour market conditions / rising poverty levels
- Growing fragmentation of families
- Reduced welfare provision

To some extent we can commission services that can prevent and alleviate some of the personal circumstances; however, current government policy is not addressing the structural factors. Without any change in government policy in relation to structural causes reducing or slowing the flow of people becoming homeless will be limited.

[28] https://www.theguardian.com/society/2020/nov/08/tens-thousands-homeless-despite-uk-ban-evictions-covid-pandemic

[29] https://www.gov.uk/government/publications/causes-of-homelessness-and-rough-sleeping-feasibility-study

Appendix 1: Nationality of rough sleepers 2017-20, 2019-20 and 2020-21 (quarters one and two)

Nationality	2017-20	%	2019-20	%	2020-21	%
UK	1438	74.1%	626	71.7%	569	66.8%
Poland	93	4.8%	54	6.2%	38	4.5%
Romania	59	3.0%	29	3.3%	36	4.2%
Unknown	52	2.7%	34	3.9%	55	6.5%
Somalia	38	2.0%	9	1.0%	16	1.9%
Portugal	22	1.1%	15	1.7%	9	1.1%
Ireland (Republic of)	19	1.0%	7	0.8%	8	0.9%
Sudan	18	0.9%	7	0.8%	24	2.8%
Lithuania	16	0.8%	6	0.7%	7	0.8%
Slovakia	13	0.7%	8	0.9%	6	0.7%
Spain	12	0.6%	8	0.9%	5	0.6%
Hungary	11	0.6%	4	0.5%	2	0.2%
Italy	11	0.6%	6	0.7%	4	0.5%
Bulgaria	10	0.5%	4	0.5%	4	0.5%
Eritrea	10	0.5%	1	0.1%	6	0.7%
Czech Republic	9	0.5%	4	0.5%	3	0.4%
Iran	9	0.5%	4	0.5%	1	0.1%
Latvia	9	0.5%	7	0.8%	3	0.4%
Gambia	5	0.3%		0.0%		0.0%
Iraq	5	0.3%	1	0.1%	4	0.5%
Afghanistan	4	0.2%	1	0.1%	3	0.4%
Client does not wish to disclose	4	0.2%		0.0%	1	0.1%
Jamaica	4	0.2%		0.0%		0.0%
Morocco	4	0.2%	2	0.2%	3	0.4%
France	3	0.2%	1	0.1%	1	0.1%
Germany	3	0.2%	2	0.2%	4	0.5%
Libya	3	0.2%	1	0.1%	1	0.1%
Netherlands	3	0.2%	2	0.2%	11	1.3%
South Africa	3	0.2%	2	0.2%	1	0.1%
South Sudan	3	0.2%	1	0.1%	1	0.1%
Sweden	3	0.2%	1	0.1%	1	0.1%
Uganda	3	0.2%	3	0.3%	2	0.2%
Algeria	2	0.1%		0.0%		0.0%
Bangladesh	2	0.1%		0.0%		0.0%
Greece	2	0.1%	2	0.2%	2	0.2%
Nigeria	2	0.1%	2	0.2%	2	0.2%
Not known - Europe	2	0.1%	2	0.2%	2	0.2%
Pakistan	2	0.1%	2	0.2%	2	0.2%
Russia	2	0.1%		0.0%		0.0%
Slovenia	2	0.1%	1	0.1%	1	0.1%
Tanzania	2	0.1%	1	0.1%	1	0.1%

Tunisia	2	0.1%	1	0.1%		0.0%
USA	2	0.1%	1	0.1%	1	0.1%
Australia	1	0.1%		0.0%		0.0%
Belgium	1	0.1%	1	0.1%		0.0%
Bolivia	1	0.1%		0.0%		0.0%
Canada	1	0.1%	1	0.1%	1	0.1%
Central African republic	1	0.1%		0.0%		0.0%
Chad (Republic Of)	1	0.1%	1	0.1%		0.0%
Colombia	1	0.1%	1	0.1%	1	0.1%
Congo (Democratic Republic of)	1	0.1%		0.0%		0.0%
Congo (Republic of)	1	0.1%	1	0.1%		0.0%
Denmark	1	0.1%	1	0.1%		0.0%
Kenya	1	0.1%	1	0.1%	1	0.1%
Malta	1	0.1%	1	0.1%		0.0%
Namibia	1	0.1%	1	0.1%		0.0%
Palestine	1	0.1%	1	0.1%	1	0.1%
Senegal	1	0.1%		0.0%	1	0.1%
Syrian Arab Republic	1	0.1%		0.0%	6	0.7%
Ukraine	1	0.1%		0.0%		0.0%
Vietnam	1	0.1%		0.0%		0.0%
Yemen	1	0.1%		0.0%		0.0%
Zimbabwe	1	0.1%	1	0.1%	1	0.1%
Total	1941		873		852	

Appendix 2 – Protect Programme and Cold Weather Fund award 2020-21

Protect Programme	Protect programme Bid	Cold Weather Fund element	Agreed Funding from MHCLG
Spot purchase of hotel rooms for vulnerable rough sleepers	£224,000		£224,000
Increase provision at Hotel for most vulnerable		£58,800	£58,800
extra security at Hotel	£55,860		£55,860
Remodel use of YMCA	£44,276	£78,224	£44,276 plus £78,224,
Extra month for YHA (currently end Feb)	£10,890		£10,890
Dilapidations and deep clean at Hotel & YHCA	£30,000		£30,000
Cost for 20 block from original block (12 month contracts).	£32,375	£32,376	£0
Outstanding cost for 100 block (12 month contracts). Only 6 months covered so far	£16,1460		£0
support for additional 60 people in hotels and HMOs with high support needs	£120,000		£120,000
Spaces held with Pathways accomm for those who need to shield	£2,308		£2,308
Spaces held with Pathways accomm for those symptomatic	£3,840		£2,840
Increase social work team directly linked to emergency accommodation group	£15,280		£15,280
This has been priced to reflect two periods of SWEP (for a period of 5 days)	£32,870		32,870
Food provision to extra people at Arnos, self-isolating or at risk (approx. 20 people)	£10,000	£3,000	£13,000
Co-ordinator for Wick House decant- where around 50 of the 80 occupants (60+%) will be in Protect groups	£17,467		£17,467
Total	£759,506	£140,000 £899,506	**£705,695**

Appendix 3: References Health Needs Assessment using in the recommissioning process for the Homeless Health Service

Beijer, U., Wolf, A. & Fazel, S., 2012. Prevalence of tuberculosis, hepatitis C virus, and HIV in homeless people: a systematic review and meta-analysis. *The Lancet. Infectious diseases*, 12(11), pp.859–70. Available at: http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=3494003&tool=pmcentrez&rendertype=abstract [Accessed May 28, 2015].

Bonner, C. et al., 2009. *The seeds of exclusion 2009*, Available at: http://uki-cache.salvationarmy.org/41281856-cd9d-4c4f-9c43-672e34cae846_The Seeds of Exclusion 2009.pdf.

Collins, E., 2003. A service to address the sexual health needs of the homeless population. *Nursing times*, 99(37), pp.53–4. Available at: http://www.ncbi.nlm.nih.gov/pubmed/14533329 [Accessed June 23, 2015].

Crisis, 2011. *Homelessness: A silent killer: A research briefing on mortality amongst homeless people*, Available at: http://www.crisis.org.uk/data/files/publications/Homelessness - a silent killer.pdf.

Department for Communities and Local Government, 2014. *Homelessness statistics*, Available at: https://www.gov.uk/government/collections/homelessness-statistics [Accessed June 23, 2015].

Dunmoulin, D. & Jones, K., 2014. *Reading counts: why English and maths skills matter in tackling homelessness*, Available at: http://www.mungosbroadway.org.uk/documents/5078/5078.pdf.

Fitzpatrck, S. et al., 2015. *The homelessness monitor: England 2015*, Available at: http://www.crisis.org.uk/data/files/publications/Homelessness_Monitor_England_2015_final_web.pdf [Accessed June 23, 2015].

Gorton, S., Manero, E. & Cochrane, C., 2003. *Listening to homeless people: involving homeless people in evaluating health services*, Available at: http://www.health-link.org.uk/publications/Listening_to_Homeless_People.pdf.

Griffiths, S., 2002. *Health of rough sleepers: sleeping rough in Oxford*, Available at: http://www.fph.org.uk/uploads/r_sleeping_rough_in_oxford.pdf.

Hendry, C., 2009. *Economic evaluation of the homeless intermediate care pilot project*, Available at: www.mungosbroadway.org.uk/documents/4482.

Hewitt, N., 2010. *Evaluation of the London pathway for homeless patients*, Available at: http://www.pathway.org.uk/wp-content/uploads/2013/02/London-Pathway-Report-1st-12-Months.pdf.

Homeless Link, 2010. *Bristol Health Needs Audit - Key Findings*, Available at: http://www.bristol.gov.uk/sites/default/files/documents/housing/homelessness_and_prevention/Bristol Health Needs Audit - Key findings_0.pdf.

Homeless Link, 2003. *Putting homelessness back on the agenda*,

Homeless Link, 2014. *The unhealthy state of homelessness*, Available at: http://www.homeless.org.uk/sites/default/files/site-attachments/The unhealthy state of homelessness FINAL.pdf.

Hutchinson, S., Alcott, L. & Albanese, F., 2014. *Needs to know- including single homelessness in Joint Strategic Needs Assessments*, Available at: http://www.mungosbroadway.org.uk/documents/5380/5380.pdf.

John, W. & Law, K., 2011. Addressing the health needs of the homeless. *British journal of community nursing*, 16(3), pp.134–9. Available at: http://www.ncbi.nlm.nih.gov/pubmed/21378655 [Accessed June 23, 2015].

Jones, G., 2015. *Assistant mayor's briefing - Q4(& year end)2014-15 Homelessness Trends in Bristol (Based on P1E Homelessness provisions data supplied to the CLG 21/04/15)*,

Kemp, P.A., Neale, J. & Robertson, M., 2006. Homelessness among problem drug users: prevalence, risk factors and trigger events. *Health & social care in the community*, 14(4), pp.319–28. Available at: http://www.ncbi.nlm.nih.gov/pubmed/16787483 [Accessed June 23, 2015].

NHS England, 2013. *Everyone counts: planning for patients 2014/15 to 2018/19*, Available at: http://www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf.

Noell, J. et al., 2001. Incidence and prevalence of chlamydia, herpes, and viral hepatitis in a homeless adolescent population. *Sexually transmitted diseases*, 28(1), pp.4–10. Available at: http://www.ncbi.nlm.nih.gov/pubmed/11196044 [Accessed June 23, 2015].

Office of the Chief Analyst -Department of Health, 2010. Healthcare for Single Homeless People. *2010*. Available at: http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_114369.pdf [Accessed June 23, 2015].

Porter, K., 2011. *Bristol Wet Clinic Evaluation 2010-2011*,

Reeve, K. & Batty, E., 2011. *The hidden truth about homelessness - experiences of singles homelessness in England*, Available at: http://www.crisis.org.uk/data/files/publications/HiddenTruthAboutHomelessness_web.pdf [Accessed June 23, 2015].

St Mungo's Broadway, 2014. *A future. Now. Homeless Health matters: the case for change*, Available at: http://www.mungosbroadway.org.uk/documents/5390/5390.pdf.