**All Party Parliamentary Group for Ending Homelessness**

**Homeless deaths –**

**Officers Meeting Minutes**

14 January 2019, 17.00-18.30, House of Commons, Committee Room 17

**Attendees:**

**Witnesses:**

* Maeve McClenaghan, Bureau of Investigative Journalism
* Jez Stannard, Public Health England Senior Programme Manager (Alcohol, Drugs and Tobacco Division)
* Mark Davies, Director of Population Health, Department of Health and Social Care
* Bill Thorpe, Deputy Director of Homelessness and Rough Sleeping Strategy, Ministry of Housing, Communities and Local Government

Neil Coyle MP, APPG Co-Chair

Will Quince MP, APPG Co-Chair

Rachael Maskell MP, APPG Vice-Chair

Sandy Martin MP

Sir Peter Bottomley MP

Liz McInnes MP

Ivan Lewis MP

Baroness Lister of Burtersett

Lord Best

Lord Bird

**Parliamentary Assistants:**

**Apologies:**

Helen Hayes MP

Frank Field MP

Maria Miller MP

Julie Cooper MP

Jo Stevens MP

Lord Judd

Lord Puttnam

Nick Thomas-Symonds MP

Steve Baker MP

Mark Prisk MP

Caroline Lucas MP

Mhairi Black MP

Pauline Latham MP

Angela Rayner MP

Peter Dowd MP

Lord Inglewood

Dr Alan Whitehead MP

Victoria Prentis MP

Sir Paul Beresford

Lord Beecham

Ronnie Campbell MP

Emma Poole, Office of Richard Graham MP

Thomas Claridge, Office of Will Quince MP

**Secretariat:**

Leah Miller, Secretariat to APPG

**Other:**

Matthew Downie, Crisis

Hannah Gousy, Crisis

Jacqui McCluskey, Homeless Link

Pam Orchard, Connection at St Martin’s

Dan Dumoulin, Depaul

Victoria Nevin, Centrepoint

Rory Weal, St Mungo’s

Ieuan ap Rees, West London Homelessness Coordinator

Claudia Essen-Jayes, National Housing Federation

Polly Harrold, National Housing Federation

Jess Mullins, National Housing Federation

Molly Jarritt, New Local Government Network

Pawda Tjoa, New Local Government Network

Maddy Berry, Homelessness Prevention Project

Louisa Steele, Standing Together

Guddy Burnet, Domestic Abuse and Housing Alliance

Sara Nelson, Healthy London Partnership

Steven Pidgeon, Health London Partnership

Paul Anders, Public Health England

Lauren Beadle, Office of Lord Chadlington

Miranda Griffith, North London Housing Partnership

Neelam Sunder, West Midlands Homelessness Task Force

Alex Bax, Pathway

Dr Caroline Schulman, Pathway Homeless Team

Dr Zana Khan, Pathway Homeless Team

Professor Andrew Hayward, UCL Collaborative Centre for Inclusion Health

Duncan Gall, Emmaus

Chris Burgess, Porchlight

Mhairi Tordoff, One Housing

Lucy Smith, Naccom

Lindsey Henderson, Fulfilling Lives

David Parker-Radford, The Queen’s Nursing Institute

Andrew Farris, Rhythms of Life

Dr Al Story, UCL Collaborative Centre for Inclusion Health

Steve Gill, NOAH Enterprise

Paula Harriott, Prison Reform Trust

Rachel Annison, NACRO

Serena Luchenski UCL Collaborative Centre for Inclusion Health

Ranjit Senghera, NHS England

Grainne Bellenie, NHS England

Gina Rowlands, Bevan Healthcare

Hugo Sugg, Homelessness campaigner

Jake Mckey, National Landlords Association

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| **Welcome and apologies** | |
| Introductions | |
| Neil Coyle MP | Co-Chair of the APPG for Ending Homelessness Neil Coyle (NC) MP opened the session by thanking attendees and witnesses for coming.  He explained that the meeting would focus on recent research into homeless deaths in the UK and how we prevent deaths in the future.  The group was pleased to be hearing from Maeve McClenaghan, Bureau of Investigative Journalism; Jez Stannard, Public Health England Senior Programme Manager; Mark Davies, Director of Population Health, Department of Health and Social Care; Bill Thorpe, Deputy Director of Homelessness and Rough Sleeping Strategy, Ministry of Housing, Communities and Local Government.  NC then handed over to Maeve who he explained would present on the Bureau of Investigative Journalism’s Dying Matter’s project, which found that 554 people had died whilst homeless in the UK over a 12-month period. |
| Presentations | |
| Maeve McClenaghan | Maeve McClenaghan (MM) began by explaining how the Bureau’s project had originated.  The project was sparked by a series of stories about homeless deaths. Official figures showed that homelessness and rough sleeping figures had been rising, but there was no official statistic on the numbers of people dying whilst homeless.  Setting out to find out what that figure was, she soon found that there was no comprehensive record of homeless deaths. She had approached coroners who had referred her to the police, the police who had referred her to hospitals, hospitals who had referred her to local councils, and local councils who had referred her back to coroners.  The Dying Matters project had been set up to fill this evidentiary void and gain an understanding of just how many people were dying due to homelessness.  The next step was to consider what methodology to use. She had decided to use a wider definition of homelessness, adopting the Crisis definition which includes people sofa-surfing; sleeping in tents, cars and buses; and living in unsuitable temporary accommodation.  Data was collected through a network of local journalists carrying out research, google searches, an online form, FOI requests and CHAIN data; and a database was set-up recording each death they uncovered. This also included information about each person and their life, where possible, to better highlight the human cost of the crisis. A year-on, the database had recorded 554 deaths.   * 84% of people who had died were men, 16% female and 10% unknown * 84 people had died on the streets, 60 in temporary accommodation and 20 in hospital. * The average age of death was 48 for men and 54 for women – well below the national averages of 79 for men and 83 for women.   There were many causes of death including drug and alcohol misuse, suicide, violence and delayed treatment for medical conditions. The deaths were largely premature and preventable.  Accompanying issues facing people who had died whilst homeless, included No Recourse to Public Funds, family breakdown and ill mental health.  Safeguarding Adult Reviews were important to understand if agencies were working together to support homeless people, understand failings and better prevent deaths occurring in the future.  However, FOI requests filed for 83 homeless deaths found that an SAR had not been carried out in a single one of them.  Furthermore, the research found that only 8 reviews had been carried out into homeless deaths since 2010.  Some councils, including Leeds, had committed to carrying out thematic reviews to understand the wider issues around homeless deaths, although progress on these was unclear.  MM went on to note that Housing, Communities and Local Government Secretary James Brokenshire had said, in response to initial findings from the research published in October, that SARs should be carried out when a homeless death occurs. However, many local authorities were still arguing that the statutory criteria for carrying out an SAR was not being met in the case of homeless deaths.  She argued that it was necessary to review the current statutory criteria and that local authorities should receive better guidance and financial support for carrying out SARs.  Moving on, MM noted that the research had also sparked the ONS to start collecting its own figures on homeless deaths. The ONS had access to death records that TBIJ did not. Its research had found 597 people had died whilst homeless in England and Wales during 2017.  Furthermore, the ONS research had looked at the numbers of deaths in previous years. Very worryingly, this research had uncovered a 24% increase in homeless deaths over 5 years (since 2012).  The ONS’ findings with regards to average age of death and causes had been very similar to TBIJ’s.  The average age of death was recorded as 42 in men and 44 in women. Over half of deaths in 2017 had been due to drug poisoning (32%), liver disease or suicide.  MM highlighted that these were experimental statistics and that the ONS had not committed to continuing to collect these. It was important that the body continue collecting this information, she said.  However, she went on to question whether statistics were enough. It was also important that the individual stories were told. The Bureau of Investigative Journalism would be moving onto new projects, so she questioned who would step in to carry out this work.  Furthermore, she questioned whether SARs were enough, if a change in the statutory criteria for these needed to change or if local councils needed more support and resourcing. |
| Questions | Sandy Martin MP asked whether the research had included any analysis of whether splitting up housing and social care services had any impact on the numbers of people dying whilst homeless.  In response, MM said there was anecdotal evidence that splitting up services and the lack of a joined-up approach resulted in higher death rates.  She went on to highlight that one problem with SARs was that they involved local authorities “marking their own homework”, suggesting that an independent review might be necessary.  Rachael Maskell MP noted that 11 people had died whilst homeless in York. She argued that lack of ownership of responsibility for the problem was an issue and questioned whether any local authorities were using a multidisciplinary approach.  Responding, Director of External Affairs at Crisis, Matthew Downie said we were currently losing precious opportunities to learn the lessons from homeless deaths due to finger-pointing. Noting that local authorities often blamed lack of funding, he suggested that we should find out how much extra resource was needed and make this available to prevent deaths.  Liz McInnes MP asked what the current statutory criteria for an SAR to take place was.  Responding, MM said that the current criteria stated that an SAR should take place where it was suspected that a person had died as a result abuse or neglect.  Homeless Link had published guidance on this to encourage SARs into the deaths of homeless people, she added.  Dan Dumoulin from Depaul suggested that there were missed opportunities for interventions that could have prevented deaths.  In reply, MM agreed that this was correct. For example, many people were being discharged from hospital without their housing need being addressed. She added that Pathway was a great service provided in some hospitals, but that missed opportunities were evident where it didn’t exist.  In addition, lack of priority need for housing resulted in many people’s needs going unmet. People in receipt of benefits were also sometime being refused access to services or housing. Others with mental health problems were being refused access to services as these were not seen as severe enough. She noted that her research had uncovered this in the case of a suicidal woman.  Chief Executive of Pathway Alex Bax highlighted that London ADASS was currently reviewing SAR protocol to enable more SARs to take place. However, he acknowledged that this fell short of an automatic assumption for an SAR for all homeless deaths, which would be preferred.  The adoption of the Pathway model in hospitals in the UK had been too slow, he added, arguing that support was needed to help accelerate the adoption of the model by NHS trusts.  Furthermore, he argued that the increase in deaths was party a marker of austerity and services being cut.  Any incidence of homelessness was a catastrophic and life-shortening event, he continued. A strong safety net was needed to ensure people never had to experience homelessness. |
| Jez Stannard | Public Health England Senior Programme Manager Jez Stannard (JS) noted that homeless people experience some of the most severe health inequalities.  It was shocking that the average age of death of a homeless person was 30 years lower than the national average.  He went on to highlight the contrast in the proportion of the general population dying from drug & alcohol abuse or suicide and the proportion of the homeless population dying from these causes.  Only 0.7% of deaths among the general population were due to drug poisoning, compared to 32% of homeless people.  1.2% of deaths among the general population were due to alcohol-specific causes, compared to 10% of the homeless population.  0.9% of deaths among the general population were due to suicide, compared to 13% among homeless people.  Many homeless people had co-existing problems, including poor physical and mental health, and substance dependence problems.  The Alcohol, Drugs and Tobacco Division of PHE was now responsible for vulnerable groups, including people experiencing homelessness and migrants. This meant it could look more broadly at addressing complex needs.  Statistics from drug and alcohol treatment services showed that 20% of people treated for their dependence were homeless. Whilst this demonstrated that homeless people were accessing treatment services, there was clearly more to do to ensure their needs were being adequately met.  PHE had appointed a new National Homelessness and Rough Sleeping Programme Manager to help coordinate this work.  An audit of health services in the 83 Rough Sleeping Initiative areas was currently being carried out. This will also help inform how the £30m funding announced in the NHS long-term plan would be spent. An additional £2m of Department of Health and Social Care funding will be allocated next financial year to test models that improve access to health services for people with co-occurring mental health and substance misuse problems. |
| Questions | Lady Lister noted that Nottingham was applying an outreach model that employed support workers to work closely with vulnerable homeless people, build up trust and ensure their multiple needs were being addressed.  NC added that Southwark was looking at a similar model as well.  Responding, JS said PHE was very interested in looking at these kind of assertive outreach models.  Following on, NC highlighted that 27% of people were exiting prison with no fixed address, adding that it was unacceptable that people were falling through the gaps like this.  It was suggested that Housing First could be a good model for supporting homeless people with multiple complex needs, including prison leavers.  In reply, JS said that PHE was very interested in this model and added that it was something MHCLG was piloting.  Professor Andrew Hayward from UCL Collaborative Centre for Inclusion Health highlighted a review they had carried out into mortality among excluded groups, including homeless people. The review had found that mortality was higher for all groups. As such, he welcomed that PHE was employing a joined-up approach towards these groups.  Dr Zana Khan, Clinical Lead for The King’s Health Partners Pathway Homeless Team, said that she had seen an increase in the number of patients who were sleeping rough (25%-50%).  More patients were being seen with acute problems and complex needs. However, at the same time, they were losing high quality mental health, drug and alcohol services. It was becoming more difficult to find appropriate housing for patients.  Whilst she welcomed the £30m funding in the NHS long-term plan, she said that the “devil is in the detail”, stressing the importance of this funding going towards high quality, effective, joined-up services.  Ranjit Senghera from NHS England that the £30m would be directed towards mental health services for rough sleepers, but that the detail of these services was still being mapped out.  The funding areas would be announced in the next couple of weeks and the criteria for services set out in mid-February, she added. |
| Bill Thorpe | Bill Thorpe (BT) suggested that the best way to bring down homeless deaths was to reduce the number of people sleeping rough. The immediate focus of MHCLG was to bring down rough sleeping levels and the Rough Sleeping Initiative was employing an approach based on the Lousie Casey model.  £30m funding would be allocated this year to local authorities to support rough sleepers, and a further £45m next year. This would include commissioning more move-on accommodation and healthcare specialists. Housing First would play a crucial role for taking more vulnerable people out of homelessness, he added, noting that the department had funded Housing First pilots in Liverpool, the West Midlands and Greater Manchester.  The Rough Sleeping Strategy also set out the importance of SARs taking place in the event of homeless deaths. |
| Mark Davies | Mark Davies said DHSC was auditing and piloting rough sleeping services that help move people off the street.  Prevention was the most crucial thing, he continued. Rough sleeping was a catastrophic event and reducing the number of these would also reduce the number of deaths.  It was therefore important to tackle the housing crisis and service shortages.  Moving on, he noted that NHS hospitals were now subject to the Duty to Refer, which should help ensure the needs of homeless people and those at risk of homelessness were being picked up.  He also noted that NICE would be publishing guidance to support targeted homelessness prevention, integrated care and recovery later this year, as promised in the Rough Sleeping Strategy.  He went on to note that SARs had never been designed to review every single death of vulnerable people.  DHSC was investing in new medical examiners who would be tasked with reviewing every single death in community and hospital settings and identifying patterns of death. He hoped that there would be an early focus on rough sleepers and homeless people. |
| Questions & discussion | |
|  | Dr Caroline Schulman said that fear of scapegoating was currently a barrier to SARs. She suggested that SARs be mandated to take place in the context of a ‘no blame culture’, as is currently the case with maternal deaths.  Chief Executive of Homeless Link Jacqui McCluskey noted that Homeless Link had produced guidance on SARs. It was agreed that this should be circulated around the APPG members.  Ivan Lewis MP argued that to prevent homeless deaths it was vital to rebuild the architecture of public services which were currently being decimated.  Bill Thorpe noted that local authorities had been asked to publish improved rough sleeping strategies that used a more joined-up approach.  Mark Davies stressed the importance of a personalised approach to service delivery. The audit currently being carried out would help identify gaps in services and which were working successfully.  Guddy Burnet from the Domestic Abuse and Housing Alliance highlighted the problem of women’s hidden homelessness. She said there was some good work on Housing First and women with multiple disadvantages that should be replicated more widely. Most homeless women had experienced sexual violence meaning it was vital that housing and health services also worked with local Violence Against Woman and Girls teams.  Andrew Farris from Rhythm of Life offered to disseminate a report the charity had produced showing the day-to-day struggles facing people living on the streets.  Lucy Smith from NACCOM questioned what could be done to support people with No Recourse to Public Funds.  Bill Thorpe acknowledged that this was the biggest challenge the Government faced in terms of meeting its commitment to end rough sleeping.  However, he pointed to the Controlling Migration Fund which had reopened with an increased focus on tackling rough sleeping. |
| AOB | |
| Close | NC thanked the witnesses and all other attendees for attending and contributing to the meeting. Noting how many people were at the meeting, he said this was indicative of just how important it the issue was.  He invited attendees to get in contact with the Secretariat if they wanted any further information on the work of the APPG. |
| Actions and deadlines | Secretariat to send around minutes to attendees.  APPG to write to relevant Ministers on the points raised at the meeting.  APPG to set up meeting with London ADASS to discuss their SAR guidelines.  APPG to ask ONS if they will be continuing to collect statistics on homeless deaths.  Secretariat to circulate Homeless Link guide on SARs to APPG members. |