September 2025

Homelessness in Blackburn with Darwen:

A Needs Assessment



Blackburn with Darwen Borough Council

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Executive Summary

Homelessness remains a significant public health challenge in Blackburn with Darwen, where individuals facing housing instability experience stark health inequalities. This Health Needs Assessment was undertaken to inform the development of the upcoming drug and alcohol service specification and support wider Public Health interventions, strengthen cross-sector collaboration, and guide the Homelessness and Rough Sleeping Strategy 2026–2031.

A mixed-methods approach was employed, combining quantitative and qualitative data that were analysed and interpreted to identify key health challenges, service gaps, and opportunities for targeted intervention. The assessment draws on 131 survey responses and five focus groups involving professionals and individuals with lived experience, offering both breadth and depth of insight.

The following key findings emerged from the assessment, highlighting the most pressing health and service related issues affecting the homeless population.

Key Findings:

- Mental health needs: 63% of respondents reported a diagnosed mental health condition, with depression and PTSD being the most prevalent.
- Substance misuse and co-occurring conditions: 59% disclosed drug use, and 47% were in recovery. Many described using substances to self-medicate underlying trauma or mental health issues.
- Barriers to healthcare: Although 94% were registered with a GP, access to dental care and continuity of care following hospital discharge were limited. Digital exclusion was a recurring issue, with some referrals rejected due to lack of phone access.
- Lifestyle and health risks: Smoking rates were exceptionally high (82%), and poor nutrition was common, contributing to wider health disparities.
- Housing instability: Frequent moves between HMOs and anxiety around transitions were consistent themes, undermining stability and wellbeing.
- Service gaps: Participants highlighted fragmented support, particularly for those with co-occurring conditions, and expressed a lack of advocacy and coordinated care.

This assessment provides a robust foundation for strategic planning, commissioning, service redesign and interventions. Its findings will inform the development of a multi-agency action plan. The call to action is clear: bold, compassionate, and coordinated efforts are needed to ensure that homelessness is not only addressed, but prevented, alleviated, and ultimately ended.

Introduction

Why Conduct a Health Needs Assessment?

A health needs assessment is a structured, evidence-based process used to identify gaps between current health conditions and desired outcomes within a population. In the context of homelessness, it plays a crucial role in uncovering the specific health challenges faced by individuals experiencing homelessness, evaluating the adequacy of existing services, and guiding the prioritisation of interventions based on severity, urgency, and potential impact.

This assessment was undertaken to inform the development of the upcoming drug and alcohol service specification, strengthen cross-sector partnership working, and support the shaping of the Homelessness and Rough Sleeping Strategy 2026–2031. It ensures that health-related actions are grounded in local data, responsive to real-world needs, and aligned with best practice.

By identifying what is working well and highlighting areas for improvement, with a particular focus on collaboration and investment, this assessment supports more effective resource allocation and strategic decision-making, helping to shape a targeted and impactful action plan.

The Overarching Aim of the Homelessness Health Needs Assessment

To reduce health inequalities among individuals who are homeless or at risk of homelessness in Blackburn with Darwen, by enabling more effective, integrated, and person-centred support.

Scope of the needs assessment:

The population included in this Health Needs Assessment comprises individuals experiencing homelessness within the BwD district. Specifically, it focuses on:

- Adults aged 18 and over, with no upper age limit
- Individuals residing in temporary accommodation designated for homeless people, primarily within large Houses in Multiple Occupation (HMOs).
- People from BwD who are currently in prison on short-term sentences (less than 12 months)
- Individuals in inpatient or rehabilitation services who are of no fixed abode or are expected to return to an HMO upon discharge.
- Rough sleepers
- Note: All temporary accommodation provision for individuals experiencing homelessness is delivered through HMOs or the homeless pods

The following groups are excluded from this assessment:

- Sofa surfers, due to the hidden nature of this population and the need for a different methodological approach.
- Individuals under 18 years old; given the distinct legal, safeguarding, and service frameworks that govern their care and wellbeing.

Methodology

To identify and understand the health needs of the homeless population in Blackburn with Darwen, a mixed method approach was adopted to establish key priorities. This included both quantitative data analysis and qualitative community engagement.

Data Analysis

A comprehensive review of local, regional, and national datasets was undertaken, with particular emphasis on locally sourced information provided by the Housing Needs team at Blackburn with Darwen Council (BwD). This enabled the contextualisation of broader trends and the identification of specific local challenges affecting the homeless population.

Community Engagement Activities

Direct input was gathered from individuals currently experiencing homelessness, as well as those with lived experience. This was achieved through:

Homeless Health Questionnaires: A total of 131 questionnaires were completed during July and August 2025. The survey was developed locally, with feedback from the Homeless Health Needs Assessment Steering Group and was piloted prior to rollout to ensure relevance and clarity.

The survey consisted of 123 questions covering the following topic areas:

- Access of Health Services
- Physical Health
- Mental Health
- Drugs and Alcohol/ Gambling
- Vaccinations and Screening
- Accommodation/ Sleeping Situation
- Demographics

Focus Groups: Five focus groups were conducted in August 2025 across community settings such as the Phoenix Hub, Salvation Army and an HMO setting. These sessions involved individuals with lived experience and key stakeholders, providing qualitative depth and helping to validate emerging themes from the survey data.

Data Protection Impact Assessment, Consent and Data Collection

Participants were required to confirm consent prior to completing the questionnaire, with the option to withdraw consent and associated personal data, at any time. Focus group participants received a detailed Participant Information Sheet, outlining the session format, data collection procedures, and storage protocols.

Both paper and electronic formats of the questionnaire were available, supported by a QR code displayed on posters. Although no electronic submissions were received, both formats allowed participants to pause and resume completion if needed. Questionnaires were often completed with support from partner organisations, enabling clarification and assistance. All responses were self-reported. Data collection took place between 10th July 2025 to 26th August 2025. All data was anonymised to ensure confidentiality and stored securely on Blackburn with Darwen Council's network, with retention policies applied in line with data protection standards.

Introduction

Data Entry and Analysis for Questionnaires

The data from completed questionnaires were entered into Microsoft Forms via Microsoft Teams by the Public Health team at Blackburn with Darwen Council. Analysis was conducted using Microsoft Excel and Microsoft Teams, allowing for efficient data management and thematic review.

All analysis was carried out by the author of this needs assessment, ensuring consistency and contextual understanding throughout the interpretation of findings.

Approach for Focus Groups and Data Analysis

Unstructured focus groups allowed for open, flexible discussions, with varied themes emerging across sessions. To mitigate any risk of psychological harm to participants, the facilitator trained in drug, alcohol, and mental health support and was prepared to signpost individuals to appropriate services if distress occurred.

Thematic analysis using Braun & Clarke's reflexive model (2019 version) enabled deep engagement with the data and reflection on researcher experience. This method was chosen over Interpretative Phenomenological Analysis (IPA) to focus on shared service needs and systemic issues, rather than individual psychological interpretations. A colleague without experience in this area contributed to coding to reduce bias and challenge assumptions.

Quantitative data was analysed using Microsoft Excel, balancing cost efficiency with manual immersion to enhance interpretive depth.

Health & Safety

A comprehensive risk assessment was completed and shared with all partners. Participants were informed of their right to withdraw and were signposted to support services when needed. Sessions were held in trauma informed environments, with trained professionals present to ensure participant safety and emotional wellbeing.



Definition of Homelessness

Homelessness is not limited to sleeping rough. It encompasses a wide range of living situations where individuals lack stable, secure, and adequate housing. According to the charity Shelter, ***"the definition of homelessness means not having a home."***

As shown in Table 1, homelessness includes far more than rough sleeping. Recognising this diversity is essential for designing inclusive services, shaping effective policy, and ensuring that support reaches those who need it most.

Table 1: Categories Commonly Recognised as Homelessness

Category	Description
No accommodation	Individuals, couples, or families with no place to live.
Temporary/emergency accommodation	Staying in shelters, hostels, hotels, or B&Bs.
Staying with others	"Sofa surfing" or relying on family/friends for shelter.
Unable to remain in current accommodation	Due to domestic abuse, unsafe conditions, eviction, or legal barriers.
Leaving institutions	Discharged from hospital, prison, or care with nowhere to go.
Squatting	Occupying property without legal rights.
No recourse to public funds	Often affects migrants and those with unresolved immigration status.
Asylum seekers/refugees	Awaiting accommodation or support.
Mobile accommodation	Living in vehicles or caravans without legal standing or location.
Sleeping rough	Living on the streets or in places not meant for habitation.

A full terminology is included in appendix one.

National Context

Understanding the national policy and legislative framework is essential for shaping local responses to homelessness. Several key strategies and legislative developments inform current practice and priorities.

Homelessness Reduction Act (2017)

- A landmark piece of legislation that placed new duties on local authorities to prevent homelessness.
- Introduced the Duty to Refer, requiring public bodies (e.g. hospitals, prisons, Jobcentres) to refer individuals at risk of homelessness to housing authorities.
- Emphasised early intervention and personalized housing plans.

Ministry of Housing, Communities and Local Government (MHCLG) Rough Sleeping Strategy (2018)

In August 2018, the MHCLG published the Rough Sleeping Strategy, committing to:

- Halve rough sleeping by 2022
- End rough sleeping entirely by 2027

The vision was for all parts of central and local government, alongside businesses, the public, and wider society, to work together to ensure no one has to experience rough sleeping. The strategy introduced cross government initiatives, including:

- Improved health provision for people who sleep rough
- Prevention work in prisons to reduce post release homelessness.

Ending Rough Sleeping for Good (2022)

Published in September 2022, this cross-government strategy builds on earlier commitments and sets out a long-term vision to end rough sleeping sustainably. The strategy defines success as:

"Prevented wherever possible, and where it does occur it is rare, brief, and non-recurrent."

Key investments include:

- £500 million for the Rough Sleeping Initiative over three years
- £12 million for a Test and Learn Programme to trial innovative approaches
- £200 million for the Single Homelessness Accommodation Programme, aiming to deliver up to 2,400 homes with wraparound support, including Housing First models.

National Context

Domestic Abuse Act (2021)

Introduced in April 2021, the Domestic Abuse Act aims to:

- Raise awareness and understanding of domestic abuse
- Improve justice system responses
- Strengthen statutory support for victims and their children

Key housing related provisions include:

- A duty on local authorities to provide support in refuges and other safe accommodation
- Amendments to Part 7 of the Housing Act 1996, granting automatic priority need for homelessness assistance to eligible victims
- A requirement for local authorities to offer new lifetime tenancies to social tenants fleeing domestic abuse
- Updates to the Homelessness Code of Guidance to reflect these changes.

Criminal Justice Bill (2023)

The Criminal Justice Bill, introduced in 2023, replaced the outdated Vagrancy Act 1824. It aims to:

- Protect the public and reduce antisocial behaviour
- Provide police and authorities with powers to address nuisance begging and rough sleeping when it causes disruption, damage, harassment, or distress.

Mental Health and Homelessness

While not a single policy, multiple NHS England initiatives, particularly under the Inclusion Health Framework, have focused on integrated care models for people experiencing homelessness and mental ill health. These include:

- Outreach mental health teams
- Mobile health units
- Integrated care systems targeting socially excluded groups.

National Context

NHS 10-Year Plan—Fit for the Future (2025)

The NHS 10-Year Plan explicitly acknowledges homelessness as a major driver of health inequality. It marks a shift in national health policy by:

- Recognising homelessness as a public health priority
- Supporting Neighbourhood Health Services to identify and intervene early
- Promoting cross sector collaboration between health, housing, and social care
- Improving data visibility through housing status markers in NHS records



Local Context

The developing BwD Homelessness & Rough Sleeping Strategy (2026–2031) has a vision to

"Together in Blackburn with Darwen:
Ending Homelessness, Eradicating Rough Sleeping".

Strategic Priorities of the Strategy

1. Stop Homelessness Before It Starts Bold prevention efforts across all sectors.
2. Guarantee Safe, Suitable Housing for All Emergency shelter and long-term affordable homes.
3. Keep People Housed Support to maintain tenancies and break the cycle.
4. End Rough Sleeping Make it rare, brief, and non-recurrent.
5. Unite for Impact Strengthen partnerships for seamless housing solutions

Integrated Local Support for Complex Needs

Changing Futures

Blackburn with Darwen is one of the areas participating in the national Changing Futures programme, which supports adults facing multiple disadvantages, including homelessness, substance misuse, mental ill health, domestic abuse, and offending. With over 95% of beneficiaries experiencing homelessness, the programme uses trauma informed navigators with lived experience to build trust, advocate for access to services, and support recovery. Evaluation data shows reduced repeat homelessness presentations and increased engagement with drug and alcohol services, demonstrating both cost effectiveness and improved outcomes.

Integrated Support: Blackburn Phoenix Hub

The Phoenix Hub, operated by The Salvation Army in Blackburn, exemplifies integrated, trauma informed support for individuals experiencing homelessness and multiple disadvantages. Operating Monday to Friday, it functions as a multi-agency access point, bringing together housing, healthcare, mental health, substance misuse, and peer advocacy services under one roof.

In addition to specialist support, the Hub meets essential daily needs by providing hot meals, showers, clothing, laundry facilities, and a warm, welcoming space. Visiting services also offer sexual health screening, hepatitis testing, and immunisations, ensuring holistic care is accessible on-site.

The Hub's collaborative model enables seamless referrals and coordinated care. It serves as a cornerstone of Blackburn with Darwen's inclusive response to homelessness, offering a safe, non-judgemental environment where individuals are treated with dignity and compassion.

Local Context

Integrated Local Support for Complex Needs

THOMAS Soup Kitchen and PRE

The Soup Kitchen, also known as the THOMAS drop-in centre, provides hot meals, emergency support, and guidance to help individuals access further services. It is a warm and welcoming environment that not only provides nourishment, but also fosters connection and care.

The Promoting Recovery Engagement (PRE) project, also delivered by THOMAS, is designed to support individuals with substance misuse issues, particularly those who are disengaged from treatment or recovery pathways. PRE places lived experience at the heart of its approach e.g., using peer led, relationship-based interventions. This approach is particularly effective for those who are sleeping rough or at risk of homelessness.

Network of services

Blackburn with Darwen offers a robust network of services supporting individuals facing homelessness, including statutory housing support from the Council, temporary accommodation, and emergency assistance. Organisations like Stepping Stones, Shelter, and Roots Recovery provide tailored support with housing, legal advocacy, addiction recovery, and reintegration. Outreach work is also observed to take place with the rough sleeper's team and the wound care nurse. Additional partners such as Spark offer specialist support in areas such as, substance misuse. Together services form a coordinated, trauma informed ecosystem aimed at meeting complex needs and promoting long term stability.



Factors Affecting Homelessness

Homelessness arises from a complex interplay of structural, societal, and economic determinants, including poverty, deprivation, lack of affordable housing, unemployment, social exclusion, and systemic discrimination. Individuals experiencing homelessness often face profound health and social inequalities, with unmet needs that are both causes and consequences of their housing instability.

There is a high prevalence of psychological trauma and adverse childhood experiences among this population, which further compounds vulnerability and entrenches disadvantage. These intersecting challenges reflect a pattern of severe and multiple disadvantage, requiring coordinated, trauma informed responses.



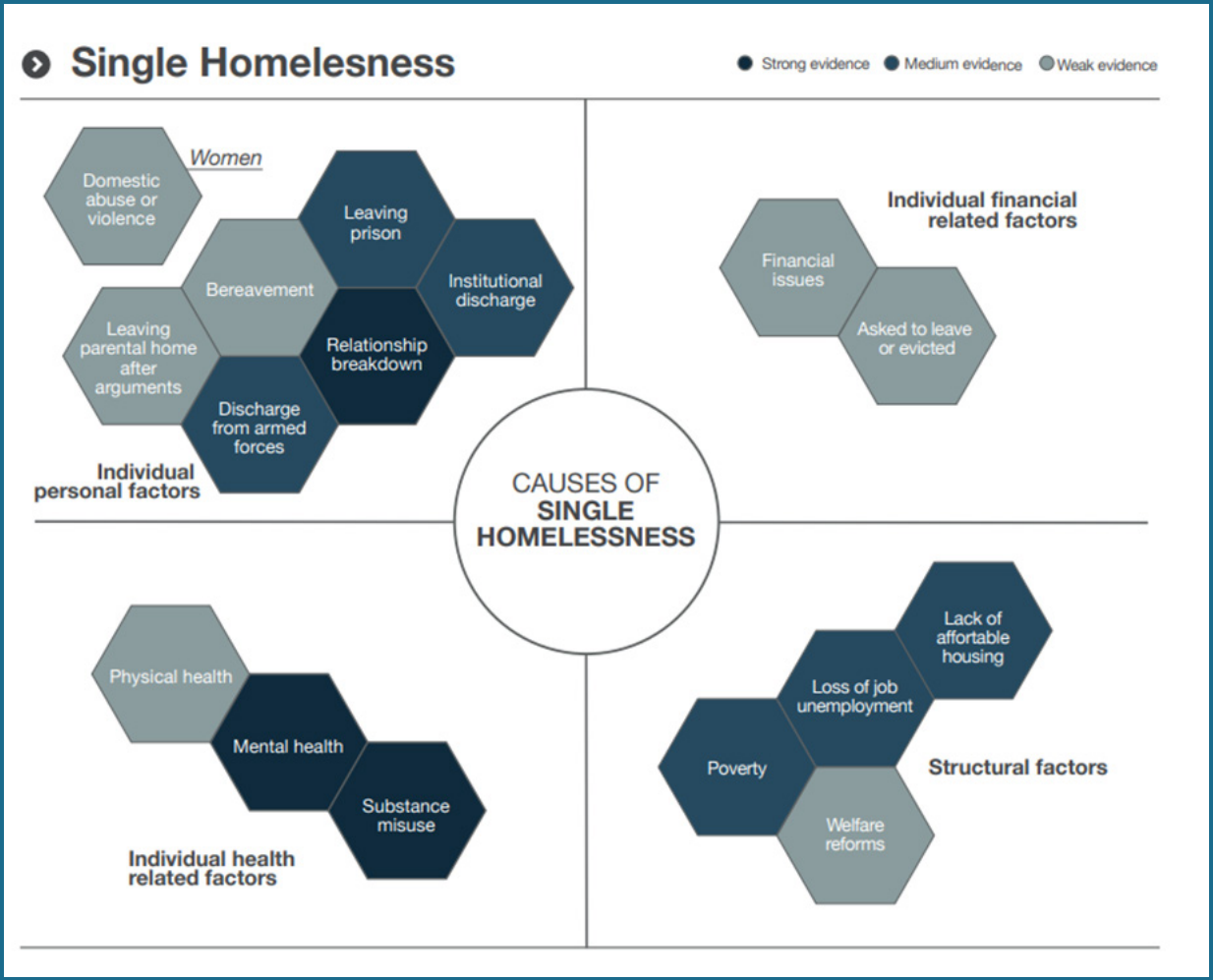
Causes of Homelessness in the UK

Causes of homelessness can be described as individual circumstances, e.g., mental health or experience in the criminal justice system or from wider external factors such as poverty and unemployment[i]. However, the reality is often more nuanced, with multiple overlapping factors contributing to someone's experience of homelessness.

A recent rapid evidence assessment synthesised existing research and evaluated the strength of evidence to identify key contributing factors across three distinct forms of homelessness: rough sleeping, single homelessness, and family homelessness. Understanding these drivers is essential for designing effective interventions, targeting support, and allocating resources appropriately.

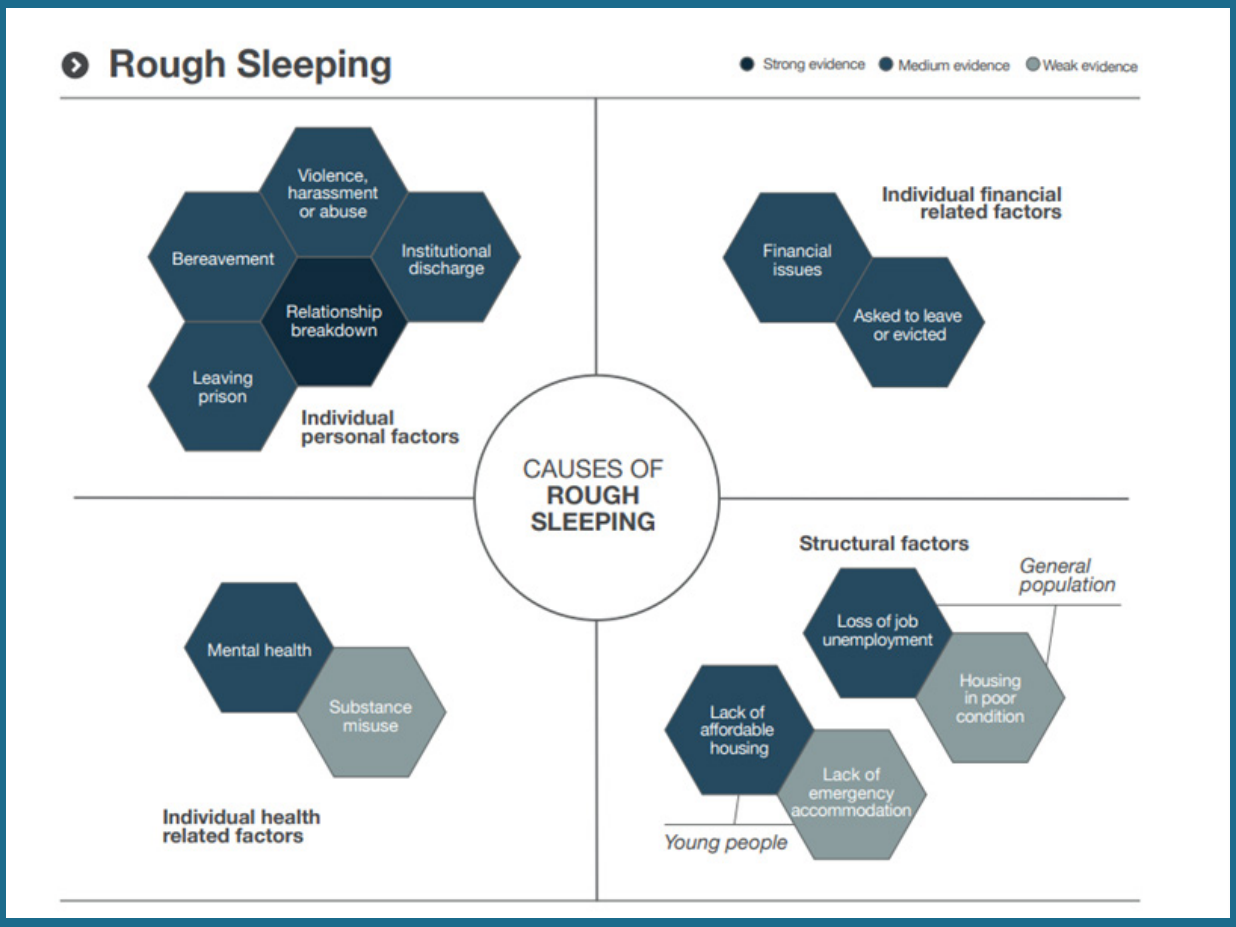
The findings are summarised in figure 1.

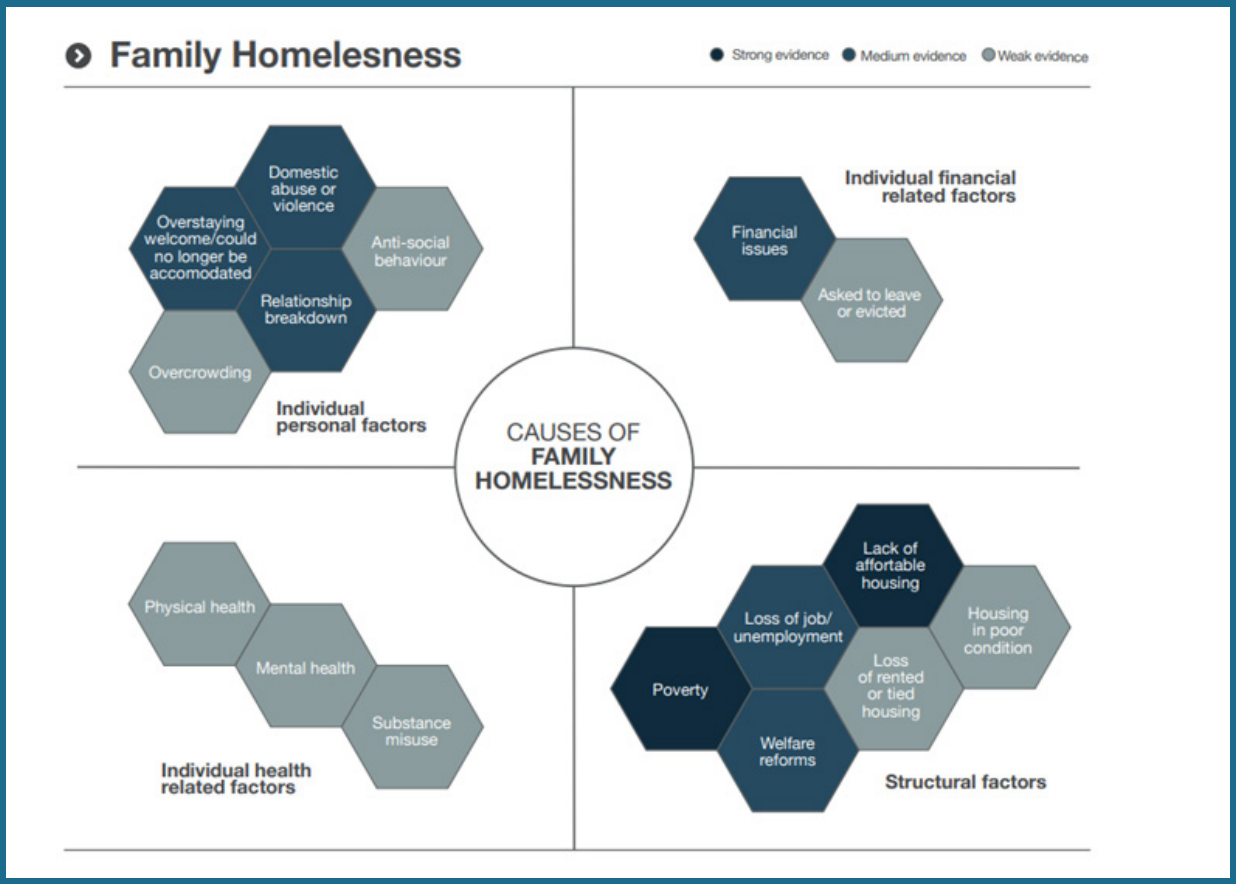
Figure 1: Causes of homelessness for individuals, rough sleepers and families



Causes of Homelessness in the UK

Figure 1: Causes of homelessness for individuals, rough sleepers and families

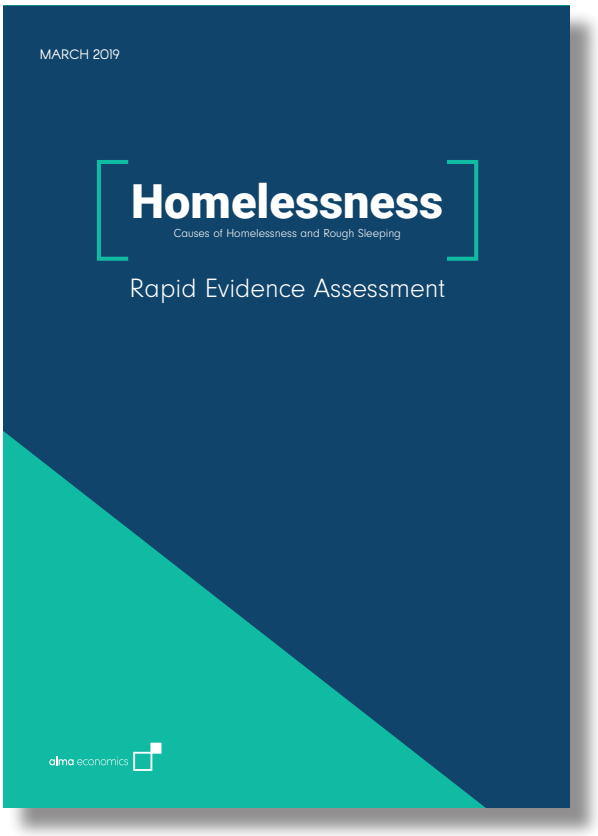




Causes of Homelessness in the UK

This report highlights the multifactorial nature of homelessness in the UK. While individual circumstances such as mental health and relationship breakdown are significant, structural issues, particularly housing affordability, welfare policy, and economic instability are consistently powerful contributors across all groups. Addressing homelessness requires a coordinated response that integrates health services, housing policy, financial support, and social care.

Above taken from [Homelessness: Rapid Evidence Assessment]



Literature review: Impacts of Homelessness

Health inequalities are prevalent among homeless individuals. Increased morbidity and mortality are associated with accident and injury, suicide and long-term conditions including infectious and cardiovascular diseases[i], [ii]. Blood-borne viruses such as hepatitis C are more prevalent[iv] and there are increased risks of human immunodeficiency virus (HIV), and tuberculosis associated with homelessness[v].

There is also a link between poor mental health within homeless populations, where research has found the 45% of individuals describe self-medicating with drugs or alcohol to cope with their mental health problems.

People experiencing homelessness suffer from worse physical and mental health than the general population[vi].

The UK Office for National Statistics (ONS) estimated 741 deaths of homeless people in England and Wales registered in 2021. Of those deaths, drug poisoning accounted for a third of deaths (259 estimated deaths; 35.0% of the total number), which is consistent with previous years reports. The second and third most common cause of death was suicide deaths (n99) and alcohol specific deaths (n71), accounting for 13.4% and 9.6% of deaths respectively and important to note, 87.3% of the total deaths were in men[vii].

Based on ONS data for 2019, the mean age of death for homeless people, was 45.9 years for males and 43.4 years for females in 2019; in the general population of England and Wales, the mean age at death was 76.1 years for men and 80.9 years for women[viii].



Taking a Public Health Approach to Homelessness and Homeless Health

A preventative public health approach to homelessness involves addressing the 'causes of the cause' the deeper, upstream social and structural conditions that increase vulnerability to homelessness long before immediate triggers such as eviction or relationship breakdown occur. These social determinants of homelessness must be tackled to prevent individuals from becoming homeless in the first place. A prevention approach is outlined in the Crisis report "The plan to end homelessness" which summarises the prevention as follows[ix].

Primary prevention:
Action to avoid a person or household becoming homeless. This is applied at a population level. It is often best expressed as 'minimising the risk of problems arising', through national and local strategies in a collaborative approach including poverty alleviation, education and school programmes, or generally increasing the supply of housing.

Secondary prevention:
Action to prevent future homelessness based on a judgement that people/ households are from a high-risk group.

Tertiary prevention:
Rapid rehousing or resettlement for those people who have already experienced homelessness. This is commonly also referred to as 'homelessness relief.'

Demographics Borough wide

In 2023, it was estimated that Blackburn with Darwen had a total resident population of 157,503. There was a 1.1% increase in total borough population from mid-year 2022 to mid-year 2023. This is similar to regional and national changes. The North West population increased by 1.1% and England's population increased by 1% between mid-year 2022-23.

Blackburn with Darwen has a younger age profile than average. 28.3% of the borough's population is aged under 20, compared to 23.5% in the North West and 23.1% in England. Based on 2021 Census data, Blackburn with Darwen had the 6th highest proportion of under 20-year-olds in England.

The 2021 Census is the most recent source of official statistics for the ethnic breakdown of the borough's population, and the relationship between ethnic groups and other social characteristics. The proportion of Blackburn with Darwen residents who described themselves as Indian (15.8%), was the largest amongst authorities in the North West and the proportion of residents who described themselves as Pakistani (17.8%), was the 5th highest amongst authorities in England.

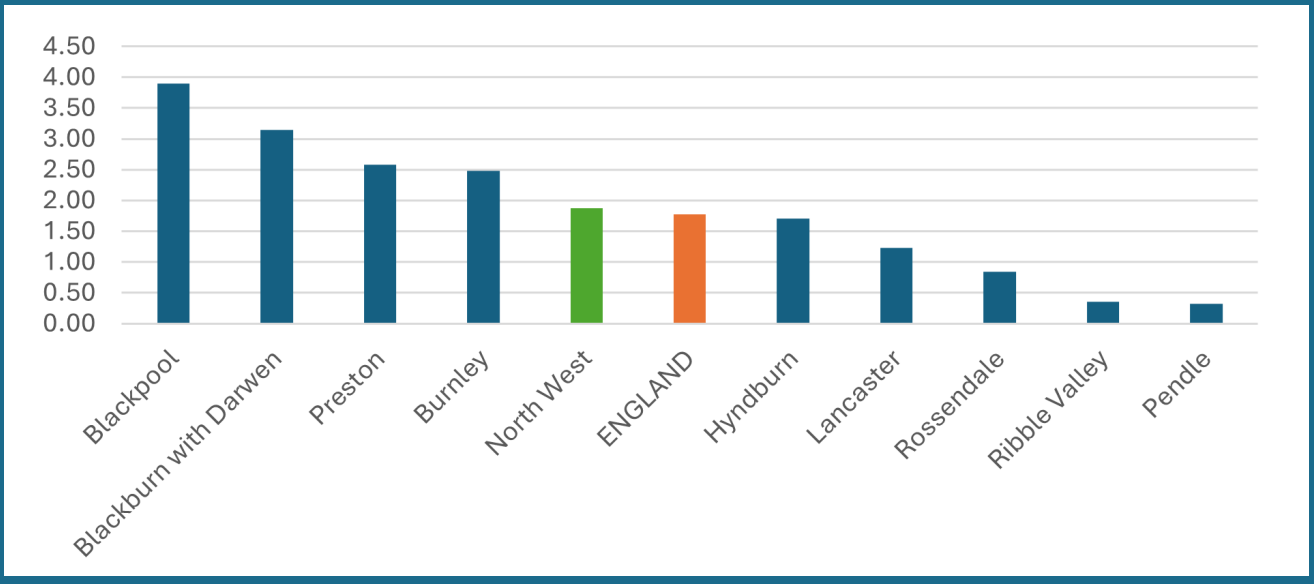
The 2019 Indices of Deprivation, published in September 2019, are constructed from an array of deprivation indicators covering 'domains' such as poverty, health, education, crime, living environment, housing and access to services. The best-known output is the Index of Multiple Deprivation (IMD), which combines 39 indicators. The next Indices of Deprivation is provisionally due to be released in 2025. Index of Multiple Deprivation mapped for Blackburn with Darwen's 91 Lower Super Output Areas (LSOAs). 33 of them (i.e. over a third) are among the most deprived tenth (or 'decile') of LSOAs nationally. Two of these LSOAs, mostly in Blackburn Central ward (outlined in red), are among the most deprived 1% in England, and a further 12 are in the most deprived 5%. Data from the 2021 Census estimates that around 36% of the borough's residents live in an area classified as being in the most deprived decile.

More demographics data for Blackburn with Darwen can be found here Population | Blackburn with Darwen Borough Council.

Homeless Data

Blackburn With Darwen has a consistently higher number of people presenting as homeless. Based on most recent available data, the rates in October to December 2024 found the number of households presenting homeless is higher than the NW and English average with 2.58 per 1,000 in Blackburn with Darwen, 1.87 per 1,000 in NW and 1.77 per 1,000 in England. This is higher than most of the neighbouring and nearby local authorities, with the exception of Blackpool which has a rate of 3.89, as illustrated in figure 2.

Figure 2: Households assessed as homeless per 1,000 (October to December 2024)

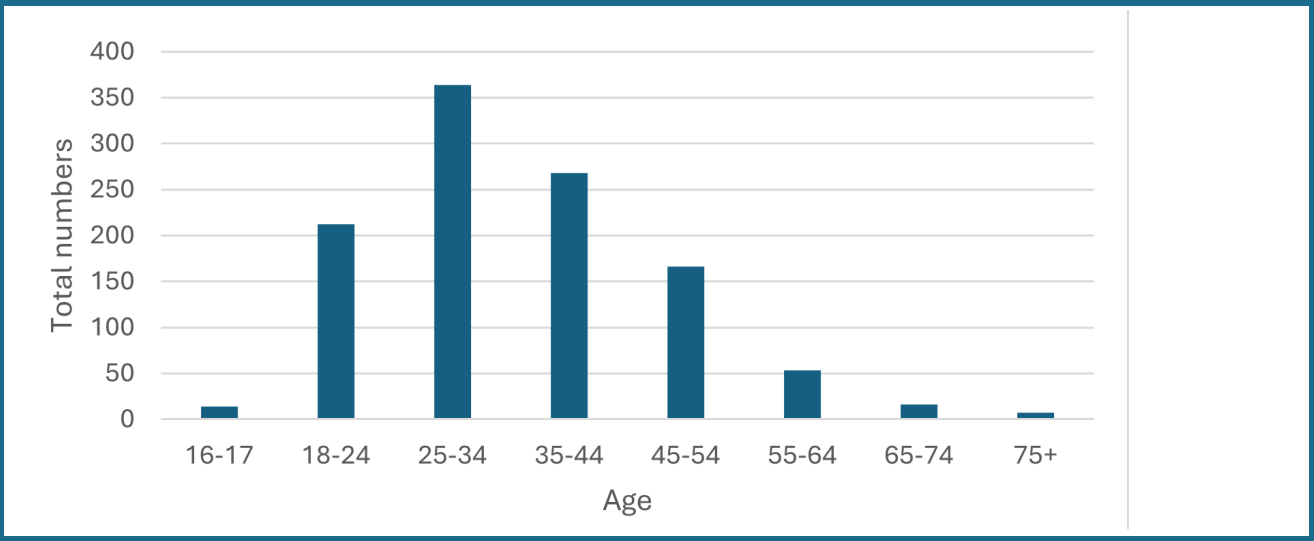


Tables on homelessness - GOV.UK[i]

Demographic data on people accessing the homeless service

In 2024/25, the most common age of people accessing the Blackburn with Darwen homeless service was 26-35 years old (figure 3), which is consistent with previous years data collected by the housing needs team and national data[xi].

Figure 3: Age of people accessing homeless services in Blackburn with Darwen in 2024/25



Internal data hold by Housing Needs Team

Homeless Data

Gender

Males represented 59% of the population who presented homeless in Blackburn with Darwen. This is slightly lower than in England and Wales, where 67.1% males presented homeless[xii].

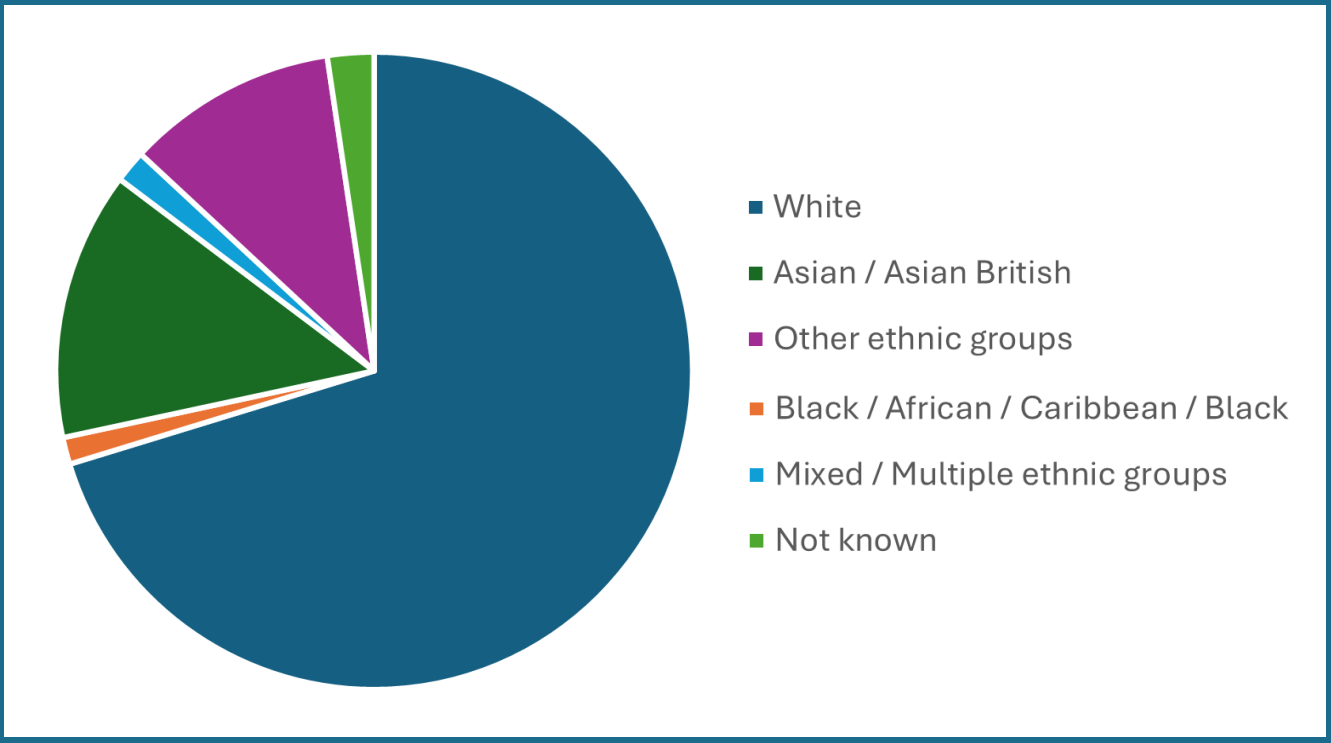
Ethnicity

A study in 2025 by the Institute for Social Policy, Housing, and Equalities Research (I-SPHERE) at Heriot-Watt University found that minoritised communities face highly disproportionate risks of homelessness. For example, Black people are almost four times as likely to face statutory homelessness as White people[xiii] and in contrast, Asian communities tend to experience lower rates of homelessness[xiv].

Blackburn with Darwen has a diverse population, 0.6% of residents are Black, and over 36.5% are South Asian. This data brings to light that the applications submitted for prevention or relief duty in 2023/24 do not reflect the representation of the Blackburn with Darwen population. 70% of individuals who present for homelessness support are White compared to 14% who are Asian, despite their substantial representation in the local population.

This discrepancy may reflect the lower prevalence of homelessness among the South Asian communities, as suggested by national research. However, it could also point to barriers in accessing support services, such as cultural stigma or lack of awareness. These findings highlight the importance of targeted outreach and culturally responsive services to ensure equitable access for all communities.

Figure 4: Ethnicity of Main Applicant Owned a Prevention or Relief Duty, 2023-24 in Blackburn with Darwen



Internal data hold by Housing Needs Team

Prevention and Relief Duty

Prevention duty

Local authorities must take reasonable steps to prevent homelessness for any eligible applicant who is at risk of homelessness within 56 days, regardless of priority need. This can involve assisting them to stay in their current accommodation or helping them to find a new place to live.

Relief duty

When an applicant is already homeless, councils must take reasonable steps to help them secure suitable accommodation. For example, providing a bond guarantee, funding a rent deposit or working with a private landlord to make properties available.

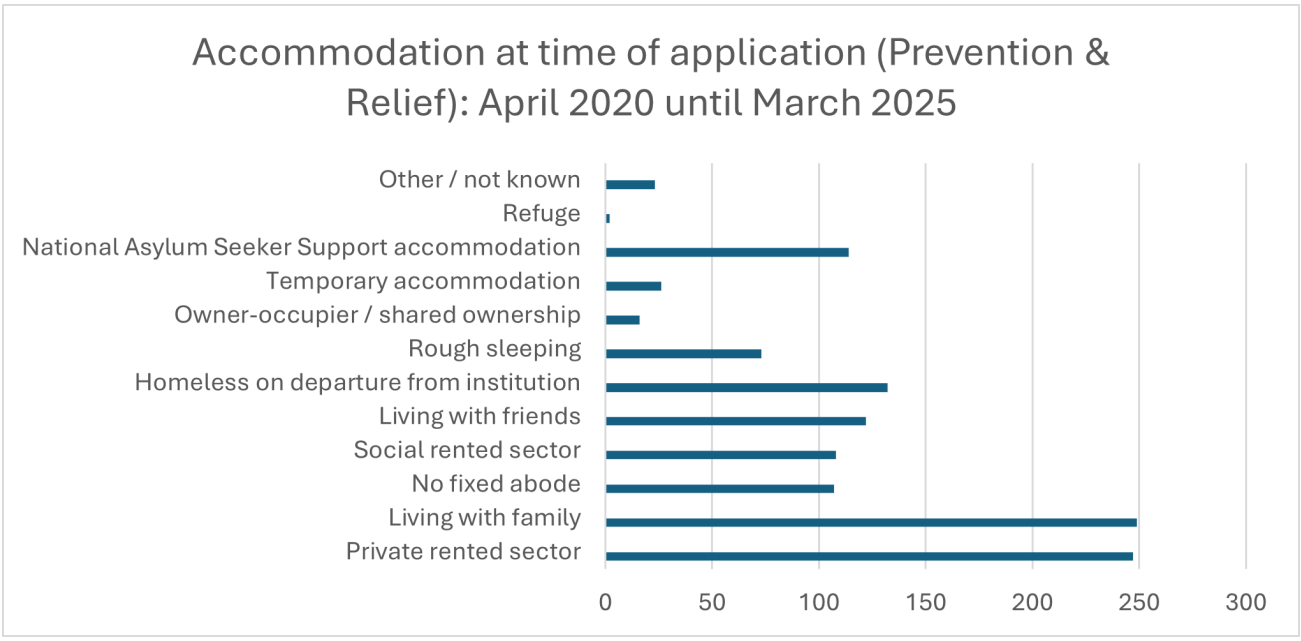
This shift from prevention to relief signals a growing urgency in local homelessness responses and the need for targeted interventions that address both upstream and crisis level factors.

Accommodation prior to applications for prevention or relief duty

Between 2020 and 2025, the majority of individuals accessing homelessness services in Blackburn with Darwen were either living with family or in the private rented sector prior to applying for prevention or relief duty, as illustrated in figure 5.

This pattern reflects the key reasons for homelessness which include family breakdown or tenancy loss, which may result from affordability issues, eviction, or insecure rental arrangements. Understanding these accommodation pathways is crucial for shaping early intervention strategies. Strengthening tenancy sustainment support, promoting mediation services for families, and improving access to affordable housing could help reduce the number of people reaching crisis point.

Figure 5: Accommodation at time of homeless application, April 2020 to March 2025



Internal data hold by Housing Needs Team

Prevention and Relief Duty

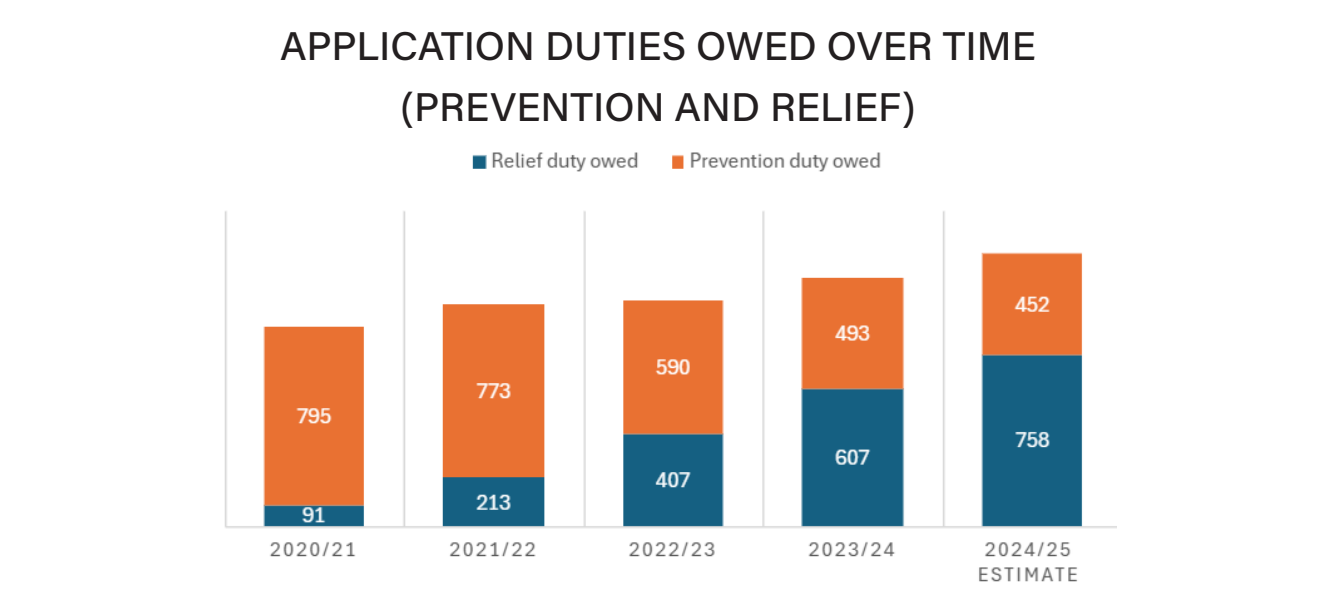
Trend data on prevention and relief duty in Blackburn with Darwen

Over the past five years, Blackburn with Darwen has seen a notable shift in homelessness duty application, as illustrated in figure 6

Prevention duty applications have declined from 795 in 2020/21 to an estimated 452 in 2024/25

In contrast, relief duty applications have risen sharply from 91 in 2020/21 to an estimated 758 in 2024/25. This sharp increase indicates that more individuals are presenting as already homeless, requiring urgent assistance to secure accommodation.

Figure 6: Prevention and Relief Applications in Blackburn with Darwen (2021/ 22 to 2024/25)



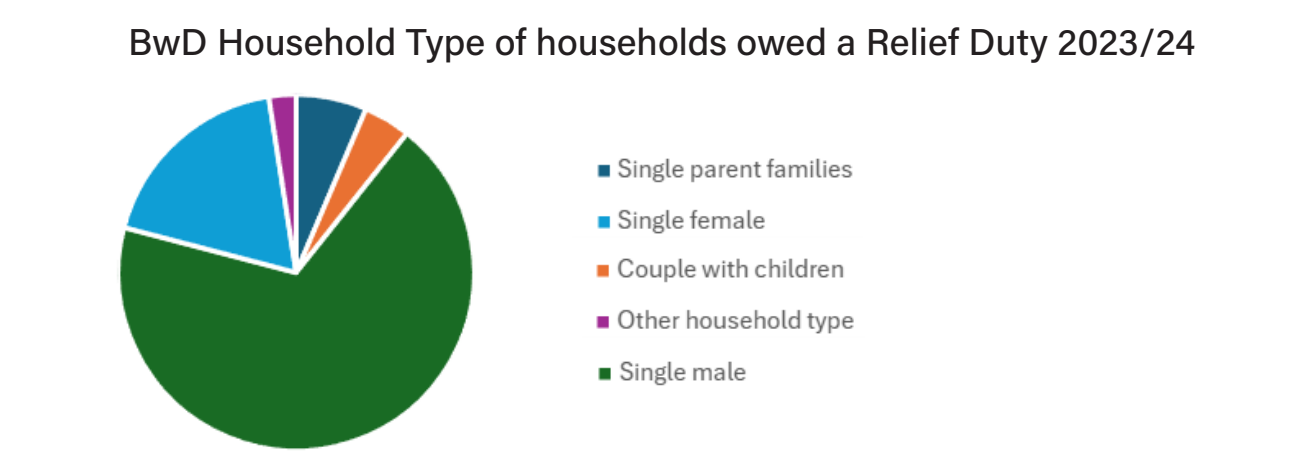
Internal data hold by Housing Needs Team

Prevention and Relief Duty

Composition of household presenting for relief or prevention duty

Relief duty
In Blackburn with Darwen, 607 individuals presented for a relief duty during 2023/24. The majority (68%) were single males, while 10% were single parents or couples with children, as illustrated in Figure 7.

Figure 7: Composition of household presenting for relief duty (2023/24)

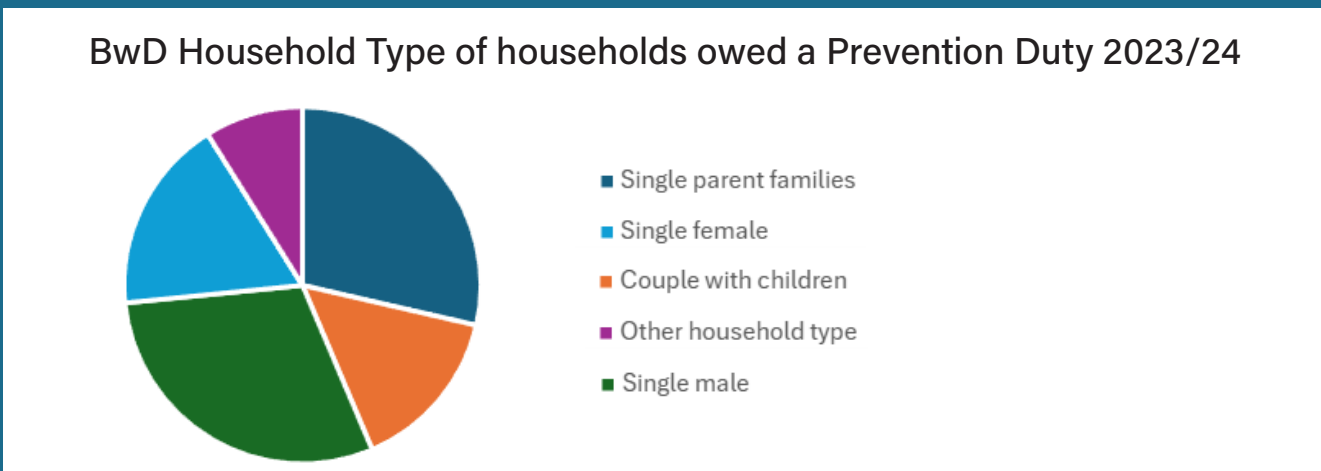


Internal data hold by Housing Needs Team

Prevention duty
Unlike the relief duty, the prevention duty in Blackburn with Darwen shows a different demographic pattern. In 2023/24, 215 households with children, including both single parents and couples, accessed the service, accounting for 44% of all prevention duty presentations. In contrast, single males made up 30%, as shown in figure 8.

This indicates that families are more likely to engage with services at an earlier stage, seeking support before homelessness occurs, whereas single males more often present once homelessness has already happened.

Figure 8: Composition of household presenting for prevention duty (2023/24)



Internal data hold by Housing Needs Team

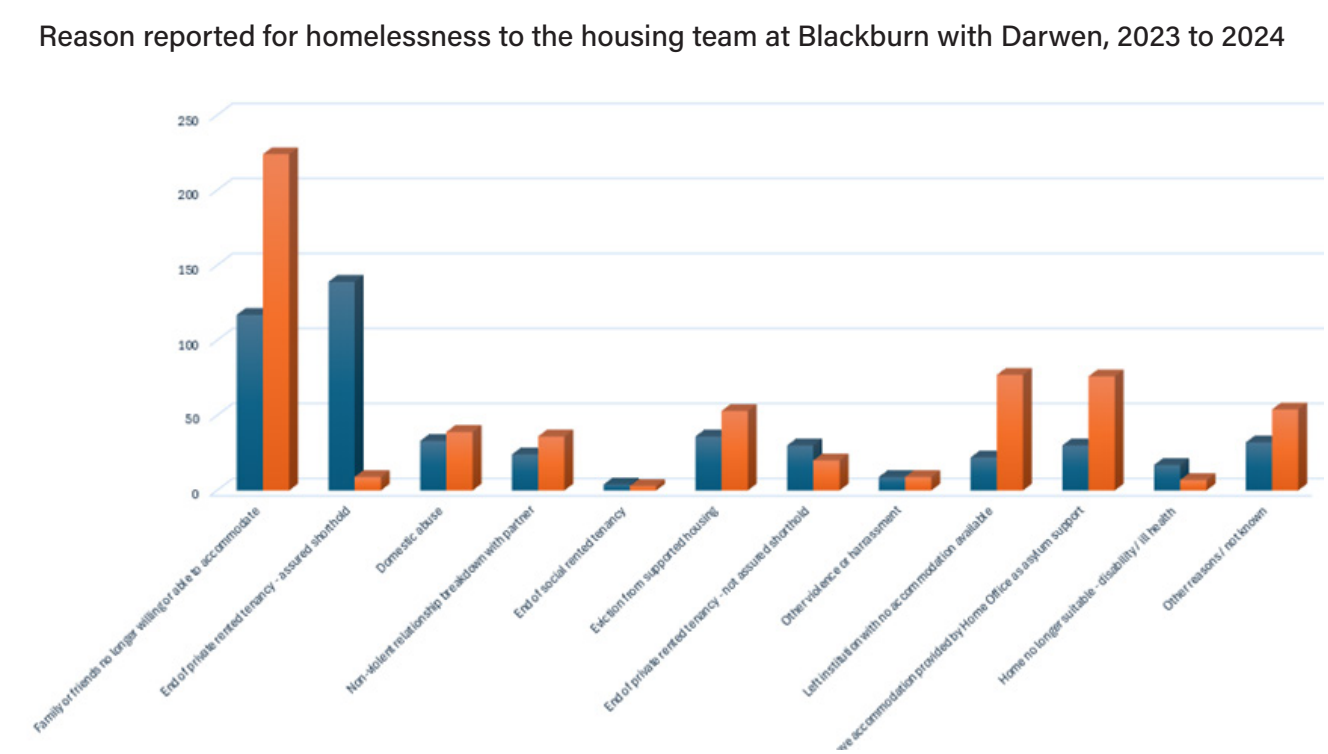
Prevention and Relief Duty

Reasons for Homelessness Presentations in Blackburn with Darwen (2023/24)

People present as homeless for a variety of reasons, as outlined in figure 9. In Blackburn with Darwen, the most common reason for relief duty was that family and friends were no longer willing or able to accommodate, highlighting the fragility of informal housing arrangements.

In contrast, the primary reason for prevention duty was linked to the end of tenancy agreements, indicating that many households sought support before losing their accommodation.

Figure 9: Reason reported for homelessness (2023/24)



Internal data hold by Housing Needs Team

Trends in Prevention Duty Triggers (2020/21–2023/24)

Over the past four years, the most consistent reason for accessing homelessness prevention services in Blackburn with Darwen has been family or friends no longer willing or able to accommodate, with this category peaking in 2023/24.

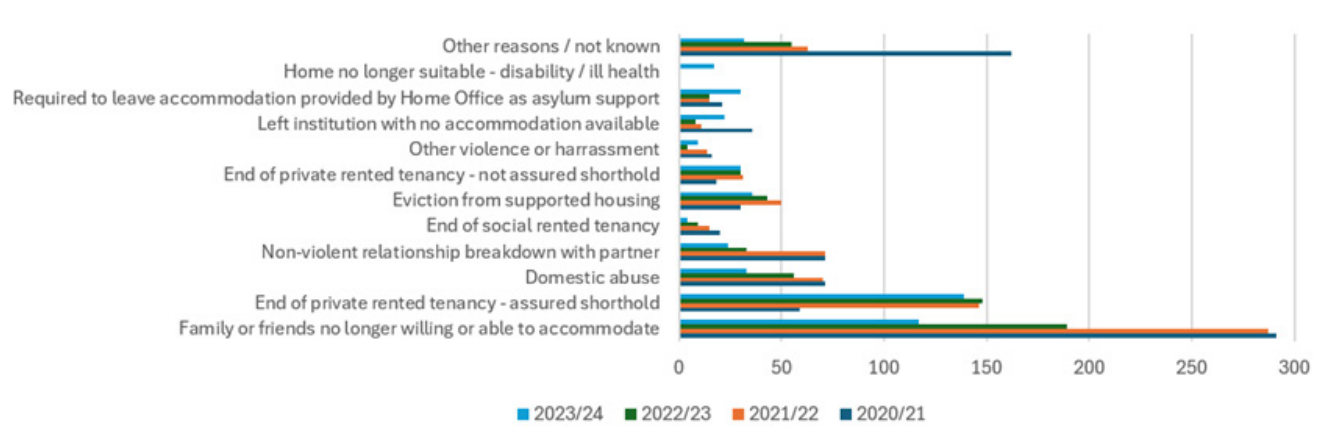
The second most common reason throughout the period was the end of a private rented tenancy (Assured Shorthold Tenancy), which showed a slight increase in 2023/24, reflecting growing pressures in the rental market.

Domestic abuse remained the third highest ranking reason across all years, with figures remaining relatively stable, indicating a persistent need for targeted support.

Notably, non-violent relationship breakdown with a partner has shown a rising trend in the last two years, suggesting emerging vulnerabilities that may require more nuanced intervention strategies, as illustrated in figure 10.

Prevention and Relief Duty

Figure 10: Reason for accessing the homeless service for prevention duty (2020/21–2023/24)

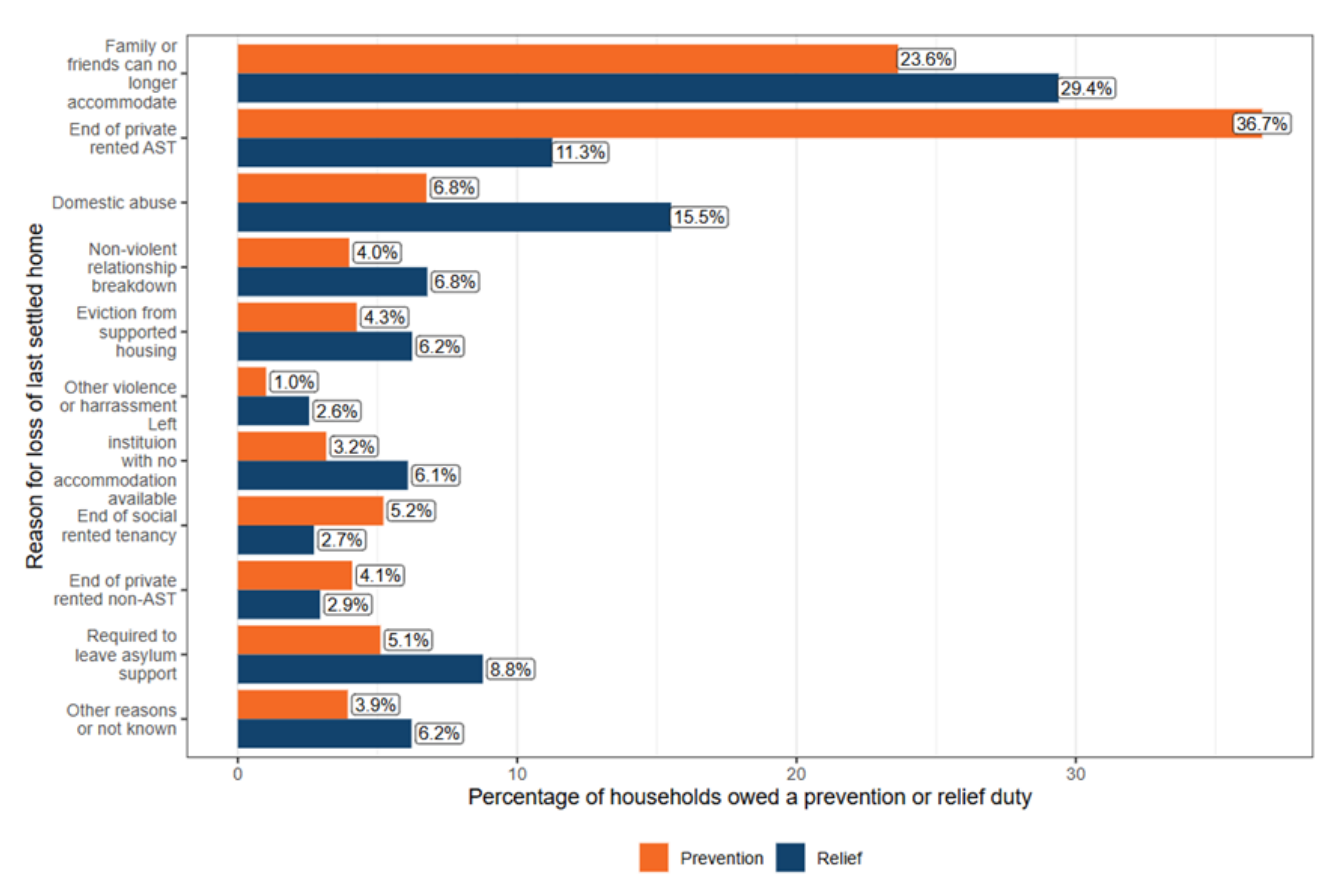


Internal data hold by Housing Needs Team

Comparing to National Data

The comparison shows strong alignment between local and national trends in key areas, particularly informal housing breakdown and private rental instability as seen in figure 11.

Figure 11: Percentage of households owed a prevention or relief duty by their reason for loss of last settled home in January to March 2025 (national data)



Statutory homelessness in England: January to March 2025 - GOV.UK

Support Needs of Those Owed a Homelessness Duty (2023/24)

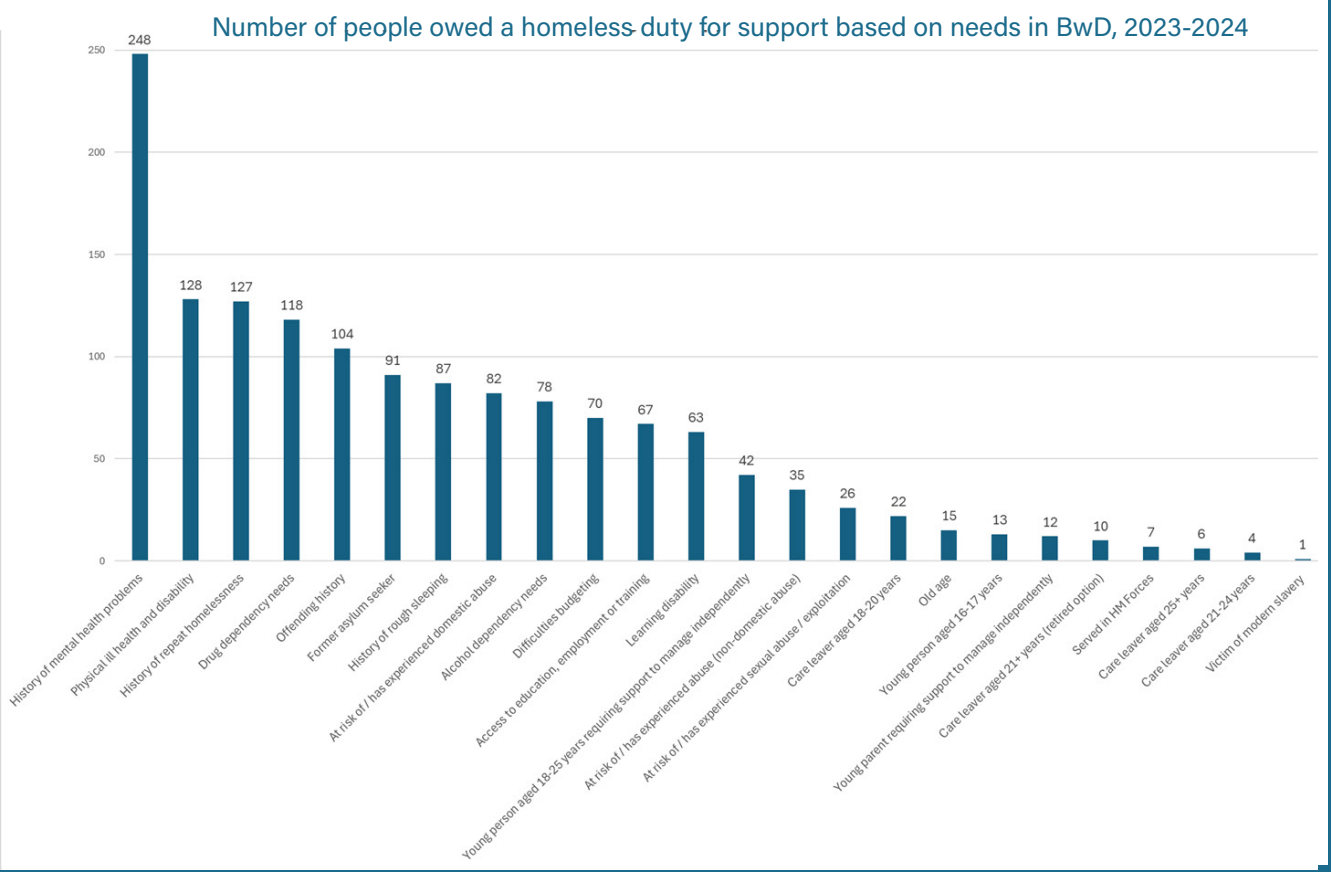
In Blackburn with Darwen, individuals owed a homelessness duty in 2023/24 were assessed for additional support needs as seen in figure 12. The most frequently reported need was mental health support, affecting 22% of those assessed.

Other commonly identified support needs included:

- Physical ill health and disability
- Substance use
- History of repeat homelessness

These findings highlight the complex challenges faced by those experiencing homelessness, the importance of integrated support services that address both housing and health related vulnerabilities.

Figure 12: Support needs reported for people owed a homeless duty in 2023-24 (Internal data hold by Housing Needs Team)



Prevention and Relief Duty

Homelessness Among Adults Aged 55 and over in Blackburn with Darwen

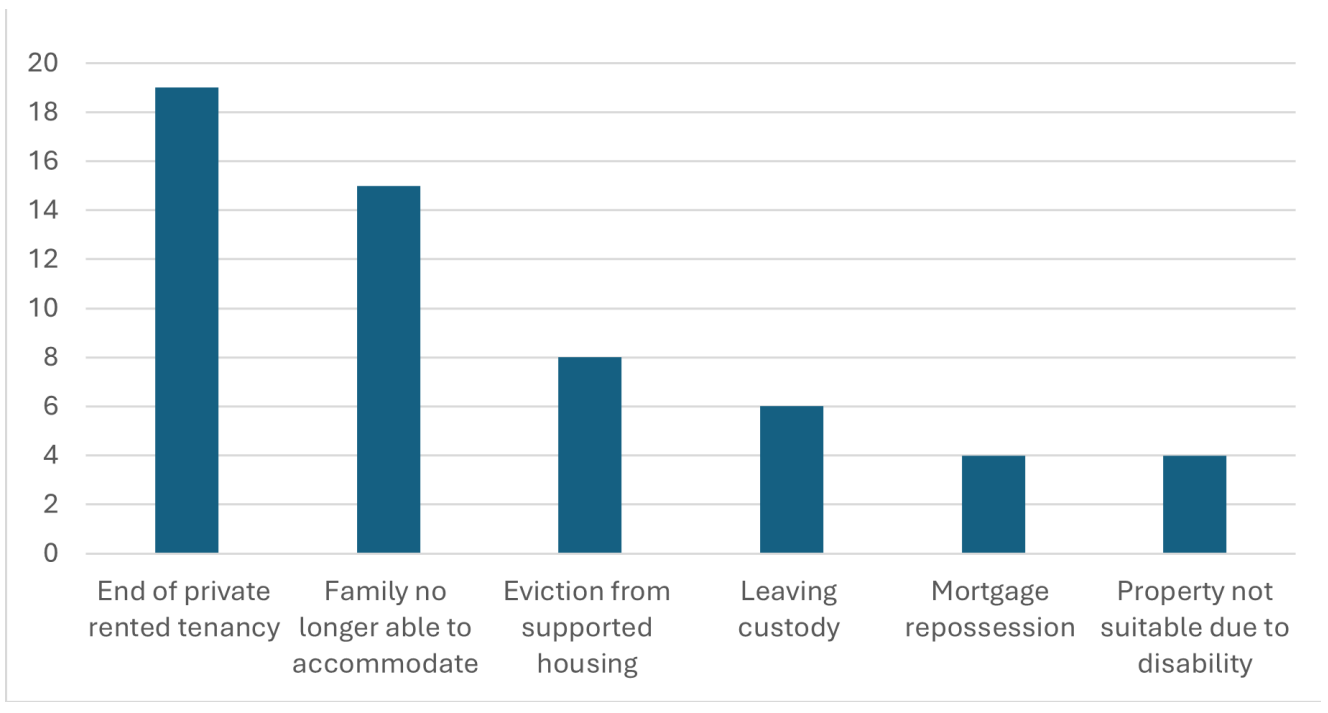
Systematic review has highlighted that homelessness is on the rise amongst older adults . Older homeless individuals are identified as those aged 55 and above. Prolonged exposure to homelessness and rough sleeping in this age group is associated with accelerated ageing and increased prevalence of mental and physical health conditions .

In 2024/25, 81 individuals aged 55+ presented to the homelessness service in Blackburn with Darwen. Of these, 57% were male, 32% were female and 11% did not disclose their gender.

The leading cause for homelessness among this group was the end of a private rented tenancy (23%), aligning with national trends. The second most common reason was family or friends no longer able to accommodate (19%), followed by evictions from supported housing.

These figures show the need for age specific interventions, particularly around tenancy sustainment and supported accommodation pathways as seen in figure 13.

Figure 13: Main reasons for individuals aged 55 and over presenting to homelessness services in Blackburn with Darwen 2023/24



Internal data hold by Housing Needs Team

Of all homelessness applications received in 2024/25, 36% of people were supported under the prevention duty, which enables a range of interventions aimed at helping individuals remain in their current accommodation. Many of these applicants required targeted support and advice, highlighting the importance of early engagement and tailored assistance.

Among the 81 applicants aged 55 and over, 58 were successfully supported to secure alternative accommodation. This outcome demonstrates the effectiveness of intervention pathways for older adults and reinforces the value of proactive, person-centred approaches.

Prevention and Relief Duty

Children

In 2024/25, just under a third (39%) of residents who were either threatened with homelessness or already homeless had dependent children.

Children experiencing homelessness face a heightened risk of:

- Poor physical and mental health outcomes, both immediately and over the long term
- Disrupted education and social development
- Severe poverty and material deprivation

Homelessness during childhood is recognised as an adverse childhood experience (ACE), which can have lasting effects on emotional wellbeing, cognitive development, and life opportunities. These findings reinforce the urgent need for family focused prevention strategies, early intervention, and wraparound support services that protect children from the compounding harms of housing instability.

Rough Sleeping

National Trend Data and Exposure to Violence

Accurately estimating the number of rough sleepers across England remains a challenge due to fluctuations in visibility, mobility, and reporting. The most widely accepted method is a single night snapshot count conducted in autumn, offering a momentary glimpse into the scale of street homelessness.

Local authorities select a date between 1 October and 30 November, meaning the count does not occur on the same night nationwide. The data is gathered by outreach teams, local charities, and community groups, and is independently verified by Homeless Link to ensure consistency and credibility.

In the 2024 autumn count, an estimated 4,667 people were sleeping rough across England[xvii]. This marks the third consecutive annual increase, although the figure remains 2% below the peak recorded in 2017. The upward trend signals growing pressures on housing and support systems, and reinforces the need for sustained, targeted interventions.

Rough sleepers have increased vulnerability to repeat victimisation of physical, sexual assault and violence[xviii]. According to their research based on a survey of 458 current or recent rough sleepers in England and Wales:

- People sleeping on the streets are almost 17 times more likely to be victims of violence than the general public
- They are 15 times more likely to suffer verbal abuse
- Nearly 8 in 10 reported experiencing violence, abuse, or antisocial behaviour in the past year
- 35% had been deliberately hit or kicked
- 7% had been sexually assaulted
- 9% had been urinated on
- 48% had been intimidated or threatened with violence
- 59% had been verbally abused or harassed[xix]

These findings paint a stark picture of the dangers faced by rough sleepers and reinforce the need for urgent, trauma informed interventions.

Rough Sleeping Trends in Blackburn with Darwen

In the 2024 autumn snapshot count, 11 individuals were recorded as sleeping rough in Blackburn with Darwen. This represents a near doubling compared to the previous year and signals a concerning shift in local street homelessness.

Over the past 15 years, rough sleeping figures in the borough have fluctuated significantly as seen in figure 14:

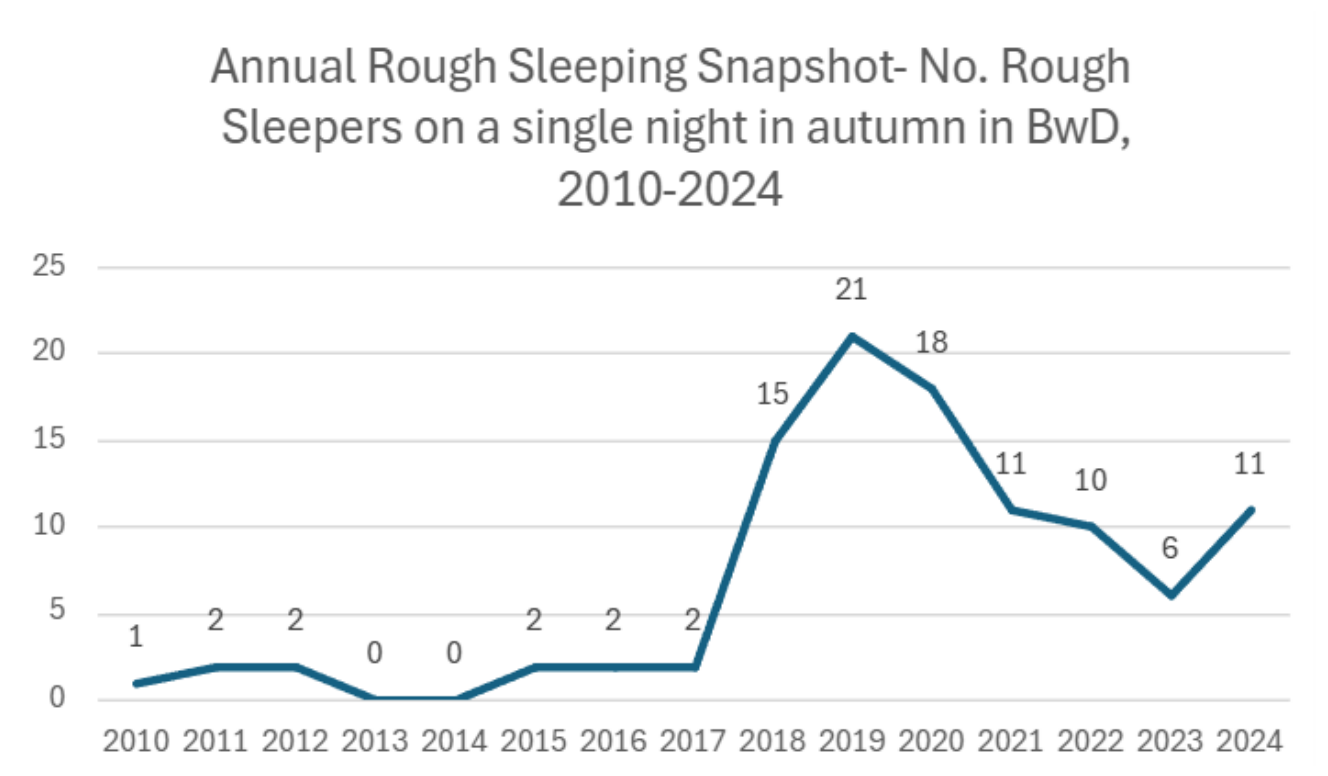
- Between 2010 and 2017, counts remained consistently low, ranging from 0 to 2 individuals
- In 2019, the number spiked to 21, marking the highest recorded figure in the period
- Following this peak, numbers declined steadily until 2023, before rising again in 2024

It is important to note that rough sleeping data during the COVID-19 pandemic (2020–2021) may not reflect true levels of street homelessness due to government interventions, such as the Everyone In initiative, which temporarily housed thousands of rough sleepers to reduce transmission risk.

Rough Sleeping

These trends highlight the need for continued investment in outreach services, early intervention, and sustainable housing solutions to prevent further increases in rough sleeping.

Figure 14: Rough Sleeping Trends in Blackburn with Darwen (2010 to 2024)



Internal data hold by Housing Needs Team

Demographic Profile of Rough Sleepers in Blackburn with Darwen (2017–2024)

Between 2017 and 2024, a total of 94 individuals were recorded as sleeping rough in Blackburn with Darwen. The demographic breakdown reveals patterns that are broadly consistent with national trends, though with some notable local distinctions.

Of the rough sleepers 79 were males, representing 84%, this figure is consistent with the national data of 83% over the same time period .

The majority of the rough sleepers in Blackburn with Darwen from 2017 to 2024 were over 25 years old (79%), 18 to 25 years old (19%) and in 2% the age was unknown. This rate is consistent with national data over the same time period, with 83% of people sleeping rough on a single night in autumn being recorded as male[ix].

95% of rough sleepers in Blackburn with Darwen were recorded as UK nationals. This contrasts sharply with the national figure of 62% UK nationalsix, suggesting that Blackburn with Darwen has a less diverse rough sleeping population in terms of nationality.

Rough Sleeping

Rough Sleeping Drug and Alcohol Treatment Grant (RSDATG) – Service Overview and Impact

Substance misuse and mental health issues frequently co-exist among individuals experiencing street homelessness. In response, the Rough Sleeping Drug and Alcohol Treatment Grant (RSDATG) was established to support local areas in delivering evidence-based treatment and wraparound support for people who are sleeping rough or at risk of doing so, including those with co-occurring mental health needs.

As of April 2023, the service in Blackburn with Darwen has provided assertive outreach and direct access to treatment for this vulnerable population. Key components include:

- Harm reduction advice and support
- Engagement and motivational interventions
- Referral pathways into structured treatment
- A Band 6 nurse offering wound care to individuals not accessing mainstream health services

Between April 2024 and April 2025, the service engaged 228 unique individuals, demonstrating strong uptake and highlighting the critical need for targeted, accessible support.

In April 2025, the RSDATG was consolidated into the Drug and Alcohol Treatment and Recovery Improvement Grant (DATRIG), streamlining funding to enhance continuity and impact across treatment pathways.

Rough Sleeper Team

The Rough Sleeper Team in Blackburn with Darwen Council has developed strong collaborative relationships with key partners, including SPARK (the local drug and alcohol treatment service), PRE, Changing Futures, the Phoenix Hub and the wound care nurse. Working closely with partnerships enable swift, direct communication, particularly when safeguarding concerns arise, ensuring timely and coordinated responses.

To improve engagement with hard-to-reach people, the team has introduced peer supported drop-in sessions for assessments, replacing traditional appointment-based models that often saw low attendance. This flexible approach has significantly increased accessibility and reduced barriers to treatment, especially for those who may struggle with trust, routine, or formal service settings.



Analysis of Questionnaire Data

This section presents a summary of findings from the 131 questionnaire responses, offering quantitative insight into the experiences and service access patterns of individuals affected by homelessness. While the focus groups provided depth and emotional context, the questionnaire data complements this by highlighting broader trends and systemic touchpoints. The analysis below covers key areas including demographics, access to general practice, barriers to healthcare, and patterns of service utilisation.

Demographics of responses

80% of respondents identified as male. The age range spanned from 18 to over 75 years old, with the majority aged between 36 and 45.

Most respondents described their ethnicity as White British and the majority also identified their status as UK resident.

The sample size and age profile of the questionnaire were reflective of individuals accessing homelessness services, lending credibility and relevance to the findings.

Access to General Practice

Research has found that individuals experiencing homelessness are 40 times less likely to be registered with a mainstream general practice compared to the general population[i]. This is not consistent with the local picture which shows a significant number of people experiencing homelessness are registered with the GP. The questionnaire found that out of 124 people experiencing homelessness, 117 (94%) were registered with a GP, 107 with a permanent practice and 10 with a temporary one, leaving only 7 unregistered. This sharply contrasts with the national finding. This suggests that targeted local interventions may be effectively mitigating barriers to primary care access.

Barriers to healthcare for people who are homeless noted in research include:

- Language, literacy, and cognitive issues
- Mental health and addiction issues
- Poverty (e.g. having no credit on one's phone)
- Digital exclusion
- Lack of trust
- Embarrassment
- Concerns about NHS charges[ii]

Barriers to accessing healthcare include stigma[iii], social exclusion and unsuitable communication pathways.

Data on homelessness within general practice is limited due to the lack of a standardised method for identifying individuals as homeless in EMIS, the electronic patient record system used by the NHS, making it difficult to interrogate primary care data further. Other GP systems in use across England, such as SystmOne and Cegedim Vision, further complicate matters, as each platform operates with distinct functionalities. These differences pose challenges for the sharing of clinical notes and continuity of care across practices.

Analysis of Questionnaire Data

Healthcare Service Utilisation

The questionnaire revealed that GPs were the most frequently accessed service among respondents, with 91 visits recorded. This was followed by:

- 60 visits to Accident & Emergency (A&E)
- 42 hospital admissions
- 42 visits to an optician
- 41 uses of ambulance services

This pattern suggests a high reliance on primary and secondary emergency care, with notable engagement in acute services such as hospital admissions and ambulance use. The data highlights the importance of accessible, coordinated healthcare for individuals experiencing homelessness or multiple disadvantage, and may reflect unmet needs in preventative or community-based care.

Barriers to accessing healthcare can significantly worsen health outcomes for people experiencing homelessness. Delayed diagnosis and treatment often lead to the escalation of preventable conditions, increased reliance on emergency services, and poorer long-term health.

Research shows that homeless individuals are up to 60 times more likely than the general population to attend Accident & Emergency (A&E) departments . This disproportionate use of urgent care reflects both the severity of unmet health needs and the systemic obstacles that prevent engagement with routine primary care.

Over an eight-month period, a questionnaire revealed that more than half of respondents (66 out of 128) had used A&E or ambulance services which is strikingly high rate, especially compared to the general population, while 32 said they had not. The remaining 30 were unsure or couldn't recall, highlighting both high emergency service usage and challenges in memory or record keeping among participants.

Respondents reported 35 separate admissions to A&E over the eight-month period, with a combined estimated stay of 190 days. Lengths of stay ranged from 1 to 45 days, with an average duration of just over 5 days per admission. This highlights not only frequent use of emergency services but also extended stays, suggesting complex health needs and potentially avoidable hospitalisations.

Hospital Discharge and Continuity of Care

Just over half of respondents reported that hospital staff ensured they had somewhere suitable to go upon discharge. However, a significant proportion did not respond to this question, which may reflect:

- Memory recall challenges, especially among individuals with complex health or housing histories
- Uncertainty or lack of communication during discharge planning
- Potential gaps in documentation or follow up support

This suggests that while some discharge procedures are working, there may be inconsistencies in how discharge planning is communicated or experienced, particularly for those facing multiple disadvantage. Ensuring clear, compassionate discharge protocols and follow up support could help reduce hospital readmissions and improve long term outcomes.

Analysis of Questionnaire Data

Dental Access Among Respondents

Out of the total responses:

- 56 individuals reported having no access to a dentist
- 38 individuals had a permanent dentist
- 12 individuals were registered with a temporary dentist

This highlights a significant gap in access to routine dental care, with over half of respondents lacking a permanent dental provider.

Barriers to Healthcare Registration

When asked whether they had been refused registration with a GP or dentist in the past 12 months:

- 10% of respondents reported being refused.
- The majority of refusals were linked to dental, registration.

The most frequently cited reasons included:

- Dental practices being at full capacity
- Refusals due to missed previous appointments

This suggests that access to dental care is not only limited by availability but also by policies that may disproportionately affect vulnerable individuals, particularly those experiencing unstable housing or mental health challenges, where missed appointments are more likely.

Access to Information About Local Healthcare Services

Out of 128 respondents, 71 individuals reported that they had received information about local healthcare services, while 36 said they had not. The remaining 21 were either unsure or did not respond.

Among those who had received information, an overwhelming 90% found it useful, indicating that when information is provided, it can play a vital role in enabling access to appropriate care.

Who Supports Health Among People Experiencing Homelessness

When asked who looks after their health, respondents most commonly identified staff at temporary accommodation, HMOs, and drug services as their primary sources of support. This was followed by homelessness projects such as THOMAS and the Phoenix Hub, then friends and peers, and GPs. A range of other sources were also mentioned, while only six respondents stated that nobody supported their health.

This pattern suggests that informal and community-based support networks play a more prominent role in health management than traditional healthcare providers. It highlights the importance of trusted relationships, peer led support, and accessible, non-clinical environments in promoting engagement with health services, particularly among individuals facing multiple disadvantage.

Analysis of Questionnaire Data

Lifestyle factors

Smoking

82% of respondents reported that they smoke, five times higher than the general population rate of 16.6% in Blackburn with Darwen[v]. 42% of respondents reported that they vape.

Desire to Quit: 30% expressed a desire to stop smoking, indicating a significant opportunity for targeted cessation support.

Support Offered: Among the 98 respondents who answered questions about receiving help:

- 39% said they had not been offered any advice or support to quit.
- 53% said they had been offered support but did not take it up.

There's a high smoking prevalence in this group, paired with a moderate interest in quitting. A majority either weren't offered support or didn't engage with it, suggesting that current approaches may not be accessible or relevant.

It's important to note that the smoking cessation service in Blackburn has been operating for less than a year, which may explain limited awareness or uptake.

Diet and Nutrition

Most respondents reported eating three meals a day, suggesting a level of routine in food access. However, 31% said they consumed no fruit or vegetables, and only 3% met the recommended "five-a-day" intake, highlighting significant gaps in nutritional quality. This suggests that while meal frequency may be stable for many, nutritional value remains a major concern, with limited access to fresh produce likely contributing to poor diet-related health outcomes, such as vitamin deficiencies.

Physical Activity Patterns

When asked about recent exercise habits:

- 29% of respondents reported doing no physical activity in the past seven days
- 15% said they exercised twice a week
- 14% reported exercising daily

These figures suggest that while a small portion of the population maintains a consistent daily routine, a significant number remain inactive. This highlights the need for more accessible and motivating opportunities to engage in regular physical activity.

Among those who reported no exercise:

- 42% expressed a desire to become more active
- 35% said they were not interested
- 23% were unsure

Analysis of Questionnaire Data

These responses suggest that nearly half of the inactive group is open to change, presenting a valuable opportunity for targeted interventions, community programs, and awareness campaigns to encourage healthier lifestyles.

Physical Health Care

When asked whether they currently suffer from, or have previously experienced, wounds related to substance misuse, 25% of respondents answered yes. The most commonly reported condition was Deep Vein Thrombosis (DVT), followed by leg ulcers and abscesses.

These findings flag the serious physical health consequences associated with substance misuse, particularly among individuals who inject drugs. The high prevalence of DVT and other chronic wounds reinforces the importance of targeted healthcare interventions and supports the ongoing work of outreach wound care services commissioned by Public Health to address these needs within the community.

Common Health Conditions Reported

Respondents identified a range of physical health issues, with the most frequently reported conditions in order included:

1. Joint ache / muscle pain
2. Chest pain / breathing problems
3. Dental and teeth problems
4. Fainting or blackouts
5. Vision difficulties / eye problems
6. Stomach problems
7. Skin and wound infections

This list reflects a mix of chronic pain, respiratory concerns, untreated dental issues, and symptoms that may indicate underlying or unmanaged conditions. The prevalence of these issues highlights the need for accessible, integrated primary care and targeted outreach services that address both acute and long-term health needs.

Notably, eye health emerged as the fifth most common concern, with 42 recorded visits to an optician in the above data set. This level of demand suggests a clear opportunity to expand or enhance optical services, particularly in underserved areas or among populations with limited access to routine eye care.

Mental Health

Most respondents reported experiencing mental health difficulties, with symptoms ranging from:

- Chronic stress and anxiety
- Sleep disturbances
- Panic attacks
- Self-harm
- Suicidal thoughts
- Or a combination of these experiences

Notably, 63% of individuals reported having a mental health need or condition that had been formally diagnosed by a doctor or other health professional.

- The most commonly reported condition was depression, reflecting the emotional toll of prolonged instability and isolation.
- The second most common was co-occurring conditions involving both mental illness and drug or alcohol misuse, underscoring the complex interplay between trauma, addiction, and survival.
- The third most prevalent diagnosis was post-traumatic stress disorder (PTSD), often linked to experiences of violence, abuse, or chronic exposure to unsafe environments.

Analysis of Questionnaire Data

When asked about support, most respondents did not provide an answer, which may reflect a deeper issue: their needs are not currently being met, or perhaps they may feel disconnected from available services.

Among those who did respond:

- The second most common support mentioned access to talking therapies, indicating a desire for emotional and psychological support through structured conversation.
- Other frequently cited needs included practical support for day-to-day living, such as help with appointments, paperwork, or basic tasks.
- Several individuals also expressed interest in engaging in meaningful activities, such as art, creative expression, or volunteering, which can foster a sense of purpose, routine, and community.

These findings reinforce the need for mental health outreach services that meet individuals where they are, especially those disconnected from traditional care systems.

59% of respondents reported using drugs or alcohol to cope with their mental health, a behaviour commonly referred to as self-medicating. This reflects a pattern where individuals turn to substances as a way to manage emotional distress, trauma, or untreated mental health conditions.

Substance misuse is frequently intertwined with mental health struggles. The dual burden of mental illness and addiction, often described as co-occurring conditions creates significant barriers to recovery, stability, and engagement with services.

Addressing these challenges requires integrated, trauma informed care that is responsive to the realities of homelessness.

Substance Misuse

Substance misuse continues to pose a significant challenge, with data revealing both the scale of the issue and the opportunities for more responsive support. 59% of respondents reported current drug use and 47% identified as being in recovery from a drug problem.

The most commonly used drug was crack cocaine, followed by cannabis. 26% were prescribed medication through substance misuse services. A small number reported injecting drugs. Of those, 70% were aware of the needle exchange service

The overlap between current use and recovery highlights the cyclical nature of addiction, requiring long term, flexible support.

40% of respondents said they are receiving support for their substance use and that it meets their needs.

19% are receiving support but would like more help.

These figures suggest that while a significant portion of individuals are accessing effective support, nearly 1 in 5 feel their current level of help is insufficient.

Respondents most commonly cited that support helped them:

- Gain better control over their drug use
- Stop using drugs
- Reduce their drug use

Analysis of Questionnaire Data

Awareness of harm reduction services like needle exchange is promising, but coverage and accessibility must be expanded to reach those not yet engaged. Uptake of prescribed medication reflects engagement with formal treatment pathways, though further outreach is needed to boost participation.

Further work is needed to understand what additional support is required to fully meet people's needs and sustain recovery.

Alcohol Use Patterns

Survey responses revealed a diverse range of drinking behaviours among participants:

- 36% reported that they do not drink alcohol
- 12% identified as occasional drinkers, consuming alcohol monthly or less often
- 27% reported drinking every day

While over a third abstain from alcohol, the prevalence of daily drinking among 27% of respondents may indicate patterns of dependency, self-medication, or coping mechanisms linked to mental health challenges and housing instability.

Awareness and Recovery

- 34% acknowledged having an alcohol problem, demonstrating a high level of self-awareness
- Another 34% stated they are recovering from an alcohol problem

This suggests that many individuals are not only aware of their alcohol use but are actively engaging in recovery efforts.

Support Access and Needs

Support-related responses (noting that just under half did not answer) showed:

- 32% said they receive support and that it meets their needs
- 17% receive support but would like more help
- 14% do not receive support, but believe it would help them

When asked how support helps, the most common response was:

"Helps me to stop drinking"

When asked what support would help, responses largely mirrored current support experiences. However, a notable increase was seen in individuals expressing a desire for help to manage the impact of drinking on their health, reflecting growing self-awareness of alcohol-related harms.

Across both substance misuse and alcohol use, a significant proportion of respondents indicated that although they are receiving some support, they would like more help. This points to a clear need for deeper exploration into the nature of these unmet needs, including the types of support individuals feel are lacking and the barriers they may face in accessing more comprehensive care.

Analysis of Questionnaire Data

While acknowledging that the focus group sample size was relatively small, it is notable that when drug and alcohol services were discussed, this theme of unmet support did not emerge prominently in the qualitative analysis. This discrepancy between survey responses and focus group insights may suggest:

- A need for more targeted questioning in future qualitative work—potentially aligned with the upcoming recommissioning of drug and alcohol services
- Potential underreporting or discomfort discussing service gaps in group settings
- Differences in perception between individual and collective experiences

This reinforces the importance of triangulating data sources to capture the full spectrum of lived experience, especially around service adequacy and accessibility.

Gambling

- 70% of respondents reported no gambling activity in the past 12 months (including lottery, sports betting, online gambling, etc.) This is higher than the UK which found that 50% of adults had participated in a gambling activity in the last 12 months .
- Among those who do gamble:
  - 6% reported gambling daily
  - 27% reported gambling weekly

Difficulties Encountered

The most commonly reported challenges associated with gambling were:

- Debt accumulation
- Borrowing money from friends or family

Other challenges including evictions, relationship break up and loss of employment.

A small proportion of individual who gamble reported receiving support. Most commonly through gambling support groups or financial advice services. A small number reported being refused support, though no rationale was provided. Very limited information was shared about the types of support individuals would like to receive, indicating a potential gap in awareness or engagement

These findings highlight the need to improve awareness and accessibility of gambling related support services.

Screening

For those over 45, 11% had been screened for bowel cancer, compared to the district average of 63.7% uptake.

Cervical Screening

- 27% of respondents reported having access to cervical smear services in the past 3 years
- Of those invited to screening, 91% attended, showing a strong willingness to engage when services are accessible

Among those who did not attend, the most common reasons were no transport, no money to attend appointments and forgot the date.

These findings suggest that logistical and financial barriers, rather than reluctance or lack of awareness, are the primary obstacles to screening uptake.

Analysis of Questionnaire Data

Health Checks

55% of respondents reported attending a health check within the past three years

The majority of these checks focused on:

- Physical health, particularly conditions related to heart function
- Mental health assessments

Only one response cited a barrier to accessing health checks with lack of trust in healthcare services. Due to the limited number of responses, no definitive conclusions can be drawn about broader barriers or challenges.

Given the moderate uptake and minimal reporting of barriers, there is an opportunity to enhance awareness and improve accessibility of the NHS Health Check programme, particularly through targeted outreach initiatives.

Immunisation

25% of respondents reported receiving a flu jab in the past 12 months and 26% stated they did not know whether they had received the vaccine. It would be worth exploring community-based delivery models to increase uptake and visibility of flu jab campaigns.

Sexual Health

18% of respondents reported having a sexual health check in the past 12 months

7% disclosed experience with sex work

68% stated they know where to access advice about sexual health

Most people responded to going to the GP/ registered nurse, Brook, the specialist sexual health provider and then homeless and housing staff. The relatively low uptake of sexual health checks may reflect barriers to access, stigma, or low prioritisation of sexual health among individuals facing multiple challenges.

Housing History, Tenancy Experience & Support Needs

The most commonly reported reason for leaving a previous property was a relationship breakdown, which aligns with existing data held by Housing Needs.

40% of respondents said they had been evicted or asked to leave a property and 57% reported having been placed in temporary accommodation at some point.

Many respondents demonstrated strong tenancy experience and self-belief. 67% had previously held a tenancy in their own name and 59% felt confident they could manage a tenancy independently.

When asked what support would help them maintain a tenancy, the most common themes were:

- Budgeting support
- Help with substance misuse
- Mental health support
- Social care was also frequently mentioned

These responses highlight the need for integrated support services that address both practical and emotional challenges to tenancy sustainment.

Analysis of Questionnaire Data

Feeling Safe in Accommodation

25% of respondents reported that they did not feel safe in their current accommodation. This lack of safety may reflect concerns about physical violence, but also broader anxieties related to housing insecurity, such as the risk of eviction, unstable tenancy, or overcrowded living conditions.

This finding highlights the importance of not only providing shelter but ensuring that accommodation offers a genuine sense of safety and stability.

Disability

52% of respondents considered themselves as having a disability and 59% felt that their health prevents them from undertaking training, volunteering, or employment. This highlights a significant barrier to social and economic inclusion.

When asked to share more about their health or the health services they use, the most commonly mentioned issues were:

- Mental health challenges
- Long-term health conditions
- Mobility-related difficulties

These responses reflect a complex intersection of physical and mental health needs.

Focus group findings

Thematic analysis of the focus group discussions revealed six key themes that were not identified through the questionnaire responses:

- **Accessibility to Health Care**
- **HMO Provision**
- **Move-On Accommodation**
- **Impact of Poor Quality Housing**
- **Advocacy**
- **Food Insecurity**

Accessibility to Health Care

Professionals strongly advocated for a "right care, right person" approach (FG5), yet discussions revealed persistent barriers to accessibility. Practical challenges, such as not having a phone or a fixed address, were frequently cited as obstacles to engaging with healthcare services. This raises a longer-term risk of digital exclusion, which is particularly concerning given the NHS's increasing reliance on digital platforms for service delivery under future plans.

> FG5: "A lot of the people we support, we don't have the address. We don't have a phone number. It can be quite difficult to get them on with a GP or to arrange a GP appointment".

Beyond logistical barriers, a broader theme emerged around living in a state of constant uncertainty. Participants described the difficulty of planning ahead or engaging with structured support when their circumstances were unstable. The emotional toll of not feeling "settled" was reflected in a mindset of taking each day as it comes.

> FG3: "Because I don't know what I'm doing tomorrow because you're not settled"

This quote reflects the lived reality of instability and short-term survival, helping to explain the preference for face to face, drop-in appointments at accessible locations like Phoenix Hub.

People in the focus groups who were homeless identified a deeper systemic failure, particularly in mental health support, which was exacerbated when combined with substance misuse. Many described feeling bounced between services, with little coordination, and expressed desperation for help.

> FG1: "I think, the need to get people into services quicker, a lot quicker than what they're doing, ummm, because, I know there is a big thing about mental health and then putting and linking it with addiction, ummm, I understand people, you know, can have bad mental health through addiction and that thought , but, you can't treat one without the other, and they try to, well, get clean, and then we'll start your mental health.
>
> But we can't do mental health until you get, do them. But you know, work together and do it together because the mental health is always going to be the mental health and sometimes with drugs and I know this sounds a bit silly to you but the drugs make is better. You are able to cope, you are able to think, you are able to function, you are able to do stuff, without those drugs you are kicked off the mark, and they need to come together and work together, there is a person there crying out for help"

Focus group findings

The key message here is professional need to come together and work together, with a particular focus on co-occurring conditions.

The transitional phase for young people was described as a particularly vulnerable period, where individuals often fall through the cracks due to age-based eligibility criteria and differing thresholds for support.

FG1: "Some people are almost too chaotic for Early Break, but too young for Spark."

Concerns were also raised about access to dental care. One participant used a metaphor to describe the fragmented and temporary nature of support, likening it to patching a punctured tyre rather than receiving comprehensive treatment.

FG2: "It's like having a puncher in a car. Yeah, you can go tyre specialist and get the whole tyre changed. There's your full time dentist, but you know that tyre well, so you're on side of the street, you get punching, you put the tyre well."

HMO Provision

Discussions highlighted a recurring pattern of "HMO hopping," driven by the wide availability of low-cost HMOs and bedsits in Blackburn. While this range of provision offers flexibility, it does not always meet the specific needs of individuals, particularly those with complex support requirements. As a result, frequent moves between accommodations have become common, contributing to heightened instability among residents.

This availability of provision has led to an increase in out-of-area placements, where individuals experiencing homelessness, originally from other districts, are relocated to Blackburn with Darwen by external local authorities.

The Housing needs team have sole referral rights into all the HMO's that receive specified housing benefit rate, this is a higher rate of housing benefit awarded to accommodation projects that provide extra care and support to residents. This ensures that only applicants with a local connection to BWD are referred into these accommodation providers. However, other accommodation providers including commercial bed and breakfasts and HMO's that do not claim specified housing benefit take referrals from Local Authorities outside of BWD. Such placements disrupt continuity of care and community formation, and place additional strain on local services.

FG4: "We know that the challenges we have with HMO's, but it's a double edged sword for us because we're able to offer singles like xxx says, multiple offers quite often of accommodation, whereas other neighbouring authorities don't have that. So other neighbouring authorities will, you know, find single people non priority homeless and just don't support them just because they don't have the accommodation. That's not something that we'd ever do in Blackburn. We'd always look to support individuals into accommodation and even the most complex individuals."

FG5: "Hostel hopping because their needs are unmanageable. So, although we have a lot of accommodation for this particular group, it isn't necessarily the right type of accommodation to be able to manage those needs."

These reflections highlight a local tension between availability and suitability. While Blackburn offers more housing options than neighbouring areas, the mismatch between provision and individual needs can result in repeated moves, fragmented support, and unmet needs and negative health outcomes.

Focus group findings

Move-On Accommodation

Sub-Themes

Community Formation and Emotional Safety in HMOs

This theme is complex. Participants described forming communities within HMOs, accessing support, and feeling emotionally safe, often referring to these spaces as their "safe zone." Despite the intended temporary nature of such accommodation, there was a clear fear of moving on. The emotional attachment to temporary accommodation was strong, with participants expressing anxiety about leaving spaces they considered safe. Early support for transition was flagged, with some participants unclear about next steps. One resident even suggested a sense of being deliberately held back.

> FG2: "They don't want us to move on, yeah, because they get paid so much money.", co

Fear of Transition

Participants expressed a deep fear of leaving temporary accommodation, which they viewed as a place of safety and stability.

> FG1: "It's a safe zone, isn't it? I spent two years not knowing where I was going to go, what I was going to do, and it really then and when I got here and six months down the line around saying, oh, do you want to move? I'm like, no, I'm not just not ready because I'm. I'm safe here. I'm comfortable like. And I haven't felt that for such a long time that I just need it for that little bit longer."

> FG2: "There was a general fear of moving on and a sense people felt safe in temporary accommodation, with a fear of the unknown"

Some participants also described their experiences in temporary accommodation positively, highlighting the sense of community and connection.

> FG3: "We get together as a group, don't we and eat outside, we play Dominos and stuff and get on really well together."

Isolation and Vulnerability

Transitioning out of addiction or temporary housing was described as a significant challenge. Without adequate support, participants felt they were stepping into the unknown, often alone and vulnerable.

> FG2: "It's like going to the unknown, when we have nobody."

> FG2: "It's not just leaving the drugs, it's the community, it's our safety net and fear, fear of the known. When you are in addiction, hmm, right, you are in a community and it's like coming out of that community."

FG5: "But whilst we're still in crisis for mental health, we're also still in addiction for at risk of being cuckooed or for properties could turn into drug dens. Then things kind of need addressing before we can kind of look at the moving on process forward. We're going to make sure we're not setting them up to fail"

The reference to being "cuckooed" is a term used to describe the exploitation of vulnerable individuals by criminal networks.

Housing Quality for Move-On Accommodation

Participants described the quality and availability of move-on housing as inadequate and, in some cases, harmful to recovery and mental health.

FG1: "If I was a drug user and moved into that house how it was, I would have been back on drugs in three weeks, it was, it was awful."

This quote powerfully illustrates how poor housing conditions can directly impact health and relapse risk.

Lack of Care Post-Signature

There is a strong perception that housing providers disengage once tenancy agreements are signed, leaving residents unsupported in substandard conditions. While this concern was not specific to formerly homeless individuals, it reflects broader issues within the social housing stock.

FG1: "Once they got my signature they didn't care, couldn't have cared less."

This suggests a transactional approach to housing provision and a breakdown in ongoing support.

Limited Choice and Coercive Systems

Participants felt pressured to accept unsuitable housing due to rigid policies around permanent accommodation offers.

FG1: "You've only got 3 properties, you can look at before you. If you turn down three properties, you kicked off the waiting list long enough. It's almost like you're in desperate need and they are taking advantage of that, although, I am sure they are not, but that's what it feels like."

While the "three offers" policy is standard practice nationally, designed to reduce void properties and increase the number of people moving into permanent accommodation, it highlights the need for clearer communication around the move-on process, the rationale behind such decisions and knowledge of how to appeal a decision. Without this, individuals may perceive the system as coercive, especially when choices feel limited and urgency is high.

Focus group findings

Advocacy

This theme captures participants' experiences of disempowerment, lack of procedural transparency, and emotional fallout from interactions with housing agencies and support systems.

Sub-Themes Identified

Lack of Procedural Clarity

Participants expressed confusion and frustration over the absence of clear procedures.

> FGI: "You've only got 3 properties, you can look at before you. If you turn down three properties, you kicked off the waiting list long enough. It's almost like you're in desperate need and they are taking advantage of that, although, I am sure they are not, but that's what it feels like."

This quote highlights both systemic failure and a lack of public awareness. The participant's account of being "just left to the streets" signals the emotional toll of eviction and the perceived abandonment.

Power Imbalance and Erosion of Trust

There's a strong sense that participants feel powerless to challenge decisions, especially when appeal processes are either absent or ineffective and the high value placed on trust and how it impacts relationships.

> FGI: "I don't think it would have mattered with you wrote an appeal process. It didn't seem to be any appeal process. I don't think it would have mattered to you because once that trust was gone."

This quote reveals a deep cynicism toward accountability. Even if an appeal process existed, the participant felt it would be meaningless.

Inconsistency in Eviction Decisions

Participants described evictions from temporary accommodation as arbitrary and lacking explanation, reinforcing feelings of vulnerability and injustice.

While not directly quoted, this theme is implied through the broader discussion of rationale and inconsistency in decision-making. It connects to the emotional tone of abandonment and confusion. The lived experience groups appeared to have limited awareness of the licence agreement and the difference in tenancy for people in temporary accommodation under the licence scheme.

Focus group findings

Food Insecurity

The analysis found a number of themes associated with food insecurity. Participants who had experienced street homelessness described unique challenges related to food access and waste.

Weekend Food Scarcity

Participants described a lack of food provision over weekends, creating critical gaps in access over the weekend.

Food Bank Hesitancy

While food banks were acknowledged, many expressed a preference for food to be redirected to others in greater need, such as single parents.

> FG1: "You've only got 3 properties, you can look at before you. If you turn down three properties, you kicked off the waiting list long enough. It's almost like you're in desperate need and they are taking advantage of that, although, I am sure they are not, but that's what it feels like."

Inconsistent and Inappropriate Supply

Food donations were often unsuitable or excessive and people unable to carry it, leading to stockpiling in locations like bushes or under tents. This raised concerns about hygiene and attracted pests.

> FG2: "We used to store ours like under the tent and say I come back and there would be like slugs, spiders, everything just over it all."

> FG2: "Food bank on Saturday, we just left it all there. There is no way you can carry it all."

Cycle of Waste

The combination of poor access, unsuitable food, and lack of storage led to significant food waste, reinforcing a cycle of inefficiency and loss.

Appendix

Terminology table

Term	Definition
Homeless	Legally, the Housing Act 1996 defines a person as homeless if either they: ▪ have no accommodation available to occupy in the UK or abroad. ▪ are at risk of violence or domestic abuse. ▪ have accommodation but it is not reasonable for them to continue to occupy it. ▪ have accommodation but cannot secure entry to it. ▪ have no legal right to occupy their accommodation. ▪ live in a mobile home or houseboat but have no place to put it or live in it[12] e.g. this can include caravan sites where rules do not allow individuals to live there. Importantly accommodation must be available for the homeless occupant and those who would normally reside with them as a family member or other reasonable relationship.
Statutory homelessness	Individuals deemed to fall under the local authority's legal obligation or duty to house following being found to be homeless following assessment via application to the local authority as homeless.
Non-statutory homelessness	These individuals may be homeless but have not formally applied to the local authority as homeless or found not to be deemed as being 'owed a duty' by the local authority. Such individuals could for example be non-statutory but vulnerable (in temporary accommodation or supported accommodation by the council); rough sleepers prior to applying to the council for assistance; sofa-surfers or squatters; or individuals with no recourse to public funds.

Appendix

Terminology table

Term	Definition
Intentionally homeless	A person becomes homeless intentionally if all the three following applies: ▪ they deliberately do or fail to do anything in consequence of which they cease to occupy accommodation; and, ▪ the accommodation is available for their occupation; and, ▪ it would have been reasonable for them to continue to occupy the accommodation. However, for this purpose, an act or omission made in good faith by someone who was unaware of any relevant fact must not be treated as deliberate
Rough Sleeping	People sleeping rough are defined as: ▪ People sleeping, about to bed down (sitting on/ in or standing next to their bedding) or bedded down in the open air (such as on the streets, in tents, doorways, parks, bus shelters or encampments). ▪ People in buildings or other places not designed for habitation (such as stairwells, barns, sheds, car parks, cars, derelict boats, stations, or 'bashes' which are makeshift shelters, often comprised of cardboard boxes).
Houseless	In temporary accommodation including transitional accommodation such as women's shelters; refuges; emergency hostels; accommodation for immigrants; those in institutions (hospitals, prisons etc.) due for discharge without housing options; staying with friends or family i.e. sofa surfing; staying in a hostel, hotel or bed and breakfast.

Appendix

Appendix 1: Terminology table

Term	Definition
Street homeless	A much wider term than rough sleeping, considering street lifestyles of some people who may not actually sleep on the street, but routinely spend time on the streets during the day. Some will end up sleeping outside, or in a derelict or other building not designed for human habitation, perhaps for long periods. Others will sleep at a friend's house for a very short time, stay in a hostel, night-shelter or squat, or spend nights in prison or hospital.
Insecure housing	People living with the threat of eviction or being in temporary housing and needing to move multiple times therefore being unable to create a home.
Inadequate housing	People living with the threat of eviction or being in temporary housing and needing to move multiple times therefore being unable to create a home.
Squatters	People sheltering in accommodation not intended for habitation, it may be unsafe and requires trespassing. Often difficult to visualise given the nature of sleeping space.
Sofa surfing	People staying with friends or relatives and may not be known to services.
Hidden Homeless	People who become homeless but do not show up in official figures. Includes people without access to suitable housing, who may be staying with friends or family or living in squats, hostels and may not be known to services. Often a temporary solution.
Prevention duty	Places a duty on housing authorities to work with people who are threatened with homelessness within 56 days to help prevent them from becoming homeless. Under the Homeless Reduction Act 2017.
Relief duty	Requires an authority to 'take reasonable steps to help the applicant to secure suitable accommodation that becomes available for the applicant's occupation' for at least six months. Under the Homeless Reduction Act 2017

Appendix

Terminology table

Term	Definition
Priority need	Priority need for accommodation applies to certain individuals all the time, and others if they are 'vulnerable.' Always priority need: ▪ at risk of domestic abuse. ▪ pregnant or living with dependent children. ▪ homeless because of fire, flood or other disaster. ▪ a care leaver aged 18-20. ▪ aged 16 or 17 possibly. Possibly priority need if vulnerable: ▪ mental health problems or learning disability. ▪ physical disabilities or serious health condition. ▪ time spent in care, prison, or the armed forces. ▪ fleeing violence from someone who is not a partner or relative. ▪ old age. Other special circumstances
Severe and multiple disadvantage	Those in the homelessness, substance misuse and criminal justice systems in England with 'poverty an almost universal, and mental ill health a common, complicating factor.'
Multiple exclusion homelessness (MEH)	People have experienced MEH if they have been 'homeless' (including experience of temporary/ unsuitable accommodation as well as sleeping rough) and have also experienced one or more of the following other domains of 'deep social exclusion': 'institutional care' (prison, local authority care, mental health hospitals or wards); 'substance misuse' (drug, alcohol, solvent or gas misuse); or participation in 'street culture activities' (begging, street drinking, 'survival' shoplifting or sex work).
Co-occurring condition	Term used to describe individuals with a mental illness and co-occurring substance misuse issue.

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Appendix

Appendix 1: Wider context to homelessness in BwD

Number of HMO's in BwD (Blackburn central ward)	
Salvation Army	55 Beds
Canterbury House	21 Beds
Cherry Bridge lodge	40 Beds
Islington (UC rates, not supported)	55 Beds
Pump Street	20 Beds

Number of HMO's in BwD (Outside Blackburn town centre)	
Skye Crescent Lodge	60 Beds
Homeless pods	10/11 9 single pods and 1 double pod

Rough sleepers, 11 on the current count 6/6/25

Fluctuates between 11 to 23 people.

Estimated number of homeless people in BwD is 272 people.

Numbers to be confirmed using a range of internal records including housing benefits, homeless applications and information recorded by services working with homeless people.