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East Sussex
Homeless Health Needs Audit
July 2016

Department of Public Health

About this document:

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Executive Summary

Findings

Demographics

- In total, 285 people took part in this survey, 68% of whom were 'resident' in Eastbourne and Hastings. Questionnaires were mostly completed by housing support services.
- The average age of homeless respondents was 17 years younger than the average age of the general population of East Sussex. There were more males than females at a ratio of three to two, although the proportion of females in the East Sussex audit was higher than the national audit. This may be due to the high number of responses from young people's accommodation services.
- Respondents were 92% white and 95% were UK nationals. This compares with 96% of the East Sussex population who are white.
- The current accommodation of respondents varied from rough sleeping to those housed in their own tenancy. However, half of all respondents had slept rough at some point in the past and two thirds had sofa surfed.
- Only 8% of respondents were employed. A third of respondents stated they had a long-term sickness or disability preventing them from working.
- Around a third of respondents were ex-offenders.
- 13% reported having been in LA care at some point in their lives.
- Being a victim of domestic violence was reported significantly more frequently than in the general population of East Sussex in women but not in men.
- Learning disabilities were reported 10 times more frequently amongst respondents than the estimated prevalence of learning disabilities in the general population (21% and 2.0% respectively).

Health and Wellbeing

- There are substantial inequalities in the physical and mental health of homeless people compared with the general population which need to be addressed.
- The three most commonly reported physical health problems were musculoskeletal problems, dental problems and asthma.
- Two thirds of respondents reported having a long-standing illness or disability.
- The majority (78%) of respondents reported having at least one mental health problem. This is much higher than the national general population (23%).
- On average, the East Sussex homeless population reported a lower health quality of life than the general population.
- 31% of respondents stated that their health is now worse than it was 12 months previously

Substance Misuse

- The proportion of respondents reporting drug use in the past 12 months was five times higher than in the general population.
- A quarter of respondents reported having a drug problem.
- A larger proportion of homeless people in this audit drank alcohol on most days of the week [5 or more days in the week] compared with the general population.
- A quarter of respondents also reported an alcohol problem.
- 37% use drugs or alcohol to help them cope with mental health.

Access to Health Services

- 93% of respondents were registered with a GP. Some respondents reported having been refused registration with a GP because of lack of ID.
- Use of health services was higher amongst homeless respondents than in the general population of East Sussex: A&E use was two and a half times higher and hospital admission was 4 times higher. There are some respondents making frequent visits to A&E/ having several ambulance call outs and/or several hospital admissions over a 12 month period.
- Half of the respondents had struggled to be seen for a physical or mental health problem in the past year.
- A high proportion had been admitted to hospital in the past year (40%). Many reported being discharged to unsuitable accommodation or onto the street.
- Some respondents discharged from hospital were readmitted within 30 days. A higher proportion of those discharged to the street were readmitted than those discharged to suitable accommodation.

Health Behaviours

- Smoking rates amongst homeless respondents were much higher than the general population (79% and 16% respectively).
- A minority of smokers stated they wanted to give up smoking.
- Homeless respondents had poor diets, with many not able to eat regular meals, and very few ate sufficient fruit and vegetables.
- Respondents had lower levels of physical activity than the general population of England.

Screening and immunisations

- Hepatitis B vaccination uptake was low in this homeless audit, even amongst target high risk groups, though just under half of the target group reported having had at least one dose of hepatitis B vaccine.

- Flu vaccination was also low and many who would benefit from receiving the flu vaccine reported not having had one in the past year.
- Uptake of cervical, breast, and bowel cancer screening was lower than in the general population.
- Around a third of respondents attended a sexual health screen in the past year.
- Up-take of NHS Health Checks for those eligible was higher than in the general East Sussex eligible population, however, this could be an over-representation as respondents may have included all health checks and not just those that were part of the official programme.

Recommendations

The recommendations in this report are derived from the audit findings and are for consideration by health and social care, and housing.

Strategic

- Re-establish a homeless health service in Eastbourne, to include surveillance of infectious diseases, in line with the hub model developed in Hastings.
- Ensure there are mechanisms in place so that homeless people who may have care and support needs receive an assessment.
- Continue to ensure care leavers are provided with the support they need to live independently.
- Improve access to mental health treatment and on-going support for homeless people, particularly those with drug and alcohol problems, for example through an outreach mental health service.
- Develop and implement a protocol/pathway for planning the hospital discharge of homeless people from East Sussex Healthcare Trust.
- Consider establishing an intermediate care/step-down bed facility for high risk, repeat NHS emergency service users.
- Explore the feasibility of introducing a Housing First model for people with complex needs.
- Develop a partnership approach, between the NHS and providers of homeless services, so as to deliver a co-ordinated response to meet the health needs of homeless clients.
- Establish a homeless health forum in East Sussex to promote partnership working.

Operational

Health and Wellbeing

- A Psychologically Informed Environment [PIE] should be established in all health and social care settings.
- Ensure all homeless people are offered an annual health review, including medications review, and a review of their welfare benefits.
- Prioritise homeless clients within the NHS Health Check programme in view of their increased CVD risk.
- Conduct opportunistic screening for cognitive impairment, mobility, urinary problems, and traumatic brain injury particularly in homeless older persons [over 50].

Substance Misuse

- Ensure that substance misuse services provide appropriate levels of support to clients with substance misuse problems who are difficult to engage.
- Ensure recovery is sustainable by increasing the focus on longer term peer support and mutual aid.

Access to Health Services

- Ensure GP practices are up to date with NHSE guidance on requirements for registering patients.
- Develop and implement a protocol/pathway for planning the hospital discharge of homeless people from ESHT.
- Conduct an audit of hospital discharges of homeless patients from Eastbourne District General Hospital and Conquest Hospital using this discharge protocol.

Health Behaviours

- Pilot the provision of tailored stop smoking sessions within existing homeless services eg Seaview in Hastings and Salvation Army in Eastbourne.
- Ensure that all staff working with homeless people receive training in “making every contact count” [MECC] to help them to support clients around their health-related behaviours and to keep well.
- Ensure the needs of homeless people are considered in MECC training provided for hospital staff.

Screening and immunisations

- Set up a homeless influenza vaccination programme within existing homeless service providers including outreach work, for example encourage people to be taken to the walk in centre for ‘flu vaccine.

- Explore how homeless people’s access to screening and immunisation programmes might be improved.
- Undertake opportunistic screening for Infectious Diseases, TB, lice etc

INTRODUCTION

Homelessness is an increasing problem. The latest figures for East Sussex show that the number of people sleeping rough in 2015 increased by roughly 50% from 2014 and has more than doubled since 2010.[1] Rough sleeping is only the tip of the iceberg of homelessness. The numbers of hidden homeless (people "sofa surfing" and those living in squats, vehicles, emergency and temporary accommodation) are likely to be much higher.

Under section 179 of the Housing Act 1996, Local Authorities in England have a duty to provide advice and assistance to all those who may be either homeless or at risk of homelessness. However, only those people who are 'statutory homeless' are entitled to housing; that is they are 'eligible for public funds', have a 'local connection', are 'unintentionally homeless' and can prove they are in 'priority need'.

Priority need includes:

- People with children or who are pregnant
- The elderly or those aged 16-17 years
- Those with physical or mental health problems
- People fleeing domestic violence
- Ex-offenders who are likely to re-offend if not adequately housed
- People who are homeless as a result of an emergency, such as a fire or flood

(See Appendix 1 for further detail about definitions of homelessness)

The number of 'statutory homeless acceptances' in East Sussex has risen from 272 in 2010/11 to 591 in 2015/16 (a 117% increase). The numbers remained fairly stable between 2010/11 – 2013/14 but rose sharply between 2013/14 and 2015/16. This sharp increase was largely due to the increase in acceptances in Hastings which have been steadily increasing, from 45 in 2010/11 to 252 in 2015/16 (a 460% increase). During the same five year period the numbers in Eastbourne, whilst much lower than in Hastings, rose from 12 in 2010/11 to 77 in 2015/16 (a 542% increase). In the same five year period, homeless acceptances in Lewes increased from 51 to 60 (18% increase) and in Rother from 37 to 94 (154% increase); in Wealden they have decreased from 127 to 108 (15% decrease). It should also be recognised that there is greater pressure on available housing supply in urban compared to rural areas; for example, between 2010/11 and 2015/16, the number in temporary accommodation in Hastings rose from 11 to 50 (a 355% increase).[2]

The snapshot head count of rough sleepers in East Sussex was 28 people in 2014 and 40 people in 2015. Annecdotal reports suggest these numbers are increasing in Hastings and Eastbourne.

People who do not fulfil the criteria for statutory homelessness are not eligible to receive housing and are therefore more likely to experience ongoing homelessness unless they are reconnected with their local area.

Homeless people experience widespread ill health on a background of generally unhealthy lifestyles and typically do not get enough help with their health.[3] In 2014, the average [mean] age of death of homeless people nationally was only 48 years for men and 43 years for women [4] compared to 77.9 years for men and 82.9 years for the general population in East Sussex.

This audit aims to provide a local picture of the health of homeless people in East Sussex and can be used to guide the development of new and existing services to help address the health needs of homeless people in East Sussex.

2. METHODOLOGY

2.1 The audit tool

The questionnaire used for this audit was adapted from the Homeless Link health needs audit toolkit. Homeless Link developed the Health Needs Audit in partnership with the NHS, Local Authorities, and the voluntary sector. In 2015, with funding from Public Health England, it was up-dated to take into account changes to local commissioning environments and other relevant reforms impacting on homelessness and health.

The Audit asks homeless people about their health, lifestyle and use of healthcare services. Some additional questions were included in the East Sussex audit to cover local health services. The version used in this audit is available in full in Appendix 2**.**

It is intended that the findings will be used by commissioners and providers to better plan and deliver health services for homeless people locally.

The questionnaire was distributed to all homeless service providers in East Sussex. Clients were interviewed by a member of staff in each participating service and supported to complete the questionnaire. Responses were collected during October and November 2015.

At the end of the questionnaire there were comment boxes for both the client and interviewer to provide free text feedback. Selected quotes from this feedback are included throughout the report.

2.2 Definition of homelessness

The definition of homelessness for the purpose of inclusion in the audit was that used by Homeless Link and included only single people who were:

- Living on the street
- Sofa surfing with friends or family
- Squatting
- In bed and breakfast, hostel, or other temporary accommodation
- In their own tenancy but at risk of losing it (evidence via past history or current support needs)

2.3 Data entry and analysis

The data from the questionnaires were input using the Homeless Link online tool, either by workers in each service or the Safer East Sussex Team. Data were analysed using Microsoft Excel Professional Plus 2010. Where possible, data have been compared with local and national statistics, including Census and Office for National Statistics surveys. Statistics for the general population have been adjusted to match the age and gender profile of this sample of the East Sussex homeless population (where age and gender stratified data were available).

As the questionnaire used in this audit is a more recent version than that used for the Homeless Link report of 2014, it was only possible to make comparisons with national homeless data in a minority of cases. Statistical significance testing where relevant was carried out using Fisher's exact test. Reported confidence intervals are 95% throughout.

2.4 Survey of homeless service providers

It was recognised that some of the more complex clients may not have engaged with the audit, either because the questionnaire took too long to complete or because they did not regularly engage with the support services and hence were not asked. In acknowledgment of this, it was considered important to ask those providing services to homeless people about the health needs of clients with complex/multiple needs.

A simple online survey tool was devised and circulated to those agencies that attended the initial stakeholder meeting. Three questions were asked; these were purposely kept open to allow for free text responses:

1. How do you think health services for people with multiple complex needs could be improved?
2. Can you tell us about any positive experiences clients have had in accessing health services?
3. Do you have any other comments in relation to the health needs and/or access to services for clients with multiple complex needs?

The findings of the survey can be found in section 3.7.

3. FINDINGS

3.1 Demographics

3.1.1 Sample size

There was a good response from services across East Sussex with a total of 285 respondents completing the audit. However, not all questions were completed by all respondents; the number completing each question is indicated.

A large proportion of the respondents came from Supporting People commissioned services including Home Works, a county-wide service which supports people aged 16 to 64 years who are at risk of losing their tenancy.

Whilst the largest number of clients was from Home Works, they were careful to select those clients who fitted the definition outlined by Homeless Link (see 2.2). It is also important to point out that the significant time investment required to fill in the questionnaire meant that some services were more able to complete it with their clients than others.

Table 1: Number of responses from services

Service	No. of responses
Home Works	135
Eastbourne Foyer	37
SAHA Newhaven Foyer	37
Seaview	18
Refuge	13
Sanctuary Supported Living	8
Fulfilling Lives	7
Merrick House	6
Salvation Army	5
Matthew 25	4
St John Homeless Service	4
STEPS	3
STAR (Lift House)	2
Place of Calm/ Brightview, Sussex Oakleaf	2
Eastbourne and Wealden YMCA	1
South East Independent Living	1
St. Mungo's Broadway	-

"Foyer are supportive and have 24 hour staff, this is reassuring as there is always someone there."

"I receive support from Home Works which has helped me get my life back. I do not drink now, my mental health has improved"

3.1.2 Representativeness of this audit

Responses in this audit represent a convenience sample of the homeless population in East Sussex. The audit will not have captured the needs of those who are less well engaged with the services involved and homeless people with the most complex needs may also be under-represented.

"[It was] difficult for my client to sit still for 20 minutes to get through questions"

The number of people in the audit who stated they were currently sleeping rough (24) represents 60% of the number counted in the East Sussex 2015 rough sleeper count. This figure provides a snapshot of the number of rough sleepers at a particular time and is likely to be an underestimate of the total numbers.[1]

3.1.3 Location

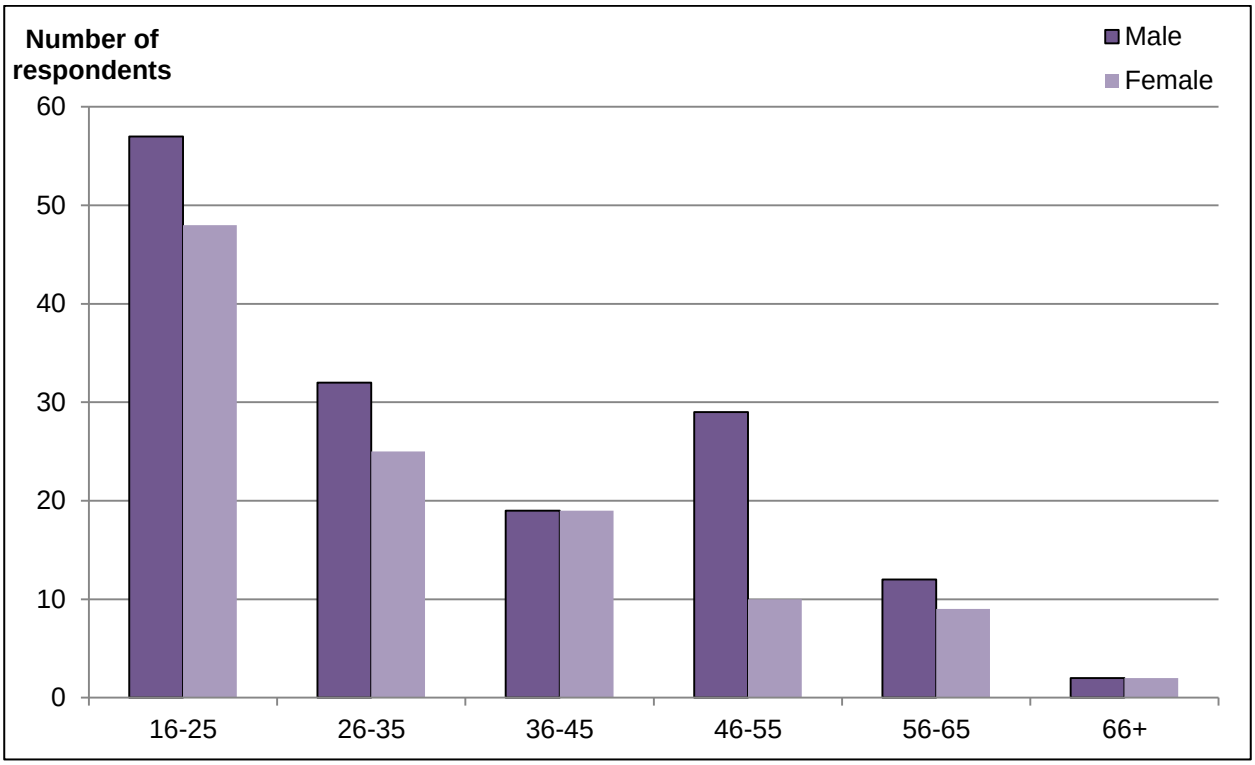
The current residence of the 285 respondents (self-selected by the respondent) is shown in Figure 1. The majority of respondents resided in the urban areas of Eastbourne and Hastings.

Figure 1: Distribution of respondents in East Sussex

"[I needed] someone to speak to when [I was] first made homeless, [I] was told Hastings could not help me and to return to London. I felt stressed out and unwell"

3.1.4 Age and gender

Figure 2: Number of respondents by age and gender



Respondents in the audit were, on average, younger than the general population. The mean age for all respondents was 33.5 years; the mean age of females was 32.3 years and the mean age of males was 34.4 years. The mean age of the East Sussex population for those aged 16 and over is 51 years.[5] There were 46 persons aged 50 and over in the audit.

Respondents were predominantly male (61%), however, this percentage is lower than that of the national homeless audit report (71% male) [3] and the homeless audit in Brighton & Hove (78% male).[6] In East Sussex as a whole, 48% of the population are male.

> *"What is available does not meet my needs. More services are needed for young people"*

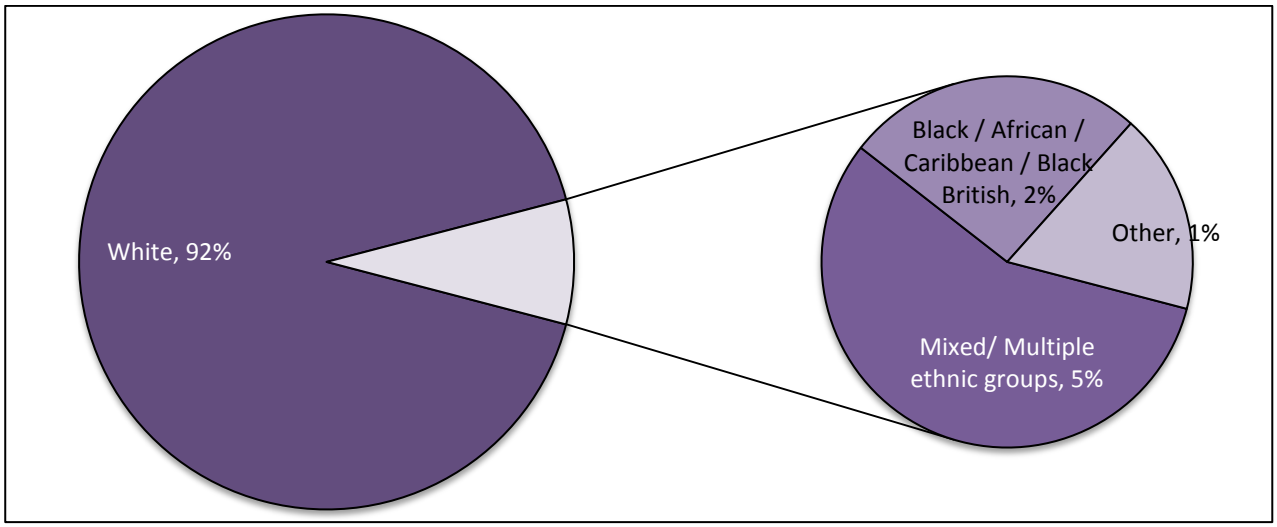
3.1.5 Sexual Orientation

Of the 278 respondents, 91% identified as heterosexual, 6% bisexual, and 3% homosexual.

3.1.6 Ethnicity

In terms of ethnicity, 92% of respondents reported this as white. Comparatively, 86% of the East Sussex general population reported their ethnicity as white (Figure 3). The East Sussex data are similar to the national homeless audit report, where 93% reported their ethnicity as white. [3]

Figure 3: Ethnicity 283 total respondents

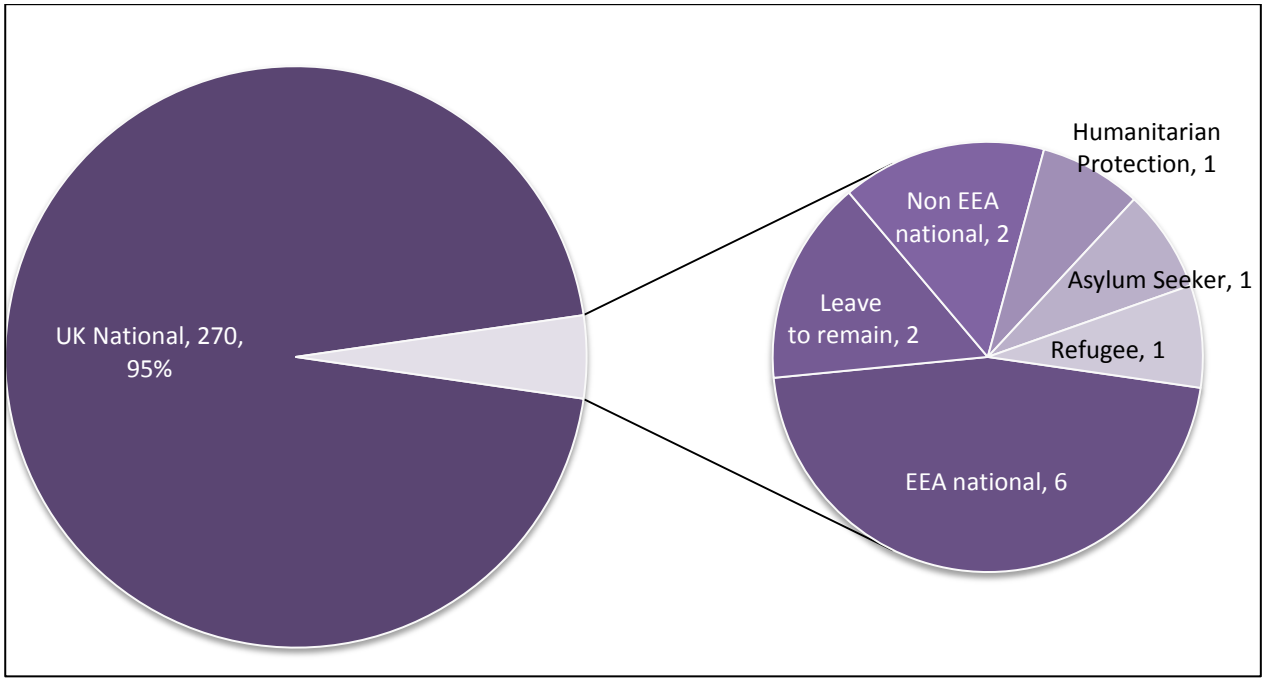


Of the 259 people who stated their ethnicity was white, 95% (246) identified as “English/ Welsh/ Scottish/ Northern Irish/ British”, 5 as “Gypsy or Irish Traveller” and 8 as “Other”.

3.1.7 Immigration status

When asked about their immigration status, 95% of respondents reported they were UK nationals (Figure 4). This is the same proportion as the general population of East Sussex.[7] In the national homeless audit report 93% were UK nationals. [3]

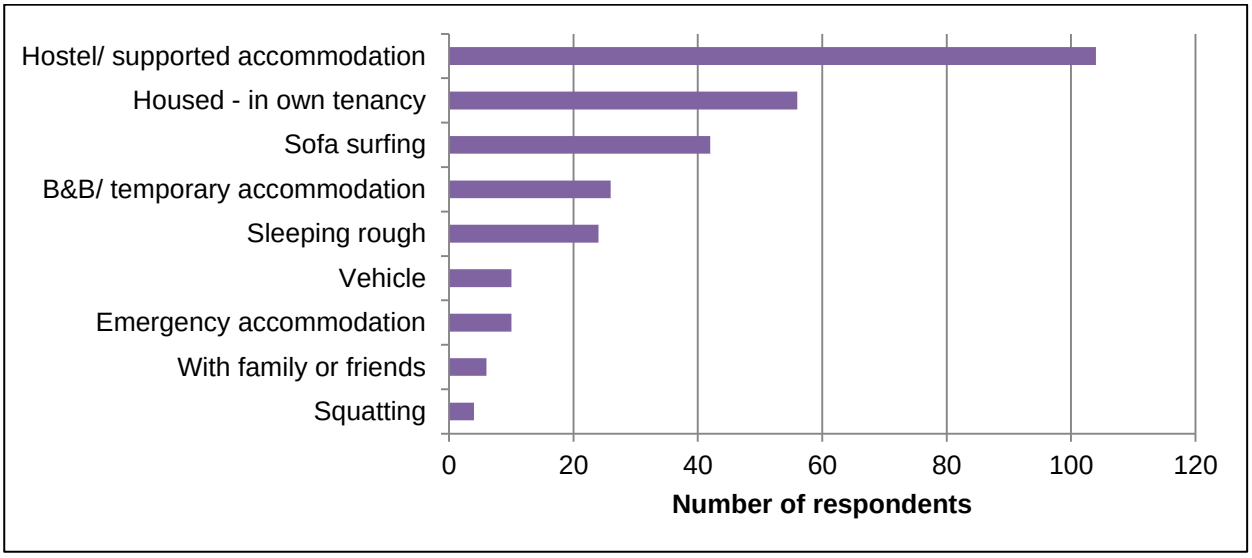
Figure 4: Immigration status, 283 total respondents



“[I] feel let down by the system, I am a British National and see lots of immigrants coming into the UK and getting housing, why not me?

3.1.8 Accommodation status

Figure 5: Current accommodation status, 282 total respondents



The current accommodation status of the 282 respondents who answered this question is shown in figure 5.While only 8% of respondents were sleeping rough at the time of the audit, 48% reported they had slept rough at some point in the past. Likewise, while 15% of respondents were sofa surfing, 75% had sofa surfed at some previous point in time. Two thirds of respondents had previously applied to a local council as homeless.

"When [you are] homeless it's hard to keep yourself mentally and physically well. Now I have a home things have improved"

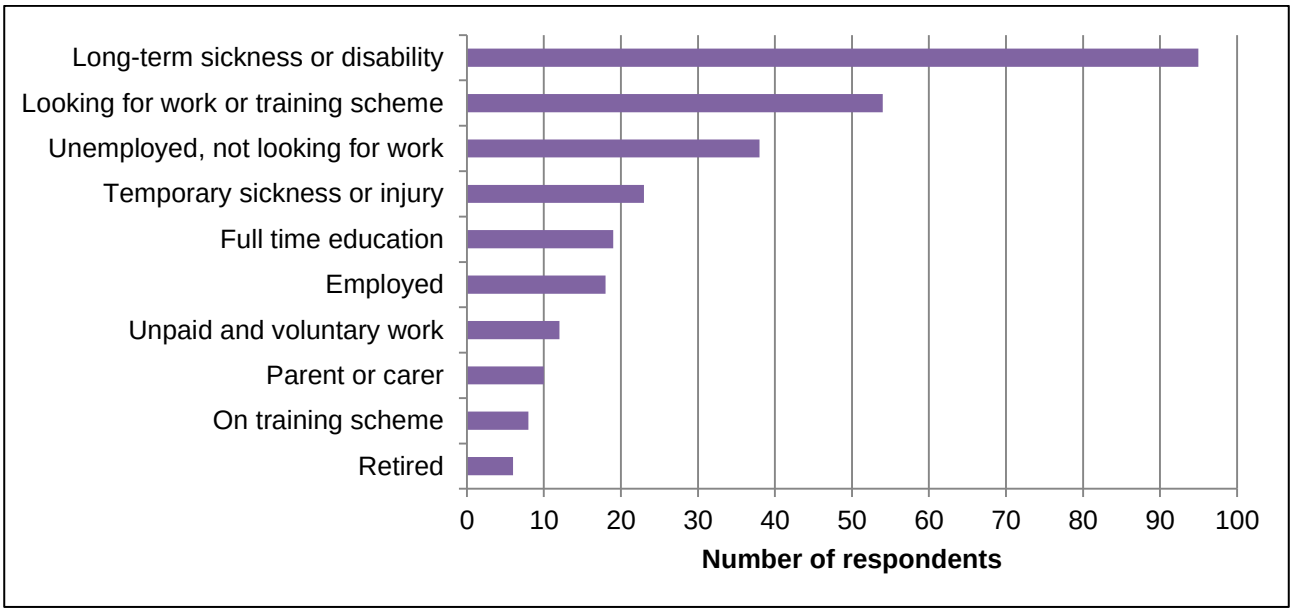
"If I was housed my health would improve and I wouldn't feel unwell."

"[I] do not want to start hepatitis treatment or support for alcohol misuse until I have somewhere to live"

3.1.9 Employment

Respondents were asked about their employment status (see Figure 6). Only 6% of respondents were currently employed, the same proportion of respondents as found in the national health needs audit. This rate is much lower than the national employment rate in the general population, which was 74% in the most recent labour market statistics release.[8]

Figure 6: Current employment status, 283 respondents



3.1.10 Reason for becoming homeless

Respondents were asked to select one primary and one secondary reason for when they most recently became homeless. Table 2 shows that the main primary reason was that "parents/ care-givers no longer able or willing to accommodate". Of note, domestic violence/abuse was the second most common reason for becoming homeless. The main contributory factor (secondary reason for becoming homeless) reported was "mental or physical health problems".

The main factors predisposing to homelessness in the older group (aged 50 years and over) differed: six people were homeless as a result of a non-violent breakdown of a relationship, and seven from end of a tenancy or mortgage arrears.

Table 2 Primary and secondary reasons for becoming homeless

Top 5 primary reasons for becoming homeless	
Parents / care-givers no longer able or willing to accommodate	71
Abuse or domestic violence	37
Eviction or threat of eviction	34
Non-violent relationship breakdown with partner	26
Other relatives or friends no longer able or willing to accommodate	16

Top 4 secondary reasons for becoming homeless	
Mental or physical health problems	33
Other relatives or friends no longer able or willing to accommodate	27
Drug or alcohol problems	22
Parents / care-givers no longer able or willing to accommodate	11

"I was healthy before I fled domestic violence"

3.1.11 Background factors

Respondents were asked if they had ever been: in prison; a secure unit or young offender institution; on probation or in a Youth Offending Service; in LA care; the Armed Forces; admitted to hospital for a mental health issue; or a victim of domestic abuse.

Prison

Almost half (45%) of the 167 male respondents reported having been in prison, a young offender institute, or on probation. Of the 116 female respondents this proportion was 21%. In all, 35% of all respondents were ex-offenders.

> *"[Need better] communication between GP and probation service"*

Armed forces

The proportion of respondents reporting they had been in the armed forces (3.5%) was not significantly different from the 2.4% estimated to be veterans in a UK population of similar age range.[9] This would support the Royal British Legion's position that the ex-service community are not more likely to experience homelessness than the general population.

LA care

Thirty-seven respondents (13%) reported having been in LA care at some point in their lives; of these 16 were male and 21 were female, twelve of whom were 25 years of age or younger. Recent research found that 25% of single homeless people had been in local authority care at some stage.[10]

Domestic violence/abuse

Domestic violence amongst women was reported twice as often in homeless respondents compared to the general population of England and Wales (51% and 27% respectively, $p<0.001$). Domestic violence in male respondents was reported at a similar level to the general population of England and Wales (14% and 13% respectively, $p=0.65$).[11] A quarter of women stated abuse or domestic violence as the primary reason for becoming homeless (24.8% of 113 respondents); the proportion of men who reported abuse or domestic violence was fivefold lower (5.4% of 166 respondents).

Learning disabilities or difficulties

Learning disabilities or difficulties ("as told by a health professional") were reported 10 times more frequently amongst respondents than the estimated prevalence of learning disabilities in the general population (21% and 2.0% respectively).[12] This is consistent with a study in Hull that demonstrated an increased prevalence of learning disabilities amongst the homeless population.[13]

Autism and Attention Deficit Hyperactivity Disorder (ADHD) were asked about separately from learning disabilities or difficulties (see Appendix 2, question16). ADHD was reported by 13 respondents (6% of 234) and Attention Deficit Hyperactivity Disorder was reported by 234 respondents (10% of 235). This is much higher than reported levels of ADHD in the general population (3.3%, age adjusted).[14]

> *"[The questionnaire was] quite difficult for clients with learning difficulties"*

3.1.12 Demographics - key points

- In total, 285 people took part in this survey, 68% of whom were 'resident' in Eastbourne and Hastings. Questionnaires were mostly completed by housing support services.
- The average age of homeless respondents was 17 years younger than the average age of the general population of East Sussex. There were more males than females at a ratio of three to two, although the proportion of females in the East Sussex audit was higher than the national audit. This may be due to the high number of responses from young people's accommodation services.
- Respondents were 92% white and 95% were UK nationals. This compares with 96% of the East Sussex population who are white.
- The current accommodation of respondents varied from rough sleeping to those housed in their own tenancy. However, half of all respondents had slept rough at some point in the past and two thirds had sofa surfed.
- Only 8% of respondents were employed. A third of respondents stated they had a long-term sickness or disability preventing them from working.
- Around a third of respondents were ex-offenders.
- 13% reported having been in LA care at some point in their lives.
- Being a victim of domestic violence was reported significantly more frequently than in the general population of East Sussex in women but not in men.
- Learning disabilities or difficulties were reported 10 times more frequently amongst respondents than the estimated prevalence of learning disabilities in the general population (21% and 2.0% respectively).

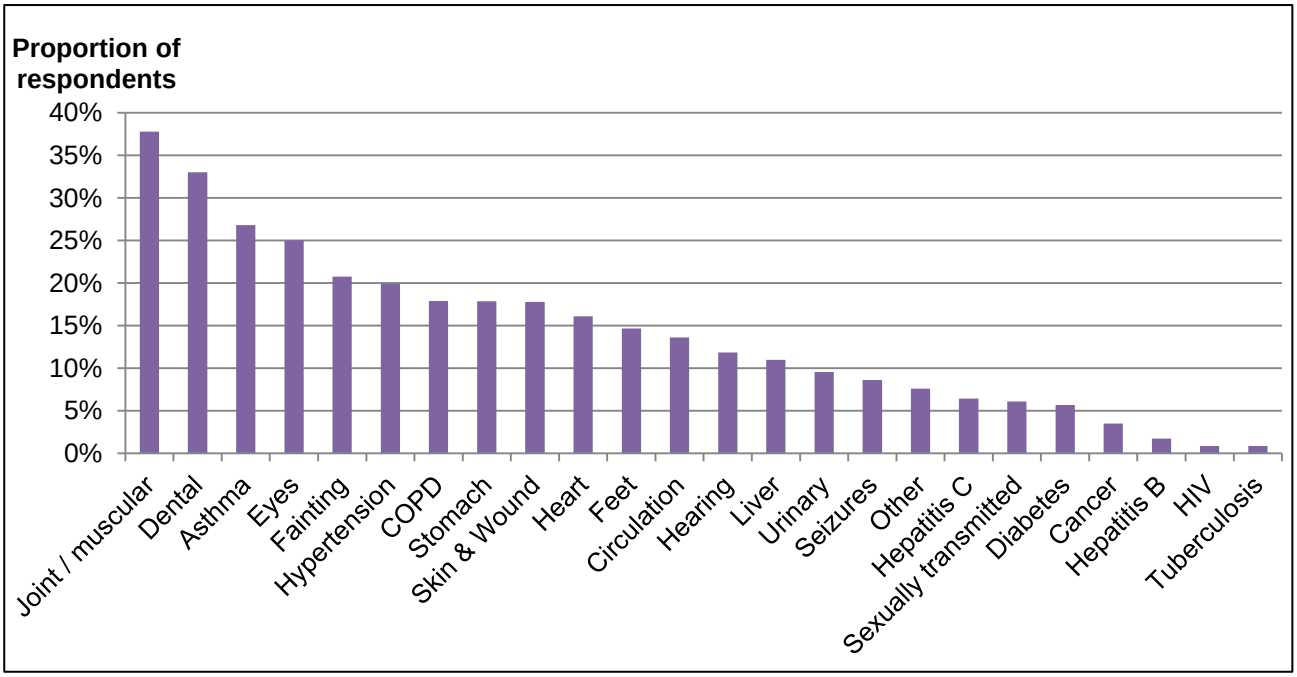
3.2 Health and wellbeing

3.2.1 Physical health

Two thirds (67% of 276 respondents) of respondents reported having a long-standing illness, disability, or infirmity. This is much higher than the general population of East Sussex, where 42% reported a long standing health condition ($P<0.0001$, age adjusted).[21]

The majority (77% of 285 respondents) reported having been told by a health professional at some point in their life that they had a physical health problem. A breakdown of reported physical health problems is shown in figure 7. Just over half (56% of 285 respondents) had been told by a health professional in the past year that they had a physical health problem.

Figure 7: Reported physical health problems at any time



Of the 182 respondents who reported ever having been told they had a physical health problem, 73% (132 respondents) said they were receiving support for this. However, many (30%) also reported that they would like more help with their physical health problem (Table 3).

Table 3 Support for physical health

Receiving support for physical health problem?		%
No, but it would help me	19	10%
No, I do not need any	29	16%
Yes, and it meets my needs	79	43%
Yes, but I'd still like more help	55	30%
Total	182	

Fifteen respondents reported they had been told they had Hepatitis C; of these, five reported they had received treatment, five that they had been offered treatment but did not take it up, and four that they had not been offered treatment.

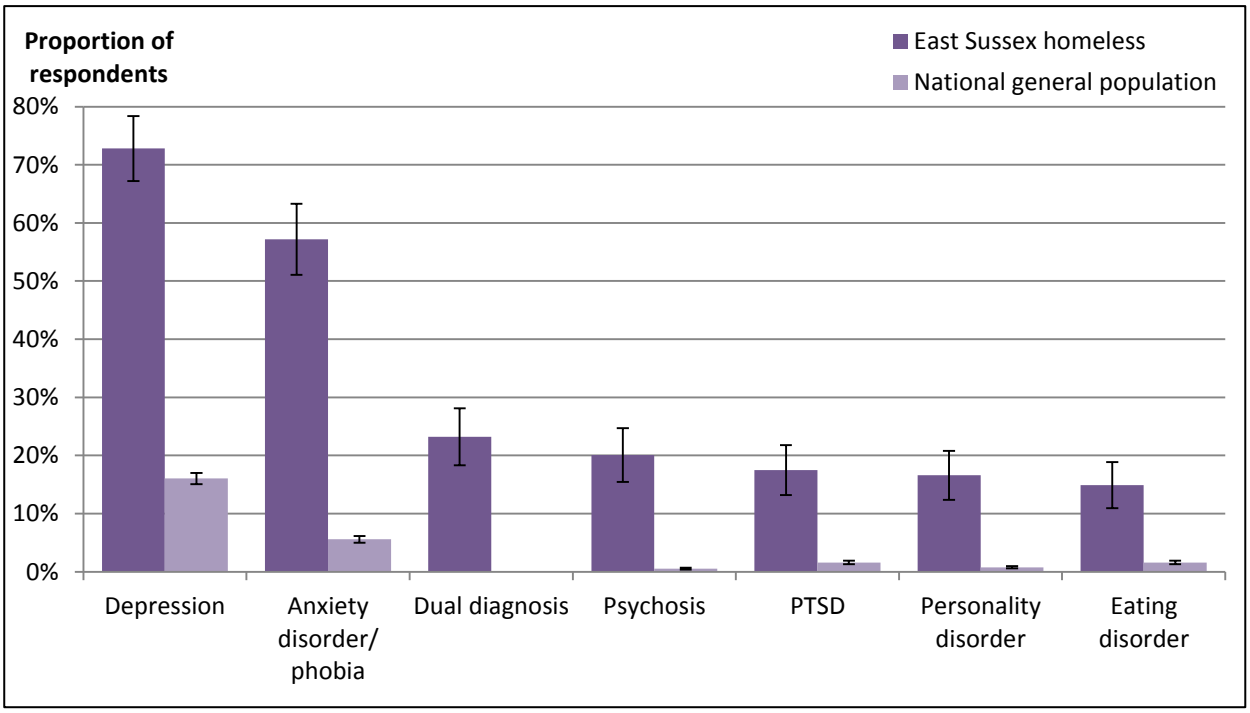
3.2.2 Mental health

Of the 285 respondents in this audit, 78% (222) reported at least one mental health condition, as told by a doctor or health professional; levels of depression and anxiety were particularly high (Figure 8). Nationally, 23% of the general population reported having at

least one mental health diagnosis. [14] This difference in mental health diagnoses is highly significant (p<0.0001).[Fn1]

"[There should be] more support for people with mental health problems, they should be given more priority"

Figure 8: Reported mental health problems at any time: comparing audit respondents and the general population (2014, HSE, age and gender adjusted)



"[There should be] more support for mental health before crisis point."

The majority (69% of 223 respondents) of respondents who reported a mental health problem said they were receiving support for this. However, as was the case with physical health, many (29%) felt they needed more help and some of those not receiving help said they would like help (17%).

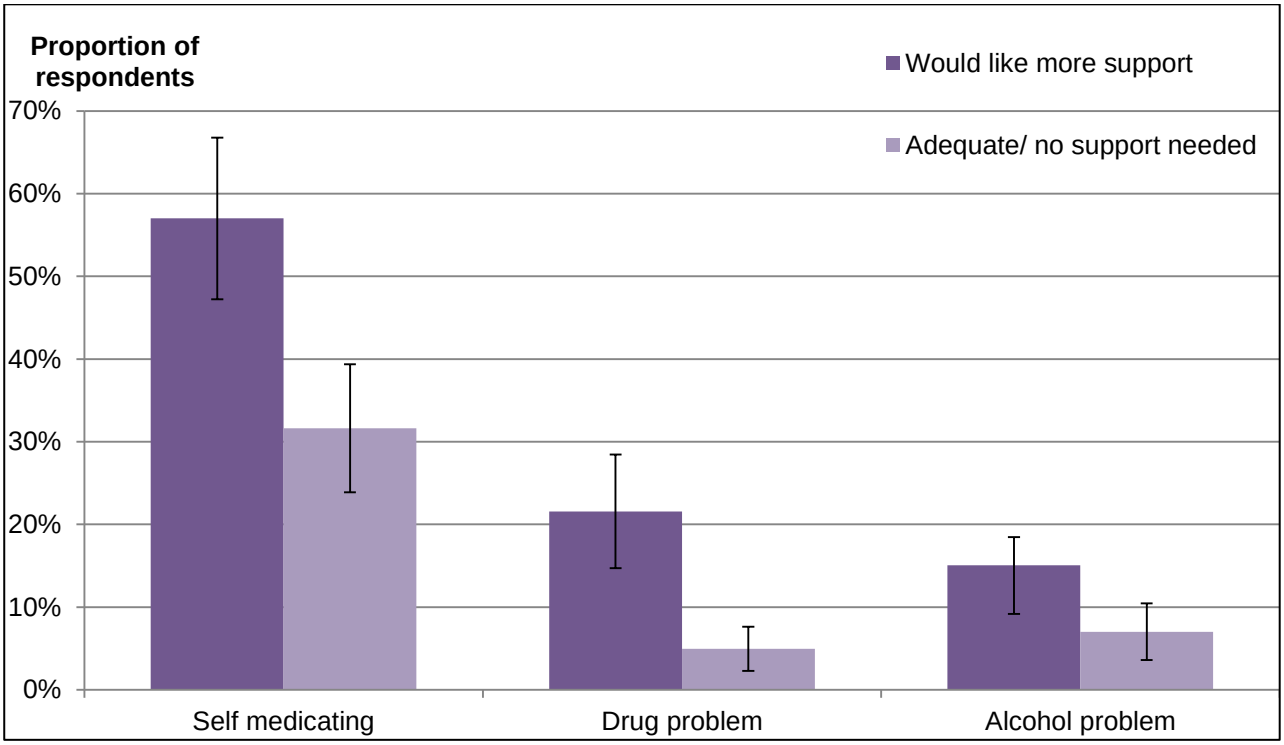
Table 4 Support for mental health

Receiving support for mental health problem?		%
No, but it would help me	37	17%
No, I do not need any	33	15%
Yes, and it meets my needs	88	39%
Yes, but I'd still like more help	65	29%
Total	223	

[Fn1]In the Health Survey for England, participants were asked about mental health diagnoses. Whereas in this audit, participants were asked about mental health conditions as told by doctor or healthcare professional. This difference in phrasing is likely comparable.

Respondents who said they were not receiving any support for their mental health problem but agreed “it would help me” (17%) or who were receiving some help but agreed “I’d still like more help” (29%) reported more drug (p=0.0002) and alcohol (p= 0.0721) problems than those who said they “do not need any” or they receive help “and it meets my needs”. They were also more likely to report using drugs and alcohol to self-medicate for their mental health problems (p=0.0002). Dual diagnosis refers to those people who have a concurrent serious mental health problem and problematic use of drugs or alcohol; PTSD is post traumatic stress disorder.

Figure 9: Alcohol and drug problem in respondents with mental health problems



3.2.3 Use of prescribed medicines

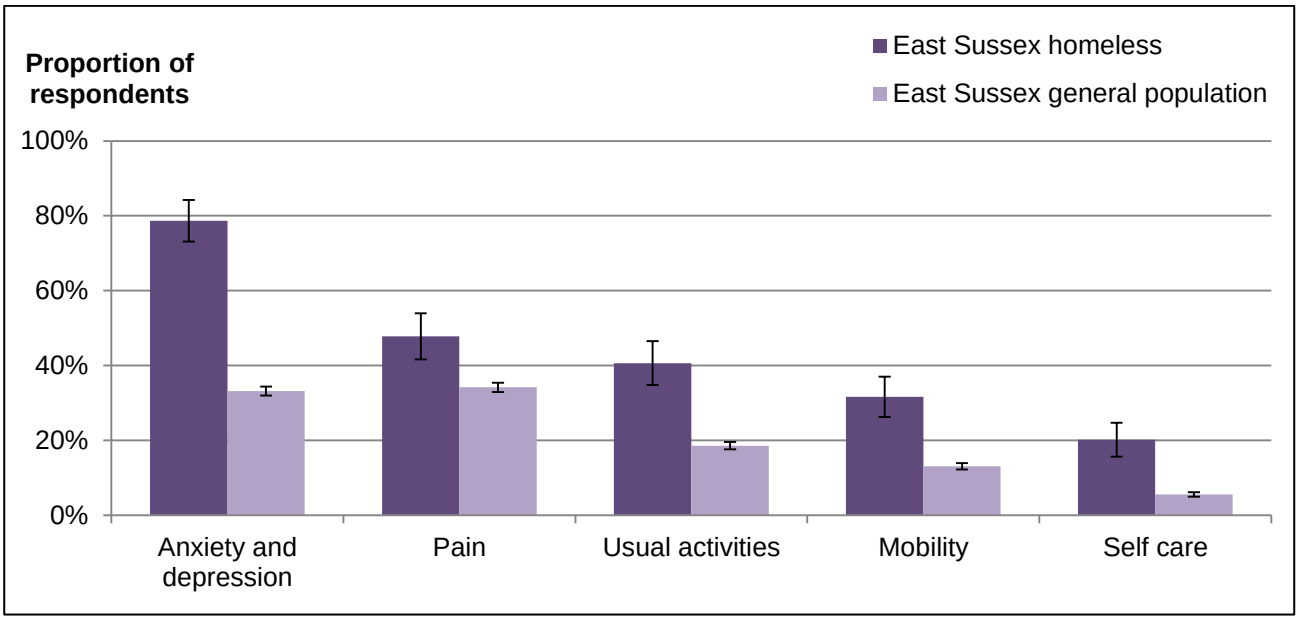
Respondent’s use of prescribed medications in this audit was much higher than in the general population: 69% of respondents reported taking medication prescribed for them at the time. In the 2013 Health Survey for England (HSE), 30% of participants reported taking prescribed medications in the last week (age and gender adjusted).

> *“Pain medication helps me to be mobile. Antidepressants maintain my mental health.”*

3.2.4 State of health

Respondents were asked about the state of their health using the “EQ-5D” questionnaire. The EQ 5D is a standardised measure of health-related quality of life. Respondents in this audit reported more problems than the East Sussex general population in all five areas of the EQ-5D (age adjusted).[21]

Figure 10: Reported problems in EQ-5D of respondents and the general population



3.2.5 Health and wellbeing – Key points

- There are substantial inequalities in the physical and mental health of homeless people compared with the general population which need to be addressed.
- The three most commonly reported physical health problems were musculoskeletal problems, dental problems and asthma.
- Two thirds of respondents reported having a long-standing illness or disability.
- The majority (78%) of respondents reported having at least one mental health problem. This is much higher than the national general population (23%).
- On average, the East Sussex homeless population reported a lower health quality of life than the general population.
- 31% of respondents stated that their health is now worse than it was 12 months previously.

3.2.6 Health and wellbeing – Recommendations

- A Psychologically Informed Environment [PIE] should be established in all health and social care settings.
- Ensure all homeless people are offered an annual health review, including medications review, and a review of their welfare benefits.
- Prioritise homeless clients within the NHS Health Check programme in view of their increased CVD risk.
- Conduct opportunistic screening for cognitive impairment, mobility, urinary problems, and traumatic brain injury in homeless older persons [over 50].
- Consider outreach mental health service for homeless people, including those with drug and alcohol problems, to improve their access to treatment and on-going support.

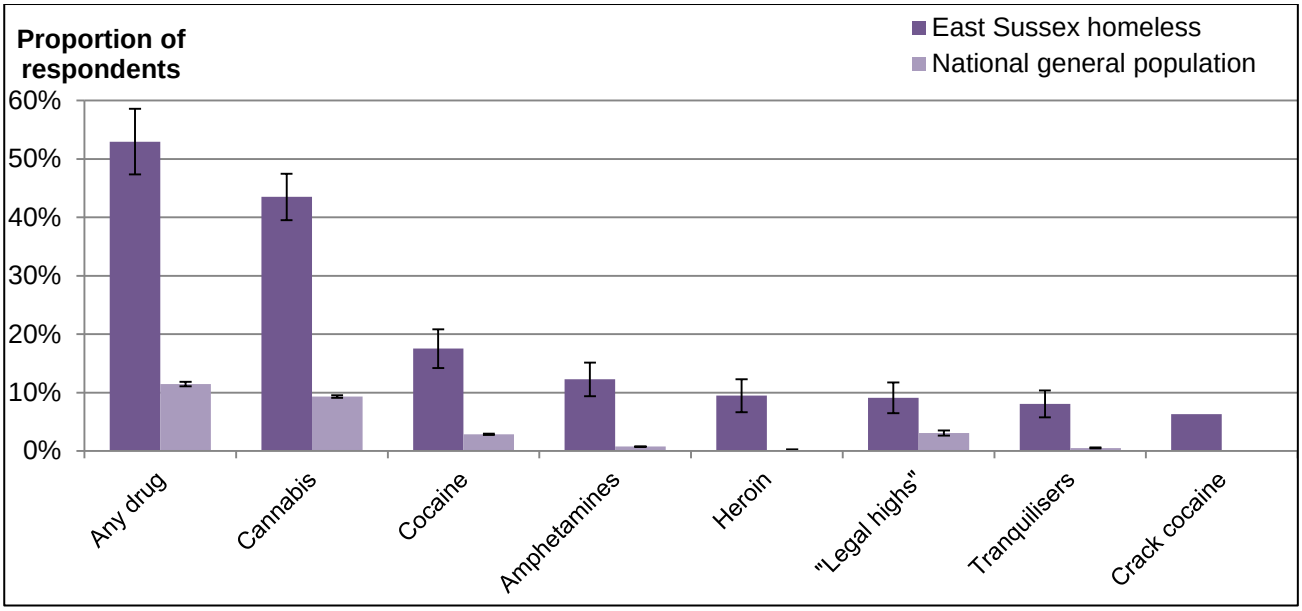
3.3 Substance misuse

3.3.1 Drug use

Drug use in the past 12 months was substantially higher in this homeless audit population than in the general population for all drugs included. Use of ecstasy and hallucinogens were not specifically included in the audit questionnaire. Comparative data are shown in Figure 11. General population usage of cannabis, cocaine, amphetamines, and "any drug" is age adjusted to enable comparison; age stratified data for the general population for heroin, New Psychoactive Substances ("legal highs" some of which may include illegal substances), tranquilisers, and crack cocaine were not available.

> *"I feel that I am judged because of my past history of drug abuse"*

Figure 11: Reported drug use in the past 12 months of respondents and the general population



In total, 56% of the 285 respondents reported having taken at least one illicit drug in the previous 12 months. This is five times higher than the general population of England and Wales, where the proportion is 11% (age adjusted).[15]

> *"I still think there is discrimination once you tell a health professional you have a using background, no matter how well you've done"*

Of the 285 respondents 11% reported that they had a *current* drug problem and another 12% stated that they were *recovering from* a drug problem. There may be under reporting for fear of losing a tenancy.

Table 5: Support for drug problems

Receiving support for drug problem?		
No, but it would help me	6	10%
No, I do not need any	9	15%
Yes, and it meets my needs	31	52%
Yes, but I'd still like more help	14	23%
Total	60	

Three quarters of those with a current or previous drug problem were receiving support for their problem. However, a third of those with a current or previous drug problem reported that they would like some (10%) or more support (23%) for their problem. Over a third (37%) stated that they used drugs and/or alcohol to help them cope with their mental health.

"Merging of the drug and alcohol service puts people off getting help"

3.3.2 Alcohol Use

Table 6 shows that around a quarter (24%) of the 259 respondents reported having an alcohol problem, either a current problem or in recovery; of these, around half (56% of 61 respondents) reported receiving support for their alcohol problem. Sixteen out of 61 would like some or more help with their alcohol problem. Over a third admitted to having an alcohol problem but did not feel they needed any support.

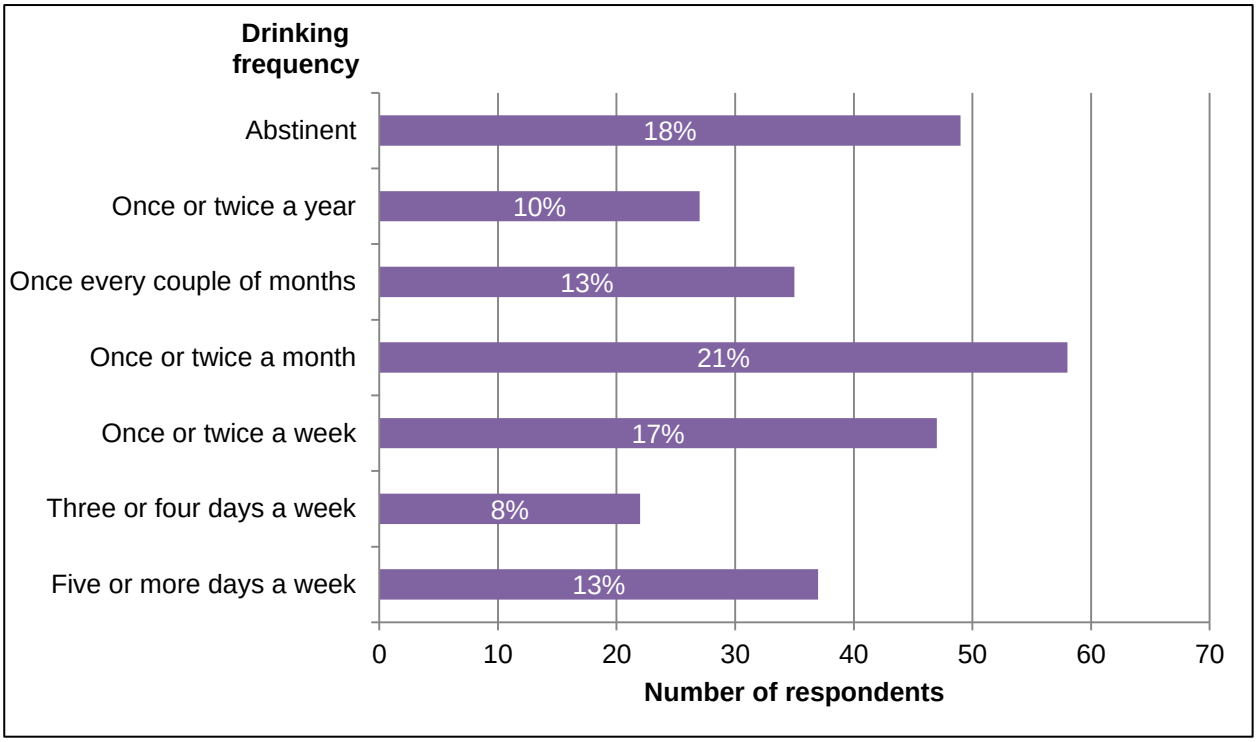
Table 6: Support for alcohol problems

Receiving support for alcohol problem?	Number	%
No, but it would help me	5	8%
No, I do not need any	22	36%
Yes, and it meets my needs	23	38%
Yes, but I'd still like more help	11	18%
Total	61	

"My GP is a good listener, [which is] important if you want to get off drink or drugs"

Around 13% of respondents (CI 10% - 18%) reported that in the past *12 months* they had drunk on 5 or more days a week, on average (Figure 12). In Great Britain, 7% of the general population reported drinking alcohol five or more times in the past *seven days* (age and gender adjusted).[16] It is difficult to make a direct comparison between these figures because of the differing time periods in question. It is known that people will generally underestimate their level of alcohol consumption. It is likely that asking people to give an average of their drinking behaviour in the past 12 months could lead to a greater under-reporting of drinking habits.

Figure 12: Drinking frequency in the past 12 months



A lower proportion of this homeless population reported being abstinent than the general population of Great Britain. Out of 275 respondents, 18% reported not drinking any alcohol, in Great Britain the proportion is 21% (age and gender adjusted).[17]

As discussed in the demographics section, it is likely that the heaviest drinkers and drug users were not captured in this audit because their complex needs prevented them completing the interview.

3.3.3 Substance misuse – Key points

- The proportion of respondents reporting drug use in the past 12 months was five times higher than in the general population.
- A quarter of respondents reported having a drug problem.
- A larger proportion of homeless people in this audit drank alcohol on most days of the week [5 or more days in the week] compared with the general population.
- A quarter of respondents reported an alcohol problem.
- 37% use drugs or alcohol to help them cope with mental health

3.3.4 Substance misuse – Recommendations

- Ensure that substance misuse services provide appropriate levels of support to those clients with substance misuse problems who are difficult to engage.
- Ensure recovery is sustainable by increasing the focus on longer term peer support and mutual aid.

3.4 Access to Health Services

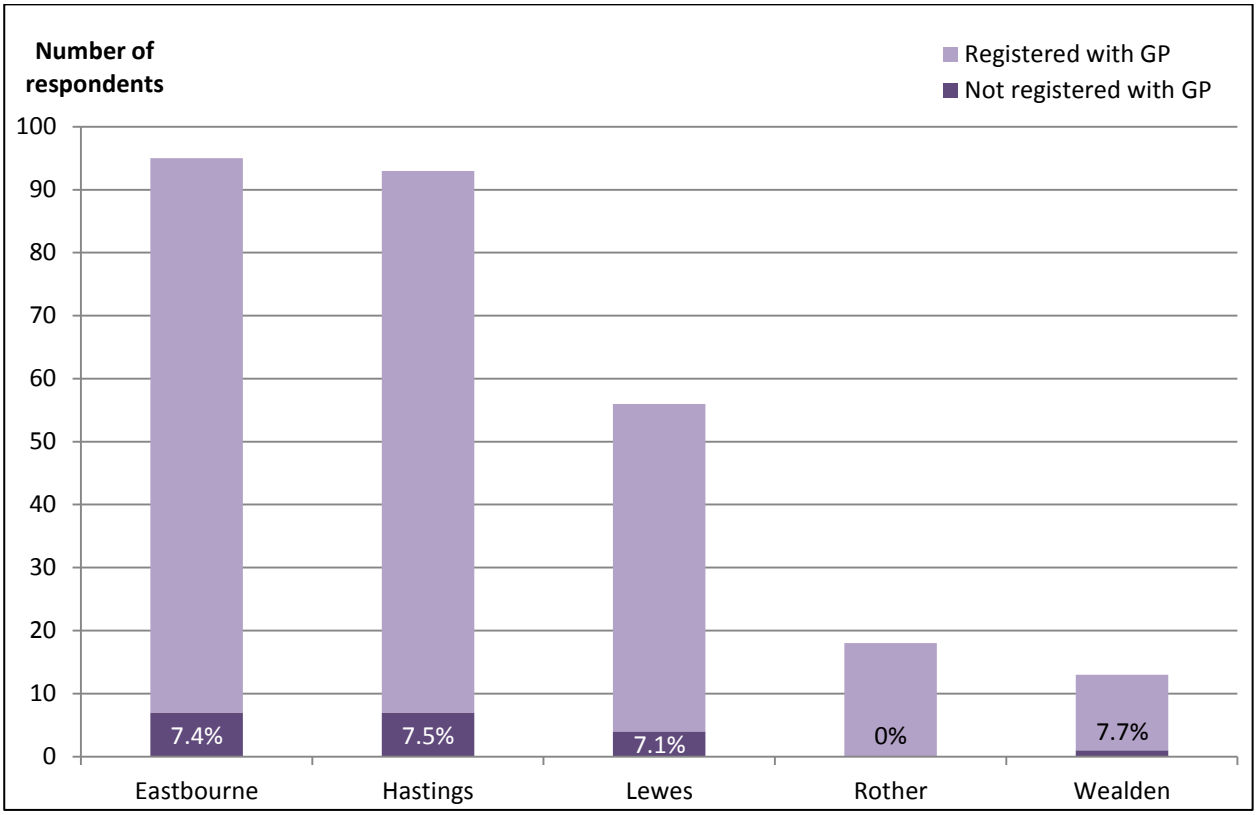
3.4.1 Registration with Health Services

Of the 285 respondents, 93% were registered with a GP. This is very similar to the proportion in the national homeless audit report, in which 92% of homeless people were registered with a GP. Likewise, both locally and nationally, 58% of homeless respondents were registered with a dentist (268 respondents in East Sussex). Of the 261 respondents in East Sussex 44% were registered with an optician; this question was not included in the national audit.

> *"Every time I see my GP I try to say about my other health problems but he only seems interested in one thing. I need longer than 10 minutes to see the GP"*

GP registration rates were consistent across the districts and boroughs of East Sussex (Figure 7). All respondents from Rother were registered with a GP however there were only 18 total respondents from this District (Figure 13).

Figure 13: GP unregistered respondents by local authority



The proportion registered with a dentist was similar in the group who reported ever having a dental problem and those who reported no dental problems (63% and 58% respectively). In the previous 12 months, fifteen respondents reported being refused registration with a GP practice, nine had been refused registration with a dentist, and three had been refused registration with an optician. The reasons given for refusal of registration with these

services were: missed appointments, conflict with staff, no identification, no contact details, and no capacity in the service.

NHS England guidance on GP registration states that “inability by a patient to provide identification or proof of address would not be considered reasonable grounds to refuse to register a patient.” The guidance specifically addresses the problems homeless people face when registering with a GP.[18]

> *“[We need] more GP appointments that you can book a few days in advance instead of several weeks in advance”*

GP unregistered respondents were generally younger and reported less ill health than those who were registered with a GP. They also used health services less frequently. However the unregistered respondents still reported being admitted to hospital more frequently than the general population (see Appendix 3). It is positive that those who would benefit most from GP services are registered, but more still needs to be done to improve registration.

3.4.2 Use of Health Services

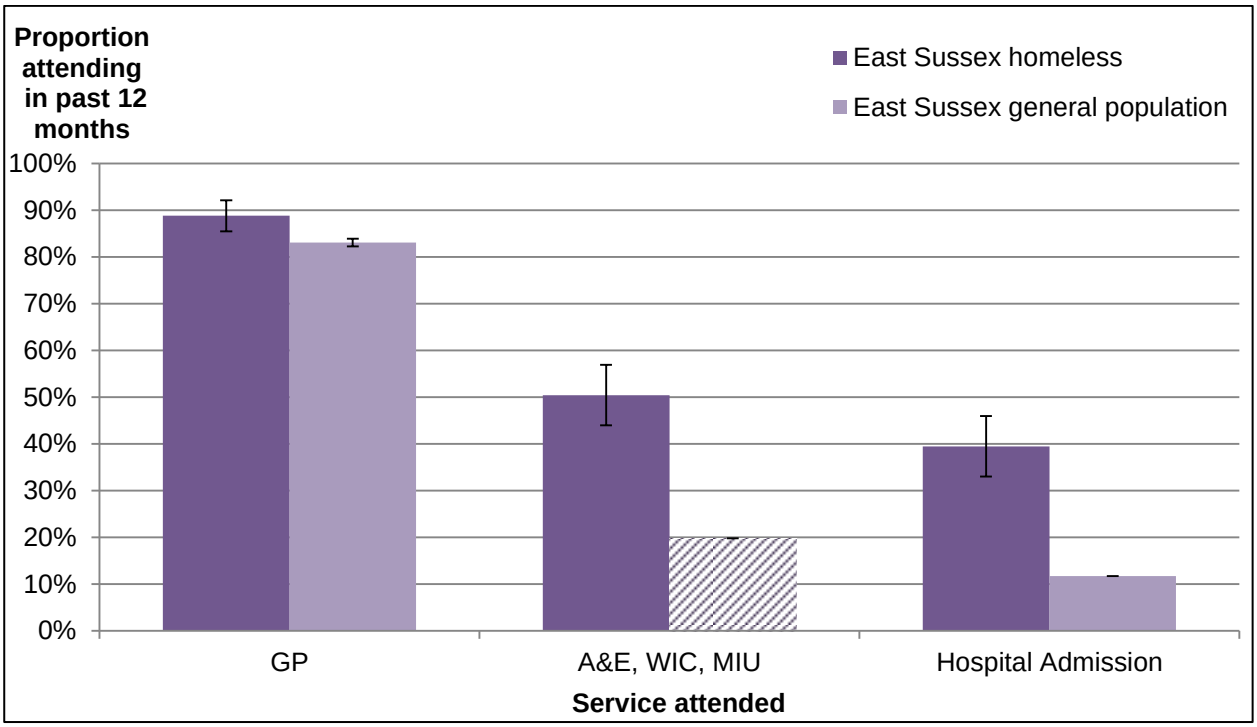
Of the 250 respondents who answered this question, 89% had seen a GP in the past 12 months; 54% had seen the GP more than three times in that period. In the general population of East Sussex 83% had seen a GP in the past year (age adjusted). *This indicates that GP use amongst homeless respondents was significantly higher than the general population (p=0.016).*

> *“A GP service for the homeless [is needed]”*

In the past 12 months 50% (of 226 respondents) reported having visited an accident and emergency (A&E) department, walk in centre (WIC), or minor injuries unit (MIU); 12% had visited A&E more than three times in the last 12 months (Figure 14). In East Sussex as a whole, 20% of the general population visited A&E in the 2014/ 2015 financial year (age and gender adjusted). Note that the proportion in the homeless population is self-reported and includes use of WICs and MIUs. Data are not available for the combined use of A&E, WICs, and MIUs in the general population, making a direct comparison impossible. In the last 12 months 32% of respondents had used an ambulance and 7% had used an ambulance more than three times.

Almost 40% (228 respondents) reported being admitted to hospital in the past year; 7% had been admitted to hospital more than three times. In the general population of East Sussex, 12% were admitted to hospital in the 2014/ 2015 financial year (age and gender adjusted, $p<0.001$). This equates to roughly a fourfold higher use of inpatient services, which is in line with Department of Health (DH) estimates of acute service use by homeless people.[16] When factoring in length of stay, the DH also estimated that homeless people use in-patient services eight times more than the general population.

Figure 14: Service use in the last 12 months of respondents and the general population



Note: A&E, WIC, MIU for the East Sussex general population only includes A&E use.

3.4.3 Access to services

In the past year, 31% of 273 respondents reported they had a time when they could not get an assessment or treatment for a physical health problem. A similar proportion (33% of 275 respondents) reported a time in the past year when they could not get an assessment or treatment for a mental health problem.

Together, 47% of respondents had a time in the past year where they reported they could not get an assessment or treatment for either a physical or mental health problem.

> *"I find it hard to book a GP appointment; [you] need to ring up in the morning on the day for an appointment. [Being able to] book one for the following week would help me."*

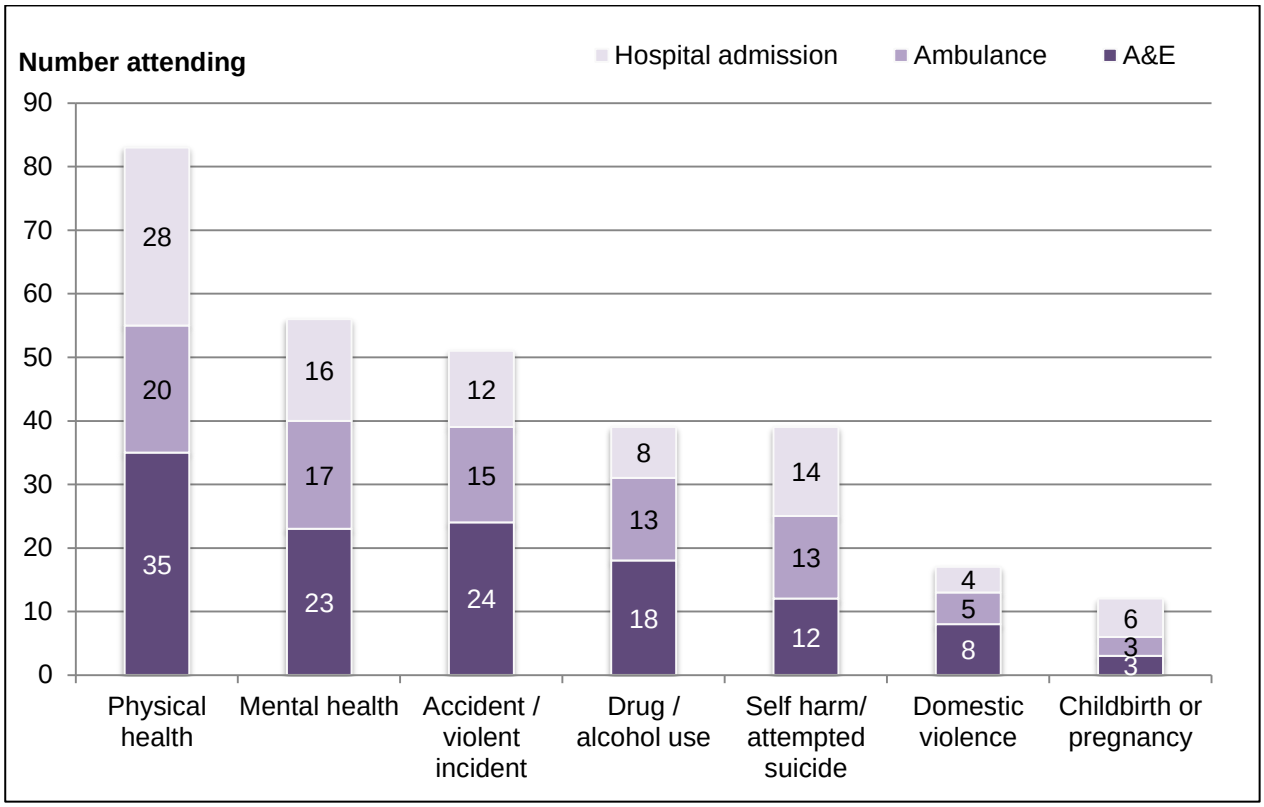
Reported difficulty in accessing the GP was similar in both GP registered and unregistered respondents (48% and 42% respectively, p=0.64). While it might be expected that GP unregistered respondents would have found it more difficult to be seen for physical and mental health problems, they generally had fewer health problems (as discussed above) so their need for consultation was likely to be lower.

> *"More outreach is needed. Eastbourne has lost this."*

3.4.4 Reasons for Service Use

The most common reason given for health service use in the past 12 months was a physical or mental health problem. However drug use, alcohol use, self-harm and attempted suicide make up a substantial proportion of the reasons reported and eight respondents reported being admitted to hospital for a drug or alcohol problem. Figure 15 shows the reason for service use and the service used for each category. Unfortunately there are no good comparative data available which consider the reason for service use in the general population.

Figure 15: Reason for service use in past 12 months



3.4.5 Hospital admission

Of 253 respondents, 96 (38%) had been admitted to hospital at least once in the past year. Table 7 shows admissions by the admitting hospitals.

Table 7: Location of admitting hospital

Admitting hospital	Admitted	Proportion
Conquest Hospital	43	45%
Eastbourne DGH	26	27%
Royal Sussex County Hospital	15	16%
Other/ no answer	12	13%
Total	96	

At the time of discharge, 47 (51%) of 93 respondents said they were asked if they had somewhere suitable to go on discharge, 28 said they were not asked, and 18 could not remember if they were asked.

Asking someone whether or not they had somewhere suitable to go on discharge did not seem to make a difference as to the appropriateness of discharge arrangements. If a respondent was asked if they had somewhere suitable to go on discharge, 62% went on to be discharged to what they thought was suitable accommodation. Of those who were not asked if they had somewhere suitable to go, 48% were discharged into what they felt was suitable accommodation. This difference was not significant (p=0.31).

Although the numbers were very small, a larger proportion of those discharged to the street reported being readmitted within 30 days (29%) compared to those discharged to what they perceived to be suitable accommodation (5%) (Table 3, p=0.03).

Table 8: Readmission to hospital within 30 days by accommodation on discharge

	Readmitted	Total	Proportion readmitted
Suitable accommodation	2	41	5%
Unsuitable accommodation	2	15	13%
Street	4	14	29%

Those discharged into suitable and unsuitable accommodation did not differ significantly in their average age, length of illness or disability, or proportion taking prescribed medications and had a similar number of reported physical and mental health diagnoses (see Appendix 4).

A large number of homeless people were discharged to unsuitable accommodation or onto the street. The data from this audit suggest, despite the low sample size, that homeless patients discharged to suitable accommodation have a lower rate of readmission to hospital. The link between discharge destination and readmission rate of homeless patients has been highlighted in a previous study in the US.[19]

Currently at the Conquest Hospital, homeless patients can be referred to the Hastings Homeless Service, run by St John Ambulance. This service works in partnership with ward staff, the adult social care team at Conquest Hospital, and Hastings Borough Council housing service with the aim of rehousing homeless patients on discharge and ensuring appropriate support is provided. Whilst the scheme has had some success, it is not systematically implemented relying on referrals from ward staff who must both recognise that a patient is homeless and be aware of the referral process.[20]

3.4.6 Access to health services – Key points

- 93% of respondents were registered with a GP; some respondents reported having been refused registration because of lack of ID.
- Use of health services was higher amongst homeless respondents than in the general population of East Sussex: A&E use was two and a half times higher and hospital admission was 4 times higher. There are some respondents making frequent visits to A&E/ having several ambulance call outs and/or several hospital admissions over a 12 month period.
- Half of the respondents had struggled to be seen (when they thought they needed an assessment or treatment) for a physical or mental health problem in the past year.

- A high proportion had been admitted to hospital in the past year (40%). Many reported being discharged to unsuitable accommodation or onto the street.
- Some respondents discharged from hospital were readmitted within 30 days. A higher proportion of those discharged to the street were readmitted than those discharged to suitable accommodation.

3.4.7 Access to health services – Recommendations

- Ensure GP practices are up to date with NHSE guidance on requirements for registering patients.
- Develop and implement a protocol/pathway for planning the hospital discharge of homeless people from ESHT.
- Conduct an audit of hospital discharges of homeless patients from Eastbourne District General Hospital and Conquest Hospital using this discharge protocol.

3.5 Health Behaviours

3.5.1 Smoking

Smoking rates in the homeless population are known to be high. In the national audit report 78% of homeless people were smokers.[3] This audit closely matches the national data, with 79% of 281 East Sussex respondents reporting smoking cigarettes, cigars or a pipe. In the general population of East Sussex 16% reported being smokers.[21]

Desire to quit smoking was low with only 35% of 217 respondents wanting to stop smoking altogether; 18% did not know whether they wanted to give up and 47% did not want to give up. This is considerably lower than the proportion that wants to give up smoking in the general population; previous studies have consistently found that around two thirds would like to give up smoking.[22]

> *"[It is] difficult to motivate the client to obtain support for his alcohol/smoking issues whilst he is sofa surfing"*

Of the 76 respondents who wanted to quit smoking, 37% reported being offered support to quit and took it up, a further 26% had been offered support but did not take it up, and 37% had not been offered support.

3.5.2 Meals and diet

As reported in the national audit report, this audit found poor diets amongst respondents. In East Sussex, 38% (99 of 258 respondents) reported eating one meal a day with 5% (14 of 258 respondents) reporting that on average they ate less than one meal a day. In total 44% reported eating less than two meals a day. This is greater than the national audit where 35% of homeless people reported not eating at least two meals a day.

"[I get] butterfly feelings in my stomach not knowing where next meal is coming from"

Only 4% of respondents reported eating the recommended "5 A DAY" portions of fruit and vegetables and more than half (61% of 256 respondents) reported eating fewer than 2 portions of fruit and vegetable per day. Nationally, adults aged 19 to 65 consume on average 4.1 portions of fruit and vegetables per day and 30% meet the "5 A DAY" guideline.[23]

3.5.3 Physical Activity

Levels of physical activity were lower than in the general population. In this audit 28% of men (155 respondents) and 22% of women (103 respondents) exercised for 30 minutes 5 or more times a week. This corresponds to the pre-2011 guidelines on physical activity. Therefore, comparative data for physical activity in the general population have been taken from older surveys using these guidelines. In the general population, 47% of men and 34% women in England exercise for 30 minutes five or more times a week (Physical activity and fitness, 2008, age adjusted).

"I use my bike every day to get about this keeps me fit and healthy"

3.5.4 Health behaviours – Key points

- Smoking rates amongst homeless respondents were much higher than the general population (79% and 16% respectively).
- A minority of smokers stated they wanted to give up smoking.
- Homeless respondents had poor diets, with many not able to eat regular meals, and very few ate sufficient fruit and vegetables.
- Respondents had lower levels of physical activity than the general population of England.

3.5.5 Health behaviours – Recommendations

- Pilot the provision of tailored stop smoking sessions within existing homeless services eg Seaview in Hastings and Salvation Army in Eastbourne.
- Ensure that all staff working with homeless people receive training in "making every contact count" [MECC] to help them support clients around their health-related behaviours.
- Ensure the needs of homeless people are considered in MECC training provided for hospital staff.

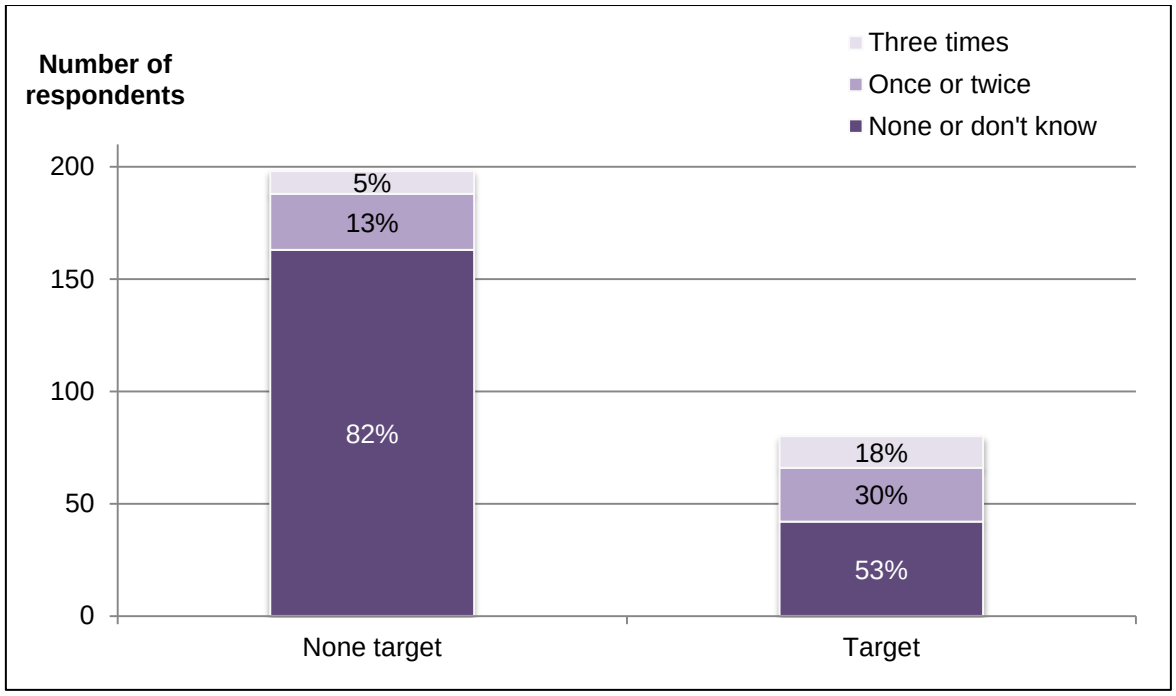
3.6 Screening and immunisations

3.6.1 Hepatitis B

A full immunisation course for hepatitis B involves three vaccinations over four to six months; booster vaccinations are required every five years to ensure continuing immunity. In this homeless population, 9% (24 of 278 respondents) reported having had the full course of hepatitis B vaccinations. A further 18% (49 of 278 respondents) reported having had an incomplete course of vaccination (one or two vaccinations).

However, hepatitis B immunisation is only recommended in certain groups who are at higher risk. Those measurable in this audit are: intravenous drug users, prisoners, and those with liver disease who make up 29% (80 of 278) of respondents. Figure 16 shows that a greater percentage of those recommended to have hepatitis B immunisation reported receiving a full course compared to the non-target group; however, this was still only 18% (14 respondents) of the target group. A further 30% had received a partial course of the vaccine.

Figure 16: Hepatitis B vaccination status of target and non-target respondent groups



3.6.2 Influenza

Previous research has shown that although homeless people are more likely to be eligible for influenza (flu) vaccination, they have much lower uptake rates than the general population.[24]

In this audit, 17% (48 of 280 respondents) reported having had a flu vaccine in the last year and a further 21% (60) reported having had a flu vaccine more than a year ago. Again, flu vaccination is recommended in certain groups. Those measurable in this audit are people with: asthma, COPD, HIV and those aged 65 and over. These make up 108 (39%) of 280 respondents. The reported uptake of the flu vaccine in these targeted

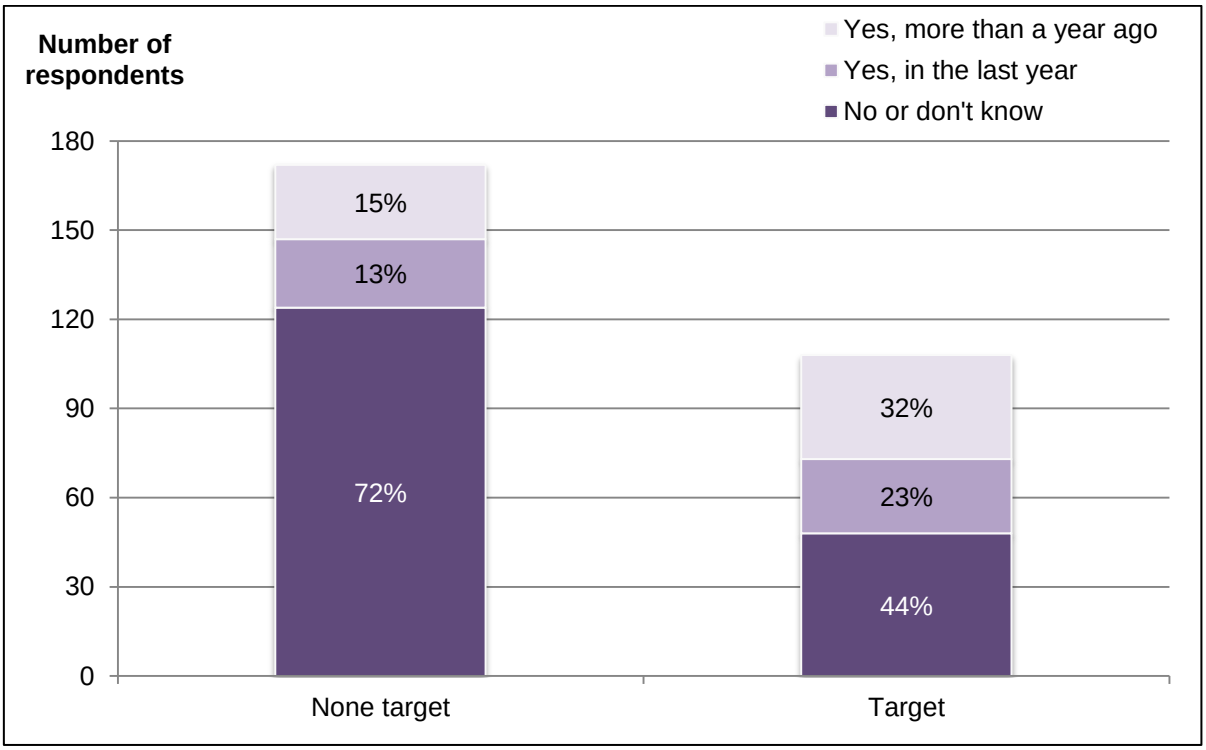
groups, although still low, was better than that of the whole sample of respondents (see Figure 17).

There are many circumstances in which flu vaccination would be recommended that were not measured in this audit. Many more homeless people would benefit from the flu vaccine because of their poor diet and overall poor health. The Salvation Army health service in Hastings has regularly offered flu vaccination to its clients including in 2015/16.[20]

> *"The Homeless Health Service in Seaview is good"*

For adults, flu vaccination is available between October and March each year. The questionnaire for this audit was sent out at the end of September 2015 and completed in October and November 2015. It is likely that the timing of the questionnaire, at the beginning of the flu vaccination period, might have led to a degree of under-reporting of flu vaccine uptake.

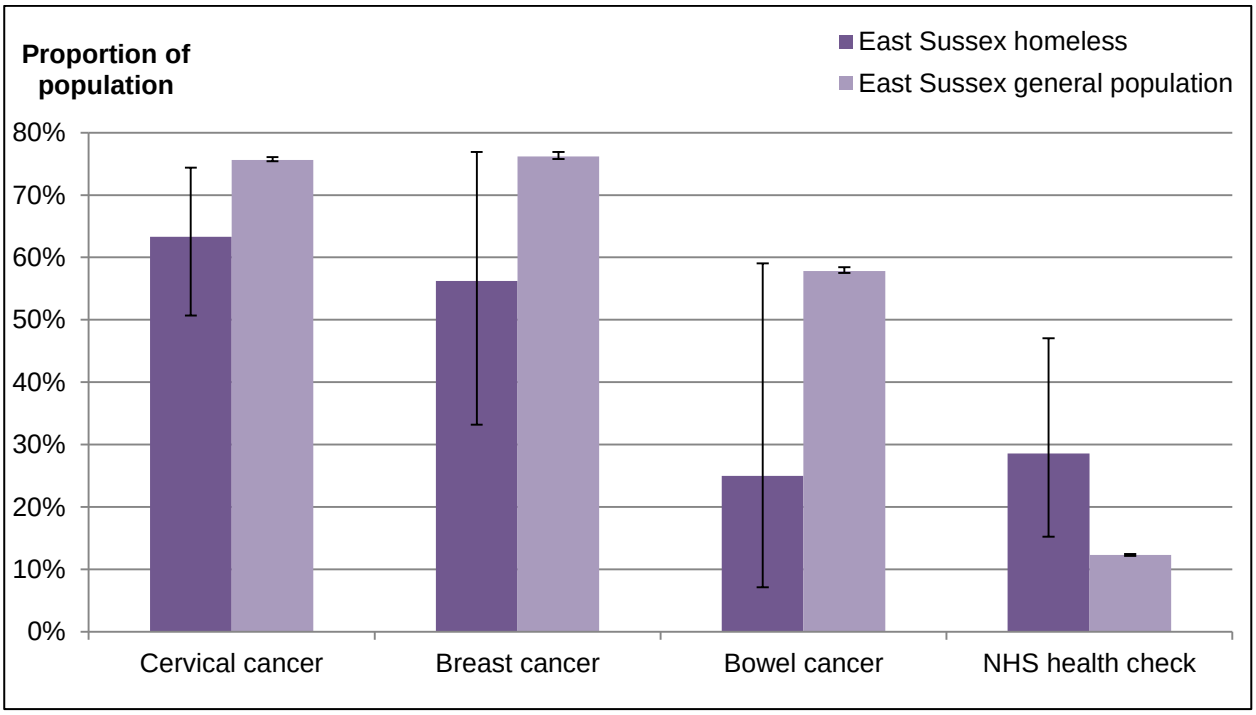
Figure 17: Influenza vaccination status of target and non-target respondent groups



3.6.3 NHS cancer screening programmes

Respondents eligible for the NHS cervical, breast and bowel cancer screening programmes were asked about their participation in cervical, breast and bowel cancer screening. All of these screening programmes invite participants by post and require participants to be registered with a GP, both of which provide a barrier to access in the homeless population. Figure 18 compares participation of this audit population with that of the general population.

Figure 18: Participation in national screening programmes of respondents and the general population



Cervical screening is offered to women every three years from 25 to 49 years of age, and every five years from 50-64 years of age. In this homeless audit, 63% (38 of 60) women aged 25-49 reported having had a cervical smear in the past 3 years. This was worse than the uptake in the general population of East Sussex, which was 76% (p=0.04).[25] The audit did not separately ask about cervical screening in the past 5 years so uptake in the over 50s cannot be compared.

Breast cancer screening is offered to women aged 50 to 70 every three years. Amongst women aged 50-70 in this audit, 56% (9 of 16) reported having participated in breast screening. While this was worse than the 76% uptake in the general population of East Sussex, this difference was not significant (p=0.1).[25]

> *"Despite having my telephone number they never call to offer appointments, always by letter."*

Bowel cancer screening is routinely offered to people aged 60-74 years. There were only 8 people aged 60-74 in this audit. Of these, just 2 (25%) reported having participated in the bowel screening programme. Again, uptake was worse than in the general population of East Sussex, which was 58%, but it did not reach statistical significance due to the small sample in this audit (p=0.1).[25]

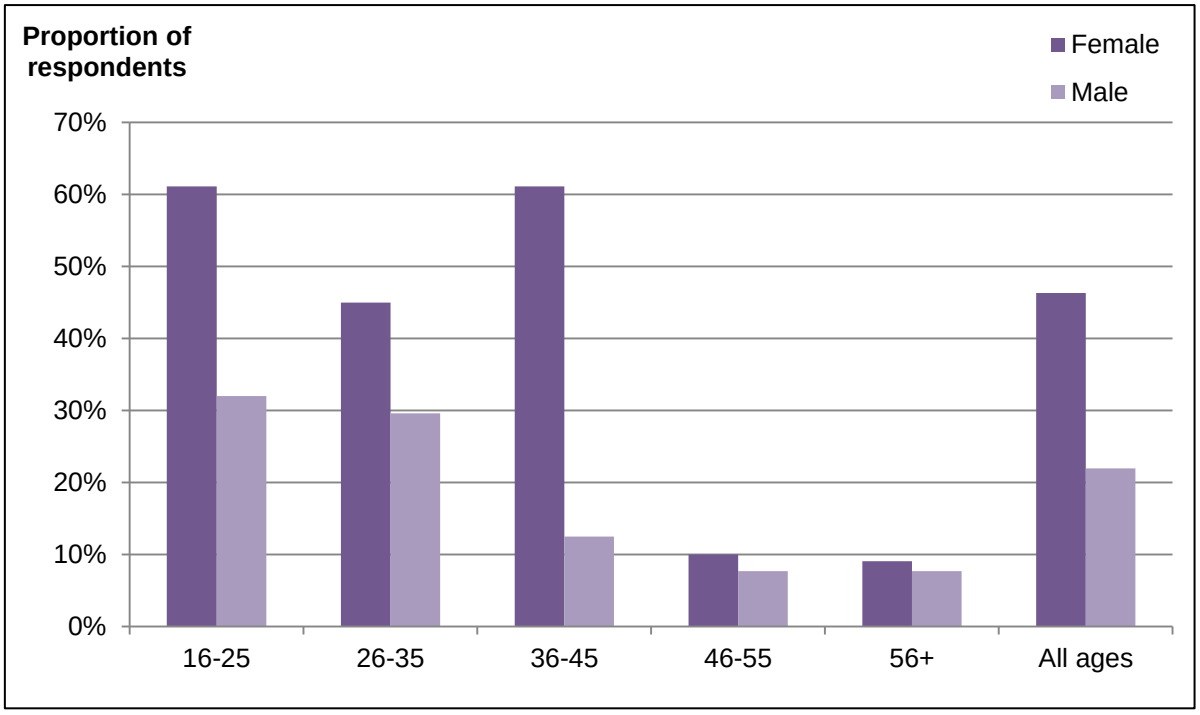
Respondents were also asked about participation in the new NHS Health Check programme. This programme is designed to identify and provide advice/referral re cardiovascular risk factors. To be eligible for an NHS Health Check a person must be aged 40-74 without certain pre-existing conditions (heart disease, diabetes, and circulatory disease) as the patient would already have been assessed for their cardiovascular risk.

Of the eligible population in East Sussex, 12% said they had had an NHS health check in the 2014/2015 financial year.[26] Reported uptake of NHS health checks in this homeless audit was 29% in the previous 12 months (8 of the 28 eligible respondents) which is better than the general population. This difference was surprising and was statistically significant ($p<0.01$). However, it may have been that the question did not clarify that it only included a screening health check as part of the official NHS Health Check programme.

3.6.4 Sexual health

Out of all respondents, 31% reported having had a sexual health screen in the preceding 12 months. This proportion was higher in women and in the younger age groups.
83% of respondents reported knowing where to access sexual health services.
Respondents indicated that they would go to a GUM clinic (48%), GP or nurse (43%), or a specific homeless service (6%) for sexual health advice.

Figure 19: Uptake of sexual health screening in the past 12 months by age and gender



3.6.5 Screening and immunisations – Key Points

- Hepatitis B vaccination uptake was low in this homeless audit, with 18% having the full course and 30% a partial course.
- Flu vaccination uptake was also low and many who would benefit from receiving the flu vaccine reported not having had one in the past year.
- Uptake of cervical, breast, and bowel cancer screening was lower than in the general population.
- Around a third of respondents attended a sexual health screen in the past year.
- Up-take of NHS Health Checks for those eligible was higher than in the general East Sussex eligible population, however, this could be an over-representation as

respondents may have included all health checks and not just those that were part of the official programme.

3.6.6 Screening and immunisations – Recommendations

- Set up a homeless influenza vaccination programme within existing homeless service providers and provide access via outreach work or at the walk in centre.
- Explore how homeless people's access to screening and immunisation programmes might be improved.
- Undertake opportunistic screening for Infectious Diseases, TB, lice etc

3.7 Views of Service Providers

In recognition that some of the more complex clients may not have engaged with the audit due to the length of time it took to complete the questionnaire, or because they did not regularly engage with services, an on-line survey of providers was conducted. Three open questions were asked:

1. How do you think health services for people with multiple complex needs could be improved?
2. Can you tell us about any positive experiences clients have had in accessing health services?
3. Do you have any other comments in relation to the health needs and/or access to services for clients with multiple complex needs?

A total of 30 responses were received from the following organisations (see Table 9).

Table 9: Service provider responses

Organisation	Responses
CRI	1
Eastbourne Borough Council	1
Fulfilling Lives	1
Home Works	19
Salvation Army	1
Seaview	1
Southdown Housing	4
St John Homeless Service	2
Total	30

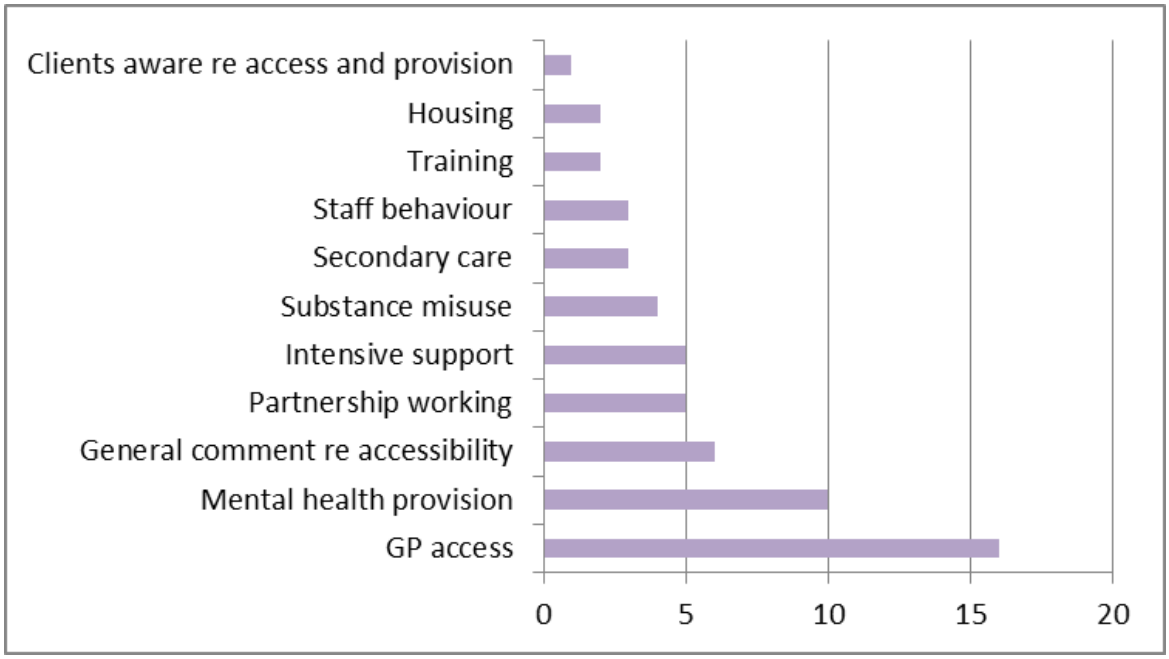
Responses for each question were grouped together and key themes identified. Whilst the data was qualitative in nature some quantitative analysis was conducted in order to identify the strength of each theme.

3.7.1 Ways to improve services

Figure 20 shows the themes that arose in response to question: How do you think health services for people with multiple complex needs could be improved?

Better access to GPs received the most comment: providers commented on current access to GP appointments (8) and also expressed the need for GP/health outreach sessions in a drop-in clinic set up (6) or through home visits (2).

Figure 20: Areas for service improvement for people with multiple complex needs



"*I have had many clients whose experience of accessing services has not been positive. Many have reported issues with initially getting an appointment to see their GP. People with complex needs may need to book an appointment in advance so that they can plan, often they have to ring on the day but cannot get an answer, they may not have funds to make the call, they may have difficulties explaining what they want and therefore this puts them off.*"

"Most clients complain about having to phone up their surgery at 8am to try and get an appointment."

"*GP appointments should be available not just on a call in on the morning basis to enable all walks of life to get health appointments that are not reliant upon having credit on their mobiles.*"

Continuity of care for clients with complex needs was also raised as an issue; those who have had a lot of bad experiences in their past do not want to keep re-telling/reliving their story. Another provider commented on the difficulty of having to wait around to be seen

and that this was an issue for those clients who find it difficult to behave appropriately; others mentioned the need to follow up those who do not at first engage.

The second most common theme was **mental health**. Respondents wanted more accessible services: they observed that access to mental health community support or outreach appeared to have reduced; they commented on the need to follow up clients who missed appointments rather than discharging them. It was said that too often clients were left to get on with things/left too long without any interventions and that they needed regular reviews - those prescribed medication for depression or anxiety should be routinely referred to Health in Mind. The need for staff cover when key workers were on holiday was also mentioned and one respondent commented on the specific therapy to which a client had been referred saying that group appointments were not appropriate for someone who was anxious around other people.

> *"I, and many of my clients, have noticed a reduction in front-line services, such as Mental Health Outreach, in recent years. This has further isolated people recovering from mental health breakdowns, and people have remained unwell for longer as a result. Economic troubles compound this, as does a shortage of affordable housing."*

The difficulty those with substance misuse issues had in accessing mental health services was mentioned by a number of respondents; one commented on the need for mental health professionals to receive training in substance misuse. Comments were also made on the need for easier access to scripting at STAR and about the current premises (specifically the lack of disability access, the visibility of the current location and the need for a more discreet entrance).

> *"I have heard over the years clients that are dual diagnosis are told by the mental health team that until they've dealt with their substance misuse issues they're not able to work with them and often the reason for substance misuse is because of the mental distress that the client has experienced. I feel that mental health workers should have substance misuse training for this client group. When a client approaches mental health services and are told this and told to go elsewhere, which can take weeks, the client is more likely to disengage.*

Another key theme was **partnership working**; respondents mentioned the need for more flexible working; better communication between services; fewer and clearer pathways between services and better services user involvement.

In terms of **secondary care**, respondents mentioned the need for quicker referrals to secondary care appointments; the need for easier access to information when clients had been in hospital and the need for post discharge support.

The need for greater **one-to-one support** for people with complex needs in the form of key workers/case workers was also stressed.

It was said that clients were often put off from accessing services due to past negative experiences, outlining the importance of staff training for primary and secondary

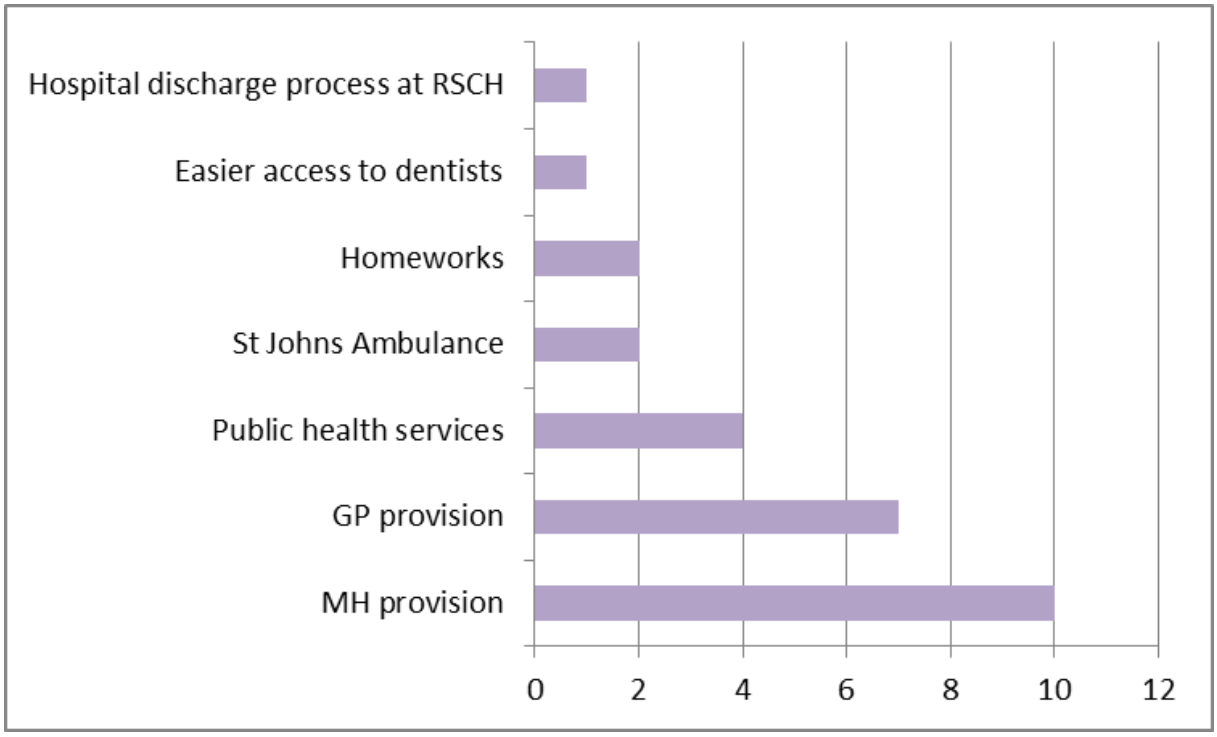
healthcare staff, particularly receptionists. One respondent said that when a health professional managed to engage with someone with complex needs they should share the learning as to what worked.

Four respondents mentioned **housing-related issues**: one commented on the difficulty clients have in proving their vulnerability to Hastings Borough Council when they require a GP letter in order to do so (ie they may be unable to pay for such a letter or may not have a GP). Another commented on the shortage of affordable housing and a third the need for better access to safe supported housing. One felt that proactive support from housing was required even for people with mild mental health or substance misuse issues; the impression s/he had was that local authority housing options teams viewed such people as ‘capable' of coping with 'homelessness'.

3.7.2 Client’s positive experiences

Figure 21 outlines the key areas of service that respondents identified when they were asked the question “Can you tell us about any positive experiences clients have had in accessing health services?” - 26 of the 30 respondents made some comment. The two most common responses related to having good relationships with mental health professionals or with a GP.

Figure 21: Positive experiences of service provision



Hence, whilst providers identified the need for **more accessible mental health services** for their clients, they did note where things had worked well. There were several references to the Health in Mind service and the one-to-one counselling provision or CBT available here. Other respondents mentioned the one-to-one support from particular CPNs; the mental health nurse working with Sussex police (Street Triage); the assertive outreach team at Amberstone hospital; and the behaviour of a community mental health team worker who continued to support a client even when he had been transferred to

another member of staff as he recognised the client's vulnerability and the importance of continuity of care.

There were six references relating to **GPs or GP practices**: the importance of a good relationship with a GP was mentioned by three respondents, (comments related to their empathic and compassionate attitude and behaviour); Warrior Square surgery and Eastbourne station practice were given specific mention, as was the drop-in at Station Plaza in Hastings.

> *"One of my clients … had a very positive experience with her GP … She was empathetic and took the time to listen … She made relevant referrals and made follow up appointments in advance to check on progress, this made her feel confident and that she was important. …The GP would ensure that she did not have to wait long to be seen (as she had very bad anxiety) and was very good at liaising with other agencies and following through what she stated she would do."*

> *"..When we have had the last two Pop-Up Hubs, both times the medical room was utilised here with a doctor available to see clients, through this service one client was admitted into hospital and another two clients were able to get the medical help they desperately needed"*

The support provided by **St John's ambulance** and **Home Works** was commented on and their ability to help clients access other services noted.

> *"Our St John Homeless service is open on a walk-in basis … and fully accessed by the street community. Although this is a nurse run clinic and does not replace GP services, we often find that we can avert the client needing a GP appointment with early intervention."*

> *"We have found that some of the clients have undiagnosed mental health issues. We have worked very closely with these clients and attended doctor's appointments with them … this has led to them getting a diagnosis, and on to being put on the proper benefit[s] and referred to mental health for further treatment."*

Public health services such as health visitors, health trainers and the smoking cessation service Quit 51 were also mentioned.

"I have referred a lot of my chaotic clients to more mainstream services funded by the NHS like the health trainers and quit 51 and have seen the positive impact this has had on their lives "

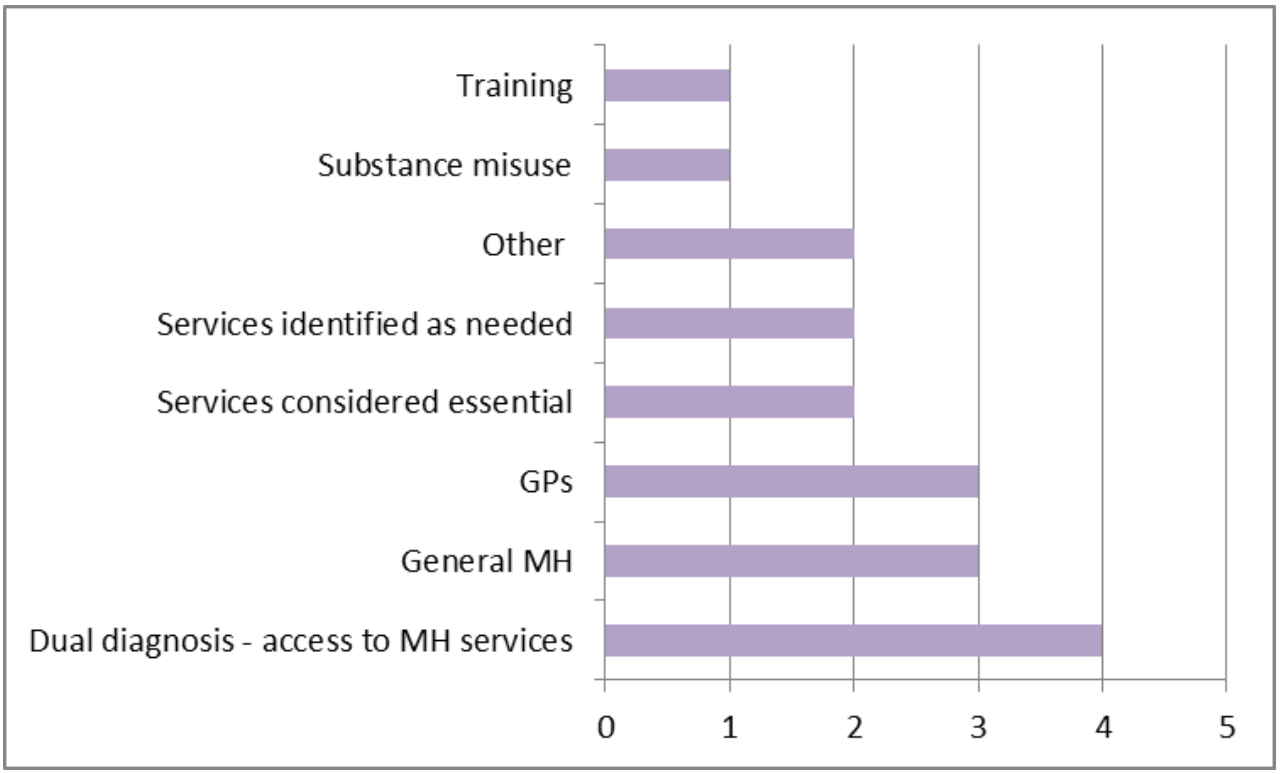
"Often, it's particular GPs who have an empathic and compassionate attitude - those who are seen to be willing to 'listen' who are appreciated by clients."

Other positive comments were that is now easier for homeless people to register with a dentist, and that clients have had positive experiences of the discharge processes at the Royal Sussex County Hospital in Brighton.

3.7.3 Additional comments

Figure 22 identifies the main themes elicited when providers were asked: Do you have any other comments in relation to the health needs and/or access to services for clients with multiple complex needs?

Figure 22: Additional comments about health needs and/or access to services for clients with multiple complex needs



The issue most commonly referred to was the poor access to **mental health services for those with substance misuse issue**s. One person commented on the long wait to for scripting via STAR (substance misuse services).

"Some clients find it hard to receive support around their mental health issues if they are self-medicating with substances."

"Chicken and egg sums it up. It is well known that people often self-medicate with alcohol to manage their emotional wellbeing. So, for this person to stop their only form of treatment before they can engage with mental health services might cause them to refrain from accessing the service

.

In terms of **general mental health provision**, the following were mentioned: access to psychiatric assessments and the mental health crisis team; the long wait to access mental health services; and the lack of provision other than medication. The need for an aftercare service following the resolution of a crisis was also commented on.

"I find there are long waiting times for accessing mental health services and community support services and this can be very frustrating for the client who has finally made the initial contact for support."

"The 3 missed appointments system and you're off the service doesn't work … it isolates people further, instead … why not a three missed appointments and let's look at other ways we can get this person to engage."

…

The comments relating to **GPs** were around the need to build relationships, difficulty registering with a GP when new patient registrations are restricted, the lack of continuity of care at some practices which puts clients off attending, and the need for GPs to make links with other services.

"It's going to take time to get them to engage well and to build the trust needed (due to past experiences) I hear a lot that the person I've referred is rude and aggressive towards them … but more often than not the person they're speaking about has never been that way towards me; I believe this is down to the fact that they feel more under pressure in those first meetings with health professionals.

The overlaps in service provision were also mentioned as an issue; Health in Mind and Seaview were cited as 'essential services'.

The need for funding for the provision of outreach workers and a one-stop-shop in Eastbourne were identified, as was the need for staff training.

" There is confusion between services over who does what and clear overlaps in many services."

"There is a need for multi-skilled key workers who have case ownership throughout a client's journey (eg whilst in hospital, whilst in the community, during and after a custodial sentence) to coordinate a client's care"

…

Other things mentioned were the need for literacy support; and the difficulty that a lack of ID can cause a homeless person and the suggestion that a letter from a health professional or a benefits letter should suffice.

4. CONCLUSION

The people identified by homeless services within this East Sussex audit provide local evidence of the spectrum of being homeless, ranging from rough sleepers to those living in potentially unstable, supported tenancies. The factors predisposing these people to becoming homeless are consistent with the evidence review from Public Health England [PHE], *Preventing Homelessness to Improve Health and Wellbeing,* summarised in Appendix 5.[27] There were high levels of domestic violence in the background of the women; almost half of the men had been involved in the criminal justice system; 13% reported having been in LA care at some point in their lives and the prevalence of learning disability/difficulty was around ten times higher than in the general population; levels of autism and ADHD, which were asked about separately, were also relatively high.

The audit findings demonstrate that homeless people in East Sussex have high health needs. There are substantial inequalities in their physical and mental health compared with the general population which need to be addressed.

The high physical health burden is reflected in the two thirds (67%) reporting a long-standing illness, or disability, which is much higher than the general population of East Sussex (42%). There was high mental health need found with 78% of respondents reporting at least one mental health condition, compared to 23% in the general population nationally. Overall, the homeless population reported a lower health-related quality of life, as measured by the EQ-5D questionnaire, than the general population in East Sussex.

High levels of substance misuse were reported, including use of illegal drugs and new psycho-active substances. In fact use of drugs in the previous 12 months was five times higher than in the general population. A quarter of respondents reported having a current or previous drug problem. Furthermore, a larger proportion of the homeless people in this audit drank alcohol on most days of the week compared with the general population nationally. This is likely to be an under estimate in view of the way the question was asked. Many of those with drug and alcohol problems said they would like more support to help them with these problems.

The audit findings demonstrate that Homeless people are high users of health services.

Of some reassurance is that most (93%) respondents were registered with a GP. However, GP registration is a requirement of all Supporting People commissioned services (who returned over 80% of all respondent questionnaires) and hence may be over-representative of the general homeless population in East Sussex. Some respondents reported being refused registration because of a lack of ID. GP use by homeless respondents was significantly higher than the general population of East Sussex. The proportion using A&E was two and a half times higher, and a higher proportion (40%) were admitted to hospital in the past year compared to the general population of East Sussex (12%).

Access to health services was sometimes restricted with 47% reporting a time in the past year when they could not manage to be seen for a physical /mental health problem. This is compounded by problems with telephone access to appointments and lack of drop-in clinics reported by professionals in the field.

Poor health behaviours were evident in the homeless population. Smoking prevalence was high with 79% saying they were current smokers compared to 16% in the general population of East Sussex, and only a minority wanting to give up smoking. Homeless respondents had poor diets with 44% eating only one meal per day or less and very few eating sufficient fruit and vegetables. The lack of regular meals highlights the importance of the meals provided by homeless organisations such as Seaview and Matthew 25. Respondents also reported lower levels of physical activity than the general population.

Low levels of screening and immunisation uptake were found. The proportion of homeless people in target groups who completed a course of hepatitis B vaccine was low (18%), although a higher proportion (30%) received a partial course of vaccine. Uptake of flu vaccine in homeless people in the defined clinical risk groups was lower than in the general population, although the timing of the audit in early autumn may have resulted in under reporting. Uptake of cervical, breast and bowel cancer screening was lower than in the general population illustrating the problems of access for the homeless population when invites relate to GP registrations and are sent to postal addresses.

It is important that due recognition is given to the different health needs of subgroups within the homeless population. The health risks and needs of older persons [aged 50 or older in this context] are very different from those of younger persons. There were 46 people [28 male and 18 female] aged 50 or older identified in this audit. Their health and social care needs will differ on account of premature biological ageing and the reasons for their becoming homeless. It may be appropriate to introduce opportunistic screening specifically for people in this age group in any future commissioned service for the homeless.

In terms of reducing the risk of homelessness in specific groups: for Looked After Children there is a protocol in place whereby ESCC Children's Services are able to refer those who are leaving care directly to Supporting People young people's services to ensure they get the support they need; for offenders, Kent Surrey and Sussex Community Rehab company have commissioned Southdown Housing to secure sustained accommodation to reduce the likelihood of reoffending.

Further insight into the health needs of homeless people comes from the views of professionals working within the homeless services in East Sussex. Key issues raised were the need for: more flexible and accessible health services particularly GP provision and mental health services (more outreach provision was wanted); dedicated provision in the form of a homeless health clinic/ one stop shop in Eastbourne; better support from key workers/case workers; better aftercare following hospital discharge; improved partnership working between services/continuity of care, and more staff training. The issue of poor access to mental health services for those with substance misuse issues was particularly highlighted.

The positive experiences of clients related to assistance provided by particular services, such as St John's Ambulance and Home Works, and having good relationships with staff, whether GPs or mental health staff. Public health services such as health visitors, health trainers and the smoking cessation service were also mentioned.

The recommendations derived from the audit findings are listed in Section 5. It would be appropriate to conduct a local audit in two or three years to determine whether these have been implemented or if any other definitive changes have occurred as a consequence.

In the process of carrying out the audit, suggestions for improving the audit questionnaire were identified. These have been shared with Homeless Link and it is hoped this will assist in improving the quality of information obtained in future audits.

5. RECOMMENDATIONS

5.1 Strategic

- Re-establish a homeless health service in Eastbourne, to include surveillance of infectious diseases, in line with the hub model developed in Hastings.
- Ensure there are mechanisms in place so that homeless people who may have care and support needs receive an assessment.
- Continue to ensure care leavers are provided with the support they need to live independently.
- Improve access to mental health treatment and on-going support for homeless people, particularly those with drug and alcohol problems, for example through an outreach mental health service.
- Develop and implement a protocol/pathway for planning the hospital discharge of homeless people from East Sussex Healthcare Trust.
- Consider establishing an intermediate care/step-down bed facility for high risk, repeat NHS emergency service users.
- Explore the feasibility of introducing a Housing First model for people with complex needs.
- Develop a partnership approach, between the NHS and providers of homeless services, so as to deliver a co-ordinated response to meet the health needs of homeless clients.
- Establish a homeless health forum in East Sussex to promote partnership working.

5.2 Operational

5.2.1 Health and Wellbeing

- A Psychologically Informed Environment [PIE] should be established in all health and social care settings.
- Ensure all homeless people are offered an annual health review, including medications review, and a review of their welfare benefits.
- Prioritise homeless clients within the NHS Health Check programme in view of their increased CVD risk.
- Conduct opportunistic screening for cognitive impairment, mobility, urinary problems, and traumatic brain injury particularly in homeless older persons [over 50 years].

5.2.2 Substance Misuse

- Ensure that substance misuse services provide appropriate levels of support to those clients with substance misuse problems who are difficult to engage.
- Ensure recovery is sustainable by increasing the focus on longer term peer support and mutual aid.

5.2.3 Access to Health Services

- Ensure GP practices are up to date with NHSE guidance on requirements for registering patients.
- Develop and implement a protocol/pathway for planning the hospital discharge of homeless people from ESHT.
- Conduct an audit of hospital discharges of homeless patients from Eastbourne District General Hospital and Conquest Hospital using this discharge protocol.

5.2.4 Health Behaviours

- Pilot the provision of tailored stop smoking provision in existing homeless service(s) eg Seaview in Hastings and Salvation Army in Eastbourne.
- Ensure all staff working with homeless people receive training in “making every contact count” [MECC] to help them support clients to engage with other services.
- Ensure the needs of homeless people are considered in MECC training provided for hospital staff.

5.2.5 Screening and immunisations

- Set up a homeless influenza vaccination programme within existing homeless service providers and include outreach work, for example encourage people to be taken to the walk in centre for ‘flu vaccine.
- Explore how homeless people’s access to screening and immunisation programmes might be improved.
- Undertake opportunistic screening for Infectious Diseases, TB, lice etc

APPENDICES

Appendix 1: Definitions of homelessness

The information below is taken directly from Homeless Link's report: *Preventing homelessness to improve health and wellbeing* (2015).[27]

In England homelessness is legally defined, and protections are given to certain homeless groups. Under the legal definition, a person is considered homeless if they have no home in the UK, or anywhere else in the world available to occupy. This includes people facing eviction, those living in temporary accommodation, squatters, rough sleepers, people at risk of violence, those housed in property potentially damaging to their health and those who cannot afford their current accommodation.

In England, not all homeless people who meet the legal definition of homelessness will be provided with housing. Under the 1996 Housing Act, local authorities have a statutory duty to find accommodation for households deemed to be homeless, eligible and in 'priority need'. Most commonly, 'priority need' applies to adults with dependent children and/or households with a vulnerable member.[Fn 2] Many non-statutory households are single homeless people.

Whilst the definition of homelessness in England is set out in law, there are distinctions made between the varying circumstances of homelessness. There is often a distinction made between 'statutory' and 'non-statutory' homelessness and there is widespread acceptance that homelessness is more than just rooflessness.

The European Typology of Homelessness and housing exclusion [ETHOS] was developed as a means of improving understanding and measuring different types of homelessness across Europe. The ETHOS categories are:

- Rooflessness (without a shelter of any kind, sleeping rough);
- Houselessness (with a place to sleep but temporary in institutions or shelter);
- Living in insecure housing (threatened with severe exclusion due to insecure tenancies, eviction, domestic violence);
- Living in inadequate housing (in caravans on illegal campsites, in unfit housing, in extreme overcrowding).

The ETHOS approach understands homelessness as a process rather than a static event that can occur at different points in people's lives. In recent years commentators have developed the homelessness pathway to map out the different routes into homelessness, which identifies the different groups that are more likely to become homeless than others.

[Fn2] Priority need categories set out under the Housing Act 1996 and the Homeless (Priority Need) Order 2002 are pregnant women and those with dependent children, homeless as a consequence or flood, fire or other disaster, aged between 16 and 17 unless owed an accommodation duty by children's services, care leavers under 21, a 'vulnerable' person as a result of old age, mental illness or disability, leaving prison or Armed Forces, being in care, at risk of violence or threats of violence.

The triggers and causes of homelessness have been broadly defined as either structural or individual/personal factors. However both are often interrelated and it is difficult to disentangle these from each other (Fitzpatrick 2005, Jones and Pleace 2010). Harding et al (2011) set out the structural and individual/personal factors out below. Some recent studies of homelessness have moved away from viewing homelessness in terms of causality, instead conceptualising homelessness as careers and pathways (Ravenhill 2008, Clapham 2003). Homelessness and housing choices are not viewed as linear but rather that they can change significantly over the life course dependent on factors such as relationships, economic status and health.

Factors predisposing to homelessness:

Structural	Individual
Housing demand (linked to demographic trends) Lack of affordable housing (Eviction / Repossessions)	Family disputes / Childhood disputes
Poverty	Physical and emotional abuse
Unemployment/ welfare benefits	Poor physical health and mental health problems
Ethnicity	Institutionalisation / Offending behaviour (Care, prison, armed forces)
Changing trends in family formation and fragmentation	Drug or alcohol misuse
	Lack of qualifications and skills
	Social Networks
	Debt

Source: Harding, Irving and Whowell (Cited in Homeless Link, 2013)[27]

Generally speaking, the health of older people, children, disabled people and people with long-term illnesses are at greater risk from poor housing conditions. Ill health also puts some households at a greater risk of housing need – for example poor physical health and mental health can make it harder to access and sustain tenancies, so is also a trigger of homelessness.

Once people experience more acute forms of housing need, for example homelessness or prolonged periods of rough sleeping, the rate at which health problems occur increases rapidly. Evidence suggests that single homeless people – those who are not typically owed a statutory duty by their local authority to find them accommodation – are particularly affected by poor physical and mental health.

Homelessness Link references

Fitzpatrick, S (2005) Explaining homelessness: a critical realist perspective, *Housing, Theory and Society*, 22 (1), pp 1-17.

Jones, A and Pleace, N (2010) *A review of single homelessness in the UK 2000-2010*, London: Crisis. Available at http://www.crisis.org.uk/data/files/publications/ReviewOfSingleHomelessness_Final.pdf Last accessed 11 March 2015.

Harding, J; Irving, A; and Whowell, M (2011) *Homelessness, Pathways to Exclusion and Opportunities for Intervention*, Newcastle upon Tyne: Northumbria Graphics. Available at: http://www.qni.org.uk/docs/Neil%20Baird.pdf Last accessed 11 March 2015.

Ravenhill, M (2008) The culture of homelessness, Farnham: Ashgate.

Clapham, D (2003) Pathways approaches to homelessness research, Journal of community 7 Applied Social Psychology, 13 (2) pp 119-127.

Appendix 2: Audit Questionnaire

Homeless Health Needs Audit
Printable version of the survey

Welcome to the Health Needs Audit. This is the paper version of the audit questions. If you are using the paper version, please input the responses afterwards onto the online tool.

This survey asks clients questions about their health needs and access to health services in your local area. Please refer to the Guidance to help you carry out the survey. Make sure that the client has read Appendix Two of the Guidance, **Information for participants** and that they understand how this information will be used.

Questions marked with an asterisk (*) are mandatory. If the client does not wish to answer the question, please tick the 'No answer' option.

INTRODUCTION

Before you get started, please confirm which service you are completing this survey with. Please also ask the client to confirm that they understand how their data will be used and that they have not already completed a survey for the current audit:

NAME OF SERVICE: ……

☐ I (the client) understand how this information will be used and am happy to go ahead

☐ I have not previously undertaken this survey

A FEW QUESTIONS ABOUT YOU

01* IN WHICH LOCAL AUTHORITY ARE YOU CURRENTLY RESIDING?

O	Hastings	O	Eastbourne	O	Rother
O	Wealden	O	Lewes	O	No answer

1* HOW OLD ARE YOU? ……..
O No answer

2 WHICH OF THESE CATEGORIES BEST DESCRIBES YOU AT PRESENT? Please tick **only one**:

O Going to school or college full-time (including on vacation)
O In paid employment or self-employment (or away temporarily)
O On a Government scheme for employment training
O Doing unpaid work or voluntary work
O Waiting to take up paid work already obtained
O Looking for paid work or a Government training scheme
O Intending to look for work but prevented by temporary sickness or injury (CHECK MAX 28 DAYS)
O Permanently unable to work because of long-term sickness or disability (USE ONLY FOR MEN AGED 16-64 OR WOMEN AGED 16-59)
O Unemployed and not looking for work
O Other (please state)…….

3* HAVE YOU EVER (IN YOUR LIFETIME) DONE ANY OF THE FOLLOWING? IF YES, PLEASE INDICATE THE AGE AT WHICH THIS FIRST OCCURRED. Tick **all** that apply:

	Yes	**Age**
Stayed at a hostel, foyer, refuge, night shelter or B&B hotel, or any other type of homelessness service	☐	**……..**
Stayed with friends or relatives because had no home of own ('sofa surfed')	☐	**……..**
Slept rough	☐	**……..**

Applied to the council as homeless	☐	……..
None of the above	☐	
No answer	☐	

4* **WHERE ARE YOU CURRENTLY SLEEPING?** (if this frequently changes, please say where you slept last night). Please tick **only one**:

O Sleeping rough on streets/parks
O In a hostel or supported accommodation
O Squatting
O Sleeping on somebody's sofa/floor
O In emergency accommodation, e.g. nightshelter, refuge
O In B&B or other temporary accommodation
O Housed - in own tenancy
O Other (please state)……..
O No answer

5 **THINKING ABOUT THE MOST RECENT TIME YOU BECAME HOMELESS, WHAT WAS THE MAIN REASON FOR THIS?** Please give **one primary** reason and **one secondary** reason if applicable.

	Primary reason	Secondary reason
Parents / care-givers no longer able or willing to accommodate	O	O
Other relatives or friends no longer able or willing to accommodate	O	O
Non-violent relationship breakdown with partner	O	O
Abuse or domestic violence	O	O
Overcrowded housing	O	O
Eviction or threat of eviction	O	O
Rent or mortgage arrears	O	O
Other debt-related issues	O	O
End of tenancy (social housing)	O	O
End of tenancy (private rented sector)	O	O
Financial problems caused by benefits reduction	O	O
Unemployment	O	O
ASB or crime	O	O
Drug or alcohol problems	O	O
Mental or physical health problems	O	O
Leaving institutional care (e.g. hospital, prison, care etc.)	O	O
Other (please state)……..	O	O

6 **DO YOU HAVE ANY OF THE FOLLOWING BACKGROUNDS?** (This helps us understand how your past experience may have affected your health or service access)**.** Tick **all** that apply:

☐ Spent time in prison
☐ Spent time in a secure unit or young offender institution
☐ Been on probation or attended a Youth Offending Service
☐ Spent time in local authority care
☐ Spent time in the armed forces
☐ Admitted to hospital because of a mental health issue
☐ Been a victim of domestic violence
☐ None of these backgrounds

7* **WHAT IS YOUR GENDER?** Please tick **only one**:

O Male
O Female
O Other (please state)……
O No answer

8 **WHICH OF THE FOLLOWING BEST DESCRIBES YOUR SEXUAL ORIENTATION?** Please tick **only one**:

O Heterosexual or straight
O Gay or lesbian
O Bi-sexual
O Other (please state)……..

9* **WHAT IS YOUR ETHNIC GROUP?** Please tick **only one:**

White	Mixed/Multiple ethnic groups	Asian/Asian British	Black/Black British	Other ethnic group

O English / Welsh / Scottish / Northern Irish / British O Irish O Gypsy or Irish Traveller O Other white	O White & Black Caribbean O White & Black African O White & Asian O Other mixed	O Indian O Pakistani O Bangladeshi O Chinese O Other Asian	O African O Caribbean O Other black	O Arab O Any other ethnic group Please state: ……	
O No answer					

10 WHAT IS YOUR IMMIGRATION STATUS? Please tick **only one:**

O UK National
O European Economic Area (EEA) national
O National from outside of the EEA
O Asylum Seeker
O Refugee
O Permanent residence/Indefinite leave to remain
O Unknown
O Other (please state)……

11 DO YOU HAVE RECOURSE TO PUBLIC FUNDS (BENEFITS)? Please tick **only one:**

O Yes O No O Don't know

12* DO YOU HAVE ANY LONG-STANDING ILLNESS, DISABILITY OR INFIRMITY? By long-standing I mean anything that has troubled you over a period of time or that is likely to affect you over a period of time. Please tick **only one**:

O Yes O No O No answer

SOME QUESTIONS ABOUT YOUR PHYSICAL HEALTH

13* HAS A DOCTOR OR HEALTH PROFESSIONAL EVER TOLD YOU THAT YOU HAVE ANY OF THE FOLLOWING PHYSICAL HEALTH PROBLEMS? Please choose the appropriate response for each item:

	Yes, in past 12 months	Yes, 12 months + ago	No	No answer
Difficulty seeing/eye problems	☐	☐	☐	☐
Problems with hearing	☐	☐	☐	☐
Dental/teeth problems	☐	☐	☐	☐
Chronic breathing problems (bronchitis, emphysema, obstructive airways disease)	☐	☐	☐	☐
Asthma	☐	☐	☐	☐
Heart problems (heart attack, angina, murmur or abnormal heart rhythm)	☐	☐	☐	☐
Liver problems	☐	☐	☐	☐
Stomach problems, including ulcers	☐	☐	☐	☐
Urinary problems/infections/incontinence	☐	☐	☐	☐
Problems with feet	☐	☐	☐	☐
Skin/wound infection or problems	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐

Circulation problems/blood clots	☐	☐	☐	☐
Joint aches/problems with bones and muscles	☐	☐	☐	☐
Fainting/blackouts	☐	☐	☐	☐
Epilepsy/seizures	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Sexually transmitted diseases (STDs)	☐	☐	☐	☐
HIV	☐	☐	☐	☐
Tuberculosis (TB) (*go to Q13a)*	☐	☐	☐	☐
Hepatitis C (*go to Q13b)*	☐	☐	☐	☐
Hepatitis B	☐	☐	☐	☐
Other (please state)……	☐	☐	☐	☐

13a ***IF YES TO TB*, HAVE YOU RECEIVED ANY TREATMENT?** Please tick **only one**:
O Yes O No

13b ***IF YES TO HEPATITIS C*, HAVE YOU RECEIVED ANY TREATMENT?** Please tick **only one**:
O Yes O No, offered but didn't take it up O No, not offered any

13c ***IF YES TO ANY PHYSICAL HEALTH NEED*, ARE YOU RECEIVING SUPPORT/ TREATMENT TO HELP YOU WITH YOUR PHYSICAL HEALTH PROBLEM?** Please tick **only one**:
O Yes, and it meets my needs O Yes, but I'd still like more help
O No, but it would help me O No, I do not need any

14 WAS THERE ANY TIME DURING THE PAST TWELVE MONTHS WHEN, IN YOUR OPINION, YOU NEEDED A MEDICAL EXAMINATION OR TREATMENT FOR A PHYSICAL HEALTH PROBLEM BUT YOU DID NOT RECEIVE IT? Please tick **only one**:
O Yes, there was at least one occasion O No, there was no occasion (*go to Q15*)

14a ***IF YES TO Q14*, WHAT WAS <u>THE MAIN REASON</u> FOR NOT RECEIVING THE EXAMINATION OR TREATMENT (THE MOST RECENT TIME)?** Please tick **only one**:
O Couldn't get an appointment
O Waiting list
O Have been banned from the service
O Too far to travel/no means of transportation
O Fear of doctor/hospitals/examination/ treatment
O Wanted to wait and see if problem got better on its own
O Was refused treatment/examination
O Other (please state)……..

15* DO YOU SMOKE CIGARETTES, CIGARS OR A PIPE? Please tick **only one**:
O Yes O No (*go to Q16*) O No answer

15a ***IF YES TO Q15*, WOULD YOU LIKE TO GIVE UP SMOKING ALTOGETHER?** Please tick **only one**:
O Yes O No O Don't know

15b ***IF YES TO Q15*, HAVE YOU BEEN OFFERED HELP BY A HEALTH PROFESSIONAL TO STOP SMOKING?** Please tick **only one**:
O Yes, and took this up O Yes, but did not take this up O No

SOME QUESTIONS ABOUT MENTAL HEALTH AND DEVELOPMENT

16* HAS A DOCTOR OR HEALTH PROFESSIONAL EVER TOLD YOU THAT YOU HAVE ANY OF THE FOLLOWING MENTAL HEALTH OR BEHAVIOURAL CONDITIONS? Please choose the appropriate response for each item:

	Yes, in past 12 months	Yes, 12 months + ago	No	No answer

Depression	☐	☐	☐	☐
Anxiety disorder or phobia	☐	☐	☐	☐
Psychosis (incl. schizophrenia or bipolar disorder)	☐	☐	☐	☐
Personality disorder	☐	☐	☐	☐
Post traumatic stress disorder (PTSD)	☐	☐	☐	☐
Eating disorder	☐	☐	☐	☐
Dual diagnosis - a mental health problem alongside drug or alcohol use	☐	☐	☐	☐
ADHD (attention deficit hyperactivity disorder)	☐	☐	☐	☐
Learning disability or difficulty	☐	☐	☐	☐
Autism/Asperger's	☐	☐	☐	☐
Other (please state)…….....	☐	☐	☐	☐

16a ***IF YES TO ANY MENTAL HEALTH NEED*, ARE YOU RECEIVING SUPPORT/ TREATMENT TO HELP YOU WITH YOUR MENTAL HEALTH PROBLEM?** Please tick **only one**:

O Yes, and it meets my needs
O Yes, but I'd still like more help
O No, but it would help me (*go to Q17*)
O No, I do not need any (*go to Q17*)

16b ***IF YES TO Q16a*, WHAT TYPE OF SUPPORT ARE YOU RECEIVING?** Tick **all** that apply:

☐ Talking to a professional like a counsellor or therapist (e.g. counselling, CBT, psychological therapies)
☐ Support from a specialist mental health worker – e.g. Community Mental Health team, Community Psychiatric Nurse
☐ A service that deals with my mental health and drug/alcohol use at the same time
☐ Activities like arts, volunteering or sport
☐ Practical support that helps me with my day to day life
☐ Training and activities to learn new skills/gain employment
☐ Medication that has been prescribed for me
☐ Peer support - support from others who have been through a similar experience
☐ Other (please state)……..

17 **WAS THERE ANY TIME DURING THE PAST TWELVE MONTHS WHEN, IN YOUR OPINION, YOU PERSONALLY NEEDED AN ASSESSMENT OR TREATMENT FOR A MENTAL HEALTH PROBLEM BUT YOU DID NOT RECEIVE IT?** Please tick **only one**:

O Yes, there was at least one occasion
O No, there was no occasion (*go to Q18*)

17a ***IF YES TO Q17*, WHAT WAS <u>THE MAIN REASON</u> FOR NOT RECEIVING THE ASSESSMENT (THE MOST RECENT TIME)?** Please tick **only one**:

O Couldn't get an appointment
O Waiting list
O Have been banned from the service
O Due to my drug or alcohol use
O Too far to travel/no means of transportation
O Fear of doctor/hospitals/examination/ treatment
O Wanted to wait and see if problem got better on its own
O Was refused treatment/examination
O Other (please state)……..

18 **DO YOU USE DRUGS OR ALCOHOL TO HELP YOU COPE WITH YOUR MENTAL HEALTH – this can be called 'self-medicating'?** Please tick **only one**:

O Yes
O No

SOME QUESTIONS ABOUT DRUG AND ALCOHOL USE

19* **IN THE PAST 12 MONTHS HAVE YOU TAKEN ANY OF THE FOLLOWING?** Tick **all** that apply:

☐ Heroin
☐ Crack

☐ Cocaine
☐ Cannabis/weed
☐ Amphetamines/speed
☐ Tranquilisers, such as benzodiazepines/benzos, not prescribed for you
☐ Any other prescription drugs, not prescribed for you
☐ New Psychoactive Substances (also known as legal highs)
☐ Drugs you inject
☐ No drug use in the past 12 months
☐ Other (please state)……..
☐ No answer

20 DO YOU TAKE METHADONE, SUBUTEX OR ANY OTHER SUBSTITUTE DRUGS?
Please tick **only one**:
O Yes, it is prescribed for me O Yes, but it is not prescribed for me O No

21* DO YOU HAVE OR ARE YOU RECOVERING FROM A DRUG PROBLEM? Please tick **only one**:
O Yes, I have a drug problem O Yes, I am in recovery O No (*go to Q22)*

21a *IF YES TO A DRUG PROBLEM,* ARE YOU RECEIVING SUPPORT/TREATMENT TO HELP YOU WITH YOUR DRUG PROBLEM? Please tick **only one**:
O Yes, and it meets my needs O Yes, but I'd still like more help
O No, but it would help me (*go to Q22)* O No, I do not need any (*go to Q22)*

21b *IF YES TO Q21a*, WHAT SUPPORT ARE YOU RECEIVING TO HELP YOU ADDRESS YOUR DRUG USE? Tick **all** that apply:
☐ Advice and information (e.g. from GPs, A&E departments)
☐ Harm reduction services, such as needle exchange
☐ Self-help groups (often called Mutual Aid), e.g. Narcotics Anonymous
☐ Community prescribing (drug treatment prescribed as part of a care plan)
☐ Counselling or psychological support
☐ Attendance at day programmes, delivered in the community
☐ Detox (help with withdrawal as an inpatient)
☐ Residential rehabilitation
☐ Aftercare (support following structured treatment)
☐ Peer support - support from others who have been through a similar experience
☐ Other (please state)……..

22* HOW OFTEN HAVE YOU HAD AN ALCOHOLIC DRINK DURING THE PAST 12 MONTHS?
Please tick **only one**:
O Almost every day
O Five or six days a week
O Three or four days a week
O Once or twice a week
O Once or twice a month
O Once every couple of months
O Once or twice a year
O Not at all in the past 12 months (*go to Q24*)
O No answer

23* HOW MANY UNITS DO YOU DRINK ON A TYPICAL DAY WHEN YOU ARE DRINKING? Please refer to flashcard to work this out.
……..
O No answer

24* DO YOU HAVE OR ARE YOU RECOVERING FROM AN ALCOHOL PROBLEM? Please tick **only one**:
O Yes, I currently have an alcohol problem O Yes, I am in recovery
O No (*go to Q25)* O No answer

24a ***IF YES TO AN ALCOHOL PROBLEM,*** **ARE YOU RECEIVING SUPPORT/TREATMENT TO HELP YOU WITH YOUR ALCOHOL PROBLEM?** Please tick **only one**:

O Yes, and it meets my needs
O Yes, but I'd still like more help
O No, but it would help me (*go to Q25)*
O No, I do not need any (*go to Q25)*

24b ***IF YES TO Q24a*****, WHAT SUPPORT ARE YOU RECEIVING TO HELP YOU ADDRESS YOUR ALCOHOL USE?** Tick **all** that apply:

☐ Advice and information (e.g. from GPs, A&E departments)
☐ Self-help groups, e.g. Alcoholics Anonymous
☐ Community prescribing (drug treatment prescribed as part of a care plan)
☐ Counselling or psychological support
☐ Attendance at day programmes, delivered in the community
☐ Detox (help with withdrawal as an inpatient)
☐ Residential rehabilitation
☐ Aftercare (support following structured treatment)
☐ Peer support - support from others who have been through a similar experience
☐ Other (please state)……..

SOME QUESTIONS ABOUT YOUR ACCESS TO SERVICES

25* **ARE YOU REGISTERED WITH THESE SERVICES IN YOUR LOCAL AREA?** Please choose the appropriate response for each item:

	Yes	No	No answer
GP or homeless healthcare service	☐	☐	☐
Dentist	☐	☐	☐
Optician	☐	☐	☐

25a ***IF YES TO BEING REGISTERED WITH A GP OR HOMELESS HEALTHCARE SERVICE*****, PLEASE GIVE THE NAME OF THE PRACTICE OR SERVICE:**

……

26 **HAVE YOU BEEN REFUSED REGISTRATION TO A GP/HOMELESS HEALTHCARE SERVICE, DENTIST OR OPTICIAN IN THE PAST 12 MONTHS?** Please choose the appropriate response for each item:

	Yes	No (*go to Q27)*
GP or homeless healthcare service	☐	☐
Dentist	☐	☐
Optician	☐	☐

26a ***IF YES TO Q26-<u>GP</u>*****, WHY WERE YOU REFUSED REGISTRATION TO A GP?**

……

26b ***IF YES TO Q26-<u>DENTIST</u>*****, WHY WERE YOU REFUSED REGISTRATION TO A DENTIST?**

……

26c ***IF YES TO Q26-<u>OPTICIAN</u>,*** **WHY WERE YOU REFUSED REGISTRATION TO AN OPTICIAN?**

……

27* **IN THE PAST 12 MONTHS HAVE YOU-:** Please choose the appropriate response for each item:

	No	Once	Twice	3 Times	Over 3 times	No answer
Been to a GP or homeless healthcare service?	☐	☐	☐	☐	☐	☐
Been to A&E / a walk in centre (WIC) / minor injuries unit (MIU)?	☐	☐	☐	☐	☐	☐

Used an ambulance?	☐	☐	☐	☐	☐	☐
Been admitted to hospital?	☐	☐	☐	☐	☐	☐

27a ***IF YOU HAVE USED <u>ANY</u> OF A&E, HOSPITAL OR AMBULANCE IN THE PAST 12 MONTHS*** **PLEASE ANSWER THESE QUESTIONS: What was the reason why you last used:** *Please select the reason which best fits the primary cause of using the service, or use the other box if the reason is not listed.*

	A&E	Ambulance	Admitted into hospital
Domestic violence	☐	☐	☐
Other violent incident or assault	☐	☐	☐
Accident	☐	☐	☐
Relating to a physical health problem or condition	☐	☐	☐
Relating to a mental health problem or condition	☐	☐	☐
Self-harm/attempted suicide	☐	☐	☐
Relating to drug use	☐	☐	☐
Relating to alcohol use	☐	☐	☐
Relating to childbirth or pregnancy	☐	☐	☐

Other for A&E (please state)…….....

Other for ambulance (please state)…….

Other for hospital admission (please state)……

IF YOU WERE ADMITTED INTO HOSPITAL, PLEASE ANSWER QUESTIONS 27b-27e ABOUT YOUR MOST RECENT ADMISSION:

27b **WHICH HOSPITAL WERE YOU ADMITTED TO?** Please tick **only one**:

O	Conquest Hospital A&E	O	Bexhill Hospital
O	Eastbourne DGH A&E	O	Rye Memorial Hospital
O	Kent & Sussex Hospital A&E	O	Firwood House
O	Princess Royal Hospital A&E	O	Newhaven rehab centre
O	Royal Sussex County A&E		

27c **DID STAFF ASK YOU IF YOU HAD SOMEWHERE SUITABLE TO GO WHEN YOU WERE DISCHARGED?** Please tick **only one**:

O Yes O No O I can't remember

27d* **WHEN YOU WERE DISCHARGED FROM HOSPITAL WHERE DID YOU GO?** Please tick **only one**:

O I was discharged onto the street
O I was discharged into accommodation, but it was *not* suitable for my needs
O I was discharged into accommodation, and it *was* suitable for my needs
O I can't remember
O No answer

27e* **AFTER BEING DISCHARGED, WERE YOU READMITTED WITHIN 30 DAYS?** Please tick **only one**:

O Yes O No O I can't remember O No answer

27f **IN THE PAST 12 MONTHS HAVE YOU EVER ATTENDED ANY OF THE FOLLOWING? (MIU means minor injuries unit. WIC means walk in centre).** Tick **all** that apply:

☐	Eastbourne station (WIC)	☐	Pembury Hospital MIU
☐	Hastings station plaza (WIC)	☐	Uckfield (MIU)
☐	Crowborough War Memorial (MIU)	☐	St John Ambulance Seaview/Hope Kitchen
☐	Lewes Victoria (MIU)	☐	Other (please

state)…….

27g ***IF YES TO 27F,*** **DID STAFF ASK YOU IF YOU HAD SOMEWHERE SUITABLE TO GO AFTER YOUR MOST RECENT VISIT?** Please tick **only one**:

O Yes O No O I can't remember

SOME QUESTIONS ABOUT STAYING HEALTHY

28* **BY PLACING A TICK IN ONE BOX IN EACH GROUP BELOW, PLEASE INDICATE WHICH STATEMENTS BEST DESCRIBE YOUR OWN HEALTH STATE TODAY:**

MOBILITY Please tick **only one**:

O I have no problems in walking about
O I have some problems in walking about
O I am confined to bed
O No answer

SELF-CARE Please tick **only one**:

O I have no problems with self-care
O I have some problems washing or dressing myself
O I am unable to wash or dress myself
O No answer

USUAL ACTIVITIES Please tick **only one**:

O I have no problems with performing my usual activities
O I have some problems with performing my usual activities
O I am unable to perform my usual activities
O No answer

PAIN/DISCOMFORT Please tick **only one**:

O I have no pain or discomfort
O I have moderate pain or discomfort
O I have extreme pain or discomfort
O No answer

ANXIETY/DEPRESSION Please tick **only one**:

O I am not anxious or depressed
O I am moderately anxious or depressed
O I am extremely anxious or depressed
O No answer

28a* **To help people say how good or bad a health state is, we have a scale on which the best state you can imagine is 100 and the worst state you can imagine is marked 0. We would like you to indicate on this scale how good or bad your own health is today, in your opinion. PLEASE DO THIS BY SAYING WHERE ON THIS SCALE YOUR HEALTH STATE IS TODAY.**

……

O No answer

29 **COMPARED TO TWELVE MONTHS AGO, HOW WOULD YOU SAY YOUR HEALTH IS NOW?** Please tick **only one**:

O My health is better than it was 12 months ago
O My health is about the same as it was 12 months ago
O My health is worse than it was 12 months ago

30 **ARE YOU TAKING ANY MEDICATION PRESCRIBED FOR YOU AT THE MOMENT? This includes medicines, pills, syrups, ointments, puffers or injections.** Please tick **only one**:

O Yes O No

31 **HAVE YOU BEEN VACCINATED AGAINST HEPATITIS B?** Please tick **only one**:

O Yes (once) O Yes (twice) O Yes (three times)
O Never O Don't know

32 **HAVE YOU BEEN VACCINATED AGAINST FLU?** Please tick **only one**:

O Yes (in the last year) O Yes (more than a year ago)
O Never O Don't know

33 ***CLIENTS OVER 40 ONLY*: HAVE YOU HAD AN NHS HEALTH CHECK IN THE PAST 12 MONTHS?** Please tick **only one**:

O Yes O No O Don't know

34 **HAVE YOU HAD A SEXUAL HEALTH CHECK IN THE PAST 12 MONTHS?** Please tick **only one**:

O Yes O No O Don't know

35 **DO YOU KNOW WHERE TO ACCESS FREE CONTRACEPTION?** Please tick **only one**:

O Yes O No

36 **DO YOU KNOW WHERE TO ACCESS ADVICE ABOUT SEXUAL HEALTH?** Please tick **only one**:

O Yes O No (*go to Q37)*

36a ***IF YES TO Q36*, Where would you go?** Please tick **only one**:

O GP or nurse
O Homeless/housing staff
O GUU/sexual health clinic
O Other (please state)…….....

37 ***FEMALE CLIENTS OVER 25 ONLY*: HAVE YOU HAD A CERVICAL SMEAR IN THE PAST 3 YEARS?** Please tick **only one**:

O Yes O No O Don't know

38 ***FEMALE CLIENTS OVER 50 ONLY*: HAVE YOU HAD A BREAST EXAMINATION/ MAMMOGRAM IN THE PAST 3 YEARS?** Please tick **only one**:

O Yes O No O Don't know

39 ***CLIENTS AGED 60 OR OVER ONLY*: HAVE YOU HAD A BOWEL SCREENING TEST? Bowel screening is where you put a sample of your motions onto a special paper card to find out if there might be any blood.** Please tick **only one**:

O Yes O No O Don't know

40 **ON AVERAGE, HOW MANY MEALS DO YOU EAT A DAY? If this is difficult, please think about the meals you ate yesterday.** Please tick **only one**:

O None O One O Two O Three or more

41 **HOW MANY PORTIONS OF FRUIT AND VEG DO YOU USUALLY EAT PER DAY? If this is difficult, please think about what you ate yesterday.** Please tick **only one**:

O None O Less than 1 portion O One portion O Two portions
O Three portions O Four portions O Five portions or more

42 **HOW OFTEN PER WEEK DO YOU EXERCISE FOR 30 MINS OR MORE? (Activity that raises your heart rate and makes you breathe faster).** Please tick **only one**:

O Never O Once O Twice
O Three times O Four times O Five times or more

43 **IS THERE ANYTHING ELSE YOU WOULD LIKE TO TELL US ABOUT YOUR HEALTH & THE SUPPORT YOU RECEIVE?**

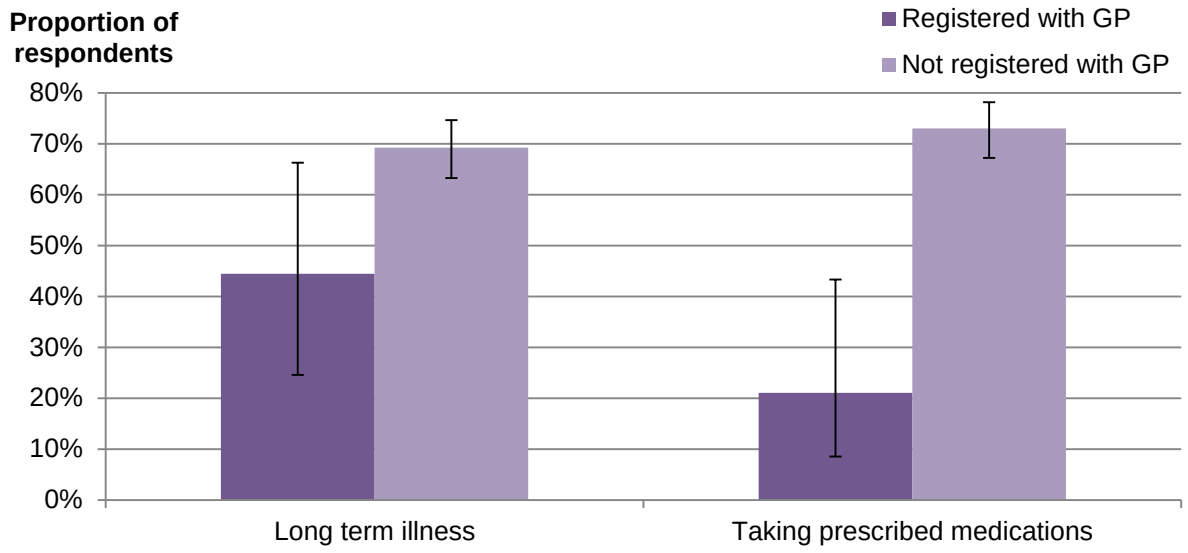
What works well
What could be improved?
Any other comments

44 **COMMENT BOX FOR THE <u>INTERVIEWER</u> TO MAKE ANY COMMENTS OR OBSERVATIONS:**

Appendix 3: GP unregistered respondents

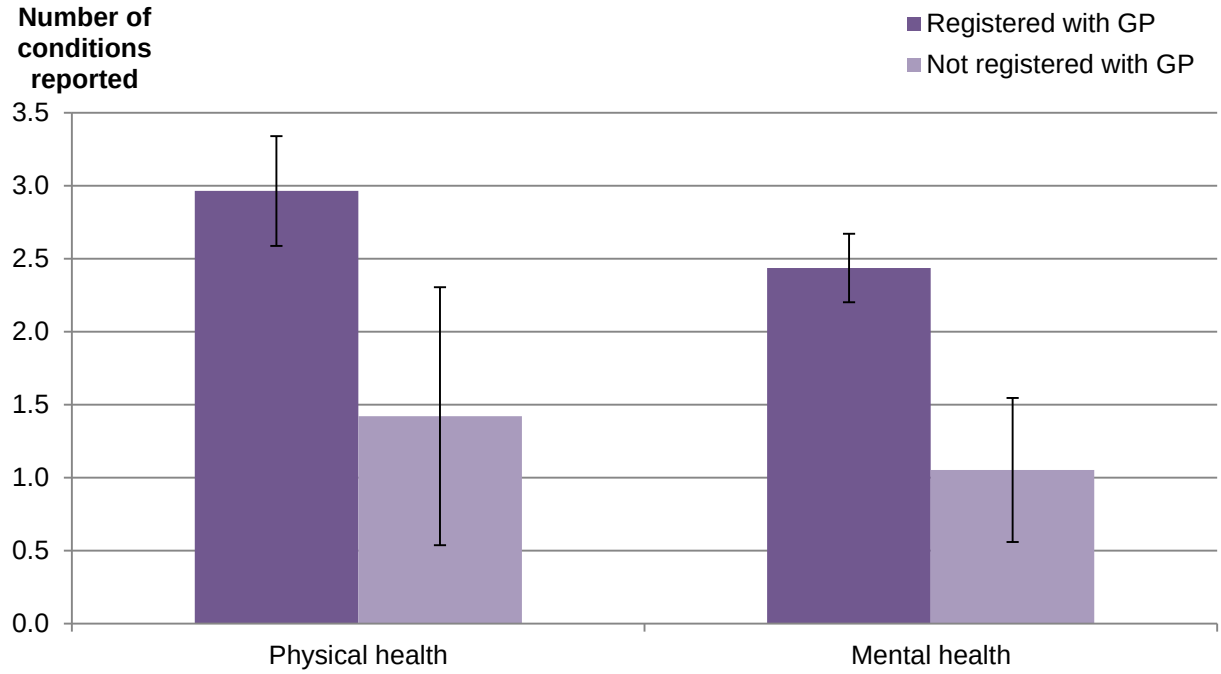
Respondents who weren't registered with a GP were younger (mean age of 30 years compared with 34 years for GP registered respondents), less likely to report long term illness (44% compared to 69%), less likely to be taking prescribed medications (21% compared to 73%).

Figure A1. Long term illness and medication use by GP registration status



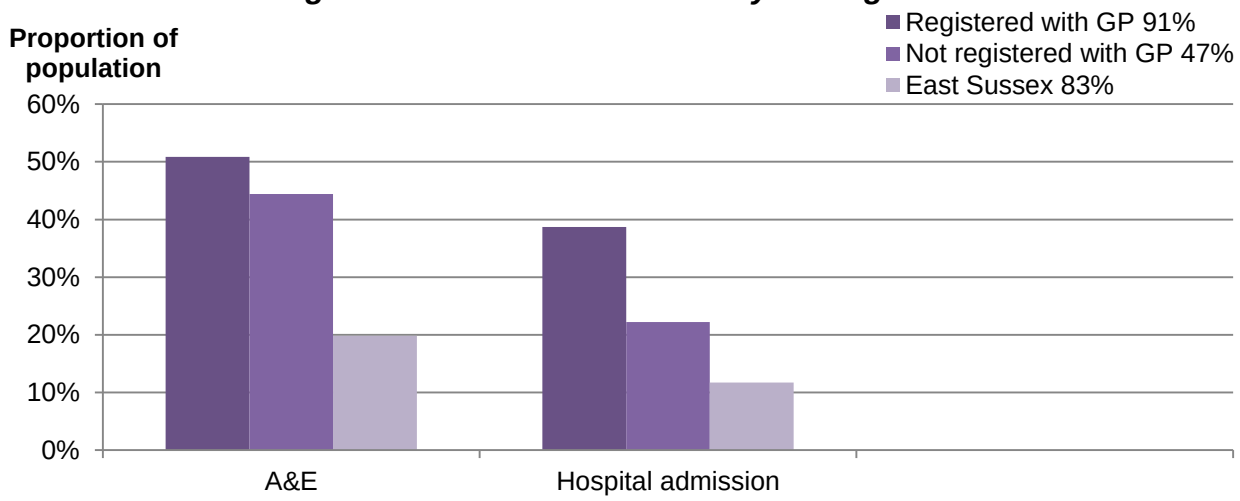
GP unregistered respondents reported roughly half as many physical and mental health problems. This suggests that ill-health prompts registration.

Figure A2. Average number of reported physical and mental health problems by GP registration status.



A lower proportion of GP unregistered respondents visited a GP in the last 12 months compared to registered respondents (47% compared to 91%, p<0.0001); this is also lower than the general population of East Sussex (83%). Use of A&E was slightly lower in GP unregistered compared to registered respondents (44% compared to 51%, p=0.63) but this was not statistically significant. Similarly, a lower proportion of GP unregistered respondents were admitted to hospital (22% compared to 39%, p=0.21) but this was not significant. Notably, A&E and hospital admission rates for GP unregistered respondents were still higher than the general population.

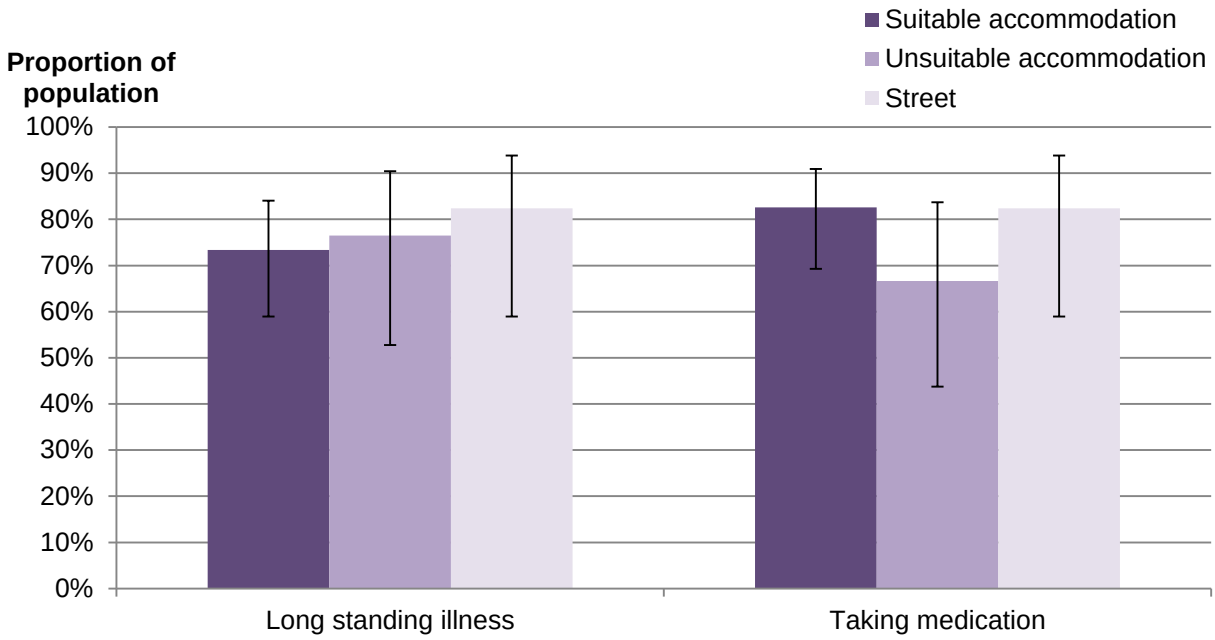
Figure A3. Health service use by GP registration



Appendix 4: Discharge from hospital

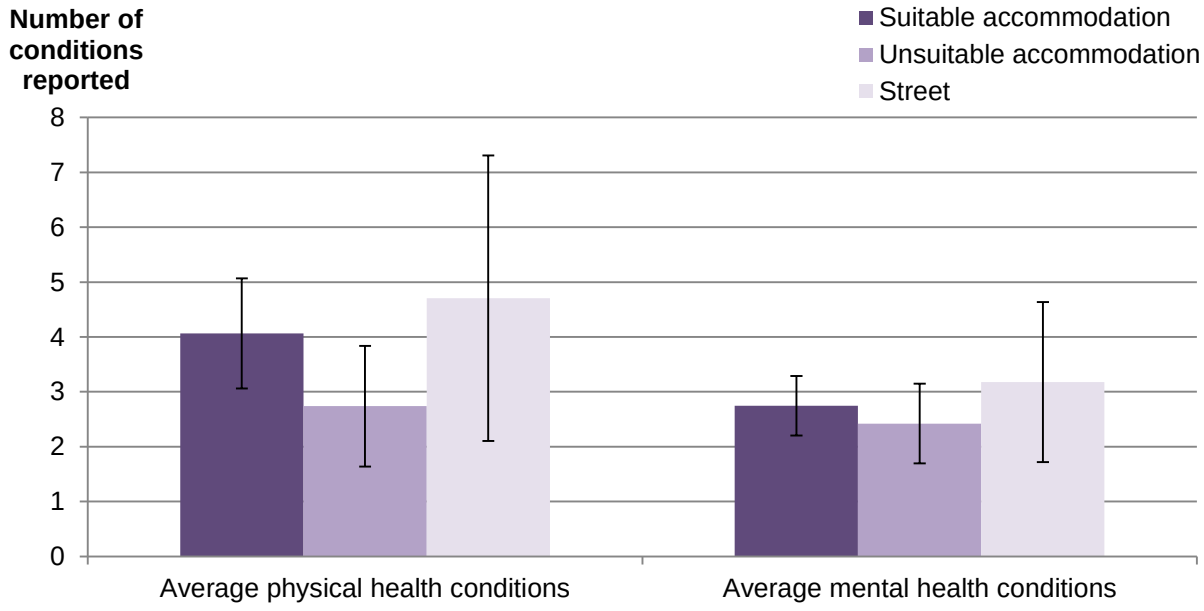
Respondents who reported being discharged to suitable accommodation, unsuitable accommodation and onto the street did not differ significantly in levels of reported long term illness or reported prescribed medication use (figure A4).

Figure A4. Long term illness and medication use by discharge destination.



Where someone was discharged to following a hospital admission did not appear to be associated with their level of physical or mental ill-health in that the average number of reported physical and mental health conditions did not differ significantly in those reporting they were discharged to suitable accommodation, unsuitable accommodation or onto the street.

Figure A5. Average number of reported physical and mental health problems by discharge destination.



Appendix 5: Effective interventions for preventing homelessness

Public Health England (PHE) commissioned Homeless Link to conduct a rapid review of the evidence in order to understand what interventions were effective in preventing homelessness. The review provides local authorities and their partners with a resource that can be used to inform commissioning decisions around health, wellbeing and homelessness.

The information provided below is an extract from their report: *Preventing homelessness to improve health and wellbeing* (2015).[27]

Key findings from the review

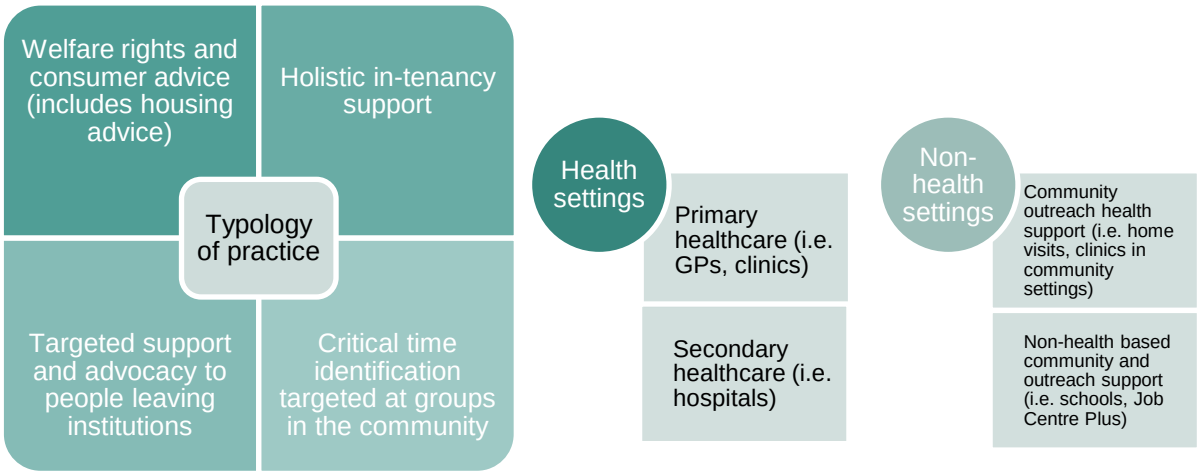
Models of preventative action are identified in three stages which can also be applied to homelessness: primary prevention which minimises risk; secondary prevention which targets individuals or groups at risk; and tertiary prevention requiring intervention once a problem arises to stop it getting worse.

Whilst many studies have looked at early intervention within a housing setting (for example in-tenancy support administered through a housing provider or local authority) there are few studies to show how effective interventions have been in responding to health and wellbeing needs amongst households at risk of homelessness. Where outcomes have been measured, the interventions have mainly been evaluated through qualitative methods.

The majority of interventions found were led by housing, rather than being health-led, and emerged in response to locally identified need or were implemented as pilot projects. Current practice is mainly focused on secondary and tertiary prevention of homelessness to prevent repeat homelessness and target 'at risk' groups. There were few examples which focused on primary prevention.

The rapid review identified the following four models of practice within four main settings:

Models of practice and their settings:



Models of current practice mainly consist of holistic in-tenancy support, hospital discharge services, and community outreach health and housing support targeted at vulnerable

groups - including former rough sleepers, young people, and households with complex needs and entrenched issues, such as alcohol and substance misuse and antisocial behaviour.

Four models of practice

1. Welfare rights and consumer advice (includes housing advice) – primary and secondary prevention.

Most welfare rights and consumer advice has been targeted at particular groups on the basis of their demographics or health needs (secondary prevention). The literature has examined older people aged 60 and over, young people aged 16 to 24, people with cancer and patients in psychiatric hospitals. Advice can be effective in health settings provided that healthcare staff understand the benefits of advice and are supportive of the service to allow maximum use and access for patients/clients in their care.

As well as preventing homelessness and providing financial gains (to both the client and public services), the studies also showed improvements to mental health and wellbeing especially by decreasing stress and anxiety among the advice recipients.

Many services are funded on a short term basis and, due to a lack of national or wider strategy in this area, there is an inconsistent geographical spread of advice services.

2. In-tenancy[3] holistic support – secondary prevention.

Holistic in-tenancy support is targeted to 'at risk' groups who struggle to maintain their tenancy or have a previous history of tenancy failure. As Pawson (2008) notes, existing evaluations of tenancy sustainment services have been largely positive about their benefits for a number of client groups. However, these services have not been delivered in response to a health and wellbeing need but rather triggered by a housing need. There were a number of positive lessons drawn from the tenancy sustainment studies including early contact with the client, quick access to crisis intervention, viewing the service as a befriending rather than management service, and locating the service so that people were aware it existed.

Housing First

The Housing First model places homeless people with complex needs straight into housing rather than requiring them to progress within a 'stepped' model of accommodation which usually entails people moving through hostels and supported accommodation before they are placed in their own tenancy. The Housing First approach provides intensive wrap-around support based on client needs. There have been a number of evaluations of Housing First in both the US and Europe (for example Padgett et al, 2006, Pleace, 2008, Tsemberis, 2010).

Rates of tenancy sustainment (i.e. homelessness prevention) range from 70% to 90% (Pleace and Quilgars 2013). Outcomes in relation to mental health and substance misuse were more mixed but were generally positive (Johnsen and Teixeira, 2010). The overall evidence of improved mental health outcomes is also mixed, with some evidence pointing

[3] In-tenancy support refers to support and services available to people living in their own homes to help them live independently and successfully maintain their accommodation.

to improvements (Busch-Geertsema, 2013) and other studies showing stabilisation (Tsemberis et al, 2004). Housing First has not been found to lead to deterioration of mental health.

On other health and wellbeing outcomes a study by Sadowski et al (2009) showed that Housing First clients spent fewer days in hospital and had fewer emergency visits than homeless people in more traditional service settings. But there is very limited evidence on the impact on people's physical health (Pleace and Quilgars, 2013) and the impact on substance misuse and psychiatric symptoms (Pearson et al 2009). Whilst there has been some research which has identified a reduction in alcohol use there is some uncertainty of the positive outcomes for people with severe and active addictions (Kertesz et al 2009, Kertesz and Weiner, 2009).

3. **Targeted support and advocacy to people leaving institutions – secondary and tertiary prevention**.

Hospital discharge interventions and those transitioning from other institutions focus on a very niche group within a specific health and wellbeing setting, mainly those already experiencing homelessness who are identified whilst staying in hospital. The studies highlighted in the review have shown interventions for patients in hospital for both physical and mental health issues.

Good discharge planning, which should consist of sourcing appropriate housing, helping the tenancy set up process and providing in-tenancy support for housing and health needs are vital to improving outcomes for these groups and preventing repeat homelessness. Where care leavers are concerned, longer term support over a 12 month period helps to improve health and employment outcomes as well as tenancy sustainment.

A report by the Centre for Health Service Economics & Organisation in 2011[28] showed that projects and models which have been implemented to improve admission and discharge practice have demonstrated cost benefits in two different ways: firstly, the average length of stay will change due to a reduction in 'bed blocking' as homeless people are more likely to be discharged sooner if their housing and next steps are adequately catered for (however some may stay longer if this is deemed necessary); and secondly, if patients are discharged at a clinically appropriate time and to suitable accommodation they will more ably recover from an illness, resulting in fewer emergency readmissions to hospital within 28 days.

4. **Critical Time Identification Targeted at Groups in the Community**

Working with at risk groups in the community can have a positive impact on both reducing repeat homelessness and providing a cost effective solution. These targeted interventions both prevent repeat homelessness, and by working longer term with people with greater needs are more likely to lead to improvements in mental and physical health.

Gaps identified

Drawing together the evidence collected through the academic and grey literature and the current practice case studies from the call for evidence submissions, there are a number of gaps that have been identified in three main areas:

- Gaps in current practice – there is very little evidence of homelessness prevention activity that takes place in response to associated health and wellbeing needs. Aside from activity occurring at the more acute end of the homelessness scale such as hospital discharge projects and services which target vulnerable groups; primary prevention activity is not widespread and is mainly led by housing rather than health commissioning.
- Gaps in evidence –there is a lack of evaluation among current practice and future studies should also consider methods such as Social Return On Investment, social impact, and social values measurements.
- Gaps in interventions for certain groups – the review showed that proactively targeting prevention activity at particular groups is an effective way of preventing homelessness (secondary and tertiary models of prevention). Some groups have been adequately captured in current practice but there are some 'at risk' households which are not represented: ex-armed forces, LGBTQ groups with health needs, migrants, families and single people that fall outside the multiple and complex needs group.

Homeless Link References

Pleace, N and Quilgars, D (2013) Improving health and social integration through housing first: A review, DIHAL: Delegation Interministerielle a L'hebergement et a L'acces au lodgement.

Johnsen, S and Teixeira, L (2010) Staircases, elevators and cycles of change – 'Housing First' and other housing models for homeless people with complex support needs, London: Crisis.

Busch-Geertsema, V (2013) Housing First in Europe: Final Report, European Union Programme for Employment and Social Solidarity. Brussels: European Commission. Available at:

http://socialstyrelsen.dk/housingfirsteurope/copy4_of_FinalReportHousingFirstEurope.pdf Last accessed 11 March 2015.

Tsemberis, S; Gulcur, L and Nakae, M (2004) Housing First, consumer choice, and harm reduction for homeless individuals with a dual diagnosis, *American Journal of Public Health*, 94 (4), pp 651-656.

Sadowski, LS; Kee, RA; VanderWeele, TJ and Buchanan, D (2009) Effect of a hosing and case management program on emergency department visits and hospitalisation among chronically ill homeless adults: a randomised trial, *Journal of the American Medical Association*, 301 (17), pp 1771-1778.

Pearson, C; Montgomery, AE and Locke, G (2009) Housing stability among homeless individuals with serious mental illness participating in Housing First Programs, *Journal of Community Psych*ology 37 (3) pp. 404-717.

Kertesz, SG; Crouch, K; Milby, JB; Cusimano, RE and Schumacher, JE (2009) Housing First for Homeless Persons with Active Addicition: Are we overreaching?, *The Millbank Quarterly*, 87 (2) pp 495-534.

Kertesz, SG and Weiner, SJ (2009) Housing the chronically homeless: high hopes, complex realities, *Journal of the American Medical Association*, 301, pp 1822-1824.

Audit Report References

[1] Department for Communities and Local Government, “Rough Sleeping Statistics Autumn 2015, England,” 2016.

[2] East Sussex County Council, “East Sussex In Figures”, [Online]. Available http://www.eastsussexinfigures.org.uk/Accessed 13 November 2016]

[3] Homeless Link, “The unhealthy state of homelessness,” Homeless Link, 2014.

[4] B. Thomas, “Homelessness kills: An analysis of the mortality of homeless people in early twenty-first century England,” Crisis UK, 2012.

[5] Office for National Statistics, “Nomis official labour market statistics,” 2011. [Online]. Available: http://www.nomisweb.co.uk/census/2011/ks102ew. [Accessed 4 April 2016].

[6] R. Carter, “Brighton & Hove homeless health needs audit,” Brighton & Hove City Council, 2014.

[7] Office for National Statistics, “Annual Population Survey,” Nomis official labour market statistics, 22 January 2014. [Online]. Available: https://www.nomisweb.co.uk/articles/804.aspx. [Accessed 6 April 2016].

[8] Office for National Statistics, “UK Labour Market: March 2016,” March 2016. [Online]. Available: http://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/bulletins/uklabourmarket/march2016. [Accessed 6 April 2016].

[9] The Royal British Legion, “A UK household survey of the ex-service community,” RBL, 2014.

[10] K Reeve with E Batty, The Hidden truth about homelessness in England, Centre for Regional Economic and Social Research and Crisis, 2011.

[11] Office for National Statistics, “Crime Statistics, Focus on Violent Crime and Sexual Offences, 2012/13,” Office for National Statistics, 2014.

[12] Public Health England, “People with Learning Disabilities in England 2013,” PHE, 2014.

[13] P. M. Oakes and D. C. Ros, “Intellectual disability in homeless adults,” *Journal of Intellectual Disabilities,* vol. 12, no. 4, pp. 325-334, 2008.

[14] S. Bridges, “Health Survey for England, 2014: Chapter 2 Mental health problems,” The Health and Social Care Information Centre, 2015.

[15] D. Lader, “Drug Misuse: Findings from the 2014/15 Crime Survey for England and Wales,” Home Office, 2015.

[16] DH Office of the Chief Analyst, “Healthcare for Single Homeless People,” Department of Health, 2010.

[17] C. Orchard, “Adult Drinking Habits in Great Britain, 2013,” Office for National Statistics, 2015.

[18] NHS Commissioning Operations; Primary Care Commissioning, “GP Patient Registration Standard Operating Principles for Primary Medical Care,” NHS England, 2015.

[19] K. Doran, K. Ragins, A. Iacomacci, A. Cunningham, K. Jubanyik and G. Jeng, “The revolving hospital door: hospital readmissions among patients who are homeless,” *Medical Care,* vol. 51, no. 9, pp. 767-73, 2013.

[20] R. Nuttall, “Hastings Homeless Service End of Year Report,” St John Ambulance, 2015.

[21] NHS England, “GP Patient Survey,” [Online]. Available: https://gp-patient.co.uk/. [Accessed 6 April 2016].

[22] Lifestyle Statistics, Health and Social Care Information Centre, “Statistics on Smoking: England, 2013,” National Statistics, 2013.

[23] Public Health England, “National Diet and Nutrition Survey: Results from Years 1-4 (combined) of the Rolling Programme (2008/2009 – 2011/12),” PHE Publications, 2014.

[24] A. Story, R. W. Aldridge, T. Gray, S. Burridge and A. C. Hayward, “Influenza vaccination, inverse care and homelessness: cross-sectional survey of eligibility and uptake during the 2011/12 season in London,” *BMC Public Health,* vol. 14, no. 1, p. 44, 2014.

[25] Public Health England, “Public Health Outcomes Framework,” [Online]. Available: http://www.phoutcomes.info/public-health-outcomes-framework. [Accessed 6 April 2016].

[26] NHS, “Explore NHS Health Check Data,” [Online]. Available: http://healthcheck.nhs.uk/commissioners_and_providers/data/previous_years_data/. [Accessed 6 April 2016].

[27] Homeless Link. Preventing homelessness to improve health and wellbeing. Evidence review into interventions that are effective in responding to health and wellbeing needs amongst households at risk of homelessness.July 2015.

[28] Centre for Health Economics and Organisation, Homelessness and hospital discharge in Wirral: an investigation into the Hospital Discharge Project, 2011.