

High Wycombe and Aylesbury Single Homeless Health Scoping Study

A report undertaken by IDRICS



in partnership with



with support from Buckinghamshire County Council
and Chiltern CCG and Aylesbury Vale CCG

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- **Anne Cooney, Prevention and Housing Support Commissioning Manager, Buckinghamshire County Council (BCC)**
- **Debbie Duncan – Outreach Nurse, Old Tea Warehouse**
- **Sheena Dykes, Chair of Trustees, Wycombe Homeless Connection (WHC)**
- **Margaret Greenfields, Professor of Social Policy & Community Engagement Director IDRIS, Faculty of Society & Health, Buckinghamshire New University**
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EXECUTIVE SUMMARY

Introduction:

The purpose of this study has been to collect further evidence of the health needs of homeless people in Aylesbury and Wycombe to inform future commissioning and/or provision of health services to the homeless population of Aylesbury and High Wycombe.

Both qualitative and quantitative evidence indicates that the number of people becoming homeless is rising in Buckinghamshire and will continue to rise in the next few years, placing additional pressure on homelessness services. This will also need to be taken into account in service planning. Another factor to be taken into account will be increasing numbers of non-British nationals becoming homeless, who may come to Buckinghamshire looking for work and accommodation near the capital, and will need specialised service support.

Overall, while excellent quality service is provided to the homeless population in Aylesbury and High Wycombe by the voluntary sector, there is a clear problem in provision of access to timely and appropriate healthcare, which has severe implications for individual and population health.

An overview:

It is well documented that ill health is both a cause and a consequence of homelessness. Poor living conditions mean a person is more likely to face infectious disease, malnutrition, mental health problems, problems influenced by environmental conditions such as bronchitis, and violence and abuse. Such issues are compounded by frequent difficulties accessing primary care, and subsequent overuse of acute/emergency services. National data demonstrates¹ that 89% of all admissions of homeless people to hospital in 2010 were emergency, compared to around 41% of admissions for non-homeless people. Their average stay in hospital was also three times longer.

This study covers 50 respondents who were street homeless, insecurely accommodated (such as sofa surfing) or in temporary accommodation, and focuses on people who are single or in a couple rather than those with young families, as the latter would be subject to statutory housing duties. Findings have been informed by an extensive literature review, and use of a standardised national audit, focus groups, and staff surveys.

When compared to national Homeless Link data, the homeless population in Aylesbury and High Wycombe has a higher number of street homeless, and appear to have a slightly older age profile than in other areas of the country, with a greater proportion who are White British. Comparisons show lower levels of alcohol misuse, but similar levels of mental health problems, dual diagnosis and substance misuse. In addition, with lower access rates to primary care, there is likely a direct correlation to higher rates of communicable diseases and higher rates of A&E use.

¹ http://www.homeless.org.uk/sites/default/files/site-attachments/Health%20Audit%20Findings_National%20evidence_2010.pdf

Key findings:

Literature Review Summary

There has been an increasing emphasis nationally to consider the needs of homeless people over recent years. This literature review focused on the issues for single / non-priority homeless people. Ill health is both a cause and a consequence of homelessness. Poor living conditions mean a person is more likely to face infectious disease, malnutrition, mental health problems, problems influenced by environmental conditions such as bronchitis, and violence and abuse. These issues are then compounded by frequent difficulties accessing primary care, and subsequent overuse of acute/emergency services.

Evidence shows that 73% of homeless people nationwide are experiencing physical health problems, and 80% of homeless people nationwide are experiencing mental health problems. A large number of people – between 27% and 39% - also have, or are recovering from, a problem with alcohol or drugs. In 2010, 89% of all admissions of homeless people to hospital were emergency, compared to around 41% of admissions for non-homeless people. Their average stay in hospital was also three times longer.

Accordingly to a health needs audit by Homeless Link in 2014² despite increased awareness of these issues, general trends relating to ill health and the homeless population have shown no improvement since 2010. A key issue from the review was that healthcare professionals did not consider patients' housing issues, or were not in a position to offer or signpost relevant support. Barriers such as 9-5 hours, or difficult to access referral pathways also played a part. The literature on best practice relating to specialised and preventative care shows that evidencing it can be difficult. However, essential principles of good practice involve joint working between agencies, and service design that overcomes access barriers.

Service Users Audit – Summary of Survey Data and Findings

Using information from 49 questionnaires, administered over three locations, the survey data highlights the extent to which people who are homeless experience some of the worst health problems in society.

Lifestyle factors: Being homelessness can make it much harder to have a healthy lifestyle. High levels of smoking and poor diet can cause long- term health problems or exacerbate existing issues. Analysis of the data found that 86% were current smokers, 45% do not eat at least two meals a day, with the same amount having no fruit or vegetables on an average day. However 49% reported that they were exercising at least twice a week.

With regard to communicable disease and vaccinations, 18% of respondents had been vaccinated for flu, 16% for Hepatitis A, and 21% for Hepatitis B. Around a quarter (24%) had been tested for Hepatitis C, with 8% testing positive. Almost a third (30%) of respondents had been tested for HIV, with 8% testing positive. For tuberculosis (TB) 22% surveyed had been tested, of which 8% were TB+. Only 2% of those who reported screening positively for Hepatitis C; 4% found to be TB+ and 4% of those found to be HIV+ indicated that they were not offered treatment or advice for their conditions.

² Homeless Link, '[The unhealthy state of homelessness: Health audit results 2014'](#) (2014) (accessed 04/09/15)

Physical health: National comparable data shows that almost all long-term physical health problems are more prevalent in the homeless population than in the general public. Over half (51%) were experiencing joint or muscular problems, 31% of these had been for 12 months or longer. Feet were also an issue for 33%, with 10% suffering for 12 months plus. 18% reported stomach problems, 14% for over 12 months. Breathing problems or chest pain was the second biggest area of concern (40%) with half of these (20%) having had problems for 12 months or longer. 18% reported episodes of fainting or blackouts.

Less than a third of respondents (29%) indicated they received adequate support for their physical health needs, and a further 18% indicated the support they received was not adequate. 22% of respondents said they were not receiving any support for their physical health needs, which they felt they needed. Overall, based on the survey data, a total 40% of respondents therefore had unmet or poorly met physical health needs.

Mental Health: Our data shows that the proportion of homeless people with diagnosed mental health problems (45%) is nearly double that of the general population (around 25%). In particular, the incidence of depression amongst homeless people is substantially higher (40%). A high proportion of homeless people also have other mental health problems including diagnosis of schizophrenia, bipolar disorder and personality disorder (each was reported by 7% of respondents).

Homeless people also experience high levels of stress, anxiety and other signs of poor mental health. Nearly three quarters of respondents (72%) reported frequent feelings of stress; 74% had frequent experiences of anxiety; and 68% expressed frequent depression (39% for 12 months or longer). Almost a third (30%) had experienced suicidal feelings, and 12% those had been for more than 12 months). Self-harm was reported by 14% (8% of these was long term).

In addition, 20% of participants diagnosed with mental health issues also reported drug and alcohol issues. This 'dual diagnosis' often restricts homeless people from accessing support, as services are unable or unwilling to provide support around mental health while still using drugs or alcohol. 49% of all participants said they used alcohol or other substances to cope with stress and their mental health issues, which shows the high cost of being unable to access the right support. 20% of respondents reported 'hearing voices', and over half (54%) indicated they had problems with anger management.

Worryingly, only 6% of those who received mental health service support felt it was adequate, and a further 22% stated that the help they received was not adequate. 29% said they were not receiving any support for their mental health needs, which they felt they needed. When asked what services they felt would be most helpful, the most popular answer was a specialist mental health service (29% of total respondents) closely followed by talking therapies (27%) and practical support (24%).

Alcohol use: 55% of respondents could be said to be low-risk drinkers, drinking alcohol once a week or less. However, 14% of respondents said that they drank alcohol every day, and 17% said they were likely to consume 10 units or more in a session of drinking. Further analysis is needed to understand if this would be on a regular or sporadic basis. 29% of respondents said they had or were recovering from an alcohol problem. Of these, 9% suggested that they received adequate assistance with their alcohol problem; 12% reported that the help they received was not adequate, and a further 7% indicated they did not access support but felt they needed it.

Drug use: When asked about drug use, 42% of respondents said they had or were in recovery from a drug problem. The most commonly used drug was cannabis (30%) followed by crack/cocaine (27%) and heroin (22%). 45% of respondents indicated they had taken methadone in the previous month, 10% on prescription. 9% of respondents said were injecting drugs, and all were aware of needle exchange programmes. 11% of respondents were receiving support with drug misuse and felt that it was adequate, but a further 18% stated that the help they received was not adequate, the majority of those answering the question. When asked what support they required, the most frequent answer was help to stop taking drugs (14%) followed by support in controlling intake (8%).

Sexual Health: Whilst 67% of respondents had not accessed sexual health screening in the previous 12 months, 71% of them said they knew where to go to access support with sexual health, the majority citing a GP/nurse or GUM clinic.

Specialist Women's Health Services: Of the six female respondents to this survey, only one had accessed cervical screening in the previous 3 years. None had accessed breast screening.

Accommodation Data: Of those surveyed, when asked about accommodation, almost half (45%) were sleeping rough. 22% were based in a hostel, 8% were in supported accommodation and 2% (1 person) was sofa-surfing. 18% had other forms of accommodation. A fifth of respondents (20%) were in training, employment or volunteering. Of the remainder, 36% said that their current health status impacted on their ability to train, work or volunteer. Data also showed that 16% of respondents had left prison within the previous year, and 16% had left prison at an earlier point. 2% (1 person) had left care in the previous five years. A third (33%) indicated that they had a disability, the most common of which was mental health (20% of total respondents) followed by mobility-related (18% of total).

Help with healthcare: Despite 84% of those surveyed reporting that they are registered with a GP, a significant number of homeless people report that they are not receiving help with their health problems. Of these, 31% had seen their GP five times or more in the previous six months, demonstrating a significant need for continuous healthcare. 10% said they had been previously been refused registration at a GP practice. There was a direct correlation with those admitted to hospital in the same period. High-level analysis shows those not registered with a GP were likely to rely on A&E for their care. 28% had needed an ambulance in the previous 12 months, and 26% had been admitted to hospital. The most common given reasons for admission were violent incident/assault and accidents.

Only 41% were registered with a dentist. 60% of respondents said they had not seen a dentist in the previous 6 months, although 39% reported having dental problems. Despite 37% reporting eye problems or difficulties with vision, 70% of respondents had not seen an optician within the last 6 months. 57% of respondents had never had a nurse appointment. Support from a nurse could prevent reliance on GP and emergency/acute services. However 43% having had at least one appointment is high for the age range of participants.

On the whole, the service user data and information gathered relating to pattern of access, satisfaction levels with healthcare services and provision of homelessness support mirrors the evidence supplied by service providers, indicating that whilst the homeless population in High Wycombe and Aylesbury are offered some high quality voluntary sector services, there is a

quantifiable problem in relation to provision of sustainable, rapid access to healthcare. This has implications for both individuals and population health.

Focus groups

Two focus groups were conducted with ten service users from WHC and AHAG. The group findings offer further meaningful information and identify some of the barriers that people who are homeless face in accessing everyday services. Group members agreed that health problems were often caused by a combination of personal neglect and difficulties accessing care due to structural barriers. Physical and mental health issues both intensify in line with increasing isolation from society. The major health concerns for the group were drug and alcohol problems, as these became the highest priority. They also experience difficulties in maintaining personal hygiene, which has a negative effect on physical health and self esteem. Depression is commonplace, and affects people's motivation and confidence. The group talked about dangers they face by being homeless. These were summarised as difficulty finding a safe place to sleep, violence and aggression from other homeless people and the public, and sexual exploitation and violence (particularly for women). There was also discussion that homelessness services may be 'ruined' by bad behaviour from others.

Focus group participants said they could experience prejudicial attitudes from the public and staff, and often face barriers in trying to access services. Some of these barriers include waiting lists, costs of phone calls, service eligibility barriers, long and overcomplicated forms, need for postcodes, lack of information about what is available, and short length of appointments. Continuity of care was difficult to achieve, as they had to see different staff, and were often trying to continue to access care while having to move around. Lack of healthcare access can cause homeless people to be unable to deal with health problems until they reach a crisis point. There was a general feeling that deterioration of health issues resulted in a 'revolving door' scenario of A&E access, back onto the streets, and further decline in health. In addition, there is often a lack of awareness from professionals of what support is available else, pointing to a need for more integrated working across services.

On a positive note, they were able to offer suggestions and solutions for how services could be improved. Consensus around what would make accessing healthcare a good experience involved caring and respectful (non-judgmental) attitudes from staff; a familiar location for services; flexibility with appointments, such as a drop in service; and longer appointments for people with complex needs and/or people who are not aware of all the problems they may have.

Good mental health care is essential to this group. Mental health support and counselling would ideally be delivered in face-to-face meetings rather than phone calls, with people available at short notice to discuss problems – trained people, and also those just willing to listen and care. Short waiting times to see a specialist would also be beneficial, particularly to avoid a crisis situation.

Other specialist services they would like to be available to homeless people included immunisations, dental services, a safe place to store medication, information about services available and ideally a central clinic with a range of services such as foot care, wound cleaning, counselling, internet use, hair care, sexual healthcare, and non-judgmental staff to talk to.

The group concluded that money spent to deliver a targeted homeless health service is essentially well spent given the potential to reduce costs in inappropriate health care access.

Health Professional and Homelessness Services Staff Feedback

To give a broader picture, which supplements the data and feedback contributed by participating homeless people, we asked front line staff to share their own experiences and observations, particularly relating to the health of the homeless population in Aylesbury and Wycombe, and the services they access. Comments were received from eight sources.

A general consensus was the critical need for early intervention to prevent deterioration of physical and mental health, with a need for flexibility/referring on service users. Staff felt that often there are long waits for services, and multiple stages required before a service user can obtain medical care, during which time problems can get worse. Due to clients' chaotic lives, they would achieve more with the option of speedy and opportunistic health care interventions to support people.

Another area that could be improved was the complex interface between mental health and substance misuse services, and gaps in provision for dual diagnosis. Follow on care can be compromised by lack of a stable address, or problems in managing to maintain a regular routine or attend multiple appointments.

In conclusion, professional workers identified a real need for specialist basic health services, and expressed a desire to see these delivered in an easily accessible way at known and trusted locations, familiar to homeless people, and staffed by experienced professionals. They felt that access to such services could provide service user's with expedited medical care, thereby increasing compliance, and resulting in beneficial impacts on health and wellbeing for individuals, and potentially public health (in the case of those individuals with communicable diseases).

Outcome and conclusions:

The work detailed in this report identified significant gaps in access to basic primary care provision, mental health services and a general inability for 'usual services' to meet the needs of this adult population. Based on these findings, we would highlight again the view that investment in a dedicated homeless health service not only has the potential to improve health outcomes for this patient cohort, but also is likely to reduce costs in the longer term. Provision of this type of service would contribute directly to reducing health inequalities, target healthcare resources more effectively and reduce the incidence of emergency admissions. These objectives fit strategically with national strategies and programmes.

Common themes in providing appropriate primary care to homeless people include a flexible approach, longer appointments to enable assessment and investigation of complex healthcare needs, assertive outreach offering support in a range of settings, and a triage approach where different health needs are prioritised and addressed through a structured health programme. Any proposal for such a service should particularly target homeless adults who are often excluded from accessing health services. In line with national guidance, such a scheme would provide more personalised support, and enable this vulnerable group to better manage their own health. It would also provide an opportunity to understand their patient journey, see how care could be improved and link this to future commissioning intentions.

In conclusion, with clear evidence of need for this type of targeted healthcare provision in the High Wycombe and Aylesbury localities, we would suggest delivery of an integrated service that aims to provide dedicated primary care health services, available at known and trusted locations which are

familiar to homeless people, staffed by experienced professional and that can be easily accessed by service users. A further critical success factor will also be delivery of a service that both meet the needs identified by homeless services users, and works in partnership with experienced staff and services with whom they already have an existing, and trusting, relationship. It is hoped that by taking this direction, there will be beneficial outcomes for not just financial, but human costs, supporting a fully inclusive 'health for all' approach.

Wycombe Homeless Health Report V2 Jan 2016

1. Introduction and Background to Report

This report of a scoping study on the health needs and status of homeless people in High Wycombe and Aylesbury has been undertaken to provide the background to a business plan pertaining to options for provision of services to the above population. Concerns have been raised repeatedly by front line service delivery staff (Wycombe Homeless Connection (WHC) and Aylesbury Homeless Action Group (AHAG) over the difficulties experienced by their clients in accessing appropriate, sustainable medical care in a timely manner that reduces avoidable mortality or morbidity. Failure of homeless service users, many of whom have complex needs (see further literature review below) to access medical care has, in addition to significant human cost, fiscal implications for CCGs, NHS Healthcare Trusts and local authorities who are ultimately responsible for meeting the needs of vulnerable service users.

WHC and AHAG are members of the Thames Valley Homeless Health Network (TVHHN), affiliated to the Faculty of Homeless Health, membership of which organisation includes both civil society agencies/front line homeless projects and medical professionals. Following substantial discussion between members of the TVHHN; WHC; AHAG; the NHS Trust and Chiltern CCG and staff from Bucks County Council with responsibility for public health it was recommended that a scoping study be undertaken to elaborate the state of knowledge of the health of homeless people in South Buckinghamshire with the intention of considering the viability of provision of a dedicated service.

This scoping study which was undertaken collaboratively by members of the advisory panel and review board convened to consider the need for specialist health services for homeless people in the above areas (see acknowledgements for details of panel membership) has been supported by Buckinghamshire New University who have provided funding for a Student Intern (Racheal Mealing) to work on data-gathering under the auspices of a Research Professor (Margaret Greenfields). Members of the advisory panel have undertaken discrete roles including distribution of survey questionnaires, collation of case studies; supporting and co-convening focus groups with homeless people; the development of a background literature review and provision of examples of good practice models of service delivery. The Buckinghamshire New University team (Greenfields and Mealing) have undertaken analysis of raw data and collated the report of this work. See below for information on the methodology underpinning this study.

In undertaking this scoping study we have utilised the **definition** of 'homelessness' that includes:

Those individuals who are 'street homeless/roofless'

People who are insecurely accommodated (for example 'sofa surfing' or staying at a hostel)

People living in short-term temporary accommodation for example while their claim for local authority housing is assessed.

This scoping study is focused on single homeless or couples (i.e. not those with children subject to statutory homeless duties)

We are critically aware of the implications for long term health status of temporary and/or long-term homelessness (in particular with reference to the social determinants of health (SDOH) and have included within the survey (see methodology below) data gathered from service users accessing agencies such as the Old Tea Warehouse (OTW), High Wycombe; AHG and WHC who may at the precise point of interview be in some form of accommodation but who have recently, or are currently, experiencing homelessness. For clients interviewed movement through different forms of

homelessness frequently forms part of a cycle which may include squatting, street homelessness; residence in vehicles; periods of hospitalisation, staying with relatives/friends on a temporary basis and/or hostel or temporary accommodation. Accordingly, the precise accommodation status of respondents at the moment of interview (other than when health status is fundamentally endangered by rooflessness and simultaneous precarious health) is frequently less analytically critical than the fact that respondents are *accessing* dedicated services and are currently within a cycle of homelessness.

Wycombe Homeless Health Report V2 Jan 2016

2. Methodology

An advisory panel and working group was formed in Spring 2015 to develop a scoping study as outlined above. Following contact and discussions with Dr Nigel Hewitt (Pathway); Margaret Greenfields from Buckinghamshire New University joined the advisory panel in the early summer of 2015 and was able to identify a student intern to participate in the study with particular reference to data gathering, a phase which commenced in July 2015. The advisory panel met on four occasions between May and October to review the progress of the scoping study and review documents and data under development and work in progress.

The scoping study undertaken between May and October 2015 consisted of a number of phases.

A background **literature review** was undertaken in relation to best practice in homeless health, and current state of knowledge on the health of homeless people (carried out by Tiffany Williams, Buckinghamshire County Council). This element of the study was subsequently reviewed, and where appropriate additional suggestions proposed by members of the advisory panel in relation to emergent themes arising from front line service delivery and knowledge of trends in research. A second sweep of literature was subsequently undertaken and incorporated into the review shortly prior to completion of the scoping review.

A **survey questionnaire** was designed, initially using a combination of existing materials previously utilised by Greenfields in earlier studies, and based extensively upon the excellent, standardised Homeless Link health audit questionnaire used widely throughout the UK. Incorporation of standardised questions not only feeds into the base-line review of homeless health and service provision³ undertaken by Homeless Link who supported this study in the latter stages by enabling their Strategy and Partnership Manager to attend meetings and provide input to the scoping review; but further enables consideration of how Buckinghamshire (in the localities studied) compare with other locations within the UK.

The survey which was administered to service users attending at three different locations/agencies (The Old Tea Warehouse, High Wycombe; Aylesbury Homeless Action Group and High Wycombe (Wycombe Homeless Connection). The questionnaire was administered in two formats (face-to-face, supported by staff at the above agencies and the student intern working on this project) and via an e-format (little used). In total 49 questionnaires were completed. The data was then entered and uploaded into the database administered by Homeless Link and subsequently **analysed using automatic analytical tools, supplemented by manual review of core themes**. Findings are presented below.

Buckinghamshire New University staff convened **two focus groups**. They utilised a topic guide drawn from previous BNU studies, and amended it in collaboration with the advisory panel to reflect the needs of service users in the local area/Homeless Link advice. These two focus groups, which took place in High Wycombe (at WHC) and Aylesbury (AHAG) respectively, consisted of 10 participants (8 male and 2 female) see Topic Guide at Appendix 2 below for details of subjects discussed. Core themes and quotations from these focus groups are summarised below.

Staff comments in relation to core recommendations/experience of service user needs and recommendations/preferences for service delivery models were invited to enrich the data gathered

³ <http://www.homeless.org.uk/facts/homelessness-in-numbers/health-needs-audit-explore-data>

from service users. In total, eight comments were received from front-line staff members (see Appendix 3).

The Old Tea Warehouse, WHC and AHAG developed **Case Studies** based upon anonymised examples of typical service user health pathways. In total 5 case studies were received and **worked examples of typical costs associated with particular pathways** have been developed for two of these examples.

Service Delivery Models: Members of the advisory group collated examples, and these are included below to provide scope for consideration of potential commissioning opportunities/ models.

Wycombe Homeless Health Report V2 Jan 2016

3. Literature Review

The research case for a specific national focus in commissioning and practice on the needs of homeless people has built up over recent years following the publication of the Marmot Review, and the launch of the Inclusion Health programme in 2010. This review will concentrate on the literature concerning single people or couples with non-dependent children, sometimes called single homeless or non-priority homeless as they are not given priority in the homelessness legislation. Evidence shows that homeless people often have a combination of physical health, mental health and substance abuse needs. Added to these are present or past risk factors that are more common among homeless people, poverty, exposure to violence and abuse, and infection. Finally, historically they have experienced a range of difficulties in gaining access to primary and secondary healthcare, despite having multiple needs.

The majority of the homeless population nationally are experiencing at least one form of ill health. The membership charity for homelessness organisations, Homeless Link, performed a health needs audit in 19 local areas in England in 2014⁴, which represents the most comprehensive and up-to-date source of data on this topic. The health audit showed that despite increased awareness of the issue, general ill-health trends in the homeless population have not improved since 2010. Data gathering continues across the country and has now reached 3,500 homeless people. As they work with homeless organisations, data is slightly biased to those already receiving support.

3.1 Physical health

73% of homeless people in that study reported physical health issues, of which 41% were long-term.⁴

The most common physical health problems reported were joints and muscular (22% long-term, 25% within 12 months), followed by chest and breathing (15.2% long-term, 21% within 12 months), and dental (15% long-term, 22% within 12 months).

In their report on homelessness for Health and Wellbeing Boards⁵, St Mungo's Broadway cited a systematic review by Beijer et al. (2012)⁶ which found significant differences in prevalence of HIV, tuberculosis and hepatitis C in homeless populations, compared to general populations.

A study commissioned by Shelter⁷, which is about the wider homeless and inadequately housed population offers several examples of direct cause and effect between the physical environment and health. Poor air quality influences respiratory illness, poor repairs can cause accidents and injury, and poor heating and insulation can cause death in extreme cold, particularly for older and vulnerable people.

⁴ Homeless Link, '[The unhealthy state of homelessness: Health audit results 2014](#)' (2014) (accessed 04/09/15)

⁵ St. Mungo's Broadway, '[A Future. Now.: Homeless Health Matters – the case for change](#)' (2014) (accessed 04/09/15)

⁶ Beijer U et al (2012) 'Prevalence of tuberculosis, hepatitis C virus, and HIV in homeless people: a systematic review and meta-analysis' *The Lancet Infectious Diseases*; 12: 11, 859–870

⁷ NatCen Social Research, '[People living in bad housing – numbers and health impacts](#)' (2013) (accessed 04/09/15)

The Inclusion Health programme, in their recent data evaluation, 'Hidden Needs' (2014)⁸ found there was limited specific data on the nature and cause of physical health problems of this population, but some GP practices reported a high rate of cases of fracture and assault in homeless patients. The health audit found assault was the most common reason for admission to A&E (16.2% of reported admissions)⁴.

3.2 Nutrition and Oral Health

35% of respondents did not eat at least two meals a day.⁴

If the individual has limited access to food, this will also place their health at risk. A project working with homeless people in the University of Southampton in Hampshire⁹ found that only 63% of their 79 participants had two meals daily, and 14% had only one small meal. Substance misuse in addition to poverty is a significant cause of this; 69% of 79 homeless individuals interviewed said they would spend money on cigarettes, alcohol or drugs over food. The QNI's report, 'Food, Nutrition and Homelessness'¹⁰ lists other potential influences on malnutrition; mental health difficulties, little access to facilities to cook or store food, or putting others' needs, such as children's, over one's own.

- 15% had a long-term dental problem, 22% had a dental problem within 12 months.

Tooth decay is a commonly occurring health problem for single homeless people, due to a combination of factors including poor diet, poor knowledge of nutrition, inability to maintain hygiene routines, and greater tolerance of the problem¹¹. They may also face difficulties accessing and affording dental care. Dental health problems may be another influence on malnutrition¹⁰. Untreated dental problems can lead to abscesses and/or gum disease¹², which in turn can lead to tooth loss and severe, possibly fatal infections of the dental nerves, sinuses and bone¹³.

3.3 Mental Health

80% of the Homeless Link sample reported that they had mental health issues, of which 45% had been clinically diagnosed with a specific condition.⁴

The charity Crisis conducted a literature review¹⁴ on mental health in the adult single homeless population and found a range of reliable statistics that indicated significant inequalities in rates of prevalence of mental health conditions compared to the general population – for example, they were up to 100 times more likely to have a psychotic disorder.

⁸ Peter Aspinall, '[Hidden Needs: Identifying Key Vulnerable Groups in Data Collections: Vulnerable Migrants, Gypsies and Travellers, Homeless People, and Sex Workers](#)' (2013) (Inclusion Health, accessed 04/09/15)

⁹ Alison McKay, '[Food, Health and Homelessness](#)' (accessed 21/08/15)

¹⁰ Anne Coufopoulos, Kathleen Mooney, '[Food, Nutrition and Homelessness: Guidance for Practitioners](#)' (QNI, 2012) (accessed 04/09/15)

¹¹ Office of the Deputy Prime Minister, '[Homelessness and Health Information Sheet 3: Dental Services](#)' (2005)

¹² NHS, '[Dental abscess- Causes](#)' (accessed 23/09/15)

¹³ NHS, '[Dental abscess – Complications](#)' (accessed 23/09/15)

¹⁴ Sian Rees, '[Mental ill-health in the Adult Single Homeless Population](#)' (Crisis, 2009) (accessed 04/09/15)

Mental health issues can be a cause of homelessness. The Marmot Review¹⁵, a broad study of health inequalities across England, found a strong correlation between deprivation and mental health issues, including severe mental health conditions. A report from the Royal College of Psychiatrists¹⁶ details how people with mental health conditions often have low incomes and face exclusion from wider society.

Women are more likely to face independent risk factors that can cause both homelessness and mental health issues. A 2006 study¹⁷ by Crisis found that 20% of the 188 homeless women across England that they spoke to had become homeless escaping from violence from a person they knew. Many also reported a history of child abuse, though this is also an issue for men. A critical issue for homeless women is (re-) victimisation, as they may be targeted for sexual exploitation.

Other groups likely to face independent risk factors causing both homelessness and mental health issues are recent migrants and refugees¹⁸. Those who have faced war and conflict are particularly vulnerable to mental disorder, and are at risk of homelessness and poor housing once in the UK.

At the same time, homelessness and poor housing conditions are independent risk factors to cause mental health issues. A 2004 review by Shelter¹⁹, found half of parents and 71% of childless people living in temporary accommodation were feeling depressed, and 63% felt their mental health was made worse by their living situation.

The most common reported diagnosed mental health conditions in the health audit were depression (36%), dual diagnosis (12%) and personality disorder (7%). Self-reported mental health problems included high levels of stress (73%), depression (67.3%) and anxiety (64.8%)⁴. Other research has suggested that in particular personality disorder is much higher in the homeless population; up to 60% of adults living in hostels in England will have a diagnosable personality disorder.

There is increasing recognition of the trauma and abuse in the background of the majority of people that enter homeless services for any length of time.

They typically:

- 'Have difficulty managing their emotions
- Self-harm and /or have an uncontrolled drug or alcohol problem
- Appear impulsive and don't consider the consequences of their actions
- Appear withdrawn or socially isolated and unwilling to engage with help on offer
- Exhibit anti-social or aggressive behaviour
- Lack structure or daily routine
- Have not been in work or education for significant periods of time
- Have come to the attention of the criminal justice system for offending behaviour'

¹⁵ Sir Michael Marmot '[Fair Society, Healthy Lives: The Marmot Review](#)' (Institute of Health Equity, 2010) (accessed 04/09/15)

¹⁶ Royal College of Psychiatrists Social Inclusion Scoping Group, '[Position Statement: Mental Health and Social Inclusion: Making Psychiatry and Mental Health Services Fit for the 21st Century](#)' (2009) (accessed 04/09/15)

¹⁷ Kasia Reeve et al. '[Homeless Women: Still being failed yet striving to survive](#)' (2006) (accessed 04/09/15)

¹⁸ Crisis, '[Homelessness among different groups](#)' (accessed 04/09/15)

¹⁹ Shelter, '[Sick and tired: The impact of temporary accommodation on the health of homeless families](#)' (2004) (accessed 04/09/15)

Clients have often had a lot of negative experiences and accepting help from agencies is problematic.²⁰

3.4 Suicide

Recent research by Crisis in partnership with the University of Sheffield found that homeless people were three and a half times more likely to commit suicide than the general population in England. Depending on the data scenario this estimate went up to five times more likely for women. The average age at the time of death was 37, compared to 46 for the general population.²¹

The Crisis literature review¹⁴ cites a study of emergency admissions for attempted suicides between 1988 and 2002, which found that 3.6% of the sample group were of No Fixed Abode. These patients accounted for 10% of presentations, indicating that they made multiple attempts.

3.5 Substance abuse

39% were taking drugs or were recovering from a drug problem

27% had or were recovering from an alcohol problem

66% consumed more than the recommended amount of alcohol each time they drank⁴

Substance abuse is highly prevalent in the homeless population nationwide. It can be a cause of homelessness; 35% of St Mungo's Broadway clients surveyed in 2014⁵ cited drug use, and 33% alcohol use as a factor contributing to their homelessness.

In many cases substance abuse closely linked to mental health and emotional issues; as mentioned in the section above; dual diagnosis was the second most commonly reported diagnosed mental health condition in the health audit. Most studies suggest that between 10 and 20% of homeless people would fulfil the diagnostic criteria¹⁴. Individuals may use substances as a coping mechanism. A study by Depaul UK²² involving 380 homeless young people in interviews, focus groups and a survey found that 35% said they used alcohol and drugs for the specific purpose of coping with mental health issues.

Substance abuse also has a significant ability on an individual's physical health and their capacity to manage everyday life. In the Hampshire project⁹ cited above, 69% of 79 homeless individuals interviewed said they would spend money on cigarettes, alcohol or drugs over food.

²⁰ DCLG, '[Psychologically Informed Services for Homeless people Good Practice Guide](#)' (2012) Accessed 23/10/15

²¹ Bethan Thomas, '[Homelessness Kills: An analysis of the mortality of homeless people in early twenty-first century England](#)' (Crisis, 2012) (accessed 23/10/15)

²² Anne Crowley, '[Summary of research into the health needs of young homeless people led by Depaul UK and AstraZeneca under the Young Health Programme](#)' (Depaul UK, 2012) (accessed 04/09/15)

3.6 Access to help

- 92% were registered with a GP, and 58% were registered with a dentist.
- 18% had at one stage been refused service from a GP or dentist.
- 82% had seen a GP within the previous 6 months, compared to 71% of the general population (sourced from the GP Patient Survey Annual Summary Report)
- 30% (of the total respondents) seen a GP five or more times in the previous 6 months.
- 26% had been admitted into hospital in the previous six months.
- 16% of people with physical health issues, 16% of people with mental health issues, and 15th of people with alcohol problems were not receiving any help, though they would like to.⁴

Homeless people face a significant burden of ill health compared to the average person in the general population. Department of Health data shows that homeless people are high users of secondary and emergency care. The original Inclusion Health report by the Chief Analyst in 2010²³ found that 89% of all admissions of homeless people to hospital were emergency, compared to around 41% of admissions for the comparator non-homeless population. The average stay in hospital for a homeless person was also three times longer than that of the average person (6.16 compared to 2.13 days). Even when the different mix of cases was accounted for, it was evident that homeless people required a longer stay; they were presenting in worse health than a non-homeless person with the same condition.

Further supporting this data on over-use of services and poor health status of homeless persons, the 2015-16 Clinical Audit on accident and emergency department use by homeless people²⁴ (a study of findings from 23 A&E Departments participating in a 6 week pilot clinical audit consisting of an analysis of organisational and patient responses to homelessness) reported that Homelessness is estimated to have increased by 40% between 2011-2015 with homeless patients being nearly 5 times more likely to attend Emergency Departments than housed-controls and over half being brought into non-ambulatory and brought in by ambulance.

The most common reasons for emergency admission to hospital, according to the health audit, are violent incident or assault (16.8%) and accident (15%). 14.9% are related to drug and alcohol use and 9.7% are related to mental health.⁴

In contrast, homeless people are less likely to use primary care. As the statistics above from the health audit demonstrate, they are less likely to be registered with a GP, and particularly unlikely to access dental services.

There have been several estimates of the financial burden that these inequalities place on services. The original Inclusion Health report²³ estimated the total cost of use of acute services to be £85 million, proportionally 4 times higher than the general population at the time and 8 times higher than the working-age population. This estimate was based on the known number of homeless people at the time, which was then expected to be an underestimate and by this time will certainly

²³ Office of the Chief Analyst, 'Healthcare for single homeless people' (DH, 2010) (accessed 04/09/15)

²⁴ The Faculty of Homeless and Inclusion Health In Partnership with the Royal College of Emergency Medicine, and the Royal College of Physicians (December 2015) *Pilot Reports of the 2015-15 Clinical Audits* London: Faculty of Homeless and Inclusion Health/RCEM/RCP <http://www.pathway.org.uk/publications/faculty-for-homeless-and-inclusion-health-publications/> (accessed 10/01/15)

be higher due to the increase in homelessness. A 2015 study by Crisis²⁵ compared the costs to the public sector of preventative interventions with the cost of care after 12 months of homelessness; in every scenario the cost after 12 months of homelessness was at the very least twice the cost of prevention.

The literature review by Crisis¹⁴ cites a number of individual barriers that may hold a homeless person back from seeking healthcare. As was also raised by the QNI briefing on nutrition¹⁰, they may put other priorities first until the situation is critical. They may be held back by pride and/or by the social stigma that is associated with both homelessness and ill health. The Homeless Link health audit showed a significant proportion did not perceive they required help with their health problems, particularly mental health problems (38% did not require help, compared to 18% with physical health problems)⁴.

They may also have limited knowledge of what support is available to them or of health in general. Research carried out by St. Mungo's Broadway²⁶ shows up to 51% of homeless people lack basic English skills, which is a barrier to learning about health conditions and to managing health.

Finally, the original Inclusion Health report²³ raised the fact that many homeless people had poor engagement skills and chaotic lives that made it difficult for them to manage and attend appointments, and to keep up a course of treatment. If they presented challenging behaviour or otherwise respond poorly to treatment, the outcomes data at that time appeared to reflect badly on the performance of the Trust in question.

Service design may be directly or indirectly discriminatory towards homeless people. For example, services may require a postcode, proof of address or payment, and if the individual is not aware of it and how they can be excepted from these rules, they may avoid accessing healthcare.

Public Health England commissioned Homeless Link²⁷ to provide evidence for the healthcare needs of homeless people and examples of practice, which sets out a range of barriers to provision for this group. One message that stood out was that professionals did not recognise or find out about patients' housing issues, or were not in a position to provide or refer them to relevant support. Practical barriers such as 9-5 opening hours, and referral pathways that did not allow walk-in or self-referral also played a part in this.

3.7 Best practice

The literature on best practice around specialised and preventative care shows that evidencing this can be difficult. The more recent report from Inclusion Health shows that Department of Health data on homeless patients varies by service, which makes it more difficult to see details of the levels of need and use of services in this population.

Homeless Link, in their report for PHE, found that housing, rather than the health sector, led many homelessness prevention interventions, and their capacity to deliver this has been limited by decreasing funds and increasing demands. Interventions such as the Troubled Families initiative and hospital discharge projects have proved successful in reducing individuals' use of services. However

²⁵ Nicholas Pleace, ['At What Cost?: An estimation of the cost of single homelessness in the UK'](#) (2015) (accessed 04/09/15)

²⁶ St Mungo's Broadway, ['Reading Counts: Why English and maths skills matter in tackling homelessness'](#) (2014) (accessed 04/09/15)

²⁷ Homeless Link, ['Preventing homelessness to improve health and wellbeing'](#) (2015) (accessed 04/09/15)

many of these are small-scale and short-term funded, which means it is difficult to measure and establish whether they have led to long-term improvement in general health. Furthermore, use of one service may lead to increased use of another before better overall outcomes; for example if primary care identifies acute health needs in a patient.

For homeless people, their health, social care and housing needs are even more closely linked than for the general population. Guidance around best practice therefore places emphasis on the need for a holistic and flexible approach to commissioning and practice with this population. The RCGP²⁸ recently released commissioning guidance for socially excluded groups, which underlined the following principles:

- Removing material and psychological barriers to services
- Improving joint working between professionals and voluntary sector organisations and other potential providers
- Asking the right questions and building up the data and evidence base
- Establishing proportionate and appropriate services where there is unmet need
- If users are not coming to the service, take the service to them

These guidelines are based on examples of good practice and on literature and analysis undertaken by specialists in the sector.

Most recently (January 2016) the National Inclusion Health Board have published a report on educating healthcare professionals to work with vulnerable groups,²⁹ including homeless service users; having identified the low level of knowledge and skills amongst the majority of health care staff in terms of supporting such categories of patient, with gaps in care often arising from a combination of absence of such training from the professional curriculum, as well as limited and intermittent contact with particular categories of vulnerable groups.

3.8 Conclusion

Homeless people face a far heavier and more complex burden of ill health than the general population, and the evidence base for this is increasing. Ill health is a cause and a consequence of poverty, poor environmental living conditions and exclusion and abuse from society. Substance abuse is also a major cause and consequence of ill health in this population and can further exacerbate their ability and capacity to manage health and everyday life. As more and more people across the country face homeless, these inequalities will become more and more evident.

However, historically there have been multiple barriers preventing homeless people from accessing primary and preventative care. This leads to a disproportionate use of emergency and acute services and heavy avoidable costs to the health service. The complications can originate in the patient themselves, in practical access barriers, and in wider issues of commissioning and joint working. Evidence on good practice is limited by how it can indicate outcomes; many interventions are short-term and locally based and therefore not in a position to demonstrate long-term improvement in

²⁸ Paramjit Gill et. al, '[Improving access to health care for Gypsies and Travellers, homeless people and sex workers: An evidence-based commissioning guide for Clinical Commissioning Groups and Health & Wellbeing Boards](#)' (RCGP, Inclusion Health, 2013) (accessed 04/09/15)

²⁹ June David and Mary Lovegrove, 'Educating health professionals to support vulnerable groups' <https://www.gov.uk/government/publications/educating-health-professionals-to-support-vulnerable-groups> (QNI, Inclusion Health, 2016) (accessed 09/01/16)

health and wellbeing in those who use the service. Moreover frontline staff may have only limited knowledge or experience in how to best engage or support homeless service users and hence often struggle to deal with significant presentation problems or multiple conditions from a position of limited experience exacerbated by stereotypes of homeless populations such as are commonly found in public discourse and which are reconstituted through training experiences and peer attitudes.^{30 31 32}

In the next section of this report we turn now to the primary data gathered as part of this scoping study to enable a consideration of the key health factors impacting on service users in the High Wycombe and Aylesbury areas.

³⁰ June David and Mary Lovegrove, 'Educating health professionals to support vulnerable groups' <https://www.gov.uk/government/publications/educating-health-professionals-to-support-vulnerable-groups> (QNI, Inclusion Health, 2016) (accessed 09/01/16)

³¹ Deborah Quilgars and Nicolas Pleace 'Delivering Health Care to Homeless People: An Effectiveness Review' (Centre for Housing Policy, University of York, 2005)

³² Fine, Alison G., Tony Zhang, and Stephen W. Hwang. 'Attitudes towards homeless people among emergency department teachers and learners: a cross-sectional study of medical students and emergency physicians.' (BMC medical education 13, no. 1 (2013): 112).

4. Service Users Audit – Survey Data and Findings

4.1 Introduction and Demographics

In total 49 questionnaires were completed, administered across three locations. In this first section basic demographics are presented. Table One below summarises the gender of respondents by location. Whilst it is noteworthy that the overwhelming number of respondents are male (72%); the percentage of homeless women in the age groups (<45 years of age) averages at 18% (rounded figure) somewhat less than the 26% of female single homelessness service users estimated by Crisis (2015)³³. The age-range of service users of both genders does however broadly correspond to the wider national picture, with 52% of homeless service users being under the age of 25 according to 2014 headline figures provided by Homeless Link.

Table One: Survey Respondents (homeless people accessing front line services OTW/AHAG/WHC) by gender and age (rounded percentages)

Site	WHC	AHAG	OTW	
m/f	31/6 (84%m / 16%f)	5/0 (100%m)	7/0 (100%m)	
Age-Range				Number/%
16-17	-	-	-	
18-25	6 (m) / 2 (f)	2 (m)	3 (m)	13 (27%)
26-35	6 (m) / 2 (f)	-	3 (m)	11 (22%)
36-45	8 (m) / 2 (f)	-	-	10 (20%)
46-55	9 (m)	1 (m)	1 (m)	11 (22%)
56-65	2 (m)	-	-	2 (4%)
66-75	-	2 (m)	-	2 (4%)

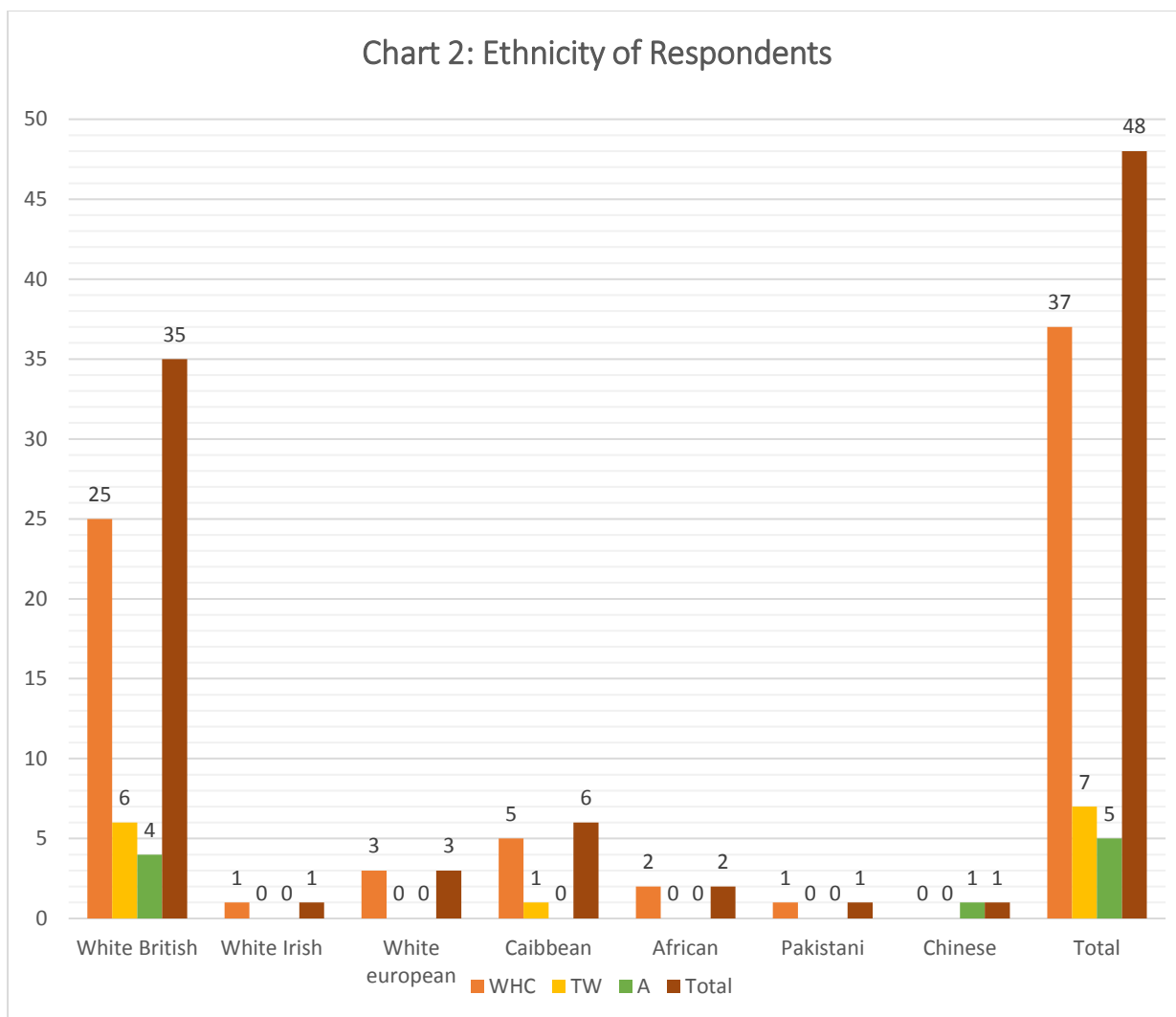
Chart One (below) illustrates data on age of respondents by survey site.

³³ Crisis (2015) 'Homelessness amongst Different Groups' (data snapshot)
<http://www.crisis.org.uk/pages/homeless-diff-groups.html>



4.2 Ethnicity/Nationality

The majority of respondents to the High Wycombe and Aylesbury research (86%) identified as White British with the next largest category of service users identifying as Black Caribbean (7%) and a similar percentage as White EU nationals. A small number of respondents (three cases in total) reported being of African or Pakistani heritage and one further client stated that they were of mixed White British/Caribbean ethnicity. One non-response was recorded in relation to the question on nationality/ethnicity. Chart 2 below reports in full on ethnicity data.



4.3 Sexual Orientation

The majority of respondents reported that they identified as heterosexual (87%); 8% of participants declined to respond to the question on sexual orientation and 5% of respondents indicated that they were bi-sexual. No participants stated that they were lesbian, gay and only individual (2%) identified as transgender.

4.4 Health Care Registration Status and Contacts with Medical Services/Preventative Care

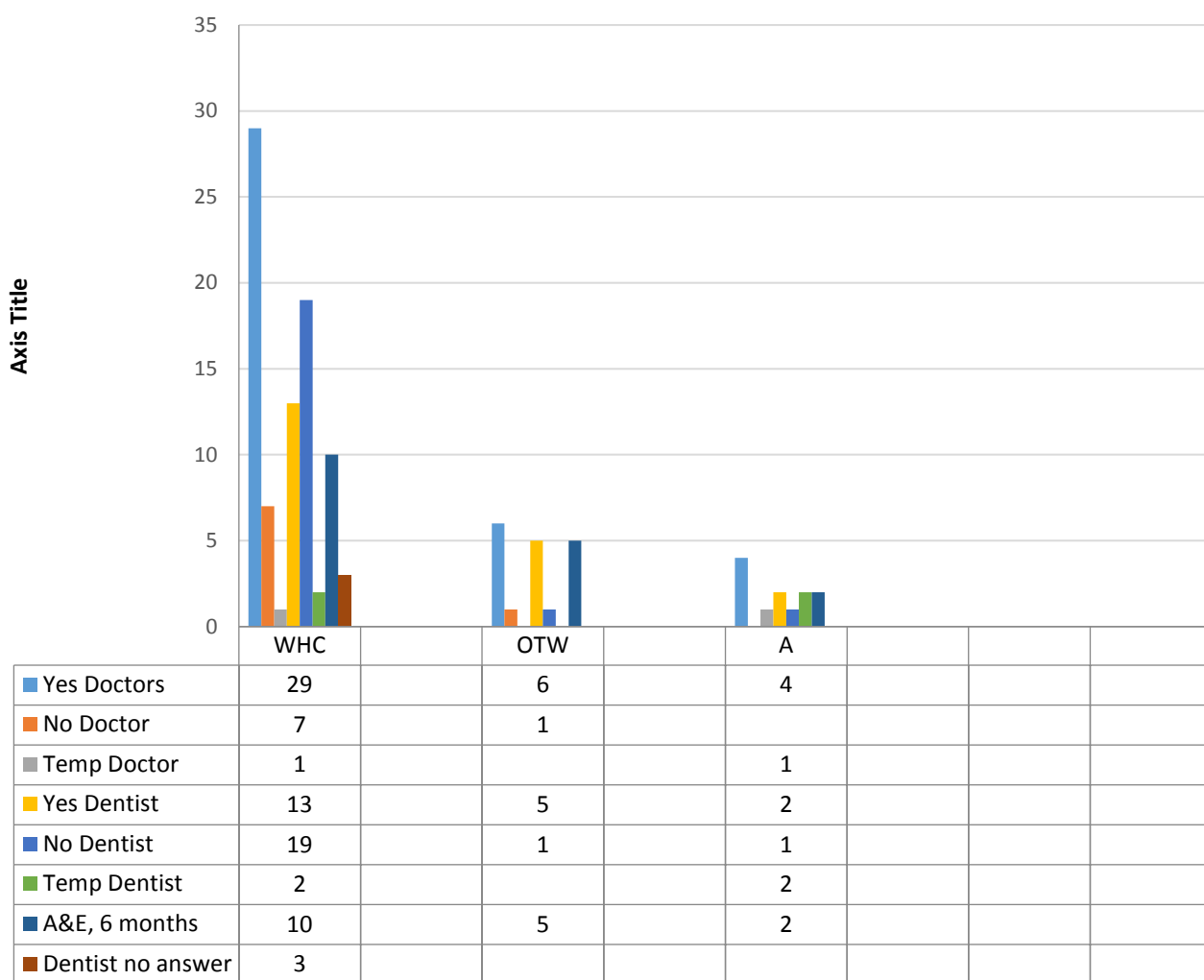
Findings from the survey data in the remainder of this document (specifically pertaining to access to specific services and health conditions of respondents) are presented in aggregated (combined) format, for all three survey sites.

The data is predominantly presented in the form of charts to enable an overall visual representation of key issues relevant to the health status of homeless people in the study area.

Chart 3 (below) illustrates respondents' registration with GP services (temporary or permanent status) and whether/how frequently respondent has attended at A&E services in the six months prior to survey.

Analysis of A&E access reveals that unsurprisingly for respondents who are not registered with a GP reliance on A&E services and similarly admittance to hospital appear to be higher than for those participants who are registered with primary care services.³⁴

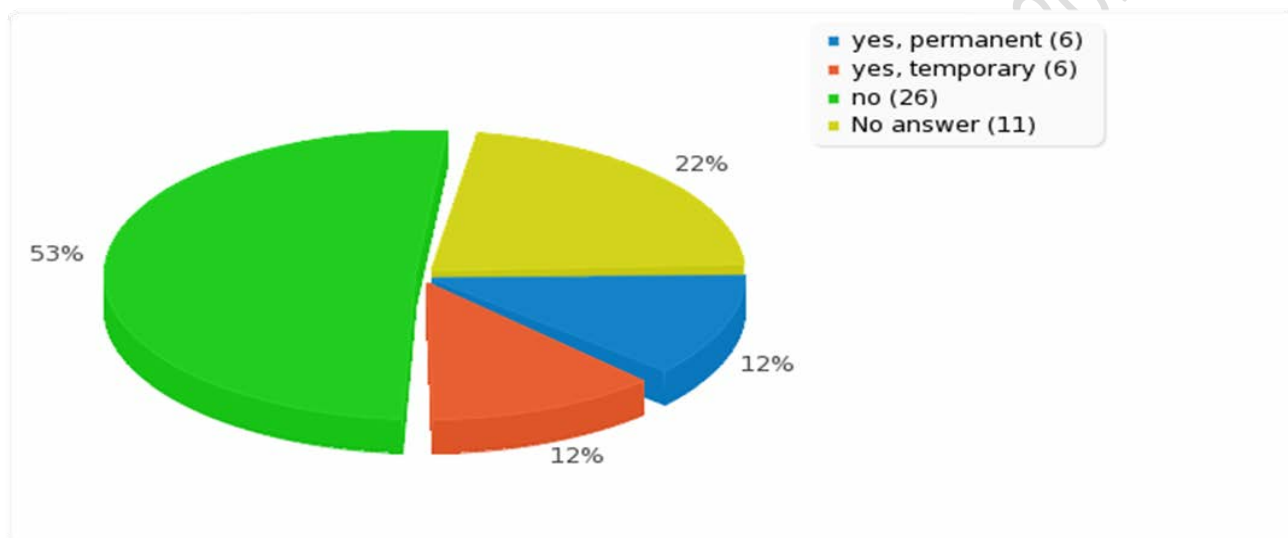
Chart 3 - Whether registered with doctor or dentist and number of A&E visits in previous 6 months



³⁴ Nb: the data tool available through the e-survey server does not permit of an in-depth degree of analysis/cross-tabbing to be undertaken automatically and hence preliminary manual analysis has been commenced demonstrating some degree of correlation in relation to over-use of A&E services for those participants who are not registered with a GP. Further analysis is required to be able to gain a clearer picture of such A&E use, emergency admittance by age, gender and accommodation status (eg whether sofa surfing or street homeless etc.) as well as substance (mis)use or known to mental health services. Case studies provided by front-line staff elsewhere in this report provide a clearer picture of typical (frequently chaotic) circumstances of service users and typical patterns of access to health services.

In the remainder of this section on access to health care the majority of which is based upon the pre-existing homeless health survey from Homeless Link questions are standardised for use at national level. As such some elements may not fully pertain to the local situation, thus as illustrated in Chart 4 below the question is asked in relation to homeless healthcare or no fixed abode (NFA) outreach health services which do not exist in any dedicated manner in the study area.

**Chart 4: Registration status with specific targeted services in respondent's local area?
[Homeless healthcare or NFA health service]**



Answer	Count	Percentage
Yes, permanent (a)	6	12.24%
Yes, temporary (b)	6	12.24%
No (c)	26	53.06%
No answer	11	22.4%

Chart 5 illustrates the number of times in which homeless clients registered with a GP (on either a permanent or temporary basis) have accessed the service in the previous 6 months. A substantial number of respondents (15/39 or 31% have seen the GP in excess of 5 occasions, which given the age-range of the majority of respondents (<50 years of age) and preponderance of male participants is substantially higher than would be anticipated³⁵ and suggestive of the proposition that homeless people first see a GP or other medic when sicker than housed contemporaries and require a greater degree of continuous input from health services (resulting from accommodation conditions and/or 'revolving door' from hospital discharge than do those in housing. See further case studies supplied by staff and literature review above. In total 10% of respondents indicated that they had been

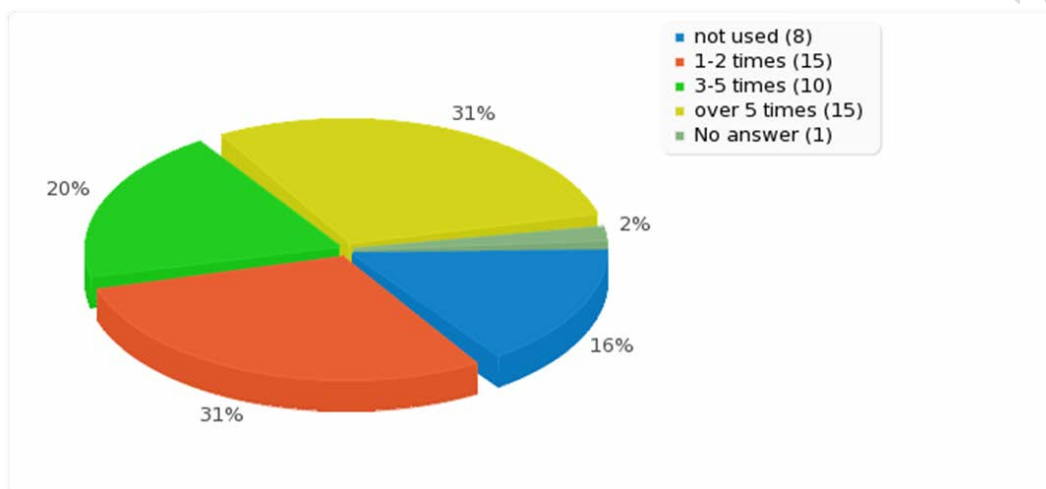
³⁵ Whilst somewhat dated, findings from the longitudinal review of GP consultations (1995-2008) undertaken on behalf of the NHS information centre suggests that males aged under 45 will on average visit a GP on two occasions per annum whilst for females although this figure is higher (reflecting peak child-bearing age) it is still likely to be less than 4 visits per year. It is not until the 'average' patient reaches their mid 60s that trends similar to those reported in the Buckinghamshire survey in relation to GP contact will be seen. See further *Trends in Consultation Rates in General Practice 1995 to 2008: Analysis of the QResearch® Database* (2009) available at <http://www.hscic.gov.uk/catalogue/PUB01077/tren-cons-rate-gene-prac-95-09-95-08-rep.pdf> p15

refused registration when seeking primary medical care via a GP surgery with qualitative supporting comments received from 5 respondents as follows:

- ✘ *No proper Address*
- ✘ *Surgery overfilled*
- ✘ *[Name of surgery given but no further details provided]*
- ✘ *No fixed address*
- ✘ *No address*

As such it can be seen that from this admittedly small sample, being homeless or of No Fixed Abode (NFA) can act as a significant barrier to appropriate healthcare.

Chart 5: Number of GP contacts in previous 6/12



Nurse appointments (both booked as an alternative to seeing a doctor as a follow-up to a GP appointment) see Chart 6 below, indicate some degree of over-representation amongst respondents to the survey given the age of most participants. Despite this, over half of all respondents have not seen a nurse in the previous 6 months. Arguably, increased accessibility of primary health screening for homeless people and greater accessibility of nurse led appointments can offer scope to reduce GP appointments through identification of health conditions and sign-posting to services prior to health having deteriorated.

Chart 6: Number of contacts/appointments with a nurse in the previous six months.

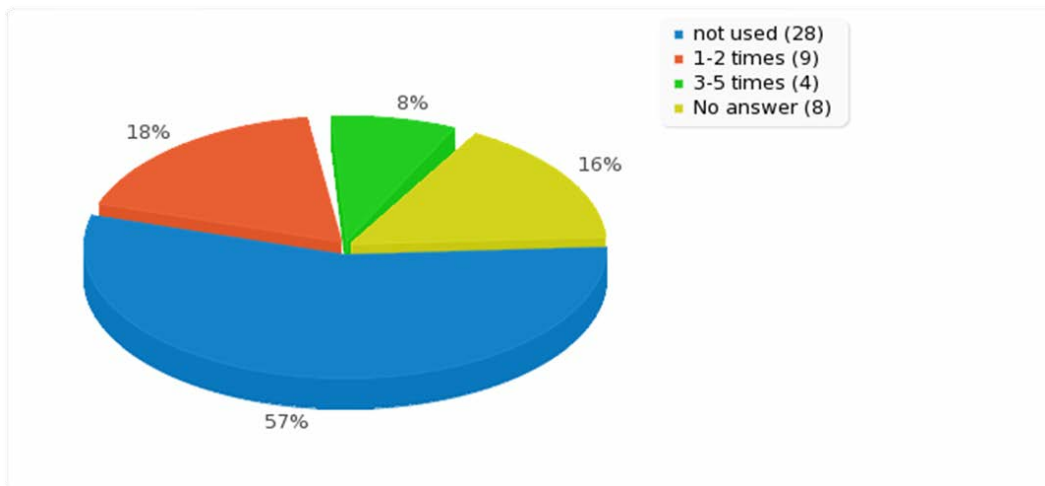


Chart 7 below in relation to dental care demonstrates that nearly 60% of respondents to the survey have not accessed dental care in the previous six months. Given the difficulties which may pertain in relation to access to NHS dental care this may not entirely indicate that homeless people are substantially over-representation in those without access to dental care in the locality but as noted in the literature review lack of adequate access to oral health services can have profound implications for health and wellbeing as well as providing opportunities for issues such as oral cancers to be identified at an early stage.

A shocking 39% of respondents indicated that they experienced dental or mouth/teeth problems with 9% of the sample referring to long-term pain/problems lasting in excess of one year. Further comments made in the focus group suggested that such dental problems are common place amongst homeless people with 'self-help' including removal of one's own (or friends') teeth not being uncommon amongst homeless people unable to access dental care and suffering from pain.

Chart 7: Access to dental care/check-up in previous six months

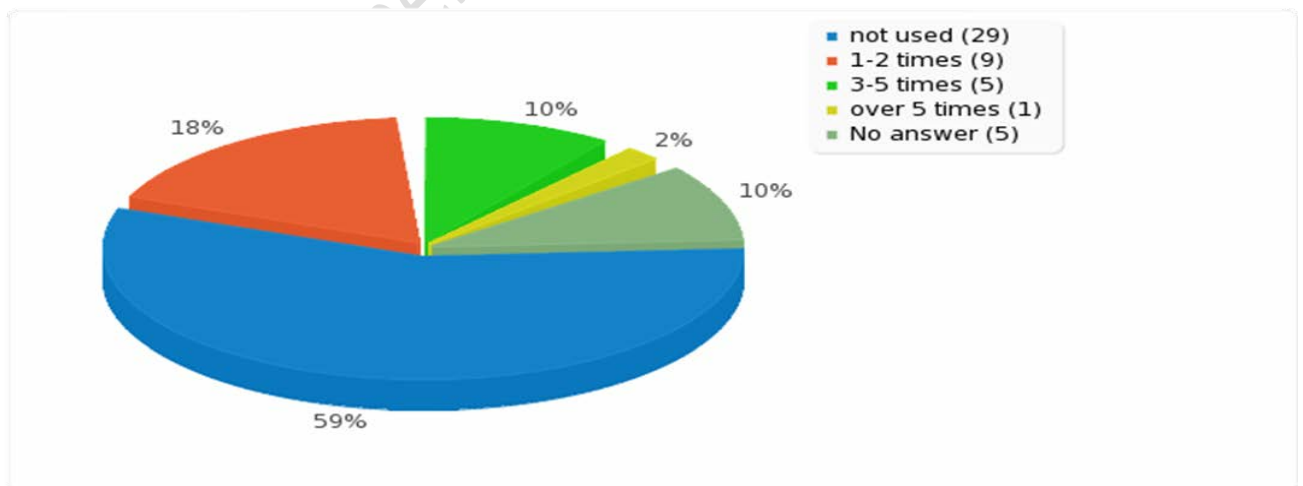
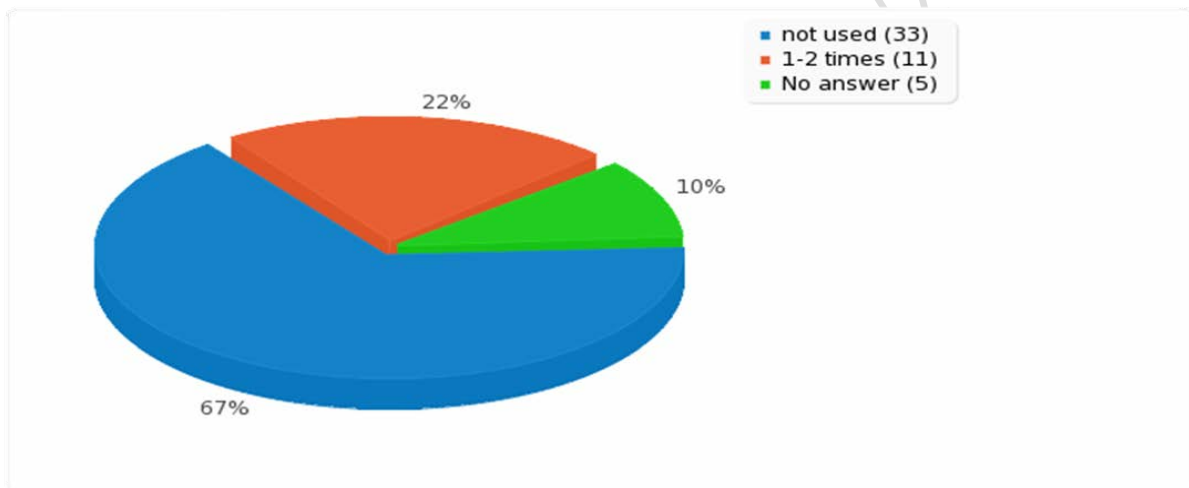


Chart 8 below further demonstrates that participants are even less likely to have accessed optical treatment or testing within the previous six months than to have seen a dentist, reducing opportunities to identify glaucoma, diabetes and a range of other conditions routinely checked during optical appointments. N.B: 37% of respondents to the survey reported having 'eye problems'

or 'difficulties with vision' with 14% indicating that these are long-standing problems dating from at least one year previously. However the type of condition, severity and onset are not detailed within the data collated within the survey.

Chart 8: Access to optical services/check-up in previous six months



4.5 Use of Emergency Care (Hospitals and Ambulances)

Despite underuse of preventative services (or potentially because of this omission) survey data suggests that use of ambulances and admissions to hospital are higher amongst this group of service users than would be expected amongst a general population within the age-range outlined in the demographics section. See Charts 8 and 9 below. Particularly important is the finding that 28% of respondents have been required to use ambulances (specifically 999 services) in the previous six months and that over a quarter (26% in total) have been admitted to hospital in the prior half year; with 8% of respondents having been so on multiple (>3) occasions.

Chart 9: Use of ambulance services in the previous six months

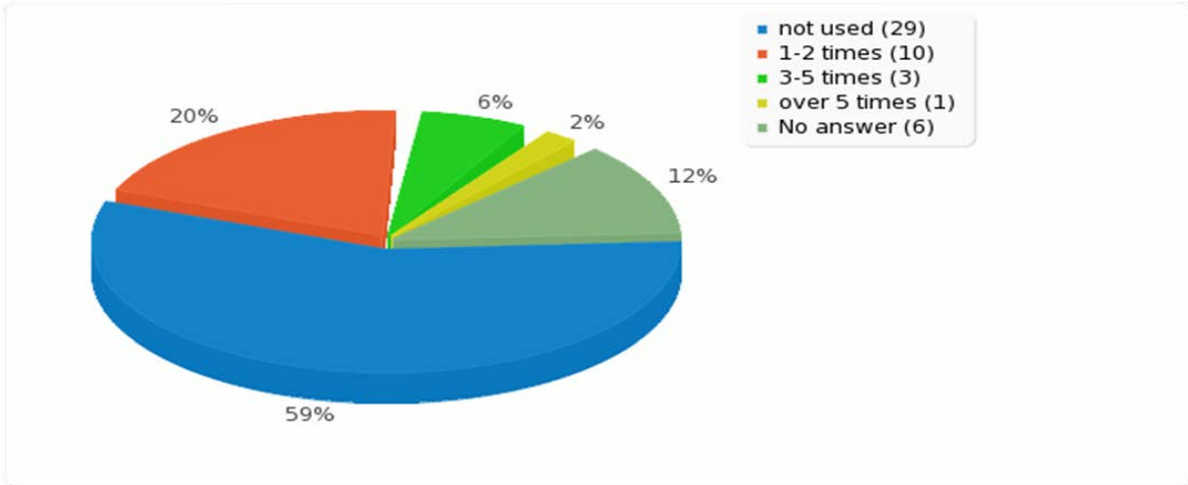
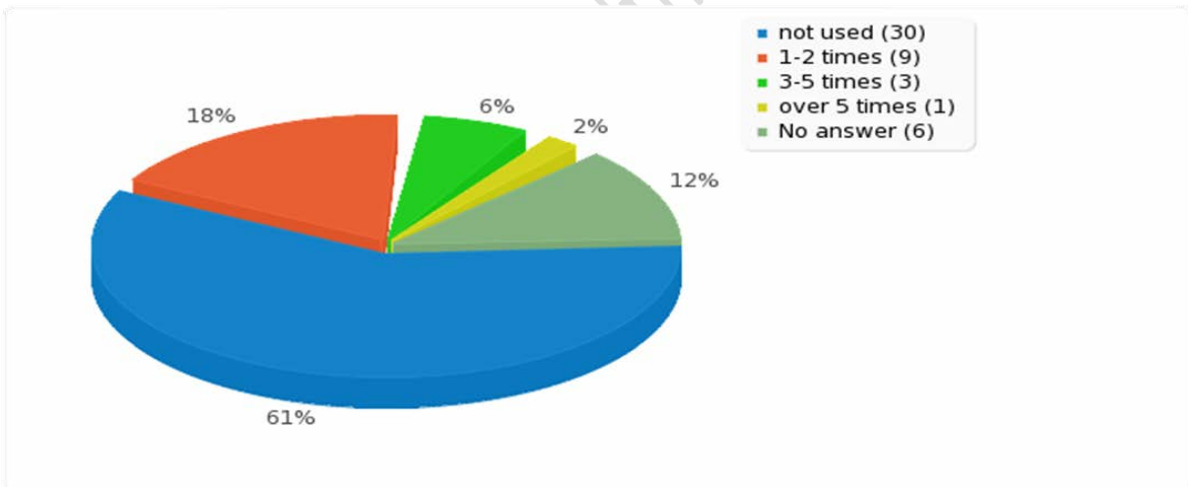
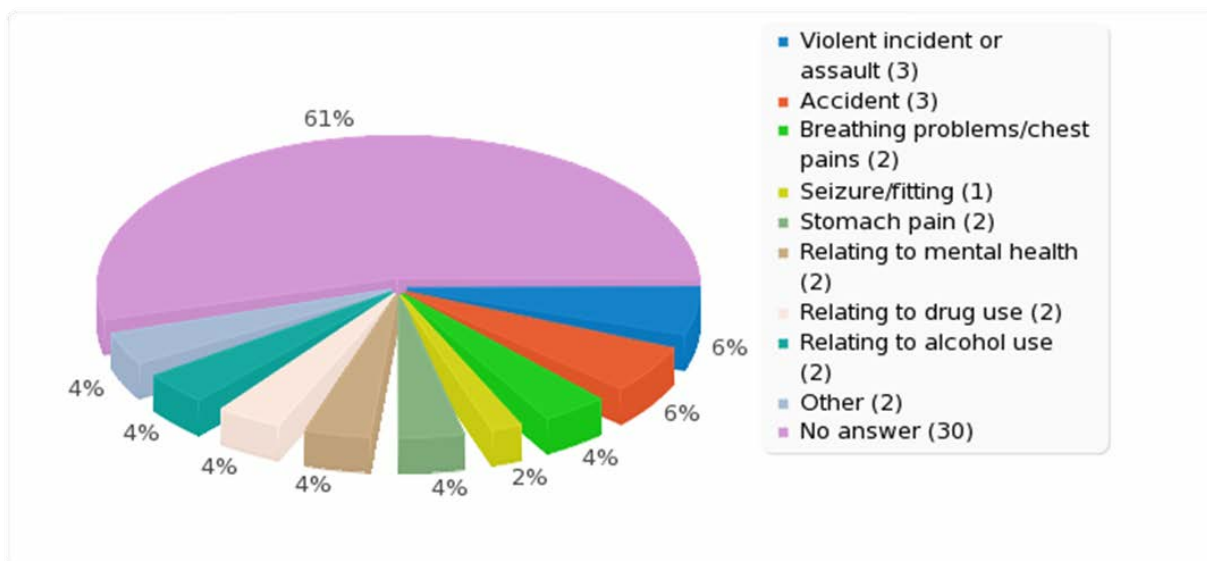


Chart 10: Admission to hospital in the previous six months



A further breakdown of reasons why service users/respondents (29% of respondents provided detailed reasons) have resorted to ambulance services or been admitted to A&E provides clarification of the underlying issue for the call/admittance, providing a snap-shot of both general health status of the population and the hazards of homelessness. See further detail in Chart 11.

Chart 11: Reasons for a) calling an ambulance or b) admittance to hospital



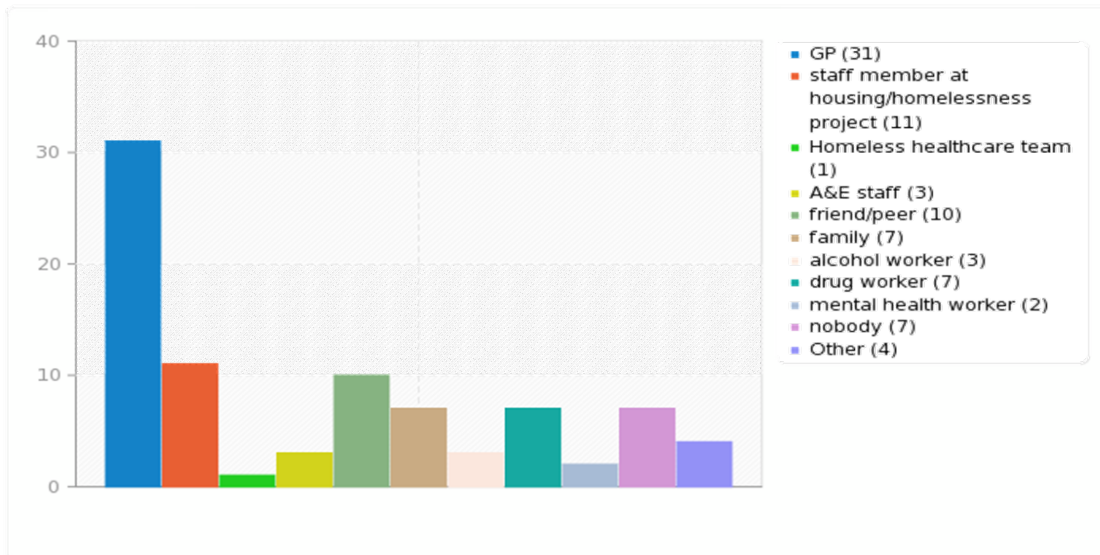
Of those respondents admitted to hospital, the average length of stay was 2.6 nights. Whilst the majority of respondents did not reply to the question on whether on discharge medical staff enquired as to the suitability of place of discharge, 19% stated that they had not been asked this question and only 9% responded that such enquiries had been made although whether this information was acted upon was unknown.

Respondents were asked whether their homeless health agency had provided them with information on where and how to access health. 31% weren't sure, 30% said 'no' and 39% responded positively, indicating the important role in acting as a sign-posting service offered by such front-line agencies and potential to develop this facility through use of a checklist undertaken with all service users at point of contact.

4.6 Services of most help in accessing healthcare

Given the barriers identified above for some participants in terms of accessing on-going healthcare it was considered appropriate to ask which services/individuals were most helpful in assisting them with their health. Chart 12 below summarises the information provided.

Chart 12: Agency or individual who provides the greatest help in relation to healthcare?

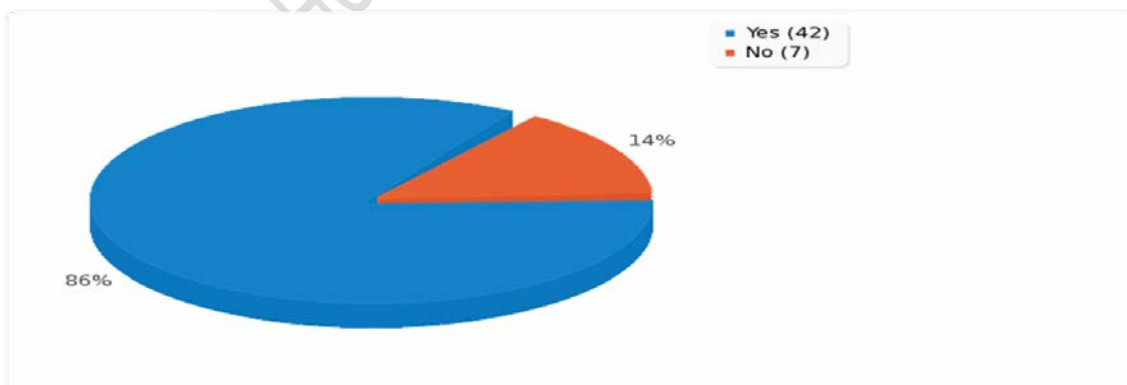


Whilst unsurprisingly GPs were seen as most helpful in terms of supporting health (by 63.27% of respondents) 22.45% of those who replied indicated the important role of staff members at specialist homeless outreach services further emphasising the scope for these agencies to act as health facilitators for homeless clients.

4.7 Physical Health of Service Users (substance use and exercise)

A series of questions (summarised below) concentrated on the physical health and health behaviours of respondents. In total a concerning high number of homeless clients were tobacco smokers, although as was indicated in focus group data (see below) use of substances such as tobacco and alcohol were seen as daily ways of 'coping'; with the longer-term impacts on health of such behaviours being of less concern for those struggling to survive in difficult and at times hostile situations. The Charts below summarise the key findings in relation to the physical health of respondents.

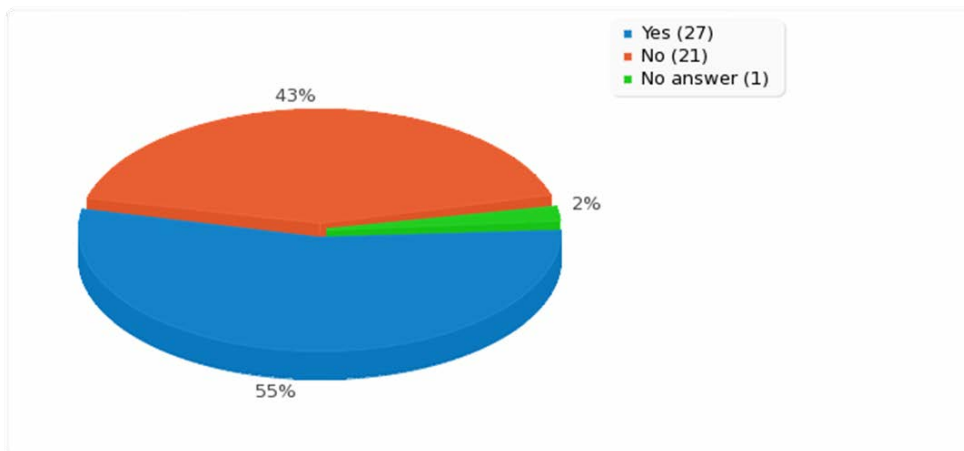
Chart 13: Tobacco use of respondents (100% response rate)



Of respondents whilst 33% indicated that they would like to stop smoking, 50% were content to continue smoking. The remaining 17% did not respond. Although the vast majority of respondents had been offered smoking cessation advice or access to support 50% had failed to take up this service, whilst 10% had accessed some smoking cessation advice. The remainder of the sample did not respond.

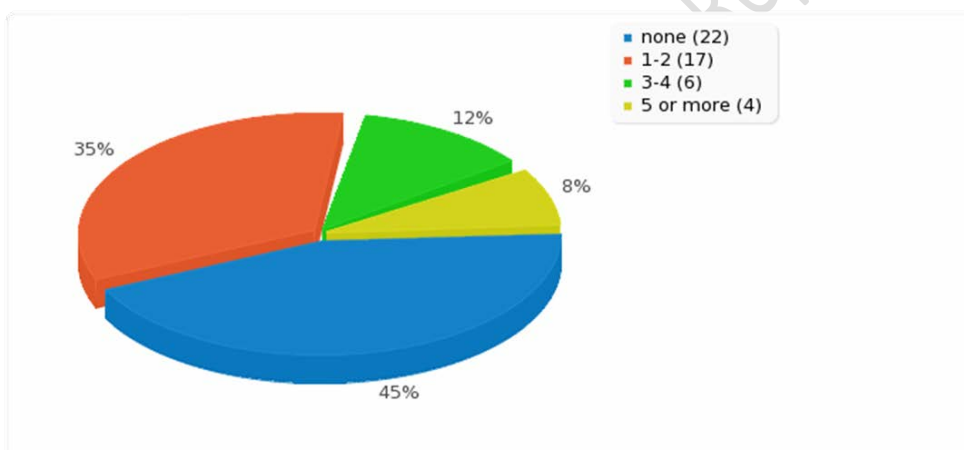
Diet and healthy eating were particularly concerning with (Chart 14) only 55% indicating that they were able to eat a meal on average twice a day.

Chart 14: Regularity of eating 2+ meals a day on average.



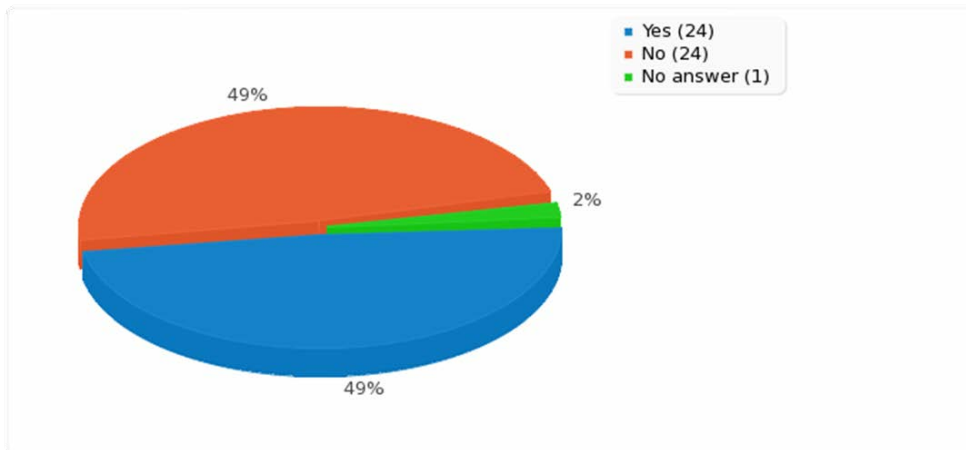
Questions on whether fresh fruit or vegetables formed a regular part of respondents' diet elicited the finding that 45% ate no fruit or veg daily and only 8% indicated that they kept to recommended '5 a day' guidelines (Chart 15 below).

Chart 15 Average number of fruit or vegetable portions eaten daily



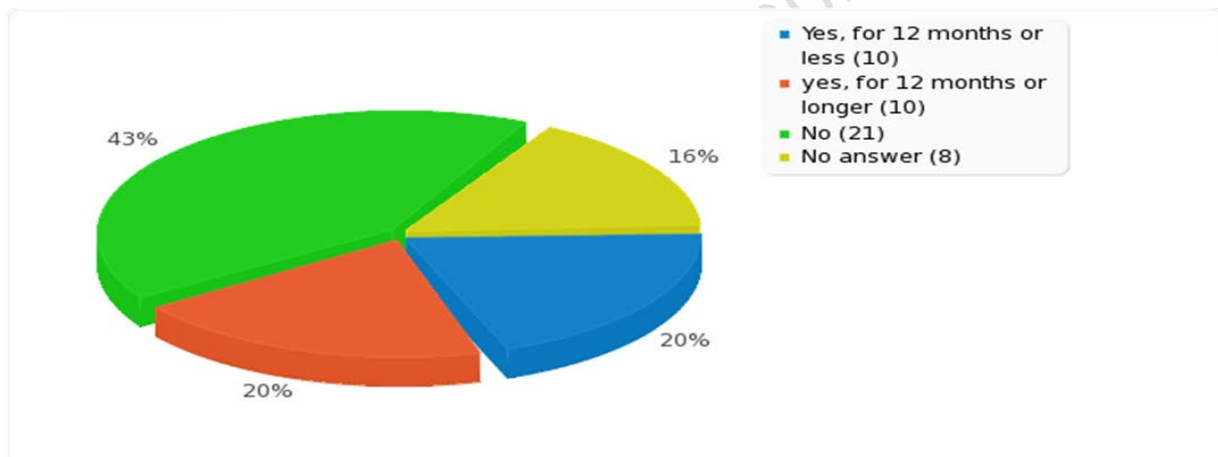
In contrast, questions pertaining to exercise (unspecified) elicited a far more positive response with nearly half of all respondents stating that they exercised at least twice a week (Chart 16). Whilst in part this may be related to necessity and related to their precarious status/poverty (e.g. walking rather than access to public transport/car) this response is in fact significantly greater than is likely to be found in a comparable group of the public. Moreover 26% of those who stated that they did not exercise twice weekly indicated that they would like to if the opportunity existed. It may therefore be seen that this finding could provide an opportunity to enable targeted health and exercise classes (perhaps associated with medical check-ups and access to a healthy meal) for homeless populations in the study area.

Chart 16 – frequency of exercise: at least twice a week



4.8 Specific physical health conditions:

Chart 17: Respondents reporting chest pain/breathing problems³⁶

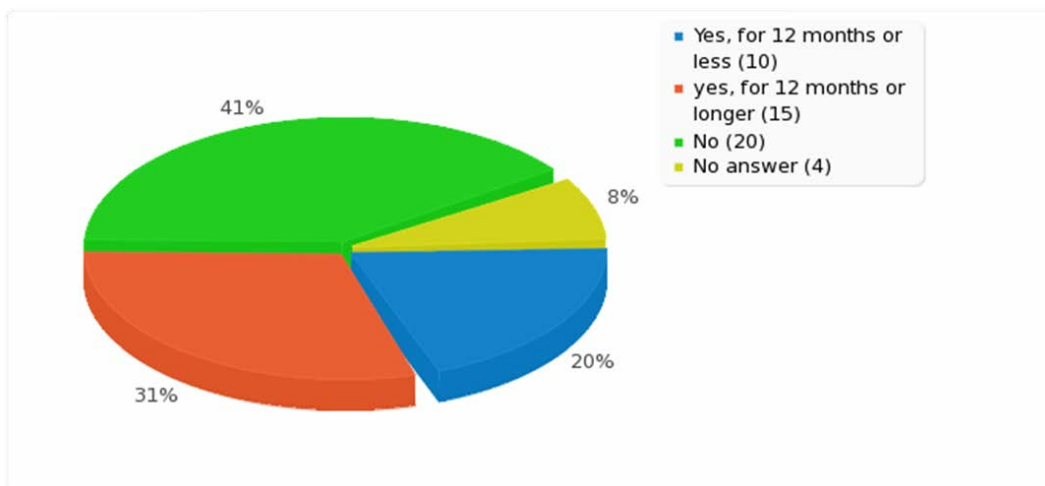


Overall 40% of respondents reported having chest pains or breathing problems. The conflation of these categories makes it difficult to disaggregate temporary from chronic conditions and potentially more 'sinister' (including COPD or warning signs of heart-attack) from asthma or temporary chest infections. However, it is noteworthy that the same percentage of respondents reporting having long standing conditions >12 months as shorter-term symptoms.

Chart 18 (again segmented by conditions/symptoms lasting for < 12 months and over one year) illustrates findings pertaining to 'joint aches or pains pertaining to muscles/bones' without providing clearer evidence on diagnosis. Despite the relatively youthful profile of respondents 31% reported experiencing such symptoms for over one year, a finding common a number of health studies of homeless people which commented on muscular pains, rheumatism, arthritis etc. associated with living conditions (see further literature review).

Chart 18: Respondents reporting joint aches/pain in muscles and bones

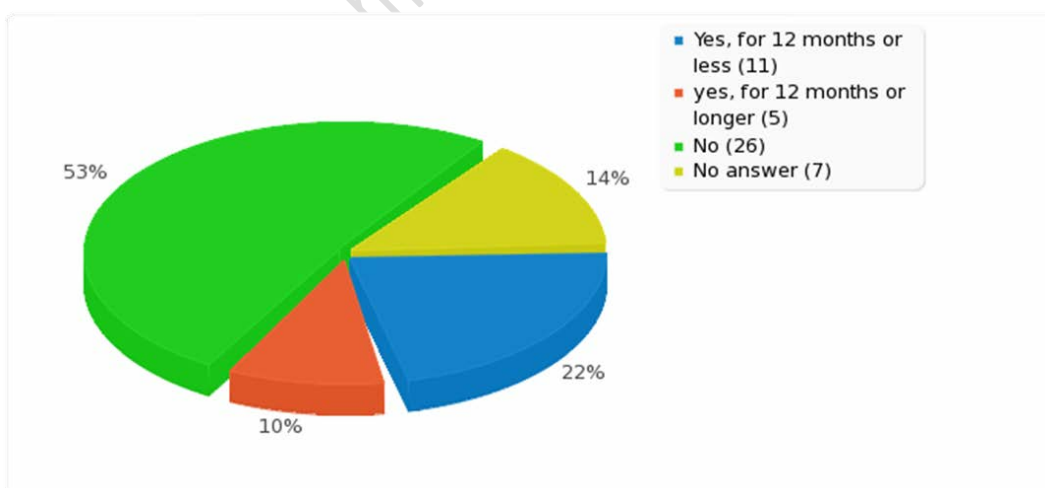
³⁶ More detailed analysis and cross-tabulation will be required to assess whether respondents who report particular types of condition correlate with those who have accessed GP surgeries, or have been admitted to hospital. Given the age of the client group these findings do represent an overrepresentation which is greater than might be expected in relation to these conditions but can be anticipated to reflect not only smoking status, poor diet etc but also the implications of homelessness. Additional analysis is also required by gender.



Skin wounds/infections - Whilst only a relatively small number of respondents reported such conditions (which may be associated with untreated and dangerous long-term conditions such as diabetes); of the 16% of indicated living with such a condition half (8%) had done so more over one year. Inevitably problems with hygiene/access to washing, dry conditions etc. as well as complications from untreated or poorly managed condition create a greater risk of infection for homeless people, as well as an exacerbated likelihood that healing will be greatly delayed as a result of poor access to health care and the inability to manage wound dressings appropriately, etc.

In a similar way, **feet problems** – most typically associated with conditions such as ‘trench foot’; an inability ensure that feet are dry and well-cared for; overlong wearing of shoes; poorly fitting shoes etc. (all common to homeless and particularly street homeless populations) were reported by fully 33% of respondents (see Chart 19)

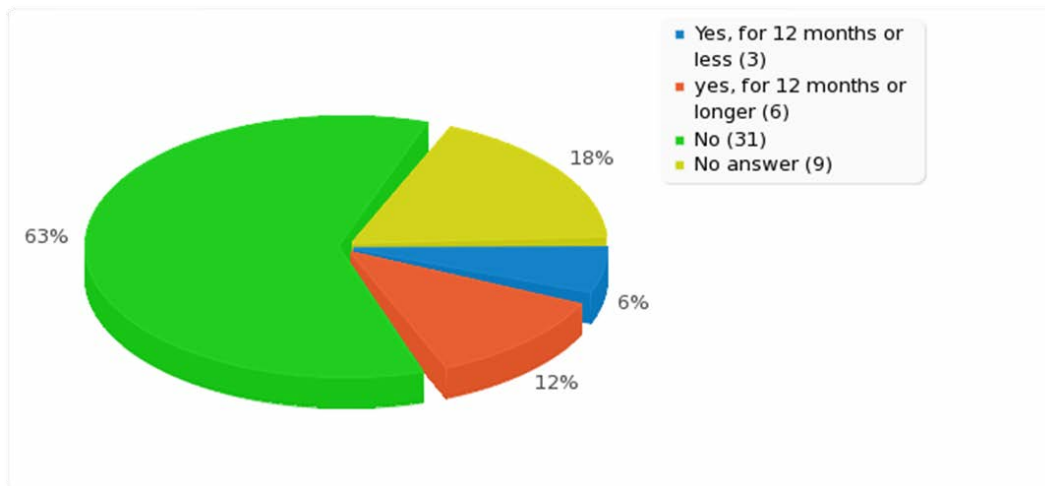
Chart 19: Respondents reporting ‘feet problems’ by duration



Fainting and ‘Black-outs’ - In total 18% of respondents suffering from blackouts and fainting. Again without further information on the underlying health conditions of respondents it is difficult to assess whether these episodes relate to malnutrition, anxiety or indeed are indicative of serious

health problems rather than one-off episodes. Breakdown of duration of such episodes reveal that 6% of respondents have had such experiences for in excess of one year although it is impossible to assess how frequently these occur or whether the respondent is aware of an underlying explanatory condition. See Chart 20 below.

Chart 20: Respondents' suffering from 'fainting' or 'blackouts'



Urinary Tract infections - A low percentage of respondents (2%; 1 case) reported urinary tract infections indicating that this was of relatively recent duration. Whilst it is recognised that there is an increased risk (particularly for homeless women) of urinary tract infections causing potential health complications this finding is not outside of the usual range within any population.

Circulation problems/blood clots - Similarly, albeit potentially offering significant risks to patients, only 6% - 3 cases – of respondents reporting suffering from blood clots or circulation problems with 2 respondents indicating these conditions were of greater than one-year duration. Further analysis is required to explore age/general health status of those respondents reporting such conditions, but in terms of percentage of population experiencing such problems this does not seem to be an unusually disproportionate finding per head of population.

Liver & Stomach Disorders - Only one respondent (2% of the sample) reported liver problems; whilst 18% of the sample indicated that they suffered from stomach disorders (unspecified). Of these, 14% described the conditions as being of long-standing (greater than one year). Comments made within a focus group suggested that stress exacerbated stomach problems including ulcers and problems associated with poor diet were not uncommon amongst homeless service users, frequently commencing at a relatively young age.

Diabetes was reported by 4% of the sample (2 respondents) with one respondent each indicating that the condition had been diagnosed more than a year ago, or less than a year previously.

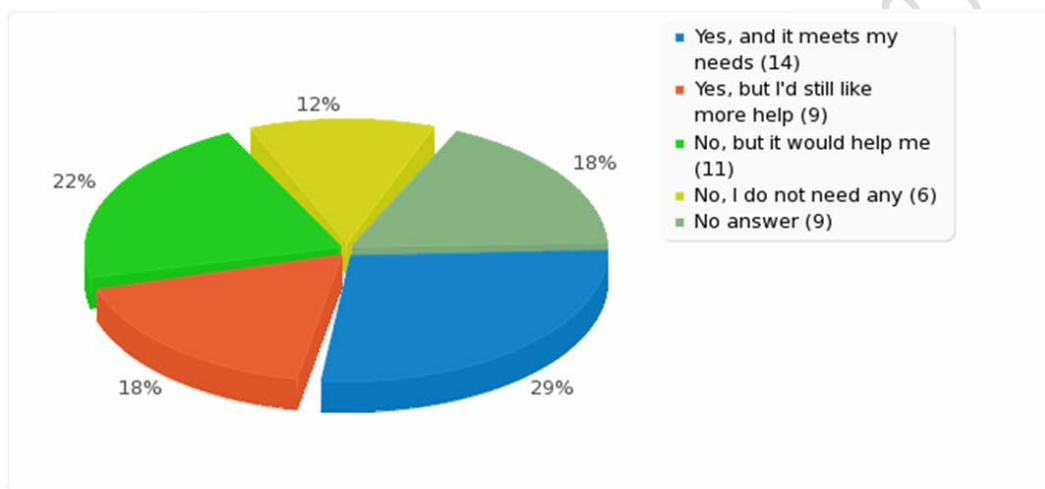
An identical number of respondents indicated that they were diagnosed with **epilepsy** (one within the previous year and another more than a year previously).

4.9 Satisfaction with services/support for physical health needs.

29% of respondents indicated that they received adequate support for their physical health needs although a further 18% indicated that despite access to health services they were not receiving appropriate or adequate help to support their health conditions. In addition, 22% of respondents indicated that they were not in receipt of medical support/services to help them to meet their physical health needs.

Accordingly overall 40% of homeless service users within the study area are experiencing unmet or poorly met physical health care needs suggesting that there is an urgent need to provide services to this group within the population. Chart 21 below illustrates this key finding:

Chart 21: Percentage of respondents indicating that they are receiving/not receiving support for their physical health care needs



4.10 Mental Health Needs of service users

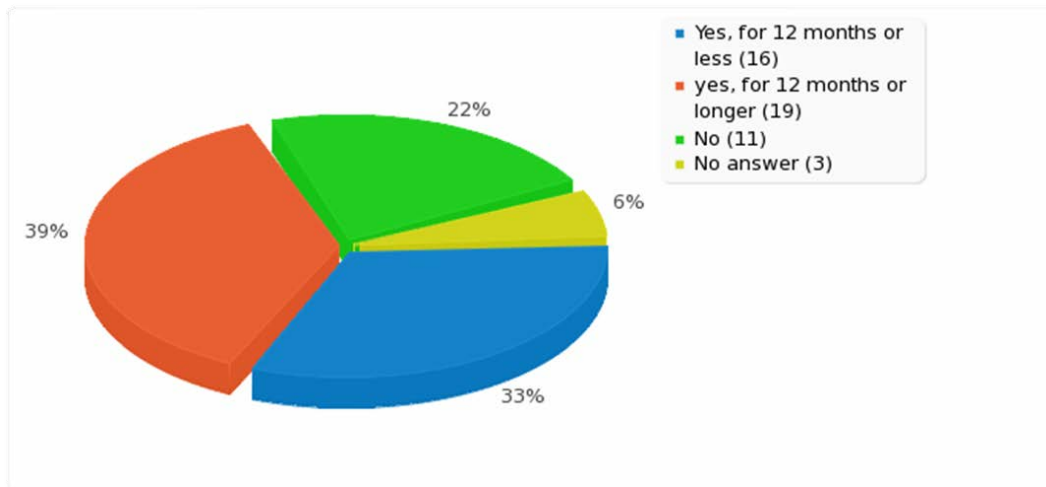
This element of the survey revealed significant (and disturbing) unmet or under-met need for support from homeless respondents in the study area. Findings are broadly in line with data from wider studies into the health of homeless people (see further Homeless Link reports³⁷ and literature review above).

Chart 22 illustrates responses questions pertaining to mental health of respondents, with particular reference to self-reported **stress (by duration of condition)**. Additional analysis is required to explore duration of homelessness by length of time anxiety/stress or depression has been experienced, as it is often difficult to unpick the complex interrelationship between mental health needs and homelessness and which came first or exacerbated the risk of experiencing the other condition/circumstances.³⁸

³⁷ Homeless Link 'Homelessness and health research' data-snapshot webpage (2015) <http://www.homeless.org.uk/facts/our-research/homelessness-and-health-research>

³⁸ For a discussion on factors influencing vulnerability to homelessness and pathways once homeless (including mental health and other 'risk factors' including being a member of an ethnic minority community; an LGBT young person; Gypsy/Traveller etc). see further: Greenfields, M (2012) 'Insecure Accommodation' in Greenfields, M., Dalrymple, R & Fanning, A. eds. "Working with Adults at risk of Harm" Maidenhead: OUP

Chart 22: Mental Health: frequent feelings of stress experienced by respondent (by duration of condition)

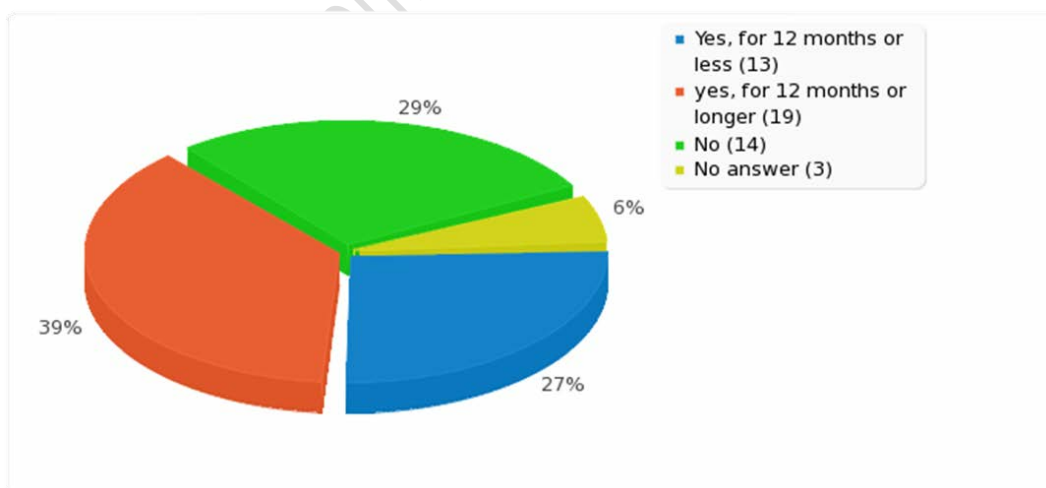


On being asked whether they frequently or often suffered from anxiety the percentage of respondents answering positively **increased to 74%** (36% stating that they had experienced frequent anxiety for over one year and the remaining 36% of respondents indicating that this had been a frequent occurrence for less than one year).

38% of respondents indicated that they frequently or often experienced **panic attacks** with 20% indicating that this had been a feature of their lives for over one year.

Chart 23 illustrates findings pertaining to **depression**. Overall 68% of respondents suffer from this condition with 39% reporting that they had lived with depression for over one year.

Chart 23 - Number of respondents indicating that they often or frequently experience depression (by duration of condition)



In total 62% of homeless respondents indicated that they experienced difficulties with sleeping and once again, findings emerging from the focus groups suggested that this often arose from a

pp105-130 available free to download at:

https://www.academia.edu/4157517/Chapter_on_multivariate_risk_factors_impacting_on_people_living_in_insecure_accommodation_gender_faith_ethnicity_sexual_orientation_from_edited_collection_-_republished_courtesy_of_Open_University_Press

combination of anxiety, depression, insecurity and fear of assault (see above for information on respondents requiring hospitalisation/use of an ambulance following a violent assault) as well as the deeply uncomfortable conditions experienced by many homeless people (e.g. sleeping in cars, street homeless or sofa surfing).

4.11 Suicidal Thoughts/Self-harm

It is of major concern that 30% of respondents reporting feeling suicidal feelings (with 12% reporting that they had felt suicidal/experienced periodic suicidal thoughts for over one year). In addition, 14% of the sample reported 'self-harming' with 8% having been self-harming for in excess of one year. Charts 24 and 25 (below) illustrate these findings. Given that as evidenced above a not insubstantial percentage of respondents indicate disrupted or inadequate access to health care there is a critical need to ensure that homeless service users are able to access appropriate mental health support. Findings from the focus groups (see below) highlighted the excessive level of mental health need amongst respondents and barriers to service access amongst this group of local residents suggesting that there is an urgent and substantial need to improve outreach and tailored provision for this group of clients.

Chart 24: Respondents often or frequently experiencing suicidal thoughts (by duration)

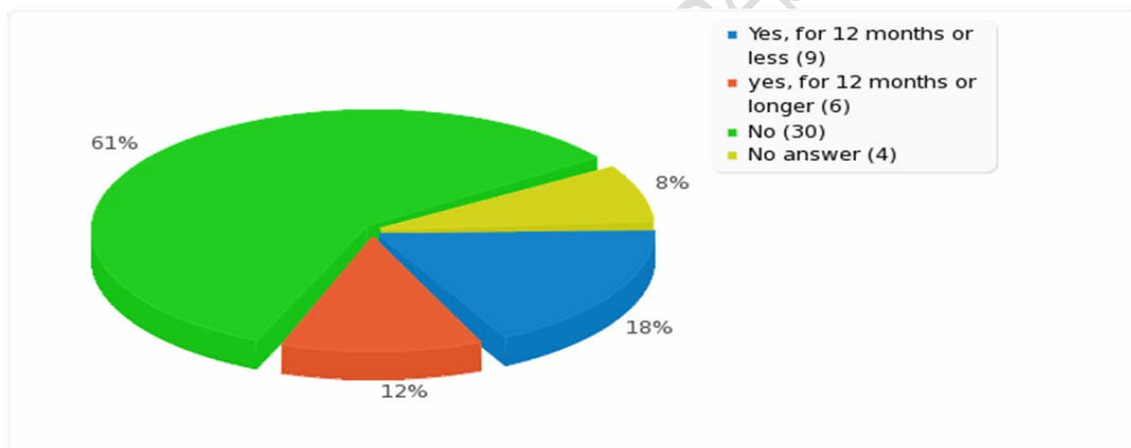
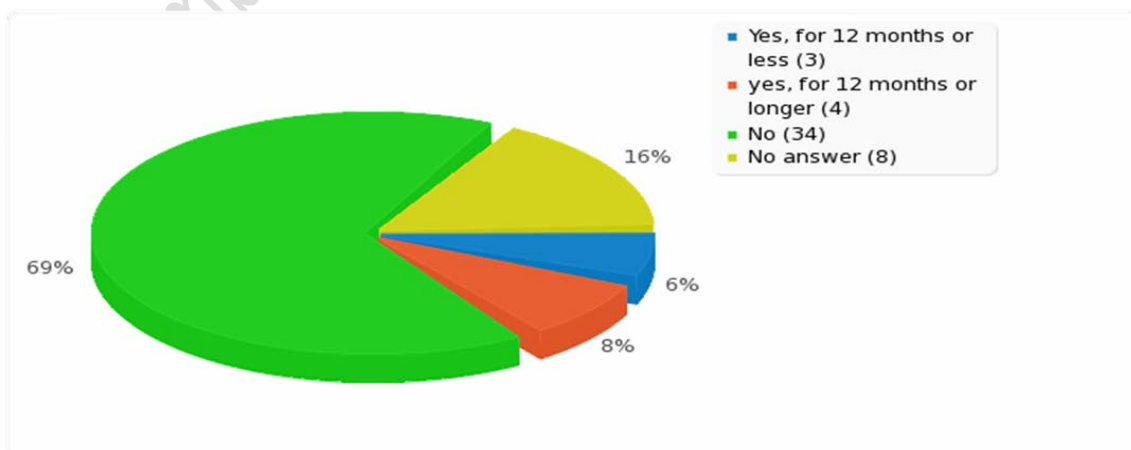


Chart 25: Respondents who 'self-harm' by duration of self-harming



4.12 Mental Health Conditions (self-report and diagnosed)

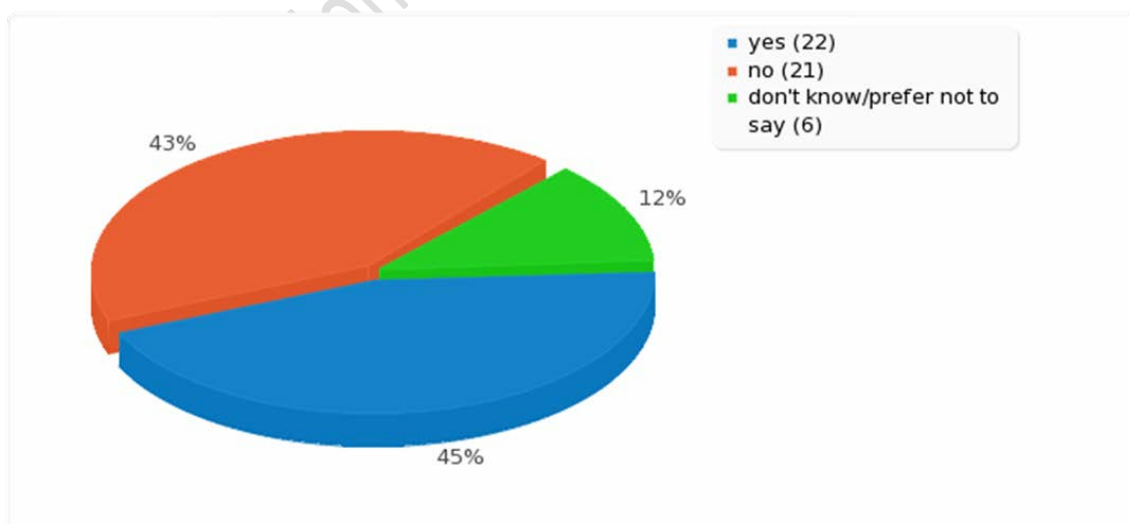
Overall **20% of the sample reported 'hearing voices'** (whether or not a formal mental health diagnosis of a serious condition had been given) with 8% (4 respondents) indicating that this been occurring for in excess of one year.

Anger management/control problems (in some cases, as discussed within focus groups, associated with stress and frustration at their housing/homeless situation) were identified by **54% of respondents**. Of these 27% stated that they had had difficulties with anger management/control problems for over one year.

Overall 38% of respondents stated that they have been aggressive or violent towards others, with 22% of respondents stating that this had been an ongoing issue for in excess of one year whilst 16% suggested it was of more recent duration < 12 months. Once again it is suggested that anger management issues and the risk of violence or aggression towards others is frequently associated with stress, danger and anxiety pertaining to homelessness and accommodation circumstances³⁹.

Given the high percentage of self-disclosure of stress, anxiety and other mental health symptoms by respondents, it is perhaps unsurprising that a relatively high percentage of respondents (**45% have been formally diagnosed with a mental health condition (albeit full information does not exist within this survey on the precise nature of the condition/diagnosis)**). Given the medically recognised health status of these respondents, that that all of the sample are homeless (or insecurely accommodated) and that a relatively high number of respondents have indicated that their access to health services if problematic, concern must exist that there is a need to develop more appropriate and accessible services for this population. Chart 26 (below) presents findings on the mental health status/diagnosis of respondents. The 12% of respondents who did not wish to respond or who were 'unsure' may potentially further increase the pool of respondents who have been diagnosed with such health conditions. Overall 27% of those who reported having a diagnosed mental health condition noted that this was diagnosed over one year prior to interview with a further 14% suggesting that diagnosis took place within the previous year.

Chart 26: Respondents diagnosed with a mental health condition



³⁹ American Psychological Association news story (December, 2009 accessed 3-11-15))
<http://www.apa.org/monitor/2009/12/violence.aspx>

Duration of selected diagnosed mental health conditions: 7% of the sample indicated that they were diagnosed with **schizophrenia** more than a year prior to interview, as did a further 7% who had been diagnosed as being **bi-polar**. A further 7% of respondents reported that they suffered from **personality disorder**.

4% of those with a diagnosis of **personality disorder** reported that this was diagnosed within the previous 12 months. Of individuals experiencing post-traumatic stress disorder (**PTSD**) 4% had been diagnosed within the previous year and 4% (8% of sample in total) had been living with the condition for over a year.

4.13 Dual Diagnosis

20% of the sample reported having a 'dual diagnosis' (mental health and substance (including alcohol) dependency; with 13% stating that this dual diagnosis was of long-standing >12 months prior to interview.

By far the largest group of mental health conditions experienced by respondents consisted of **depression (40% of the sample)** with 27% of respondent suffering from depression for at least one year and 13% saying that their depression was more recent and had been diagnosed one year previously or less.

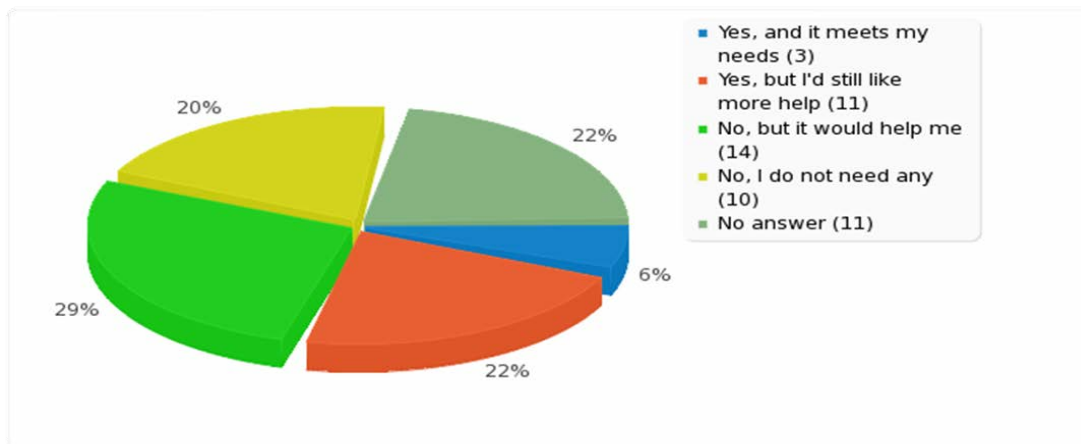
A further **10% indicated that they had been diagnosed with another form of mental health condition**. Given the range and number of responses it is likely (albeit further analysis is required) that some respondents have been diagnosed with more than one form of psychological illness.

4.14 Access to support for mental health needs received from agencies, health practitioners etc.

Mirroring the question asked in relation to physical health needs and the effectiveness/extent of available support, respondents were asked whether agencies or individuals provided adequate services to support for their mental health needs. Chart 27 summarises the responses to this question.

As can be seen only 6% of those who received mental health service support felt that it was adequate, with a further 22% stating that more help was required. In addition, 29% of respondents who did not receive mental health services/support felt that they required access to such services. Once again it would appear from this response that a role is indicated for agencies that are able to signpost and support services users in accessing appropriate mental care, suitable for those experiencing homelessness.

Chart 27: Whether mental health support is received and is adequate/suitable

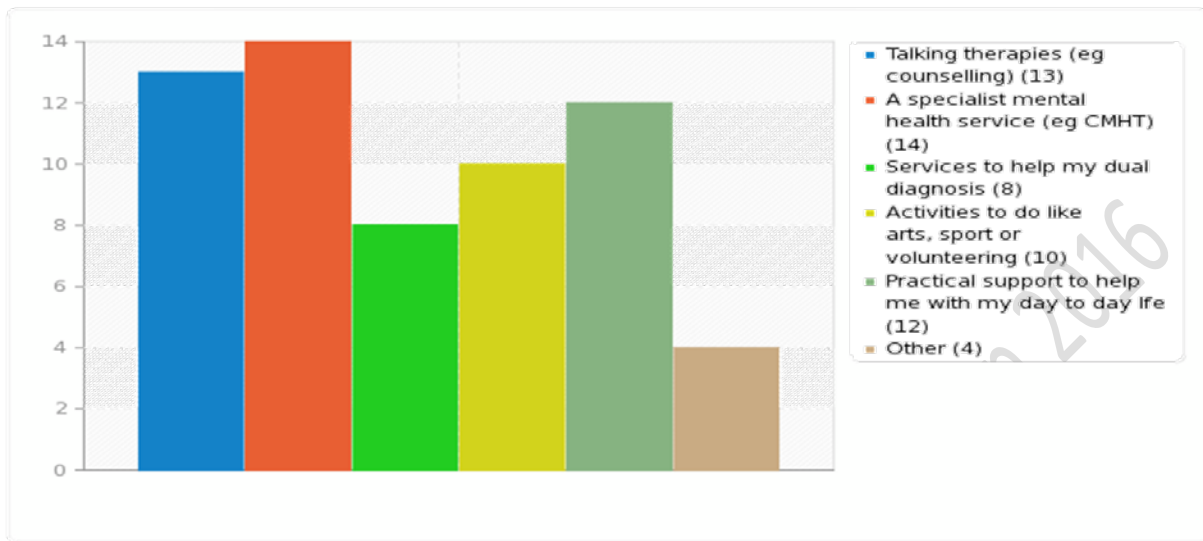


Respondents were asked both **what type of mental health services they found most suitable to support their needs** and also what type of service they would wish to receive. Whilst analysis has not been undertaken at this stage to map across mental health condition by desired form of service/therapy it is noticeable that very few respondents were able to supply a response in relation to effective services delivered to them.

Whilst further investigation is required, this is suggestive of the proposition that homeless clients may not be able to access a full range of services suitable to best support their needs. In total **only 16% of respondents replied to this question, split evenly in their answers so that 4% each (2 respondents per category) suggested that they required help to meet their 'daily living needs'; services tailored towards supporting those with dual diagnosis; 'talking therapies' and access to a 'specialist mental health service'** i.e. one where staff were familiar with the both the condition from which they suffered and the specific circumstances of homeless clients.

In contrast when asked to identify (from a pre-set category list) **what services they felt would be most helpful to them**, respondents replied in the following way: see **Chart 28** below. Interestingly, 20% (10 cases) suggested that they would welcome access to occupational/art therapies or volunteering activities. As such an opportunity potentially exists to enable trained and selected homeless or formerly homeless people to volunteer at specialist homelessness charities subject to adequate support which would both fulfil their desire to be involved in meaningful activities whilst meeting the needs of other homeless people who may need the support of individuals who are familiar with their own lived experience and challenges faced.

Chart 28: Desired mental health services



Respondents were asked about **self-medication** (alcohol and other substances both sharing of prescribed drugs not intended for the service user and/or illicit substances) as a way dealing with their mental health needs. In common with other studies⁴⁰ we identified that at a significant proportion of respondents (**49% of our sample**) reported use of alcohol or other substances to help them cope with stress and other mental health needs. In contrast 40% indicated that they did not use such substances/self-medicate and 10% did not reply to the question.

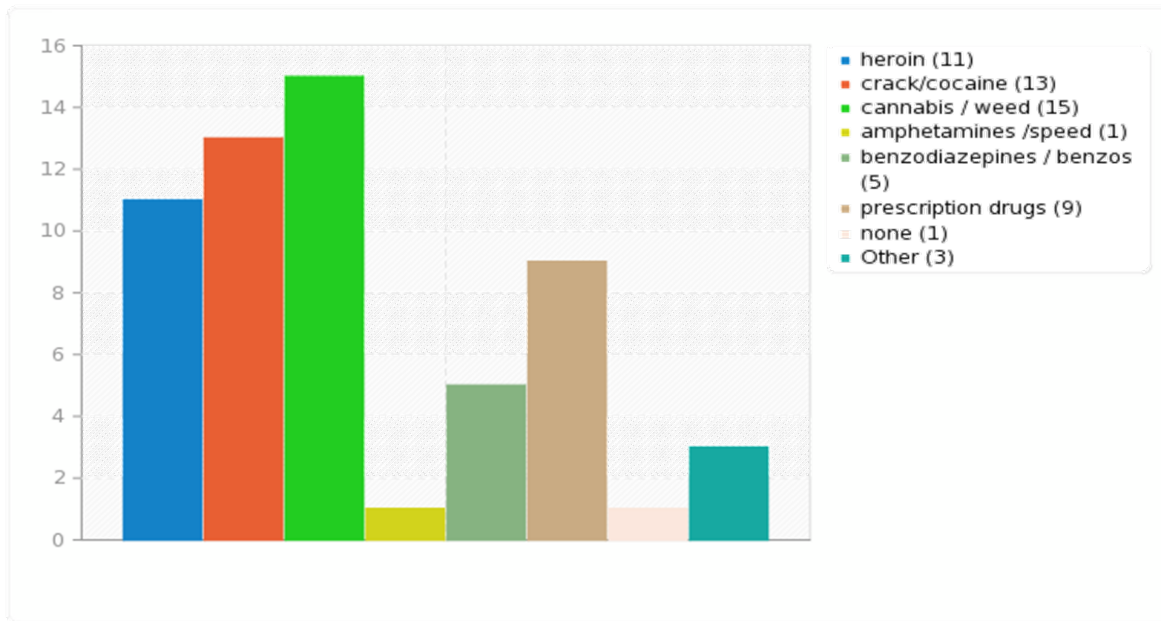
4.15 Substance Use Issues

Of our sample, 42% reported that they either currently took or were in recovery from drugs use (specifically illicit drugs) problem whilst 10% of respondents declined to answer this question. 38% of participants indicated that they did not have and had not had a drugs misuse problem.

Chart 29 below provides information on respondent's replies in relation to recent use of illicit substances. It is important to note that some respondents may be poly-drug users (e.g. using multiple substances), which may create an artefactual presumption of higher (or more problematic) rates of substance misuse than in fact exist amongst services users. More in-depth analysis is required to explore this supposition.

⁴⁰ Numerous research studies in a variety of geographical locations have found evidence of 'self-medication' to unmet support mental health needs e.g Harris and Edlund, 2005 'Self-Medication of Mental Health Problems: New Evidence from a National Survey' Health Service Research. 2005 Feb; 40(1): 117–134. available (full free-text, open access) at: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1361129/>

Chart 29: Types of substance (drugs) utilised by respondents in the month prior to interview



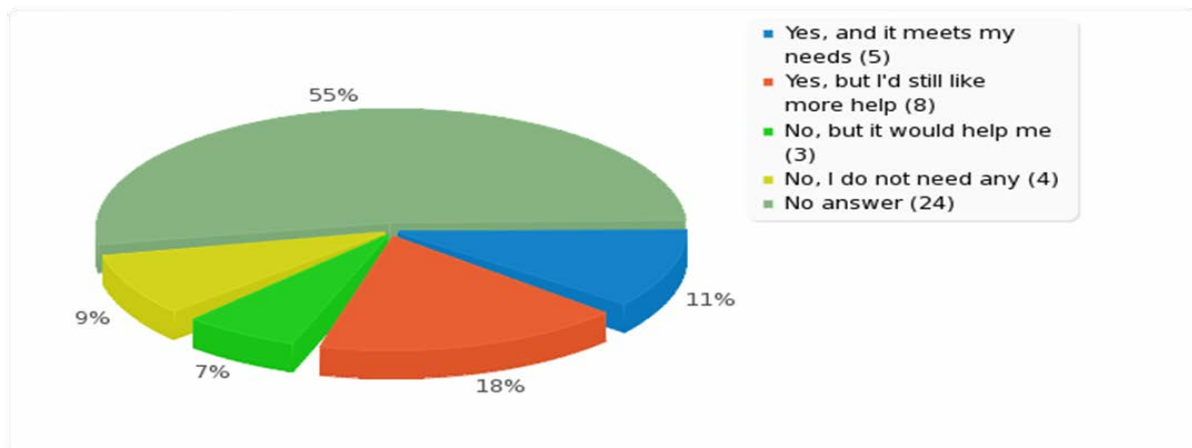
In addition, and supplementary to questions pertaining to heroin use, respondents were asked if they had taken **methadone** in the previous month. Whilst 45% responded in the negative and 45% responded affirmatively to this question a further 10% declined to answer. Of these **10% indicated that they were in receipt of prescribed methadone** whilst the remainder declined to answer.

9% of respondents indicated that they were currently injecting drugs, (potentially indicating scope for inclusion of health promotion around 'healthy injecting'/appropriate interventions and screening for conditions such as Hepatitis C and HIV); **43% stated that they did not inject drugs** and 48% declined to answer or the question was not relevant to them given earlier responses in relation to not using drugs/illicit substances.

Of the 10% of respondents who indicated that they do inject drugs, extremely positively all were aware of needle exchanges facilities in their local area and again all stated that they did not share needles/works with others. Similarly all indicated that they were aware of safe injecting techniques and had received advice on this matter from health professionals or specialist agencies.

Respondents were asked whether or not they received advice and support in relation to their substance misuse behaviours. Whilst it is likely that the 55% of respondents who failed to answer do not take drugs; or do not consider themselves in need of support as they only take recreational drugs occasionally/ do not indulge in substances typically considered to be addictive, it is of some concern that 25% of respondents to this question (11 respondents) reported that they required further support or were not currently accessing needed substance (mis)use advice/care. Chart 30 below summarises responses to this question.

Chart 30: Whether respondents consider that the advice/care they receive in relation to substance misuse is adequate or more is needed.

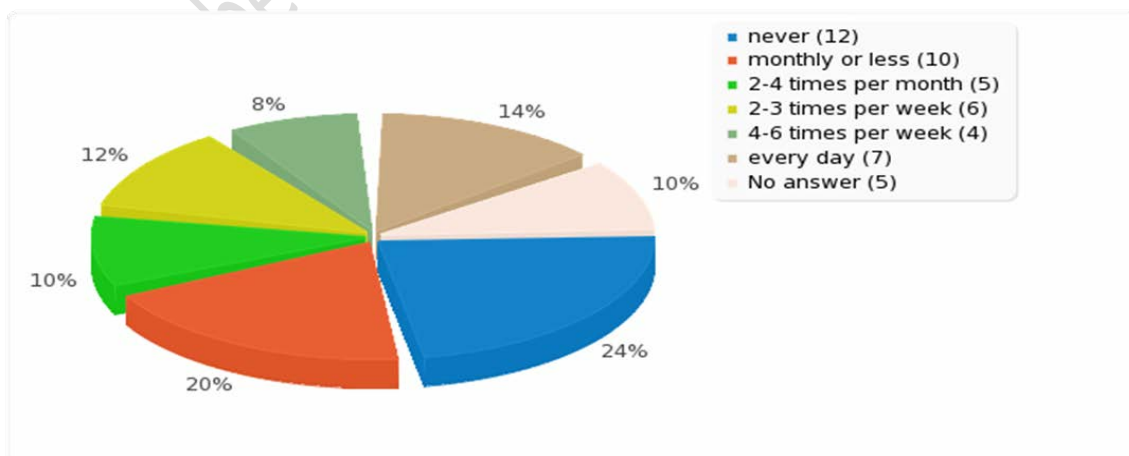


Of those respondents receiving care/advice in relation to substance misuse issues, questions were asked in relation to the type of care/help provided. 8% indicated that support services helped them to reduce their drug intake; 4% (each) stated that they were receiving help to stop taking drugs or to take drugs more safely, and 2% reported that they working on 'control' issues in relation to substance intake.

In contrast, 14% of respondents indicated that what they required from health services was help to stop taking drugs; 8% each support in reducing or controlling their intake and 4% more advice on safer drugs use. These findings suggest that there is scope to enhance and refine substance misuse services to better meet the aspirations of homeless, substance using respondents.

Responses to questions pertaining to alcohol use were somewhat surprising, indicating a lower level of alcohol dependency and regular use that might be expected amongst homeless people. In part this might pertain to the age and demographics of respondents and/or the cost of alcohol, which could potentially be out of the reach of some homeless service users. Overall, 55% of respondents could be classified as light or social alcohol users with 12% of participants indicating that they never drunk alcohol. Chart 31 below maps reported patterns of alcohol use amongst respondents.

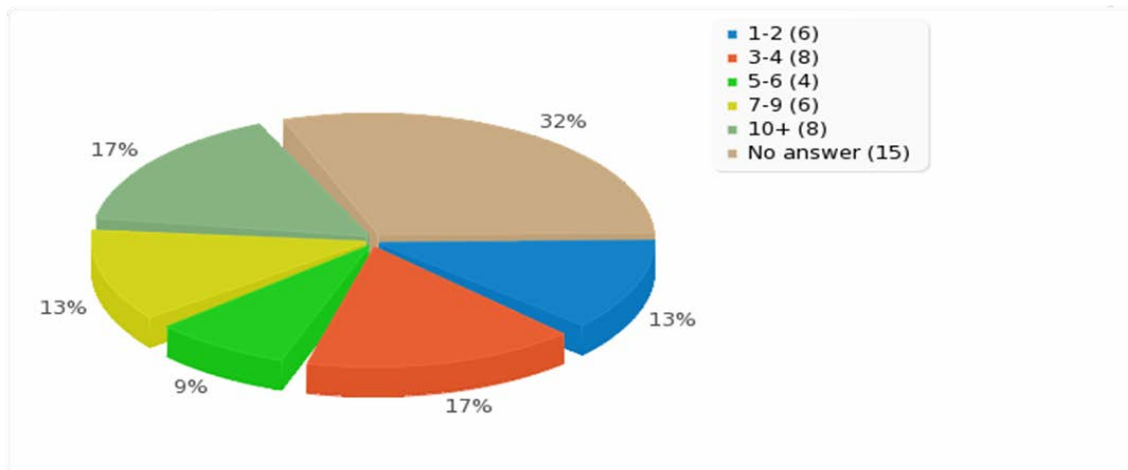
Chart 31: Alcohol intake/regularity of alcohol use



Whilst self-reported alcohol consumption overall is relatively low amongst respondents to this survey, participants were asked how much alcohol they would consume when they were drinking.

Indications were found that patterns of binge-drinking or high levels of alcohol intake were common amongst a minority of respondents with some participants (17% of those who responded) indicating that they might consume in excess of 10 units in an alcohol use session. Whilst this finding requires further analysis and may pertain potentially to binge-drinking sessions associated with access to finances such as welfare benefits with 'dry periods' in between, it would suggest that there is scope to engage with additional education/interventions in relation to safe drinking for at least some homeless service users.

Chart 32: Typical number of units of alcohol consumed on a day when respondent is drinking



Overall 29% of respondents indicated that they either had or were recovering from an alcohol problem. A further 71% indicated that this was not a health problem that they experienced.

Of those who reported that they have or are recovering from an alcohol problem; 9% suggested that they received adequate assistance to deal with their habit; 12% reported that they required additional help to that they received and a further 7% indicated that they did not receive support but that they would benefit from accessing such services. Help obtained from specialist alcohol services included help to stop drinking (6%) assistance with controlling intake (6%); reduction in use of alcohol (4%) and access to medical care in relation to impact of alcohol use (4%). In contrast, on being asked what assistance they would require from specialist alcohol services, respondents indicated that 12% wished for help in controlling their alcohol intake; 6% wanted to reduce their intake and 8% each wanted to help to stop drinking entirely and to manage the health impacts caused by alcohol use.

Accordingly a slight mismatch can again be identified in terms of help received and desired by services users; suggesting scope exists for enhancing services to meet the needs/desires of homeless service users. Again we suggest that a potential exists to work with former homeless, substance and alcohol using people to provide peer support in reducing dependency on alcohol and illicit substances.

4.16 Communicable Diseases and Vaccinations

This element of the survey asked respondents a series of questions in relation to **testing for and treatment of a range of conditions such as TB, Hepatitis and sexually transmitted diseases as well as contraception use**. Respondents were extraordinarily open and willing to respond to these very personal questions with only a small number of non-responses to this section of the survey.

When asked if vaccination had been given for **Hepatitis A and B**, 16% and 21% (respectively) indicated that they had received such a vaccination. Around 25% of respondents were unsure and approximately 50% indicated 'no' on each occasion with a very small number of 'did not respond' found.

When asked about receipt of **'flu vaccinations** – an important form of immunisation given the prevalence of chest infections and often poor conditions experienced by homeless people only 18% of respondents indicated that they had receive a 'flu vaccination in the previous 12 months; 18% were unsure and 51% were clear that they had not received such protection.

Testing for **Hepatitis C** had not been carried out for 51% of respondents (a further 12% did not respond and 10% declined to answer. Of those who had been tested 16% were HepC – and 8% were HepC+.

Similarly, of those asked **about TB screening. 12% did not respond; 8% did not wish to answer; 14% tested negative for TB and a concerning 8% were found to be TB+**; enhancing risk for other homeless people with whom they come into contact, for example in night shelter or squats.

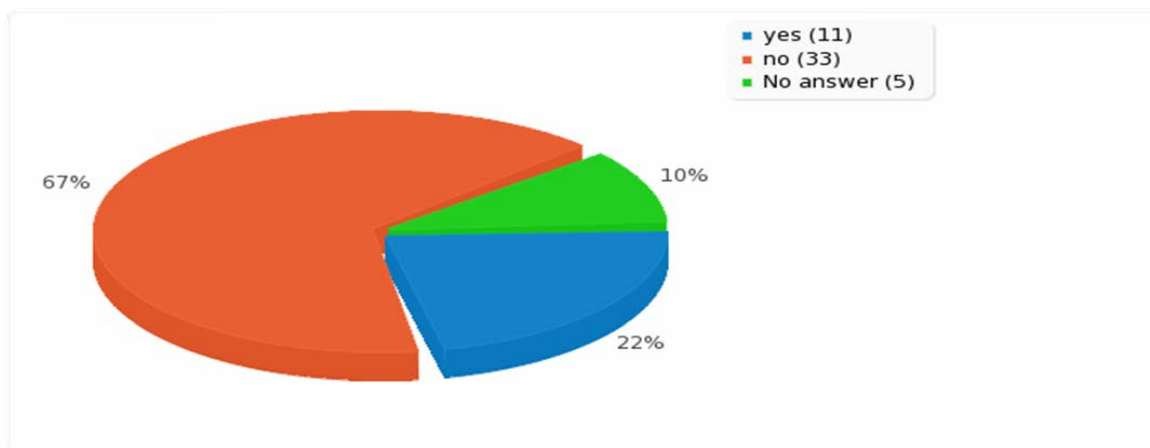
On being asked whether they had been **tested for HIV**; 10% of respondents did not wish to provide an answer in relation to their screening status; 10% declined to answer; 22% of those who were tested were HIV- and **8% were found on screening to be HIV+**. Given that we are predominantly dealing with a White British, non-injecting, heterosexual population this finding must be regarded as being worthy of some concern in terms of population health within the study area and consideration should be given to rolling out additional screening and provision of advice in an accessible manner via trusted homeless health/support services.

Treatment for identified communicable diseases - Whilst overall a small percentage of respondents were found to test positive for the conditions detailed above and not all respondents replied to questions pertaining to treatment options; it is still noteworthy and of concern that **2% of those who reported screening positively for Hepatitis C; 4% of those found to be TB+ and 4% of those found to be HIV+ indicated that they were not offered treatment or advice for their conditions**. An urgent need therefore exists to monitor, trace and offer treatment for homeless people found to test positive for the above conditions, utilising appropriate and trusted outreach services familiar with working with homeless populations. Once again it is worth reiterating that these respondents may have multiple conditions and represent a small group of 'hard to reach' service users at significant risk of transmitting communicable diseases amongst themselves and the wider population.

4.17 Sexual Health

Whilst clearly not all respondents may be sexually active, Chart 33 presents findings from the question pertaining to sexual health screening. Overall 67% report not having undertaken sexual health screening the previous 12 months whilst 22% have accessed such services. 10% of respondents declined to answer the question.

Chart 33: Take-up of sexual health screening in the previous 12 months



Given that there is abundant evidence that homeless/roofless people, (particularly women) are likely to engage in unsafe sex, sometimes in exchange for a place to stay, it was considered relevant to explore issues of sexual health and knowledge of where and how to access contraception in the local area.

71% of respondents indicated that they were aware of how and where to access contraceptive advice in the local area, whilst 22% of respondents were unsure. Again whilst this service may potentially not be relevant for a high percentage of respondents it is important that wider awareness and information sharing exists in relation to sexual health and screening services amongst the local homeless population.

On being asked **where they would seek to access contraceptive or sexual health advice, 47% of homeless respondents indicated that they would see a nurse or GP; 40% a specialist sexual health or genital-urinary service and 8% a homeless support service.** Access issues to these services, particularly for those of NFA thus require guidance and information packaged in an accessible format to ensure that service delivery matches service users need.

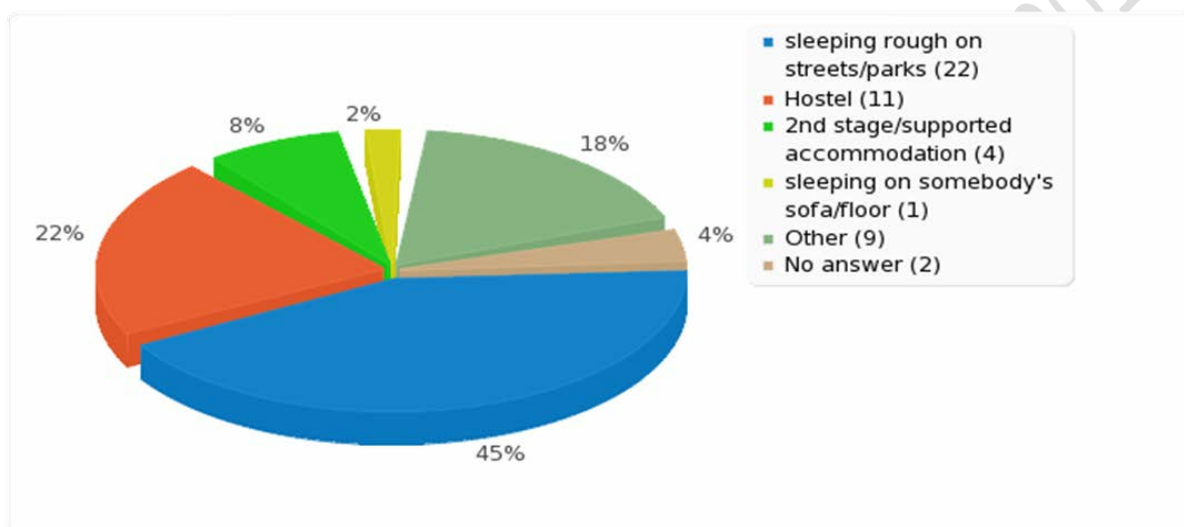
4.18 Specialist Women's Health Services

Whilst women account for a very small percentage of homeless health service users at 12% of respondent (6 cases) (see above) **only one respondent indicated that she had accessed cervical screening in the previous three years** indicating that a gap in service provision exists and should be considered when devising appropriate services for this sector of the population. **Similarly no women had accessed breast-screening services via their GP or specialist women's health agencies.** Whilst the population of homeless women interviewed are all under the age for routine breast screening it is suggested that access to women's health services including cervical and breast screening should be made available to homeless women on a routine and opportunistic basis to avoid preventable deaths.

4.19 Accommodation Data

The concluding section of the questionnaire focused on the accommodation situation of respondents to the survey and should be read in close conjunction with the demographics of the sample outlined above. Inevitably the accommodation status of the service user has significant impacts on both physical and mental health status and regardless of whether a client is currently homeless or accommodated in a hostel the health implications of prior homelessness and/or risk of ongoing 'revolving door' homelessness (particularly for those with substance misuse and/or mental health issues) cannot be underestimated. Chart 34 provides information on the current accommodation situation of participants.

Chart 34: Accommodation status at time of interview



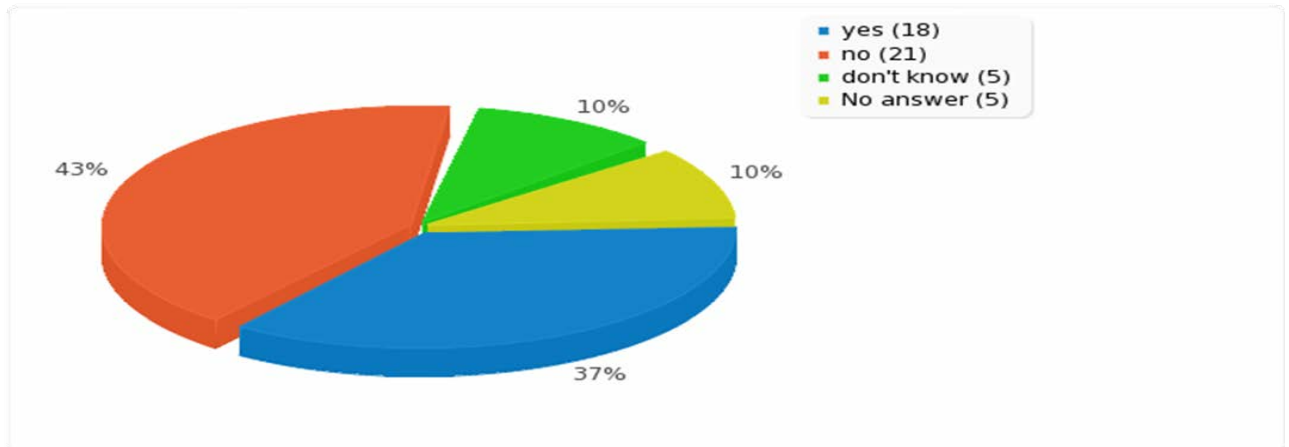
45% of respondents were sleeping rough ('street homeless') representing the most vulnerable sector of the population in greatest need of access to health services whilst 30% were (at least temporarily) resident in hostels or supported accommodation. 18% indicated that they were in 'other' situations with limited information available to enable drilling down further in relation to their housing situation.

Overall only 6% of respondents indicated that they were in training/studying at the point of interview, with all of these in at least a state of semi-stability associated with resident in 'other' accommodation or residing with a relative/sofa-surfing etc. **Again 6% of respondents (3 cases) indicated that they were volunteering** at a project at the time of interview. **10% of participants (5 cases) were in employment**, again typically associated with a slightly more stable form of accommodation. In some cases (suitable for further analysis) there appears to be an overlap between employment and training with participants mapping across into both categories. **In total 20% of respondents (10 cases) indicated that they had or were currently accessing guidance and support pertaining to entering employment, training or study.** It is unclear whether this is in part related to requirements in order to access social security benefits or was a self-motivated activity.

4.20 Health Status impacting on employment, training or volunteering opportunities.

Chart 36 below illustrates responses to this question. As can be seen fully 36% of respondents report that they feel their current health status impacts on their ability to enter into work, training or to take up a role as a volunteer.

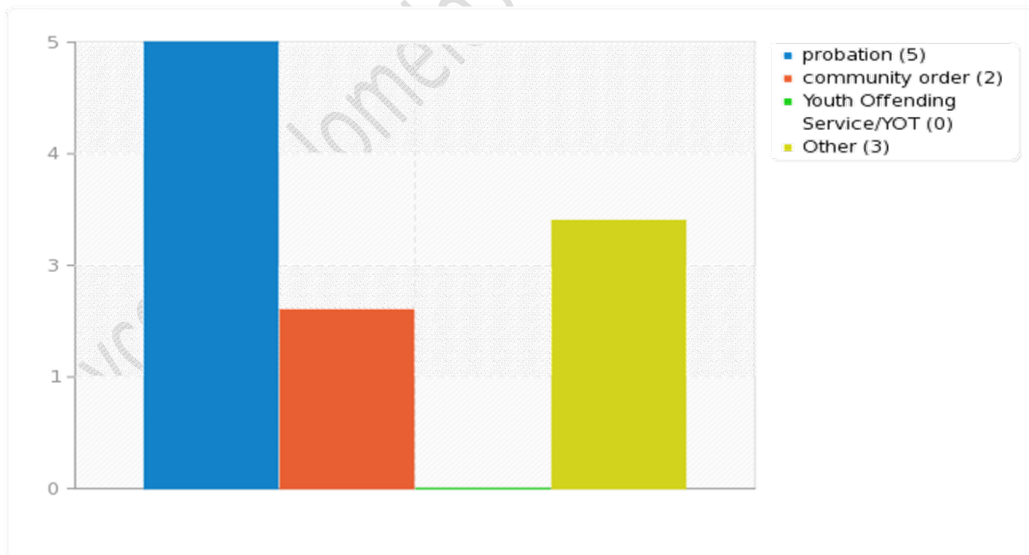
Chart 36: Whether health status impacts on respondents' training, volunteering or employment opportunities



4.21 Contact with prison/probation or 'looked after children' services.

As is widely recognised, homeless people are over-represented in terms of being care leavers or those who have a criminal justice record. Respondents were asked about their contact/background in relation to these services. Chart 37 below illustrates responses to this question. Overall, 16% of respondents had left prison within the 12 months prior to interview; 16% had left prison over a year previously; 2% (1 case) had been a child 'leaving care' in the previous five years and 39% did not fall into these categories. At the time of interview 4% of respondents were subject to a community order and 10% were under the care of probation services.

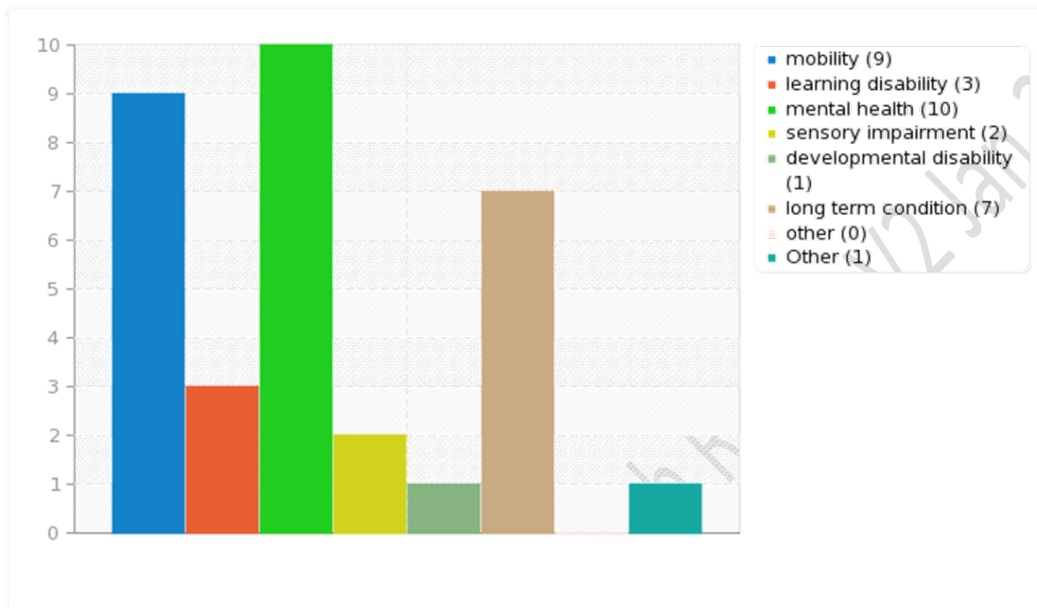
Chart 37: prison, probation or 'leaving care' status.



4.22 Disability status of respondents

Overall, 63% of respondents stated that they did not have a disability; 6% did not reply to the question and 33% of participants stated that they did have a disability. Chart 38 below provides additional data on the type of disability reported by respondents. Unsurprisingly given the data above, mental health accounted for the greatest percentage of reported disabilities followed thereafter by mobility issues. Long-term conditions included epilepsy, diabetes and other conditions such as cardiac or circulatory problems.

Chart 38: Disability self-reported by respondents



Additional comments in relation to 'what works well' in terms of health service delivery and care for homeless people. Few responses were received in relation to this question or the 'general' issue of whether respondents wished to make any other statement in relation to the survey. In total 7 responses were received.

4.23 Conclusions and Discussion

Overall the picture of homeless service users in the High Wycombe and Aylesbury areas paints a picture of health that is slightly worse and subtly different from that found amongst homeless people elsewhere in the country. Based upon comparisons with findings from Homeless Link samples it would appear that the health status of homeless people in our local study area demonstrates a higher rate of communicable disease (i.e. HIV+; TB; Hepatitis C); slightly lower access to primary health care and preventative screening; higher rates of emergency hospital access and significantly more 'street homeless' (in contrast to sofa surfers and hidden homeless) when compared with the national homeless population identified in Homeless Link surveys. The prevalence of mental health concerns, dual diagnosis and substance misuse levels remain broadly similar to national patterns although when contrasted with the UK samples alcohol use is under-represented amongst our respondents.

Similarly noteworthy, is that the pattern of homeless people in the study area has a significantly older age profile⁴¹ (which will inevitably increase the risk of premature death and poor health for this group) and far greater proportion of 'White British' respondents than is common elsewhere in the country, particularly when contrasted with other areas close to London.

Overall the data and information gathered in terms of pattern of access, satisfaction levels with medical services and provision of homelessness support service mirrors the evidence provided by service providers; indicating that whilst High Wycombe and Aylesbury offers some extremely high quality voluntary sector services staffed by dedicated personnel, there is an identifiable problem in terms of provision of sustainable, rapid access to health care for homeless people with implications for both individual and population health.

It is worth stressing too that evidence from both service providers and discussions in relation to 'street knowledge' gleaned from homeless people, as well as policy indicators in relation to trends in homelessness and migration; (for example the 4% increase in evictions leading to homelessness in 2014⁴²; the 29% of homeless households occasioned by the ending of assured short-hold tenancies⁴³ associated in London in particular with the impact of increasing rental costs and the 'push to the margins' from London accommodation overflows) is suggestive of the fact that homelessness in the High Wycombe and Aylesbury area is likely to increase in the next 3-5 years. This projected growth will place a further burden on service provision and impact on the speed of service response and number of clients who can be supported by current homelessness services in terms of mental and physical health access, unless there is a developed strategic and targeted response to the trends and issues outlined above.

Given the increase in 'rough sleepers' in both London (37%) and more widely (7% nationally) in 2015⁴⁴ (most recent figures, with 2015 data due for publication in Spring 2016); this anticipated uplift in homeless people locally, with a very high likelihood that they will experience the ill-health and associated issues explored above in the literature review and within Part 4 of this report, suggests increased traction in relation to rates of 'street homelessness' in the High Wycombe/ Aylesbury areas. Such a growth if borne out will have implications for the planning of health services targeted at such service users given the potential individual and public health impacts of untreated health conditions as outlined above (particularly communicable diseases).

⁴¹ See Homeless Link (2015) 'Young and Homeless' report which suggests that young people under the age of 25 account for 50% of all homeless people accessing services at a national level.

<http://www.homeless.org.uk/sites/default/files/site-attachments/201512%20-%20Young%20and%20Homeless%20-%20Full%20Report.pdf>

⁴² News report The Independent 4/12/2014 'Evictions cause 4% increase in homelessness'

<http://www.independent.co.uk/news/uk/home-news/evictions-cause-4-increase-in-homelessness-9918884.html> (accessed 03/1/15)

⁴³ Communities and Local Government *Statutory Homelessness: July to September Quarter 2015*

England London: CLG (2015a) available at

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/486671/2015_Q3_Statutory_Homelessness.pdf (accessed 19/1/16)

⁴⁴ Communities and Local Government *Rough Sleeping Statistics England - Autumn 2014 Official Statistics*

London: HMG (2015b)

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/407030/Rough_Sleeping_Statistics_England_-_Autumn_2014.pdf

We would highlight too as a point of note (with potential impacts in relation to access to translation and 'reconnection'⁴⁵ services), that whilst the number of non 'White British' migrants interviewed for this study was small, at a national level non-British nationals accepted as statutorily homeless stands at 18%; representing a 7% increase in the 3rd quarter of 2015 over the same period in 2014⁴⁶ whilst 54% of rough sleepers are non British Nationals (figures which include EU migrants, third country nationals and failed asylum seekers⁴⁷).

Given the close proximity of Buckinghamshire to North West London and the current and growing 'push' pressures on accommodation in the urban conurbation we anticipate that there will be an increase in the non British citizen homeless population in the study area over the next 3-5 years as individuals seek accommodation and/or employment some distance from the city in a manner similar to that outlined in Case Study 2 below. Accordingly we recommend that awareness of this potential growth and need for the provision of specialist services and translation access is taken into account when planning service delivery for the next 5-10 years.

⁴⁵ Reconnection services are aimed at supporting destitute (predominantly EU) migrants to return home and reconnect with their communities of origin. For an example of such projects' work in London and suggested significant savings pertaining to health care see <http://www.thamesreach.org.uk/news-and-views/news-archive/news-archive-2010/homeless-migrants-facing-destitution/> (2010) and similar work in the East Midlands (2014) http://www.frameworkha.org/blog/1165_helping_homeless_migrants_-_an_example_to_follow

⁴⁶ CLG 2015a 'homeless statistics' *ibid* (see footnote 42) at p11.

⁴⁷ CLG 2015b 'Rough Sleepers' *ibid*. (see footnote 43) at p7. and further: St Martins and St. Mungo's (2015) *Home Office consultation: Reforming support for failed asylum seekers and other illegal migrants Joint response from The Connection at St Martin's and St Mungo's Broadway (September 2015)* London <http://www.mungos.org/documents/6641/6641.pdf> (accessed 23-1-16)

5. Healthcare Provider and NGO Staff - Feedback and themes

In order to supplement the data from service users and to map recommendations across from focus group findings, front line workers from homeless support projects were invited to send in comments on their recommendations for service provision/experience of positive initiatives (see Appendix 3). In total, 8 sets of comments were received (combined data from respondents in High Wycombe and Aylesbury). Whilst it difficult to create an overall thematic map from these comments essentially the core issues identified by these highly experienced staff support findings from the client/service user survey and literature outlined above, and focus on the themes of:

- A need for flexibility in accessing/referring on service users
- The necessity of speedy and opportunistic health care delivery to clients whose difficult and chaotic lives intervene and impact on general health care and day-to-day engagement with health literacy
- The complex interactions between mental health needs and substance misuse and the gaps in provision for people with dual diagnosis
- Recognition that circumstances can change rapidly with clients' health declining dramatically in a short timeframe. This, factor in itself has implications for the individual and costs to the health service/local authority given long-term need which can emerge in circumstances where earlier timely intervention might have led to opportunities for increased wellbeing for the client as well as reduction in intensive/long-term therapeutic engagement both physical and psychological.

The data below consists of a summary of comments/recommendations/additional information supplied by front-line staff including those from all three agencies where data was collected, nurses, reception staff and doctors.

- *Clients addressing substance misuse, in Aylesbury, need to be registered with a GP before they can be scripted. It's not always easy for them to access a GP and can be a lengthy process. Substance misuse, particularly Heroin, is likely to worsen if they are waiting long periods of time.*
- *Health matters and issues do not seem or appear important to homeless people as much as to people who are housed. Due to the chaotic nature of many of their lives they frequently miss or forget appointments.*
- *A diagnosis for Mental Health can sometimes be vital for the client to access appropriate support. There is no simple way for homeless clients to access mental health teams. Healthy minds require an 'over the phone' referral. This is not possible for clients who do not have phones or the finances to put credit on them.*
- *When sleeping rough, cuts and injuries can easily become infected if not kept clean and dressed properly. For clients with GP's, same day appointments are rare. Sometimes a week can be too long to wait if infection is setting in. Chest infections are particularly common.*
- *For follow up treatments/appointments, letters are sent out to notify clients. If you have no fixed abode it becomes really tricky to keep to these appointments.*
- *Clients are often told that a full assessment cannot take place whilst they have no fixed abode the impact of this is huge in terms of moving forward. A client who shares personal details to a MH professionals and then told they won't be eligible for further support are unlikely to go back to the service to get that support in the future.*
- *Guests [service users] feel that surgeries (particularly the phone systems) are not for them [costs/difficulties of access for homeless person] and they are not always made to feel welcome [when attending surgeries in person]*

- *Many clients are on medication from GP's with basic contact but no therapy is offered or pursued, so the medication becomes a suppressant rather than dealing with the root cause. Clients often don't have the 'tools' to cope with episodes of depression.*
- *Mental Health (MH) diagnoses gives AHAG and/or any other housing advice service/provider a clearer picture of a path forward for the client.*
- *MH diagnoses and access to appropriate treatment enables services to provide a stronger referral for supported housing.*
- *From my experiences some residents find it difficult to openly communicate their issues to new people such as a doctor/nurse and need support.*
- *A lot of clients find it difficult to access/be accepted for mental health services e.g. Healthy Minds if they are suffering from addiction/substance misuse as well. [They] are told that they must address their addiction first before receiving the necessary support for their mental health [needs]. However, often mental health issues and substance misuse go hand in hand and it becomes a question of what came first: The chicken or the egg! I believe that improved availability of mental health services to homeless people would prove invaluable.*
- *There are a lot of cases I hear about where homeless [people] have their belongings stolen. Maybe somewhere to store their belongings, as this sometimes is all they have [items that they can carry with them/bedding]. There are lots of empty buildings in High Wycombe not being used. Why not a project where the homeless can repair/revamp these buildings for homes? Camping equipment and an area to set up camp each night while some people are waiting to be housed. This would have to be in an area that is kept clean for the daytime, but there is a lot more that can be done!!*
- *A system should be in place where people can be reminded of [health] appointments, as some people don't have phones.*
- *An improved support system should be in place to help people feel comfortable and confident in registering with GPs. They should be allocated a regular GP who they see regularly at the surgery, not locums or different doctors, as they are likely to feel more comfortable in attending appointments if they are talking to one person rather than different people.*
- *From sitting on reception I can see the struggles the homeless have to gain appointments with doctors and dentists and how this can have an effect on their mental health and wellbeing.*
- *A homeless person cannot always access healthcare services for a number of reasons. Why not take the services to them?*
- *GPs operate an appointment system that is not accessible to many of our clients as they often have no credit to make the call and their lives are chaotic so being organised enough to be in a telephone queuing system at 8 am is becomes unrealistic.*
- *It cannot be right for any society to allow a young woman to freeze to death alone in a car park. Yet this is what happened to Josie Razzell⁴⁸ on (of all days) Christmas Day 2006. She was the beginning of my long journey that finally led me to volunteer with AHAG. In my untrained and unqualified experience, every person who presents as homeless is in crisis with a complex mix of issues but always present in the situation somewhere are mental health problems. Sometimes, the homelessness is the cause of stress and anxiety and the good work I see done by AHAG helps*

⁴⁸ See reference to the death of Ms Razzell by exposure when sleeping rough in High Wycombe – statement in Hansard by MP Steve Baker 13-12-2013 cited in Wycombe Homeless Connection newsletter http://www.wyhoc.org.uk/news/view/it_is_a_thorough_and_utter_disgrace

the person out of homelessness and the problem is solved. However, when mental health is the root cause, AHAG will never be able to help that person out of homelessness because mental health care is outside their remit. It's a complete no-brainer that the homeless need access to full medical services with a GP and nurses (and a dentist?) and a mental health professional. As I say, I am no qualified expert and I only volunteer in the kitchen so am just a sympathetic pair of ears. But I do have experience of close family with mental health issues – one having been sectioned and one who died by suicide. I have had much contact with other people bereaved by death by suicide and hear many stories that have uncanny parallels with those I hear among the homeless. In summary, I would like every homeless person to have access to much improved healthcare provision.

Summary

An overarching sense emerges from this 'service provider' data that there is a need for specialist basic health services, available at known and trusted locations which are familiar to homeless people, staffed by experienced professionals and which can be accessed easily by clients presenting with multiple needs and co-morbidities. Access to such services it was suggested in discussions and within the data summarised below, could reduce the number of stages required before a service user can obtain medical care and increase compliance with resultant beneficial impacts for individuals (and in the case of those individuals with communicable diseases, public health/wellbeing).

A number of respondents stressed that the delays between referral to diverse specialist services can increase the negative impact of the presenting symptom whether this pertained to substance misuse, psychological need (emphasised by all respondents) or physical illness. Similarly, if a homeless service user initially saw a GP or attended at A&E it was reported that follow-on care was typically difficult to access given lack of a stable address or problems for clients in managing to maintain a routine and attend for set appointments.

See further below (Section 8) for suggestions of a range of homeless health service provision models utilised elsewhere which offer scope to meet the needs of this particular set of clients as summarised within this report.

6. Focus Groups with homeless people - Emerging key themes

As noted above two focus groups, each lasting approximately 1.5 hours, were held with a total of 10 services users from WHC and AHAG (See Appendix 2 for Topic Guide/Questions asked). Given a lack of resources to enable full transcription; staff and volunteers at the homeless support agencies concerned were able to provide key point transcriptions for the audio recordings. Light-touch analysis and identification of core themes have been undertaken by BNU/IDRICS staff. Summaries of key themes and particularly pertinent quotations from the discussions are summarised below.

After general introductions and a discussion on access to services/routes into homelessness the theme of gendered access to and use of health services was introduced albeit mainly service users we interviewed were male. Despite this, several respondents referred to perceptions of female homelessness and one respondent (female) in particular discussed concerns over risk of sexual violence, hygiene and the difficulties in trying to remain well groomed when homeless.

“If you are living in your car you get condensation and everything gets damp, you can’t change into clean clothes as you only have minimal belongings anyway. You haven’t got a wardrobe of fresh clothes. You usually [have] only got what you are wearing”

Whilst this respondent indicated that whilst she had been able to live in a car, and was not as at great risk as some women, she was aware (as confirmed by male respondents) that physical safety was a particular concern for homeless females.

“It is harder for women; they are more in danger, so tend to sleep with someone, or try to get off the street”.

Several men echoed her comments in relation to the dangers faced by homeless women: *“Homeless people feel very vulnerable, especially females”.*

Who are homeless people?

It was considered important to identify who service users constituted as being the group identified by the public as ‘homeless’; to both give voice to the internal perceptions of this group, and to enable them to discuss who they felt should be able to access specialist dedicated homeless health services, such as to ensure both that attendees at such services felt comfortable, and to avoid overload of staff time.

Under this theme, a discussion ensued on the definition of ‘homeless people’ through the eyes of participants:

- *Not sofa surfers, they have a roof over their heads*
- *People who are too helpless to find a home*
- *People in hostels and institutions.*

Key Barriers to health/access to health care for homeless people

Some respondents identified health problems experienced by homeless people as due to a toxic combination of personal neglect (typically associated with substance misuse issues) as well as resulting from structural barriers in relation to access to facilities. There was widespread agreement that these challenges coalesce into both physical and mental ill-health as individuals become aware of their decreasing contact with ‘mainstream’ society and services and become isolated; in turn creating increased barriers to engagement with agencies which are unfamiliar with supporting

homeless people which then reduces the likelihood of access to timely and appropriate interventions.

- *95% of people on the streets have drug and alcohol problems*
- *Trying to keep clean is a huge problem. Don't have the amenities to shower or wash your hair and keep clean. Once you start to feel rubbish you continue to feel rubbish and you get used to being dirty. You have no choice in keeping clean and you have no one who cares so you don't care either*
- *If you are living in your car you get condensation and everything gets damp, you can't change into clean clothes as you only have minimal belongings anyway. You haven't got a wardrobe of fresh clothes. Usually only got what you are wearing*
- *Some might be too embarrassed to go to the Doctor's due to their physical appearance and poor level of hygiene*
- *Drink numbs the pain and is your main concern on a daily basis. People on the streets have as many mental health problems as physical problems*
- *Continuity of care is a real problem, especially with mental health. You see one GP, pour out your problems start to discuss treatment and then the next visit you see someone different and have to start again from the beginning. [You] stop talking to people after a while*
- *Attitudes from staff can be very harsh. A homeless man went to the hospital to attend a genuine appointment, but security guard would not allow him in as he had been sleeping rough in A & E the previous week. He had gone for his dressings to be changed [staff member assisting in facilitating focus group]*
- *Difficult to get dressings changed by community nurses if you are constantly sofa surfing and moving around. Don't know where you will be the following week.*

Where homeless drop-in centres were able to provide access to washing or other facilities there was a wide-spread perception of the 'humanising' aspect of such services even when these were available far less frequently than individuals in mainstream housing would tolerate: "You can get clean at the Hub once a week" as well as commentary on the difficulties in accessing facilities elsewhere in public spaces: "[I] used to wash myself in Tesco's disabled toilet at 6am before the cleaners arrived."

What are the most important health concerns of homeless people?

Whilst a number of participants referred explicitly to the dangers of street homelessness, for example when sleeping rough in car-parks or under bridges:

"Personal safety, you can be attacked while on the streets" (and see further below for a discussion on risk factors) the majority of respondents to this question commented on the rapid decline in physical and mental health associated with homelessness and (in the main) loss of continuity in terms of contact with medical practitioners, as well as a sense of bewilderment as to how to access services predominantly designed for people living in settled accommodation:

- *I have been trying to register every month with the 3 nearest GP's but they won't take me as their lists were full*
- *I didn't know that I could register as a temporary patient, [there is] clearly a need for more information to ensure you know all the facts*
- *Need clear, informative sign posting to tell you where you can go to get clean, charge your phone or something to eat.*

Even when an individual has been able to access temporary or emergency health care (for example via A&E services) there was a perception that without a specific point of on-going contact to assist service users in maintaining their health/well-being they would simply deteriorate rapidly and enter into a revolving door situation with repeated declines in health, A&E access and then back onto the streets.

- *It can be difficult to access medical care. My GP wouldn't let me sign up to a Dr because I was homeless. They wouldn't accept me, even when I was in a hostel, as it was a temporary address*
- *Have tried 3 different surgeries and they all refused to take me. [I] had to travel right across town*
- *Epilepsy: if I have a fit people walk past thinking I am blind drunk. Although I'm not necessarily treated that way because I am are homeless.*
- *Without an address you can't get a regular prescription*
- *Malnutrition is a big problem due to them [homeless people with substance misuse issues – with whom the speaker did **not** personally identify] spending cash on drugs and alcohol, instead of food*
- *Being able to keep clean and fight infection*
- *The effect of cold and damp in trying to fight colds and illnesses, difficult to keep well*
- *Mental illness is hard to fight; you get very low and depressed*
- *Leaving health problems for too long and they develop into major issues such as a cold or chest infection becomes pneumonia.*

Access to 'Rehabilitation', was mentioned in several places in transcripts and seen as important; for example contact with services which can refer on and aid homeless people with maintaining contact with agencies (i.e. both medical/health and social 'rehabilitation').

The theme of stigmatising stereotypes also arose at several points during the focus groups, as well as the importance of having experienced, non-judgemental health and support staff to assist homeless people in accessing services (health and social care as well as legal and welfare benefits advice) with such actors/agencies seen as important in sustaining compliance/on-going contact with a range of key services.

- *More places for people with medical problems to go to if they are homeless. There are many barriers to getting help*
- *[I] lost access [to services previously accessed before being made homeless] and hard to find help for mental health as everything [services] has merged together, so waiting times are very long*
- *Complicated forms don't help those who aren't that academic, [they give the] perception that they're designed to confuse and block access*
- *Lack of clarity on how to get help, and complex description of various help and benefits [is confusing]*

NB: both of these latter comments refer to a thematic area of discussion on support required to enable access to advice, referrals and welfare benefits all of which are available through NGOs/specialist services but are unavailable if isolated homeless people aren't in contact with specialist services. See further too under suggestions for available services as dedicated homelessness service drop-ins.

In contrast to the barriers mentioned above, one individual referred to the fact that they "*had good experiences from my GP, they did everything they could to help me*" and it was also indicated in the

other focus group that “*some homeless are able to stay with the same Dr even though they have lost their home*” although on probing this was found to be a case where the GP in question had been the family doctor for that focus group participant for a number of years and was personally supportive and aware of their difficult circumstances; indicating the importance of continuity and personal relationships with care providers breaking down stereotypes of homelessness.

What other problems do people face when trying to access a GP?

Whilst some topic guide questions appeared discrete (e.g. main health care concerns and difficulties in accessing GP surgeries) it became abundantly clear that respondents identified overlapping concepts, as the overwhelming impact of homelessness led to a coalescence of medical and social barriers to retaining surgery registration:

- *A lack of clean clothes or being able to brush their teeth, you feel very dirty going in to see the Doctor*
- *Some people are feeling too depressed to care or don't know it [support service through NGO to help access GPs] is here*
- *Some are just too embarrassed to come and get help*
- *If you are made homeless quickly, you cannot prepare. GP dropped them because they're not close enough, so couldn't prepare for long term health*
- *Nothing is dedicated to helping homeless people get off drugs and because they're constantly moving about, it's hard to keep them with a certain GP. Consequently no continuity of care.*
- *Need an easily accessible clinic to help, and a lot of homeless people don't have a GP so can't access prescriptions from a doctor*
- *You need the confidence to be able to stand up for yourself and fight your corner. Often need to be persistent to get what you need and not be put off [N.B. Links to discussions on how difficult this is when depressed or have lost confidence re issues of access/hygiene, stereotyping etc.]*
- *Ringing the Dr is difficult, phone runs out of credit, or battery is flat and no access to charge it. Often told to ring back and may have borrowed a phone so can't*
- *Leave it too long to seek help so that health problems build up and then need longer than a 10-minute appointment. [N.B. See recommendations later re double/long appointments and their role in making for a 'good' health care experience]*
- *Care in the community really isn't available in real life. Difficult to access any care.*

Why do people go to the GP?

In this question we sought to ascertain what would act as a trigger for accessing preventative health care amongst homeless people, of whether homeless people generally would only seek help when very unwell. Whilst one individual who felt that many homeless people were generally homeless as a result of their own personal ‘deficiencies’ such as substance misuse leading to reliance on benefits and would access a GP “*to get a sick note to claim benefits and to sign on*”, the remaining respondents were clear that medical care was generally only accessed in an emergency.

However, there was a general consensus that if there was available preventative health care which was accessible to homeless people they would use it, and might even actively seek out a nurse or doctor who had time to spend with them and could see beyond their homeless status:

- *Only when a health problem has reached crisis point? [When most homeless people use health services]*

- *Mainly go for emergency care, rather than preventative care. It does depend on where the homeless person is mentally*
- *GPs don't tend to offer jabs, blood pressure checks etc. If there were a specific service would you use it? Where would it be good to hold the clinic? Yes [to use of specialist service]*
- *Somewhere that was already offering services, e.g. somewhere one can trust, or during meal times at Wycombe Homeless Centre. People would probably only use it if they were encouraged to come in. Most feel there is no point as no one really wants to help them so they don't look for help.*

Have you ever had a bad experience at a Dr's surgery/What puts you off seeking medical care?

Within the discussions on a perceived general reluctance for homeless people to access medical services (see above), and reprising the theme of stigma which arose repeatedly the following issues, we explored concepts of 'poor' quality of accessibility at GP surgeries, and (further below), what would lead to good quality health access experience for a homeless person.

- *After a serious seizure I went to see my Dr as advised by the hospital for a check up. They wouldn't offer an appointment for over 3 weeks. [Service user] became very aggravated over the frustration of the situation*
- *Receptionists: Can be judgemental, three words come into people's minds when they hear homeless: "Drugs, alcohol and dirty"*
- *Being judged by others. You will lie and cover up your situation*
- *Receptionists, who can be very rude, unpleasant, un-PC, asking for paperwork, which creates barriers*
- *Going to a homeless clinic can be degrading and judgemental*
- *Difficult to get post sent to you [if homeless]*
- *Time keeping, easy to miss appointments [when life is chaotic or might face being moved on from where sleeping, broken nights, etc.]*
- *You need a sympathetic doctor who understands the need for letters to be written to authorities regarding health issues in the correct format. You can be charged for the Doctor to write such letters. [For example, in relation disability claims or to apply for housing as a homeless person] Some waive the fee but not all do*
- *Red tape: there always seems to be huge barriers to prevent you from accessing the care you need: Having to keep explaining the same problem over and over again. We need a dedicated centre for homelessness, with the same staff available each week*
- *You need Doctors who are knowledgeable for say ESA [employment support allowance], it would be helpful to have a health advisor present or a support worker at the surgery to assist the Dr to write the correct form of letter, or for Doctors to be trained to understand what is required*
- *To seek advice by phone you often have to ring 0845 numbers or premium rate numbers. These are very expensive; you need a lot of phone credit*
- *Difficult to get letters from the Doctor without a permanent address and many surgeries contact you solely by telephone, this can be a real difficulty*
- *Sometimes you ring and they say they will ring you back within 3 hours, but that can be difficult if [your] phone is not charged enough.*

What would make accessing health care a good experience?

- *Wycombe Homeless Centre offer a great drop in centre [could add health services to the services available]*
- *Some GP's can be great and very caring, but it is a complete lottery. Need a General Policy on helping people in our situation*
- *Drop in centre rather than an appointment system; this would encourage people to go when they had the right frame of mind or why they were feeling positive*
- *GPs need to follow up on your health and not just assume that you are being treated. After a referral you never go back to see the GP. Homeless people are more vulnerable and need to have follow up to ensure that they did get treated*
- *Longer appointments of say 20-30 minutes would be much more helpful*
- *A one-stop place that you could have longer appointments: that would be a great help*
- *At the GP, longer appointments would be helpful to people with complex problems or are vulnerable. Or have a wide range of undiagnosed issues that need attention*
- *When you are run down, you may not even be aware that you are unwell, become used to feeling the way you are and need a Doctor to look you over and do some observations*
- *Double appointments are a good idea as it takes you a while to explain the problem as often lacking in confidence*
- *Flexibility of appointment times would help homeless people get to the surgery, offering the last appointment of the day helps some as the GP was prepared to stay on a bit longer to listen and help.*

Question: What does good mental health care look like?

We were concerned to seek to identify how best to meet the mental health needs of homeless people given the barriers to continuity of care and risk of sudden deterioration; self-harm or suicide identified within the literature review and the number of occasions in which mental health was mentioned by service users in questionnaires and within the focus groups. The following comments were received in relation (once again) to the necessity of flexible, responsive, easily accessed services to meet the needs of homeless people before their mental health deteriorated further:

- *Face to face meetings, rather than a phone call*
- *Quick turn-around/follow through from GP to actually seeing a specialist... [This individual mentioned that he received a GP appointment and saw a psychiatrist – with support from the NGO in] “Less than 6 weeks”. Although other participants felt that this was far too long to wait, it was acknowledged to be a relatively fast service - a tribute to support provided by supportive health care staff/NGO - and identified as probably the minimum time possible before seeing a specialist unless someone was in absolute crisis and seen at A&E in crisis]*
- *Trained people need to be available to see [someone] quickly*
- *People don't realise how totally depressing it is to be homeless, people are desperate and hanging on by their fingernails. Suicide can be a very attractive proposition*
- *It is incredibly difficult to trust people*
- *Most homeless people crave acceptance and often just need to talk to someone, even volunteers at a drop in centre if they are kind and supportive*
- *Depression can also cause self-harm, I feel like the way depression is treated is wrong and those who do reach for help are often forced to talk to strangers for long periods of time which may not*

be beneficial [this respondent favoured rapid access to mental health staff/counsellors who have familiarity with the needs of homeless people, preferably accessible in a familiar environment]

What dangers do homeless people face?

This question which links both to mental health status/wellbeing status as well as physical safety, resonates with the theme of social stigma which arose in several places within the focus groups; and indeed the chaotic lifestyle of many homeless people which in turn acts as a barrier to accessing services. Where relevant quotations in relation to danger/stigma were provided in relation to other questions; these have also been incorporated under this key heading to enable a rounded conception of the lived reality of homeless people's (and particularly rough sleepers') lives.

- *Lack of trust of other homeless people*
- *Centres ruined by other drunks and poor behaviour*
- *[Being] physically threatened (with a hammer) by members of own family to make you go away and leave them alone*
- *Face constant aggression and abuse from strangers*
- *Accessibility to health care is slow and hard, meanwhile things then get worse. Help needs to be available quickly for when a homeless person is in the right frame of mind to say give up drugs not having to wait 6-8 weeks to see someone*
- *A & E is a safe place to sleep over night if you pretend you are waiting to be seen. Similar to sleeping at Heathrow, pretend you are travelling and also the night bus*
- *Homeless women and risk: [Women] tend to cling on to someone for protection and this makes them even more vulnerable. [Homeless women are] at risk of rape and sexual violence. Often, many more men than women [are homeless and sleeping rough], which again makes them more vulnerable. Women tend to sofa surf more, especially if they have children. Often they are reluctant to ask for help as they fear children may be taken into care as a result of their addictions [formerly homeless, but accommodated, female participant] N.B. links to discussion above re gendered issues of homelessness.*

What special services should be available to homeless people?

Participants were asked to identify what specific health services should be made available to people in their situation, whether accessible through GP surgeries or via (as was made clear by participants, their preferred access route) a dedicated health care and associated 'one-stop' service for homeless people at an accessible location:

- *Immunisation against flu available during the winter*
- *Evening appointments would be helpful or at least after midday. Homeless people find it difficult to get up in the morning, due to lack of sleep. [N.B. The topic of broken night sleep as a result of noise, danger, cold etc. emerged on several occasions in relation to rough sleeping, sleeping in cars and also in hostels, which could be noisy]*
- *A central clinic that provides consistency and understanding, not judgemental. More likely to go earlier in an illness, before it gets really bad*
- *Once you are at a Health clinic you may take up use of other services such as feet care, nurses to clean wounds. Best to start at the bottom with a nurse's appointment, and then get referred "up" to see a Doctor if you have problems. More likely to make a nurse appointment*
- *Create a "health check" service while you are under the centre's roof. Nip problems in the bud before they get too big, or cover several issues in one visit, while they are there*

- *The atmosphere within [a] centre is very important, needs to be friendly and supportive. Almost like a baby clinic style but for homeless people- but with dignity [female participant]*
- *Drop in Clinic would be a much better idea than an appointment system, makes it much more likely to attend. Time keeping is very difficult if you are homeless*
- *Dentists cannot really attend drop in centres, it is incredibly difficult to see a dentist when you are homeless. Very hard to find an NHS dentist to accept you. [There was general agreement that whilst dentists are almost unheard of in homeless clinics, access to dental care would be greatly welcomed by service users].*

What services would you like to be provided if a dedicated homeless health service were to be provided in the area?

Given the clear multifactorial needs of this group of clients, and recognising that holistic approaches have been repeatedly identified in the literature as highly effective in meeting the needs of homeless people⁴⁹, this final question was aimed at eliciting information on preferred services which homeless people would like to see made available in a dedicated facility, over and above access to medics and nurses.

This element of the focus groups attracted the greatest interest from participants, all of whom were eager to make suggestions which were practical, generally low cost, and would in their experience be well-used by homeless people in the area; offering the authors' of this paper would suggest, a cost-effective range of solutions given the health status of homeless people (see further below for sample worked examples of costs associated with unmet health needs of homeless people).

Some discussion took place in relation to how homeless people would find out about the services on offer but there was general consensus that

- *Information sharing makes what is available well known amongst the homeless community.*

One individual also commented that whilst younger people who were homeless were often more self-sufficient and likely to attend at A&E, or other services - at least in earlier stages of their homeless career - knowledge of availability of dedicated, sympathetic service provision would be important for older homeless people:

- *Age is important. Younger people try to sort themselves out without seeking help [unlike older people] very young homeless man.*

As the discussion took place over facilities that could be made available at a specialist drop-in service, several people commented on the fact that if they are taking medication it could be difficult retain it safely and as such, having access to a storage facility at a drop-in centre could be a useful solution.

⁴⁹ Cameron, A., Abrahams, H., Morgan, K., Williamson, E. and Henry, L., 2015. 'From pillar to post: homeless women's experiences of social care'. *Health & social care in the community*; Cornes, M., Manthorpe, J., Hennessy, C., Anderson, S., Clark, M. and Scanlon, C., 2014. 'Not just a talking shop: practitioner perspectives on how communities of practice work to improve outcomes for people experiencing multiple exclusion homelessness'. *Journal of interprofessional care*, 28(6), pp.541-546. Arblaster, L., Lambert, M., Entwistle, V., Forster, M., Fullerton, D., Sheldon, T. and Watt, I., 1996. 'A systematic review of the effectiveness of health service interventions aimed at reducing inequalities in health'. *Journal of Health Services Research*, 1(2), pp.93-103.

- *An individual was on numerous drugs for epilepsy and found it difficult to physically carry around a month's supply of medication. He had nowhere to store them safely. Similar problem with insulin, refrigeration need etc., and morphine too. [Staff member co-facilitating focus group]*
- *Have pharmacists ever offered to store it [medications]? No, approached the police station for information as to where to store it. Chemist was of no help whatsoever, didn't offer to store it. [Follow up questions re above asked of focus group participants in relation to the challenges of having medication/controlled drugs without access to fridge etc.]*
- *Somewhere to have a shower, and lay down to sleep safely*
- *A mixture of Wycombe Homeless Centre and the Hub so they can do everything in one place, charge phone, laundry, shower, medical care etc.*
- *Drop in centres can offer health care, hairdressers, foot care, dentists and mental health specialists*
- *Mental issues are more important; they [homeless people] really do need specific help to overcome their issues. They need much more support to face their problems [than do many other groups]*
- *A drop in centre that offers a wide variety of services including mental health would be very welcome. Especially due to cut backs in other voluntary sectors e g MIND*
- *What should be available at this ideal drop in centre? Substance abuse counsellors, foot care, diabetes checks, dressing of sores and wound, staff with experience of homeless people, who can empathise with [service users] problems*
- *Sign posting to other services would be good, nurses can be more approachable sometimes rather than a Dr so it would be good to have some available to do most of the screening at the drop in centre. Social workers could be available for a chat*
- *Good foot care is very important and also dental care being available*
- *A barber would be helpful to keep hair under control, and would help raise self-esteem. Perhaps getting links with a local college and use trainee hairdressers. If you are happy it helps your mental health*
- *Sexual health. It would be a good idea for sexual health to be available at a one-stop shop. Some homeless people turn to prostitution to fund their lives*
- *TB is on the increase now and pleurisy too. We need screening to prevent the spread of diseases. Again a drop in centre would catch these people and provide them access to care*
- *Opening times would ideally be say one morning and one afternoon a week. To cater for all types of people and those who may have part time work or have difficulty get up in the morning due to depression*
- *An opportunity to use the Internet at the drop in centre would be very helpful*
- *Winter can be a more demanding time of year health wise as once you become cold and damp you become more vulnerable to illness perhaps more access to be available during the Winter months?*
- *Would having a health advocate be a useful addition to the homeless community? [Follow-up question] to provide health advice and sign posting to different services? Yes possibly.*

As can be seen from the focus group summaries there is a strong preference amongst participants for access to dedicated services, available through pre-existing 'known and trusted' locations such as

NGO bases, findings which coincide with perceptions of health care expert working in the field in the UK and internationally⁵⁰, in terms of the positive health outcomes for homeless people and their engagement in health promotion activities.

To enable enriched discussion of this finding (that dedicated services are preferred by homeless service users) in the concluding section of this report (Section 8); we summarise common examples of health care delivery models provided to homeless people which can be read in conjunction with the findings above to enable discussion of potential service design within the High Wycombe and Aylesbury areas should such a service be commissioned.

⁵⁰ Oliver et. al. 2010. 'Outreach and Engagement in Homeless Services: A Review of the Literature' *The Open Health Services and Policy Journal*, 2010, 3, 53-70 offers a meta-analysis of findings in relation to outreach services to homeless people in Canada <http://homeless.samhsa.gov/ResourceFiles/m1tifkgu.pdf>; (accessed 28-1-16) and Kertesz, SG, Holt, CL, Steward, JL et al. 'Comparing homeless persons' care experiences in tailored versus nontailored primary care programs'. *Am J Public Health*. 2013; 103: S331–S339. For a UK summary see further: Hwang, S. W and Burns, T. 'Health interventions for people who are homeless' *The Lancet Volume 384, No. 9953, p1541–1547, 25 October 2014* and Coles,E.; Themessl-Huber,M and R. Freeman 'Investigating community-based health and health promotion for homeless people: a mixed methods review' *Health Educ. Res.* (2012) 27 (4): 624-644. <http://her.oxfordjournals.org/content/27/4/624.full.pdf+html> (accessed 28-1-16)

7. Case Studies - Service User Profiles and Costings

In this section, we have detailed some of our Service User's profiles, and given worked examples of simple service delivery costings.

7.1 Case Studies of clients accessing services

During the final stages of the research we requested examples of case histories and 'health pathways' experienced by clients/service users supported by staff from local homelessness agencies, to enable us to gain a rich and nuanced picture of a 'typical' service user in the locality.

Whilst these case studies provide an indicative snapshot of health conditions and circumstances common to homeless people in High Wycombe and Aylesbury, the picture painted is indeed broadly similar to other examples of client studies found in the literature (albeit with lower levels of EU migrant homeless), and of course within our survey findings outlined above.

In total five indicative case studies have been provided by local NGOs/Voluntary Sector support agencies working with homeless people and two of these case studies are (below) treated to a simple cost analysis to identify the likely fiscal cost to health services and social care agencies of late provision of services with an associated discussion on the potential savings which can arise from ensuring access to timely health and associated care delivered at an earlier stage.

In undertaking the costings review below we utilise a light-touch methodology based upon methodologies common to a range of in-depth health audits and specialist reports on the 'cost of homelessness'⁵¹.

Case studies have been anonymised and clearly identifying data (including agencies accessed by the service users) have been removed.

Health Audit Case Study 1

Gender: Female

Decade of Birth: (1980s)

Ethnicity: White English

Background: The client lost custody of her son after getting into difficulties following the death of her mother in 2012. She experienced problems with addiction and also became homeless shortly afterwards. She stayed in our night shelter between January and February 2013 and we then managed to find her accommodation. She kept this accommodation until April 2014 when she became homeless again. She has remained homeless since.

Health issues: The client has received ESA for alcoholism but is now suffering primarily from depression and anxiety. This got worse following her witnessing the death of a close friend. She also has a propensity to self-harm.

⁵¹ E.g Berry, M. and Horn, M., 2003. *Counting the cost of homelessness: a systematic review of cost effectiveness and cost benefit studies of homelessness: final report*. Canberra : Australian Housing and Urban Research Institute; Dept. Communities and Local Government. 2012. *Evidence Review of the Costs of Homelessness* London: DCLG
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/7596/2200485.pdf
(accessed 10-1-16)

Health and associated services involved with client: The client has contact with her GP for health assessments for ESA.

Difficulties in accessing and interacting with these services: The main difficulties that the client suffers from when trying to access health services are that she struggles to keep to appointments. She believes that this is equally due to her homelessness which affects her capability to be organised and her mental ill health.

The impact this has had: The client's health has continued to deteriorate which is putting her increasingly at risk; this has also caused significant suffering on her part.

Health Audit Case Study 2

Gender: Male

Decade of Birth: (1960s)

Ethnicity: Unspecified

Background: Client X is 52-year-old male who was referred into our night shelter. He had been sleeping rough since his partner had been hospitalised due to chronic health issues and he had no access or legal rights to the property.

Health issues: On admittance to the night shelter client X had a number of health conditions:

Physical health: severe deep vein thrombosis affecting his mobility, stomach ulcers, incontinence, infected feet, Irritable Bowel Syndrome (IBS), kidney stones, urinary incontinence and general poor health due to chronic alcoholism.

Mental health: chronic depression including several serious suicide attempts requiring hospital admission. Poor memory.

Finances: Client X was in receipt of Employment Support Allowance

Health and associated services involved with client: Client X attended our night shelter for 7 nights. During this time we had to call emergency services on a couple of occasions due to concerns around the client's mobility and pain due to DVT. We were unable to meet his support needs as he was incontinent, needed assistance with washing and dressing and needed his feet bathed and dressed each evening. On a couple of occasions his toenails fell off during being bathed.

AHAG referred the client to AVDC as we felt that his medical needs would indicate that he was priority need. The client had poor engagement with his GP but was well known to A and E services. On one report he had 4 admissions in 2 days.

AVDC housed the client in temporary housing in Griffin Place. [AHAG] provided bedding, incontinence pads, clothing and kitchen utensils and also provided the client with a phone so that we [AHAG] could continue to support him.

AHAG referred the client into Bucks Floating Support for an urgent assessment. We also referred him into Smart for his alcohol support. We liaised with the hospital who offered daily appointments for the client to have heparin injections and did an urgent referral to a chiropodist. We continue to liaise with his GP and tried to get the client to visit his surgery.

Unfortunately the client only managed to maintain his property for a week before being evicted.

The impact this has had:

Unfortunately the client returned to sleeping rough, which has caused both his physical and mental health to deteriorate.

Both Smart and Bucks Floating Support withdrew their services as he failed to engage. Chiropody offered an appointment 3 months later, but as he failed to attend, he did not receive his appointment and his case was also closed.

Client X continues to sleep rough. He occasionally turns up at our offices but only when he is in town collecting his benefits. He is too drunk for us to work with him when he arrives.

He is well known to emergency services and uses A and E on a regular basis. He regularly has injuries such as fractures, bruising and abrasions. His mental health remains very poor, with little motivation to change.

AHAG have really struggled to get our client the support and care he needs. He is unable to manage accessing support through appointments yet desperately needs a full assessment for his medical needs. If this was to happen we would be more likely to access the appropriate support and be able to retain housing.

Health Audit Case Study 3

Gender: Male

Decade of Birth: (1950s)

Ethnicity: White British

Background: The client has lived in the local area all of his life. He was evicted from his accommodation in October 2014 because the landlord wanted to sell the property. He wasn't able to find himself alternative accommodation and wasn't considered to be in priority need by Wycombe DC. We found him accommodation in February 2015.

Health Issues: The client suffers from anxiety and depression. He has previously been alcohol dependent and has said that he uses alcohol to self-medicate. He is now suffering from a heart problem which doctors have told him is a result of his alcohol intake. He had a heart attack in March 2015. He also injured his back and has had to wear a back brace for the past few months.

Health Services Involved: The main health services the client interacts with are his GP and the hospital (primarily A&E), as well as receiving help from STaRS, which includes a medical aspect for alcohol detox.

He is currently on Employment and Support Allowance as well as Disability Living Allowance, which requires him to get medical certificates from his doctor. We helped him to get a doctor when he moved to Wycombe.

Since we have known him he has been taken to hospital by ambulance 4 times (that we know of), in addition to this he has visited hospital as an emergency once, after being sectioned, and once after

not eating for a number of days. These (A&E visits) have been for being overly drunk; seizures; a heart attack and a back injury. He has also visited Wrexham Park hospital for appointments for his back injury.

Difficulties in Accessing and Interacting with these Services: The client has had numerous difficulties in accessing these services, the main ones being:

- He often misses appointments due to extreme anxiety. He is sometimes in a state of being unable to leave the house.
- He has had occasions of not picking up his medication due to both anxiety and back pain. Where appropriate and possible we have picked it up for him.
- He misses appointments and doesn't take medication due to memory loss. We have helped him to remember to take it. We have also had to suggest methods for improving his ability to remember to go to the pharmacy.

At the time of him losing his initial accommodation he found it hard to work with this GP (anxiety preventing him from getting to appointments, feeling that his GP didn't really understand his needs).

He has had a heart attack linked to his alcohol intake but wasn't connected up with STaRS (or a similar service) after being discharged from hospital. We had to do that [make referrals/connections] instead.

The Impact this has had:

Worsening health and added difficulties with housing.

His back injury occurred due to him falling over whilst drunk. If he had had better interventions with his drinking earlier, this might have been avoided.

His heart attack occurred due to him continuing to drink alcohol, as above it might have been avoided if he had had better intervention with that [drinking].

Wycombe District Council found him not to be in priority need for housing, due partly to noticing that he was drinking alcohol at the time that they came to visit him. Had he had a better working relationship with his doctor, this decision may have been possible to overturn with medical evidence.

Health Audit Case Study 4

Gender: Male

Decade of Birth: (1960s)

Ethnicity: White European

Background: The client originates from East Europe. He had worked in the UK for 10 years before becoming homeless in 2011. He then spent a number of years as a rough sleeper in Wycombe, being supported by Wycombe Homeless Connection. We found him accommodation in early 2014. With our support he has retained his tenancy since that time, with short instances of returning to rough sleeping.

Health issues: The client has had problems, mainly with his physical health. He suffers from alcoholism, seizures (which may be related to his alcoholism) and leg ulcers. In January 2014 he

received a head injury after being knocked down by a car. This has also led to him losing his sight completely in one eye and partially in the other.

Health and associated services involved with client: The main health services the client interacts with are his GP and the hospital (usually Stoke Mandeville).

He is currently on Employment and Support Allowance (ESA), which requires him to get medical certificates from his doctor. This was originally due to his leg ulcers, it is now also due to his eyesight problems.

Within the past year (September 2014 – August 2015) he has been taken to hospital by ambulance 4 times (that we are aware of). Each of these occasions has been due to him having seizures.

He is also an outpatient at the ophthalmology department at Stoke Mandeville.

Difficulties in Accessing and Interacting with these Services: the main difficulties the client suffers from when trying to access health services are:

He has memory problems. This can often mean that he misses appointments that have been set up for him both with his GP and the ophthalmology department. This has led to him having his benefits sanctioned and having to rely on food parcels at times. His eyesight also seems to be deteriorating.

When we are made aware of appointments set for him, he can be difficult to get in touch with to inform him of these. He often has no mobile phone, and only comes to visit us sporadically.

After being brought into hospital he is usually stuck there and has had to ask us to help him get back to Wycombe on numerous occasions.

He didn't receive suitable follow up care after his head injury. They [medical services] didn't pick up on the cause of his sight loss at the time, which seems to have led to it [sight loss] getting worse. We also had to ensure that he had his stitches removed and accessed some kind of follow up care. He was discharged to the Street at the time. We took him into our night shelter.

The impact this has had:

The client's eyesight has suffered.

The client's ability to work has decreased. This is especially important to him as a migrant from an EEA nation. He has lived and worked in the UK for long enough that recent rules changing the entitlement to various benefits to EEA migrants shouldn't affect him, but because he hasn't been in work for the last 4 years this was difficult to prove. It took a long time for him to pass his 'Habitual Residency' Test, which led to him building up rent arrears due to housing benefit not being paid. This could have led to his eviction.

The client is taken to hospital by ambulance regularly. This is expensive and might be avoidable if his seizures are better managed.

Health Audit Case Study 5

Gender: Male

Decade of Birth: (1960s)

Ethnicity: not provided

Background: Client Z is a 50-year-old gentleman who accessed the night shelter. Client Z grew up in Iran and following the death of his parents returned to England. He had a history of living in shared private rental accommodation that had been sub-standard, and has had issues with neighbours. When client Z came into the shelter he had voluntarily moved from his room in a house that was not the legally required size.

Health issues: Obesity, hypertension, asthma. No mental health issues diagnosed.

Financial Status: Client receives Job Seeker's Allowance.

When Client Z used the night shelter it was observed that he struggled to engage with other clients and appeared socially isolated. He spent many hours researching in the reference library. It was also noted that he snored very loudly, which caused issues with other guests.

Health and associated services involved with client: Following concerns [staff] contacted Client Z's GP. GP stated that he had had also had a call from the Job Centre and agreed to give the client a 20 minute appointment and requested that a caseworker attended.

Following the appointment, the client was referred to a Sleep Clinic in Oxford and also for an Autism Assessment. He was also placed on Employment Support Allowance.

We were able to support the client through this process and he was diagnosed with severe sleep apnoea and was given the appropriate medical intervention. This has resulted in an improvement in his weight, general health and he is now volunteering [potentially a step into employment].

AHAG were able to house Client Z in a self-contained property that was well maintained and safe. We referred him into Bucks Floating Support who continue to support him in maintaining a tenancy. Client Z has maintained his property for over a year and a half, which is the longest period of time he has sustained a tenancy.

The impact this had had: Being able to access the right medical diagnosis has enabled Client Z to access the support and housing he deserved.

7.2 Costing for selected case-studies

In the second part of this section of the report we provide a simple costings pathway for two of the above case studies to demonstrate the cost to public services in the Wycombe and Aylesbury areas occasioned by un-serviced health care needs of homeless clients. Undertaking this exercise enables consideration of potential savings to the public purse (in addition to uncountable human cost) which could potentially be made through delivering targeted health and wellness support services for homeless clients with a particular emphasis on substance misuse, mental health and rehabilitation (areas all highlighted by service users within the questionnaire/survey and focus groups - see further above).

In undertaking this exercise we have elected to concentrate on Case Studies 3 and 4 as exemplar cases; although would also note that in relation Case Study 1 (homeless woman) should successful support and intervention be provided and prove successful, a potential might also exist for carefully monitored family reunification/contact with children removed to foster care, occasioning greater

savings still in terms of the public purse as well as enhanced well-being for the mother who is currently experiencing physical and mental ill health.

Case Study 5 as an example of successful support and intervention through liaison between service providers and flexible care delivery (longer appointment with GP) demonstrates clearly the scope for tailored health pathways and reintegration into mainstream society of service users and should support be retained, based upon the fact that the client is now 'volunteering' leads to consideration of the opportunities for re-entering employment. N.B. Within the focus groups on more than one occasion clients referred to the fact that if their lives were more stable they would be interested in returning to employment; and three participants suggested that they would be interested in acting as volunteers to help assist and reassure homeless service users coming into contact with homeless health outreach/drop-in services should such services be developed; offering once again an indication of the wider 'ripple' effects which may occur if supported services were delivered for this population through the medium of existing NGOs.

Costs and potential savings on Case 2 are harder to calculate given the very complex needs, severity of condition at the time he came into contact with services and that the client was unable to retain accommodation for more than one week. However we would suggest that if he was able to remain in highly supported residential accommodation with access to health care located at a single location (i.e. within an NGO facility) whilst working with known and trusted specialist health staff, it might prove possible to stabilise his condition with savings broadly similar to those in the worked examples below.

This very simple modelling is based upon calculation of incidents of known contact with medical/A&E services by the client in question; with the presumption that at an absolute minimum 50% of fiscal cost could be saved through the medium of access to tailored, supported services. Should medication maintenance and stabilisation occur as a result of the client accessing regular health maintenance and access to services delivered within community/homeless sector settings the cost is likely to drop further as physical and mental deterioration is slowed; new conditions are identified at an earlier phase leading to faster treatment times; less incidents of hospitalisation and associated reduced cost. For some clients (e.g. see Case Study 5) there is an opportunity to create successful interventions which may permit of access to supported housing, reduction in substance misuse and opportunities for volunteering and ultimately employment.

The Department of Communities and Local Government 2012 study into the "Costs of Homelessness"⁵² noted that a meta-analysis of a range of assessment studies aimed at calculating the costs of homelessness found that rough sleepers in particular were the most costly group but overall, each homeless person cost the public purse around £24,000-£30,000 per annum. Given that they suggest offending behaviour (often anti-social activities or associated with substance misuse, particularly alcohol) is interwoven with street homelessness it was also relevant to note that the same study gave figures from the Ministry of Justice which suggested a conviction (regardless of sentence) cost, in policing, legal aid and court time around £16,000 per incidence. Estimated costs given above, are, in the intervening 3.5 years likely to have increased.

⁵² CLG. *Evidence review of the costs of homelessness*. August 2012. London, Department for Communities and Local Government

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/7596/2200485.pdf

In terms of calculation of costs of specific treatment/appointments and A&E visits the source is the 'standard' compilation of data, updated on an annual basis to reflect current NHS costs.⁵³

Costings for Case Study 3 (to be read in conjunction with narrative above):

This client has (in terms of typical client base) medium use of hospital emergency services, although his care and health maintenance can potentially be supported more effectively through access to a specialist healthcare service with fortnightly or monthly appointments in a community setting.

Based on the narrative above this calculation assumes an average of six hospital attendances per year, at minimum cost of £112 per occurrence when the client self-refers and is ambulatory/not admitted as an in-patient, £345 if taken in by ambulance and not admitted and £953 if admitted by ambulance and has a 'short' single night stay costed at an average of £608 per night). This sum is before costs of follow-up treatment are counted.

Appointments for this client at specialist outreach homeless healthcare services, emergency and hospital care over a 12-month period were estimated (likely under as costing conservatively)

Table Three		
A&E Attendance	X 6 (£112 x per contact)	£672
Hospital Treatment (Average cost) (Out-patient)	Physiotherapy (back) x 2 appointments £20 per 30 mins)	£40
	Alcohol Service/'overly drunk' (£56 per appointment x 1)	£56
	Mental Health Services £130 per contact (£206 if A&E primary access route) x1	£206
Hospital Treatment (In-patient)	'Heart attack' assume 2 nights in-patient care (£608 per night) hospital	£1216
	In-patient acute psychiatric illness 'sectioned' x 3 nights (£521 per night)	£1563
Cost of Ambulance Service ('See, treat, convey')	(£231 x 4 episodes) = £924	£924
Missed Appointments (calculated x 6 per year – potentially an underestimate)	£46 per primary care/GP appointment assumption. Hospital appointment (varies by unit/service) e.g. £130 per session - alcohol services in hospital setting; £130 per specialist mental health service contact per session; £60 appointment with Registrar led service (back problem)	AVERAGED COST OF MISSED APPOINTMENTS (12 month period) Based on an average cost per missed appointment (Sum achieved by mean cost per unit of services accessed) £76 x 6 = £456
TOTAL COSTS PER YEAR (2014-15)	<i>Excludes</i> additional appointments, treatment costs/X-Rays; scans and services over and above those listed above	£5133

Personal and Social Services Research Unit, University of Kent "Unit Costs of Health and Social Care 2015" compiled by Curtis, L. and Burns, A. for the PSSRU. Canterbury: PSSRU <http://www.pssru.ac.uk/project-pages/unit-costs/2015/index.php>

Costings for Case Study 4 (to be read in conjunction with narrative above):

This client as a result of missed opportunities to engage with his health care needs at an earlier phase has high use of hospital services including emergency care. Similarly to Case Study 3, the data is suggestive of the fact that regular contact with a multi-disciplinary team at a single set location might prove more accessible and sustainable to this gentleman who has memory loss, visual impairment and alcohol dependency in addition to seizures.

We have made a number of conservative assumptions in terms of average appointments per annum (based on average practice) re ophthalmology and nurse-practitioners; GP services in relation to treatment for leg ulcers, seizures; primary care maintenance/contact with GP to enable access to ESA and a single alcohol service appointment per annum. This is based conservatively on presumptions given the state of knowledge available re medical contacts, although it is believed that this is likely to be an underestimate of actual service use and/or missed appointments costs.

Whilst this gentleman is not apparently accessing on-going rehabilitative support the PSSRU reference costs estimate that the *average* cost of health and social care support in 2015 in relation to ‘acquired brain injury’ for a mild-moderately injured individual with ongoing symptoms (such as might well be considered to be the case for this client given seizures and head injury) are £21,888 per year to assist with support (i.e. those elements detailed in the case study re support in attending hospital; collection of medication etc.) although this care is often supplied by relatives/informal carers such as staff at NGOs in the Wycombe and Aylesbury report delivering at no cost to the local authority/state.

Table Four		
A&E Attendance	X 4 (£112 x per contact)	£448
Hospital Treatment (Average cost) (Out-patient)	Alcohol Service (£56 per appointment x 2)	£112
	Epilepsy services x 4 (£91 per appointment)	£364
	Ophthalmology services (consultant led) x 4 (£118)	£472
	Leg Ulcer/Medical clinic x 2 (£48) nurse led	£96
	Dietician (malnutrition re poor diet) x 2 (£38 per appointment)	£78
Hospital Treatment (In-patient)	Seizures X 4 (£521 per night inpatient)	£2084
Cost of Ambulance Service ('See, treat, convey')	(£231 x 4 episodes)	£924
Community treatment (GP and nurse appointments)	6 episodes per year @ £46 per year GP appointment	£276
	4 per year nurse/dressings @ £25 per appointment	£100
Missed Appointments (calculated x 6 per year – potentially an underestimate)	£46 per primary care/GP appointment assumption Hospital appointment (varies by unit/service) e.g. £118 per consultant led visual impairment	AVERAGED COST OF MISSED APPOINTMENTS (12 month period) Based on an average cost per missed appointment (sum

	clinics; £91 per epilepsy/ seizure clinic Rehabilitative community session (neurological/ acquired injury – mainly physically stable patients with cognitive/ behavioural disabilities (local services) £407 (full day unit attendance) £25 per nurse led contact/dressings on legs)	achieved by mean cost per unit of services accessed) £160.25 x 4 (N.B: High cost of rehabilitation services inflates costs) £641
TOTAL COSTS PER YEAR (2014-15)	Excludes additional treatment costs/X-Rays; scans and services over and above those listed above	£5595

As can be seen, the costs of provision of services (and in particular costs of missed appointments) are relatively substantial, based purely on these two cases studies. Review of the survey data above indicates that these cases are typical and not especially expensive, given the higher rates of A&E access and hospital admission amongst this client group. Moreover as demonstrated within the survey findings in the sample for the local area there is a higher than to be expected incidents of TB and Hepatitis C although we were not able to cost treatment /access costs for such clients based on case studies provided.

Whilst without considering full set up costs for an outreach health unit for homeless people (even assuming relatively low costs if based within an existing 'space' utilised by homeless people and provided by NGOs) with the team consisting of specialist nurse, GP, social work practitioner (attending at a community location on two occasions per week) and a dental practitioner available for one session per month; it is still to be expected that enhanced continuity of care will be provided to 'hard to reach clients' ensuring greater treatment compliance including attendance for appointments, given that health staff engaging with specialist outreach services will have records of follow-up appointments and referrals, and that hospital services will have a central contact point.

Overall it is likely, based upon existing models (see further below) and cost-benefit analysis of similar services, that there would be substantial cost savings to be made to local health services as well as alleviating human suffering by providing specialist in-reach services located in community settings.

The following figures are based on calculations of the average 'per appointment' cost for provision of a specialist drop-in clinic (with assumptions of 'benefit' based on findings from reports into specialist 'in-reach' drop-in clinics⁵⁴); enabling consideration of the average savings provided in relation to the above clients. These figures are coupled with assumption (based on cost-benefit analysis and assessments of existing homeless health services see above) of an average 50% reduction in service costs associated with health maintenance for homeless people delivered

⁵⁴ For example see worked examples in Leeds GATE (2012) *Gypsy-Traveller Health: Who Pays? Cost Benefit Analysis – Gypsy and Traveller Health Pathways* Leeds, LeedsGATE http://leedsgate.co.uk/sites/default/files/media/Cost-Benefit-Analysis-report-Gypsy-and-Traveller-Health-Pathways_0.pdf and St Mungo's (2013) *Health and homelessness: Understanding the costs and role of primary care services for homeless people* London, St. Mungos. <http://www.mungos.org/documents/4153/4153.pdf> (both accessed 28-1-16) Van Leerdam, J (2012) *Analysing Costs and Benefits of Homelessness Policies in the Netherlands: Lessons for Europe* Amsterdam: UoA http://www.feantsaresearch.org/IMG/pdf/jvl_review.pdf (accessed 30-1-16)

through supporting their access to mainstream provision e.g. attendance at GP and outpatient appointments, less A&E attendance; fewer in-patient episodes for homeless people etc.

Table Five
Average cost of half-day specialist outreach clinic (2015 figures)
Cost of one GP, and two nurses for 3 hours (GP: £207 x 3 hours (figure excludes GP practice overheads on assumption community provided location) = £621
Nurses £59 x 3 hours x 2 (salary only: costs include on-costs) = £354
TOTAL £975
Assumption that 8 clients are seen per session (GP) and 15 clients (nurses) allowing for mixture of longer and shorter appointments) costs savings can still be expected to accrue in terms of savings = average cost per client of £42.39 per contact with health care staff (23 contacts in total).
(Costing excludes specialist alcohol/mental health staff and/or sessional dentists/chiropractist/social worker outreach team involvement in sessional activities)

Client in **Case Study 3** (assume cost of 20 appointments at outreach service in community setting (potentially reducing in year 2 onwards as situation stabilises) average cost: £43 per contact to support health maintenance = £860 and reduction by 50% in missed appointments and avoidable decline in health care necessitating hospital treatment/A&E) = minimum savings of £1706.50 per annum.

Client in **Case Study 4** (undertaking the same calculation for client in Case Study 4 – with an assumption of 30 appointments per annum in the initial year based on more complex needs = cost of outreach service appointments of £1271.70) equates to a minimum saving of £1525.80 per annum with potential to decrease costs of access to specialist services in subsequent years if medical compliance develops/stabilises and there is a reduction in the need for associated appointments at specialist services if existing health conditions do not deteriorate further.

Conclusion

Based on the above calculations and review of available evidence we would strongly recommend that consideration is paid to the development of a homeless health service in the High Wycombe and Aylesbury areas (at least on a pilot basis) which utilising existing networks such as NGOs, to engage with the most vulnerable and hard to reach populations.

Our recommendations are based on a combination of fiscal savings; public health considerations (given evidence above in relation to evidence of increased rates of communicable disease amongst this population and our presumptions (outlined above) with regard to a growth in the homeless population in the years 2016-2020); as well as humanitarian considerations and a desire to enhance the health and wellbeing of this group of service users.

8. Examples of delivery models for homeless healthcare

Whilst the research team does not make any *specific* recommendation with regard to a particular model of homeless health service delivery, considering that this is best left to local commissioners in the light of available budget and local circumstances, we would draw attention to the comments and preferences cited by service users in Section 6 of this report (focus group data) above in terms of preferences.

To assist commissioners in exploring a range of services (should such commissioning occur) we briefly summarise below some examples of existing models of homeless health service delivery successfully utilised elsewhere in the UK to meet the needs of this population.

Examples have been collated following consultation with GPs and nursing staff involved in delivering a variety of models of outreach or specialist healthcare; and also in discussion with Dr Nigel Hewitt Medical Director of Pathway⁵⁵ the specialist medical charity working in the field of homeless health.

Watford and Leighton Buzzard models: Semi-specialist drop-in provision provided within a mainstream GP practice, funded under **Locally Enhanced Services (LES)** schemes. **CCG's can provide this funding to GPs to provide additional services.** In Chelsea (for example) they have re-badged this as Out of Hospital Services. LES essentially enable the provision of an additional fee per homeless patient in return for longer appointments, or permit of drop in surgeries or outreach to a hostel or day centre, the specification for services delivered may include health checks, vaccinations, screening for blood borne viruses and signposting for dental and foot care.

Provision of this service does however require access to GPs with a particular interest in working with homeless people but input from various GP surgeries could potentially be contracted, and this could be adapted to enable practitioners to either delivering care at homeless projects or offering sessions at their own surgeries. It is recommended however to provide continuity of care and support attendance that GPs/nurses should provide care at known and trusted locations e.g. WHC or AHAG and the Old Tea Warehouse, as it could take some time for homeless people to become familiar with specific surgeries and if a GP then changes location, trust may be lost.

Multiple Service Delivery (health care and onward referral to social care and employment advice) Practice: Nurse-led outreach in conjunction with fast-track access to multi-disciplinary specialists in a range of areas including housing; social care; specialist GPs, delivering targeted services (e.g. staff expertise in working with homeless people and offering longer appointments etc.) available at a single location either a surgery or located in a hostel for a short period each week. This may work best for individuals accessing hostel accommodation (rather than rough sleeping) but could be combined potentially with Homeless Change⁵⁶ service delivery.

Simplified nurse-led health care (excluding employment and benefits advice etc. noted in model immediately above): Whilst largely similar to the example above, in being nurse-led, this service offers only health care/advice but again is typically commissioned by CCGs, although provided by a Community Health Trust in the same way as District Nursing services. This model is simpler and more flexible, working with local GP practices, and may include funding for one or two GP outreach sessions per month, but are predominantly nurse run.

⁵⁵ <http://www.pathway.org.uk/services/>

⁵⁶ Department of Health (2015) *New fund to improve the health of homeless people* (press release, 15-3-15) London: DH <https://www.gov.uk/government/news/new-fund-to-improve-the-health-of-homeless-people>

Strategic Health Partnership model: A team of multidisciplinary staff and outreach workers engaging with a range of 'vulnerable/hard to reach' communities including refugees and homeless people. Services delivered as part of an overall homelessness strategy with strong links to housing departments and social care teams. Provision of **walk-in clinics at strategic locations** involving multi-disciplinary health teams including chiropodists; dentists and GPs, mental health staff; nurses etc. and co-delivery of other advice services.

Primary Care for Homeless People (Camden Model): Whilst most cost-efficient when working with a large homeless population such as are found in Central London, the PCHP in Camden is based at a hospital but provides outreach to hostels, day centres and going out to rough sleepers at diverse locations. Various locations are linked through a shared IT system to avoid dual prescribing and ensure continuity of care. Doctors and Nurses are available on site in the hospital setting and attend at satellite locations.

Homeless Day Centre (Barnet, North London): Offers access to a (health authority funded) part-time nurse and part-time community psychiatric nurse with sessional input from GPs, dentists, and a chiropodist and an optician.

The 2003 report by Sarah Gorton⁵⁷ (a member of the advisory panel for his study) undertaken on behalf of Crisis, provides further information on a range of models although funding options and organisational issues have inevitably changed significantly in the years since this study was produced.

The Queens Nursing Institute (QNI)⁵⁸ who work very closely with Pathway, Inclusion Health (Department of Health) and a variety of homelessness charities, both convenes the UK's largest network of several hundred nurses working with homeless people and publishes regular free research updates, newsletters and access to information and training resources for staff working in this specialist field. In addition, the QNI offer small grants to support development work for staff delivering homeless healthcare projects.

In a changing financial and commissioning landscape with resource reduction and shifting priorities it is not possible to identify all available best practice models and ongoing services which deliver health care to homeless people; but the information above provides a range of examples for consideration in relation to the development and commissioning of a local homeless health services.

⁵⁷ Gorton, S. (2003) *Guide to models of delivering health services to homeless people* London, Crisis.
<http://www.qni.org.uk/docs/delivering%20health%20services%20to%20homeless%20people%20CRISIS.pdf>
(accessed 26-1-16)

⁵⁸ http://www.qni.org.uk/for_nurses/homeless_health/homeless_health_guides_and_reports

9. Conclusions and Discussions

This report summarises a range of information and findings in relation to both local service needs and the overall national homeless health profile. We have sought to provide a comprehensive picture, as well as information in relation to 'future proofing' services which may be developed, based on assumptions of population growth and demographic change including in-migration. Fiscal (and indeed social) costs are discussed in relation to our recommendations as are a variety of models for potential service delivery.

In conclusion to this report, we would again emphasise that in our opinion, money spent to deliver a targeted homeless health service is essentially well spent given the potential to reduce costs in terms of inappropriate health care access. In 2013 the NHS Intelligence Unit North West London study reported that supporting 933 rough sleepers between January 2010 to June 2012 cost £2,339,216 and that over £1.3 million was spent on inpatient admissions during this period.⁵⁹ Whilst High Wycombe and Aylesbury are looking at a vastly lower figure for homeless service users at even 5% of the number in the INWL (around 46 people which is broadly similar to the sample identified locally), the potential cost to the public purse is vast.

To emphasise this point further and bearing in mind the dramatically increased homeless population in the years since this latter study was published in 2009; the MEAM manifesto published in 2009⁶⁰ contains sample costs of support for a man with multiple needs who had previously been sleeping rough in London. The total for one year since moving off the streets was £24,350 (hospital costs £150; drug treatment £3,000; medication £400; day centre services £1,800; accommodation and support £19,000). Even removing the expense of day centre and accommodation, these costs are considerable, but noticeably lower than the report's presumptions pertaining to the expense of unsupported health and social care needs that arise for homeless people.

Indeed the MEAM provided case studies of individuals with multiple needs, both with recent episodes of homelessness, for whom drug treatment/detox costs, and mental health support costs, were reduced from £16,000 to £2,700 and £32,000 to £3,000 in moving from a state of homelessness with more piecemeal support, to stable accommodation with a more comprehensive and coordinated support provision.

Overall, we should suggest that our findings and recommendations bear strong synergies with the CLG (2012)⁶¹ study on the costs of homelessness, and that the evidence collated in this report indicates the critical need to delivering psychosocial support to local homeless people to reduce costs and improve human wellbeing within the High Wycombe and Aylesbury locality.

⁵⁹ at p42 INWL (2013) *Rough sleepers: health and healthcare* London: INWL (accessed 30-1-16)
<http://www.jsna.info/sites/default/files/Rough%20Sleepers%20Health%20and%20Healthcare%20Annex.pdf>

⁶⁰ Making Every Adult Matter (2009) *MEAM: A four-point manifesto for tackling multiple needs and exclusions* London: MEAM (at p22) <http://www.gulbenkian.org.uk/files/13-12-10-FP1%20MEAM-Manifesto.pdf> (accessed 30-1-16)

⁶¹ CLG (2012) *Evidence Review of the Costs of Homelessness*, London, CLG op. cit.

We conclude by stressing that whilst there is evidence of a need for targeted service delivery in the area, it is critically important that health improvement and promotion input must mesh with the needs identified by homeless service users working with experienced staff to build upon existing and trusting relationships. By following this route there will be incremental improvements in outcomes both in terms of reduction of fiscal costs, but equally importantly in terms of psycho-social functioning and fulfilling a moral obligation to support 'health for all'.

January 2016

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Appendix 1

Appendix of Charts, Tables and Figures

4.1 Introduction and Demographics

- Table one - Survey Respondents (homeless people accessing front line services OTW/AHAG/WHC) by gender and age (rounded percentages)
- Chart 1 - Illustrates data on age of respondents by survey site

4.2 Ethnicity/Nationality

- Chart 2 - Ethnicity of Respondents

4.4 Health Care Registration Status and Contacts with Medical Services/Preventative Care

- Chart 3 - Illustrates respondents' registration with GP, dentist services and number A&E visits in previous six months
- Table two - Survey Respondents site specific (homeless people accessing front line services OTW/AHAG/WHC)
- Chart 4 - Registration status with specific targeted services in respondent's local area?
- Chart 5 – Number of GP contacts in previous 6/12 months
- Chart 6 – Number of contacts / appointments with a nurse in the previous six months
- Chart 7 – Access to dental care / check-up in previous six months
- Chart 8 – Access to optical services / check-up in previous six months

4.5 Use of Emergency Care (Hospitals and Ambulances)

- Chart 9 – Use of ambulance services in the previous six months
- Chart 10 – Admission to hospital in the previous six months
- Chart 11 - Reasons for a) calling an ambulance or b) admittance to hospital

4.6 Services of most help in accessing healthcare

- Chart 12 - Agency or individual who provides the greatest help in relation to healthcare?

4.7 Physical Health of Service Users (substance use and exercise)

- Chart 13 - Tobacco use of respondents (100% response rate)
- Chart 14 - Regularity of eating 2+ meals a day on average
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- Chart 16 - Frequency of exercise: at least twice a week

4.8 Specific physical health conditions:

- Chart 17 - Respondents reporting chest pain/breathing problems
- Chart 18 - Respondents reporting joint aches/pain in muscles and bones
- Chart 19 - Respondents reporting 'feet problems' by duration
- Chart 20 - Respondents' suffering from 'fainting' or 'blackouts'

4.9 Satisfaction with services/support for physical health needs.

- Chart 21 - Percentage of respondents indicating that they are receiving/not receiving support for their physical health care needs

4.10 Mental Health Needs of service users

- Chart 22 - Illustrates responses questions pertaining to mental health of respondents
- Chart 23 - Number of respondents indicating that they often or frequently experience depression (by duration of condition)

4.11 Suicidal Thoughts/Self-harm

- Chart 24 - Respondents often or frequently experiencing suicidal thoughts (by duration)
- Chart 25 - Respondents who 'self-harm' by duration of self-harming

4.12 Mental Health Conditions (self-report and diagnosed)

- Chart 26 - Respondents diagnosed with a mental health **condition**

4.14 Access to support for mental health needs received from agencies, health practitioners etc.

- Chart 27 - Whether mental health support is received and is adequate/suitable
- Chart 28 - Desired mental health services

4.15 Substance Use Issues

- Chart 29 - Types of substance (drugs) utilised by respondents in the month prior to interview
- Chart 30 - Whether respondents consider that the advice/care they receive in relation to substance misuse is adequate or more is needed
- Chart 31 - Alcohol intake/regularity of alcohol use
- Chart 32 - Typical number of units of alcohol consumed on a day when respondent is drinking

4.17 Sexual Health

- Chart 33 - Take up of sexual health screening in the previous 12 months

4.19 Accommodation Data

- Chart 34 - Accommodation status at time of interview

4.20 Health Status impacting on employment, training or volunteering opportunities.

- Chart 36 - Whether health status impacts on respondents' training, volunteering or employment opportunities

4.21 Contact with prison/probation or 'looked after children' services.

- Chart 37 - Prison, probation or 'leaving care' status

4.22 Disability status of respondents

- Chart 38 – Disability self-reported by respondents

7.2 Costing for selected case-studies

- Table three – Average hospital treatment costings for case study 3
- Table four - Average hospital treatment costings for case study 4
- Table five – Average comparative costings for outreach clinic.

Appendix 2

Copy of E-Survey – Questionnaire administered to service-users

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 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:
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

1. HOW OLD ARE YOU?

No answer

2. WHICH OF THESE CATEGORIES BEST DESCRIBES YOU AT PRESENT?

Please tick **only one**:

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

- Stayed at a hostel, foyer, refuge, night shelter or B&B hotel, or any other type of homelessness service Age
- Stayed with friends or relatives because had no home of own ('sofa surfed') Age
- Slept rough Age
- Applied to the council as homeless Age
- None of the above Age
- No answer Age

Homeless Link Health Needs Audit

4. WHERE ARE YOU CURRENTLY SLEEPING?

(if this frequently changes, please say where you slept last night). Please tick **only one**:

- Sleeping rough on streets/parks
- In a hostel or supported accommodation
- Squatting
- Sleeping on somebody's sofa/floor
- In emergency accommodation, e.g. night shelter, refuge
- In B&B or other temporary accommodation
- Housed - in own tenancy
- Other (please state)
- 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
- Other relatives or friends no longer able or willing to accommodate
- Non-violent relationship breakdown with partner
- Abuse or domestic violence
- Overcrowded housing
- Eviction or threat of eviction
- Rent or mortgage arrears
- Other debt-related issues
- End of tenancy (social housing)
- End of tenancy (private rented sector)
- Financial problems caused by benefits reduction
- Unemployment
- ASB or crime
- Drug or alcohol problems
- Mental or physical health problems
- Leaving institutional care (e.g. hospital, prison, care etc.)
- Other (please state)

6. DO YOU HAVE ANY OF THE FOLLOWING BACKGROUNDS?

(This helps us to understand how your past experience may have affected your health or services you've been able to access)

Tick **all** that apply:

- Spent time in prison
- Spent time in a secure unit or young offender institution
- 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**:

- Male Female
- Other (please state)
- No answer

8. WHICH OF THE FOLLOWING BEST DESCRIBES YOUR SEXUAL ORIENTATION?

Please tick **only one**:

- Heterosexual or straight
- Gay or lesbian
- Bi-sexual
- 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
- English / Welsh / Scottish / Northern Irish / British
- Irish
- Gypsy or Irish Traveller
- Other white
- White & Black Caribbean
- White & Black African
- White & Asian
- Other mixed
- Indian
- Pakistani
- Bangladeshi
- Chinese
- Other Asian
- African
- Caribbean
- Other black
- Arab
- Any other ethnic group - please state:
- No answer

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

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

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

- Yes
- No
- 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**:

- Yes
- No
- 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

- Heart problems (heart attack, angina, murmur or abnormal heart rhythm) ○ ○ ○ ○
- Chronic breathing problems (bronchitis, emphysema, obstructive airways disease) ○ ○ ○ ○
- Asthma ○ ○ ○ ○
- Cancer ○ ○ ○ ○
- High blood pressure ○ ○ ○ ○
- Joint aches/problems with bones and muscles ○ ○ ○ ○
- Difficulty seeing/eye problems ○ ○ ○ ○
- Skin/wound infection or problems ○ ○ ○ ○
- Problems with feet ○ ○ ○ ○
- Fainting/blackouts ○ ○ ○ ○
- Urinary problems/ infections/ incontinence ○ ○ ○ ○
- Circulation problems/blood clots ○ ○ ○ ○
- Liver problems ○ ○ ○ ○
- Stomach problems, including ulcers ○ ○ ○ ○
- Dental/teeth problems ○ ○ ○ ○
- Diabetes ○ ○ ○ ○
- Epilepsy/seizures ○ ○ ○ ○
- HIV ○ ○ ○ ○
- Tuberculosis (TB) ○ ○ ○ ○
- Hepatitis C ○ ○ ○ ○
- Other (please state)..... ○ ○ ○ ○

13a. IF YES TO TB, HAVE YOU RECEIVED ANY TREATMENT? Please tick **only one**:

- Yes
- No, not offered any

13b. IF YES TO HEPATITIS C, HAVE YOU RECEIVED ANY TREATMENT?

- Please tick **only one**:
- Yes
 - No, offered but didn't take it up
 - 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**:
- Yes, and it meets my needs
 - Yes, but I'd still like more help
 - No, but it would help me
 - 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 HEALTHPROBLEM BUT YOU DID NOT RECEIVE IT? Please tick **only one**:

- Yes, there was at least one occasion
- No, there was no occasion (go to Q15)

Homeless Link Health Needs Audit

14a. IF YES TO Q14, WHAT WAS THE MAIN REASON FOR NOT RECEIVING THE EXAMINATION OR TREATMENT (THE MOST RECENT TIME)? Please tick **only one**:

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

15. DO YOU SMOKE CIGARETTES, CIGARS OR A PIPE? Please tick **only one**:

- Yes
- No (go to Q16)
- No answer

15a. IF YES TO Q15, WOULD YOU LIKE TO GIVE UP SMOKING ALTOGETHER?

Please tick **only one**:

- Yes
- No
- Don't know

15b. IF YES TO Q15, HAVE YOU BEEN OFFERED HELP BY A HEALTH PROFESSIONAL TO STOP SMOKING? Please tick **only one**:

- Yes, and took this up
- Yes, but did not take this up
- 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**:

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

Homeless Link Health Needs Audit

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**:

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

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

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

- Yes
- 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)
- IV drugs (drugs you inject)
- No drug use in the past 12 months
- Other (please state)
- No answer

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20. DO YOU TAKE METHADONE, SUBUTEX OR ANY OTHER SUBSTITUTE DRUGS?

Please tick **only one**:

- Yes, it is prescribed for me
- Yes, but it is not prescribed for me
- No

21. DO YOU HAVE OR ARE YOU RECOVERING FROM A DRUG PROBLEM?

Please tick **only one**:

- Yes, I have a drug problem
- Yes, I am in recovery
- 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**:

- Yes, and it meets my needs
- Yes, but I'd still like more help
- No, but it would help me (go to Q22)
- 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**:

- Almost every day
- Five or six days a week
- Three or four days a week
- Once or twice a week
- Once or twice a month
- Once every couple of months
- Once or twice a year
- Not at all in the past 12 months (go to Q24)
- 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.

-
- No answer

24. DO YOU HAVE OR ARE YOU RECOVERING FROM AN ALCOHOL PROBLEM?

Please tick **only one**:

- Yes, I currently have an alcohol problem
- Yes, I am in recovery
- No (go to Q25)
- No answer

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

- Yes, and it meets my needs
- Yes, but I'd still like more help
- No, but it would help me (*go to Q25*)
- 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

26. HAVE YOU BEEN REFUSED REGISTRATION TO A GP/ HOMELESS HEALTHCARE SERVICE OR DENTIST IN THE PAST 12 MONTHS?

Please choose the appropriate response for each item: Yes / No (*go to Q27*)

GP or homeless healthcare service

Dentist

26a. IF YES TO Q26-GP, WHY WERE YOU REFUSED REGISTRATION TO A GP?

.....

26b. IF YES TO Q26-DENTIST, WHY WERE YOU REFUSED REGISTRATION TO A DENTIST?

.....

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?

Used an ambulance?

Been admitted to hospital?

Homeless Link Health Needs Audit

27a. IF YOU HAVE USED ANY 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-27d ABOUT YOUR MOST RECENT ADMISSION:

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

Yes

No

I can't remember

27c. WHEN YOU WERE DISCHARGED FROM HOSPITAL WHERE DID YOU GO?

Please tick **only one**:

I was discharged onto the street

I was discharged into accommodation, but it was *not* suitable for my needs

I was discharged into accommodation, and it *was* suitable for my needs

I can't remember

No answer

27d. AFTER BEING DISCHARGED, WERE YOU READMITTED WITHIN 30 DAYS?

Please tick **only one**:

Yes

No

I can't remember

No answer

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**:

I have no problems in walking about

I have some problems in walking about

I am confined to bed

No answer

Homeless Link Health Needs Audit

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

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

USUAL ACTIVITIES Please tick **only one**:

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

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

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

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

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

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

- My health is better than it was 12 months ago
- My health is about the same as it was 12 months ago
- 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**:

- Yes
- No

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

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

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

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

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

- Yes
- No
- Don't know

Homeless Link Health Needs Audit

34. HAVE YOU HAD A SEXUAL HEALTH CHECK IN THE PAST 12 MONTHS?

Please tick **only one**:

- Yes No Don't know

35. DO YOU KNOW WHERE TO ACCESS FREE CONTRACEPTION?

Please tick **only one**:

- Yes No

36. DO YOU KNOW WHERE TO ACCESS ADVICE ABOUT SEXUAL HEALTH?

Please tick **only one**:

- Yes No (go to Q37)

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

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

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

- Yes No 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:

- Yes No Don't know

39. 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:

- None One
 Two Three or more

40. 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:

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

41. 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:

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

42. 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:

Thank you for completing this survey

Appendix 3

Topic Guide for focus group undertaken with service users (High Wycombe and Aylesbury)

Additional to the health audit questionnaire there will be two focus group opportunities.

The aim of these focus group is encourage more detailed feedback that will essentially reinforce the data collected from the questionnaires. Input and opinions from everyone that is involved with the homeless situations in both High Wycombe and Aylesbury would be really appreciated. This will enable the research team to produce valuable and insightful questions from all involved for the focus groups. We hope to put together 10 to 12 questions.

General Introductions and explanation of focus group/ice-breaker

1. What do you think are the most important health concerns for homeless people? (Expand/probe on answers – e.g. immunisations, sexual health, foot care etc.)
2. Are you aware of any difficulties that homeless people might have in accessing medical care (probe what, why, e.g. registration documents, attitudes etc.) – why do you think that is?
3. What sort of things would you visit a GP's surgery for – and what other facilities might you use? WHY? (probe re one-stop shops, immunisations etc. - and reason for choice) – *explore issues around access to sexual health, substance misuse or nurse drop-in clinics for participants/their contacts...*
4. What puts you off using GP's surgeries (or other forms of health care such as walk in clinics, A&E, etc.?) – probe re receptionist attitudes, opening hours, need to make an appointment etc. – or friend's experiences (anecdotal re get a feel for what is 'said' amongst the homeless community)
5. Can you tell us about any good experiences you have had with doctors or other forms of health care which you think are helpful for health care providers to know about – e.g. specialist practices, double appointments etc.? (Probe for case study details) and any particularly bad one (probe/explore why)
6. If you aren't registered with a GP surgery do you know how to get registered? Any particular difficulties do you think in that? What's the best way for someone to make an appointment with a doctor/drop-in etc. – e.g. issues around phones, lack of letters etc. (probe re follow up and secondary care issues here)
7. What services would you like a surgery or 'homeless health clinic' to offer? (e.g. immunisations, foot care, screening, sexual health, diabetes checks, dentists, etc. etc.) Why?
8. If there was going to be a specialist clinic for people who are homeless what sort of times do you think should be open?
9. Thinking about health generally for homeless people – [pick up on responses to Q1] can you think about any sort of special services which should be offered maybe at certain times of the year? E.g. automatic 'flu immunisations in winter, etc. PROBE re barriers to take-up + linked referrals such as to mental health services etc.

Anything else you'd like to tell us about health?

Thanks, wind-down and close.

One focus group will be held at Wycombe homeless connection on Monday 27th July, from 3pm to 5pm.

One will be held in Aylesbury (AHAG offices) on Friday 4th August from 3pm onwards.

Appendix 4

Staff Comments Form

Homeless Health Audit Research Data from front line staff

The knowledge and understanding that are gained from the people and situations that front line staff experience when working with the homeless are invaluable. We would therefore really appreciate any input, opinions or comments you have regarding how much/little access to health care services the homeless have and what the main issues/concerns are. This will enable us to capture data about the more vulnerable of homeless individuals who could not provide data within either the health audit questionnaire or focus groups due to their situations or circumstances.

Due to the time bound achievability of collating all the data for the project, a couple of paragraphs or some bullet point sentences containing your opinions, concerns or comments would be appreciated.

Wycombe Homeless Health Report 12 Jan 2016

To use your data we require your permission. This enables us to use your direct quote/s within the business plan. If you are content for this to happen, please enter your full name, the company you work or volunteer within, your role and the length of service within this role, below.

I hereby give permission to be directly quoted or my opinions used in my name by [name of agency] in conjunction with the Homeless Health needs Business plan of 2015.

Full Name: Length of service:

Company: Role:

Please return to your manager, or Racheal Mealing c/o Wycombe Homeless Connection

before Friday 25th September 2015 12pm.

Wycombe Homeless connection thank you for your input

Wycombe Homeless Health Report V2 Jan 2016