

West Sussex Public Health and Social Research Unit

Homelessness Needs Audit

2016

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Chapter 1 –Homelessness: introduction, prevalence, policy and context in West Sussex and the UK

1.1 Introduction

In this chapter we will set out the aims of the audit and the methods we used to gather data and evidence. We will provide a definition of the single homeless population and present the current policies, legislative framework and context of homelessness in West Sussex and the UK. We present the evidence around prevalence of single homelessness and we will summarise the support available to single homeless people in the county. We will also look at institutional and environmental influences on homelessness.

1.1.1 What do we aim to do?

This homeless health needs audit aims to:

- Systematically and comprehensively assess the specific needs of single homeless adults residing within West Sussex.
- Identify physical and mental health issues specific to this population
- Identify gaps relating to access and use of services.
- Make recommendations to reduce the health inequalities of this specific population

1.1.2 Why are we doing this?

This needs assessment was a result of a collaboration between Homeless Link, Worthing Churches Homelessness Project, West Sussex County Council (WSCC), Adur & Worthing Council and a number of charitable organisations. Through joint working, and an earlier report jointly commissioned by WSCC and Sussex Police, it became clear that there was both an opportunity and a need to examine and assess the needs, strengths and assets of the homeless population; the infrastructure and policies supporting them; and the organisations working with homeless people.

1.1.3 How did we do this needs audit?

As part of the collaborative approach to this project, we used The Homeless Health Audit Tool, created by Homeless link to collect data from the participants. This is a validated and widely used tool, both approved and funded by the Department of Health. At the time of this publication, 27 health audits had been conducted nationwide. Using this tool consistently across the UK not only allows us to compare findings with other local authorities, it also provides opportunities to repeat audits, to assess and monitor on-going trends within local areas. The timing of the survey (winter of 2016) was carefully planned to coincide with the statutory provision of night shelters to ensure that we were able to recruit as many participants as possible.

We used statistical programmes to analyse the data. We also used a combination of national and local research, local knowledge, the audit results, and the assessment of current policy, programmes and schemes both nationally and locally.

1.1.4 What will we do with the results?

Using the evidence and data collected, this document provides a set of recommendations. These will be well informed, collaborative, and specific and directed to a range of local stakeholders and service providers. We will share the findings throughout the council, and with partnership organisations. We will promote this report and its recommendations, with the aim of raising the profile of this issue.

1.1.5 Data assumptions and analysis

Where data from West Sussex are compared with national figures, it can be assumed that figures attributed to West Sussex are taken from this health audit (234 completed audits) unless otherwise stated. All national figures will be attributed to the aggregated results of all Homeless Link Audits (3,355 completed audits), unless specifically stated.

Sample sizes for each question may change. This is because the questionnaires were mostly conducted via interview; and while all questions had a “no answer” or “prefer not to say” option, the number of blank entries on each question varied. We have made the following assumptions:

- Responses recorded as “no answer” or “prefer not to say” suggests the respondent did not want to disclose a response to that question.
- Blank entries represent questions that were missed or skipped for various reasons. As a result, blank fields have been removed from the overall figures used to calculate response rates for each question. This means that sample size will vary from question to question.

1.1.6 Statistical tests

A statistical test was chosen which is most appropriate for the small sample sizes observed. This is particularly suitable when investigating different demographics in West Sussex. The Fishers exact test was applied to all figures, unless stated otherwise.

1.2 Homelessness – definition, context and policy

This needs audit focuses on the needs of single homeless people¹ only – a number of whom do not meet the ‘priority need’ criteria. We know that understanding the needs and lived experiences of single homeless people will inform commissioning and strategic decision making. Through talking with this population, this work aims to highlight where there are gaps in services; identify what works well and emphasis opportunities for improvements. The participants in this audit were accessing services for health, or homeless related support. However, we know that not all single homeless people will engage with services, and therefore the participants are a sample of the local single homeless population. .

¹ The total homeless population in West Sussex also includes families and other people in priority need

1.2.1 Definition

In this audit we considered someone to be single homeless if at the time of the survey or in the preceding six months, they had been:

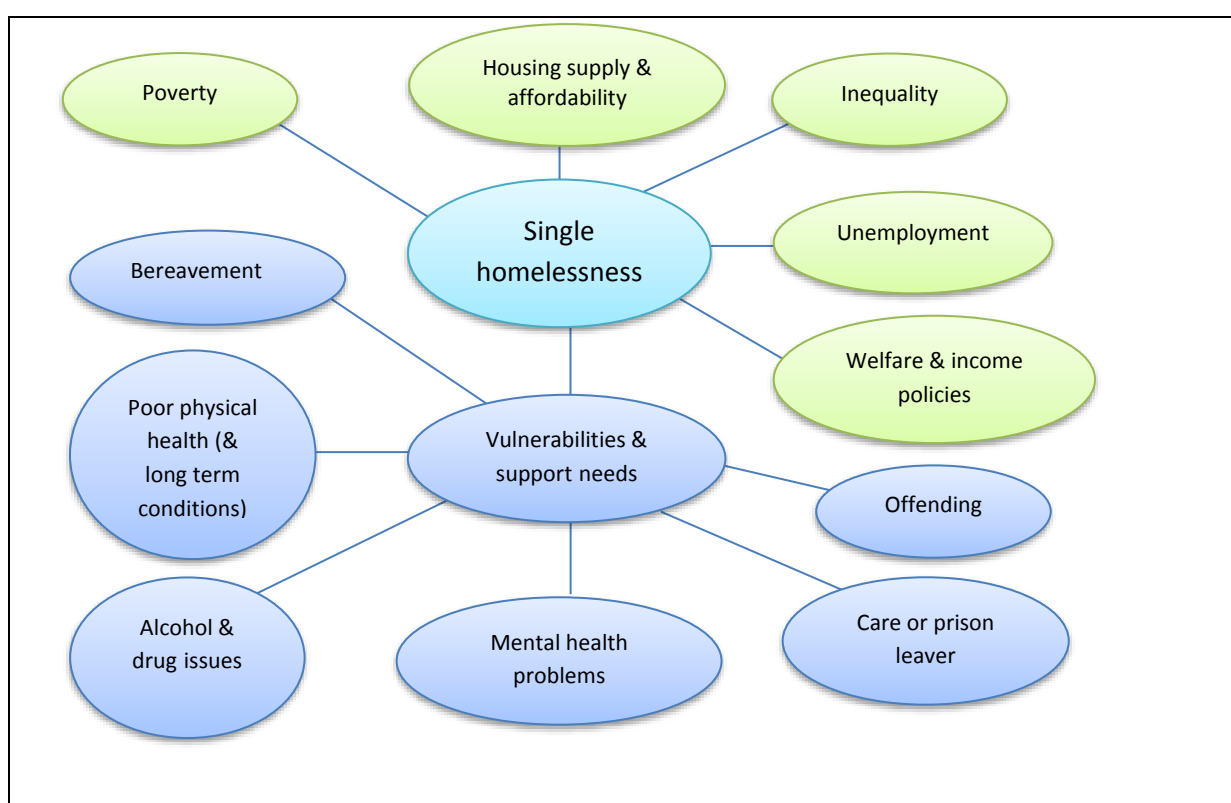
- sleeping and living on the streets;
- sofa -surfing with friends or family;
- squatting;
- in bed and breakfast, hostel or other temporary accommodation;
- in longer term supported accommodation projects; and
- in their own tenancy but at risk of losing it²

1.2.2 Environmental, institutional and individual factors

We know that factors influencing single homelessness are both environmental and institutional as well as individual (social). Figure 1 shows environmental factors in green and the individual (social) factors in blue.

² This is evidenced by history of homelessness in last year or current behaviour/support needs, meaning that in judgement of a key worker they are at imminent risk of losing tenancy.

Figure 1: Factors influencing single homelessness



While this figure maps out the issues behind single homelessness in one diagram, the complexity and multiplicity of these issues and their interdependencies cannot be illustrated here. Addressing these social and environmental issues on an individual as well as a broader social basis, is key to reducing the incidence of single homelessness, and consequently other health and social inequalities.

1.2.3 Rough sleeping

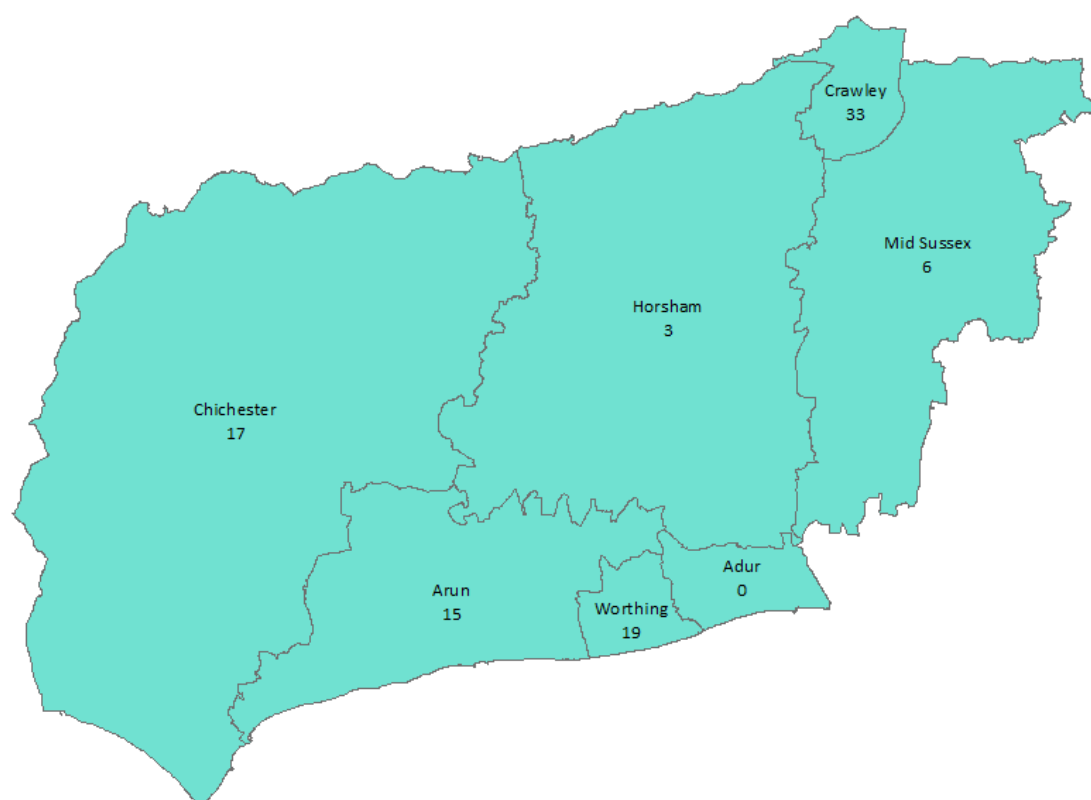
Rough sleeping is defined by the Government as ‘people sleeping, or bedded down, in the open air (such as on the streets, or in doorways, parks or bus shelters); people in buildings or other places not designed for habitation (such as barns, sheds, car parks, cars, derelict boats, stations, or ‘bashes’)³. Evidence shows that people who sleep rough experience the highest health inequalities of all population groups. This is not only because of the added effect of chronic poverty, but the fact that these people are more likely to experience multiple and complex health needs. For example, the average life expectancy for a homeless person who sleeps rough is 43 years of age.

The estimated number of rough sleepers in England given by the DCLG has doubled from an estimated 1,768 in 2010 to 3,569 in 2015. Although not on the same scale West Sussex has also seen an estimated rise of 23 rough sleepers in the same five year period, rising from 70 to 93.

The majority of rough sleepers are located within Arun, Chichester, Crawley, and Worthing (15, 17, 33, and 19 respectively).

³ House of Commons Committee of Public Accounts (2005) Office of Deputy Prime Minister: Tackling Homelessness available at <https://publications.parliament.uk/pa/cm200506/cmselect/cmpubacc/653/653.pdf>

Figure 2: West Sussex map of rough sleepers



Source: DCLG, "An estimate of the number of people thought to be sleeping rough in a local authority area on any one night in a chosen week."

1.2.4 Hidden homeless

These estimates are not able to take account of possibly large numbers of hidden homeless. Examples include "sofa surfers", those living/sleeping in vehicles, and squatters. These people will also experience similar inequalities in health, wellbeing and difficulties in accessing services.

1.2.5 Statutory homelessness and applications for homelessness in West Sussex

Local Authorities have a statutory duty to provide housing for groups of people considered to be in 'priority need'. The Housing Act 1996 and the Homeless (priority need) Order 2002 set out the priority need categories as follows: pregnant women and people with dependent children; homeless due to flood, fire or other disaster; 16 – 17 year olds (unless owed a duty by children's services); care leavers under 21; a vulnerable person (due to age, mental illness, disability, prison leavers, leaving Armed Forces; being in care; at risk of violence or threats of violence). If a person is deemed to be in priority need on application, and there is reason to believe the person is homeless, local authorities have a duty to provide suitable interim accommodation while they investigate the homelessness claim. This often includes temporary accommodation or emergency bed and breakfast (B&B) placements.

Once the local authority has completed their homelessness investigations, and conclude that the person meets the five tests of homelessness (see below) they will accept the 'main duty' for that

household to provide suitable accommodation. This accommodation may be social housing provided by the council itself, by another social housing provider, or in the private rented sector.

Homelessness applications can be made to any local authority in the country. The process should be simple and councils are open to criticism if there are any barriers that could hinder applications. This means that homeless applications are not restricted to particular forms being completed. For example, a homeless application can be made verbally.

As mentioned above the five key areas are taken into account when processing homelessness applications are:

1. **Homeless** – is the client actually homeless or threatened with homelessness within the next 28 days?
2. **Eligible** – does the client meet the criteria for assistance, based on their nationality, or length of stay in UK
3. **Priority Need** – certain vulnerable categories established in legislation, as well as Supreme Court case law which has established a complex test of vulnerability (mainly around mental health) of whether a client is 'significantly more vulnerable than an ordinary person made homeless'
4. **Intentionality** – did the client do, or fail to do, something that caused their homelessness, and was this deliberate?
5. **Local connection** – the threshold in homelessness legislation is 6 months

All five criteria must be met for a successful application and for the local authority to accept the main duty for finding suitable accommodation for the applicants

In the 2015/16 financial year there were 1,612 decisions made around homeless household applications by the seven local authorities within West Sussex. Of these, 650 decisions resulted in a household being classed as unintentionally homeless and in priority need. In these cases there was a legal requirement to house these households. The number of those unintentionally homeless and in priority need has risen 21% since 2009/10. The factors influencing this will be discussed during the course of this report.

While those accepted by local authorities will then go on to receive short term or long term duties of suitable accommodation, the remaining 962 households will not. Of these remaining 962 applications, 135 were found to be in priority need but the circumstances leading to their homelessness were deemed intentional. A further 199 applications were assessed as homeless but not in priority need, while a remaining 617 were deemed not to be homeless⁴.

The 334 applications which were declined for either not being in priority need or being deemed intentional homelessness are those most likely to end up sleeping rough and exposed to the associated health inequalities. In the past five years, the number of applications resulting in this way have fluctuated year on year, with no discernible trend.

⁴ This leaves a remaining 11 unaccounted applications. Due to the repression of small numbers at a local level, there is no way to determine from the national release which of the 3 categories they fall into.

1.2.6 Winter shelter

Local authorities have a humanitarian obligation aim to prevent deaths on the streets caused by severe weather⁵ and while there is no strict definition of what constitutes ‘severe weather’, local authorities identify weather conditions likely increase harm to people sleeping rough. As such, measures are in place to minimise weather related health impacts from extreme cold, wind and rain.

Severe Weather Emergency Protocol (SWEP) provision is normally triggered in West Sussex when the mean temperature is forecast by the Met Office to be zero degrees or below for at least three days. SWEP may also be triggered by forecasts of flooding or very high winds. There are small variations in the way that different West Sussex authorities apply SWEP.

Adur and Worthing Council make use of existing emergency accommodation provision during severe weather, assisting rough sleepers on a case by case basis. Worthing Winter Night Shelter operates out of local churches on different nights from mid-November to mid-March annually.

On nights where the SWEP is actioned, rough sleepers in Arun will be offered support. Temporary accommodation in Bognor Regis includes a night shelter managed by Stonepillow.

Chichester District Council (CDC) own temporary accommodation and use two separate unfurnished flats for SWEP. CDC does not have any hotel or B&B accommodation, but will occasionally fund other temporary accommodation arrangements if required.

During SWEP periods Crawley Borough Council may accommodate rough sleepers in B&B or in winter shelters in one of five local church halls, working in partnership with the local direct access hostel, Crawley Open House.

Horsham District Council (HDC) will accommodate in the Horsham Churches Together Night Shelter from November. If a night shelter is not suitable or available, HDC may accommodate rough sleepers in B&B accommodation; usually in surrounding districts and boroughs. Whilst staying at the night shelter, support will be provided to identify longer term housing options for residents.

Mid Sussex District Council may accommodate rough sleepers in guest houses or B&Bs outside the district during SWEP periods.

1.2.7 Housing availability, access and affordability

Insufficient affordable housing is one of the environmental causes of homelessness, but it is also a barrier to moving *out* of homelessness. Single homeless people often experience barriers to social housing because they are not in ‘priority need’ (as set out above) and so the private rental sector is often the only option available.

With the gap between income and house prices increasing, barriers to homeless people finding suitable and affordable accommodation increase. Owner-occupier housing costs account for 20% of

⁵ Homeless Link (2017) Guidance on Severe Weather Emergency Protocol (SWEP) and extended weather provision. Available at: <http://www.homeless.org.uk/our-work/resources/guidance-on-severe-weather-emergency-protocol-swepe-and-extended-weather-provision>

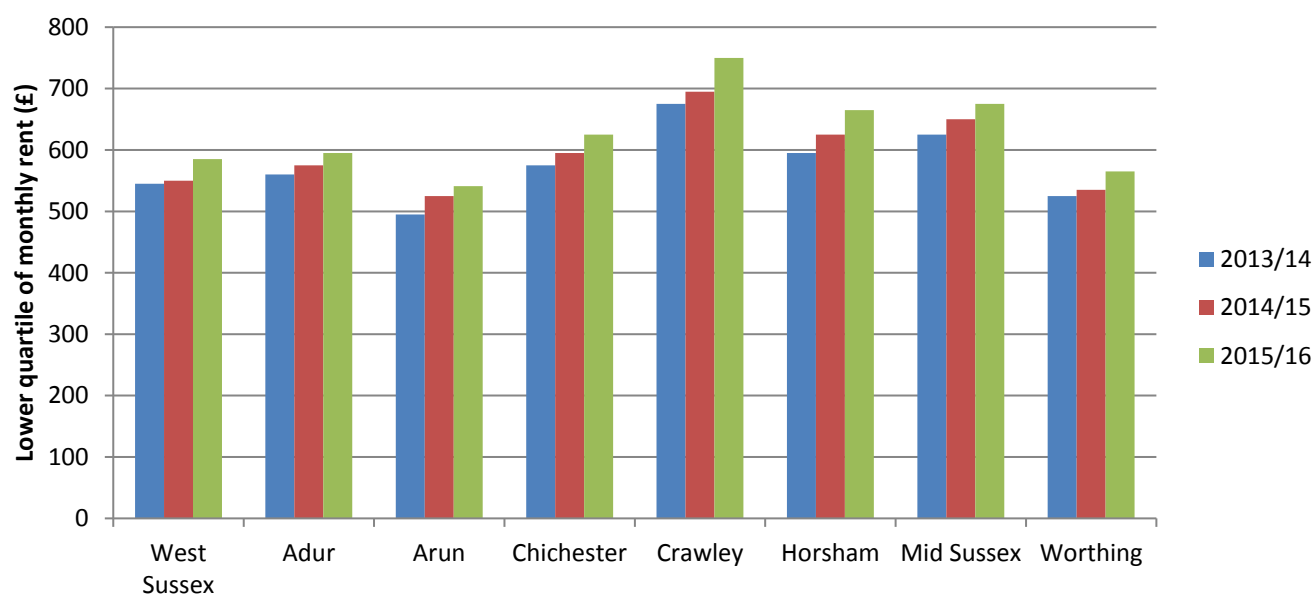
gross household income, while housing costs in the private rental sector account for 40% (47% without housing benefit) of gross household income. Costs in the private sector are considerably higher than in social housing sector which accounts for 30% of household income (and 42% when housing benefit is removed).

There are additional barriers to the private rental sector over and above availability and affordability. People who are on a low income or those receiving housing benefit may experience reluctance among landlords to let property to them. It is also challenging for people on a low income to find a deposit.

Since the 2013/14 financial year, the Office of National Statistics (ONS) has been releasing monthly rent figures for specific household types at local authority level. For the purpose of this audit we report the lower quartile of monthly rent figures for one bedroom properties in West Sussex and its seven districts and boroughs. In West Sussex the lower quartile of rent for these properties has risen from £545 to £585 per month in the last three years: an average increase of 3.6% a year. Over the same period the wage of those in the bottom quartile within West Sussex has only increased 2.44% a year

The commuter belt districts of Crawley and Horsham saw the largest increases over two years, 11.1% and 11.7% respectively. While Arun remains the most affordable of the districts in West Sussex. With the lower quartile rent of £541 per month, it has experienced an increase of 9.3%.

Figure 3: Lower quartile of monthly rent for one bedroom properties in West Sussex by year



Source: ONS

Each local housing authority holds a housing register of people applying for social housing. At the time of publication, the figures are as follows: Adur (660), Arun (1150), Chichester (1620), Crawley

(1950), Horsham (630), Mid-Sussex (1610), and Worthing (1080).⁶ It should be noted that that these are not solely single homeless people but relate to the wider demographic previously mentioned.

1.2.8 Changes in welfare and funding

Savings across local government have seen sources of funding cut, of note the removal and decentralisation of the Supporting People programme saw funding in this domain cut by nearly 50%. This in turn impacts on the ability of local authorities to evaluate and monitor programmes for homeless people to evidence their effectiveness, which in turn impacts the ability of local authority to prioritise services for this group of people.

As well as recent reforms having had an impact on single homeless people, the broader issue of austerity measures coupled with demand-led pressure on services and budgets, makes it challenging to pin down the specific effect on the single homeless population. However, any reforms affecting budgets and services invariably impact those most marginalised and vulnerable. Cuts to housing and other benefit can mean that people already finding housing costs unaffordable are in danger of becoming homeless. The Trussell Trust also highlights the increasing use of foodbanks: an indication that basic essentials are beyond the means of some households.

1.2.9 Conclusion

There are a number of social, environmental and institutional factors which present complex challenges. Chronic housing shortages and welfare reform combine to increase pressure on housing demand across the demographic. With such a broad societal impact, challenges remain in identifying the specific effects on the single homeless population. It is most likely that they will be impacted disproportionately due to their complex needs and vulnerability.

⁶ Data correct as of Sept 2017, although these are subject to constant change and therefore are rounded to the nearest ten

Chapter 2 – Findings from the audit

As well as presenting the findings from the Homeless Link survey, we will use other Homeless link findings as well as, national and local data to compare a number of aspects, including:

- population demographics;
- health behaviours and needs;
- use of and access to services; and
- overall wellbeing

A number of organisations providing services across West Sussex participated in collecting the data and helped to maximise the response level for this audit. Although there were 234 respondents, few questionnaires were fully complete. Nevertheless the response rate for each question was high.

Table 1 gives a breakdown of the organisations participating and the number of responses at each service.

Table 1: Breakdown of participants responding per service

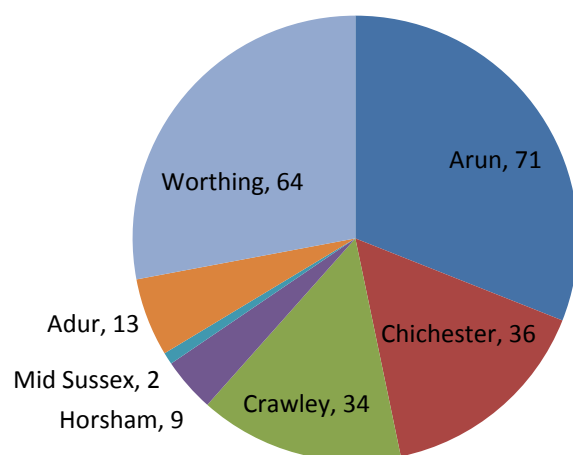
Organisation	Number of participants
Arun District Council	5
Bognor Housing Trust	22
Crawley Open House	26
Directions	2
Family Mosaic	2
Home Group	1
ILS SHA	1
MyKey	35
Phoenix	3
St Mungos	7
Stonepillow (Chichester Hub)	47
Stonepillow (Sands)	8
Stonepillow (The Lodge)	2
Stonepillow Glenlogie	6
Stonham Directions	3
Supported Housing (CRI)	3
WCHP	54
None	5
No response	2
Total	234

2.2 Location of single homeless people

The majority of respondents were currently accessing services in the more urban and highly populated areas of West Sussex (Figure 4). This may not be a true representation of the population who are single homeless or at risk of homelessness, because data was only collected from those people who access services for homeless people. Whilst collecting data at service locations allows us

to focus on the impact and effectiveness of the current services provided, it is not likely to capture the experiences of the most marginalised; those who do not access any services at all. It is also likely to under-represent people who only access acute services such as A&E.

Figure 4: Geographical location of services accessed by homeless people completing the audit



2.3 Demographics

We know that the subset of the population who are homeless differs greatly from that of the overall population. The following section aims to look at the specific differences seen in the West Sussex population, as we know that understanding these differences can prove useful when commissioning targeted services.

2.3.1. Age and Gender

Table 2 shows the age range of participants, according to their sex. Male respondents were on average 40.9 years old, while female respondents were younger, with the average age being 35.2 years old; with the overall mean age of 39.6 years. In comparison, the mean age in West Sussex (for the over 18 population) is 50.52 years. Respondents were, on average, younger than the adult general (18+) population in West Sussex, with 19% of respondents older than the West Sussex average.

Table 2: Age of participants by sex

	Female	Male	Total
18-24	13	26	40*
25 -34	11	31	42
35-44	17	40	58*
45-54	5	57	63
55-64	5	17	22
65+	0	5	6*
Total	51	177*	234*

* Columns do not add to total due to either a missing gender or age value.

There are a higher proportion of males (75.64%) compared to females (21.79%), and this pattern is largely in line with the national Homeless Link figures which show a male:female percentage split of 71:29. While this split reflects the overall Homeless Link ratio of males to females, this also represents people who access services. Further work is required to understand whether there are barriers preventing women accessing services.

2.3.2 Sexual orientation

A total of 91.2% of respondents reported they were heterosexual with 7.3% identifying as gay, lesbian, or bi-sexual. No robust local data on sexual orientation exists, which makes comparison to the local population difficult, however, sexual orientation was included in the national 2013 integrated household survey (IHS), with 92.8% of respondents identifying as heterosexual and 1.6% identifying as gay, lesbian, or bisexual. The West Sussex estimates of the number of people identifying as lesbian, gay or bi sexual are in line with the Homeless Link overall estimate of 7%. There are currently no data around transgender people in the single homeless population.

2.3.3 Ethnicity

Of those who responded to this question 89.9% identified as 'white British', similar to the overall West Sussex figure of 88.9% (2011, census). Limited data regarding ethnicity is published by the DCLG using information from P1E ⁷forms and allows us to make crude estimates around the applicants not classed as white⁸. In 2015/16 strictly more than 28 applications were received from those classed as "not white", that were identified as homeless but were unsuccessful either because they were not deemed in priority need or were deemed to be intentionally homeless. This figure was larger than the 17 respondents from the audit.

UK nationals accounted for 97% of those that responded to the question, while only 1.3% said they were from the European economic area (EAA).

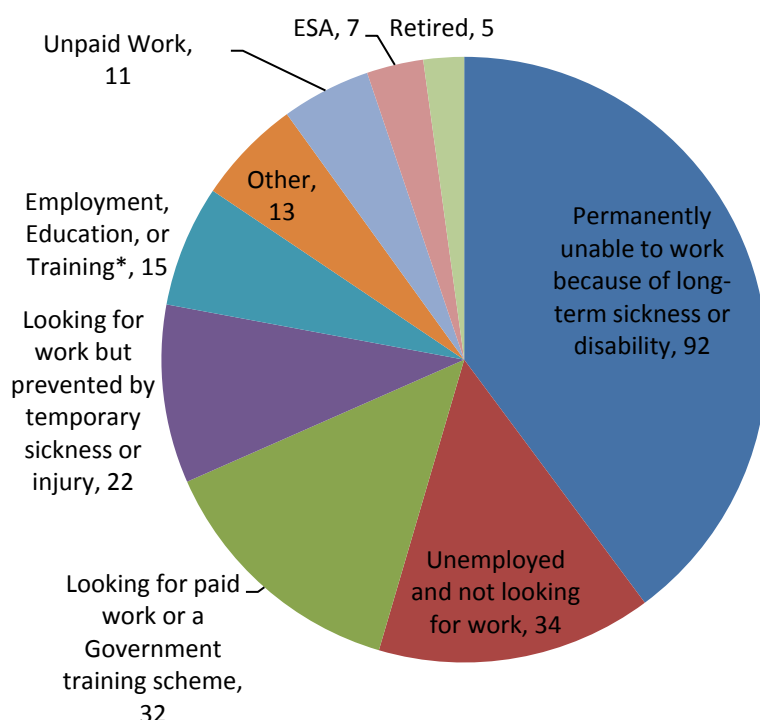
2.3.4. Education and Employment

Participants were asked about their current employment status. The majority of respondents are not in paid work with over half classed as 'economically inactive'. Only ten respondents (4.3%) were currently in paid employment (this is a subset of the "employment, education, or training" category). The category with the highest number of respondents (n=92, 39.8%) was "permanently unable to work through long term illness or disability". A further seven respondents who used the "other" option stated their answer as ESA (Employment and Support Allowance).

⁷The purpose of the quarterly P1E forms is to collect data from English local housing authorities on their responsibilities under homelessness legislation. It also includes a section on homelessness prevention and relief.

⁸ This includes "unknown" and "not stated"

Figure 5: Employments status of participants



The figures for people in employment, training or education in West Sussex, is lower than the overall homeless link figures. While the proportion of single homeless people in employment nationally is higher (6%) than West Sussex figure of 4.3%, larger differences can be seen between the county and national percentages of those either in education or training (1.3% vs. 17% respectively). In West Sussex 39.2% said they were currently looking for some form of employment or training, while an extra 9.5% want to, but are currently unable to, due to temporary illness.

While 45% of those who responded to the audit nationwide are permanently prevented from any form of work, education or training; figures for the county (39.8%) suggest that alongside the large number of homeless looking for work or wanting to look for work, that more could be done to help those able to work into paid employment.

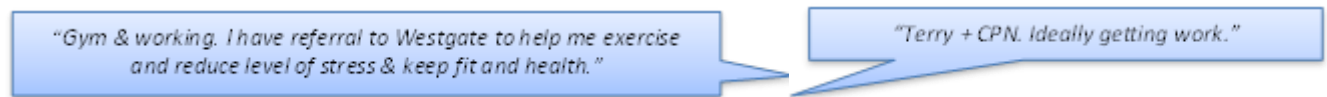
As part of the survey, service users were asked to identify areas of services which be improved, what currently works well for them and whether there were other comments. Employment was included in comments around areas for improvement in two cases, with two examples of how employment was working well for people.

What could be improved (employment)?

"Would like support from Care-Coordinator regarding suitable accommodation where it can get even better physically and mentally. Need time and space and independence. Also, need help for future employment. I hate being idle and worked all my life. Thank you."

"Find work quick and gym and home < my own place for peace of mind."

What works well (employment)?



2.3.5. Current and Previous Accommodation

Accommodation can have a large impact on a range of health factors. There is strong evidence showing that rough sleepers can suffer extreme negative health effects if their sleeping arrangements last for extended periods. Even those in accommodation can be affected by cold and damp indoor conditions in the winter months, if they are in poor quality housing.

Although many of the negative health effects are a direct result of poor sleeping conditions, there are also factors that indirectly affect health. For example, squatters, "sofa surfers" and rough sleepers can have chaotic itinerant lives that hinder their attempts to hold down a job and access health care.

When asked for additional comments, some participants highlighted the aspects of homelessness that impact on their health.

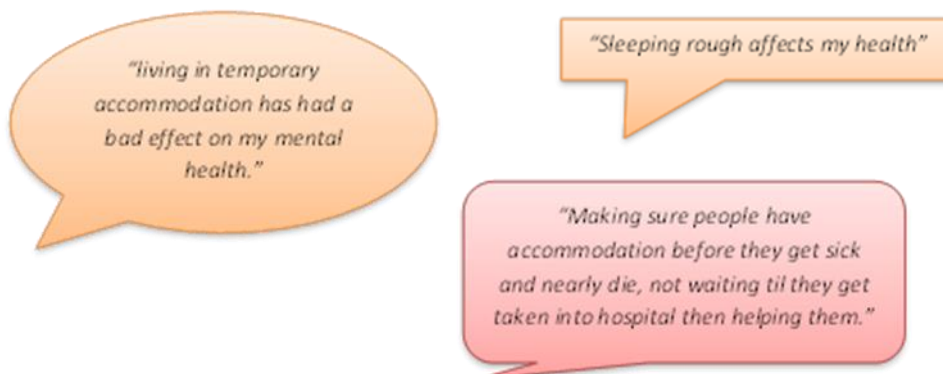
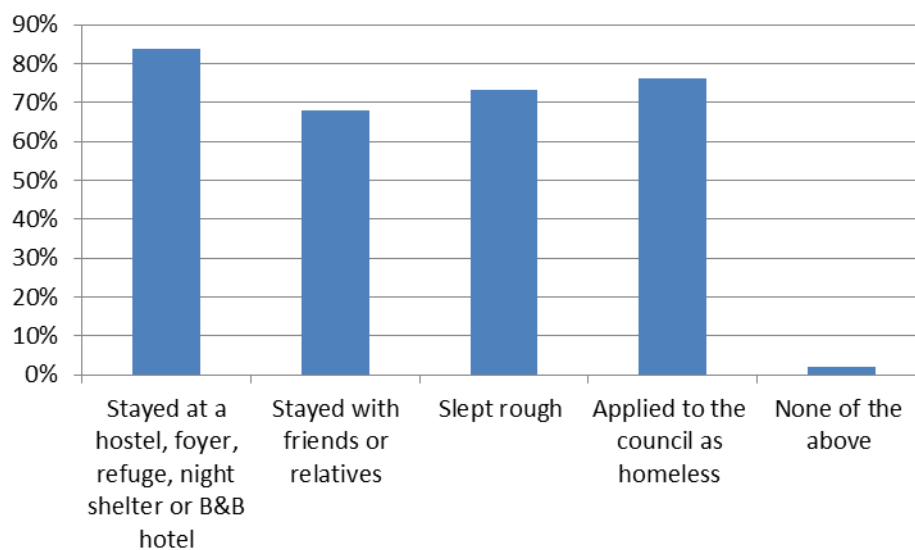


Figure 6 shows the housing and accommodation related activity over the life course for each participant.

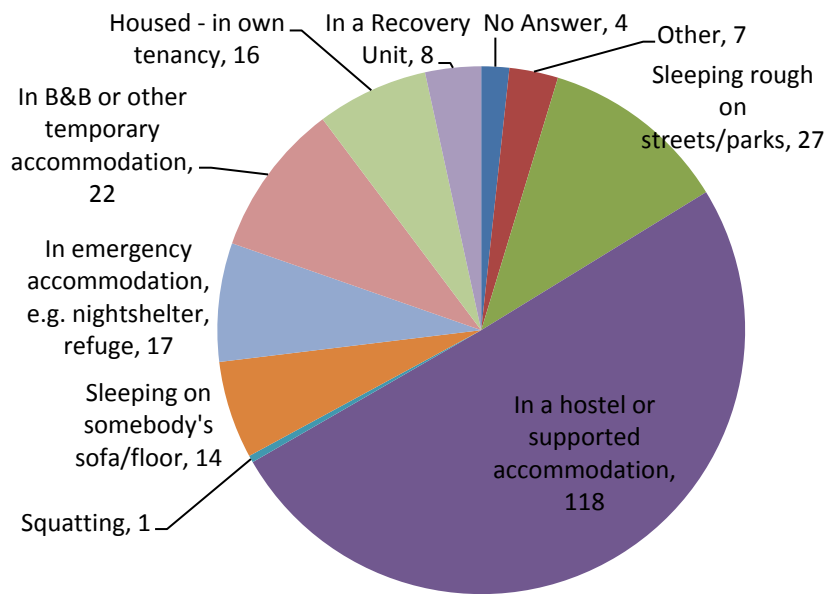
Figure 6: Proportion of participants by accommodation history



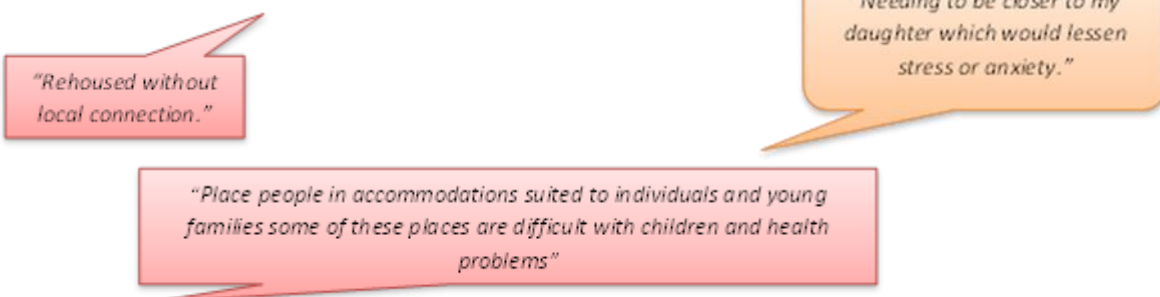
One in nine (11.5%) respondents reported they were currently sleeping on the streets, broadly in line with national Homeless Link figures. The majority of respondents (73%) reported that they had slept on the streets at least once in the past. Over half of respondents (50.4%) were housed in hostels and temporary accommodation at the time of the audit. The audit was completed during the period of winter shelter provision, which is provided between November and March. Therefore, the 17 people reporting that they were sleeping in night shelters and refuges may have returned to street sleeping later in the year.

Although 76% (n=177) of respondents had applied to the council and had been accepted as homeless, a very small proportion were currently in their own tenancy (n=16).

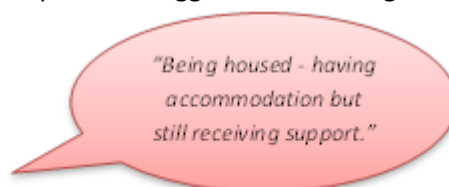
Figure 7: Current accommodation



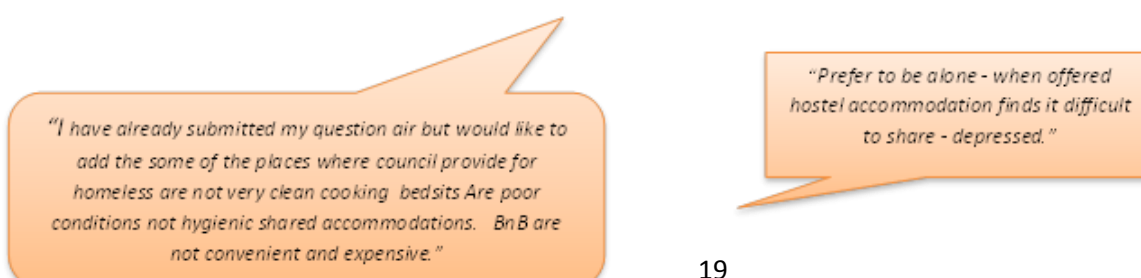
Accommodation featured in participant responses around areas for improvement and what works well, where a number of themes emerged Firstly that that accommodation 'anywhere' was not necessarily appropriate as it was away from support and established networks; and secondly that accommodation was not always suitable when it was found.

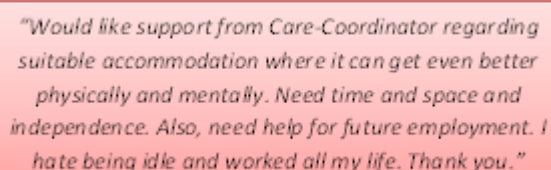


When asked what could be improved one respondent suggested that being rehoused without support was not working well for them.



Whilst one highlighted how their stable environment was working well for them, others stated issues around the types of accommodation they were currently placed in:





"Would like support from Care-Coordinator regarding suitable accommodation where it can get even better physically and mentally. Need time and space and independence. Also, need help for future employment. I hate being idle and worked all my life. Thank you."

2.3.6 Reason for homelessness

As previously suggested, homelessness is caused by a complex interplay between a person's individual circumstances and adverse 'structural' factors outside their direct control. These problems can build up over time, culminating in crises and subsequent homelessness. The five most frequent responses to the reason for most recently becoming homeless are as follows:

1. Non-violent relationship breakdown with partner (n=36, 15.6%)
2. Parents / care-givers no longer able or willing to accommodate (n=32, 13.9%)
3. Drug or alcohol problems (n=27, 11.7%)
4. Eviction or threat of eviction (n=26, 11.3%)
5. Abuse or domestic violence (n=19, 8.2%)

2.4 Contributing factors

Alongside basic demographic questions, respondents were also asked whether they experience factors common to the homeless population. These factors can indicate whether a person has been in contact with services prior to becoming homeless. Because these are complex factors and many people experience more than one, the percentages for different factors do not add up to 100%,

2.4.1. The Criminal Justice System

When asked whether they had previously had contact with the criminal justice system, 92 respondents answered that they had spent time either in prison, the youth justice system or a secure unit. Just over a third (37.2%) had previously served a prison sentence, while 11.1% (n=26) had spent time in a secure unit or the youth justice system. This local figure is relatively high compared to the national findings of 26% having served a prison sentence.

Since January 2014, a support service in place for offenders called 'Directions' has been commissioned. The service is provided by Home Group and provides accommodation and support for up to 15 people, released from prison. Ten people are accommodated in the Referral and Assessment Unit. Here, a high level of support and supervision enables residents to re-adjust to independent living. In addition, Home Group provides specialist support to five people in self-contained units in the Worthing area, on a sub-let basis.

In the first year of the contract, 43% people were successfully sustaining independent living as a result of the support they had received. In the second year, this rose to 48% and in the first two quarters of 2016/17, the success rate had risen to 62%.

2.4.2. Armed Forces

While those that have recently left or are close to leaving the Armed Forces often fall under the criteria for priority housing, veterans do not. In 2014 local authorities were sent recommendations to support the prioritisation of veteran homelessness claims. These stated that authorities could prioritise applications of veterans and that when assessing financial circumstances, any lump sum received for an injury or disability sustained on active service could be disregarded.

The proportion of respondents who had served in the armed forces was 6.4% (n=15). Figures produced by the ONS estimate that 45,000 veterans live within West Sussex, accounting for roughly 6.7% of the West Sussex population.

2.4.3. Domestic Abuse

For 26 of the respondents, domestic abuse or violence was given as a primary or secondary reason for their homelessness. Sixty (30 male, 28 female, 2 unknown) of the respondents reported that they'd experienced domestic abuse at one point in their lifetime. As a proportion, women were more likely to report they had been a victim of domestic abuse or violence, with over half of women participants giving it as a reason for their homelessness, while one in six men stated domestic abuse as either a primary or secondary reason.

2.4.4 Local authority care

Thirty seven respondents had previously spent time in local authority care. Whilst care leavers under 21 years of age are owed a statutory duty for accommodation by the local authority, there is no provision for care leavers over 21 years of age unless they meet other priority need criteria.

As of January 2017 official West Sussex figures stated there were 364 care leavers in West Sussex and 14 were classified as homeless.

Only 52 (22.2%) people reported no background factors listed above.

Chapter 3 - Health and Wellbeing

Single homeless people experience the greatest health and social inequalities compared to other vulnerable groups, as well as the general population. Homeless people are more likely to die young, with an average age of death of 47 years old and even lower for homeless women at 43, compared to 77 for the general population, 74 for men and 80 for women.⁹ Research by the Health Inequalities Unit consistently demonstrates a strong relationship between homelessness and health inequalities. This is not only due to chronic poverty often experienced by single homeless people but also a higher prevalence of smoking, substance misuse, and mental health problems.

3.1 Lifestyle

Lifestyle or health related habits (behavioural factors) can have a major impact on health. Behavioural and social issues that impact on health include smoking, alcohol, poor diet (leading to obesity or malnutrition), lack of physical exercise, high-risk sexual behaviour, and problems resulting from drug taking.

3.1.1. Smoking

The negative health effects of smoking are well documented. Evidence shows that measures taken to support people to stop smoking have a direct impact on health inequalities. Smoking while homeless both widens the health inequalities experienced by this population and increases vulnerability to ill health. Nationally, it is estimated that 16.9% of the general population smoke while in West Sussex it is estimated that 14.6% of the general population smoke.

Over 80% of respondents said they currently smoke. This is similar to the overall homeless link survey result of 78%. Homeless males within West Sussex were shown to have a slightly higher prevalence than their female counterparts (82.5% vs. 76.5%) although this was not statistically significant ($p=0.07$). A higher proportion of younger respondents smoked. Among respondents under the age of 40, 87% are current smokers; while among respondents over the age of 40, 77% smoked.

Of those who smoke, 38.6% said they would like to give up smoking altogether and whilst the prevalence of smokers under 40 was higher than in those over 40, the younger age group were more likely to state that they wanted to quit. Although 48% of the surveyed smokers said they had been offered help by a health professional to stop smoking in the past, only 14% took this up.

When asked to provide comments about what needs to be improved, two participants suggested that stopping smoking would improve their lives:



⁹ Crisis (2012) Homelessness kills: An analysis of the mortality of homeless people in early twenty-first century England. Available at: https://www.crisis.org.uk/media/236799/crisis_homelessness_kills_es2012.pdf

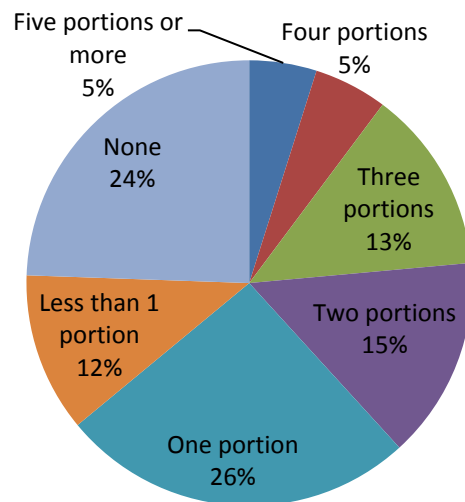
3.1.2. Eating

The importance of diet as a major contributor to chronic disease and premature death in England is recognised in the White Paper 'Healthy Lives, Healthy People'. Poor diet is linked to increased risk of some cancers, cardiovascular disease and is also linked to Type II diabetes.

Of those asked, 26% said they were having on average three or more meals per day, with 36 % eating two meals on average each day (33% having one meal and 3% having none). This figure of 36% not eating at least two meals a day was similar to the overall homeless link figure of 35%.

Only 5% of those asked thought they met the PHE guidelines of five or more portions of fruit a day (compared to 57% within West Sussex, 52% for England). The majority of respondents said they eat no more than one portion of fruit or veg on average each day (62%).

Figure 8: Portions of fruit eaten each day



When asked what they thought could be improved three respondents stated that diet was an area they thought could improve, whilst one person found that eating well was currently beneficial to their wellbeing:



3.1.3. Exercise

Physical inactivity is a leading risk factor for mortality and accounts for around 6% of deaths globally. People who have a physically active lifestyle have a 20-35% lower risk of cardiovascular disease, coronary heart disease and stroke compared to those who have a sedentary lifestyle. Regular physical activity is also associated with a reduced risk of diabetes, obesity, osteoporosis, and colon/breast cancer; and with improved mental health¹⁰.

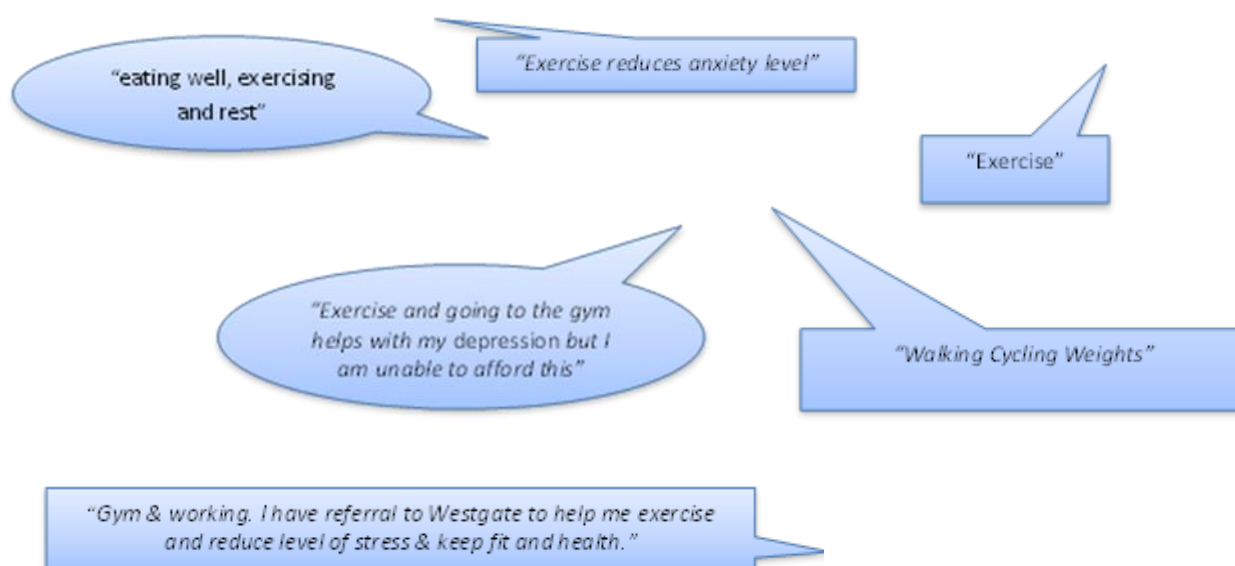
Thirty-four percent of respondents said that they exercised for 30 minutes or more, five or more times a week, therefore reaching one of the PHE guidelines for physical activity. (For comparison, 57.2% of the general population of West Sussex does this and 57% of the general population of England).

Those under 40 years of age reported higher levels of activity: 40% reported they exercised for 30 minutes or more, five times or more a week, while 20% reported being completely inactive. Among respondents older than 40 years, 29% reported five or more periods of prolonged activity each week and 37% reported being completely inactive.

Female respondents were less likely to report exercising five or more times a week (33%) and also less likely to report being completely inactive (19%). In contrast there were greater differences in activity in the male cohort: with 34% reporting that they exercise five or more times a week, while 31% reported they did no exercise at all.

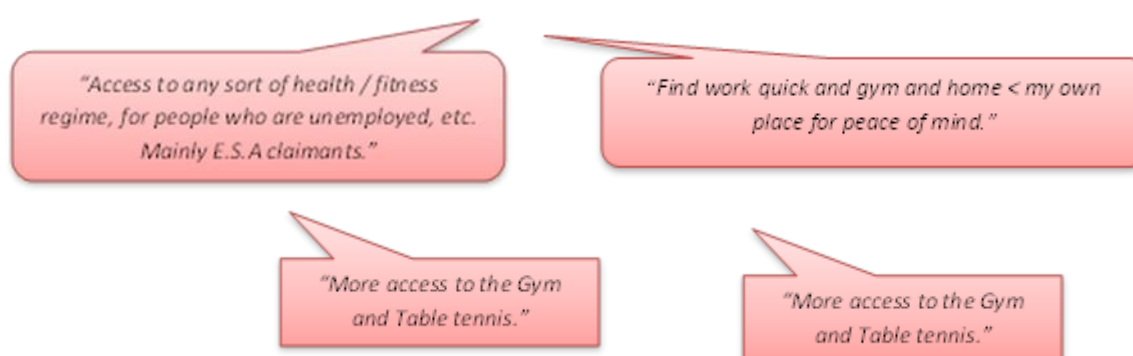
The importance of exercise in the lives of the participants and the opportunities for increasing participation in this group were highlighted through the comments given at the time of the survey.

When asked what works well for them currently, seven people stated they found exercise beneficial to their wellbeing:



¹⁰ Source: Public Health England

When asked for comments as to what might be improved, four of the participants stated that access to exercise could be improved:



3.2 Alcohol

Chronic alcohol misuse can lead to short and long-term impacts on physical health, lifestyle and mental health and wellbeing. Alcohol misuse is a contributing factor to hospital admissions and deaths from a diverse range of conditions and is estimated to cost the NHS about £3.5 billion per year and society as a whole £21 billion annually.

When asked about alcohol use, 108 participants (49%) stated they drank at least once a week. Of these, 55 reported drinking five or more times a week with a total of 38 (17%) reporting that they had not had any alcoholic drink within the last 12 months. This number increased to 111 (51%) for those who reported drinking one or two drinks a month or less.

Alcohol abstinence was more common among women completing the survey, with 28% of females reported not drinking in the last 12 months, compared with 14% of males who reported they were abstinent; this was statistically significant.

Of those who regularly drink and who answered the question "How many units do you drink on a typical day when you are drinking?" 51% reported drinking in excess of 10 units¹¹. When compared to the national estimates from Homeless Link, the proportion of those drinking in excess of 10 units is higher in West Sussex. (This is also statistically significant)

Table 3: Number of units respondents thought they drank during a typical drinking session

Units of alcohol	West Sussex	Homeless Link (All)
1-2 units per day	14%	16%
3-4 units per day	17%	22%
5-6 units per day	13%	16%
7-9 units per day	5%	11%
10+ units per day	51%	35%

¹¹ This is approximately three large glasses of wine or three and a half pints of Lager

Self-reported alcohol misuse was identified in 38 participants (17%), while an additional 38 were currently in recovery from an alcohol.

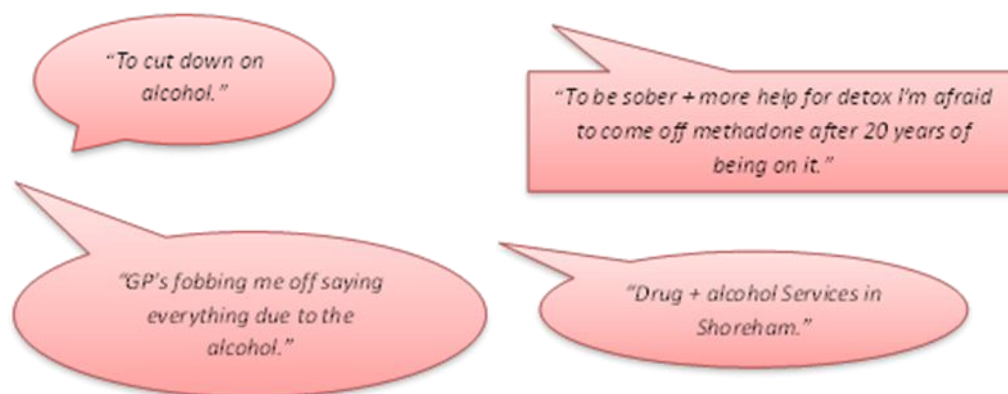
Due to the self-reported nature of the audit and a lack of clinical definition of an “alcohol problem” the figures discussed do not cover the larger picture. Of the 137 respondents that claimed to not have an alcohol problem, 21 claimed they drank at least 3 days a week.

Of those reporting current alcohol misuse, only 18 were receiving support or treatment, with twelve respondents reporting that they needed further help. A total of 19 were not receiving any support or treatment, with 14 of those reporting that they would benefit from it. One respondent self-reporting current alcohol misuse did not give a response about whether or not they were receiving any support or treatment.

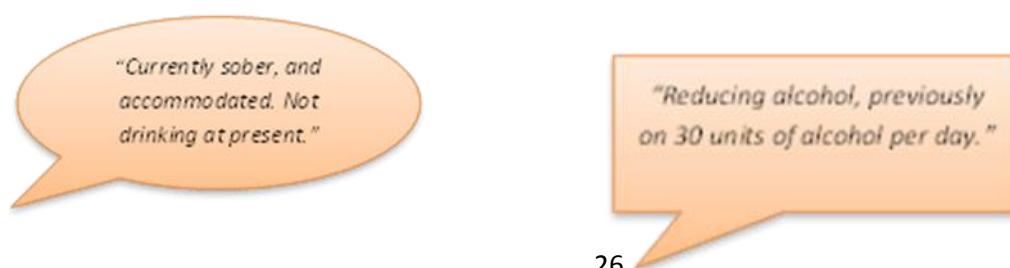
Of the 38 in recovery, 25 (65.8%) were currently in receipt of support or treatment. Of these, 18 (72%) think that the service meets their needs, while the remaining seven thought they needed more help. Advice and information (e.g. from GPs, A&E departments), self-help groups (Alcoholics Anonymous), peer support, and residential rehabilitation were all widely reported as meeting need.

All respondents in recovery who wanted treatment and support were currently receiving it at the time of the audit. There was a positive response to questions about counselling or psychological treatment: with seven of eight respondents saying it met their needs. Aftercare, peer support, residential rehabilitation, and advice and information also ranked highly: within each category over 70% of respondents stating that the service met their need. Self-help groups such as Alcoholics Anonymous were rated least effective with six of the 21 respondents using those services stating they would still like more help.

When asked what could be improved, tackling alcohol addiction and associated health issues were mentioned by six participants. Alcohol was often mentioned along with drugs:



Two comments were made about their current alcohol status when asked for any other comments:



One participant suggested that alcohol is part of their strategy for coping and was currently working well for them at the time of the survey:

"Medication, speaking to mental health nurse at WHCP, alcohol and legal highs"

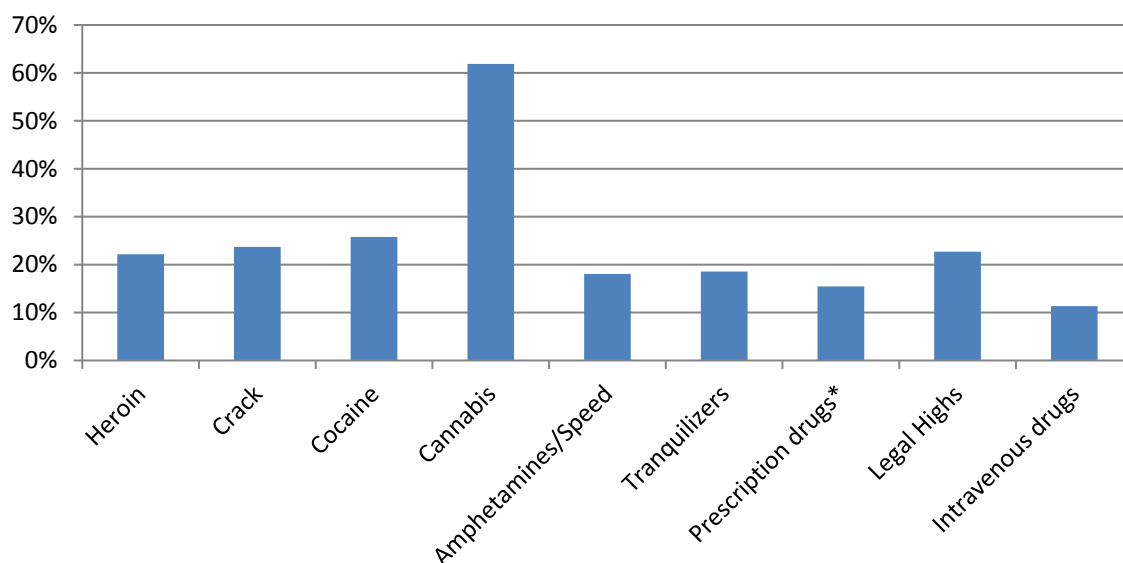
One service user suggested that they had a positive experience in a rehabilitation centre, despite a subsequent relapse.

"The help and care I received in the last year at the treatment centre enabled me to stay abstinent for that period. Unfortunately I have since relapsed."

3.3. Drug use

Of the 206 responses to the question about recreational drug use, 130 (63%) people reported that they had used recreational drugs in the past 12 months with 77 respondents reporting current prescribed medication use.

Figure 9: Percentage of respondents that have taken drugs within the last 12 months

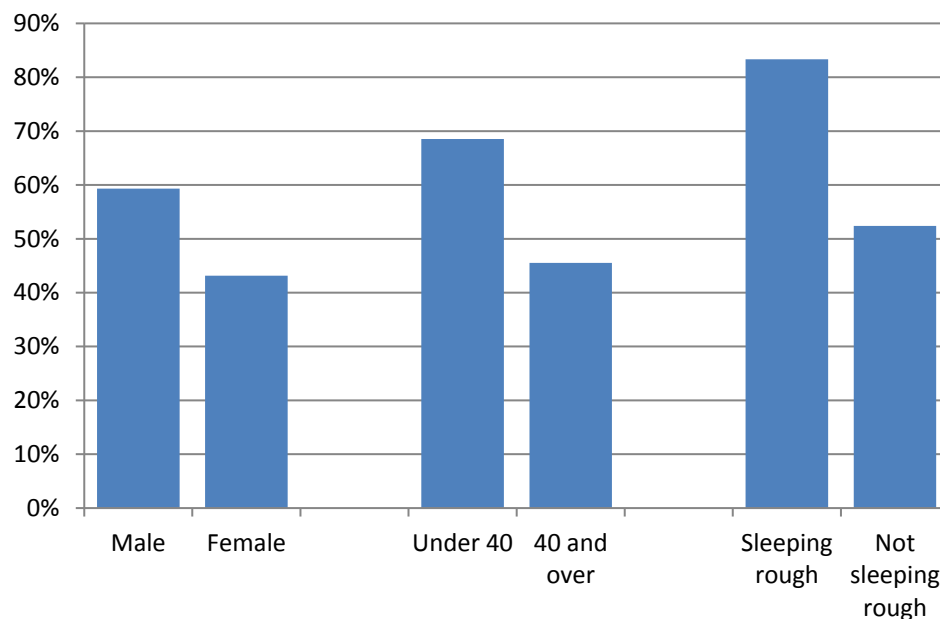


*(not prescribed to the respondent)

There were large differences in drug use across different demographics with men more likely to use drugs than women. Those under the age of 40 were also more likely to report drug use than their older counterparts. The biggest difference in reported drug use was seen between those sleeping rough and those not (83% vs. 52% respectively)

Twenty-two (11.3%) participants said they had injected drugs within the last 12 months, which is high compared to national estimates from 2014 produced by the NHS, putting the prevalence of the overall population's use of needles to administer drugs at 0.25%.

Figure 10: Percentage of respondents that had used any recreational drug in the last 12 months, by demographic



Although 26 respondents said they were currently taking Methadone, only 19 reported that it was prescribed to them. Of the 215 respondents that completed the question, regarding self-reported drug problems and recovery, 35 had identified that they had a drug problem. A further 34 said that they were currently in recovery. Of interest are the 80 respondents who said they had used drugs within the last 12 months, but did not perceive themselves as having a drug problem or being in recovery. There were no questions about frequency of use and therefore it is not possible to know whether these reported uses are regular, isolated incidents, or previous dependencies which have since stopped.

Of the 35 people reporting a current drug problem, 21 were currently receiving support or treatment, while 13 of these felt they needed more help. Of the 11 who reported not receiving support or treatment, nine said that they believed it would help them and three gave no answer to this question. The type of drug use had some correlation with the perception of a self-reported problem, with 55% of those that injected drugs believing they currently had a drug problem. This is higher than the average across all drugs at 26%. In comparison, of the 40 people that had solely used cannabis in the past 12 months, only four believed they had a drug problem.

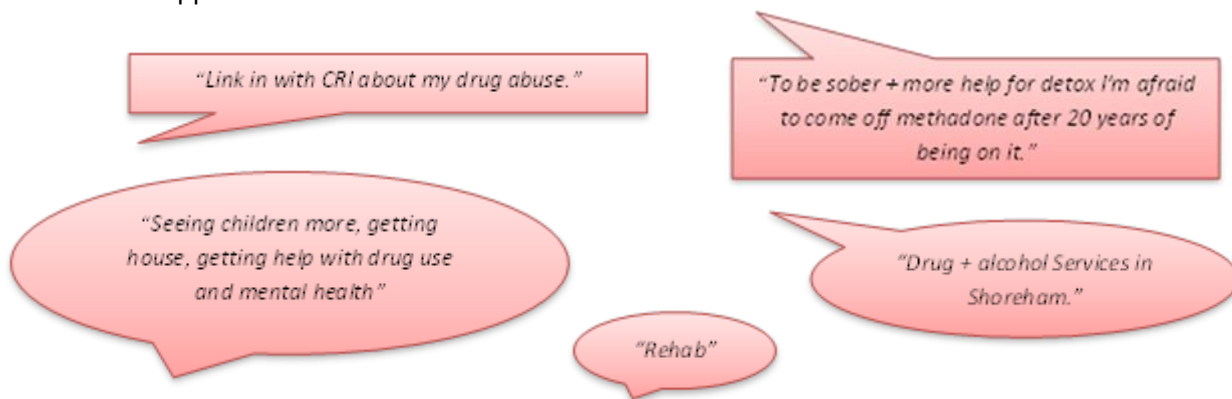
Of the 34 people reporting that they were currently in recovery, 22 were receiving support or treatment of which 13 stated that this treatment or support met their needs. The remaining nine felt

they needed more help. A further nine respondents were not in receipt of support or treatment, with three of them saying support would help. (One respondent left this question blank).

In terms of individual services or treatment, eight of the ten that were currently in or had previously used residential rehabilitation services, thought the service met their needs. Self-help groups (e.g. Narcotics Anonymous) were not thought to be effective at meeting respondent's need, with six of the 13 that used the support service needing more help. Advice and information (From GPs, A&E) and community prescribing were also perceived to be of limited benefit.

When asked to provide the reasons behind how and why they last became homeless, 27 (12%) of those who answered, reported that drug and alcohol problems were the primary cause. A further 23 reported it as their secondary cause.

Participants provided comments around areas for improvement as far as their needs, drug services and support were concerned:



When asked what was working well for them, two participants suggested that drugs were part of their coping strategies:



3.3.1 Self-medication

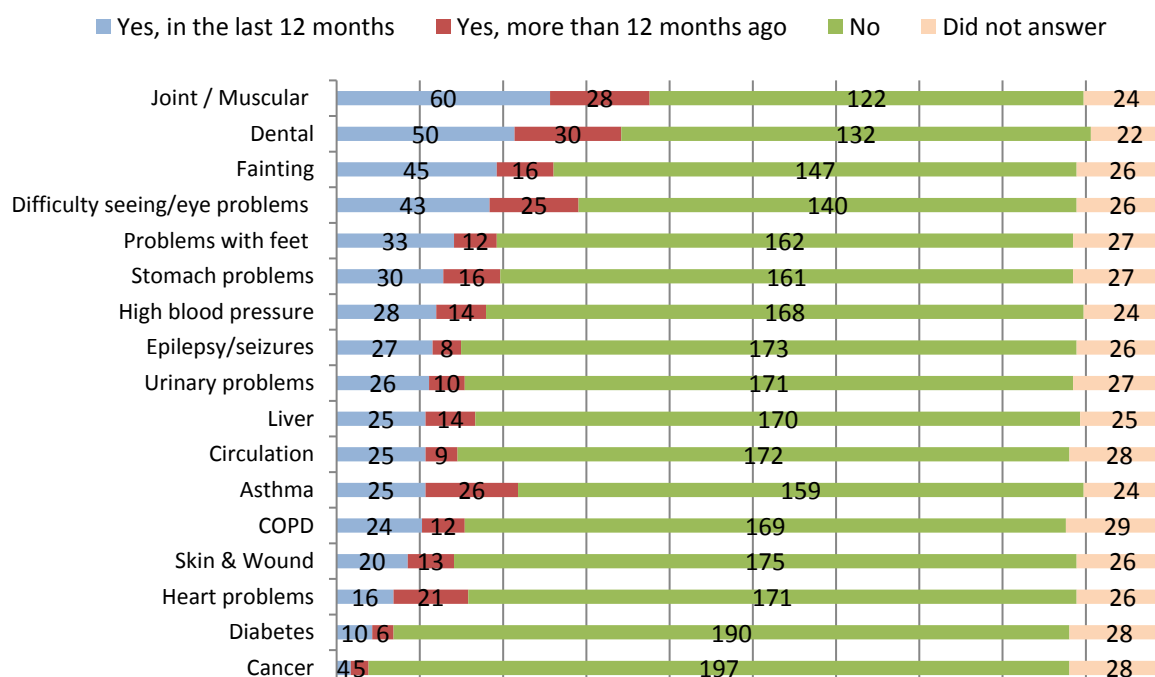
All respondents were asked whether they use or have used drugs or alcohol as a form of self-medication to cope with their mental health condition. Of the 198 with a listed mental health condition, 186 responded. Over half (n=98) said they self-medicate or have self-medicated in the past.

3.4 Physical Health

Of those that answered the question about long-standing illness, disability or infirmity, 73% reported they had at least one. Although there is no direct comparison, a near equivalent is those self-reporting a long term limiting illness (LTLI) in the 2011 Census. By that measure, 15.5% of the West Sussex population report having a LTLI.

The majority of respondents (63.7%, n=149) reported they had been told by a health professional that they had one of the physical health problems listed in figure 12 within the last 12 months. This figure rises to 185 (79.1%) when respondents were asked to consider whether a health professional has told them they have at least one of the listed health problems at any point in their life.

Figure 11: Number of respondents that had been told by a health professional in the last 12 months they had a physical health problem



The most common physical condition was joint aches and problems with bones and muscles, with 29% of those that answered saying they had spoken to a health professional about the condition within the past 12 months. A further 13% had spoken to a health professional about the condition more than 12 months ago. The overall figure of 42% is lower than the homeless link figure of 47%.

Generally, the distribution of these health issues in West Sussex was in line with the overall figures from Homeless Link. West Sussex respondents are more likely to report epilepsy and/or seizures (17% vs 5%) and reports of fainting in West Sussex respondents were also higher than the national estimate.

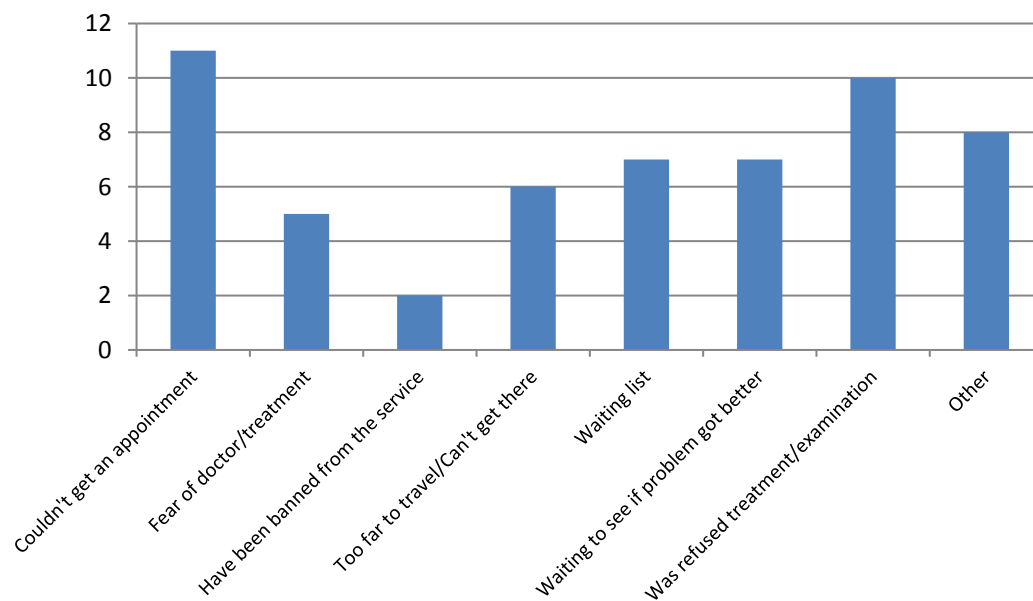
Of the 149 who reported one of the listed physical health problems in the last 12 months, 130 responded to the question "If yes to any physical health need, are you receiving support/ treatment to help you with your physical health problem?". The majority of respondents were receiving treatment (73.1%, n=95), but 45 of these said they still felt they required more help. Of the remaining 35 respondents not receiving support or treatment, 18 believed that it would help their condition if they were getting treatment and the remaining 17 did not think they needed any.

Table 4: The number of respondents receiving support for a physical health problem in the last 12 months

Answer	Count	Percentage
Yes, but I'd still like more help	45	34.6%
No, but it would help me	18	13.8%
Yes, and it meets my needs	50	38.5%
No, I do not need any	17	13.1%

Those taking part were also asked if they believed they needed a medical examination or treatment for a physical health problem but had not received it. A total of 59 respondents claimed they had not received treatment when they thought they needed it. The reasons for not getting treatment or support are detailed below in figure 12.

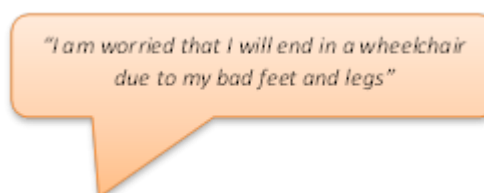
Figure 12: Reason for not receiving medical examination in the past 12 months



There were three comments made from participants about their health issues and what was – or potentially could be - working well for them;



One participant expressed concerns around further deterioration of their physical health if they remained homeless.



3.4.1 Cancer

A total of nine respondents reported they had been diagnosed with cancer, with four of these diagnoses within the last 12 months.

3.4.2 Human Immuno-deficiency Virus (HIV)

As highlighted earlier, the homeless population are far more likely to administer drugs using a needle. This practice can increase the chance of contracting a number of blood-borne infections, one of which is HIV. The risk of acquiring HIV increases when needles are shared and re-used and is currently the highest risk activity associated with HIV infection. A total of three respondents had been diagnosed with HIV, all of which had been diagnosed more than 12 months ago. These numbers are small and therefore comparison with the overall population may give misleading comparisons.

3.4.3 Hepatitis C

Like HIV, Hepatitis C is a blood-borne virus, but this is a common infection among people who inject drugs with shared needles. Overall there were 21 respondents that reported they had been diagnosed with Hepatitis C, with 13 of them being within the last 12 months. Of those diagnosed, 13 were offered treatment, although five respondents did not take this up. It should be noted that treatment for Hepatitis C is both long and arduous and this may impact on the choice to undergo treatment.

3.4.3 Tuberculosis (TB)

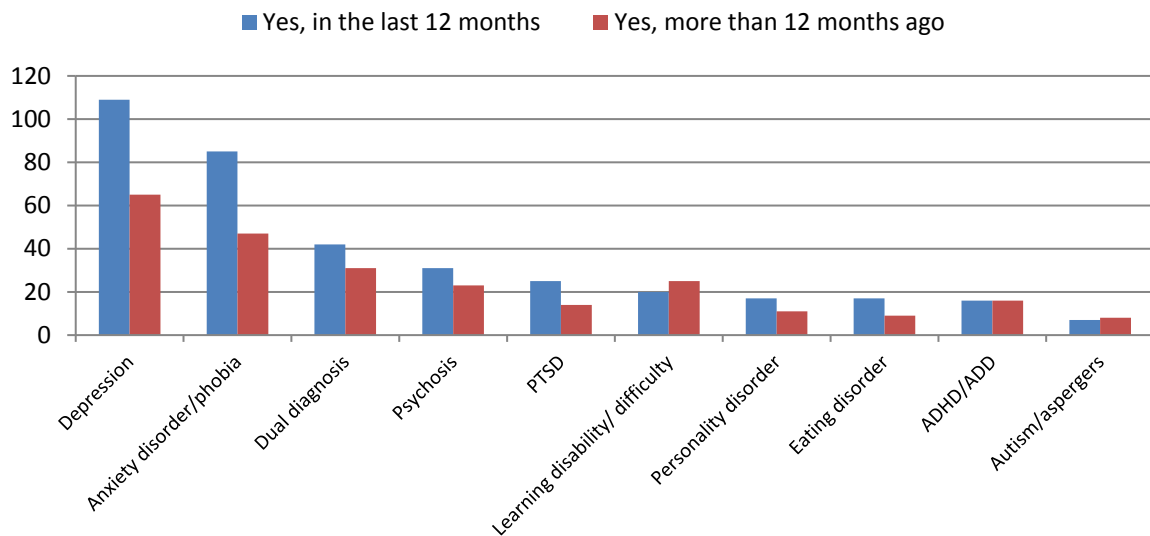
Only a small number of those that took part in the audit reported they had been diagnosed with tuberculosis. Of the three who had been diagnosed in the preceding 12 months, all had been offered and completed treatment.

3.5 Mental Health

3.5.1 Diagnosis and prevalence

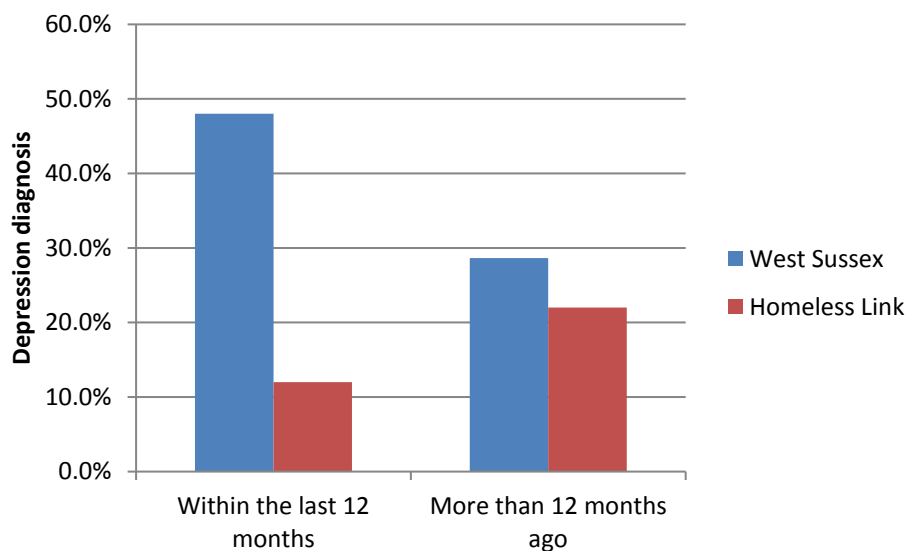
Within the last year 133 of 229 (58.1%) respondents had been told by a health professional they had at least one of the mental health or behavioural conditions listed in figure 14 below. This figure rises to 198 (86.5%) respondents when the time frame is extended past 12 months.

Figure 13: Number diagnosed with a mental health issue by a health professional



Depression, general anxiety disorder (GAD) and dual diagnosis (severe mental illness and drug or drug and/or alcohol misuse) were the three most frequently reported diagnoses; both within the last 12 months and more than a year ago. While the rates of diagnoses could not be compared with the Homeless Link figures, depression, dual diagnosis, and personality disorder could. Diagnosis rates were varied, with depression diagnosis within the last 12 months being four times higher in West Sussex than the Homeless Link average. While the prevalence of dual diagnosis within the last 12 months in the national Homeless Link sample is 5.0%, the rate in West Sussex was again four times higher at 19.9%. The rate of those with a diagnosed personality disorder in West Sussex was higher than the overall sample (8% vs. 3% respectively, of diagnosis within the last 12 months).

Figure 14: Those diagnosed with depression by a health professional



3.5.2 Treatment and support

Of the 133 respondents who reported they had been told they had/have one of the listed mental health conditions in the last year, 84 said they were currently receiving support or treatment. Of these 84 just over half (n=44) thought the services they were receiving were meeting their needs. The remaining 40 respondents thought they required further help in addition to their current support programme.

When asked about any previous admittance to hospital related to a mental health issue, over a third of respondents (35.1%) reported they had previously been admitted to hospital because of a mental health issue. This indicates that the level of mental health issue is far more severe in this population than in the general population.

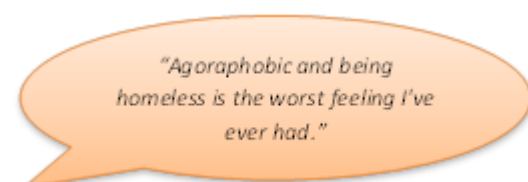
Table 5: Number of those admitted to hospital due to a mental health issue, by demographic

Demographic	Yes	Total	Percentage
Male	59	177	33.3%
Female	21	51	41.2%
Under 40	40	108	37.0%
40 and over	42	123	34.1%

In terms of diagnosis and treatments, comments were made from participants highlighting issues in the support provided:



One comment made from a participant highlighted how certain mental health conditions are exacerbated by being homeless:



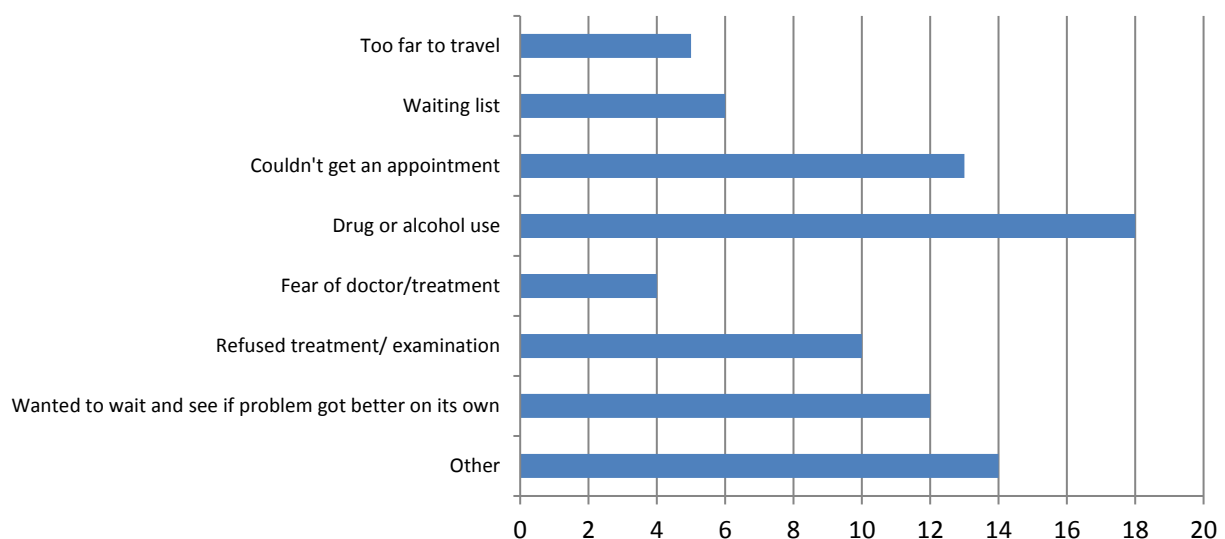
A further 47 of the 133 with mental health conditions were not receiving any support or treatment for their conditions. Of these 28 believed that support would help them, while 19 felt they did not need any support or that support would not help. There was no correlation between specific conditions and whether the respondent wanted help.

Of the range of support services and treatments, talking to a professional such as a counsellor or therapist ranked highest. 70% of those using it saying it met their needs (26 out of 36). Services that tackle mental health conditions alongside drug/alcohol use (dual diagnosis services) ranked lowest with 54% of those using it saying they felt they needed further support. Although 49% reported that medication sufficiently dealt with their condition, an equal number reported that they still needed more support while one person left the question blank. (A full breakdown of support effectiveness can be found in the appendices)

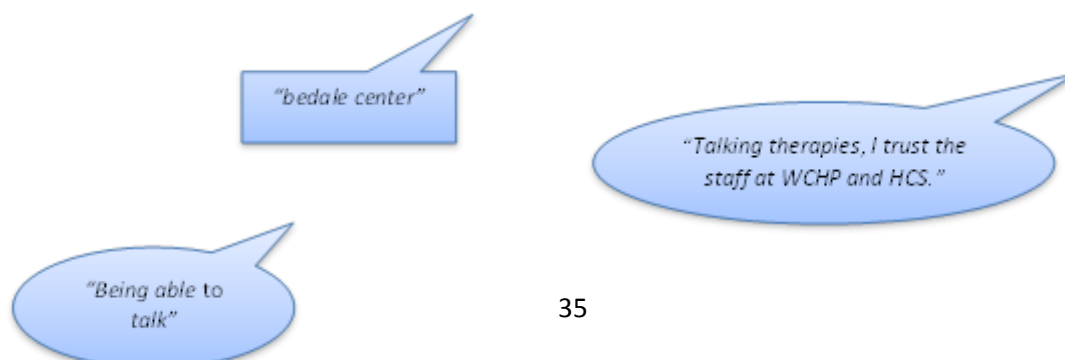
Respondents were asked if they felt they needed a professional assessment for a mental condition but didn't receive it within the last 12 months. Of the 226 respondents that gave an answer, 87 (38.5%) said that they had not received an assessment.

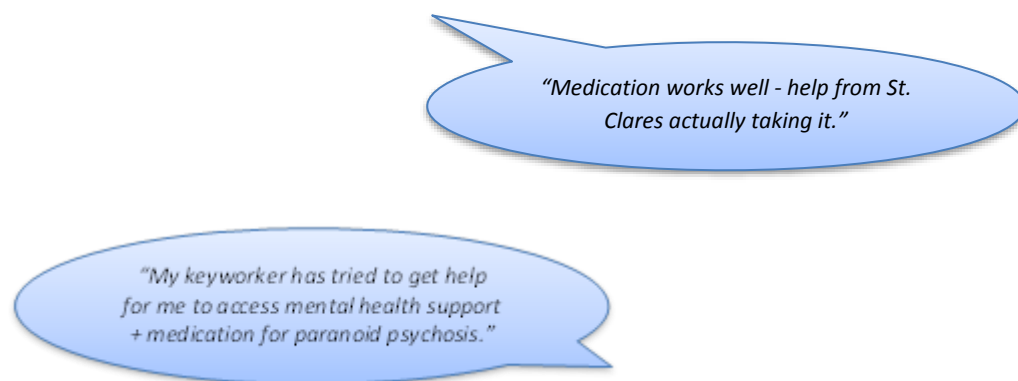
Of these 87, 82 gave a reason for why they did not receive an assessment. The most common reason was due to drug or alcohol use (n=18) with many rehabilitation programmes requiring users to be sober when attending appointments and will refuse treatment if this requirement is not met. For those with extreme addiction these demands can often be unrealistic. Refusal of treatment to addicts can often exacerbate the problem. Local authorities such as Bristol recognise that many people are unable to reach this strict condition and have started to open 'wet clinics', which relax this condition. Exploring this option locally could potentially increase the uptake and ultimately the successfulness of rehabilitation programmes for those with the highest need.

Figure 15: Reasons the respondent could not attend or receive an assessment

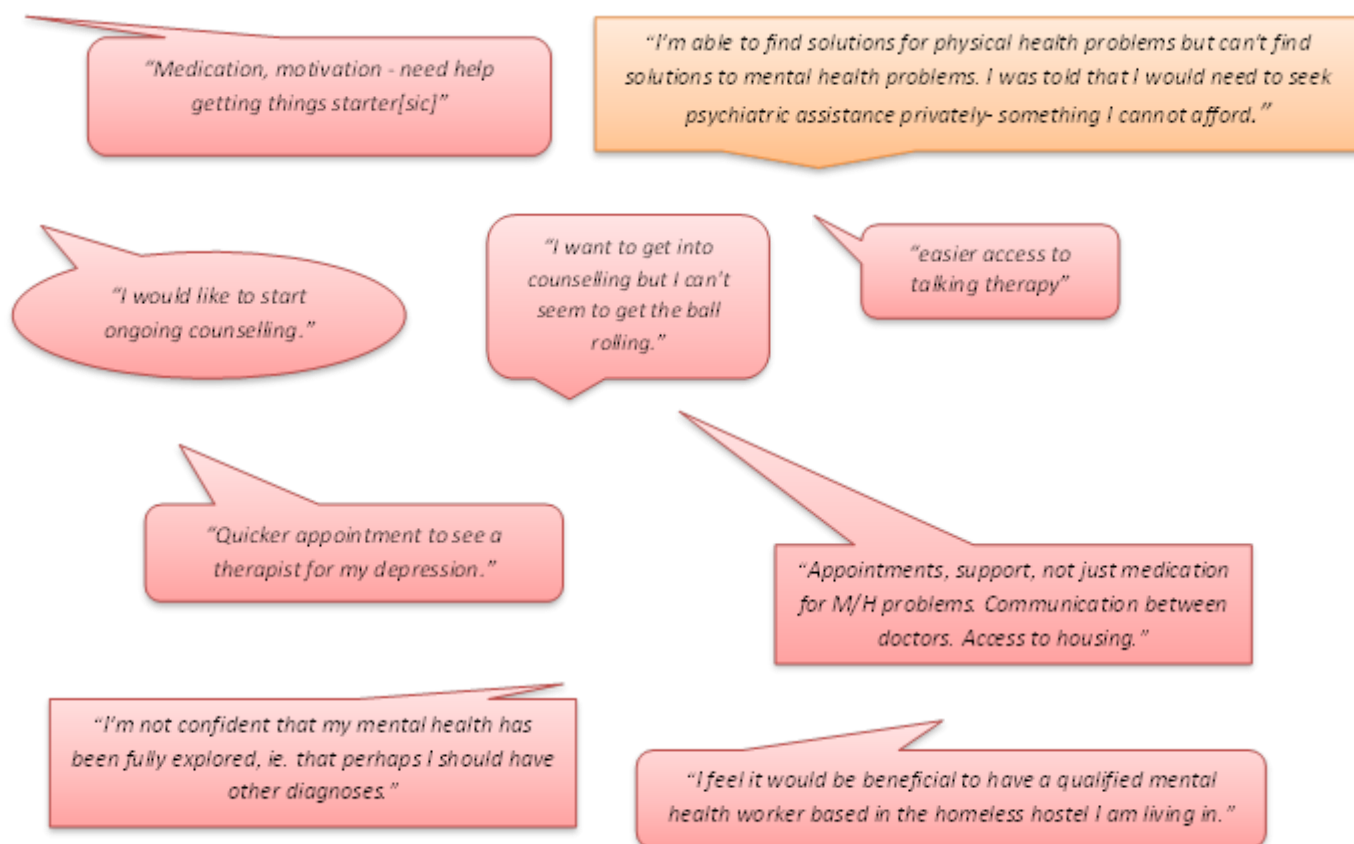


Mental health services were the main emerging theme from comments made by participants. When asked what was working well, five responses were recorded:





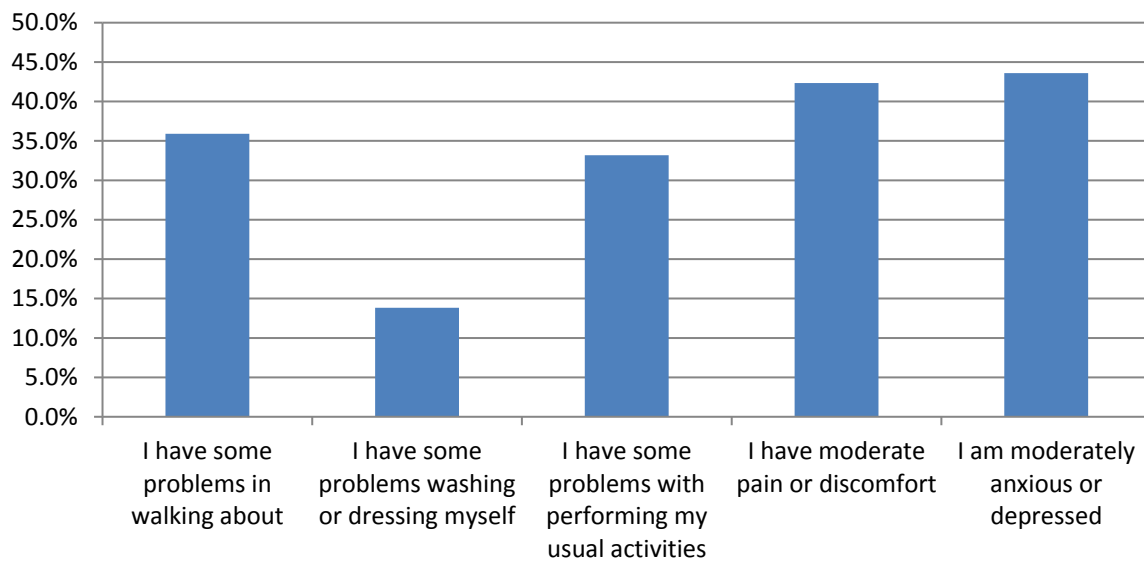
Ten participants identified improvements to their lives or current care:



3.6 Wellbeing

Participants were asked seven basic questions regarding general wellbeing, these questions were taken from the EQ-5D-3L which is a tool used to standardise the measurement of health status. Under this system, respondents were asked a simple question around five domains; mobility, self-care, usual activities, pain/discomfort, and anxiety/depression. Each question is multiple choice and all follow a style similar to, "no problems", "some problems", and a "severe problem". Figure 16 details the percentage of those replying with the "some problems" answer.

Figure 16: Responses regarding general wellbeing



Only one respondent answered they were confined to bed on the mobility domain and unable to wash or dress themselves on the self-care domain; both of these responses were for the same individual. Six people replied that they were unable to perform usual activities.

While 46% reported they were not in pain or discomfort, 42% said they were in moderate pain or discomfort with 12% (27) stating they were in extreme pain.

Just under three-quarters of the sample reported they were either moderately anxious or depressed, with 64 (30.3%) of these reporting they were extremely depressed. This was lower than the diagnosis figure for depression. This could be explained by the wording of both questions and the larger time frame involved in the latter question.

When participants were asked compare their current health with their perceived health 12 months ago, 88 thought their current health was worse than a year ago (38.6%), while 82 thought there health had improved in the same period.

When asked what was working well towards their overall wellbeing one participant commented:

"Having a dog, talking to people, seeing my children"

Chapter 4 - Access and use of services

Given the often itinerant nature of their lives, access to and use of health care and support services can be a challenge to homeless people. This section looks at identifying current barriers that hinder the demographic from accessing and using setting such as GPs and A & E and also look at discharge and readmission at hospitals.

4.1. Registration with health services

4.1.1 Dental services

Of those who responded 89.3% (n=201) reported they were registered to either a GP practice or a homeless healthcare service which is broadly in line with Homeless Link's reported figure of 92%. The registration rate is broadly similar across gender and age groups, differing no more than 2% from the overall figure, other than for 18-25 year olds who had a GP registration rate of 85.3%. However, this was not a statistically significant difference.

When asked whether they were registered to a dentist, the registration rate was reported to be far lower than for GPs at 44.3% (n=93). This was also found to be lower than the national Homeless Link reported figure of 58%. There was little variation in registration rate by age, and although the male: female split 42% to 52% was notable, it was not statistically significant.

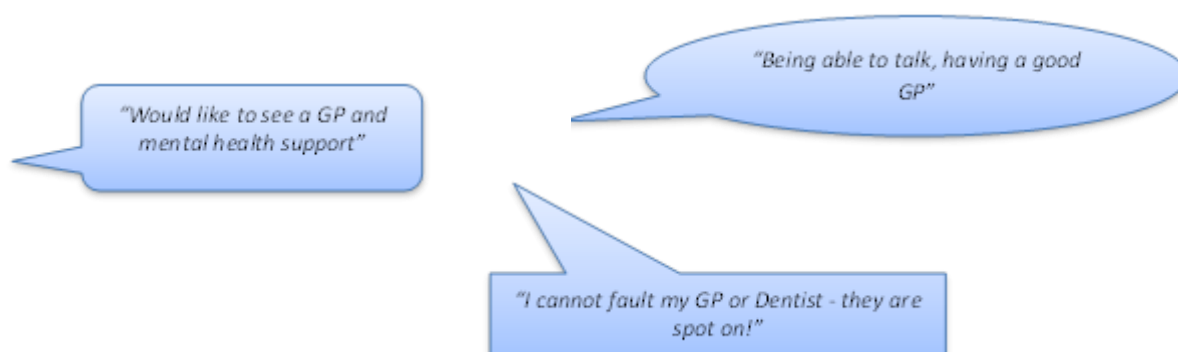
4.1.2. General Practice (GP)

A total of 163 respondents could be matched to a GP practice, and the five most reported practices are:

- Bognor Health Centre, Bognor Regis (n=28)
- Health Central Surgery, Worthing (n=20)
- Worthing Medical Group, Worthing (n=15)
- The Old Glassworks (n=15)
- Selden Medical Group, Worthing (n=9)

Across all GP practices, 64% of those that were registered who answered the question thought their GP practice was either "Good" or "Excellent", while 10% rated the service they receive as "Poor".

Three respondents identified how the support of their GP was a particular area that was working well for them:



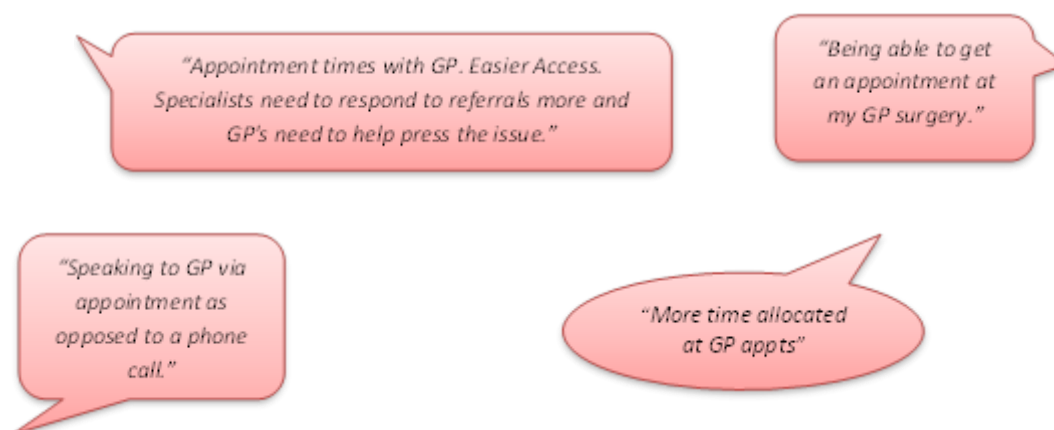
4.2 Refusal of services

4.2.1 GP services

Sixteen respondents reported they had been refused registration to a GP in the last 12 months. All 16 respondents gave a free text reason as to why they were refused. The two main themes were around lack of acceptable forms of identification and address/postcode issues (either lack of address or out of catchment area). One participant reported he had been refused registration due to a previous drug addiction. These claims go against the NHS national guidelines¹².

Outlined by national research¹³, focus on GP registration and adequate appointment systems is key to cut down on the use of urgent care services by homeless people accessing for urgent health problems.

When asked what could be improved, a number of participants identified issues with access to GP services:



4.2.2 Dental services

Eleven respondents had been refused registration to a dentist, with six providing free text responses about the reason for refusal. Identification issues were again mentioned, as were lack of spaces on the dental practice register and previously missed appointments.

4.3. Use of services

Respondents were asked about the services they use and the frequency they use them and these are detailed in the table below.

¹² NHS England (2015): Patient Registration Standard Operating Principles for Primary Medical Care (General Practice) Available at: <https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/11/pat-reg-sop-pmc-gp.pdf>

¹³ Addressing the health needs of rough sleepers: Griffiths (2003)

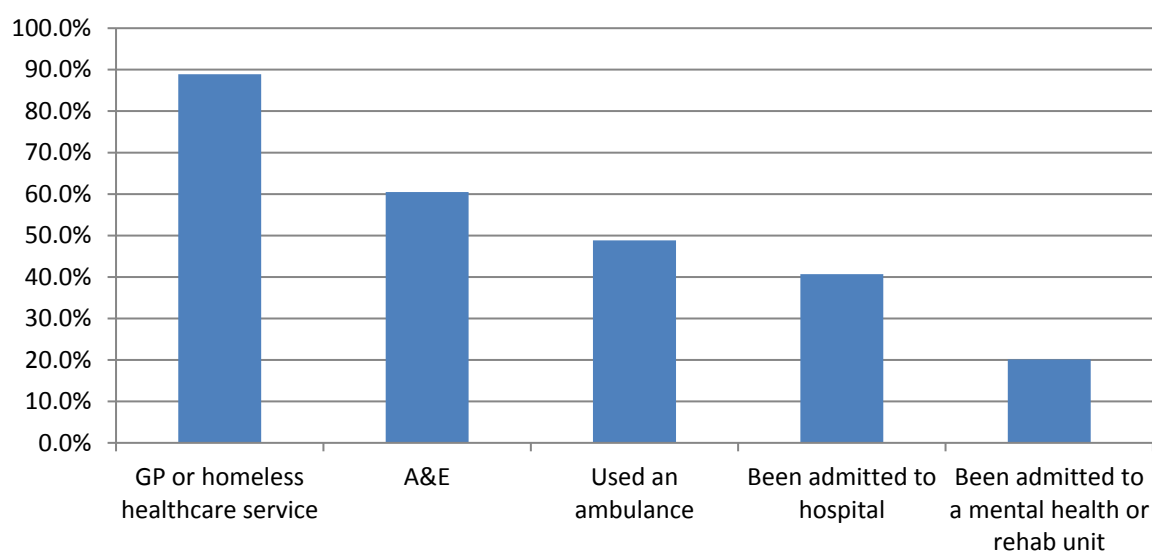
Table 6: Use of healthcare services, and reason of use

In the past 12 months have you-:	Been to a GP or homeless healthcare service	Been to A&E	Used an ambulance	Been admitted to hospital	Been admitted to a mental health or rehab unit
No	25	83	108	124	163
Once	27	36	44	35	30
Twice	28	39	28	25	4
3 Times	30	17	9	6	3
Over 3 times	115	35	22	19	4
At least once	200	127	103	85	41
% at least once	88.9%	60.5%	48.8%	40.7%	20.1%
Total Answered	225	210	211	209	204

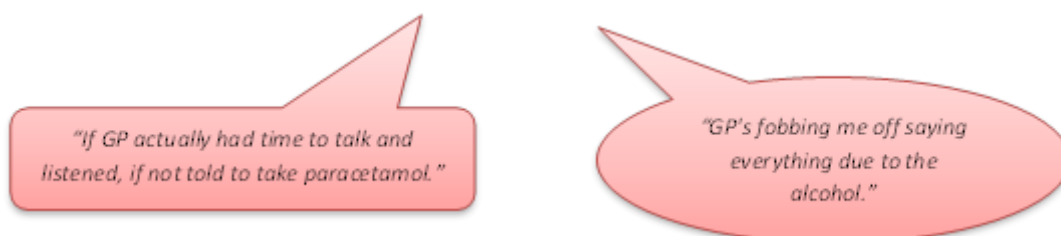
Figure 17 shows the percentage of those who responded to the question about service use and who used that service at least once in the last 12 months. As can be seen, use of a GP or homeless health care service is extremely high.

When cross-referenced with GP registration, of the 201 respondents who were registered, 183 (91%) had used the GP or homeless healthcare service at least once in the last 12 months. The 12 people who reported that were not registered to a practice were still able to access one, while five with 'unknown' registration status used a GP service.

Figure 17: Percentage of respondents that have used services within the last 12 months



When asked for comments about where improvements might be made, GP services were highlighted:



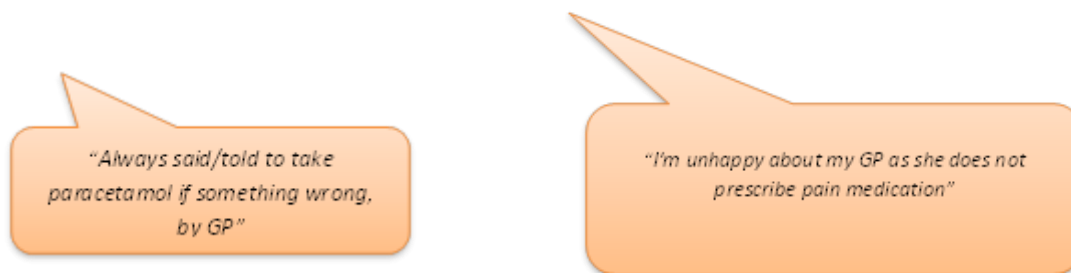


Figure 18: Reasons given for accessing health services, by route of admission

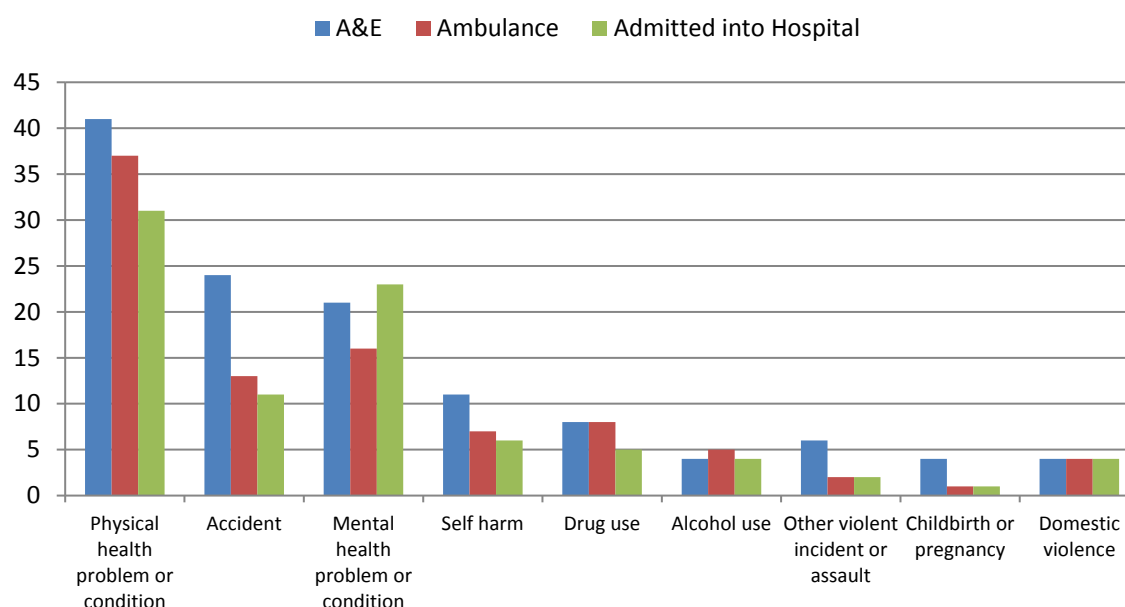


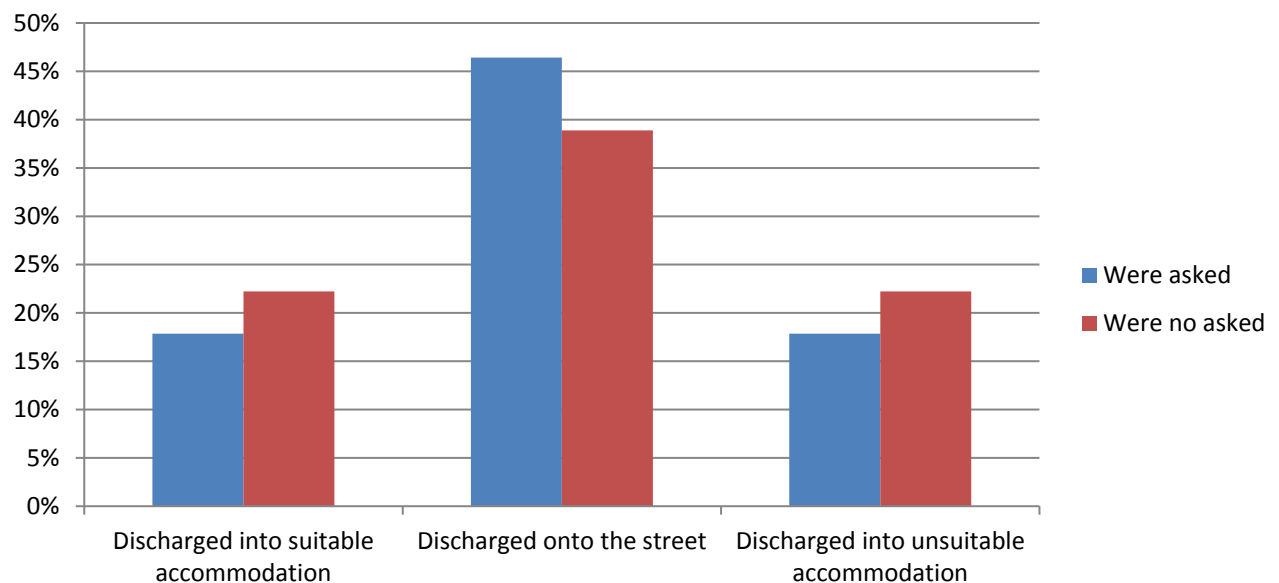
Figure 18 shows the extent of hospital and A&E services in the county in the homeless population. While use of services due to accidents and genuine emergencies is often unavoidable, greater access and use of primary health care through GPs and drug and alcohol services could in part help reduce the numbers of homeless people using emergency services for non-urgent conditions as well as mental, or alcohol and drug related conditions.

4.4. Discharge from hospital

Respondents who said they had been admitted to hospital in the last 12 months were asked two questions regarding their discharge. "Did staff ask you if you had somewhere suitable to go when you were discharged?" and "After being discharged, were you readmitted within 30 days?"

Of the 85 respondents who had been admitted to hospital in the previous 12 months, 79 responded to the first question. Of these, 36 were asked by staff if they had somewhere suitable to go after discharge; 28 specifically said they were not asked; while the remaining 15 could not remember.

Figure 19: Percentage of those being discharged, by discharge destination and whether or not they had been asked where they would go on discharge



Due to the self-reporting nature of the survey and lack of guidance or definition, “suitable accommodation” is determined without criteria by the respondent.

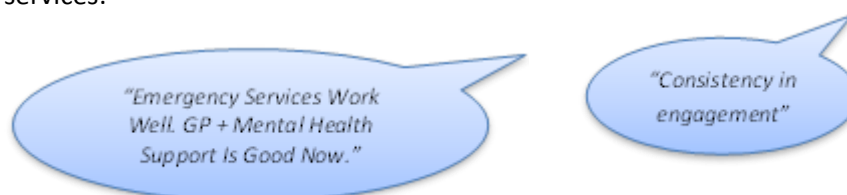
Figure 19 above shows that those who were asked whether they had suitable accommodation were more likely to be discharged onto the street. Those who were not asked were less likely to be discharged into unsuitable accommodation. This is counterintuitive and unexpected.

In total 31 respondents were discharged onto the streets. This issue has been highlighted nationally by Homeless Link, and if there is no need for social service involvement at discharge it is not within the local authorities duty to ensure they are discharged into suitable accommodation.

4.5 Readmission

Respondents who had been discharged were asked if they were readmitted within 30 days. Of the 85 people who had been admitted to hospital in the last 12 months, 75 answered the question. Of these 18 said they were readmitted within the next 30 days and four could not remember.. Nine of these were respondents who had been discharged onto the street, while five respondents who were readmitted had been discharged into unsuitable accommodation.

There were comments made from participants about what was working well in their access to health services:



Another two participants expressed frustration about waiting times – although this is a commonly expressed issue in the general population.

"I've got to wait on results"

"Waiting times"

Other comments from service users provided feedback on use of health and other support services (including services for homeless people). When asked what was working well, there were a number of positive comments:

"Outreach"

"Support from Staff"

"Support worker from council + medication"

"Community Outreach Keyworker (Arun) Worthing Churches and the support in supported accommodation"

"The support at Stonepillow Sands"

"Advocacy, and having support to access services"

"When U find a keyworker that U can build a rapport with that it can be longer for a few months"

"Professionals who are caring and understanding."

"Being here at Sands Project Stonepillow I got all the support I need."

"Talking to staff at the Chichester Hub as they understand my needs"

"Engaging with staff at stonepillow"

"I would highly recommend rehabilitation in Stonepillow Sands project."

"Very grateful to Crawley Open House Support."

There were a number of areas for improvement identified by participants:



4.6 Screening, Immunisation and Health protection

Uptake of preventative measures such as screening, vaccinations and health promotion services can not only greatly improve the long term health outcomes most people, but also present an opportunity to reduce the need to for urgent care use. The homeless population are often are at a higher risk of a number of preventable health conditions and ensuring prevention is accessible for people who are homeless can improve health outcomes. ..

4.6.1. Influenza

Research has shown that while the homeless population are more likely to be eligible for free vaccinations, they are less likely to take this up compared to the general population¹⁴. This could be due to a number of factors, including accessibility, health literacy and perceived benefits.

Of the 205 responses to the question regarding vaccination uptake, 120 (59%) said they had never received an influenza vaccination before. Of the remaining 85 that had been vaccinated only 43 of them had been vaccinated in the last year. It was not clear as to whether the respondents had been offered the vaccine during the course of any contact with healthcare services.

Currently the flu vaccine is provided for free by the NHS each year to those in at risk groups including (but not limited to) those over 65 year of age, certain health conditions, and pregnant women. Those that are measurable from the audit are asthma, chronic obstructive pulmonary disease (COPD) and HIV. A total of 75 respondents were identified to meet these medical criteria, 29 had received one within the last year, 16 in previous years, while 27 had never received a flu jab (three identified did not answer the question surrounding the flu vaccination). Again, it is not clear whether they had been offered the vaccination during contact with health services.

4.6.2 Hepatitis B

Those taking part in the audit were asked whether they had been vaccinated for Hepatitis B and if so how many times. The immunisation programme is not available to all, but rather on an at risk basis. However, in order to benefit from the vaccination a series of three must be administered over the course of four to six months, with blood tests to confirm that the host is immune. This is often an unsuitable schedule for a largely itinerant population whom may be unable to plan ahead. This could, in part, explain the 88 respondents that had never been vaccinated for Hep B, as well as the

¹⁴ Influenza vaccination, inverse care and homelessness: cross-sectional survey of eligibility and uptake during the 2011/12 season in London

tailing off of those receiving the second and third injections. While 43 people had received one injection, only 25 and 18 had received two and three injections respectively.

4.6.3 Sexual health

The survey asked whether participants had had a sexual health check in the preceding 12 months. Of those who answered, 24.8% (n=53) reported having had a sexual health check during that time. This was lower than the overall Homeless Link results 35% (p=0.002). Differences between gender and age within West Sussex were also present with a significant difference between males (20.5%) and females (38.8%) taking up sexual health checks within the last 12 months, similar differences are seen countrywide.

The survey does not ask the respondent as to whether they are currently sexually active or what type of sexual activity they may have engaged in and whether there were any high risk sexual behaviours or safe sex i.e. condom use.

Respondents were asked a number of questions around access to sexual health advice, 86% reported they knew where to find advice, with the majority stating they would contact a GP, nurse or attend a sexual health clinic. Eight-two percent also stated they knew where to access free contraception.

4.6.4 Screening

Participants were asked three questions regarding health checks and screening (not including the sexual health checks already covered earlier in the survey). The three checks the audit covered were:

- NHS health checks for those over 40;
- Cervical smear test for females over 25; and
- Breast screening / mammograms for females over 50.

Of the 123 respondents who were 40 years old and over, 51 (41%) reported they had accessed a NHS health check within the last 12 months; this uptake rate was significantly higher than the overall West Sussex uptake of 21.0% of the eligible population aged 40-74.

There were a total of 38 females over the age of 25, 18 of these had received a cervical smear test in the last three years. These figures are in-line with the national uptake rates although lower than the West Sussex coverage of 75%¹⁵.

Of the seven respondents who were female and over the age of 50, four had accessed breast cancer screening in the past three years.

¹⁵ West Sussex and national comparison covers a period of 3.5 years, not 3 years

Chapter 5 - Conclusions and Recommendations

This report, whilst highlighting parts of the system working well, also identifies a number of areas for improvement. Since the audit was undertaken there has been a further piece of work published by Helen Keats Associates Ltd which examines the issues of chronic homelessness in West Sussex, and we would recommend that these findings and recommendations are considered alongside those in *Chronic homelessness in West Sussex: an analysis of the issues for statutory and non-statutory services*.

Conclusion	Recommendation
<p>Strategic multi-systems working to meet need</p> <p>There were a number of findings around lack of support and access to services as follows:</p> <ul style="list-style-type: none"> • Diagnosed prevalence of certain mental health conditions in West Sussex is four times higher than the general homeless link findings. • Over half of people reporting a physical health problem either were not receiving support or did not believe the support they were receiving were adequate. • People reported not receiving an examination, and therefore not receiving treatment and support in some instances (See appendix) • Half of people receiving mental health support found it didn't meet their needs. A full breakdown of which types of support met respondents need can be found in the appendices. • Access to GPs was highlighted as an area for improvement; work to advise GPs on NHS guidelines on access for patients without a fixed address or identification. • Registrations with dentists are lower locally than national findings from homeless link. 	<p>This recommendation is for:</p> <p>West Sussex Health & Wellbeing Board, West Sussex County Council, Coastal and Crawley and Horsham & Mid-Sussex Clinical Commissioning Groups, district & borough councils, dental health services, and the voluntary and community sector</p> <p>In line with the report from Helen Keats Associates, a homelessness health forum should be established as a priority to ensure a multi-agency approach to address these specific issues. Public health, housing, CCGs, dental health services and third sector representation is essential to ensure that a systems wide approach is adopted and that services are appropriate and sensitive to the needs of homeless people, who are not able to access services in the same way as those who without such complex needs.</p>

<p>Homeless women and equity of access</p> <p>Women do not access homelessness services when compared with men, this suggests there are barriers preventing women accessing predominantly male dominated services.</p>	<p>This recommendation is for:</p> <p>West Sussex County Council, Coastal and Crawley and Horsham & Mid-Sussex Clinical Commissioning Groups</p> <p>WSCC and local CCGs should co-ordinate and commission research to better understand the level of unmet need in the population of homeless women specifically. This should be co-produced with people and professionals who are able and willing to engage with homeless women to provide their view and lived experiences.</p> <p>Commissioners should provide services accessible for women using evidence gathered.</p>
<p>Non-UK nationals and equity of access</p> <p>There is a lack of knowledge and insight into the enablers and barriers for non-UK nationals accessing services.</p>	<p>This recommendation is for:</p> <p>West Sussex Health & Wellbeing Board, West Sussex County Council, Coastal and Crawley and Horsham & Mid-Sussex Clinical Commissioning Groups district & borough councils, dental health services, and the voluntary and community sector</p> <p>The recent Black, Asian and Ethnic Minorities (BAME) Needs Assessment by WSCC made a series of recommendations, specifically mentioning homelessness, to ensure that barriers to accessing services are addressed. This work has been taken forward by the Health and Wellbeing Board and we recommend that these recommendations are considered alongside those made here. The full Needs Assessment can be found at: http://jsna.westsussex.gov.uk/wp-content/uploads/2016/05/Black-Asian-and-Minority-Ethnic-Communities-Needs-Assessment-2016.pdf</p>

<p>Economically active people</p> <p>The audit suggested that while there were a higher percentage of homeless people seeking work or formal training locally, that there were significantly fewer actually in employment, training or education.</p>	<p>This recommendation is for:</p> <p>West Sussex County Council, district & borough councils, and the voluntary and community sector</p> <p>Further, urgent, work is needed to understand what the barriers are to people accessing employment, education and training. The current disparity between people's appetite for employment and the lack of opportunity needs to be understood, to ensure so that homeless people are supported to become economically active.</p>
<p>Smoking cessation</p> <p>Due to the complexity of need and very high prevalence of mental health issues – a homeless person is much more likely to smoke when compared with the general population.</p> <p>Local data highlights that while many current homeless people who smoke want to quit and although they regularly access healthcare, they are not getting adequate support to do so.</p>	<p>This recommendation is for:</p> <p>West Sussex County Council</p> <p>Commissioners should consider testing a tailored approach to smoking cessation support in outreach settings where they are within easy reach of homeless people – specifically homeless day services or shelters.</p> <p>In addition, this could be supported by an information campaign about where to access stop smoking support in the community for those also able to access pharmacies.</p>
<p>Healthy body, healthy mind</p> <p>There is a clear demand for more physical activity opportunities and an appreciation of the impact of physical activity on physical and mental wellbeing within the population surveyed. There are clear barriers to accessing preferred forms of exercise which were largely identified as gyms and exercise classes – these were felt to be too costly for most of the participants.</p>	<p>This recommendation is for:</p> <p>West Sussex County Council, Coastal and Crawley and Horsham & Mid-Sussex Clinical Commissioning Groups, district & borough councils, and the voluntary and community sector</p> <p>Commissioners of leisure activities should capitalise on the appetite for accessible and affordable fitness opportunities expressed within this population. Subsidised gym and exercise</p>

	<p>programmes can include homeless people, but should be developed alongside the organisations working with homeless people to ensure optimum use and engagement.</p> <p>Commissioners of existing social prescribing programmes should have access to affordable gym and exercise provision for people who are homeless.</p>
<p>Alcohol and addiction</p> <p>Over a half of respondents identified as having an alcohol problem were not receiving any form of support, while two-thirds of those receiving support reported that this support was not meeting their need. Many respondents suggested they were unable to meet strict criteria around abstinence.</p>	<p>This recommendation is for:</p> <p>West Sussex County Council, providers of alcohol and addiction support services and the voluntary and community sector</p> <p>Further work is needed with homeless people to understand what aspects of current alcohol services are not currently meeting their needs, to improve access and adherence.</p> <p>Commissioners and providers should increase awareness and accessibility of the current 'wet' services available – not limited only to alcohol services – but hostels and other services where people are able to access services during crises.</p>
<p>Discharge from hospital into homelessness</p> <p>Despite a small project focusing on this issue, challenges remain with continued practice of discharging people from hospital into homelessness or into unsuitable accommodation.</p>	<p>This recommendation is for:</p> <p>West Sussex County Council, Coastal and Crawley and Horsham & Mid-Sussex Clinical Commissioning Groups</p> <p>Evaluation of the current project which aims to reduce the instances of discharge to homelessness or unsuitable accommodation is needed.</p> <p>Hospitals need to ensure that staff responsible for discharging patients are both trained and ably supported by discharge protocols which reflect the need to ensure that homeless people are discharged into suitable accommodation.</p>

<p>Health protection</p> <p>Although the proportion of homeless people with high risk characteristics is higher than in the general population, the uptake of free vaccinations are comparatively low. This may increase the risk of serious illness and hospital admissions.</p>	<p>This recommendation is for:</p> <p>West Sussex County Council, Coastal and Crawley and Horsham & Mid-Sussex Clinical Commissioning Groups</p> <p>Commissioners and health protection staff should ensure that as many homeless people as possible, who are in at risk groups of certain infections, are aware that they are entitled to free vaccinations. Homeless people are more likely to need help and support to access and use these services.</p> <p>We would recommend that a vaccination awareness campaign is undertaken, with easily accessible opportunities for homeless people to access this service. It may be that an opportunistic or outreach approach is the most effective to impact on the low uptake rates.</p> <p>Services working with homeless people can collaborate with commissioners and health protection staff to raise awareness and support their service users to access free vaccinations.</p>
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Appendices

Use of mental health support or treatment by type and effectiveness (Question 18, 18a, and 18b)

Type of mental health support or treatment	It meets my needs	I'd still like more help	No Answer	Total
Talking to a professional like a counsellor or therapist (e.g. counselling, CBT, psychological therapies)	26	10	1	37
Support from a specialist mental health worker – e.g. Community Mental Health team, Community Psychiatric Nurse	20	21	3	44
A service that deals with my mental health and drug/alcohol use at the same time	13	15	0	28
Activities like arts, volunteering or sport	13	10	0	23
Practical support that helps me with my day to day life	20	13	0	33
Training and activities to learn new skills/gain employment	6	3	0	9
Medication that has been prescribed for me	43	43	1	87
Peer support - support from others who have been through a similar experience	16	9	1	26
Other	3	7	2	12

Use of drug use related support or treatment by type and effectiveness (Question 23, 23a, and 23b)

Type of drug related support and treatment	It meets my needs	I'd still like more help	No Answer	Total
Advice and information (e.g. from GPs, A&E departments)	7	8	1	16
Harm reduction services, such as needle exchange	7	7	0	14
Self-help groups (often called Mutual Aid), e.g. Narcotics Anonymous	5	6	2	13
Community prescribing (drug treatment prescribed as part of a care plan)	8	10	0	18
Counselling or psychological support	5	4	1	10
Attendance at day programmes, delivered in the community	4	3	0	7
Detox (help with withdrawal as an inpatient)	0	0	0	0
Residential rehabilitation	8	1	1	10
Aftercare (support following structured treatment)	3	2	0	5
Peer support - support from others who have been through a similar experience	7	3	3	13
Other	0	1	0	1

Use of drug use related support or treatment by type and effectiveness (Question 26, 26a, 26b).

Type of alcohol related support an treatment	It meets my needs	I'd still like more help	No Answer	Total
Advice and information (e.g. from GPs, A&E departments)	13	4	1	18
Self-help groups, e.g. Alcoholics Anonymous	12	6	3	21
Community prescribing (drug treatment prescribed as part of a care plan)	3	2	0	5
Counselling or psychological support	7	0	1	8
Attendance at day programmes, delivered in the community	7	2	2	11
Detox (help with withdrawal as an inpatient)	0	0	0	0
Residential rehabilitation	6	1	1	8
Aftercare (support following structured treatment)	4	1	0	5
Peer support - support from others who have been through a similar experience	12	2	2	16
Other	4	8	1	13