A rapid Health Needs Assessment of people that are homeless within the Cwm Taf Morgannwg University Health Board footprint

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Acknowledgements

Thanks go to all who participated in the focus groups, interviews and steering group: including people who are homeless, service providers and representatives from Cwm Taf Morgannwg University Health Board and Rhondda Cynon Taf, Merthyr Tydfil and Bridgend County Borough Councils.

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Executive Summary

People experiencing homelessness die younger than those living in stable, appropriate housing. In fact, they have a lower life expectancy than the average person living in the poorest, least healthy countries on the planet. Whilst this report focusses on health services available to people who are currently homeless, it is important to acknowledge that by the time someone becomes homeless, the wider societal system has already failed.

The vital public health principle of prevention should not be neglected. Prevention of homelessness is a broad and complex issue that requires societal attention and the same forces that shape homelessness – for example the availability of appropriate, affordable housing; strength of communities; accessibility of appropriate services; unequal distribution of wealth – shape the wellbeing of everyone.

Homelessness is a complex issue. People become homeless for a myriad of overlapping reasons – including poor health which is exacerbated and compounded in many complex ways through being homeless. The homeless population is difficult to see and measure, and represents a broad group with a diverse set of needs. This report is therefore not designed to be definitive: it gathers what we do know and can measure about this seldom heard group in the Cwm Taf Morgannwg University Health Board (CTMUHB) area. It is hoped this report serves as a starting point for further work to better understand the needs of this population, rather than being treated as the final word. Because of the complexity of the issue, this report does not give simple answers and identifies relatively few 'off-the-shelf' policies that should be implemented. Instead the report aims to give an indication of the needs of the homeless population, a flavour of how services are working in the CTMUHB area and takes an honest approach to identifying gaps in knowledge and services.

The report combines local quantitative data as well as qualitative data from focus groups and questionnaires conducted with people experiencing homelessness in this area. These local data sets are supplemented with national data to fill in information gaps and place the situation in the CTMUHB area into a wider context. The fieldwork for the project was undertaken during the lockdown period of Covid 19 in April and May 2021 so some potential respondents were unable to make themselves available.

The main health issues identified will be familiar to people experiencing homelessness and many people working with this population. Mental health is once again flagged as an important health need, substance misuse is very prevalent in this population and some specific physical health issues as well as more general physical health issues cause death and disease. Crucially, these very often overlap.

What is currently working well?

The commissioning of this report demonstrates the commitment of the Health Board with partners to consider its health response to some of the most vulnerable people in its community. All NHS services contacted were keen to look at their service and consider how it could be made more accessible to homeless people. In particular the merger and subsequent restructuring within CTMUHB was seen as an

opportunity by many services and leaders to consider how they reached the most vulnerable in their communities.

There were pockets of activity identified where individual service areas have identified health and homelessness as an issue and taken steps to consider how best to improve services for this group. These include:

- Enhanced services in primary care for the homeless
- Investment secured by the Taf Ely Primary Care Cluster for a homeless nurse for one year
- A pilot project by the podiatry service
- A review of immunisation and vaccination by the Local Public Health Team
- Investment in mental health services by hostel providers and through Supporting People funds
- Local relationships developed by hostel services and providers of primary health care in their local area
- Indirect improvements in services to homeless people as a consequence of the Covid-19

What could work better?
It will be no surprise to the Health Board that an overall strategic approach to meeting the health needs of homeless people was not evident. Homelessness is a complex issue and the responses need to be highly individual and tailored to truly make a difference to people's health, based on using the available health intelligence to plan and deliver services, and through working in partnership at both strategic and operational levels. In addition, those areas that were working well were not consistently applied across CTMUHB. A particular focus of attention should be mental health services. It is no surprise that mental health was a major cause of ill-health in this piece of work, yet there was not clarity that mental health services were fully meeting the needs of homeless people or tailoring services to their specific needs.

A number of specific recommendations are made at the end of this document and we encourage partners to have the courage necessary to establish the leadership and service responses to make a real difference for this vulnerable group of CTMUHB residents.

Background

In 2018 and 2019 the Supporting People Teams in Rhondda Cynon Taf, Merthyr Tydfil and Bridgend County Borough Councils commissioned reviews of aspects of their hostel services provision from Hugh Irwin Associates Ltd and Bruce Whitear Consulting. In the course of undertaking that review the consultants observed the respective interaction of homeless services, with some strengths identified, and also some areas that warranted further exploration. During the period since the original fieldwork the strategic arrangements for joint planning for homelessness have changed, with the Regional Collaborative Committee (RCC) from April 2019 re-aligned to cover all three local authorities, in line to the changes in the boundaries of CTMUHB. Additionally, there are plans to strengthen the alignment of the RCC to the Regional Partnership Board established under the Social Care and Well-being (Wales) Act 2014. As all parts of the strategic planning system have changed it is timely to look at the health needs of homelessness people across the area.

The findings in relation to health from the original projects was reported back to the Supporting People Teams earlier in the year and as a consequence a specific meeting was held with CTMUHB, the three local authorities and the Local Public Health Team in October 2019 to explore the issues further and to consider what steps might be taken to improve access to healthcare for homeless people. It is well-documented that homeless people are high users of healthcare services and that their access is made difficult by their circumstances, not least to either having no address, or frequent moves of address. This results in challenges to putting in place a preventative approach and an over-reliance on crisis and emergency pathways into healthcare.

The outcome of the October 2019 meeting included a series of areas to be explored. These are as follows:

1. A rapid review of the health needs for homeless people, based on studies that have been undertaken elsewhere (e.g. Wales, Newport etc.).
2. Seeking out models of delivery of healthcare in other areas of the UK similar to the challenges of CTMUHB i.e. dispersed urban areas / small towns to study as exemplars
3. To review current pathways of care for the homeless to understand in detail what works well and where there are opportunities for strengthening arrangements, particularly in respect of services where homeless people are known to be potentially high users. These services include:
    - Primary care (the purpose and functioning of enhanced services for the homeless)
    - Dental Services, through Community Dental Service and/or General Dental Services
    - Podiatry
    - A&E
    - Specialist mental health services i.e. CMHT and Crisis Mental Health Services
    - Primary Mental Health Care Services

- Substance misuse services (including dual diagnosis)
- Health Visiting

4. Referral pathways from prison health services to community services on release (tying-in to potential changes to prison health services)
5. Developing an understanding of the information and training needs of support workers working with the homeless to enable them to act as health navigators
6. Developing an understanding of the information and training needs of key primary and secondary health professionals on the needs and access requirements of homeless people
7. Developing an understanding of the information and training needs of generic health navigators on the needs and challenges of working with the homeless
8. Considering options for a model of how health navigation / advocacy should work for people with complex needs i.e. primary care vs generic navigators vs specialist advocacy

There was also discussion of the governance and delivery arrangements for this piece of work, specifically:

- The mandate for the work to be taken to the RCC in the first instance, to ensure all partners are in support, and through this route reported to the RPB
- The need to influence the strategic plans of the RPB (to potentially access Transformational Funds to support the outcomes identified from this work)
- Aiming for inclusion of the work and its conclusions into CTMUHB's Integrated Medium Term Plan
- Establishing a task and finish group to undertake required work programme.

Homelessness
For the purpose of this review the term 'homeless' refers to:

- People sleeping rough;
- Single homeless people living in hostels, shelters and temporary supported accommodation;
- Statutorily homeless households: households seeking housing assistance from local authorities on the grounds of being currently or imminently homeless;
- Hidden homeless households: people considered homeless but who are not visible on the streets or in official statistics. This includes overcrowded households, squatters, sofa-surfers, and people involuntarily sharing with other households on a long-term basis.

Priority groups for statutory housing support in Wales include:

- pregnant women;
- a person with whom a dependent child resides;
- someone vulnerable as a result of old age, mental illness or handicap, physical disability, or other special reason;

- homeless as a result of an emergency such as flood, fire or other disaster;
- someone who is homeless as a result of domestic abuse;
- 16 and 17 year olds;
- 18-21 year olds who are care leavers or at particular risk of sexual or financial exploitation;
- ex-service men or women;
- a person who has a local connection with the area and is vulnerable as a result of being an ex-prisoner.

The most visible homeless people are those who sleep rough. Broadly defined as people sleeping, about to bed down or actually bedded down in the open air; such as on the streets, in tents, doorways, parks, bus shelters or encampments. It includes people in buildings or other places not designed for habitation, such as stairwells, barns, sheds, car parks, cars, derelict boats, stations, or 'bashes,' makeshift shelters, often made of cardboard boxes.

Homelessness can be caused by structural issues, such as the impact of recession on welfare arrangements and the housing and labour markets[1]. Some people may be vulnerable to homelessness because of individual and interpersonal circumstances.

Homelessness in the Cwm Taf Morgannwg UHB area
Enumerating homelessness is difficult and sometimes contentious. Official rough sleeper figures are collected by a street count on one night each year by local authorities and charities. There is no agreed estimate of the number of people living in the hostel system. Statutory homeless are people accepted as being homeless by local authorities. Many do not have this formal recognition, but are homeless nonetheless. They may be living informally with friends or relatives, having their cases treated by 'homelessness prevention' and 'homelessness relief' activity or have never declared themselves as homeless to any authority. Hidden homeless people include families which are homeless, at risk of homelessness, people fleeing abusive relationships, and families who are staying in the homes of relatives and friends.

Table 1 provides comparative figures of people assessed as homeless across Wales in 2018. This highlights that Bridgend and Merthyr Tydfil County Borough Councils experienced more homelessness proportionately than Rhondda Cynon Taf County Borough Council. However, in relation to actual presentations – Bridgend recorded the most at 666, RCT 516 and Merthyr Tydfil 300.

[1] Fitzpatrick, S., et al, 2017, The homelessness monitor: Wales 2017. Crisis, Herriot-Watt University, University of York, Joseph Rowntree Foundation, University of New South Wales).

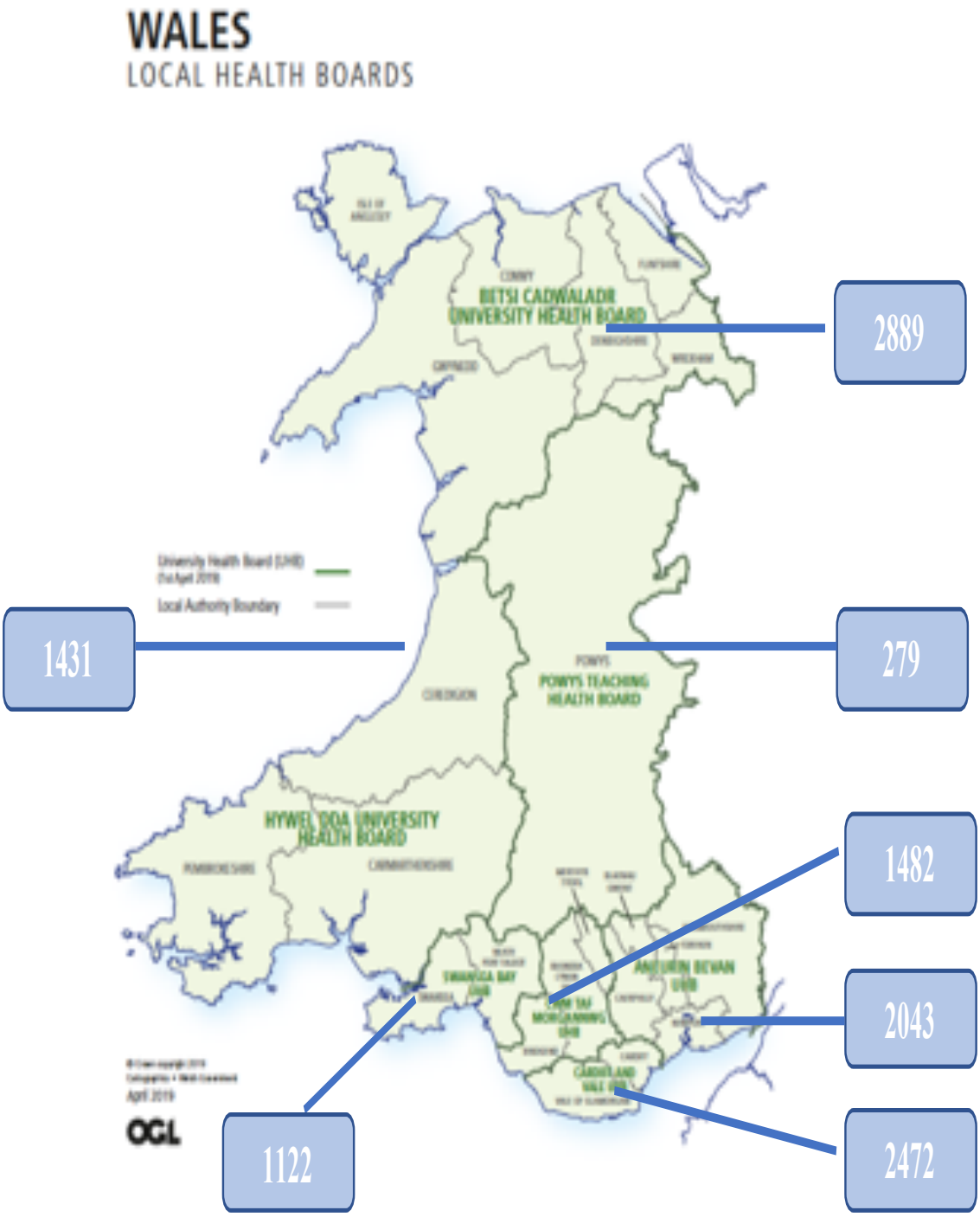
Table 1 – Households assessed as homeless and owed a duty by the local authority(rate per 10,000 households)[2]

Local Authority	Rate of households assessed as homeless per 10,000 households
Blaenau Gwent	43
Powys	47
Swansea	47
Rhondda Cynon Taf	50
Monmouthshire	50
Pembrokeshire	55
Vale of Glamorgan	56
Ceredigion	59
Caerphilly	63
Gwynedd	63
Isle of Anglesey	82
Flintshire	83
Wales	87
Neath Port Talbot	99
Conwy	102
Torfaen	104
Wrexham	104
Bridgend	108
Carmarthenshire	117
Merthyr Tydfil	121
Newport	127
Cardiff	142
Denbighshire	147

Figures 1 & 2 provide a comparative overview of homelessness based on health board footprints in Wales. CTMUHB is at the mid-point of the seven health boards with the 4th highest households assessed as homeless and the second lowest rough sleeping count out of the seven health boards. There are a number of factors (including timing issues and local authority IT reporting systems), varied systems for counting people that sleep rough - which impact on the quality and accuracy of the data collected and published on homelessness. The statistics should therefore be used for indicative purposes only.

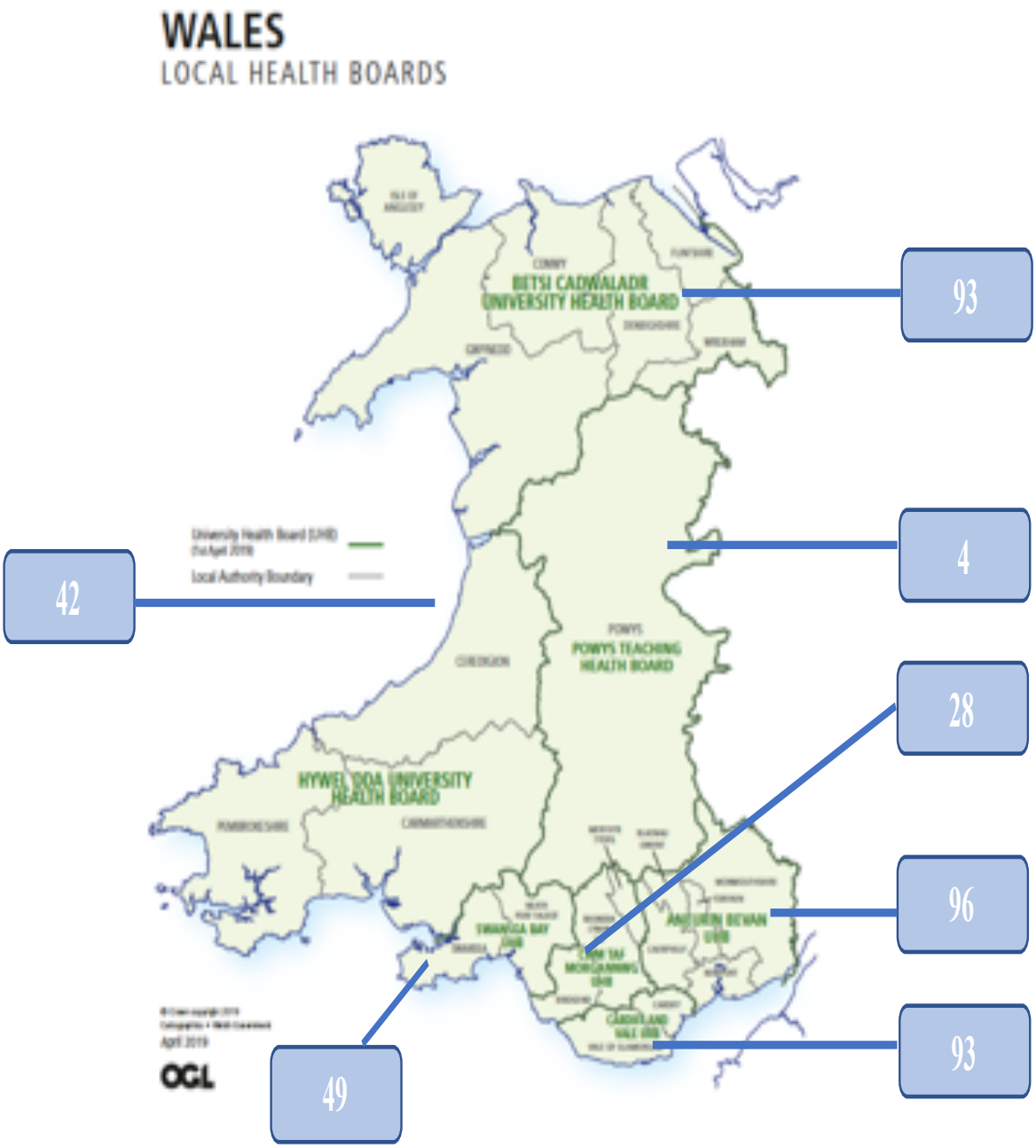
[2] Stats Wales Relief of Homelessness by Area and Measure (Section 73) (2018/19)

Figure 1: Relief of Homelessness by Health Board Area 2018/19: number of Households[3]



[3] Stats Wales Relief of Homelessness by Area and Measure (Section 73) (2018/19)

Figure 2: Estimated Number of People Sleeping Rough counted over a 2-week period in October 2019 by Health Board Area[4]



[4] Stats Wales Rough Sleepers by local authority 2019

Methods

Background
The Health Needs Assessment was commissioned by the Local Public Health Team of CTMUHB in early 2020. As the contract was finalised in March 2020 it became increasingly evident that the response to Covid-19 would have a direct impact on the way in which this study would need to be conducted. The study methodology was therefore re-designed to reflect the need to deliver the project using a methodology that was safe for all stakeholders. This is reflected in the methodology described below. In addition it should be noted that the four hostel services in RCTCBC and Merthyr Tydfil CBC moved to the management of the Pobl group on 1 April 2020, and the researchers would like to acknowledge the support of the new management in enabling access to residents and staff at this time.

Strategic workshop
We commenced our work with two workshops with senior strategic stakeholders in the homelessness and health service sectors. The purpose of the workshops was to finalise the framing, purpose and scope of the project - agreeing a shared language and definition of the requirements for the project and its place within local policy and practice.

Desktop review
We also undertook a desktop appraisal of documents, literature and policies that related to the scope of the project including national and local evidence and Welsh policy context.

Health Needs Asessment
A quantitative Health Needs Assessment (HNA) tool was designed and made available on a digital platform, based. The main aim of the HNA was to find out about the range of health needs of people with experience of homelessness across Bridgend, RCT and Merthyr Tydfil as well is their experience of accessing health services. The HNA design was based on Homeless Link's Health Needs Audit Tool[5] with some amendments, that enabled benchmarking of the data collected with other areas where similar studies have been undertaken. The questionnaire is provided at Appendix 3.

Homelessness and supported housing organisations were asked to conduct the interviews with people using their services and an information sheet for both interviewers and participants (Appendices 1&2) was provided to provide both context for the activity and instructions for staff relating to the interview process. Extra context and support for staff carrying out the interviews was offered by way of a meeting via a digital platform or phone call.

The consultants also assisted with interviews where there were some capacity challenges. The vast majority of data collated in the HNA was quantitative. Each

[5] Homeless Link 2014 Homeless Health Needs Audit, Better Planning to Improve the Health of People who are homeless in your area.

assessment took approximately 30-40 minutes to complete and 65 participants took part from all three local authority areas.

Case Studies
To supplement the quantitative data collection staff were also asked to collect case studies of the stories of individuals and their experience of using health services. A number of case studies that had been collected in previous work with the local authorities were also included.

Digital Workshops with frontline staff and managers
Two workshops were held with supported housing staff about their experiences of accessing health services on behalf of their clients. A total of 18 people took part from a range of services providing housing support to homeless people.

Depth Interviews – health providers
Interviews were planned, held by telephone, with each of the leads for the key service areas that homeless people are most likely to access. The interviews planned were designed to cover the following service areas.

- Primary care (the purpose and functioning of enhanced services for the homeless)
- Dental Services, through Community Dental Service and/or General Dental Services
- Podiatry
- A&E
- Specialist mental health services i.e. CMHT and Crisis Mental Health Services
- Primary Mental Health Care Services
- Substance misuse services (including dual diagnosis)
- Health Visiting
- Prison Health

The interviews covered:

- Role of the service
- Role of the service in meeting the needs of homeless people
- Any specific services or access arrangements for homeless people

Results

The findings are presented according to each of the groups contacted.

Survey of Homeless People
Sixty-five people completed the survey questionnaire of who 55% were male and 45% female. The data is presented below in percentages to allow comparison with national data drawn from Homeless Link[6], which provides aggregates data across local authorities in England, who have undertaken a similar survey. The comparative data in this report is drawn from June 2020, covers 27 local authorities and is referenced throughout these findings. Comparison should be taken with caution given the relatively small sample size, and also as the Homeless Link cohort is largely drawn from more urban centres than CTMUHB .

Thirty-one of the people completing the questionnaire were RCT residents, 22 from Bridgend and 11 from Merthyr Tydfil. The following is a summary of further demographic data for this survey.

Socio-demographic profile of the homeless people in CTMUHB who completed the survey

Sample size
65 respondents

*RCT – 48% *Bridgend – 35% *Merthyr – 17%

Gender
55% Male
45% Female

Age
16-17 – 5%
18-25 – 21%
26-35 – 27%
36-45 – 25%
46-55 – 15%
66-75 – 5%
75+ - 2%

Sexuality
85% Heterosexual
15% LGBTQ+

Disability
56% self report disability

Migration/ethnicity
94% White British
98.5% UK Resident

[6] https://www.homeless.org.uk/facts/homelessness-in-numbers/health-needs-audit-explore-data

Accommodation

Care Leavers

2% in last 5 years

Sleeping Rough

6% recent experience of sleeping rough

Current Accom

51% Frontline Hostel
28% Supported Accom
15% Other

Occupation

Learning

12% in training or education

Employment

6% in employment

Volunteering

3% in volunteering

Contact with criminal justice system

Probation Contact

39%

Community Service

2%

Prison Leaver

47%

Gender and Sexuality

- The proportion of each gender is more balanced in the CTMUHB sample with 55% Male 45% Female compared to 71% male and 29% female in the Homeless Link cohort.
- Fifteen per-cent of the CTMUHB sample identified as LGBTQ compared to 7 % in Homeless Link cohort.
- Data on sexual identity is produced by the Office for National Statistics from the Annual Population Survey (APS). In this survey in 2018 1.5% of people in

Wales aged 16 and over identified as gay/lesbian, 0.8% as bisexual, and 0.8% who identified as other.

Ethnicity

- Three (6%) of the respondents came from an ethnic minority group. This is fewer people than seen in the Homeless Link data, which shows a rate of 11%.

Disability

- Fifty-five per-cent of the CMTUHB respondents reported having a disability. This compares to 36% in the Homeless Link cohort and 44% in the population of the CTMUHB area as a whole.
- 20% of people in Wales had fair health and 9% bad or very bad health and 71% good health. In CTMUHB – 20% fair health and 12% bad/very bad health and 68% good health [7].

Care Leavers

- One of the respondents (2%) had left Local Authority Care in the last 5 years. This is lower than the Homeless Link cohort which stands at 5%

Rough Sleeping

- Three of the respondents (6%) had recent experience of rough sleeping, compared to 10% in the Homeless Link cohort.

Education and Training

- 12% of the CTMUHB respondents were in Education or Training compared to 17% in the Homeless Link cohort. However, of the 17 under 25s in CTMUHB 13, or two-thirds were not in education or training.

Volunteering

- Two people (3%) of the CTMUHB respondents were involved in a volunteering role compared to 13% in the Homeless Link sample.

Justice Services

- Thirty-nine percent of respondents were in contact with probation services compared to 15% in the Homeless Link cohort.

[7] Adult general health and illness (National Survey for Wales) 2018/19

- Forty-seven per-cent of respondents were prison leavers compared to 26% in Homeless Link Cohort.

Access to Health Services

- Ninety-four per-cent had permanent registration with a GP compared to 92% in the Homeless Link cohort. An additional 5% had temporary registration.
- 56% of people in CTMUHB had used a GP more than 3 times in the last 12 months.
- 57% were registered with a dentist comparted with 56% in the Homeless Link data

  "I'd like more help finding dentist - it's really difficult" – quote from respondent.

- Forty-five per-cent of respondents have used A&E in the last 6 months, compared to 38% in the Homeless Link cohort. Nine per-cent had used A&E more than 3 times in the same period compared to 11% in the Homeless Link cohort.
- 38% of respondents had used an ambulance, primarily for mental health and substance misuse, compared to 26% in the Homeless Link Cohort.
- Twenty-five per-cent had been admitted to hospital in the last 12 months compared to 26% in the Homeless Link cohort.

Lifestyles

- 75% of respondents are current smokers compared to 78% of the Homeless Link cohort. Seventeen per-cent of adults in the general population smoke in Wales and there has been a general downward trend in recent years. [8]
- Half of the smokers don't want help to quit, with 50% wanting to, or might want help to quit. Forty per-cent of smokers in the Homeless Link cohort want to give up smoking.
- Thirty-seven percent of respondents haven't been offered help or advice to quit compared to 32% in Homeless Link cohort.
- Twenty-nine per-cent of respondents don't eat 2 meals a day, 37% don't eat fruit or vegetables daily and 42% eat 1-2 portions. In the general population 8% of adults report eating no fruit or vegetables the previous day[8].
- Seventy-two per-cent reported exercising at least twice a week. Half of those who do not exercise want to in future and 17% were not sure. In the general population 53% of adults were active for at least 150 minutes in previous week and 33% inactive.[9]

[8] National Survey for Wales Adult Lifestyle April 2018 to March 2019
[9] National Survey for Wales 2018-19: Adult lifestyle

Physical Health

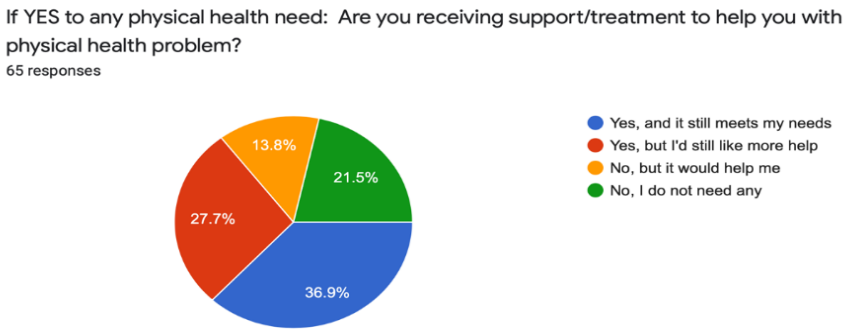
- 72% of adults reported good or very good general health.
- 46% of adults reported at least one longstanding illness compared to 33% in the general population.[10]

Respondents were asked about the types of longstanding illnesses they were experiencing. In the table below these are compared with the Homeless Link Cohort and data on the CTMUHB population and the population of Wales as a whole, recognising that the survey methodology for the latter is different. The gaps in the table mean there is no available data.

Table 2: Physical illness reported by homeless people in the CTMUHB area compared to other populations.

Health Problem	CTMUHB Homeless	Homeless Link Cohort	CTMUHB general population[10]	Wales[10]
Chest/breathing	43%	36%		
Eyes	37%	28%		2%
Feet	18%	23%		
Fainting	22%	21%		
Urinary	12%	13%		2%
Joint aches	57%	47%	17%	17%
Skin wounds/care	28%	18%		1%
Circulation	17%	14%	13%	13%
Liver	15%	14%		
Stomach	28%	24%	9%	7%
Dental	34%	37%		
Diabetes	8%	6%		
Epilepsy	5%	6%		
Other	6%	14%		

Figure 3: Reported treatment responses received by homeless people in the CTMUHB area for physical health needs



[10] Stats Wales General health and illness by local authority and health board 2018

Mental Health

- Ninety-one percent of respondents reported difficulties with mental health compared to 86% in the Housing Link cohort.
- Nine percent of the general adult population in Wales reported having a 'Mental Disorder' for Wales and this was 10% for the CTMUHB area[11].

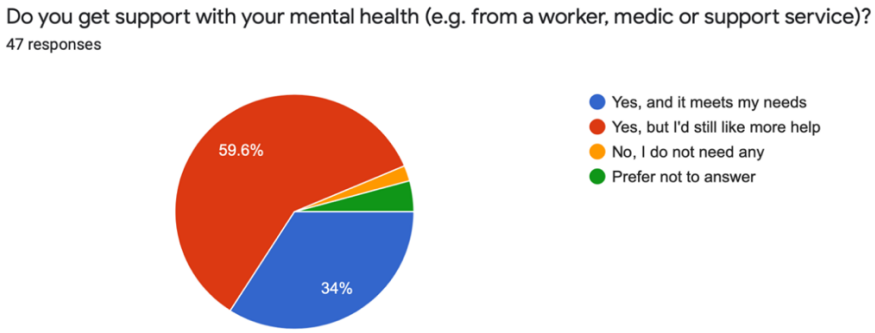
The table below is a summary of the mental health problems that the CTMUHB respondents reported as having with comparative data for the Housing Link cohort.

Table 3: Self-Reported Mental Health Problems for homeless people in the CTMUHB area compared to the Homeless Link cohort

Mental Health Problem	% of CTMUHB homeless people reporting this problem	% of Housing Link cohort reporting this problem
Total respondents with a diagnosed mental health problem	73%	44%
Depression	66%	34%
Dual diagnosis	26%	13%
Psychiatric Disorder	28%	7%
Post-Traumatic Stress Disorder	26%	7%
Schizophrenia	15%	6%
Bi-polar	14%	5%

Nearly two thirds of respondents who self-reported mental health diagnosis still would like more help than they are currently receiving.

Figure 4: Reported treatment responses received by homeless people in the CTMUHB area for mental health needs



[11] Stats Wales General health and illness by local authority and health board 2018

Table 4: Preferences for types of mental health support for homeless people with self-reported mental health problems in the CTMUHB area

What type of support helps me in relation to my mental health?	% of respondents with a diagnosed mental health problem answering yes
Talking Therapies	68%
Service to address dual diagnosis[12]	11%
A specialist mental health worker e.g. community mental health team	57%
Arts/volunteering/creative activities	55%
Practical support with my day to day life	34%

The following are quotes from respondents in relation to their mental health service access.

"My mental health is the main issue. It would help me to see someone for counselling, but this isn't available in Bridgend. The process is ridiculous. I see my GP (who already knows), he refers me to the Hospital to see a Psychiatrist 10 weeks later, normally someone I cannot relate to, I see them, try different medication and return in 6 weeks. That's it. No volunteering, no talking therapy, no healthcare program to monitor or focus on improving things. It's just a never-ending cycle".

"I think there is not enough professional support about. Would benefit from this. More crisis intervention is needed. They are not helpful in the Crisis Department in the Royal Glamorgan. Rhondda Valley mental health support needs improving".

Substance Misuse

- 42% of CTMUHB respondents use drugs or are in recovery from drug use compared to 41% in the Housing Link cohort.
- Across England and Wales around 1 in 11 (9.4%) adults aged 16 to 59 had taken a drug in the last year.[13]

Table 5: Types of drugs used by homeless people in the CTMUHB area who reported using drugs compared to a UK sample of homeless people.

Drug	% of respondents that use this drug	% of the Homeless Link Cohort using this drug
Heroin	33%	30%
Crack/Cocaine	41%	27%
Cannabis	60%	62%
Amphetamines	33%	18%
Benzodiazepines	37%	19%
Prescription drugs	41%	31%
Spice	11%	N/A
Methadone	30%	31%
Other	7%	N/A

[12] People who are experiencing co-occurring substance misuse and mental health challenges
[13] Statistics on Drug Misuse England 2019 (includes Welsh data)

- 3 people (11%) inject drugs and all of these stated they share equipment.
- 30% of respondents that use drugs stated that they would like more help with addressing drug use, 30% don't want any help and 37% state current help meets their need

For those who use drugs and currently access support the next tables show their responses to the questions 'how does the current support help?' and 'how could further support help?'

Table 6: How homeless people in the CTMUHB area who use drugs reported that current services support them with their drug use

How does current support help?	% of respondents
Better control drug use	90%
Reduce drug use	60%
Help with stopping use	30%
Take drugs more safely	20%

Table 7: How homeless people in the CTMUHB area who use drugs reported how further support could help them with their drug use

How could further support help?	Number of respondents
Reduce drug use	11
Better control drug use	8
Help with stopping use	7
Take drugs more safely	2

Alcohol

- Twenty per-cent of respondents use alcohol at least 4-6 times per week – identical to the 20% in the Housing Link cohort.
- 49% of those that drink, drink more than 7 units of alcohol during typical days drinking compared to 47% in the Housing Link cohort.
- Of those who drink currently, or previously drank alcohol, or who are currently recovering from an alcohol problem – just over half (17 people) of these want more help.
- In general, in Wales 18% of adults are at least 'hazardous drinkers', drinking an average of 1,194 units of alcohol a year.

For those who use alcohol and currently access support the next tables show their responses to the questions 'how does the current support help?' and 'how could further support help?'

Table 8: How homeless people in the CTMUHB area reported that services help with their alcohol use

How does current support help?	Number of respondents
Better control alcohol use	2
Reduce alcohol use	3
Manage impact of drinking	4
Help with stopping drinking	3

Table 9: How homeless people in the CTMUHB area reported that further services could help with their alcohol use

How could further support help?	Number of respondents
Better control alcohol use	7
Reduce alcohol use	13
Manage impact of drinking	5
Help with stopping drinking	3

Co-morbidity

- Nearly two thirds of respondents who self-reported a mental health diagnosis also reported that they use drugs or alcohol to 'self-medicate'.

Vaccinations & Testing

- Around two thirds of respondents had not received, or didn't know if they had received the following vaccinations.

Table 10: Percentage of homeless people in the CTMUHB area reporting that they had not had, or didn't know if they had, vaccinations.

Vaccination Type	'No' and 'don't know'
Hepatitis A	72%
Hepatitis B	65%
Flu (last 12 months)	68%

- 3 people reported they had tested positive for Hepatitis C and one person reported they had HIV. This is generally lower than the comparable figures for the Homeless Link cohort as shown in the table below.

Table 11: Percentage of homeless people in the CTMUHB area reporting being tested and their testing status compared to a UK sample of homeless people.

Tested for?	Not tested	Homeless Link	Number of respondents that tested positive	Homeless Link
Hep C	58%	64%	3 (5%)	9%
TB	63%	70%	0 (0%)	4%
HIV	63%	64%	1 (2%)	5%

Sexual Health

- Twenty-nine per-cent of the CTMUHB respondents had received a sexual health check-up compared to 35% in the Homeless Link cohort.
- 11% of respondents stated they did not know where to go for sexual health advice, with the remainder stating they would attend either the GP or sexual health clinic for help if required.

Female health

Women over 50 are eligible for breast screening through Breast Test Wales and women between the ages 25 and 64 with a cervix should be invited for screening. In the CTMUHB sample there were four women between age 45 and 54 who hadn't had breast screening in the last three years. Six women over 26 and under 64 had not been for cervical screening in the last 3 years.

Covid 19

The majority of respondents (94%) stated they had received enough information about how to protect themselves during the pandemic and received information from a wide variety of sources including the media and support staff.

59% stated they had felt increased levels of anxiety during Covid 19 pandemic with most citing either not having access to family, friends or partners or boredom as key contributors.

The following are examples of what respondents said about the impact of Covid-19 on them.

"I live a lonely existence anyway, but now don't have the option of integration"

"I have felt like I am in prison so if I could have gone out more it would be better for my mental health"

Case Studies

A total of 21 case studies were collected of which 18 were provided by stakeholders and three were secured by the researchers in recent previous work in the area. Mental health and substance misuse were frequently mentioned topics in the case studies compared to other health challenges. Both housing support staff and homeless people reported difficulties and frustrations in accessing the 'right service at the right time'. Homeless people in CTMUHB (similar to the national trend) had common experiences of accessing services problems where their mental health and alcohol/drug use co-occurred at the same time.

The case studies demonstrate a commonly poor responses to crisis for those close to or with a history of suicide attempts. Death by suicide is common for people with a history of alcohol or drug use being recorded in 54% of all suicides[14] The case studies highlight that people with co-occurring conditions are often unable to access the care they need. Perceptions and experience of exclusion exist where mental health services are not currently set up to work with co-occurring alcohol/drug use, a particular problem for those diagnosed with mental illness. All names have been changed in the following case studies, and stock photographs used.

Access to mental health services

Accessing help was perceived to be difficult for those who do not meet the criteria for specialist/secondary mental health care, and whose symptoms are considered outside the scope of services aimed at managing common mental health problems. Primary care, where the majority of people with common mental health conditions are treated, often had little capacity to support those who present with co-occurring conditions.

[14] The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Annual Report 2016: England, Northern Ireland, Scotland and Wales October 2016. University of Manchester).

Mike

Mike is 46, and has experienced mental health problems throughout the majority of his life and has also been a heroin user for many years. He has a history of suicide attempts, has lost both his father and brother through suicide which has had a further detrimental affect on his mental health.

Prior to Mike moving into the Kerrigan project (for people with a history of sleeping rough) he understood he had been referred to a psychiatrist. His support worker found that he did not appear to have an appointment in place or in fact a referral. Overall, Mike's experience of trying to access a service to meet his mental health needs has been quite a long frustrating process. However once the correct referrals were made and he had received support from his housing support worker, the process was more smooth.

Mike is currently receiving treatment from a drug and alcohol support organisation that provides substance misuse interventions for people with a history of offending - for his drug use. This included accessing an opioid maintenance script at the beginning. He had come to the end of the treatment process and was put on a Subutex reduction script. This negatively affected Mike as he felt he wasn't ready to be reduced and felt they weren't listening to him and subsequently began 'topping up' with heroin

During this time, Mike also expressed interest in accessing face to face support from the Community Dryug and Alcohol Team (CDAT). However due to being on a script with the other organisation he wasn't able to access this support. Overall, Mike's experience has been quite frustrating. Due to his mental health challenges, he gets confused and doesn't understand certain things.

Lack of access to the right help at the right time has historically made Mike feel very frustrated and confused as he felt he was going around in circles. When he received help from his support worker who could advocate for him and knew how to navigate the system, Mike felt a bit more at ease knowing that things were being put in place.

Understanding the various and complex pathways into mental health services were confusing for both housing support staff and homeless people in CTMUHB - particularly with how GPs, Community Mental Health Teams (CMHT), Crisis Teams and specialist homelessness teams and medical professionals within hospital settings interfaced with each other.

It was clear from both the group discussions with staff and the case study analysis that a common and shared understanding of what pathways exist in and out of statutory mental health services does not exist. The case study below highlights communication and process challenges within the NHS.

Cadi

Cadi is a 28-year-old woman with a history of homelessness and diagnosed Borderline Personality Disorder.

She is already under a psychiatrist and gets seen approximately every 6 months. She has needed to call the crisis team twice in the last month due to the decline in her mental health and suicidal thoughts.

The crisis team prescribed medication and they did a follow up with a wellbeing call 2-3 days after the event, but then discharged her. Cadi's psychiatrist was then contacted by her housing support worker to inform them of the update and they said she will still be on the routine list to be seen so it would probably be a couple of months until she is seen again.

Cadi was satisfied with the medication she had been prescribed (so the crisis team definitely helped) but then when Cadi was informed that she was still on the waiting list she became anxious and deflated and felt she didn't have the support she needed.

The crisis team being available to talk with Cadi immediately and being able to prescribe medication definitely helped Cadi but the follow up from her own psychiatrist had a negative impact as she was not offered an appointment any sooner. Both Cadi and her support worker felt there should have been an escalation of response from the psychiatrist in line with the recent escalation of need. There was a lack of understanding of why this decision was made.

Cadi felt that even just knowing she had an appointment in place would have given her a date to aim for but not being given anything left her feeling unsupported.

The medication that was prescribed by the crisis team was for 1 month (not on repeat) so Cadi's support worker phoned and spoke to the CMHT to ask about getting these on repeat. After 2 follow up calls the support worker finally spoke to someone who was able to confirm that they were on repeat for her and would be ready for her in the GP surgery. However, when Cadi went to collect it from the GP there was no record of a repeat prescription. Following numerous calls made to both the CMHT and the GP surgery over the course of a few days it was finally sorted. However, the lack of process and communication between CMHT and the GP which meant Cadi could not get hold of the medication, made her anxiety levels increase and she ended up self-harming due to the stress.

Impact of co-morbid mental health and substance misuse on service access

The case studies highlight an ongoing challenge of timely and effective responses for people with co-occurring substance misuse and mental health conditions. The perception and experiences for homeless people and support staff is that access to services which can reduce harm, improve health and enhance recovery for people with co-existing challenges are difficult and that services are not designed to respond effectively and flexibly to presenting needs and prevent exclusion.

Charlotte

Charlotte suffers with physical health conditions including epilepsy, scoliosis, hypoglycaemia and Charlotte has a long history of substance misuse.

Charlotte also lives with mental health conditions including anxiety and depression, is known to self-harm, has suicidal thoughts and has previously made several suicide attempts.

Charlotte has always been able to obtain emergency appointments and over the phone advice via her GP surgery. There has been mixed support however in regard to treatment; when Charlotte took an overdose last year the GP went above and beyond to see her weekly to check on her wellbeing while awaiting her assessment for primary mental health. However, when Charlotte was suffering with back pain due to her scoliosis, she was refused pain relief due to her overdose. It was not until she relapsed with substances due to her inability to cope with the pain that the GP finally took her seriously and prescribed her some medication and advised self-referral to physiotherapy.

Charlotte receives 1-2-1 support with MIND and attended weekly resilience sessions prior to lockdown. After her overdose last year, she engaged with a referral for primary mental health. However, after the assessment she was discharged from the service due to not having mental health concerns.

Charlotte was engaging with a third sector substance misuse organisation last summer which helped a lot and she had a good relationship with her worker and would attend courses and sessions that they would put on which had a positive influence on her. Charlotte started to disengage towards the end of the year feeling that substances were no longer an issue. However, after lapsing due to her back pain she regained support this year. Due to the GP not recognising the severity of pain to Charlotte and/or having a lack of insight to her substance misuse background, this resulted in a lapse.

Despite having a wonderful experience with MIND and the resilience sessions, Charlotte was left feeling deflated after her mental health was deemed not severe enough to require any treatment and her overdose a consequence of her alcohol intake. Charlotte has suffered with anxiety and depression, as well as hearing voices, she frequently self-harms and has made a number of attempts on her life over the past years. Charlotte was left to feel her mental health did not matter and it was a consequence of her choices with alcohol and substance misuse.

Matt

Matt is a 26 year old man with a long history of substance misuse along with mental health challenges.

He had a first appointment in October with CDAT for a urine sample and another appointment in a Drop-in later in the month and his date to see the doctor to be prescribed was in late November. This to Matt who was ready at that time to make a positive change in his life was too long for him to wait and his substance misuse escalated and his mental health and behaviour suffered dramatically.

He lost trust in the service and he got deeper in the realms of addiction – going from smoking heroin to becoming an intravenous user.

The length of time Matt had to wait did not help his situation. He also left and went to live in a different place as he felt that he had been failed by the services. His mental health needs had also escalated.

Matt lives a chaotic lifestyle and accessing a script when he'd asked instead of weeks of waiting he may have been able to get his substance misuse to a controlled level quicker.

Incidentally - during the pandemic Scripting has been completed within a week on many cases.

Garry

Garry is a 56 man and lives with physical health conditions including low blood pressure, fitted pacemaker and he is anaemic. As well, Gary, has misused alcohol for a number of years and suffers with mental health conditions including anxiety and depression. He uses alcohol to 'self-medicate'.

Garry has always been able to access local GP services as required, discussing medication reviews and same day emergency appointments. There have been occasions where Garry has been on the verge of collapse due to his health conditions and staff at the surgery provided an excellent service in providing the emergency care he required.

Garry has attempted on several occasions to engage with alcohol misuse services, however professionals have refused to work with him while he is under the influence, but due to him having a dependency on alcohol this has proven difficult as services decline to support clients when they are under the influence.

Garry has always been able to access health advice and support as required via his GP be that emergency or arranged. He has also had continual support with his mental health to support development of healthy lifestyle habits and routines to support this. The barriers Garry faces are with those with alcohol services who refuse to work with him if he is under the influence, therefore there was no consistency in the support provided.

There is a definite barrier between services declining to support clients when they are under the influence. Specifically, there is no consistency in the approach and no commitment to the needs of the individual.

Advocacy and brokerage for people who exhibit chaotic behaviour

Both the staff engagement exercises and case studies highlight the need for statutory services to understand the chaotic nature of some homeless people's needs and the impact on their ability to 'comply' with strict service access criteria. The case example below highlights support that a homeless man felt he required to help him in the early stages of engaging with a substance misuse programme.

Jack

Jack is 26 year old homeless man with a history of homelessness, substance and alcohol misuse.

Jack has been a heroin addict for around 8 years. He has been street homeless on and off since he was 18 years old. Since accessing floor space in a homelessness project, he decided that he wanted to start engaging with CDAT to start being prescribed methadone.

He found that three months of regular engagement whilst being street homeless, having mental health issues, substance misuse issues and no one to remind him of his appointments was a big barrier for him accessing and making contact with services. From the start of the initial assessment, the process of starting a script is around three months. This is regular engaging, regular testing and regular appointments to attend.

This process made him feel frustration and anger towards the length of time it takes to be prescribed, and the barriers that street homeless people face when they don't have a positive network of support around them.

It was only recently when Jack has moved into temporary supported accommodation that this has allowed staff to start the process of engagement with services for him, reminding him of his important appointments and encouraging him to attend them.

The case study below highlights the importance of timely transfer of care from CAMHS to Adult mental health services and the impact that limited community provision can have on escalation of mental health problems leading to admission.

Marc

Marc has significant mental health support needs having been diagnosed with Emotionally Unstable Personality Disorder in 2013 when still a teenager, experiencing extreme mood levels and unpredictable behaviours. He has made several suicide attempts, also history of deliberate self-harm with cutting, and recent risk of constant suicide determination led to Marc's admission to RGH psychiatric unit, requiring treatment and spent two weeks on ward. Marc has had previous admissions to the psychiatric unit in past. Prior to this admission onto psychiatric unit Marc attended Crisis MH Team only 2 months earlier, and was an inpatient in 2019.

Marc also has a genetic disorder, diagnosed in 2013, which affects physical health and cognitive functioning of learning and reading. With regard to the learning disability, Marc did not attend mainstream education but when at school he had learning support as difficulties with understanding, he needs prompting and has stated he cannot do anything on his own independently. He has been heavily reliant on family support. He was previously under care of CAMHS service up to two years ago when he turned 18 but was not then transferred over to Adult services which he evidently needs.

Marc has received support from Outreach Mental Health team with a follow-up appointment held at hospital since his discharge from psychiatric unit earlier this year, and was then referred on to CMHT for assessment for provision of any further mental health support services, for which he is still waiting some months later. Marc's mental health has been a constant struggle to him. His extreme thoughts and behaviours which lead to crisis incidents are often followed by discharge back out again without specialist mental health support being in place for him on a regular basis, - only receiving mental health intervention at times of crisis when his mental health had declined and behaviour had escalated to such a point that required admission to psychiatric unit. Delay in referral processes of transfer of care from Children's and Adolescents Mental Health Service CAMHS to Adult Service left a void in regular mental health support available. It has been a contributory factor in Marc becoming homeless as a result of his unstable behaviours affecting and increasing the stress upon his whole family which has been pushed to breaking point so that he could not return to live with them after his most recent admission.

Physical Health Issues

Several case studies demonstrated how physical health problems had led directly to homelessness for individuals, or people with complex physical health problems needing help to access the right services.

Arthur

Arthur is in his fifties. He had been involved in road-side accident several years ago, when he had broken down and was then hit by a passing lorry. Up to that point he had been working and living with his family. His main injury was severe damage to his leg, and whilst the initial injury was treated successfully, he was left with chronic lymphoedema – severe swelling in the damaged tissue due to accumulation of fluid that needs on-going treatment.

Arthur had spent a number of years in Parc Prison in Bridgend, and during his stay there had received on-going help with the bandaging and massage of his leg that is needed to reduce the swelling. Due to his health, when he left prison, he was eligible for housing support and gained a place in a homeless hostel in Bridgend. As a consequence his treatment had stopped, his leg was severely swollen, and he was using a wheelchair to move around the hostel. Untreated lymphoedema can lead to a breakdown of skin tissue and lead to further problems.

Arthur was registered with a GP and seeing the practice nurse, but felt that his health had deteriorated, and he knew his leg was much worse since leaving prison. He was waiting for an appointment to go to the specialist Lymphoedema clinic for assessment as he was a 'new' patient, but this was held in Swansea and he didn't know how he was going to get there as he had no access to transport or public transport.

Mary

Mary is in her fifties and had been a carer for her parents for many years. She had also held down a job. When her parents died she moved to live in rented accommodation above a shop in Abergavenny. She had an undiagnosed health problem for some time, and had to give up work. After a period of very poor health where she did not leave her flat, she was taken severely ill, an ambulance was called and she was resuscitated in her flat.

After a long period of treatment in hospital Mary regained some level of her health, but she was left with a level of physical disability that meant she was unable to return to her flat, as she now walked with a walker and was not very mobile.

The hospital discharged her to a guest apartment in an extra-care facility in a housing association development in Gwent, as a temporary arrangement. Though most of the residents there were older than her, she felt this was a good place for her to live as she could use the restaurant in the development, and was able to organise activities with and for the other residents.

After six months there was increasing pressure from the housing association for her to move from this temporary accommodation. Her housing need was registered in Bridgend as she had a sister there. She was advised that suitable accommodation had been found for her – she was shocked to find when she arrived that this was a hostel for homeless people. She was now sharing a kitchen with others, which she found difficult as it was not accessible to her, and also her room was not suitable to her physical needs. She had been visited by the Occupational Therapy service who had provided some adapted equipment to enable her to cope. She was advised that she would not be able to move to an extra-care property because she was too young.

Dylan

Dylan is 21 and was born with Spina Bifida. In his younger years he spent a lot of time in Great Ormond Street Hospital having multiple surgeries that have enabled him to be able to walk, but that have left him with other disabilities that are not immediately apparent. As an adult his relationship with his mother and brother have broken down due to his drug use. In the past he has sofa surfed with friends and is currently in a hostel in Bridgend.

Dylan has a supra-pubic catheter which he needs to drain when his bladder feels full. He says he is meticulous about hygiene because he needs to avoid infection in his catheter. He finds it painful to drain his catheter so avoids doing it until he is desperate. Part of his procedure is to use KY jelly to reduce the pain. Some other residents have seen his KY in his room and said he must be gay (which he isn't). He didn't like this and as a consequence he is no longer using it, which prolongs the time between emptying his bladder.

Dylan would like a relationship with a girl, but says generally they break-down after a period of time. He thought he was being looked after by a consultant in Swansea but didn't know when his next appointment was or how to find out.

Current Provision

This chapter combines the findings from interviews with staff working in organisations working with homeless people in the housing sector in the CTMUHB area, and interviews held with representatives of NHS staff working in Health Board services.

Two workshops were held via MS Teams with a total of twelve housing support and local authority staff in attendance from across the CTMUHB area. Questions focussed on service delivery in 'usual' circumstances and then any adjustments to services that had been made due to the Covid19 Pandemic. Eight interviews were held with representatives across various NHS services.

Two main factors affect the work undertaken to assess current provision. Firstly, the advent of Covid-19 at the outset of the study period meant that some staff were not immediately available and were unable to access staff in all service areas to undertake interviews. Additionally, many services had changed the way that they normally operate, and where relevant this has been reported. Secondly CTMUHB came into being only in April 2019, through a merger of the former Cwm Taf Health Board with services in the Bridgend locality. The organisation has subsequently been through a re-organisation to a locality style of management, only recently finalised. Some respondents were therefore only more recently in post and new to the services they were managing. In some cases it is clear that different delivery models are in place in the two areas due to this history, individuals were not always able to describe the service for the whole of the Health Board, and any specific arrangements for homeless people.

With some notable exceptions in most cases it is clear that there is limited specific provision for homeless people. The following narrative should therefore be considered as an overview of current provision, and further specific arrangements may emerge with further work.

In addition, it is to be noted that the main hostel provider in RCT and MT, Pobl, had only taken over the hostel services in the area in April 2020, and had not yet had the opportunity to build local relationships with health services.

Access to GP practices
The Health Board has an 'Enhanced Service' contract in place with some practices. The following is an extract from the specification that explains its purpose

'Enhanced services are elements of essential or additional services delivered to a higher specification, or medical services outside the normal scope of primary medical services, which are designed around the needs of the local population. The purpose of an enhanced service for homeless people is to provide quality care to homeless people so as to enable them to benefit from the health and social care system thereby becoming and remaining healthier.

This can be achieved by primary health care teams devoting additional time and resource to such patients. They can establish a baseline of clinical history and health

and social care needs. This enhanced service recognises the time needed to provide a thorough service to address complex needs. There is also an advocacy role by staff on behalf of homeless people to ensure effective liaison with secondary care, statutory and voluntary services which can be time intensive'

Practices who sign-up to deliver the enhanced service are paid a fixed fee for each new registration and a fee for each homeless person the remains on their patient register. The full specification for GP practices is included below:

- Identify eligible patients.
- Produce and maintain an up to date register of homeless patients.
- Register patients "permanently" (as early as possible) if they are likely to stay in the area for a substantial time.
- Carry out a medical, physical and social assessment of the patient upon registration (within 8 weeks). The assessment will be recorded in the patient record with a summary of needs and an individual patient plan.
- Work with local statutory services and homelessness agencies, sharing important information and contributing to case management.
- Ensure that practice staff demonstrates understanding and sensitivity towards homeless people. We would strongly suggest each practice nominates a champion member of staff.
- Each practice is required to undertake an annual audit
- Participate in local service planning, delivery and awareness sessions and attend at least one annual meeting with Health Boards and other services where appropriate. These sessions will be aimed at improving the joint working between service providers and keeping up to date on issues affecting homelessness and homeless people.

Support workers in the supported housing providers are actively engaged in helping people access primary healthcare services. They reported the following in relation to access to GP practices:

- There were no specific issues in gaining initial registration of patients with a GP
- Support workers support residents to get an appointment through the usual route i.e. telephone the practice on the day for an appointment, and then accompany the individual to an appointment
- There was variation in being able to access appointments: 'we need to have a redial facility as it sometimes takes an hour to get through to make an appointment' – this was described as not being helpful for working with chaotic people'
- There were no specific access arrangements for homeless people reported
- One GP practice in MT has a practice-based support worker who is helpful in making people feel more comfortable and helping them into the appointment system

- One provider stated they had a supply of registration forms so they could do the initial paperwork in the hostel prior to visiting the practice
- One provider said they had a good relationship with the practice and had built up a working relationship with them to collaborate over individuals and their needs
- Workers seemed to be aware of the violent patient scheme (which provides for dedicated services for people who have been removed from a GP practice list due to violent or threatening behaviour).

The Taf Ely Cluster of GPs have identified homeless people as one of their priorities and have secured funding for a pilot project to employ a nurse practitioner for homeless people. At the time of this report this individual had been in post for three weeks and the early development phase of designing the project.

Access to Mental Health Services

Primary Care Mental Health Support Services are aimed at individuals of all ages who are experiencing mild to moderate, or stable, severe and enduring mental health problems. They are based in Rhondda, Taff Ely, Cynon, Merthyr and Bridgend and operate either within, or alongside primary care. The service provides goal focussed mental health assessments and also treatment by way of short-term psycho-educational interventions which can be delivered individually or in group settings. Access to the service is through an individual's GP, followed by an assessment by the service within 28 days of referral and intervention within a further 28 days.

The service provides information and advice to individuals and carers as well as 'signposting' them to other sources of support, including third sector organisations. They can also support onward referral and co-ordination of next steps with secondary mental health services, where this is felt to be appropriate for an individual, and also receive referrals directly from CMHT and Crisis teams where appropriate.

The service works with substance misuse services and people can access the service if their substance misuse is stable, and examples were given where individuals have been assisted to achieve stability prior to access individual or group-based interventions.

The service is aware of homeless people accessing the service, occasionally accompanied by their support workers. Challenges were described in tracking patients, especially if they move, and the onus is on the individual to maintain contact with the service and advise of changes of address.

People with more severe mental health challenges can access Mental Health Services that include Community Mental Health Teams, Crisis Mental Health Teams and in-patient mental health services.

Young people under the age of 18 or in full time education can access the Child and Adolescent Mental Health Service that is provided along a similar model of levels of care for different levels of severity. There are also separate services in the CTMUHB area for children with intellectual difficulties (CTMUHB Intellectual

Disability Team) and neurodevelopmental problems such as Attention Deficit Hyperactivity Disorder (ADHD), Autistic Spectrum Disorders and Tourette's Syndrome (CTMUHB neurodevelopmental service).

Support workers in the housing sector described their experience of supporting people with mental health challenges. There are a variety of arrangements in place to provide low level support for mental health either directly in hostels or through partnership arrangements with local third sector service providers:

- Merthyr Valleys Mind host a staff member in hostels through a mental health resilience project funded by supporting people
- Mental Health Matters provide counselling, but there is a £10 charge to cover the basic costs of providing the service
- ARC activities in Bridgend, many are group-based activities and often not suitable for homeless people, and there is a waiting list in some cases
- Bridgend Supporting People funds an in-house Mental Health service but not counselling
- Gofal has historically provided mental health support workers

CRISIS Mental Health Teams within the Health Board are accessed by the hostels but felt to be problematic as people often, once seen, are returned to hostels. The individuals often feel they have not been helped, and it is unclear to the hostels and support workers what the plan for care is, and how they can support it.

Two examples were given where it was felt that the hostels had highlighted individuals and their behaviour as a risk to themselves, to mental health services. One was exhibiting self-harm intentions and did take their own life. The second took an overdose and died. In both cases the hostel staff felt their warnings were not sufficiently heeded, and there appeared to be no investigation.

Other points made about access to mental health services included:

- Support workers feel it is easier for young people with a social worker to access CAMHS service than those without
- There are issues with transition from CAMHS to adult mental health services
- People in Bridgend need to be free of drugs to access mental health services. If they have used they are off-listed whereas the mental health team in Merthyr Tydfil will see people if they are using drugs at the Kier Hardy Centre.

Access to Substance Misuse Services

The Community Drug and Alcohol Team provides a service for people experiencing problems with substance misuse based on a harm reduction approach which includes working towards abstinence where appropriate; providing care programmes that are developed individually with each client. Individuals with significant drug and/or alcohol misuse can access the service where there is a related risk to themselves or others and there is evidence of a commitment to actively engage in the treatment programme and comply with required standard of conduct.

Hostel workers working with the homeless described the following challenges in accessing substance misuse services for their tenants:

- Accessibility is not set up for the chaotic nature of these clients – when people reach the point of 'contemplation' (one of the earlier stages of the behaviour change cycle) there is a six-week waiting list to get into services
- Emotional support is needed to run alongside drug treatment services as part of the overall model of preparing people to be able to manage their own tenancies
- Appointments for homeless people need to be in the morning, as they can be more easily managed by the hostels at this point in the day - if they go off for the day, then they have found drugs, and far more challenging to support in engaging with services, or may not be accepted
- Offenders in the criminal justice system are able to get more direct access to treatment, for twelve months and then transfer to community substance misuse services.
- Access to Community Pharmacy for prescriptions is not a problem though in some areas it is a long walk from the hostels.
- Prescriptions have been adapted since Covid, with more rapid access to initial assessment, to give some people a greater number of days of drugs in one go, or to deliver the prescription to the hostel. In general, these changes were felt to have improved the system.
- Monthly injections of substance substitutes are being trialled in Merthyr Tydfil
- One worker described a helpful case study where an individual whose drug use needed to be stabilised prior to undergoing heart surgery, was seen by Drug and Alcohol services and stabilised for this purpose.

Access to Dentists

General Dental Services (GDS) are provided by high street dentists under contract to the NHS, and provide general dental healthcare, including free care to those that are eligible. A pattern of investment in access to GDS services in RCT and Merthyr Tydfil for a number of years was described, to correct a shortfall in access to dental services in the area. The Health Board recognises that access is more difficult in Bridgend with far fewer practices accepting new patients. At the time of the report only one practice was accepting new patients. Registration with a practice is not permanent, as it is with GPs, and patients will be de-listed in some circumstances, for example if they have not attended for 2 years.

The Community Dental Service (CDS) is provided directly from the Health Board and is dedicated to providing dental care to vulnerable patient groups in society who may otherwise find accessing treatment difficult or impossible. The service operates in both fixed and mobile clinics. Homeless people are not eligible for the service per-se; however, they may have circumstances that they would be eligible to be seen by this service. Those eligible include:

- Some physical impairments.
- Some learning impairments.

- Some mental health conditions.
- Complex medical conditions.
- Prisoners.
- People with social impairment.

Additionally, the service provides 'dental access' appointments available for people in-hours who require treatment in an emergency, but do not have their own dentist and not able to register with one.

For out of hours dental care (generally weekends and bank-holidays) the arrangements are different RCT and Merthyr, to those in Bridgend. In the north there is a dedicated telephone line that will direct patients to the emergency service. In the South people should ring 111 and will be directed to a rota of dentists providing the service across Bridgend, Swansea and Neath Port Talbot, so may need to travel some distance. This overall arrangement is due to be reviewed by the Health Board to ensure a single approach across the new organisation.

The dental services highlighted that it would be useful for them to know where the hostels were located so that would be able to send them the periodic information that is issued to the community about changes to dental services and access to GDS services.

The housing providers reported variation in access to dental services for their residents.

- Access to dentists is variable with dentists readily available in the North, with some telephoning round practices required. In Bridgend gaining registration is seen as problematic.
- Chaplins, the hostel in Merthyr Tydfil described having a good relationship with their local practice which is adjacent to the hostel.
- People in the South reported using 111 in a dental emergency and being referred to Cardiff Dental School and Swansea, presenting some logistical challenges for transporting people to services for the hostels

Podiatry

Podiatrists are the experts in treating a variety of foot and lower limb conditions which cause pain and suffering leading to loss of mobility. From musculoskeletal foot and ankle pain including those caused by sports injuries to skin pathologies such as corns, ingrown toenails and conditions associated with underlying medical conditions. Podiatrists work with people of all ages and play an important role in helping all to stay mobile and independent. Podiatry clinics are available across CTMUHB and normally accessed through a referral by a GP.

The Head of Podiatry reported on a small-scale project where the service had sought to establish specific arrangements for homeless people. The project had initially advertised a service to homeless people in Dewi Sant and that was found to not be effective. The service then moved to St Catherine's Church in Pontypridd. Whilst some homeless people from the hostels attended, they were not identified as having a health need, and the street homeless, the group with the greatest risk of foot

problems were not attending. Three sessions were held at St Catherine's Church with 9 people seen in total from all age groups. The clinician took the opportunity to provide education. This was an unfunded service using volunteer podiatrists using a model developed by a charity called 'Forgotten Feet'.

The housing providers did not identify that foot-health in general was an issue for their clients. One member of staff highlighted a case where a tenant needed assistance seeking out the provider of care the removal of pins from a fractured foot as they had moved away from the area where the surgery was undertaken.

Access to Opticians
High Street opticians are funded through the NHS and provide free eye care to those eligible and can provide eye-care check-ups as well as providing glasses. All areas reported they had no difficulty in accessing opticians where this was required for their clients.

Accident and Emergency Services
We were only able to speak to the A&E department at the Princess of Wales Hospital which is one of three A&E departments in CTMUHB. Homeless people were reported as being frequent users of A&E services in Bridgend as it is proximal to the town centre. Specifically:

- Intoxicated people (alcohol and/or drug use) bought in by the police, or when a member of the public has called an ambulance
- There are some regulars who attend with drug seeking behaviours
- Attendance increases in poor weather and people understand that the need to wait gives them time to be in shelter, and provides an opportunity to re-charge phones
- A&E have a stock of second-hand clothes provided by staff to re-clothe people especially if they come in wet

The respondent highlighted that since Covid-19 attendance to A&E by homeless people had significantly decreased. She attributed this to the housing of people in Porthcawl – that they had shelter and a safe place for their belongings. As a consequence, their social need to visit A&E had diminished.

A specific case was highlighted of a regular homeless visitor to A&E who had Chronic Obstructive Airways Disease, a severe respiratory illness, and was in his fifties. The individual was known to be a challenging individual and exhibited abusive behaviour to all services. The individual had been evicted from private rented housing that he had lived in for some time. He slept in his car for a period and was housed in Ty Ogwr. He was due to be evicted from this accommodation and a meeting of the 'Problem Solving Group' (a police run group) discussed his case. The A&E staff highlighted that his health made him too vulnerable to be evicted and that he would not survive outside. He was subsequently evicted and sadly died earlier this year.

Prison Health

Healthcare in Prisons is delivered to NHS standards and should include the full range of primary care that is available in the community. Services in prisons are generally provided by the NHS (for example in Cardiff Prison) however as Parc Prison is run in the private sector its health services are also run by a private contractor – G4S Health. We were unable to speak to anyone who understood the Prison Health Service in Parc Prison however the G4S website https://www.hmpparc.co.uk/about_haw_h.htm# for Parc provides information on the range of services available including links to external services.

Anecdotally we were advised that healthcare in Prison is good but we were unable to establish the mechanisms by which the healthcare of individuals is transferred to NHS services once someone is released. It is also important to note that residents from the CTUHB area may be released from any prison in the UK.

We were advised that Local Authorities have duties under the Social Care and Well-being (Wales) Act 2014 for people with care and support needs in secure estate, that will involve joint assessment by health and social care, and hence there are duties on release.[15] People with health needs only are not covered by this. We understand that the contract for Health Service provision at the prison is due for renewal in 2021, and this may be an opportunity to review arrangements and if they are fit for purpose for ensuring safe transfer of healthcare to the community.

Immunisation and Vaccination

The Local Public Health Team had initiated a project prior to lockdown to establish the need for, and arrangements for immunisation of homeless people for diseases such as Influenza and Hepatitis.[16] The project reached 34 homeless people across the CTMUHB area before being curtailed due to Covid-19. The findings of the study are summarised below.

Table 12: Immunisation and vaccination data on a sample of homeless people from the CTMUHB area.

	Percentage (%)	
Question	**Yes**	**No**
Are you registered with a GP?	100	0
Would you be willing to have the influenza vaccination in future?	94	6
Do you have any underlying health conditions?	80	20
Are you up to date with childhood immunisations?	89	11

[15] Social Services and Well-being (Wales) Act 2014, Part 11 Code of Practice (Miscellaneous and General). OGL 2015

[16] Beynon C, 2020 Vaccination Services for the Homeless Population in Cwm Taf Morgannwg- Scoping Paper. Public Health Wales

The most significant findings were that 32 of the 34 homeless people interviewed agreed they would receive an influenza vaccine if this service was made available at the venues visited, an important finding given the levels of chronic disease in this group and their expressed view that they would be unlikely to proactively seek vaccinations from their GP. The report also highlighted that there is a case for offering staff working with homeless people the influenza vaccination in line with workers in other settings working with vulnerable groups. Recommendations from this report have been incorporated at the end of this report.

Health Visiting and School Nursing

Health Visiting is a universal service available to all families with a child under the age of 5. Families with children under 5 living in temporary accommodation will be under the care of a Health Visitor. We were advised there is no specific additional provision to support these families, although there had been a specialist health visitor for the Homeless in the former CTMUHB some years ago.

The health of older children come under the auspices of school nurses and we were not made aware of any specific provision for children from homeless families.

Results of the Review of Literature

Homelessness Policy

Part 2 of the Housing (Wales) Act 2014 reformed homelessness law in Wales with the aim of ensuring that people who are homeless or at threat of homelessness receive help as early as possible. It included a new duty on local authorities to help anyone threatened with homelessness within 56 days; a duty to support any homeless person to help them secure a home; and new powers for local authorities to discharge their homelessness duties through finding accommodation in the private rented sector. The purpose of the legislation is to achieve:

- Fewer households experiencing the trauma of homelessness; better, more targeted, prevention work.
- Increased help, advice and information for households who receive limited assistance under the previous legislation
- More focus on the service user, helping them to address the causes of homelessness and make informed decisions on finding solutions to their housing problem
- More effective use of the private rented sector as a solution to homelessness
- A stronger emphasis on co-operation and multi-agency working.

The legislation came in to effect in April 2015. Additional resources have been provided for local authorities to support the change to the more prevention-focused approach. Although comparisons cannot be made to statistics gathered prior to the change in legislation, the homelessness data suggests that the legislation is proving successful in helping to prevent homelessness in Wales.

Health and Homelessness

Being homeless is bad for health and wellbeing. The links between poor housing and poor health are well documented[17]. People experiencing homelessness are more likely to have serious and multiple health problems, including infectious diseases, mental health disorders and drug and alcohol misuse and have much higher mortality rates[18] . People who sleep rough die, on average, between age 43 and age 47[19] – more than 30 years earlier than the general UK population. The life expectancy of people that sleep rough in the UK is lower than the life expectancy in the poorest country on earth[20].

The Faculty for Homeless and Inclusion Health provide a helpful summary[21] of the inequalities in health that homeless people face.

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[17] Acheson, D. 1998. Independent Inquiry into Inequalities in Health Report; Black, D. et al. 1982. Inequalities in Health: The Black Report;

[18] Aldridge, R. et al. 2018. Morbidity and mortality in homeless individuals, prisoners, sex workers, and individuals with substance use disorders in high-income countries: a systematic review and meta-analysis. Lancet.

[19] Greenfield, P. and Marsh, S. 2018. Deaths of UK homeless people more than double in five years. Guardian; Thomas, B. 2012. Homelessness kills: An analysis of the mortality of homeless people in early twenty-first century England. Crisis.

[20] World Health Organisation. 2016. World Health Statistics. URL: https://www.who.int/gho/publications/world_health_statistics/2016/EN_WHS2016_AnnexB.pdf?ua=1

[21] https://www.pathway.org.uk/wp-content/uploads/Version-3.1-Standards-2018-Final-1.pdf

The annual cost of unscheduled care for homeless patients is eight times that of the housed population and homeless patients are overrepresented amongst frequent attenders in Accident and Emergency (A&E) departments. High costs are associated with multi-morbidity, but can mask the fact that many homeless people have poor access to healthcare, with less resource allocation than they need. Despite this expenditure, the average age of death for homeless patients is just 43 for women and 47 years for men and is associated with the reduced quality of life caused by multi-morbidity. Standardised mortality ratios for excluded groups, including homeless people, are around 10 times that of the general population. The prevalence of multi-morbidity increases with deprivation and has an onset 10-15 years earlier in deprived groups than in the most affluent. Homelessness is an independent risk factor for premature mortality and is associated with extremes of deprivation and multi-morbidity.

There is a growing understanding, supported by international research, that chronic
homelessness is an associated marker for tri-morbidity, complex health needs and premature death. Tri-morbidity is the combination of physical ill-health with mental ill-health and drug or alcohol misuse. This complexity is often associated with advanced
illness at presentation, in the context of a person lacking social support who often feels ambivalent about both accessing care and their own self-worth. Tri-morbidity often has its roots in histories of complex trauma, including high levels of child neglect and abuse, that impact on developmental trajectories and mental health.

Housing is clearly a crucial social determinant of health. Poor health can also cause homelessness. There are many examples of ill health leading to homelessness. For example, uncontrolled mental health issues could contribute to a relationship breakdown, or a long hospital admission could lead to someone losing employment, both common triggers for homeless. Health services and health professionals therefore have a role in the prevention of homelessness, as well as maintaining health during a period of homelessness and ensuring ill-health is not a barrier to re-entering settled housing. It can be difficult to meet the needs of people experiencing homelessness. Barriers can arise from the way services are structured and provided (such as inflexibility of services and appointment systems, difficulty registering or receiving follow up for services without a fixed address, negative staff attitudes) or difficulties with people experiencing homelessness themselves (such as chaotic behaviour or drug and alcohol problems which affect engagement with services).

People experiencing homelessness therefore often require additional effort to receive an equitable share of resources. These forces combine to cost society large amounts in the provision of healthcare for people experiencing homelessness. At a UK level people experiencing homelessness are less likely to be registered with a GP, more

likely to attended hospital emergency departments, stay longer in hospital and consume around four times more acute hospital services than the general population[22]

Taking Wales Forward, the Welsh Government's programme for government, includes an aim to provide people with access to good quality, timely care as close to home as appropriate. Plans to achieve this are set out in Prosperity for All, the national strategy, and A Healthier Wales, the long-term plan for health and social care. The NHS Wales Delivery Framework 2018-2019 has been developed to measure and monitor the health of the Welsh population and their experience of health services in Wales. The framework sets out many aims; the most relevant are:

- Staying healthy – people in Wales are well informed and supported to manage their own health;
- Dignified care – people in Wales are treated with dignity and respect and treat others the same;
- Timely care – people in Wales have timely access to services based on clinical need and are actively involved in decisions about their care plan; and
- Individual care – people in Wales are treated as individuals with their own needs and responsibilities.

An estimated 41% of people classified as 'rough sleepers' have long-term physical health problems such as heart disease, diabetes and addiction problems, compared to 28% of the general population. Another 45% have been diagnosed with mental health issues, compared to 25% of the general population. Many are vulnerable adults with complex needs suffering with mental health issues and / or substance abuse, yet they cannot access the services they need to get better. Many have physical health issues, which are compounded by the living on the streets.[23]

A significant evidence base exists that highlights that traditional health services are not designed to meet the needs of the homeless population. A 'one size fits all' approach does not work and the varying needs of people affected by homelessness should be addressed individually and flexibly.

The difference in health outcomes for homeless people compared to the general population are outlined in table 13.

[22] Department of Health. 2010. Healthcare for Single Homeless People. Office of the Chief Analyst. Department of Health
[23] Public Health Matters blog by Public Health England 2018

Table 13: Health Outcomes in the general population compared to the homeless population in England [24]

Health Issue	General Population	Homeless Population
Long term physical health problems	28%	41%
Diagnosed mental health issues	25%	45%
Taken drugs in the past month	5%	36%

Homeless people are at highest risk of mental and physical health problems, and thus have a high level of use of health services, and inappropriate access of urgent care services. Best practice in other locations have in place specialist healthcare capacity that is able to provide training and networking to both housing providers and healthcare providers in the specific needs of the homeless, to assist providers in managing health needs and facilitate better access to services.

Health Impact of Covid-19

Public Health Wales has recently published its Summary of its Health Impact Assessment (HIA) of the 'Staying at Home and Social Distancing Policy' [25] that highlights both the potential positive and negative impacts of the restrictions on homeless people. The HIA highlights both positive impacts in relation to being housed / provided with accommodation and negative impacts of isolation and loss of access to services such as face-to-face support for addressing health harming behaviours.

Standards for Improving the Health and Well-being of Homeless People and Specific Vulnerable Groups

The Welsh Government's Health and Care Standards, which came into force in 2015, set out the guiding principles for delivery of health services in Wales, including the need for easy and timely access to primary care services, people are supported to get help when they need it and in the way they want it, and efforts are promoted to reduce health inequities.

In 2013 the Welsh Government published revised 'Standards for Improving the Health and Well-being of Homeless People and Specific Vulnerable Groups'. They include five standards for ensuring that homeless people have full and fair access to health services:

1. Leadership: The Health Board demonstrates leadership driving improved health outcomes for homeless and vulnerable groups.
2. Joint working: The Health Board works in partnership with the Local Authority, service users, the Third Sector and stakeholders to improve health and contribute to the prevention of homelessness.

[24] Homeless Link. Health Audit 2014

[25] Public Health Wales 2020: A Health Impact Assessment of the'Staying at Home and Social Distancing Policy'in Wales in response to the COVID-19 pandemic Executive Summary. Liz Green et al..

3. Health intelligence: The Health Board works in partnership with the Local Authority, service users, the Third Sector and stakeholders and demonstrates an understanding of the profile and health needs of homeless people and vulnerable groups in their area.
4. Access to healthcare: Homeless and vulnerable groups have equitable access to the full range of health and specialist services.
5. Homeless and Vulnerable Groups' Health Action Plan (HaVGHAP): The Health Board leads the development, implementation and monitoring of the HaVGHAP in partnership with the Local Authority, service users, the Third Sector and other stakeholders.

The HaVGHAPs should set out how services are planned and delivered to meet the health needs of homeless people and those at risk of homelessness, with the aim of addressing the social determinants of health, health inequalities and cycles of poor health and homelessness. These principles are also relevant to the Social Services and Well-being (Wales) Act 2014 and the Well-being of Future Generations (Wales) Act 2015.

Prevention of Homelessness
The Future Generation's Commissioner has agreed a general definition of prevention to help organisations and services understand their specific role in preventing negative outcomes such as youth homelessness. The definition is in four levels as follows:

- **Primary prevention** – Building resilience – creating the conditions in which problems do not arise in the future. A universal approach.
- **Secondary prevention** – Targeting action towards areas where there is a high risk of a problem occurring. A targeted approach, which cements the principles of progressive universalism*.
- **Tertiary prevention** – Intervening once there is a problem, to stop it getting worse and prevent it reoccurring in the future. An intervention approach.
- **Acute spending** – Spending, which acts to manage the impact of a strongly negative situation but does little or nothing to prevent problems occurring in the future. A remedial approach.

*The concept of 'progressive universalism', is driven by the determination to provide support for all, giving everyone a voice and vested interest, but recognises more support will be required to achieve a similar outcome for those people or areas with greater needs.

Centrepoint [26] reviewed the literature in respect of preventing youth homelessness in 2016. Their report highlights that family relationship breakdown is the main driver of youth homelessness, though many factors escalate to the point at which a young person cannot remain with their family. These reasons include young people being 'thrown out' for revealing their sexuality; involvement in offending; poverty; the introduction of a parent's new partner; not being in education training or employment; poor mental health and domestic violence. This poses a challenge to those developing

[26] Centrepoint 2016 Preventing Youth Homelessness: What works?

services to ensure there is a holistic response that can meet a range of needs and tackles multiple problems.

Centrepoint characterises primary prevention of homelessness as averting new cases by intervening well before it may occur, and secondary prevention treats new cases as early as possible, often when a young person presents to their local authority. Secondary prevention was the most prevalent form of prevention within the evidence review, with evidence of primary prevention scarcer, potentially because the effectiveness is more difficult to assess.

Centrepoint characterises the evidence in two groupings of what works, where there is good evidence of effectiveness and what could work where the evidence is more equivocal.

Table 14: Centrepoint's Model of Prevention

What works:	
Multi-agency working:	Information sharing Joint decision making Co-ordinated intervention
Single Front door:	A physical hub where agencies are co-located and facilitate access to all services, reflecting the often chaotic nature in which young people engage with services
Whole family approach:	Advice for parents on finance, housing or employment Opportunities for the family to engage in activities together Referring children and young people to specialist mental well-being services Address children and young people's education needs through securing school placement and supporting with homework Improving parent's engagement with their child's school
Positive professional relationships with service users	
What could work	
Mediation	Impartial, working closely with other delivery agencies to provide a package of holistic support that should be offered as early as possible.
Advice and information	Tailored to specific needs and situations
Emergency accommodation	Young people specific pending appropriate support to the family

The Housing Solutions Platform[27] has highlighted 50 Housing Solutions from around the world for Homelessness and Housing Exclusion that are worth exploring. Two specific examples are highlighted below that focus on prevention for young people and demonstrate the multi-agency thinking that is required to deliver these types of solutions.

The **Upstream Project Canada's** (UPC) mission is to promote student well-being by working proactively to identify vulnerable school-aged young people and support them in order to prevent them from dropping out of school and leaving home. The goal is to improve student support by helping students gain access to coordinated services in their communities and to shift the response from being reactive to being proactive. Specifically the project uses the Canadian Index of Child & Youth Wellbeing, a screening tool that is completed by all students from grades 7 to 12 to identify vulnerable students and their needs. The tool asks questions about their living situation, mental well-being, connection to peers and resiliency, amongst other things. The responses are then analysed to identify students in need of support, who will then be connected by a local case worker and offered the adequate services they may need to remain in school and in safe housing

The project has been piloted across five communities with a total of nearly 3000 students. 3.3% of the participants were identified as at risk of homelessness and another 3.2% are at risk of psychological distress and school disengagement. During the project's pilot, a total of 128 students were connected one-on-one. Of those 128 students, 38 proceeded to receive various levels of case management support from a youth worker and the remaining 90 were provided with support, a referral to another programme, or stated that they would reach out to the youth worker in the future as needed.

The **Homes for All Alliance** in Denmark provides access to student housing for homeless young people who want to become students in "the near future". The goal is to provide stable and permanent housing for homeless young adults with Housing First Case Management combined with access to healthy supportive networks with students, otherwise difficult to access for homeless young adults. The idea is also to enable homeless young people to tap into existing opportunities they are traditionally excluded from such as privately-owned student housing and student communities. To achieve this, the Home for All Alliance works to build trust between local authorities and private organisations who own student housing and will rent 10% of their student housing to young homeless people who aim to return to education. Meanwhile, local authorities commit to providing adequate case management social support to the homeless young people.

Twenty five homeless young adults have been housed, in three student housing communities. Twenty of those young people (80%) are still either in student housing or in other permanent housing. Five of the young adults (20%) have an unknown status and some might have gone back to homelessness. Those with the most complicated backgrounds were found to have a harder time integrating.

[27] Housing Solutions Forum, undated, 50 Out-of-the-box Housing Solutions to Homelessness and Housing Exclusion.

Innovations in Health Access for Homeless People

Health Services for the Homeless

The evidence of what works for marginalised population is summarised by Luchenski[28]. The key findings are that integrated multi-component care – summarised as individual care coordination supported by a multi-disciplinary team – is the best healthcare response for excluded groups and that involvement of experts by experience is vital in service design and delivery.

While the burden of homeless health problems is greater than in the general population, access to care is worse. This is because:

- The lifestyles of homeless people make it harder to live healthy lives and access mainstream services;
- Poor physical and mental health can be the cause of homelessness, and a barrier to care;
- Illness causes homelessness. Physical disorders may reduce a person's ability to earn money and thus reduce ability to find and retain accommodation;
- Homelessness causes and compounds illness. Lack of shelter results in exposure to severe weather and increases the risks of accidents. Lack of privacy increases exposure to infectious diseases in large communal dwellings. Lack of sanitation leads to disorders associated with poor hygiene. Lack of security increases exposure to violent attack and rape. Inadequate diet or malnutrition reduces immunity to disease;
- Care for homeless people is often characterised by crisis management.

Whilst an integrated approach to care is the best way to meet the needs of homeless people[29] the healthcare response is usually fragmented. Chiddick[30] categorised primary care services for homeless people in England into 5 groups and found that 38% of primary care trusts had no specialist provision, 25% provide just one outreach team and 10% offer only temporary registration:

A similar study from the Department of Health found 4 models of homeless healthcare:[31]

- Mainstream practices which provide services for homeless people: A GP from a mainstream practice holds regular sessions for homeless people in a drop-in centre or at the surgery. Patients are not registered and do not get out of hours provision;

[28] What works in inclusion health: overview of effective interventions for marginalised and excluded populations 2017, Luchenski S et al. Lancet
[29] See http://www.pathway.org.uk/wp-content/uploads/2013/02/Homeless-Health-Standards.pdf
[30] Chiddick, L., Health service provision for the homeless in England in Aspinall, P., 2014 Inclusive Practice
[31] Office of the Chief Analyst, 2010, Healthcare for single homeless people. London Department of Health

- An outreach team of specialist homelessness nurses provide advocacy and support and episodes of care (e.g. wound management), and are able to refer to other services. No guarantee of patient registration or out of hours care;
- Full primary care specialist homelessness team: A team of specialist GPs, nurses and other services provide dedicated and specialist care with a hostel/drop-in centre. This service usually registers patients and provides better access to care for people with mental health problems or drug/alcohol dependency;
- Fully co-ordinated primary and secondary care: A team of specialists spanning primary and secondary care, providing integrated specialist primary care out-reach, intermediate care beds and in-reach services to acute beds. This research suggests that no English PCTs provided a fully integrated care model with a step up and down secondary care unit.

While these are not systematic evaluations, the key emergent theme is that the approach to homeless primary care varies in different localities. However, Aspinall indicates that where specialist services do not exist homeless people are generally not registered and outcomes are likely to be worse.[32]

There are some quality and clinical standards developed by the Faculty for Homeless and Inclusion Health which will improve outcomes for homeless people that have been developed alongside standards for inclusion healthcare for the most vulnerable in communities:[33]

1. Continuity – a trusting and respectful relationship formed with a familiar clinician and team.
2. Ease of access to include walk-in provision, in-reach to hostels and street outreach to people sleeping rough
3. Integrated, multi-disciplinary collaborative care is central to effective care because many homeless people present with multiple healthcare needs.
4. Person-centred care with involvement of experts by experience in planning and delivery.
5. Cultural competence and sensitivity.
6. The Recovery approach developed by users of psychiatric services should be incorporated into the design of all services. This seeks to make shared decision making the norm: “No decision about me without me”.
7. Where specialist services are provided they should act as a catalyst to improve care throughout the local health service.
8. Health services should provide a bridge linking hospitals and community care through hospital in-reach services.
9. Health services should work closely with public health departments, particularly in relation to serious communicable diseases

[32] Aspinall, P, 2014, Inclusive Practice, Vulnerable Migrants, Gypsies and Travellers, People Who Are Homeless, and Sex Workers: A Review and Synthesis of Interventions/Service Models that Improve Access to Primary Care & Reduce Risk of Avoidable Admission to Hospital, Inclusion Health https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/305912/Inclusive_Practice.pdf
[33] See https://www.pathway.org.uk/wp-content/uploads/Version-3.1-Standards-2018-Final-1.pdf

10. Services should actively seek to offer treatment to vulnerable migrants and those with no recourse to public funds.
11. Services for homeless people should include the provision of "respite care" community-based residential medical facilities for homeless people with significant and complex healthcare problems. This could be achieved cost-effectively through joint working with local hostel providers and the voluntary sector. These services improve outcomes and reduce subsequent unscheduled hospital admissions.

The following are examples of services models derived from Health Needs Assessments undertaken in other areas of the UK that demonstrate some of the principles above – each service has its own challenges, but these provide a perspective on the principles on which services can be designed.

Oxfordshire[34]
Luther Street Medical Centre is a General Practice providing healthcare to adults (16 and over) experiencing homelessness (rough sleeping and vulnerable housing) in Oxford City. The service is run by Oxford Health NHS Foundation Trust and works with partners from a range of voluntary and statutory organisations to provide coordinated care to patients who find it difficult to register at other GPs and may otherwise not be able to access the care and treatment they require. Luther Street healthcare professionals liaise extensively with patients' link workers to ensure holistic, joined-up care across services. Services include:

- Experienced/specialist GPs providing consultations for acute and chronic conditions, a comprehensive contraception service and screening for Hepatitis B, Hepatitis C and HIV and complex mental health management that may be beyond the capacity of a generalist GP practice.
- Specialist Addiction Practitioners run joint clinics with a shared care approach with GPs to provide specialist management for alcohol and drug addiction, including opiate substitution therapy.
- Practices nurses run vaccination clinics (including free hepatitis B vaccination), smoking cessation and leg ulcer management services.
- Specialist Mental Health Practitioners assess and treat a range of mental health problems including depression, anxiety and emotional issues.
- A psychiatrist provides management and advice for severe mental illness through monthly visits.
- Dentistry provided through weekly clinics.
- Acupuncture provided through weekly clinics.
- Podiatry provided through monthly clinics.
- A social practitioner assists with the "wider determinants of health", i.e. non-clinical matters including benefits problems and appeals, training and education, and applications to the Oxford Homeless Medical Fund

[34] Oxfordshire County Council. 2019 A health needs assessment of the adult street homeless population in Oxfordshire. Dr Isaac Ghinai

- In addition, Luther Street provides training opportunities for medical and nursing students and for doctors and nurses in training.
- Patients can also access the Promoting Access To Health Scheme, helping patients to attend hospital appointments, dependent on volunteer support
- The practice also helps by coordinating post.

One user said

"Luther Street are right on the door of the night shelter. You could walk in that morning without an appointment and get one. The doctors and staff have experience of working with people in that lifestyle, so they've got an understanding of your needs. They don't judge, they're there to listen and take their time."

Luther Street Medical Centre overcome structural barriers to care by providing flexible appointments (e.g. walk-ins), cultivating a non-judgemental atmosphere, co-locating commonly needed services and offering longer-than average appointment times.

A Health Needs Assessment in Oxfordshire highlighted that around half of 1000 homeless people across the County were not registered with this practice and therefore received more variable care from routine general practice, particularly in smaller towns and more rural areas the County. Mental Health Services were also highlighted as an area where greater levels of community support for homeless people were required.

Portsmouth
A health needs audit and service review in Portsmouth proposed five approaches to delivery of homeless services[35] which helpfully describe some options for how services can be structured.

1. Homeless healthcare services that are attached to other services such as a GP practice

This model co-locates services for homeless people with other existing services. This may harness existing expertise and facilitate development of joint-working between different services and improved delivery models. The extent of co-location of services will depend partly on whether adequate space is available.

2. Using mainstream primary care services

Improving access to mainstream primary care through existing GP practices through development of widespread expertise across primary care to care for these complex and often challenging patients, and to ensure their needs are sensitively addressed. The challenge of the capacity of GPs to deliver this model was highlighted as a constraining factor.

[35] Morven Banks, Duncan Fortescue-Webb. 2015 Rapid Scoping Health Needs Assessment of Homeless People in Portsmouth, Portsmouth City Council

3. A dedicated homelessness service that is closely integrated with allied Services

A stand-alone service for homeless people allows thorough specialisation and careful adaptation to their needs. Healthcare can be delivered in close conjunction with other services addressing mental health, drug and alcohol recovery, education, employment, housing, and welfare. A 'one-stop shop' would not only improve delivery, and make it simple for users to understand and access, but would also promote joint problem solving among services. This would additionally offer an opportunity for standardised information gathering and referral routes between services. A good skill mix could be developed with on-site with medical and nursing care provided alongside housing and social services.

4. The Pathway model

This model uses a specialised team to actively coordinate and advise the many services that homeless people use so that they interact more efficiently. Providers based in primary care may visit homeless people when they are in hospital to provide expert advice and support and ensure that discharge planning addresses each patient's needs. This model could be adapted to ease other difficult transition points such as leaving care services, or prison. Improved joint-solution finding between primary and secondary care can prevent a cycle of repeated emergency admissions to hospital. While direct delivery of expertise is possible, this model primarily complements and assists delivery of services by other groups.

1. Mobile outreach services

These could be associated with any of the other options to improve access to healthcare and overcome any geographic barriers. Outreach services may act as a gateway to encourage homeless people to attend other existing services. Options include a truly mobile service on wheels, or occasional use of various local premises by a team. Particular services could choose to travel to areas where they are most needed.

Wrexham

The Community Care Hub brings together a range of organisations under one roof to provide support to Wrexham's homeless community. The hub founded in June 2016 by Wrexham GP Dr Karen Sankey, alongside mental health services from the health board and The Wallich, to provide better support to homeless people who were in crisis.

The weekly sessions are held in the Salvation Army building and supports more than 100 people who are homeless, rough sleepers or have mental health or substance misuse problems. The drop in sessions see organisations and charities including BCUHB, the Department of Work and Pensions and Wrexham County Borough Council come together to provide bespoke, co-ordinated and timely support for homeless and rough sleepers on a range of issues including health, benefits and housing.

The success of the project is attributed to the people delivering their services each week who share a passion and a vision to make a difference for this group of individuals. A key feature of the hub is the concept of 'Everyone in the Room' that brings together all the agencies that people need in the same room, at the same time every week. This system means people do not have to worry about missing appointments or needing paperwork they don't have access to. The service is based around four key aims:

- Reduce barriers to public services for those who are in crisis
- Ensure people are listened to and respected, whilst having their individual needs understood
- Bring together local socially-driven organisations, so they can work more efficiently
- Lower demand on mainstream public services

Conclusions

It is clear that there is an interest in the health needs of homeless people in most service areas in CTMUHB, and the forays that some services have made into understanding and meeting the health needs of homeless people is encouraging. Relationships at the local level between some NHS services and hostel providers is also to be welcomed and something to build upon. However, a strategic and co-ordinated multi-disciplinary approach to fully meeting the health needs of homeless people, that would meet best practice standards, appears to be largely absent.

The focus on service development in the Taf Ely area, including initial investment in a specialist service, alongside new opportunities for funding health services for the homeless, provide an opportunity to transform the healthcare experience of homeless people. There is sufficient evidence of both the local need and how services are organised elsewhere that can be utilised to design what will need to be a service unique to the circumstances of the CTMUHB area. In particular the current focus in the Health Board on a locality management model provides an opportunity for each area to test its service model design to ensure that the needs of the most vulnerable in each community, including homeless people, have been addressed.

The following are recommendations for the appropriate authorities and partners in the area to consider as priorities in their response.

1. Safeguarding procedures should be reviewed to ensure that they are sufficiently robust to ensure that individuals and organisations are able to raise concerns about the homeless, and feel that their concerns are being heard and acted on. Deaths of homeless people should be investigated through these procedures to ensure lessons are learned.

   Action: Health Board, Local Authorities and Regional Partnership Board

2. An existing forum, or new group should be convened, to oversee the implementation of the strategic actions arising from this report. This group should be comprised of key stakeholders; health, social care, housing, criminal justice and welfare services and have a line of accountability to the Regional Partnership Board. A first goal of this group should be to set out its vision for health services for homeless people, drawing on the groundwork that has been undertaken in individual services. An integrated model service delivery for homeless people should be developed for delivery in each local authority area, that takes account of the standards set out by the Faculty of Homeless and Inclusion Health and take an action learning approach to service development.

   Action: Regional Partnership Board

3. An operational forum should be established in each of the local authority areas to provide a focus for building relationships between the variety of health service providers and the hostel providers, with a specific emphasis on Primary Care to improve day to day management of healthcare for homeless people.

Action: Regional Collaborative Committee

4. A network of health professionals should be established with an interest in health and homelessness across the Health Board (including primary care) to build professional capacity and understanding of needs and services for Homeless People.

Action: Health Board

5. Data relating to service use by homeless people across the Health Board should be brought together into a single dashboard to aid understanding of the utilisation of health services by homeless people, and feed into IMTP planning and to inform the HAVGHAP. This can be achieved through interrogating existing service data, rather than needing new systems, and will provide visibility to the needs of homeless people on an on-going basis.

Action: Health Board

6. Staff in key leadership and clinical roles should undertake awareness raising of the issues raised in this report on a multi-disciplinary basis. This should include people visiting the hostels and meeting homeless people to gain empathy and challenge their unconscious bias. Training should cover these topics:

- Causes and types of homelessness
- Needs
- Access criteria and arrangements
- Escalation
- Shared risk
- Information sharing

Action: Health Board

7. The Taf Ely cluster's work on the homeless is a significant and highly positive development and should be used as a pilot to test a method of working that can be rolled out across the Health Board as appropriate. As a first step the post-holder should focus on being a vector and advocate for change in all services.

Action : Health Board

8. A specific piece of work is required to further explore the role of mental health services and substance misuse services in supporting the homeless:

   - Primary mental services are available in some but not all hostels, funded from a variety of sources outside of the NHS. Primary mental health services are also provided by the NHS accessed via Primary Mental Health Workers in Primary Care. Homeless people are most likely to access services provided in or near hostels. A consistent offer should be available across all venues that is easily accessible as stabilising mental health underpins all other interventions with homeless people.
   - There is a need for direct and regular liaison between Community Mental Health Teams, Crisis Mental Health Teams, Substance Misuse Services and hostel services to establishing a shared understanding and approach to supporting people homeless people in crisis, including exploring information sharing between mental health services and housing providers.

Action: Health Board

9. A public health approach to primary prevention of homelessness should be considered, including a review the local approach to identifying young people at risk of homelessness through school and education services, particularly those at risk due to family breakdown and families in crisis, and to assess if current arrangements are sufficiently targeted. Particular attention should be paid to how young LGBTQ are supported through family breakdown.

Action: Local Public Health Team

10. Partners should review their hospital discharge arrangements to ensure that they are not unwittingly contributing to homelessness.

Action: Regional Partnership Board

11. Some service responses to Covid-19 have seen more rapid access to services for people in need – for example more rapid access to substitute prescribing for people using substances. The Health Board should review with homelessness services how this access can be maintained.

Action: Health Board

12. Health Services should provide information on a regular basis to the homelessness hostel services, as part of their regular service updates, about how to access services eg changes in dental service access, accessing podiatry etc.

Action: Health Board

13. A model to align therapeutic interventions for homeless people with co-morbid mental health and substance misuse should be developed and implemented.

Action: Health Board

14. Further exploration of the transfer of care on release from Parc Prison should be explored in the context of re-commissioning of prison health services.

Action: Health Board

15. All organisations should consider how they can offer volunteering and other opportunities that are accessible for homeless people.

Action: Regional Partnership Board

16. An opportunistic vaccination service should be introduced to serve the needs of the homeless population in CTMUHB . This should form part of the remit of the immunisation team, when human resources allow.

Action: Health Board

17. Women in the eligible age-groups for breast and cervical screening should be encouraged and supported to attend for screening.

Action: Hostel Providers and Public Health Wales

Appendix 1

Health Needs Audit

Information for participants

How good are the health services in your local area?

Do you get the help you need?

The main aim of this audit is to find about the health needs of people with experience of homelessness in your local area. This data can then be used to help improve services and ensure that any barriers to access are removed.

During the audit, a member of staff will ask you some questions about any health needs you have, what health services you use and how your experiences can be improved in the future. This should take approximately 30-40 minutes.

The audit is not a health assessment and it will not be used to tell you what health treatment you might need. However, a member of staff should be able to give you information about where you can get this advice if you would like it once the audit has been completed.

Why should I take part?

Health is important to everybody, but people who are homeless can have poorer health as a result of barriers to accessing services, as well as specific support needs relating to their homelessness. Without a reliable source of information about what health needs homeless people have, it is difficult to know if existing services are offering effective support, or whether new ways of working or new services are required. By taking part, you will be helping us to get the evidence we need to help improve health services for homeless people in your local area.

Participants across the country have already taken part in an audit for their area. As a result, the services they work with have been able to make a range of improvements, including:

- Better links between hospitals and homelessness services.
- Greater access to services like GPs and dentists.
- Improved services for issues like substance misuse, mental health, feet & eye care.

Will the info I provide be anonymous?

Yes. Any information you share with us will be anonymised:

- We will not record your name or other personal details during the audit.
- Local services will have access to the data, but they will not be able to identify the individuals involved.
- You should always be asked for your consent to check you are happy to go ahead with the audit.
- Any information you provide will not affect any of the services you are already receiving. Please answer the questions as fully as you can. If you'd rather pass on a question, just let the interviewer know.
- The data will be stored safely electronically and Hugh and Bruce (the consultants responsible for collecting this information) will use the information to provide a report with recommendations to the Health Board. Individuals who complete the audit will not be identifiable from this data.

Thank you for taking part. If you have any further questions, please ask a member of staff.

Appendix 2

Health Needs Audit

Information for Interviewers

The Health Needs Audit

Your organisation is taking part in an audit to gather information about the health needs of people experiencing homelessness in your local area, as well as their experiences of current homelessness and healthcare services.

The information collected will be used to inform local commissioning and service improvement decisions.

An interview should take about 30-40 minutes to complete. No personal details are recorded, so all of the information collected will be anonymous.

Completing the audit

It is important that you conduct the audit in a safe and secure environment. We suggest completing interviews on a one-to-one basis with participants, in a private space where they feel comfortable.

If you have access to an internet connection, you can use the online survey for which your project should have the relevant internet link. However, you can also record responses on a paper copy of the audit and input them onto the online survey at a later date. If you collect information on paper, you can split the session to give participants a break, if necessary.

Please ask participants each of the questions in sequence, recording all of their responses. To improve data quality questions scored with an asterisk (*) are mandatory, but there is a 'client did not comment' option for those people who do not wish to respond. The more questions that are answered, the better the

quality of the data will be, so do try and encourage participants to answer as many questions as possible.

Some of the questions are conditional – i.e. they will only be relevant if the participant selects a certain response to an earlier question. These are clearly marked on the paper version. The online version will take you to the relevant questions automatically.

You do not need specialist knowledge of health to complete the survey. If you are unsure of the meaning of certain terms used in the audit, Appendix 1 should provide some useful explanations of certain health conditions and other terms. Appendix 2 contains an alcohol prompt card, which offers some useful information on unit measurements if you are not familiar with these already. Some participants may be reluctant to disclose information if they feel it will impact on their support or treatment plans, so be clear with participants that the audit will not affect the support they are receiving.

Arranging for the interview to be carried out by a different member of staff with no personal connection to the participant, or by a volunteer or peer researcher, can help to overcome this.

Remember to emphasise to participants that all of the information collected is anonymous.

Incentivising the audit

The majority of participants will be happy to talk about their health needs. However, there are a few ways you can incentivise the process to encourage people to take part:

- Re-emphasise the value of the audit to participants and how invaluable their views are in achieving positive change.
- Incorporate the audit into an existing key/support working session or wider activity.
- Arrange a drop-in for participants to come and complete the audit, which also offers tea, coffee and lunch.
- Make it part of a wider project – anything that involves peer mentors, researchers or advocates.

Frequently asked questions

What if participants find it difficult to discuss health issues?

Remind participants that all of the information collected in the audit is anonymous and cannot be traced back to them.

If a participant discloses information which is of concern, encourage them to speak to an appropriate member of staff once the audit has been completed.

How should I go about recruiting potential participants?

To ensure that your sample is as large as possible, you can:

- Promote the audit to potential participants through existing channels, such as residents' meetings.
- Be flexible – hold interview slots at different times of day.
- Try and emphasise to people why the audit is not just another paper exercise. It can help to achieve real change and ensure that health services are more open to people experiencing homelessness in the future.

What will happen to the information?

Once the information from across your area is uploaded, it will be collated via a secure online survey tool where the information is stored and will only be accessed by authorized administrators.

All information is anonymised so anyone accessing the database cannot identify the individuals involved.

The information will be analysed by Bruce and Hugh on behalf of Cwm Taf Morgannwg University Health Board in order to assess levels of need, identify gaps in service provision and inform future service development. This information will be made available to your organization for you to share with colleagues and people you support when it is complete.

Thank you for helping with this audit part. If you have any further questions, please contact Hugh on 07909402769 or hugh@hughirwinassociates.co.uk

Appendix 1 - Explanatory notes & prompts

Further definitions and prompts for questions related to health conditions, housing etc

Physical Health

Breathing problems

Prompts:
- Do you have a painful cough?
- Is it painful to breathe or are you short of breath?

Problems with bones, joints and muscles

Prompts:
- Do you have aches and pains in limbs?
- Is it difficult to walk?
- Do you have joint swelling or any stiffness?
- Do you have difficulty walking or going up stairs?

Eye problems

This can include:
- Difficulty seeing well.
- Blurred vision.
- Eye pain.

Skin/wound infection or problems

This can include:
- Skin infections.
- Rashes.
- Wounds or cuts.
- Sores or itchy skin.

Poor foot health

Prompts:
- Do you currently have any wounds or cuts on your feet?
- Do you currently have any sores or callouses, which can make walking painful?
- Do you experience any numbness?

Fainting/blackouts

Prompts:
- Do you have a diagnosis of epilepsy?
- Do you experience fitting or blackouts, including withdrawal fits?

Urinary problems/infections	This can include: • Pain passing urine. • Incontinence. • Passing blood when urinating. • Kidney infections or problems.
Problems with circulation/ blood clots	This can include: • Known DVT (Deep Vein Thrombosis). • Numbness or tingling in limbs.
Liver problems	This can include: • Known diagnosis of liver cirrhosis. • Other liver problems like liver infections
Stomach problems	This can include: • Stomach pain or discomfort. • Stomach ulcers or chronic pain
Dental/teeth problems	Prompts: • Do you have dental pain? • Do you have bleeding gums or abscesses?
Hep C	Hepatitis C is a viral infection, which primarily affects the liver. There is currently no vaccine to protect against infection, although effective treatment is available. Symptoms of hepatitis C are not always easy to detect, making it difficult to diagnose. This can lead to scarring of the liver and ultimately to cirrhosis, which is generally apparent after many years.

Mental Health

Specialist Mental Health Service

This can include:
- Community Mental Health Teams
- Counselling.
- Psychiatrists.
- Psychologists.

Talking therapies

This can include:
- Psychological therapies, including CBT (Cognitive Behavioral Therapy).
- Counselling.

Services for dual diagnosis

This refers to services that are specifically designed to help people with co-existing mental health and substance misuse problems.

Access to Services

Homeless health service

This is a specialist nurse or GP lead team, which works specifically with people experiencing homelessness.

Admitted to hospital

Please only select this option if the participant was actually admitted to hospital. This could be via a planned admission or as a result of an A&E visit if further treatment was required.

Vaccinations & Testing

Sexual health screening

Screening generally covers sexually transmitted infections (STIs). Common examples include chlamydia and gonorrhea. Treatments can vary.

Flu (Influenza)

A common disease that is caused by the influenza virus and causes fever, weakness, body aches and breathing problems.

Hep B

Hepatitis Bis a viral infection of the liver. The virus is usually transmitted through contact with infected blood
or bodily fluids. This can occur through unprotected sex or sharing contaminated needles. There's an effective vaccination, available from GPs, to protect people from Hepatitis B

Migration Status

UK resident

Full UK resident rights. This means the client has full entitlement to live and work in the UK.

EEA (European Economic Area) Nationals

The EEA includes all EU countries, as well as nationals from Iceland, Lichtenstein and Norway. Different countries within the EEA will have different reciprocal health agreements with the NHS. However, at present,

EEA nationals should only be charged for certain types of secondary healthcare. Primary healthcare and emergency treatment are free at the point of access, although this may be subject to change.

Permanent residence/Indefinite leave to remain

People with permanent residence/Indefinite leave to remain are allowed to reside indefinitely within a country of which they are not a citizen. People with permanent residence will usually have the same rights as British Citizens in relation to access to public services, including social security.

Asylum Seeker

A foreign national who has made an appeal for asylum on entering the UK, generally on humanitarian grounds. Although asylum seekers will be allowed to remain in the UK until a decision has been made on their application, they will still be subject to strict immigration controls. They should, however, be granted access to medical treatment, if needed.

Refugee Status

If an applicant is granted asylum, they will assume refugee status. As a result, they will be granted full access to all public services.

Alcohol Prompt Card

A simple tool to help calculate units of alcohol consumption

Below you will find an alcohol prompt card, which should give you a use tool to work out unit measurements if you are not familiar with these already. It is designed to be used in a one to one session with your client.

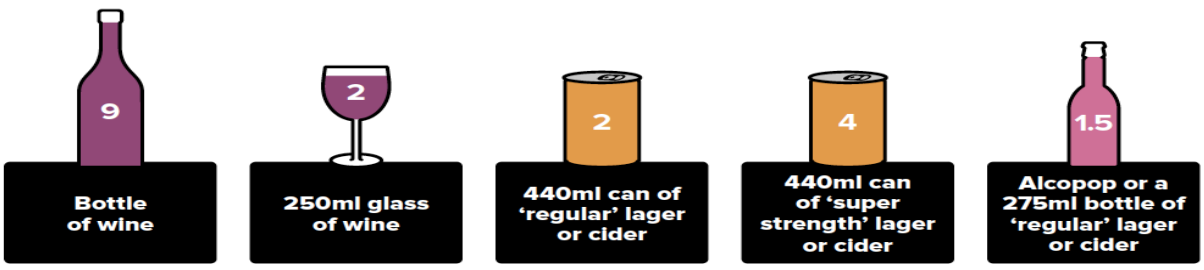
Some participants may be reluctant to disclose information if they feel it will impact on their support or treatment plans, so be clear with participants that the audit will not affect the support they are receiving.

Arranging for the interview to be carried out by a different member of staff with no personal connection to the participant, or by a volunteer or peer researcher, can help to overcome this.

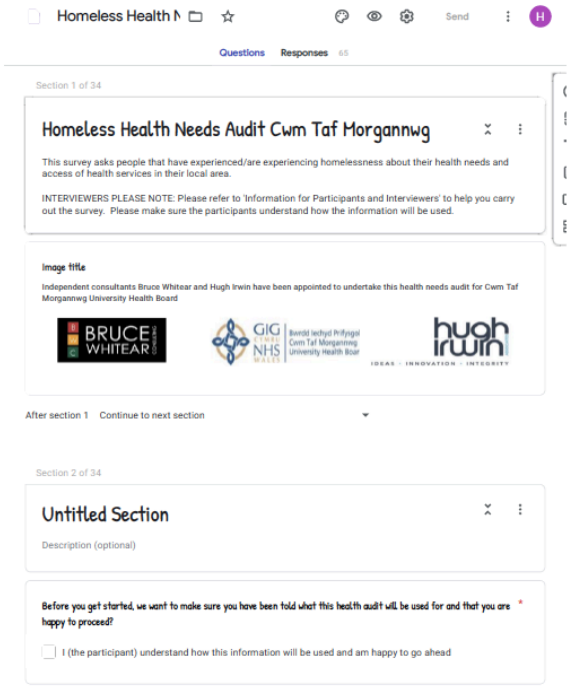
To work out which option fits your alcohol consumption best, how many units do you drink on a typical day when you are drinking? To help you work out how many units you have:

This is **1 unit...**

This is **more than 1 unit...**



Appendix 3 – Health Needs Assessment Survey



Homeless Health N

Send

Questions Responses 65

Section 1 of 34

Homeless Health Needs Audit Cwm Taf Morgannwg

This survey asks people that have experienced/are experiencing homelessness about their health needs and access of health services in their local area.

INTERVIEWERS PLEASE NOTE: Please refer to 'Information for Participants and Interviewers' to help you carry out the survey. Please make sure the participants understand how the information will be used.

Image title

Independent consultants Bruce Whitear and Hugh Irwin have been appointed to undertake this health needs audit for Cwm Taf Morgannwg University Health Board

After section 1 Continue to next section

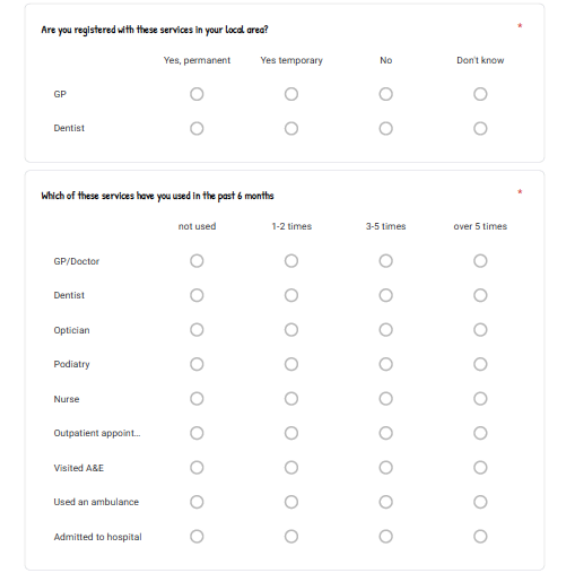
Section 2 of 34

Untitled Section

Description (optional)

Before you get started, we want to make sure you have been told what this health audit will be used for and that you are happy to proceed? *

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

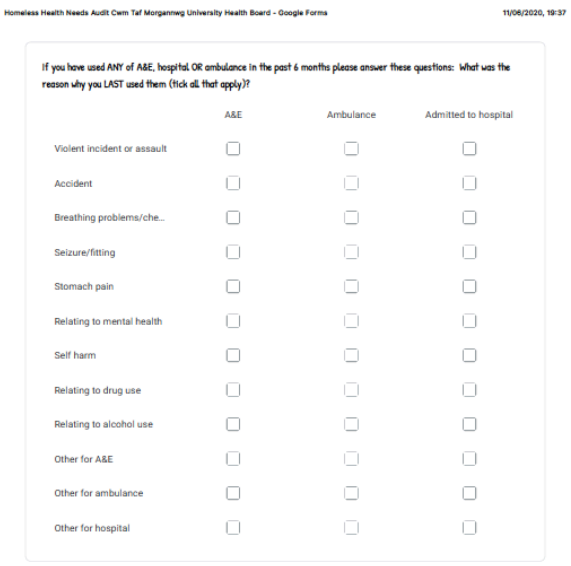


Are you registered with these services in your local area? *

	Yes, permanent	Yes temporary	No	Don't know
GP				
Dentist				

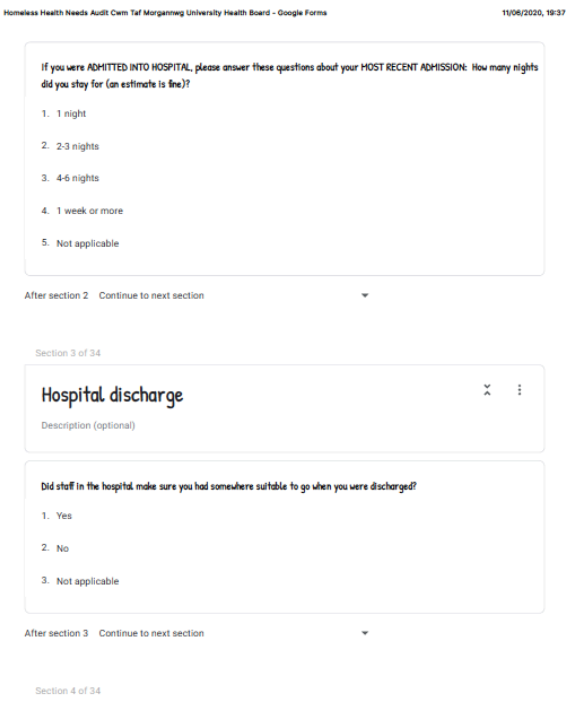
Which of these services have you used in the past 6 months *

	not used	1-2 times	3-5 times	over 5 times
GP/Doctor				
Dentist				
Optician				
Podiatry				
Nurse				
Outpatient appoint...				
Visited A&E				
Used an ambulance				
Admitted to hospital				



If you have used ANY of A&E, hospital OR ambulance in the past 6 months please answer these questions: What was the reason why you LAST used them (tick all that apply)?

	A&E	Ambulance	Admitted to hospital
Violent incident or assault			
Accident			
Breathing problems/che...			
Seizure/fitting			
Stomach pain			
Relating to mental health			
Self harm			
Relating to drug use			
Relating to alcohol use			
Other for A&E			
Other for ambulance			
Other for hospital			



If you were ADMITTED INTO HOSPITAL, please answer these questions about your HOST RECENT ADMISSION: How many nights did you stay for (an estimate is fine)?

1. 1 night
2. 2-3 nights
3. 4-6 nights
4. 1 week or more
5. Not applicable

After section 2 Continue to next section

Section 3 of 34

Hospital discharge

Description (optional)

Did staff in the hospital make sure you had somewhere suitable to go when you were discharged?

1. Yes
2. No
3. Not applicable

After section 3 Continue to next section

Section 4 of 34

YOUR PHYSICAL HEALTH

Description (optional)

Do you smoke *

- Yes
- No
- Prefer not to say

After section 4 Continue to next section

Section 5 of 34

Smoking

Description (optional)

Do you want to stop smoking?

- Yes
- No
- Maybe

Have you been offered advice or help to stop smoking?

- Yes, and took this up
- Yes, but did not take this up
- No

After section 5 Continue to next section

Section 6 of 34

Nutrition

Description (optional)

On average, do you eat at least 2 meals a day? (If this is difficult, please think about the meals you ate yesterday) *

- Yes
- No
- Don't know

How many pieces of fruit and veg do you usually eat per day? (If this is difficult, please think about what you ate yesterday) *

- None
- 1-2
- 3-4
- 5+
- Don't know

Do you exercise at least twice a week? *

- Yes
- No

After section 6 Continue to next section

Section 7 of 34

Exercise continued

Description (optional)

If you don't exercise at least 2 times per week would you like to in future? *

- Yes
- No
- Don't know

After section 7 Continue to next section

Section 8 of 34

Physical health problems

Description (optional)

Do you experience any of the following health problems? *

	Yes, for less than 1...	Yes, for 12 months...	No	Prefer not to answer
Chest pain/breathi...	○	○	○	○
Joint aches/proble...	○	○	○	○
Difficulty seeing/ey...	○	○	○	○
Skin/wound infecti...	○	○	○	○
Problems with feet	○	○	○	○
Fainting/blackouts	○	○	○	○
Urinary problems/i...	○	○	○	○
Circulation proble...	○	○	○	○
Liver problems	○	○	○	○
Stomach problems	○	○	○	○
Dental/teeth proble...	○	○	○	○
Diabetes	○	○	○	○
Epilepsy	○	○	○	○
Other	○	○	○	○

If YES to any physical health need: Are you receiving support/treatment to help you with your physical health problem? *

- ○ Yes, and it still meets my needs
- ○ Yes, but I'd still like more help
- ○ No, but it would help me
- ○ No, I do not need any

After section 8 Continue to next section

YOUR MENTAL HEALTH

Description (optional)

Do you feel any of the following mental health difficulties? *

	Yes, for less than 1...	Yes, for more than ...	No	Prefer not to answer
Often feel stressed	○	○	○	○
Often feel anxious	○	○	○	○
Panic attacks	○	○	○	○
Feel depressed	○	○	○	○
Difficulty sleeping	○	○	○	○
Suicidal thoughts	○	○	○	○
Self harm	○	○	○	○
Hear voices	○	○	○	○
I find it hard to con...	○	○	○	○
I can be aggressive...	○	○	○	○

Do you have a mental health need or condition which has been diagnosed by a doctor or other health professional? *

- ○ Yes
- ○ No
- ○ Prefer not to answer

After section 9 Continue to next section

Diagnosed mental health need or condition

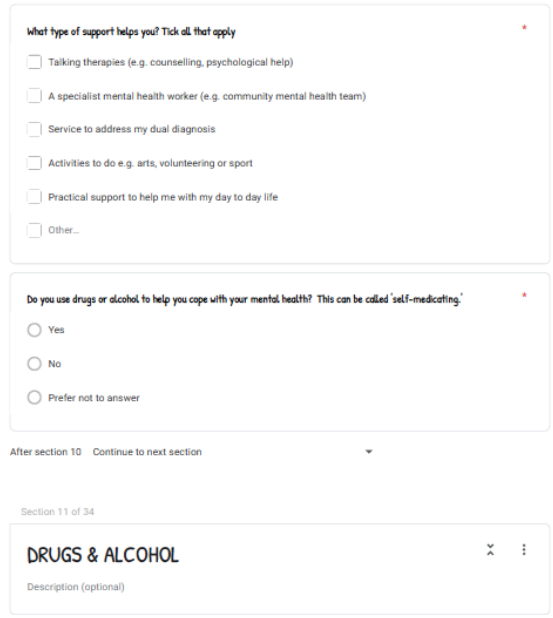
Description (optional)

If YES, what was this and how long have you experienced it for? *

	Yes, for less than 1...	Yes, for more than ...	No	Prefer not to answer
Depression	○	○	○	○
Schizophrenia	○	○	○	○
Bipolar disorder	○	○	○	○
Personality disorder	○	○	○	○
Post traumatic stre...	○	○	○	○
Dual diagnosis wit...	○	○	○	○
Other mental healt...	○	○	○	○

Do you get support with your mental health (e.g. from a worker, medic or support service)? *

- ○ Yes, and it meets my needs
- ○ Yes, but I'd still like more help
- ○ No, I do not need any
- ○ Prefer not to answer



What type of support helps you? Tick all that apply *

- [ ] Talking therapies (e.g. counselling, psychological help)
- [ ] A specialist mental health worker (e.g. community mental health team)
- [ ] Service to address my dual diagnosis
- [ ] Activities to do e.g. arts, volunteering or sport
- [ ] Practical support to help me with my day to day life
- [ ] Other...

Do you use drugs or alcohol to help you cope with your mental health? This can be called 'self-medicating.' *

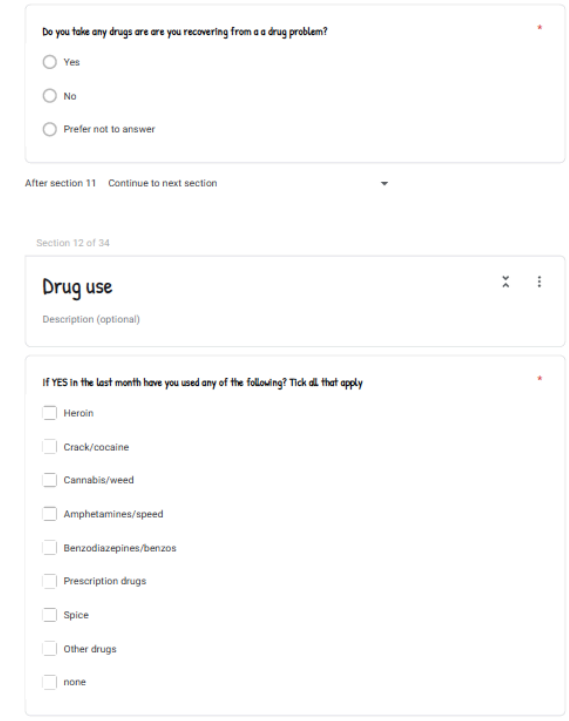
- ( ) Yes
- ( ) No
- ( ) Prefer not to answer

After section 10 Continue to next section

Section 11 of 34

DRUGS & ALCOHOL

Description (optional)



Do you take any drugs are are you recovering from a a drug problem? *

- ( ) Yes
- ( ) No
- ( ) Prefer not to answer

After section 11 Continue to next section

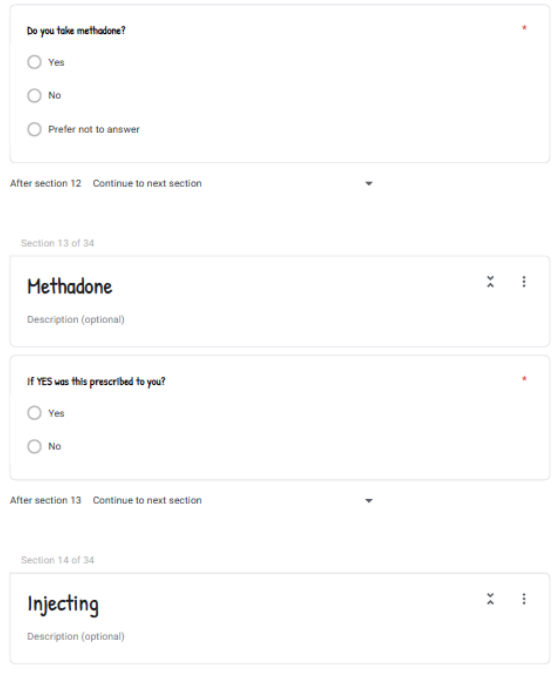
Section 12 of 34

Drug use

Description (optional)

If YES in the last month have you used any of the following? Tick all that apply *

- [ ] Heroin
- [ ] Crack/cocaine
- [ ] Cannabis/weed
- [ ] Amphetamines/speed
- [ ] Benzodiazepines/benzos
- [ ] Prescription drugs
- [ ] Spice
- [ ] Other drugs
- [ ] none



Do you take methadone? *

- ( ) Yes
- ( ) No
- ( ) Prefer not to answer

After section 12 Continue to next section

Section 13 of 34

Methadone

Description (optional)

If YES was this prescribed to you? *

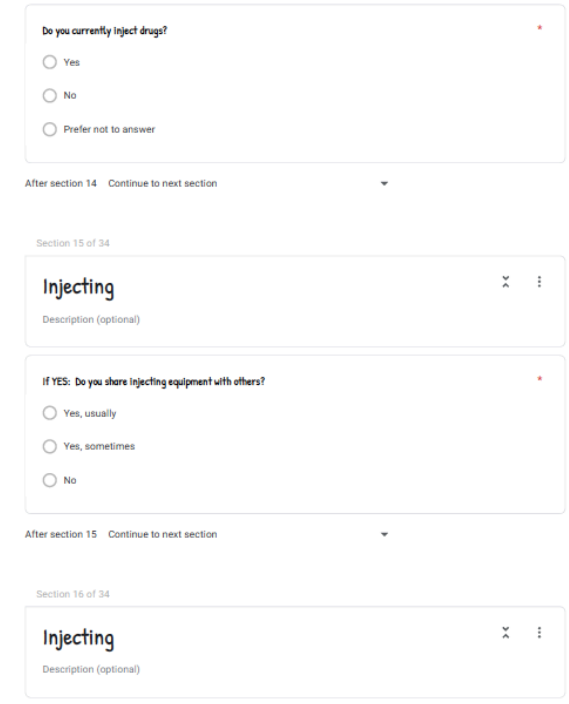
- ( ) Yes
- ( ) No

After section 13 Continue to next section

Section 14 of 34

Injecting

Description (optional)



Do you currently inject drugs? *

- ( ) Yes
- ( ) No
- ( ) Prefer not to answer

After section 14 Continue to next section

Section 15 of 34

Injecting

Description (optional)

If YES: Do you share injecting equipment with others? *

- ( ) Yes, usually
- ( ) Yes, sometimes
- ( ) No

After section 15 Continue to next section

Section 16 of 34

Injecting

Description (optional)

Do you know about? *

	Yes	No
A needle exchange scheme you c...	○	○
Advice or training on safer injecting	○	○

After section 16 Continue to next section

Section 17 of 34

Help with drug use

Description (optional)

Do you get support to help you address your drug use? *

- ○ 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
- ○ I'd rather not say

After section 17 Continue to next section

Section 18 of 34

help with drug use

Description (optional)

How does this support help you? Tick all that apply.

- ☐ Helps me to better control my drug use
- ☐ Helps to reduce my drug use
- ☐ Helps to use drugs more safely
- ☐ Help to stop using drugs
- ☐ Other...

After section 18 Continue to next section

Section 19 of 34

help with drug use

Description (optional)

How could more support help you with? Tick all that apply.

- ☐ Helps me to better control my drug use
- ☐ Helps to reduce my drug use
- ☐ Helps to use drugs more safely
- ☐ Help to stop using drugs
- ☐ Other...

After section 19 Continue to next section

Section 20 of 34

Alcohol use

Description (optional)

How often do you have an alcoholic drink? *

- ○ Never
- ○ Monthly or less
- ○ 2-4 times per month
- ○ 2-3 times per week
- ○ 4-6 times per week
- ○ Every day
- ○ I'd rather not say

After section 20 Continue to next section

Section 21 of 34

Alcohol use

Description (optional)

Homeless Health Needs Audit Cwm Taf Morgannwg University Health Board - Google Forms 11/06/2020, 19:37

How many units do you drink on a typical day when you are drinking? Please refer to the Alcohol Unit Flashcard. *

- ○ 1-2
- ○ 3-4
- ○ 5-6
- ○ 7-9
- ○ 10+

Do you have or are you recovering from an alcohol problem? *

- ○ Yes
- ○ No
- ○ I'd rather not say

After section 21 Continue to next section

Section 22 of 34

Alcohol use

Description (optional)

If YES do you get support to help with this? *

- 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 it

After section 22 Continue to next section

Section 23 of 34

Alcohol use

Description (optional)

How does the support help you? Tick all that apply *

- Helps me to better control my alcohol intake
- Helps me to reduce my alcohol intake
- Helps me to manage the impact drinking has had on my health
- Helps me to stop drinking
- Other

After section 23 Continue to next section

Section 24 of 34

Alcohol use

Description (optional)

What sort of support would help you? Tick all that apply *

- Help me to better control my alcohol intake
- Help me to reduce my alcohol intake
- Help me to manage the impact drinking has had on my health
- Help me to stop drinking
- Other

After section 24 Continue to next section

Section 25 of 34

VACCINATIONS & SCREENING

Description (optional)

Have you been vaccinated for the following? *

	Yes	No	Don't know	Rather not say
Hep A	○	○	○	○
Hep B	○	○	○	○
Flu (past 12 months)	○	○	○	○

Have you been tested for the following? *

	Not tested	Tested Positive	Tested Negative	Rather not say
Hep C	○	○	○	○
TB	○	○	○	○
HIV	○	○	○	○

If you tested positive for ANY of these, did you go on to receive any treatment? *

	Yes	No, not offered ...	No, offered but ...	Not applicable	Prefer not to say
Hep C	○	○	○	○	○
TB	○	○	○	○	○
HIV	○	○	○	○	○

If tested for TB what type of TB screening was this?

- Skin test
- Xray
- Don't know

After section 25 Continue to next section

Section 26 of 34

Sexual health

Description (optional)

Have you had a sexual health check in the past 12 months? *

- Yes
- No
- Don't know
- Rather not answer

After section 26 Continue to next section

Section 27 of 34

Sexual health

Description (optional)

Do you currently know where to access advice about sexual health? *

- Yes
- No

After section 27 Continue to next section

Section 28 of 34

Sexual health

Description (optional)

If YES – where would you go?

- GP or nurse
- Homelessness/housing support staff
- GUU/sexual health clinic
- Other

After section 28 Continue to next section

Section 29 of 34

Female health

Description (optional)

FEMALE CLIENTS ONLY: Have you had access to specialist women's health services?

	Yes	No	Uncertain
Cervical smear in past 3 ...			
Breast examination in pa...			

After section 29 Continue to next section

Section 30 of 34

COVID 19

Description (optional)

Covid 19: Have you received enough information about how you could best protect yourself during the Covid 19 pandemic? *

- Yes
- No
- Don't know

After section 30 Continue to next section

Section 31 of 34

Covid 19

Description (optional)

If YES where did you get this information from? *

1. GP or health service
2. Your homelessness/housing support service
3. Family/friend/peer
4. Media (online or TV)
5. Other

After section 31 Continue to next section

Section 32 of 34

Covid 19

Description (optional)

Have you felt any increased levels of anxiety since the outbreak of Covid 19? *

- Yes
- No
- Don't know

After section 32 Continue to next section

Section 33 of 34

Covid 19

Description (optional)

If YES what could/could have made you less anxious?

Long answer text

After section 33 Continue to next section

Section 34 of 34

SOME QUESTIONS ABOUT YOU

Description (optional)

How would you describe where you are currently sleeping? (if this frequently changes, please say where you slept most in the past week) *

- sleeping rough on the streets/parks
- hostel
- 2nd stage/supported accommodation
- squatting
- sleeping on someone's sofa/floor
- night shelter
- Other...

At the moment are you? *

	Yes	No
In training or education		
Volunteering		
In employment		

Please tick if you are currently in contact with any services for offenders

- Currently with probabtion
- Currently serving a community order
- Youth offending service/YOT
- None of these
- Prefer not to say

Do you have any of these backgrounds? (This helps us yo understand how your past experience may have affected your health or services you have been able too access) *

- Left prison within the last 12 months
- Left prison more than 12 months ago
- Left care services (for young people) within the past 5 years
- None of these backgrounds
- Prefer not to say

Do you consider yourself to have a disability? *

- Yes
- No
- Prefer not to say

If YES how would you describe this disability? (choose all that apply) *

- Mobility
- Learning disability
- Mental health
- Sensory impairment (e.g. sight or hearing problems)
- Developmental disability
- Long term condition
- Prefer not to say
- Other...

What is your migration status? *

- UK resident
- Indefinite leave to remain
- Migrated from Bulgaria or Romania
- Other EU national
- Asylum seeker
- Refugee
- Unknown
- Prefer not to say
- Other...

What age range do you fall into? *

- 16-17
- 18-25
- 26-35
- 36-45
- 46-55
- 56-65
- 66-75
- Over 75
- Prefer not to say

How do you describe your gender? *

- Female
- Male
- Non binary
- Prefer not to say/disclose

Do you identify as transgender? *

- Yes
- No
- Don't know
- Prefer not to say

What is your sexual orientation? *

- Heterosexual
- Gay man
- Gay woman/Lesbian
- Bi-sexual
- Pan-sexual
- Prefer not to say
- Other...

How would you describe you ethnicity? *

- White British
- White Irish
- White European
- White other
- Asian/Asian British - Indian
- Asian/Asian British - Bangladeshi
- Asian/Asian British - Pakistani
- Asian/Asian - other
- Black/Black British - African
- Black/Black British - Caribbean
- Black/Black British other
- Mixed heritage - White and Black African
- Mixed heritage - White and Caribbean
- Mixed heritage - White and Asian
- Other mixed
- Chinese
- Traveller/Gypsy
- Prefer not to say
- Other...