Westminster CHAT Report
2016-2017

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Abbreviations and acronyms

CHAIN Combined Homelessness and Information Network
CHAT Common Health Assessment Tool
CLCH Central London Community Healthcare
COPD Chronic Obstructive Pulmonary Disease
EASL Enabling Assessment Service London
JHT Joint Homelessness Team
HHCP Homeless Health Coordination Project
HHPA Homeless Health Peer Advocacy
HIT Health Improvement Team
IAPT Improving access to Psychological Therapies
LAS London Ambulance Service
MHU Mobile Health Unit
UCLH University College London Hospitals
INTRODUCTION

Homeless and temporarily housed people on average die 30 years sooner than the general population.¹ There is substantial evidence to show that poor physical and mental health, as well as drug and alcohol misuse, is prevalent among the homeless population.²

Often, people who are homeless experience more than one health problem. 45% have a diagnosed mental health problem, and 41% of the homeless population report having long term physical health problems (compared to 28% of the general population). Almost half stated they used drugs and/or alcohol to cope with mental health problems and 12% have both a mental health and substance misuse problem.³

Homelessness has increased nationally by 132% since 2010, and has more than doubled (104%) in London.⁴ Homelessness continues to be a particularly pressing issue for London, where half of England’s rough sleepers are located. According to the CHAIN database, 2,857 people were seen sleeping rough in Westminster in 2016 (an 11% increase since 2014/15). 65% of people were seen rough sleeping for the first time this year, while 23% were also seen in 2014/15 and 12% were returners (people who were first seen sleeping rough in 2013/14 but were not seen in 2014/15). To accommodate the health needs of the rough sleepers in Westminster, a large range of homeless health services are commissioned including; the Homeless Health Team, which does outreach services and walk-in appointments, two homeless GP surgeries, and the Joint Homelessness Team (JHT) and Enabling Access Services London (EASL), which both provide mental health services.

Evidence gathered over the last few years highlight crucial areas for improvement in the provision of healthcare services for homeless people:

- **Barriers to use of primary healthcare services.** The homeless population, especially rough sleepers, face difficulties in accessing primary care (GPs or nurse-led clinics). 7% of homeless people have been refused access to a GP.⁵ While the majority (92%) of the total homeless population are registered with GPs, only 27% of rough sleepers in London are.⁶

¹ Based on analysis of CHAIN data, which suggests that between 2009 and 2014, 307 people who had slept rough in London died. The mean average age of death was 47 for men, and for women, 43. This aligns with previously published research which used a larger sample: Thomas, B (2011) Homelessness is a silent killer Crisis
³ Homeless Link (2014) The unhealthy state of homelessness: Health audit results [http://www.homeless.org.uk/sites/default/files/site-attachments/The%20unhealthy%20state%20of%20homelessness%20FINAL.pdf](http://www.homeless.org.uk/sites/default/files/site-attachments/The%20unhealthy%20state%20of%20homelessness%20FINAL.pdf)
⁴ Crisis, The Homeless Monitor: England 2017
Homeless people access GPs roughly 1.5-2.5 times more than the general public each year, which is lower than their use of hospital services (four times more). This suggests many homeless people could still be turning to hospitals as a first choice. Previous research has highlighted the barriers they face in accessing primary care and the importance of arrangements such as flexible appointment times, putting services in homeless agencies and training to help medical staff understand the needs of homeless people.

- **Costly use of secondary healthcare services.** People experiencing homelessness are more likely to use A&E services, to spend time in hospital and to use mental health and substance abuse services. National estimates suggest that the homeless population consumes about four times more acute hospital services than the general population. This costs at least £85 million per year to the NHS. For inpatient costs, this rises to eight times more than the general population.

- **Hospital admission and discharge.** Although people who are homeless are more likely to use hospital services, formal and effective protocol for the admission and discharge of homeless patients are not widespread. National research by St Mungo’s found that only a third of these patients had received any help with their housing before being discharged.

The innovative Westminster Homeless Health Coordination Project (HHCP) commenced at the end of June 2015 to tackle some of these issues. This project currently works with 14 services across Westminster to improve health access and decrease health inequalities of those who are vulnerably or temporarily housed. The Common Health Assessment Tool (CHAT) is completed by housing staff with service users to further the understanding of current rough sleepers health needs. The CHAT was developed to ensure that all service users in supported accommodation within the rough sleeping pathway received a health assessment and was referred on for any appropriate care for physical, mental or substance use problems.

The information collected from the CHAT is illustrated in this report and makes clear that there is yet to be a real improvement in reducing the scale of health problems faced by those who have experienced homelessness. It also highlights and suggests areas where further provision of services may be focussed on. The study is a snapshot of the need of rough sleepers in Westminster and the needs and services provided may be different at the time of publication.

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7 Homeless Link (2014) The unhealthy state of homelessness: Health audit results [http://www.homeless.org.uk/sites/default/files/site-attachments/The%20unhealthy%20state%20of%20homelessness%20FINAL.pdf](http://www.homeless.org.uk/sites/default/files/site-attachments/The%20unhealthy%20state%20of%20homelessness%20FINAL.pdf)


METHODOLOGY

The CHAT was designed in 2015 with the input of clients and staff from homeless accommodation based services. Each CHAT was completed either one-to-one with the service user, or by the service user’s keyworker, between April 2016 and end of March 2017. If staff encountered problems whilst using the CHAT the HHCP coordinator was on hand to provide support and answer questions.

DATA ANALYSIS

The data collected from the CHATs was exported into a spreadsheet programme, cleaned and compiled into the format visible in this report. The data is compared, where available, to other publicly available data sources including official government statistics and CHAIN data.

SNAP SHOT OF FINDINGS

The data reveals homeless people, living in supported accommodation, have alarming levels of poor physical and mental health, at levels much higher than the general population. Although 99% of respondents reported they were registered with a GP, a significant number indicated they were not receiving help with their health problems.

A snapshot of the findings are included below:

- 77% reported they suffered from a mental health issue
- 53% reported they had a mental health diagnosis
- 77% reported they suffered from a physical health issue
- 98% registered with a GP
- 34% registered with a dentist
- 24% registered with an optician
- 26% reported they had used the ambulance service in the past 6 months
- 29% had visited A&E in the past 6 months
- 23% reported they had been diagnosed with an infectious disease
- 55% drink alcohol
- 43% use illegal drugs
- 51% reported they used substances to self-medicate
- 74% smoke cigarettes, compared to 17% in the general population and 20% said they would like help to stop
DEMOGRAPHICS

Hostels
A total of 388 CHATs were carried out over 12 months in 17 services. 333 of the 388 respondents indicated their anonymous data could be shared, therefore the following health information relates to 86% of total respondents. Table 1 (page 7) lists the hostels and the number of CHATs completed at each venue.

*Table 1: Venue and number of completed CHATs*

<table>
<thead>
<tr>
<th>Hostel name</th>
<th># of completed CHATs</th>
</tr>
</thead>
<tbody>
<tr>
<td>105 Shirland Road</td>
<td>9</td>
</tr>
<tr>
<td>113 Sutherland Road</td>
<td>13</td>
</tr>
<tr>
<td>17-19 Shirland Rd</td>
<td>10</td>
</tr>
<tr>
<td>225 Bravington</td>
<td>6</td>
</tr>
<tr>
<td>3-5 Bravington</td>
<td>10</td>
</tr>
<tr>
<td>Bruce House</td>
<td>26</td>
</tr>
<tr>
<td>Chippenham Road</td>
<td>5</td>
</tr>
<tr>
<td>Edward Alsop Court</td>
<td>72</td>
</tr>
<tr>
<td>Harrow Road</td>
<td>48</td>
</tr>
<tr>
<td>Hopkinson House</td>
<td>29</td>
</tr>
<tr>
<td>King George's</td>
<td>71</td>
</tr>
<tr>
<td>Montford House</td>
<td>12</td>
</tr>
<tr>
<td>Passage House</td>
<td>26</td>
</tr>
<tr>
<td>Shroton Street</td>
<td>19</td>
</tr>
<tr>
<td>Westbourne Park</td>
<td>1</td>
</tr>
<tr>
<td>Westminster Training Flats</td>
<td>13</td>
</tr>
<tr>
<td>Wytham Hall</td>
<td>18</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>388</strong></td>
</tr>
</tbody>
</table>

Gender
CHATs were carried out with 311 males and 22 females during the time period (figure 1).

*Figure 1: Percentage gender distribution of respondents*
Age

Of the 333 respondents; the most represented groups were the 40-49 and 50-59 year olds (figure 2).

Figure 2: Age distribution of respondents

REGISTRATIONS

GP

98% of respondents indicated they were registered with a GP. Of the seven respondents not registered with a GP, six stated they wanted to be registered and one reported they did not wish to be registered. The individual that reported they did not want to be registered was a resident at Wytham Hall, who refused any support around their health and reported no current health conditions.

91% of respondents stated where they were registered with a GP. Figure 3 illustrates that the largest amount of registrations are at Dr Hickey’s Surgery (174, 58%). 15% of the 174 clients registered at Dr Hickey’s lived further than 2 miles away from the GP surgery. Both Great Chapel Street and the Grand Union Health Centre had the 2nd highest amount of service users registered (34, 11%).

Figure 3: The number of GP surgery registrations for respondents who stated they were registered with a GP
89% of respondents stated they did not experience problems accessing their GP, however seven reported a negative experience at the GP, 11 indicated they struggled due to mobility issues, and 18 stated they struggled to access the GP for ‘another reason’.

In December 2016 Healthy London Partnership and Groundswell produced a ‘my right to health care card’. The cards have been distributed to homeless providers Pan-London to be used to support homeless clients register with a GP. The card (figure 4) can be presented at GP receptions (if a client is being refused registration) and will inform the relevant persons that the client has a right to register and receive treatment from the GP practice they are trying to register with. Alongside these cards, The HHCP developed a tool kit to support staff and clients with any enquiries or to make complaints11.

Figure 4: The Healthy London Partnership and Groundswell ‘My right to health care card’

85% reported they had used their GP within the last six months; 30% indicated they used the GP over 5 times, 20% visited 3-5 times and 34% visited their GP 1-2 times. It is worth bearing in mind that the average GP consultation costs £45 for 20 minutes, whereas the cost of providing care from a community-based nurse is £48 per hour12.

In June 2016, the peripatetic nurse programme was relaunched by CNWL in three housing services in the north of the borough. These services included Shroton Street, Semi-independent Housing and Harrow Road. The nurse supports residents with an initial health assessment, wound care if needed, and refer them to any needed health appointments. In the first six months of the peripatetic service at Harrow Road Hostel (whom visited for 4 hours a week) the nurse saw 23 clients for a health assessment, 15 clients for a follow up session, dressed 6 wounds and made 21 referrals to health services. On top of the quantitative data, qualitative data illustrated that the nurse input was important in encouraging one clients to consider alcohol rehabilitation and supporting another client around their mental health. Moving forward, CNWL are working around linking in with specialist services to improve access for this client group.

11 http://www.westminsterhhcp.org/Resources(2)/GP%20registration%20toolkit.pdf
12 http://www.homeless.org.uk/sites/default/files/site-attachments/The%20unhealthy%20state%20of%20homelessness%20FINAL.pdf
Homeless health service
The CLCH Homeless Health Team works to improve the physical and mental health of rough sleepers in Westminster and are based in; The Passage Resource Centre, West London Day Centre and Connections at St Martins. They provide clinical care, blood borne virus testing to homeless people visiting the day centres as well as delivering health training in several hostels.

Of the 333 respondents, 32% indicated they were registered with a Homeless Health service, 5% said they wanted to be registered and 63% stated they did not wish to be registered (figure 5). This illustrates an 8% decrease in the number of clients in supported housing registered with the Homeless Health Service since the CHAT report 2015-2016.

Dentist
It is important to recognise that it is not just those sleeping rough who suffer from poor oral and dental health. People who have experienced homelessness living in temporary accommodation are also likely to experience the same problems that exacerbate poor dental health and it is equally important that dental services are accessible for this group. Their chaotic lifestyle can prevent them from developing routines of regular eating and oral hygiene, as well as struggling to make and attend their dental appointments. This, combined with a lack of money, lack of awareness of diet and the acceptance among the client group that poor dental health is normal, means it is easy to see why poor dental health is so prevalent. As a result, 70% of clients that took part in Groundswell’s Healthy Mouths research stated they had lost teeth since they had become homeless and 7% had no teeth at all.

34% of the 333 respondents reported they were registered with a dentist. This illustrates a 2% increase in the number of respondents registered with a dentist since CHAT report 2015-2016. Positively, 32% clients reported they would like to be registered but 34% of clients reported they did not wish to be registered with a dentist (figure 6).

Figure 5: Percentage of respondents either registered with a dentist, not registered but would like to be and not registered and does not wish to be.

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15) http://groundswell.org.uk/healthy-mouths/
69 of the 112 respondents indicated which dental surgery they were registered. 25 indicated they were registered at Harrow Road Dental Practice, 21 at Westminster House Dental Practice and 16 at Great Chapel Street’s Homeless Dental Service (figure 6).

**Figure 6: The number of dental surgery registrations for respondents who stated they were registered with a dentist*.**

<table>
<thead>
<tr>
<th>Dental Practice</th>
<th>Registrations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Harrow Road Dental Practice</td>
<td>25</td>
</tr>
<tr>
<td>Westminster House Dental Practice</td>
<td>21</td>
</tr>
<tr>
<td>Great Chapel Street</td>
<td>16</td>
</tr>
<tr>
<td>Lupus Street Dental Practice</td>
<td>5</td>
</tr>
<tr>
<td>Wilton Dental Practice</td>
<td>2</td>
</tr>
</tbody>
</table>

* Dental surgeries with less than 2 people registered have been omitted from figure 6.

21% of respondents indicated they had visited the dentist in the past 6 months illustrating there is more work to be done to promote the importance of oral hygiene in services. 14% of respondents reported they had encountered issues when trying to access a dentist. Four clients stated they have been refused registration, seven had mobility issues that prevented them from attending the dental surgery, nine had a negative experience of service and 25 reported ‘other reason’. CLCH Community Dental service offers an in-reach dental service for anyone that can’t visit their dentist due to mobility issues.

Groundswell have recently produced a pocket sized mouth care guide for homeless and temporarily housed individuals. The HHCP utilizes the mouth action update cards produced by Groundswell by distributing them at Health Action Group meetings and forwarding the electronic printable version to services.

Current best practice in Westminster is illustrated by CLCH dental service, which offers oral hygiene awareness sessions facilitated by Oral Health Promoter Alison Fraser and the CLCH Oral Health Promotion Team. Alison and the team regularly attend hostels to broaden understanding around why it is important to regularly visit the dentist. Since July 2015, the HHCP coordinator has successfully organised sessions in the majority of services. Alison also presented at the 2017 HHCP Staff and Service User Conference, and in 2016 the HHCP developed a dental map which listed homeless friendly dental surgeries. In 2015, the HHCP met with the CLCH dental service managers to discuss the possibility of bi-annual dental screenings in Westminster, however this has not progressed as of yet.

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A best practice example in improving dental care access within vulnerable groups can be seen in Hackney, where each month dental treatment is provided via a mobile van located within easy reach of St Mungo’s Mare Street Hostel\(^\text{17}\).  

**Ocular health**  
Research illustrates homeless people have more eye problems than the general population\(^\text{18}\). For example, the 2014 Homeless Link Health Needs Audit found that 14.2% of homeless experienced ocular health problems compared to 1.4% of the general population\(^\text{19}\). Data from Vision Care Homeless People (VCHP) indicates that homeless people have difficulty in accessing community-based optometric primary care, with 85% of homeless people preferring to access special homelessness services. VHCP figures indicate a greater percentage of eye injuries as a result and conclude that 35% of VCHP patients could be considered to have a functional visual impairment\(^\text{20}\).

Research from the United States illustrates homeless people have more eye problems than the general population. There is a higher risk of macular degeneration as smoking rates are three times greater in the homeless population\(^\text{21}\). In addition general health conditions such as diabetes or hypertension, if left untreated and uncontrolled, can lead to sight loss.

Cost is a huge barrier to accessing an optician as most homeless/temporarily housed people are unaware that they are entitled to an NHS eye examination and a voucher towards glasses. Few practices provide spectacles free of charge and those who are eligible for a spectacle voucher only receive one voucher every two years\(^\text{22}\). Due to the conditions in which this client group are housed/rough sleeping it is likely individuals will have their property stolen or be assaulted resulting in damage to their spectacles before the two year interval.

Only 24% of the 333 CHAT respondents reported they were registered with an optician. This illustrates a 5% decrease in registrations since CHAT report 2015-2016. Positively, 25% of clients reported they would like to be registered with an optician but 51% of clients reported they did not wish to be registered (figure 7). 17% indicated they had visited an optician in the past 6 months, further illustrating there is more work to be done to encourage clients to visit an optician.
8% of respondents indicated they had difficulties accessing an optician, one reported they had been refused registration, five indicated they had mobility issues that prevented them from attending, two had a negative experience of service and 20 reported ‘other reason’.

In-reach clinics ensure that service users unable to attend to essential health needs, due to their chaotic lifestyles, are offered the opportunity to be assessed where they are living. A best practice example to improve access to eye care services for vulnerable groups in Westminster is currently provided by Medirex Opticians, who provide in-reach eye tests and glasses if required. Another best practice example to improve access to eye care services for vulnerable groups is witnessed by Vision Care for Homeless People, who provide weekly eye tests and glasses at a drop-in service at West London Day Centre in Westminster.

**PHYSICAL HEALTH CONDITIONS**

People with experience of homelessness are more likely to have unhealthy lifestyles, which can cause long term health problems. The 2014 Homeless Link health audit found that 77% of homeless people smoke, 35% do not eat at least two meals per day and two thirds consume more than the recommended amount of alcohol each time they drink\(^{23}\). Further research by Homeless Link found that 41% of the Homeless population experience long term physical health problems compared to 28% of the general population\(^{24}\). Furthermore over 15% of respondents with physical health problems reported not receiving support.

The CHAT asked respondents to identify the types of conditions and diagnoses they had and whether they were receiving treatment for these. The graph (figure 8) below shows a summary of the conditions/diagnoses;

77% of respondents reported they had a physical health condition at time of interview.

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\(^{23}\) [http://www.homeless.org.uk/sites/default/files/site-attachments/The%20unhealthy%20state%20of%20homelessness%20FINAL.pdf](http://www.homeless.org.uk/sites/default/files/site-attachments/The%20unhealthy%20state%20of%20homelessness%20FINAL.pdf)

\(^{24}\) [http://www.homeless.org.uk/sites/default/files/site-attachments/The%20unhealthy%20state%20of%20homelessness%20FINAL.pdf](http://www.homeless.org.uk/sites/default/files/site-attachments/The%20unhealthy%20state%20of%20homelessness%20FINAL.pdf)
The highest physical health condition reported included infectious diseases (75, 23%), with respiratory issues the second highest condition (75, 21%) and foot problems the third highest (69, 21%). The fourth highest reported condition was eye problems (54, 16%) and tooth pain being the fifth condition (41, 12%). Please refer to figure 8 for further breakdown of physical health conditions reported.

**Figure 8: Number of respondents who stated, at the time of interview, the following health diagnoses.**

Infectious diseases and respiratory issues are explored in more detail in the following sections.

**Infectious diseases**
Infectious diseases are more prevalent within homeless populations for numerous reasons including; compromised immune systems, inadequate nutrition, and an inability to maintain adequate hygiene, as well as possible intravenous drug use and sex working.

**Tuberculosis**
Tuberculosis is a bacterial infection spread through inhaling tiny droplets from the coughs or sneezes of an infected person. Symptoms of tuberculosis include a persistent cough, weight loss, tiredness and a loss of appetite. It is a serious respiratory condition that can be cured with treatment; although medication may be needed for up to six months to clear the infection.

UCLH’s Find and Treat Mobile Health Unit (MHU)\(^\text{25}\) provides bi-annual screening for tuberculosis at services in Westminster to ensure as many service users are screened, but it

\(^{25}\) [https://www.uclh.nhs.uk/OURSERCIES/SERVICEA-Z/HTD/Pages/MXU.aspx](https://www.uclh.nhs.uk/OURSERCIES/SERVICEA-Z/HTD/Pages/MXU.aspx)
is evident that increased coordination from projects is required to persuade service users to be screened on the days they visit (incentives and staff available on the day to encourage clients to be screened).

5 (2%) clients reported a current diagnosis of tuberculosis, compared to an estimated 0.01% in the UK in 2015\(^26\). These clients stated they were receiving treatment.

45% of respondents reported they had been screened for tuberculosis within the last 12 months. This illustrates a 14% decrease in the number of individuals screened since CHAT report 2015-2016. As 35% indicated they hadn’t been screened and 14% indicated they didn’t know whether they had been screened, the numbers of clients with tuberculosis is probably higher than reported.

**Hepatitis B**

Hepatitis B is a virus found in the blood and bodily fluids of an infected person. Symptoms of hepatitis B include tiredness, general aches and diarrhoea; all of which can be mistaken for flu or gastroenteritis. In addition two thirds of hepatitis B cases in the general public are reported to be asymptomatic, which can also lead to infected individuals remaining undiagnosed\(^27\). Hepatitis B vaccination is not routinely available and is only offered to anyone considered to be at increased risk of contracting the virus. Anyone sharing drug paraphernalia, suffering from any form of liver disease, or having unprotected sex should be offered a vaccination. Vaccinations and screening for hepatitis B are available via service user’s GP, substance use service or via UCLH’s Find and Treat Mobile Health Unit.

2% of clients reported they had a diagnosis of hepatitis B. Of these nine clients, four were receiving treatment, two wanted to be referred for treatment and three reported they did not want treatment.

40% indicated they hadn’t been vaccinated for hepatitis B and 23% reported they didn’t know if they had been vaccinated, therefore it can be assumed that the figures are higher than reported.

**Hepatitis C**

Hepatitis C is a virus that can infect the liver and, if left untreated, can cause serious and potentially life-threatening damage. Individuals can become infected if they come into contact with the blood of an infected person. Only one in three to four individuals illustrate symptoms while infected with hepatitis C, which can include a high temperature, tiredness, and loss of appetite and stomach pains. One in five people who experience symptoms will also become jaundice.

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\(^{27}\)http://www.britishlivertrust.org.uk/about-us/media-centre/facts-about-liver-disease/
There is a high prevalence of hepatitis C within the homeless population and best practice is illustrated by The Hepatitis C Trust, which works alongside UCHL’s Find and Treat MHU offering bi-annual in-reach screening at services.

18% of respondents reported they had a diagnosis of hepatitis C (figure 9), compared with 27% in CHAT report 2015-2016. Only 25% of those that reported a diagnosis indicated they were receiving treatment for hepatitis C.

Figure 9: Percentage of respondents that reported they had hepatitis C

As 40% of respondents indicated they had not been tested for hepatitis C and 16% reported they didn’t know if they had been tested, the amount of service users with hepatitis C can be expected to be higher than illustrated.

**HIV**

HIV is a virus that attacks the immune system and weakens the ability to fight infections and disease. Individuals can become infected if they come into contact with the blood of an infected person; and the virus can be spread by unprotected sex and sharing drug paraphernalia. There is no cure for HIV, but there are treatments to ensure that an individual infected can live a long and healthy life. If an individual is engaging with health services, it is relatively easy to be tested for HIV; as some GPs and substance use services offer testing and the test is quick and painless. In the past, Terrence Higgins Trust (THT) offered in-reach HIV screening to service users in Westminster supported accommodation; but due to funding cuts this has not been possible since 2014. To allow for home testing, HIV postal test kits\(^\text{28}\) can be ordered in some parts of the UK, but these are currently unavailable in Westminster.

3% of clients reported they had a HIV diagnosis, with one client indicating they refused treatment. These figures are considerably higher than the general population as 0.16% of the UK were estimated to be living with HIV in 2015\(^\text{29}\).

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\(^{28}\) [https://www.test.hiv/](https://www.test.hiv/)

As 47% of clients reported they had not been tested for HIV, and 15% said they didn’t know if they had been tested, the figure can be expected to be higher than reported.

UCLH’s Find and Treat team provide HIV testing on request during their bi-annual MHU visits to services, but it is also suggested that THT in-reach HIV testing in Westminster supported housing is re-instated to increase the amount of service users tested for HIV.

**Respiratory conditions**

Respiratory conditions were the second highest reported health condition with 21% of respondents reporting a diagnosis of chronic obstructive pulmonary disease (COPD) or asthma. The main cause of COPD is smoking, and the likelihood of developing COPD increases the more an individual smokes and the longer they have been smoking. The causes of asthma are unknown, but the chances of developing it increase if exposed to smoke during childhood or if there is a family history of asthma. Research has illustrated that mortality from respiratory infections is seven times greater among homeless people\(^ {30}\). Current best practice to identify individuals suffering with COPD is illustrated by UCLH’s Find and Treat MHU, which visits services bi-annually. Alternatively, if service users are engaging with their GP they can be screened for COPD or asthma if needed.

15% of respondents reported they suffered from asthma, compared with 8.4% in the general population. 7% stated they had COPD, compared with 1.9% in the general population\(^ {31}\). As 74% of respondents reported they smoke it is likely that more participants suffer from these conditions than those who reported a diagnosis.

**Flu vaccinations**

The flu virus can be fatal to anyone with an underlying health issue or a weakened immune system, therefore homeless individuals are encouraged to have the annual flu vaccine to reduce this risk. Current best practice is illustrated by UCLH’s Find and Treat Team MHU that offers the flu vaccine bi-annually when visiting services. In addition the Grand Union Health Centre visits Harrow Road Hostel to offer in house flu vaccinations to clients to increase the level of vaccinations.

The health audit found that only 34% of clients reported having the flu vaccine, compared to 42% in CHAT report 2015-2016. 43% of clients reported they hadn’t been vaccinated for flu in the last 12 months and 18% didn’t know whether they had been vaccinated (figure 10).


Figure 10: The percentage of respondents that reported to have had the flu vaccine in the past 12 months

In order to increase the number of clients being vaccinated for flu; local GP practices/pharmacies could offer a one-off flu clinic within accommodation based services.

Foot problems
Rough sleepers have considerably worse foot health than the general population; which are rarely identified without an in-reach foot screening service. Individuals living in supported accommodation often have a limited choice of socks and shoes, and can be outdoors in all weathers. This can lead to blisters, fungal and bacterial infections and, in rarer cases, frostbite, gangrene and trench foot. Additionally intravenous drug users may use their feet as an injection site and individuals with diabetes are at particular risk of foot conditions. Up until 2013, best practice for accommodation based residents included in-reach podiatry screening provided by CLCH Homeless Health Team. However, since 2014 service users or support staff in Westminster supported housing have had to make referrals to mainstream podiatry services, if and when a client complains of foot issues. Although CLCH podiatry screening is still available one morning a week in the three Westminster day centres, it is important to note that many of the clients in supported accommodation requiring an in-reach screening service would struggle to attend due to their chaotic lifestyle.

The CHAT data illustrated that 21% of respondents suffered with foot problems, compared with 18% in CHAT report 2015-2016.

In order to increase staff awareness of the podiatry services available, Alison Gardiner (CLCH Vulnerable podiatrist) gave a talk on foot health at the 2017 HHCP Service User and Staff Conference. The foot health factsheet created by Groundswell\(^\text{32}\) will continue to be disseminated to staff/service users to help reduce the incidence of foot problems within this client group.

Diabetes
Diabetes is a lifelong condition that causes a person’s blood sugar level to become too high, which becomes progressively worse if left untreated. Diabetes can lead to heart disease, stroke, nerve damage and blindness. Diabetes has been described as a national crisis and almost 3.5 million people in the UK were diagnosed with the condition in 2015\(^{33}\). Symptoms include; feeling very thirsty, urinating more than useful, extreme tiredness and blurred vision. Until the start of 2017, best practice was witnessed by the Westminster NHS Health Checks\(^ {34}\), which provides in-reach screening for diabetes in supported accommodation. Unfortunately, the Health Checker service is no longer available in Westminster and the current advice is for service users to be checked for diabetes via their GP.

6% of respondents stated they had a diagnosis of diabetes. As diabetes is closely linked with deprivation it could be assumed that more service users suffer from diabetes and haven’t been diagnosed.

In order to increase awareness of diabetes the CLCH Diabetes lead has delivered training and attended the HHCP Health Action Group In addition to this, some work will take place in Westminster Day Centres to raise awareness of diabetes during Diabetes Awareness Week (13-18\(^{th}\) June).

Cervical screening
Cervical screening is offered to all women who are registered with a GP. It is a method of detecting abnormal cells on the cervix, so they can be removed to prevent cervical cancer. The frequency of the screening depends on age: 25-49 year olds are screened every three years, 50-64 every five years and those over 65 are only entitled to screening if they haven’t been screened since the age of 50.

22 female respondents completed a CHAT and all of them were registered with a GP. 14 of the female respondents were of an age range to receive a smear test every three years. Out of the 14 respondents within the age range, 14% (2) stated they had received a smear test, 50% said they had not, and 36% stated they did not know if they had received one. As 14 female respondents were eligible for cervical screening you would expect the number to be higher than 14%.

More awareness needs to be raised around cervical screening amongst the female homeless population and female clients should be encouraged to request screening from their GP.

Sexually transmitted infections (STI’s)
Sexually transmitted infections are passed between individuals during sexual contact. Common STI’s include: genital warts, chlamydia, genital herpes, gonorrhoea, syphilis, public lice and scabies. Sexual transmitted infection testing is available either from a GP, a sexual health clinic or genitourinary medicine clinic (GUM).

\(^{34}\) http://www.londonhealthtrainers.com/
27% of respondents indicated they had been tested for an STI; 3% tested positive and 24% tested negative. 6% stated they would prefer not to answer the question, 16% did not know if they had been tested and 50% said they hadn’t been tested.

A best practice example to improve access to sexual health tests and treatment services for vulnerable groups is demonstrated by Imperial College Hospital that provides a sexual health nurse to run monthly awareness sessions at CSTM, Marylebone and Church Army day centres.

MENTAL HEALTH DIFFICULTIES

There is a large body of evidence indicating that mental health problems are more common among homeless and vulnerably housed people than in the general population (35, 36). In 2016, St Mungo’s ran the ‘Stop the Scandal’ campaign calling for the Prime Minister to lead a new national strategy to improve mental health services for homeless people and to end rough sleeping. Research conducted found that poor mental health is a consequence of sleeping rough and 8 out of the 21 people interviewed had attempted or considered suicides (37).

Research completed by Homeless Link (38) indicated that 80% of clients reported some form of mental health issues (diagnosed or undiagnosed) and 17.5% of those wanted support but were not receiving it. However, the majority of research completed thus far includes data from rough sleepers, whereas this data illustrates the mental health difficulties of individuals living solely in accommodation based services. Our data illustrates that service users experience similar levels of poor mental health to those living on the streets.

77% of respondents reported they currently suffered with mental health difficulties, diagnosed or undiagnosed. The mental health difficulties reported are illustrated in figure 11.

**Figure 11: The mental health difficulties self-reported by respondents**
Feeling anxious
Feeling anxious was the highest mental health difficulty reported as 68% of respondents indicated they suffered with the condition. 36% of respondents reported feeling anxious on a daily basis, 20% on a weekly basis and 11% on a monthly basis. 46% of respondents indicated they received support from their GP and 14% from a mental health team. 21% indicated they would like support and 18% said they did not wish to have support for their anxiety. A pocket guide on Anxiety has been produced by Groundswell and will be distributed at Health Action Groups and Westminster Services.

Feeling low
Feeling low was the second highest mental health difficulty reported as 65% of respondents stated they suffered from the condition. 27% of respondents reported feeling low daily, 23% every week and 15% each month. 43% of the respondents that reported they felt low, reported they received help from their GP and 12% from a mental health team. 19% stated they would like support and 22% stated they did not wish to have support.

Poor sleep
Poor sleep was the third highest mental health difficulty reported as 60% of respondents reported this condition. 32% reported suffering from poor sleep every day, 20% every week and 8% each month. 25% of respondents with poor sleep were getting support from their GP and 8% from a mental health team. 26% of respondents stated they would like to get support for their poor sleep. Since December 2015, the Health Improvement Team (HIT) have been running ‘how to improve your sleep sessions’ in services to equip service users with skills to improve this difficulty.

Difficultly remembering things
45% of respondents reported they had difficulty remembering things. 19% struggled to remember things every day, 15% weekly and 11% once a month. 24% of respondents reported they received help with their condition either from their GP, 8% from a Mental Health team, but 27% stated they weren’t and would like to gain support from health services.

Getting angry easily
42% of respondents reported they became angry easily. 15% of respondents said they became angry easily every day, 17% weekly and 11% every month. 21% states they were getting support from their GP, 6% from a mental health team, 29% said they weren’t being supported and would like support.

Suicidal thoughts
According to the Samaritans Suicide Statistical Report (2016), in 2014, 6,122 suicides were registered in the UK and the highest rate of suicide was for men aged 45-49. 18% of HHCP CHAT respondents reported they suffered with suicidal thoughts. 3% of respondents reported daily occurrence, 4% weekly and 11% every month. 24% of respondents with suicidal thoughts

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stated they were supported by their GP, 21% by a mental health team, but 34% stated they were not being supported and would like to be and 38% stated they did not want support.

**Self-harming**

7% of respondents stated that they self-harmed/ were self-harming. 1% of respondents reported they self-harmed every day, 1% weekly and 5% every month. 39% of respondents indicated they were getting support from their GP and 9% from a mental health team. 35% would like to get support for their self-harming but 87% stated they did not wish to have support.

It is quite concerning how many respondents do not wish to engage with support related to their mental health conditions and reflects that more work needs to be done to ensure service users are encouraged to seek treatment for their mental health conditions and take their mental health more seriously. Since October 2015, EASL and JHT have been running HHCP staff training sessions to ensure staff are supported in working more effectively with clients who have suicidal thoughts or who self-harm. In addition the HHCP coordinator has also been working with Westminster IAPT and the HIT to offer mental health sessions in services.

**DIAGNOSED MENTAL HEALTH ISSUES**

53% of respondents stated they had been diagnosed with a mental health condition. This illustrates that the proportion of clients in accommodation based services with diagnosed mental health problems is double that of the general population (around 25%)\(^1\). Table 2 illustrates the breakdown of the diagnosed mental health conditions reported.

![Table 2: The number and percentage of respondents reporting a diagnosed mental health condition](image)

<table>
<thead>
<tr>
<th>Diagnosed mental health condition</th>
<th>Number of clients</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADHD</td>
<td>9</td>
<td>3%</td>
</tr>
<tr>
<td>Autism</td>
<td>3</td>
<td>1%</td>
</tr>
<tr>
<td>Bipolar disorder</td>
<td>14</td>
<td>4%</td>
</tr>
<tr>
<td>Dementia/ Korsakoff’s</td>
<td>5</td>
<td>2%</td>
</tr>
<tr>
<td>Depression</td>
<td>159</td>
<td>48%</td>
</tr>
<tr>
<td>Dual diagnosis problem (mental health and substance use)</td>
<td>63</td>
<td>19%</td>
</tr>
<tr>
<td>Personality disorder</td>
<td>30</td>
<td>9%</td>
</tr>
<tr>
<td>Post-traumatic stress disorder (PTSD)</td>
<td>51</td>
<td>15%</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>46</td>
<td>14%</td>
</tr>
</tbody>
</table>

The largest number of mental health diagnoses reported included depression (48%, compared to 3% in the general population), a dual diagnosis problem (19%) and post-traumatic stress

disorder (15%, compared to 8% in general population). In particular, the incidence of depression is substantially higher than the general population. A high proportion of respondents also have mental health problems including schizophrenia (14% compared to 1-3% in general population) personality disorder (9% compared to 3-5% in general population) and bipolar disorder (4%, compared to 1-3% in general population42).

Depression
48% of respondents stated they had a diagnosis of depression. Depression is a mood disorder that causes a persistent feeling of sadness and loss of interest. It affects how people feel, think and behave and can lead to a variety of emotional and physical problems. Symptoms of depression are wide ranging but can include: feeling upset or down, feeling restless or agitated, feeling worthless or feeling numb or empty.

Dual diagnosis
51% of respondents reported they self-medicated using substances to cope with their mental health difficulties. Homeless Link’s research43 illustrated that almost 50% used drugs and/or alcohol to cope with mental health issues. This ‘dual diagnosis’ often restricts individuals from accessing support, as services are unable or unwilling to provide support around mental health whilst individuals are using drugs of alcohol. An example of good practice is illustrated in Hammersmith and Fulham; as weekly Dual Diagnosis Anonymous Groups began in April 2016. This group incorporates the 12 steps of Alcoholic Anonymous with an additional five steps to address underlying mental health issues.

Post-traumatic stress disorder (PTSD)
15% of respondents reported they had a diagnosis of PTSD, compared to 6% in the CHAT report 2015-2016. PTSD is an anxiety disorder caused by very stressful, frightening or distressing events. PTSD can develop immediately after someone experiences a disturbing event or it can occur weeks, months or even years later. Symptoms of PTSD can include: intrusive, upsetting memories of the event, flashbacks (acting or feeling like the event is happening again), nightmares (either of the event or other frightening things) and feelings of intense distress when reminded of the trauma.

In 2017, Westminster Rough Sleeping Commissioning team funded 10 weeks of stabilisation training sessions in three hostels to provide clients with skills to help clients with PTSD to create an inner sense of safety and emotional regulation. These sessions were a success and hostel staff have taken over running these weekly sessions.

Schizophrenia
14% of respondents stated they had a diagnosis of schizophrenia. Schizophrenia is a brain disorder that affects the way a person behaves, thinks, and sees the world. People with schizophrenia often have an altered perception of reality. They may see or hear things that don’t exist, speak in strange or confusing ways, believe that others are trying to harm them, or

43 http://www.homeless.org.uk/sites/default/files/site-attachments/The%20unhealthy%20state%20of%20homelessness%20FINAL.pdf
feel like they're being constantly watched. This can make it difficult to negotiate the activities of daily life and people with schizophrenia may withdraw from the outside world or act out in confusion and fear.

**Personality disorder**
9% of respondents indicated they had a diagnosis of personality disorder, compared to 3-5% of the general population. Personality disorders are a type of mental health problem where an individual’s attitudes, beliefs and behaviours cause long standing problems in their life. There are varying types of personality disorder and it is considered to be the result of either or all the following: genetics, parenting or childhood trauma.

**Bi-polar disorder**
4% of respondents indicated they had a diagnosis of bi-polar disorder, compared to 1-3% in the general population. Bi-polar disorder causes extreme mood swings that include emotional highs (mania or hypomania) and lows (depression). When depressed, the client may feel sad or hopeless and lose interest or pleasure in most activities. When the mood shifts in the other direction, the client may feel euphoric and full of energy. Mood shifts may occur only a few times a year or as often as several times a week.

**Attention deficit hyperactivity disorder**
3% of respondents indicated they had a diagnosis of ADHD and all respondents reported they received the diagnosis more than 12 months ago. ADHD is a group of behavioural symptoms including inattentiveness, hyperactivity and impulsiveness.

**Dementia**
2% of respondents reported a diagnosis of dementia, compared to 1.3% in the UK population. This is surprisingly low considering 19% reported they struggled to remember things every day. A St Mungo’s report found that Korsakoff’s was a common condition amongst this client group, therefore the high amount of service users reporting they struggled to remember thing every day could be attributed to the fact that 53% respondents also drink alcohol. Nonetheless, the low amount of service users reporting a diagnosis of dementia could also illustrate that work is needed to improve the pathway for service users to access memory services.

There is currently limited research into homelessness and dementia. Kings College London completed some research in 2016 investigating memory problems among older homeless people (aged 50+) and the services that they receive and need. In addition, it explored the extent to which hostel staff are aware of these problems; the needs of older homeless people with memory problems and the care and support that they receive and any gaps in service provision.

To increase staff knowledge around the signs of dementia the HHCP coordinator has organised training sessions detailing the memory services available in Westminster and has developed a

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44 [https://www.alzheimers.org.uk/info/20025/policy_and_influencing/251/dementia_uk](https://www.alzheimers.org.uk/info/20025/policy_and_influencing/251/dementia_uk)
Westminster Memory service pathway tool kit for staff. Additional suggestions include building partnerships with Westminster Memory Services to improve access.

**Autism**

1% of clients stated they had a diagnosis of autism. The Westminster Compass Team estimates around 8% of their cohort have learning disabilities, with autistic spectrum featuring amongst them. Autism is described as a hidden illness as it may not be easy to tell if someone has it, especially if they are using substances.

In 2014, the theme of autism was picked up as a critical factor in helping a number of long term rough sleepers off the street in Westminster and Camden. Keen to share the knowledge, Westminster City Council hosted a pan London event to publicise the issue and following this successfully lobbied GLA for funds for pan London awareness training and an advice clinic with the dedicated charity Resources for Autism. The attention to this issue has snowballed across London and autistic spectrum is now part of the Homeless Link annual training calendar.

A research project with the University of London with three PhD students exploring the quantitative and qualitative aspects of the prevalence of autistic spectrum among long term rough sleepers is to be published later this year.

**Mental health support**

Respondents were asked to indicate whether they received support for their mental health diagnosis and whether they felt the support they received met their needs. Figure 12 illustrates the results.

![Figure 12: Percentage of mental health support that meets clients’ needs](image)

Figure 13 illustrates that 31% of respondents were receiving support for their mental health and that it met their needs, 17% stated they would like more support, 18% said they were receiving support but it would help them and 34% stated they did not need any support.

Respondents that reported a mental health diagnosis indicated the following support was helpful in managing their condition. 29% stated that practical support was the most helpful; with 21% reporting talking therapies, 20% reporting activities, and 20% reporting a specialist
mental health worker, such as JHT. 6% stated dual diagnosis service is useful to manage their mental health condition, and 4% reported a memory service.

SUBSTANCE USE

The Homeless Link audit in 2014 found that 39% of these taking part reported they were taking drugs or recovering from a drug problem, compared to 5% of the general public. 49% of CHAT respondents indicated they currently had a substance use issue. The links between drug and alcohol abuse and homelessness are well established and drugs and alcohol are known to be both a cause and consequence of homelessness. However, the relationship between substance use and homelessness is complex and although the rates of substance use are disproportionately high, homelessness cannot be explained by substance use alone; many people who are addicted to substances never become homeless. There are many potential harms associated with substance use including; impairing the person’s ability to safely and competently make decisions, deteriorating health and accidental death. Therefore, if service users are not ready to address their addiction a harm reduction approach may be appropriate.

The substance use services within the tri-borough were restructured in April 2016, which has seen a reduction in the amount of in-reach substance use workers to support service user recovery within supported housing. At the same time, the substance use services have split access so clients need to access the alcohol only service or the drug and alcohol service.

Figure 13 illustrates the reported substance use for the 333 respondents.

Figure 123: Substance use reported by respondents

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47 http://www.homeless.org.uk/sites/default/files/site-attachments/The%20unhealthy%20state%20of%20homelessness%20FINAL.pdf
48 CHAIN data 2014/2015 for Westminster indicated 34% of rough sleepers have alcohol problems and 27% drug problems: http://data.london.gov.uk/dataset/chain-reports/resource/c432e3e5-ac13-4573-9bf6-c6c90cb9ccf8
Alcohol and drug use
55% of service users reported they drank alcohol and 43% of respondents reported they used illegal drugs. As the CHAT does not enquire about the level of substance use (as substance use services complete audits with service users) the frequency or type of substance use is not included. Since the substance use service restructure, Turning Point has offered to run training on naloxone and spice to increase the ability of staff to deal with complex issues; such as heroin overdose and the use of legal highs. In addition, HHCP health promotion volunteers have run numerous substance use awareness sessions in services.

33% reported they were already taking medication to support their substance use. Encouragingly 34% reported they would like treatment for drug or alcohol use, although the same proportion indicated they did not wish to receive support for their substance use.

Cigarette smoking
74% of service users reported they smoked, compared with 19% in the general population\(^\text{49}\). 20% of respondents who smoked indicated they wanted to stop smoking. As smoking accounts for over one-third of respiratory deaths, over one-quarter of cancer deaths, and about one-seventh of cardiovascular disease deaths in the general population\(^\text{50}\), new thinking is required around engaging rough sleepers about their respiratory health. Kick-It Stop Smoking Group sessions have been offered in 3 services in Westminster, including Passage Resource Centre, Harrow Road and CSTM, to provide in-house support for service users who wish to stop smoking.

Over the past couple of years, the HHCP has arranged for hostel staff to receive Kick-It Stop Smoking training, however, due to staff turnover none of these staff members work in Westminster anymore. The Kick-It Stop Smoking training will be promoted to staff again and it is hoped that the HHCP co-ordinator can also be trained in order to offer Kick-It Stop Smoking training for staff that are not able to attend.

USE OF COMMUNITY HEALTH SERVICES

The CHAT asked respondents to indicate the services they had used in the past 6 months and how frequently they had used these services (see figure 14).

\(^{49}\) http://ash.org.uk/category/information-and-resources/fact-sheets/
\(^{50}\) http://www.ash.org.uk/files/documents/ASH_93.pdf
Figure 134: Use of community health services in the past 6 months

- **GP**
  14% of respondents stated they had not visited their GP in the last 6 months. 34% visited 1-2 times, 20% 3-5 times and 30% had visited their GP over 5 times in the past 6 months.

- **Nurse services**
  50% of respondents stated they had not visited a nurse in the past 6 months, with 29% 1-2 times, 9% 3-5 times and 11% over 5 times. 3% stated they had difficulty accessing the nurse service due to mobility issues, 2% stated they had a negative experience of the service and 4% stated they had difficulty accessing service for 'another' reason not specified.

- **Walk-in clinic**
  81% of clients stated they had not used a walk-in clinic in the last 6 months, 11% 1-2 times, 2% 3-5 times and 4% over 5 times. 2% stated they had difficulty accessing a walk-in clinic due to mobility issues and 1% stated they had a negative experience of the service.

- **Outpatients appointment**
  74% of respondents stated they had not use an outpatient service in the past 6 months, 17% 1-2 times, 2% 3-5 times and 4% over 5 times.

**USE OF ACUTE SERVICES**

The barriers homeless individuals face in accessing primary health care tend to result in them using hospital services at a higher rate than the general population. The 2014 Homeless Link health audit51 found that homeless people use emergency services 4 times more than the general population, thus suggesting that a large proportion of homeless people could still be approaching hospitals as a first choice for health care. National cost data published in 2015 illustrates that the average cost of an ambulance call out is £216, while the average cost of an 

51 [http://www.homeless.org.uk/sites/default/files/site-attachments/The%20unhealthy%20state%20of%20homelessness%20FINAL.pdf](http://www.homeless.org.uk/sites/default/files/site-attachments/The%20unhealthy%20state%20of%20homelessness%20FINAL.pdf)
attendance to A&E is £113\textsuperscript{52}. It is essential that project workers encourage clients to engage with primary care services to reduce the number of hospital admissions and use of acute services.

Best practice to reduce the rate of homeless frequent attenders can be witnessed by the Kings Health Pathway Team. In 2011 it was estimated that the top seven frequent homeless attenders cost St Thomas’ and King’s Hospital cost an annual total of £115,274 in 2011 (a total of 337 A&E attendances and 51 admissions). With the introduction of the Pathway Team (which includes a GP, a Band 7 nurse, a Band 7 social worker and a Housing Advice Worker) and a quarterly frequent attendees meeting, the annual costs of the top 7 frequent attenders were reduced to £11,576 by 2014.

**Ambulance call outs**

26\% of respondents reported they had used an ambulance within the past 6 months; with 73\% of these using an ambulance 1-2 times, 12\% 3-5 times and 12\% over 5 times.

Table 3 illustrates that the most common reasons for requesting an ambulance included overdose, breathing problem/chest problems and seizure/fitting. Other reasons included cellulitis, swollen testicles and a blocked catheter.

\textbf{Table 3: Reasons for requesting an ambulance}

<table>
<thead>
<tr>
<th>Reason for requesting an ambulance</th>
<th>% of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Violent incident/assault</td>
<td>5%</td>
</tr>
<tr>
<td>Seizure/fitting</td>
<td>18%</td>
</tr>
<tr>
<td>Self-harm</td>
<td>0%</td>
</tr>
<tr>
<td>Accident</td>
<td>14%</td>
</tr>
<tr>
<td>Stomach pain</td>
<td>2%</td>
</tr>
<tr>
<td>Overdose</td>
<td>26%</td>
</tr>
<tr>
<td>Breathing problem/chest pains</td>
<td>18%</td>
</tr>
<tr>
<td>Mental health concern</td>
<td>9%</td>
</tr>
<tr>
<td>Cut</td>
<td>0%</td>
</tr>
<tr>
<td>Other</td>
<td>9%</td>
</tr>
</tbody>
</table>

**A&E**

29\% of respondents indicated they had visited A&E once within the past 6 months; with 69\% of these visiting 1-2 times, 15\% 3-5 times and 16\% over 5 times.

The most common reason for attending A&E were due to breathing problems/chest pains, accidents, cuts, violent incidents or assaults and seizures (table 4). Other reasons included alcohol use and allergic reactions.

\textsuperscript{52} http://www.neweconomymanchester.com/our-work/research-evaluation-cost-benefit-analysis/cost-benefit-analysis/unit-cost-database
Table 4: Reasons for attending A&E

<table>
<thead>
<tr>
<th>Reason for using A&amp;E</th>
<th>% of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Violent incident/assault</td>
<td>11%</td>
</tr>
<tr>
<td>Seizure/fitting</td>
<td>11%</td>
</tr>
<tr>
<td>Self-harm</td>
<td>4%</td>
</tr>
<tr>
<td>Accident</td>
<td>17%</td>
</tr>
<tr>
<td>Stomach pain</td>
<td>11%</td>
</tr>
<tr>
<td>Overdose</td>
<td>2%</td>
</tr>
<tr>
<td>Breathing problem/chest pains</td>
<td>17%</td>
</tr>
<tr>
<td>Mental health concern</td>
<td>10%</td>
</tr>
<tr>
<td>Cut</td>
<td>12%</td>
</tr>
<tr>
<td>Other</td>
<td>5%</td>
</tr>
</tbody>
</table>

The high use of acute services may be due to the difficulties accessing mainstream primary care. While the CHAT data found high rates of GP registration and GP attendance, this does not necessarily equate to timely and effective access to these services, as a significant proportion of respondents indicated they were not receiving support for their health issues.

WHAT WORKS ALREADY?

Numerous examples of best practice have been described throughout this report. This section expands on the prominent services currently available in Westminster.

UCLH’s Find and Treat MHU visits accommodation based services in Westminster every six months providing visual radiography which can identify respiratory and liver issues and provides flu vaccinations, alongside the Hepatitis C Trust providing hepatitis C screening. This makes TB screening, Hepatitis screening, liver checks and flu vaccinations more accessible to service users.

The peripatetic nurse programme based across three hostels is evidence that in-reach nursing services are paramount in providing access to health care to individuals with complex needs. It is likely that clients living in these three hostels would not have accessed the same support and treatment as they have done from the nurse.

GPs trained in homeless health issues have more knowledge about the health conditions that the homeless population suffer from and are able to tailor the service to meet these needs. For instance, Great Chapel Street’s Medical Centre53 provides drop in GP/nurse appointments, access to a drugs and alcohol mental health nurse & housing advisor, a dental service, psychiatrist by appointment, drop in counselling and podiatry screening. There are currently two homeless GP practices in Westminster; Dr Hickey’s and Great Chapel Street.

The Homeless Health Team is located in three day centres in Westminster, providing an in-house service for clients who may otherwise not attend to their health issues. The team also provides a homeless counselling service at day centres and the homeless GP surgeries, alongside *Anger Management* sessions.

Groundswell’s Homeless Health Peer Advocacy (HHPA) service offers one-to-one support to service users in Westminster to attend their physical health appointments. From 2017 Groundswell have also launched HHPA Plus, a project which allows them to accompany clients to their mental health appointments as well as physical health appointments. These are both an essential service to support service users to attend their health appointments, and to provide them with company during long waiting times. The HHCP promotes the HHPA using numerous methods, including the online CHAT, the e-newsletter and at health MOT events. From October 2015 to March 2017 Groundswell HHPA accompanied service users in Westminster to 545 health appointments.

The HHCP is also a model of best practice, funded until June 2019 to improve access to health services and decrease health inequalities of those in supported housing projects and rough sleepers. Consequently, 410 service users have attended in-house health awareness sessions, 166 have been screened at health MOT events and over 850 staff have attended training around prevalent physical and mental health issues. In addition, the HHCP has produced a number of tool kits, health directories, an e-newsletter and an online resource to support staff.

**IS MORE HELP NEEDED?**

Whilst there are a lot of best practice examples of homeless health support in the borough, this report clearly illustrates that more needs to be done to improve the health of service users in Westminster. Therefore, suggestions are included below on what could be implemented:

- An in-reach mobile dental unit treating service users on-site, on a quarterly basis, or dental screening in supported accommodation to identify dental health issues and signpost to appropriate services. As service users tend to respond more positively to in-reach services, the mobile dental unit would be considered to be the more effective option.

- A frequent attenders meeting to be set up and facilitated with St Mary’s and the HHCP to review the number of homeless people/ people in supported housing frequently using an ambulance/ using A&E and being admitted to hospital. The HHCP to be involved with risk assessing the hostel that the client is to be discharged to ensure a suitable environment for recovery.

- The HHCP health promotion volunteers to run service user health awareness sessions around ocular health, oral health and BBV’s. CLCH’s oral health awareness sessions to be run at HHCP Health MOTs at services.
• An annual Winter Health Drive to be facilitated by the HHCP in partnerships with the local outreach teams and UCLH’s Find and Treat MHU to screen those living on the streets for TB and vaccinate for flu.

• The peripatetic nurse services to be expanded into hostels with a high rate of ambulance call outs and services that do not currently have an in-reach health service.

• A potential research project for PhD students could be to explore the quantitative and qualitative aspects of memory issues among rough sleepers.

• There is the potential for extra resources to be sourced for the HHCP. Extra funds would be used to offer client incentives to increase attendance at in-house health checks and to access physical health training to raise staff awareness.

• It is suggested the mental health pathways available for rough sleepers and those in supported accommodation are reviewed to identify any gaps in mental health care, so recommendations can be made to mental health commissioners.

• GP practices / pharmacies local to supported accommodation to offer annual in-reach flu vaccinations to ensure a higher take up within the service users in supported accommodation.

• As a high number of service users have foot problems, there is potential to commission a quarterly in-reach service at the larger hostels (King George’s, Harrow Road, Edward Alsop and Hopkinson House).

• An end of life care unit to be provided for clients that are not able to return to their accommodation due to their physical health needs but require a safe space for palliative care.

• The HHCP to establish a client health advisory board to provide feedback and case studies of experiences of local health services, which the HHCP can feedback.

• UCLH’s Find and Treat MHU provides screening for a large number of health conditions and plans to provide additional health tests in the future. Due to transient nature of this client group, however, many will not be tested during the bi-annual MHU visits. It is therefore suggested that more frequent in-reach screening for BBV’s is made available at services. In-reach screening is recommended to ensure that service users who have chaotic lifestyles and who as a consequence are unable to attend to essential health needs, are offered the opportunity to be assessed where they are living.