Wolverhampton Joint Strategic Needs Assessment

Homeless Health Needs Audit

2023

Contents

Enquiries

City of Wolverhampton Council, Public Health and Wellbeing (Communities)

Clare Reardon, Principal Public Health Specialist

Clare.Reardon@wolverhampton.gov.uk

Stephanie Taylor, Senior Public Health Specialist

Stephanie.Taylor2@wolverhampton.gov.uk

Acknowledgements

Thank you to all of the partners of the Homeless Health Needs Audit Steering Group for their support with driving, overseeing and delivering the Audit.

Thank you to Homeless Link for their guidance, and for the provision of the Audit research and data tools to facilitate our ability to better understand the needs and experiences of people experiencing homelessness locally.

Finally, and in particular, thank you to all of the people who agreed to give up their time to share their views and personal experiences of health and accessing health care services in the City.

Figures

Tables

Executive Summary

i. Homelessness and Health

Ill health can be both a cause and consequence of homelessness. People experiencing homelessness often face some of the most significant health inequalities of all; with average life expectancy around 30 years lower than that of the general population.

To help people sustain stable accommodation, more action is required to enable better integration of health and social care, and to help people access the healthcare services they require.

The Wolverhampton Homeless Health Needs Audit (HHNA) 2023 aims to improve health outcomes and reduce heath inequalities for single adults experiencing homelessness in the City by:

- Bringing statutory and voluntary services together to develop responses to local priorities and address gaps in services,
- Increasing the national and local evidence base,
- Enabling local strategic and operational decisions to be driven by evidence of local need, and
- Ensuring that the voices of people experiencing homelessness are incorporated into local commissioning processes and service design.

The HHNA recognises the importance of gaining a deeper understanding of the barriers that people experiencing homelessness may face in accessing services, as well as how equipped healthcare services are to work with people who are experiencing often complex, interacting social and health challenges.

The HHNA represents a collective commitment to improving the outcomes for people experiencing homelessness in our City, and has been developed in conjunction with:

- Wolverhampton Rough Sleeper Partnership
- People experiencing homelessness in Wolverhampton
- Professionals who work with people experiencing homelessness
- Homeless Link.

ii. Summary of Key Findings

The following section presents a summary of the key findings from this HHNA.

Professionals said…

- The ability to access healthcare appointments is impacted by a range of factors, such as long call queues, appointment format and geographical location which must be tailored to the specific client group.
- The need for further education for some healthcare professionals to better understand the multiple and complex needs of the group was highlighted.
- Good levels of communication and service coordination were considered key to positive experiences.
- Inflexible / rigid healthcare provision exacerbates barriers to access.

Profile of People Completing the Audit

- The majority of people were aged 45-54 (33%). The average age was 39 years old.
- Three quarters of people (76.9%) were male.
- One in ten people reported being in some form of employment, education or training (11.0%). The majority of people (80.9%) were not working at the time of the survey.
- Most people had experienced multiple types of homelessness in their lifetime (85%) - staying in hostels, foyers, night shelters, B&Bs or other types of homelessness service, sofa surfing, and making a homelessness application to the Council being the most frequently experienced.
- Two thirds of people (66.9%) were currently sleeping in a hostel or supported accommodation.
- Being admitted to hospital because of a mental health condition and spending time in prison were the most common life experiences or risk factors relating to homelessness that local people had experienced. One fifth said they had not experienced any of the life experiences or risk factors highlighted.
- More than one in five said that they did not have recourse to public funds or were unsure whether they did (22.8%).
- Over half of people (54.1%) consider themselves to have a disability, three times higher than that reported by the local population (18%).

Physical Health

- Almost three quarters of people (73.7%) said they had been told by a doctor or health care professional that they had one or more physical health problems at the time of reporting. Almost four out of five people were living with multiple physical health problems.
- Joint aches / problems with bones and muscles, dental / teeth problems and difficulty seeing / eye problems were the top three most commonly reported physical health problems.
- Locally there was a higher prevalence of TB reported (5.9%) than found by Homeless Link nationally (1.0%). Positively, everyone locally had received treatment for their condition.
- Two fifths of people (40.7%) would like support or treatment for their physical health problem/s, or more help if they already receive some.
- Almost a third (32.6%) said that there was at least one occasion during the last twelve months where, in their opinion, they needed a medical examination or treatment for a physical health problem, but they did not receive it.
- Smoking prevalence was high amongst the audit cohort. Just over three quarters (76.7%) said that they smoked; a third of whom indicated that they would like to stop altogether (30.3%). Just over a quarter of all smokers (26.6%) said they had been offered support by a health professional to stop; half of whom had taken up the offer.

Mental Health

- Three quarters of people (77.4%) considered themselves to have one or more mental health conditions, compared to an estimated 12.3% of the population nationally[1].
- Nine out of ten people said that they experienced depression (91.5%) compared to 16% of adults in Britain[2].
- Types of support most commonly accessed to help with mental health conditions were medication (60.6%), Specialist Mental Health Workers (42.4%) and talking therapies (31.8%).
- Nearly 40% of people who had a mental health condition would like support or treatment for their condition, or more help if they already received some.
- One in three people felt that there was at least one occasion in the previous year where they needed an assessment or treatment for a mental health condition, but

[1] Source: NHS / IPSOS MORI (2022) - NHS GP Patient Survey 2022.pdf
[2] Source: Cost of living and depression in adults, Great Britain - Office for National Statistics (ons.gov.uk)

they did not receive it (31.3%). The main reasons cited were difficulty with accessing appointments (48.7%) and drug and alcohol use (23.1%).

- Over a third of people (35.8%) considered themselves to have a cognitive developmental condition(s); learning disability or difficulty being the most commonly reported (69.4%).
- One in ten people with a cognitive condition reported developing dementia **after** they became homeless (12.2%).
- Almost half of people (48.5%) stated that they use drugs or alcohol to help them cope with their mental health ('self-medicating').

Drug and Alcohol Use

- Just over half of people said that they had taken illicit drugs in the last 12 months (55.5%). Cannabis, crack and heroin were most commonly used.
- Nearly a third of people used drugs almost every day (30.1%) and one in three currently had or were in recovery from a drug problem (29.9%). Just under two thirds of people said that their drug use was not problematic (61.3%).
- Nearly half of the people who used drugs were receiving treatment or support and felt as though it met their needs (48.8%). One to one support, prescribed medication and group support were the most commonly accessed.
- Nearly three quarters of people had drank alcohol in the last 12 months (71.5%). When compared to the general population, reported unit volumes and frequency suggest that people experiencing homelessness are less likely to regularly drink to levels that exceed low risk guidelines.
- One in five people (20.4%) said that they have or are recovering from an alcohol problem; 28.6% of whom were accessing support that they were happy with. Advice and information, and counselling or psychological support were most commonly accessed.
- Being unable to get to appointments and waiting too long were common barriers identified in accessing treatment for both drug and alcohol use.

Access to Services

- Positively, most people were registered with a GP in the local area (90.2%). The proportion of people who said they were listed with a dentist was much lower (57.5%).
- There is a considerable difference in people not listed with and being refused access to a dentist, suggesting there may be a group that, despite the prominence of dental / teeth issues, are not engaging with universal dental services. The availability of the Special Care Dental Service locally may offer a

positive alternative for some people, although this was not directly explored by the audit.

- People experiencing homelessness were, on average, more than twice as likely to have attended A&E in the past 12 months than the general population; with more than a quarter going on to be admitted to hospital at least once during that period (28.7%).
- Physical health problems or conditions were the most common reason for attending A&E, using an ambulance and being admitted into hospital. Neither drug use or domestic violence were reported as reasons for A&E attendance or ambulance use locally (both 0%) - inconsistent with Homeless Link's findings.
- Just over a quarter of people (26.5%) said that they were not asked by hospital staff if they had somewhere suitable to go when discharged.
- Locally, people were more likely to be discharged to suitable accommodation than those experiencing homelessness and hospitalised in other areas. However, still more than one in five people who had been admitted to hospital (22.6%) were either discharged into accommodation that was not suitable for their needs (12.9%) or discharged to the street (9.7%).

Staying Healthy

- Over a quarter of people (28%) reported that their health was better now when compared to twelve months ago. Almost two in five (39.4%) said it was about the same and a third (32.6%) said it was worse now than it had been previously.
- Close to two thirds of people (60.9%) said that they were currently taking prescribed medication compared to 54% of adults in the most deprived areas in the country.
- Locally, take up of full or partial (at least one) vaccination against Hepatitis B was considerably lower (20.7%) than found by Homeless Link nationally (37%).
- Just under one in five people (19.1%) had had a sexual health check in the last 12 months; 27.5% did not know where to access free contraception and around a quarter (24%) did not know where to access sexual health advice.
- For those eligible, just under half (43.8%) said that they had not had a cervical smear and four in five (80%) had not had a breast examination / mammogram within the relevant screening periods.
- The majority of people who required sanitary products had access to them (90.0%).
- There were clear indications of poor nutrition and food insecurity. One in three people said that they ate on average one meal or fewer each day (30%), and two thirds (66.4%) ate one or fewer portions of fruit and vegetables per day.

iii. Recommendations

The following section outlines the recommendations made in response to the findings from the HHNA:

Local System

Agree an all-partner commitment to undertake the NG214 - Integrated health and social care for people experiencing homelessness self-assessment to identify good practice and respond to areas for further development.

Consider the introduction of an integrated commissioning response involving health, social care and accommodation services, informed by people with lived experiences of homelessness.

Establish a Wolverhampton Inclusion Health steering group (or equivalent) as a subgroup of the One Wolverhampton and Homelessness Prevention strategy governance structures.

Profile of Participants

Ensure effective general practice registration in line with NHS England guidance for people experiencing homelessness. This should also include the localisation of the Groundswell 'My Right to Healthcare' yellow cards for use across all Wolverhampton Primary Care Networks.

Promote the message that everyone is welcome in dental and general practice utilising key resources such as the Primary Care Network Health Inclusion Planning Toolkit, Doctors of the World Safe Surgeries Toolkit, and the Everyone Welcome in General Practice Campaign.

Develop and deliver a Rights and Entitlements training programme for healthcare professionals who work with people experiencing homelessness, particularly those who have no recourse to public funds, or whose immigration status is uncertain.

Work with DWP, CWC and the local voluntary and community sectors to better understand the barriers to accessing employment, education and training and design solutions that ensure people experiencing homelessness are supported to be economically active.

Consider the introduction of an inclusive apprenticeship offer for people with lived experience of homelessness.

Professionals

Building on the summary findings from the professionals' survey, gain a more detailed understanding of the views and experiences of healthcare professionals working with people experiencing homelessness.

Physical Health

Introduce an annual health check offer (including health action plan) to encourage people experiencing homelessness to access primary care to help them stay well, identify any problems early, and review any medication / treatment.

Test a tailored, brief intervention smoking cessation support offer delivered by specialist support and accommodation providers. This could be supported by an information campaign to raise awareness of the universal smoking cessation offer available in the city.

Mental Health

Co-design and implement a model of mental health peer support delivered by peers with experience to improve engagement with mental health services and support wellbeing.

Work with One Wolverhampton Adult Mental Health Strategic Working Group to improve access to targeted support for people experiencing homelessness who have co-existing substance misuse and mental health problems.

Drug and Alcohol Use

Undertake further investigation into reported alcohol consumption levels amongst people experiencing homelessness.

Develop and implement a fast-track pathway for people who are homeless and require specialist drug and/or alcohol treatment (including aftercare).

Access to Services

Secure additional funding for the Healthier Hostel pilot to ensure continuation of in-reach delivery whilst the evaluation is completed, and recommendations are made.

Work with NHS England Specialist Commissioning, Black Country ICB and RWT Specialist Dental Service to investigate the low level of dental access reported by people experiencing homelessness, to better understand barriers faced and how these can be addressed.

Undertake a review of homeless hospital discharge pathways from RWT New Cross Hospital and BCHT Penn Hospital, along with any associated process / protocols, to ensure that patients are discharged into suitable accommodation.

Ensure that the local end to end process for Duty to Refer is effective and efficient, enabling specified public authorities to identify and refer a person who is homeless, or may be threatened with homelessness, to a local housing authority of their choice, and where Wolverhampton is the receiving authority, that a timely and appropriate response is in place.

Pilot the introduction of specialist navigator capacity into RWT New Cross Hospital Emergency Department, alongside the High Intensity User Service, to work with people experiencing homelessness who frequently attend emergency care and whose needs could be better met elsewhere, and to reduce repeat attendances.

Staying Healthy

Ensure equitable access to screening services, providing targeted promotion and support for people experiencing homelessness to make an informed choice about participation.

Provide cancer screening promotion training to organisations who work with people experiencing homelessness in Wolverhampton.

Explore the possibility of trialling access to the third-party ordering system to increase access to and uptake of bowel screening for people experiencing homelessness.

Expand the current provision of cooking and food preparation courses to other specialist homeless support service providers in the City.

Introduce targeted engagement within the forthcoming sexual health services consultation to ensure the voices of people experiencing homelessness (and other inclusion health groups) are reflected and are representative.

Work with CWC and RWT Embrace to enhance the sexual health outreach offer for people experiencing homelessness.

1. Introduction

1.1 Homelessness and Health

Ill health can be both a cause and consequence of homelessness. People experiencing homelessness often face some of the most significant health inequalities of all; with average life expectancy around 30 years lower than that of the general population[3,4].

People experiencing homelessness are a recognised inclusion health group[5] whose experiences frequently lead to barriers in access to services. Chronic and multiple health needs are common and too often go untreated leading to extremely poor health outcomes.

There is not a single intervention that can tackle homelessness on its own, at population, or at an individual level. The *Homelessness: Applying All our Health* guidance (2019) recognised that in order to help people sustain stable accommodation, action was required to support better integration of health and social care, and to help people access the healthcare services they require[6].

In early 2022, the National Institute for Health and Care Excellence published *Integrating Health and Social Care for People Experiencing Homelessness* (NG214)[7] – the first guidance of its kind - to support improvements in access to and engagement with health and social care, and ensuring care is coordinated across different services and disciplines.

Locally, the Wolverhampton Rough Sleeper Partnership prioritised the following objective within their Action Plan 2022 – 2023:

> *'Support vulnerable people to confidently engage with physical, mental and dental health services and increase awareness of complex support needs within health services'.*

To assist in the delivery of this objective, the Homeless Health Needs Audit was introduced.

1.2 The Homeless Health Needs Audit

The Homeless Health Needs Audit is a national tool used to understand more about the health needs of people experiencing homelessness, their experiences of healthcare services, and the inequalities they face. The audit was developed by

[3] Source: Crisis. About Homelessness | Crisis UK
[4] Source: ONS (2020). Deaths of homeless people in England and Wales - Office for National Statistics (ons.gov.uk)
[5] Public Health England (2021) - Inclusion Health: applying All Our Health - GOV.UK (www.gov.uk)
[6] Source: Public Health England (2019) (Updated by Office of Health Inequalities and Disparities – 2021) Homelessness: applying All Our Health - GOV.UK (www.gov.uk)
[7] Source: NICE (2022) Overview | Integrated health and social care for people experiencing homelessness | Guidance | NICE

Homeless Link – a national membership charity for organisations working directly with people in England who are homeless.[8]

In addition to asking about individual health needs, the survey is largely focused on experience of accessing health services.

With permission from people participating in the Audit, local data is also added to the national Homeless Link database used to inform the ongoing Unhealthy State of Homelessness research.[9]

The findings of the audit will be used to inform future policy, strategy and service planning in the City.

1.3 Aims and Objectives

The audit aims to:

- Bring statutory and voluntary services together to develop responses to local priorities and address gaps in services,
- Increase the national and local evidence base,
- Enable local strategic and operational decisions to be driven by evidence of local need, and
- Ensure that the voices of people experiencing homelessness are incorporated into local commissioning processes and service design.[10]

The HHNA recognises the importance of gaining a deeper understanding of the barriers that people experiencing homelessness may face in accessing services, as well as how equipped healthcare services are to work with people who are experiencing complex, often interacting social and health challenges.

1.4 Scope

For the purposes of this audit, the following experiences of homelessness have been included:

- Single people who are currently rough sleeping
- People who are sofa surfing who have had main duty accepted
- People in emergency accommodation to prevent or relieve rough sleeping
- People in longer term accommodation including:

[8] Source: Homeless Link. Assessing the health needs of people experiencing homelessness | Homeless Link
[9] Source: Homeless Link (2022). Unhealthy_State_of_Homelessness_2022
[10] Source: Homeless Link (2022). HHNA_Starter_guide

- Supported accommodation for rough sleepers / preventing rough sleeping
- Those in tenancies with support provided by a rough sleeper service.

2. Methodology

2.1. Purpose of this Chapter

The purpose of this chapter is to outline the approach taken to develop the Homeless Health Needs Audit.

2.2. Governance

2.2.1 Homeless Health Needs Audit Steering Group

The Homeless Health Needs Audit was overseen by a Steering Group made up of representatives from specialist providers across the voluntary sector and housing, health, and the local authority.

The purpose of the Steering Group was to act as an expert advisory group who collectively oversaw, guided, contributed to, and undertook key components of the process on a monthly basis.

The Steering Group was responsible to the Wolverhampton Rough Sleeper Partnership.

2.2.2 Frontline Staff Briefings

Briefings were arranged for frontline staff to prepare for supporting completion of the survey. These sessions were held on 9 and 13 January 2023 prior to commencing data collection and covered survey content, logistics of completing the audit, and supporting resources.

2.2.3 Audit Check Ins

Weekly meetings were established to provide dedicated time and space for frontline staff to discuss any challenges and barriers, ongoing progress, and share good practice. Once data collection was established, these were reduced in the second month to bi-weekly and a drop-in format based on need and feedback.

2.3. People Experiencing Homelessness

2.3.1 Audit Questionnaire

The survey content was prescribed to us by Homeless Link and standardised to ensure comparable data was produced that could contribute to the national database.

The survey consisted of 43 questions covering the following topic areas:

- Demographics
- Physical Health
- Mental Health
- Drug and Alcohol Use
- Access to Services
- Staying Healthy.

A question was added to localise the survey around barriers to accessing treatment for both drug and alcohol use. The additional questions can be identified as QWOL1 and QWOL2 in the survey.

The full survey can be found in Appendix A.

2.3.2 Sample Size

The sample size for this audit was determined by Homeless Link. Data included in the calculation covered:

- The most recent available local rough sleeper count data
- Homeless Case Level Information Collection (HCLIC) last published data for the last quarter of 2021/2022
- An estimate of the number of people staying in supported, or temporary accommodation (excluding those in temporary accommodation who are counted in the HCLIC data - people not found in priority need).

The resulting sample size for Wolverhampton was 125. The actual number of people involved was 137, exceeding the target sample size.

2.3.3 Data Protection Impact Assessment

Working with Information Governance, a data flow map and data impact agreement were completed to show the journey of the data. The anonymisation of data, along with its usage and storage were also highlighted.

The findings of this work confirmed that a full impact assessment was not required.

2.3.4 Pilot

Before the main data collection period commenced, a short pilot was conducted to trial the audit process and identify any local learning prior to the launch date. The pilot took place over a four-week period from 14 November 2022 to 14 December 2022.

In total, 14 surveys were completed with support from three of the organisations represented at the Steering Group.

Participating organisations were provided with a pilot checklist for feedback (Appendix B). Feedback was analysed and minor adjustments were made to the process – primarily enabling a mixed format approach. This enabled organisations choice between online or paper versions of the survey to suit their preferred delivery method.

2.3.5 Consent

People were required to complete a consent form prior to participating in the audit (Appendix C). The option to withdraw consent, and therefore personal data, was available at any time. This was explained through the Participant Information Sheet

detailing the Homeless Health Needs Audit and what it involved, in addition to information to be collected and data storage (Appendix D).

2.3.6 Data Collection

Both paper and electronic formats of the audit survey were available to support completion. Both options allowed for people to pause and resume at another time if they were unable to complete all of the information in one session.

As per Homeless Link guidance, surveys were encouraged to be completed with support from, a Case Worker during a routine appointment, or with another member of Support Staff at a different time, rather than alone. This enabled any clarifications to be provided and for any disclosures to be acted upon in a timely manner.

All aspects of the survey relied on self-reported information.

Data collection took place between 16 January 2023 and 19 March 2023.

2.3.7 Confidentiality

All data was made anonymous through the use of unique ID numbers. This provided anonymity, as well as the ability to withdraw a record if requested.

For those who selected the online format, Homeless Link LimeSurvey anonymised the data upon entry by providing an ID number.

People who completed the survey on paper were allocated a unique identification number produced through random number creation on Microsoft Excel.

2.3.8 Data Entry and Analysis

The data from completed surveys were input into the Homeless Link LimeSurvey tool, and the majority of data analysis was conducted here too. Additional analysis was completed using Microsoft Excel.

Local data findings were compared to those from Homeless Link's Wave 3 research group. Wave 3 is an aggregate reflection of eight audits undertaken between 2018 and 2021: representing the voices of 522 people.

2.4. Professionals working with people experiencing homelessness

2.4.1 Professionals Survey

A short survey was devised for professionals working with people experiencing homelessness. It consisted of three compulsory questions and one optional case study example. The questions were purposefully framed as open questions to allow and encourage in depth, free text responses (Appendix E).

The survey was hosted online on the CWC Consultation Hub between 31 January and 19 March 2023 and shared via email to professional networks. There were nine responses received to this survey. A thematic analysis of the responses was undertaken and findings are presented in Chapter 3.

3. Professionals Said…

Key Findings:

- The ability to access healthcare appointments is impacted by a range of factors, such as long call queues, appointment format and geographical location which must be tailored to the specific client group.
- The need for further education for some healthcare professionals to better understand the multiple and complex needs of the group was highlighted.
- Good levels of communication and service coordination were considered key to positive experiences.
- Inflexible / rigid healthcare provision exacerbates barriers to access.

3.1. Purpose of this Chapter

The purpose of this chapter is to present the summary findings from the survey of professionals who work closely with people experiencing homelessness.

A short survey for professionals was devised to compliment the people survey for the Homeless Health Needs Audit. Previous audits in England have asked similar questions to ensure people with the most complex needs who themselves may not participate in the audit have been represented and are given a voice.

3.2. Summary of Findings

In total, nine professionals responded.

Question 1: What are the barriers to accessing healthcare for people with multiple complex needs?

Respondents were asked for their views on barriers that people with multiple and complex needs experienced when accessing health care. All nine respondents (100%) answered this question.

The summary analysis of responses is as follows:

a) Limited availability of appointments

Respondents made reference to the challenges in accessing limited available appointments, highlighting long call queues and short windows of opportunity before all appointments are allocated.

Time pressures for case workers creates additional challenges, limiting the capacity of the worker to support with arranging appointment during a time-limited routine case work appointment.

Waiting a long time for an appointment was thought to, for example, further impact limited motivation for self-care, or further exacerbate an individual's mental health; making it even more challenging for people to persevere with making appointments.

Waiting time for a new patient appointment post-registration was also highlighted, recognising that conditions may worsen during the waiting period.

The busy environment of Accident and Emergency departments added to feeling particularly unwell and extended waiting times were thought to be a particularly challenging set of circumstances for people with multiple, complex health needs.

Timely access to a prescribing healthcare professional was seen as key to ensuring people were able to continue their medication regimes where already in place, prevent any gaps in medication and importantly to prevent safety issues that may be caused by an absence of the medication.

b) Lack of understanding of people experiencing homelessness

Respondents felt that some healthcare professionals did not fully understand the complexities and challenges that people experiencing homelessness often face. As a result, they may inadvertently use an approach that increases barriers to access for the individual rather than reduce them.

Respondents highlighted the value of a trauma informed, open-door approach and felt that this would assist other professionals to understand the needs of the person seeking healthcare and respond more appropriately.

Non-attendance to appointments being perceived as non-engagement and cases being closed as a result, was highlighted by respondents as a particular case in point.

c) Lack of communication

Lack of / inconsistent communication between services that an individual may be accessing simultaneously can lead to the feeling of disjointedness which often causes individuals to have to 'retell their stories' multiple times. At best this is frustrating for individuals, but this also risks being repeatedly traumatising also.

There are particular challenges faced when someone experiences dual diagnosis of co-existing substance dependency and mental ill health. Where this occurs, there can be challenges with identifying lead professionals, or for services to treat an individual holistically.

d) Access (to information/appointments)

Respondents highlighted challenges with accessibility of some service offers in the city, for example where services rely on telephone appointments and online appointment booking systems which require a patient to possess a telephone or have access to a smart device. Furthermore, many services continue to offer an adjusted service model including telephone appointments and reduced face-to-face contact compared to pre-Covid pandemic. Digital exclusion of people experiencing homelessness adds an additional challenge to accessing healthcare (and other) services.

Without a mobile phone or other electronic device, there are also barriers to accessing relevant, timely health promotion information, where this is predominantly displayed online.

e) Transportation

Access to transport and / or means to travel can add additional barriers for people experiencing homelessness. Respondents felt geographical location was an important consideration when planning service provision; including multi access point options to reduce the distance required to travel.

The use of public transport to travel to appointments can also be restricted where an individual has limited access to financial resources.

f) Stigma

Fear of being judged or discriminated against was highlighted as a key reason that can deter people from accessing healthcare services. Not feeling listened to, not being understood, and feeling rushed were all examples highlighted as barriers to positive engagement.

When people experiencing homelessness also have a health condition / diagnosis that has historically been known to draw judgement and discrimination e.g., HIV, this only goes to further exacerbate barriers to access and risks withdrawal from help seeking behaviours to manage health altogether.

Question 2: What is working well locally?

Respondents were asked what is working well in the City to support people experiencing homelessness to access healthcare. In total, 88.9% (n=8) responses were received.

The summary analysis of findings is as follows:

a) Communication between professionals locally

Where services and professionals worked together and communicated regarding individuals and their service input; keeping each other informed through sharing invitations to multiagency meetings and reaching out directly to services, positive outcomes were achieved.

Respondents felt that professionals working in specialist services were better equipped to respond to people experiencing homelessness with their more detailed understanding of the needs of the group, as opposed to universal services catering to the general population.

Many of the respondents who commented on barriers and improvements also commented on the running and organisation of services. It was felt that potential improvements lie within further increasing knowledge of professionals working in universal services and increasing the communication between universal and specialist services.

b) Dental services / Recovery services

Local dental health services and recovery services were praised. Respondents highlighted the Special Care Dental Team and Recovery Near You service as positive examples of services working with others to overcome barriers to accessing healthcare for people with complex needs.

Both the Special Care Dental Team and Recovery Near You services in the city provided tailored support; equipped to work with the group with an understanding of multiple and complex needs, influencing factors and the diversity of individuals' needs.

Question 3: What could be improved or enhanced?

Respondents were asked what could be improved or enhanced to help people experiencing homelessness access healthcare more easily. Eight respondents (88.9%) shared their views.

The summary analysis of responses from professionals is as follows:

a) Communication and coordination

Respondents drew attention to the need for a more joined-up approach between services interacting with an individual, with coordinated care addressing all aspects and needs of individuals with complex needs wherever possible.

Respondents highlighted the value of services taking responsibility for the individual and investing in them. A holistic approach was identified as a strong way forward to

integrate support from different disciplines of healthcare, for example a key worker or equivalent for healthcare, with access to information in a single location.

Increased coordination was highlighted as a route to reducing the frequency that an individual must retell their story; therefore reducing risk of re-traumatising. This may also support continued or improved engagement.

b) Support

Enhanced support for people with complex needs such as dual diagnosis would likely improve experience of healthcare and the response they receive.

Again, relating to the need for improved communication and coordination, a need for a single point of contact or location for information to be held was thought a positive way to assist both individuals and professionals with navigating the support available.

c) Appointments

Access to appointments was highlighted as an area for improvement in relation to both the speed of accessing an appointment and the process of making one. As discussed as barriers, people may find difficulty in making and accessing healthcare appointments due to factors such as transportation limitations, finances, waiting times, digital exclusion and unsuitable formats.

Respondents suggested the provision of further education for some healthcare professionals on the needs of this particular group would help to ensure that services were as inclusive as possible and would likely improve access.

Flexibility around when and how people can access services, which is tailored to the specific group should also be considered.

d) Accommodation

Respondents identified the need for improvements to placing individuals in suitable accommodation. Suggestions included dedicated places and utilising empty spaces to increase the availability of accommodation, such as converting buildings no longer in use.

Ensuring an individual is provided with suitable accommodation could lead to positive impacts on their emotional, mental and physical health. One of the following case studies details an example of the importance of suitable accommodation.

Question 4: Case study example of healthcare experience

To demonstrate experiences, professionals were asked to share case study examples. The following three case studies were provided in response to this question.

Case Study 1:

Recently gentleman in his 40's had lived with parents, mum passed away and relationship with father deteriorated. He has a diagnosis of cancer which is now stage 4, under oncology at New Cross Hospital and receiving chemotherapy.

His companion is his dog who meets his emotional wellbeing needs and will not separate from him. He has been sleeping in his car since Christmas.

His illness is impacting on his mobility, and he is unable to walk far, or use stairs. This and his dog have affected any offers of accommodation. Person did not want to be moved out of the area due to his need to be near New Cross Hospital for treatment.

Many local hotels will also not accept referrals from the Council, and others will not accept pets or do not have a lift. He has had to continue sleeping in car near the hospital to attend his appointments with oncology. Housing were trying to support and find a ground floor flat urgently.

Case Study 2:

Person admitted to hospital using street drugs and self-discharged. No support while in hospital - not enough staff to monitor our person with complex multiple needs. By discharging himself he was back to square one. No fault of the hospital. Same person arranged detox, on standby to be admitted for 3-month residential treatment but no room as of yet.

Case Study 3:

Female crack user presented in psychosis at GP appointment which [Key Worker] had been given 2 weeks previously and had been able to support her to attend - difficulty with persons being found on the day due to drug use.

Referral was made and an appointment with Penn [Hospital] was given for the end of March (23). Also, an assessment was carried out for Healthy Minds, but the assessor commented that she is not in the place for this type of support yet.

There have been several occasions [Key Worker] has been concerned for her well-being since the initial referral was made and been unable to obtain an appointment.

The lady has presented at the surgery and been turned away and [Key Worker] has telephoned the surgery - there have been no appointments for 3 days running on one episode of psychosis. [Person] and [Key Worker] were advised to present at A&E which the lady refused.

[Key Worker] was told on another occasion to complete their online request which on the first question advised [the Key Worker] to contact the surgery immediately.

The lady is aware at times that this is her drug use but due to addiction, at times has moments of seeing this as a psychosis and the delusions not real. [Key Worker] has been at times seriously concerned for her well-being and not listened to for support and medical attention.

4. Profile of People Completing the Audit

Key Findings

- The majority of people were aged 45-54 (33%). The average age was 39 years old.
- Three quarters of people (76.9%) were male.
- One in ten people reported being in some form of employment, education or training (11.0%). The majority of people (80.9%) were not working at the time of the survey.
- Most people had experienced multiple types of homelessness in their lifetime (85%) - staying in hostels, foyers, night shelters, B&Bs or other types of homelessness service, sofa surfing, and making a homelessness application to the Council being the most frequently experienced.
- Two thirds of people (66.9%) were currently sleeping in a hostel or supported accommodation.
- Being admitted to hospital because of a mental health condition and spending time in prison were the most common life experiences or risk factors relating to homelessness that local people had experienced. One fifth said they had not experienced any of the life experiences or risk factors highlighted.
- More than one in five said that they did not have recourse to public funds or were unsure whether they did (22.8%).
- Over half of people (54.1%) consider themselves to have a disability, three times higher than that reported by the local population (18%).

4.1. Purpose of this Chapter

The purpose of this chapter is to present a summary of responses to the 'About You' questions (Q1 – 11) within the audit, giving a profile of the people involved.

4.2 Summary of Findings

Question 1: How old are you?

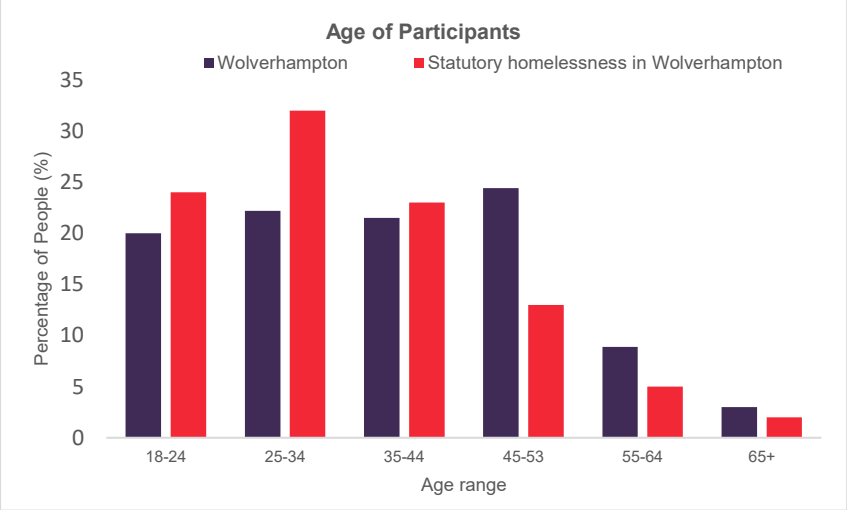
People were asked to provide their age. There were 135 responses to this question.

The age of people ranged from 18 to 69 years old. The average age of people was 39 years old.

People were most commonly aged 45 – 54 years old (24.4%, n = 33), 25 – 34 years old (22.2%, n = 30) and 35 – 44 years old (21.5%, n = 29) (Fig.1).

There was a higher proportion of 18 – 24-year-old people locally (20%, n = 27) compared to that seen by Homeless Link (14%) and an overrepresentation compared to the Wolverhampton population (8%). There was a slightly lower proportion of older people aged 55+ years (11.9%, n = 16) in Wolverhampton compared to those involved nationally (16%).

Figure 1: Age of participants



To mirror the grouping used by Homeless Link, age ranges 25 – 54 years old were then combined. Just over two thirds of Wolverhampton people (68.1%, n = 92) were aged 25 - 54 years; presenting a similar age profile to that found by Homeless Link (69%).

Statutory data about people owed a homelessness prevention or relief duty (2021 – 22) shows that nationally the proportion of people owed a duty who were aged 25 – 54 years old was very similar to those participating in the audit locally (69% and 68.1% respectively).

When looking more specifically at age ranges within the statutory data, there are differences emerging. There were slightly more young adults aged 18 – 24 years old owed a duty (24%) and in the 35 – 44-year-old cohort (23%) than involved in the audit locally (20% and 21.5% respectively). More significant variations were seen in the 25 – 34-year-old cohort, where nationally a third of people owed a duty were of this age (32%) compared to 22.2% of local people; and where just over one in ten people who were owed a duty were aged 45 – 54 years old (13%) compared to a quarter of local people (24.4%).

Question 2: Which of these categories best describes you at present? Please tick only one.

People were asked about their current training / employment status and were asked to select which category best described them at the time of completing the survey. There were 136 responses to this question.

The majority of people were not working at the time of responding to the audit survey (80.9%, n = 110). Following this, the option 'Other' was most common (8.1%, n = 11). Responses included:

- Unable to work due to health issues
- Job seeking
- On universal credit.

The third most common response was 'Going to school, college or university' and 'Doing unpaid work or voluntary work', both 3.7% (n = 5) respectively (Table 1).

Table 1: Current Training/Employment Status

Current training / employment Status	Count	Wolverhampton (%)
Not working	110	80.9%
Other	11	8.1%
Going to school, college or university	5	3.7%
Doing unpaid work or voluntary work	5	3.7%
Working	<5	2.9%
On an apprenticeship	<5	0.7%

During the latest available period (2021 – 22), one quarter of people owed a homelessness prevention or relief duty in Wolverhampton were working (24.5%) and 3.0% were a student / undertaking training[11]. It is not possible to make any other direct comparisons with the statutory data due to the differences in categorisation of employment status.

Question 3: Have you ever (in your lifetime) done any of the following? Tick all that apply.

People were asked about their homeless history, highlighting which forms of homelessness (if any) they had experienced in their lifetime. There were 134 people who responded to this question. People had the option to select all of the answers most relevant to them.

Most people had stayed at a hostel, foyer, refuge, night shelter, B&B or any other type of homelessness service (82.1%, n = 110). Nearly three quarters of people had experienced sofa surfing (73.1%, n = 98) and just over two thirds had applied to the

[11] Source: Gov.uk (2022). Statutory homelessness in England: financial year 2021-22 - GOV.UK (www.gov.uk)

Council as homeless (68.7%, n = 92) (Table 2). These local findings are consistent with those found nationally by Homeless Link.

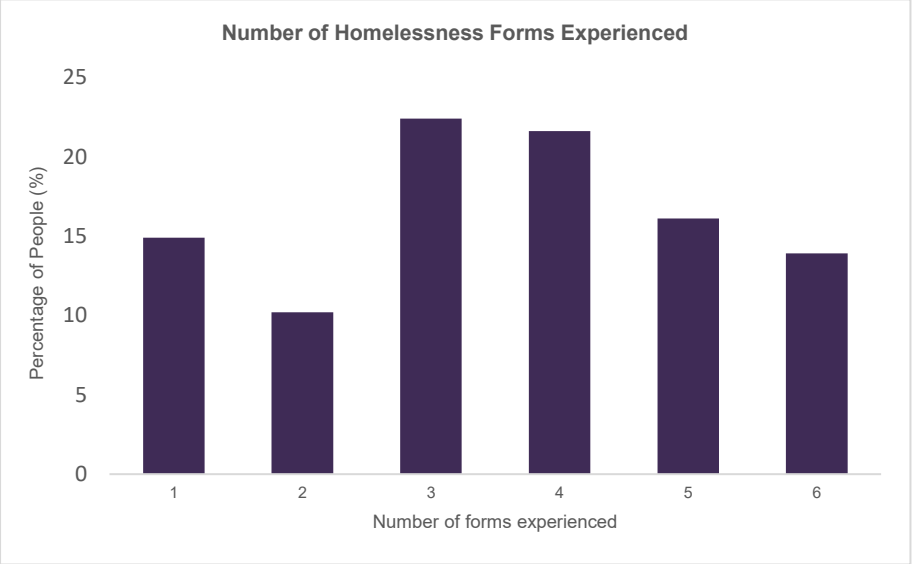
Table 2: Forms of Homelessness

Forms of Homelessness	Count	Wolverhampton (%)	Homeless Link (%)
Stayed at a hostel, foyer, refuge, night shelter, B&B or any other type of homelessness service	110	82.1%	85%
Sofa surfed	98	73.1%	69%
Applied to the council as homeless	92	68.7%	68%
Slept rough	79	59%	66%
Slept in a tent, car, other vehicle or public transport	61	45.5%	-
Squatted	38	28.4%	-
None	<5	1.5%	3%

Very few people experienced a single form of homelessness (14.9%, n = 20) and 1.5% (n = <5) said that they had not experienced any of the forms presented.

The majority of people had experienced multiple forms of homelessness (85.0%, n = 114) (Fig. 2).

Figure 2: Forms of Homelessness Experienced



Locally, people had most commonly experienced three or four forms of homelessness in their lifetime (22.4%, n = 30 and 21.6%, n = 29 respectively). There were however almost a third of local people who had experienced 5 or more forms of homelessness in their lifetime (30.6%, n = 41).

Question 4: Where are you currently sleeping? (If this frequently changes, please say where you slept last night) Please tick only one.

People were asked about their current housing status and were asked to highlight where they were sleeping at the time of completing the survey. Where this changed

regularly, people were asked where they had slept last night. There were 136 responses to this question.

Two thirds of people (66.9%, n = 91) said that they were currently sleeping in a hostel or supported accommodation; almost mirroring the picture seen by Homeless Link (68%) (Table 3).

Table 3: Current Housing Situation

Current Housing Situation	Count	Wolverhampton (%)	Homeless Link (%)
In a hostel or supported accommodation	91	66.9%	68%
Other	26	19.1%	3%
Sleeping on somebody's sofa/floor	12	8.8%	3%
Rough sleeping	<5	2.9%	6%
In B&B or other temporary accommodation	<5	0.7%	4%
Vehicle or caravan on the side of the road/car park	<5	0.7%	0%
In emergency accommodation	0	0	11%
Squatting	0	0	0%
In National Asylum Support Service (NASS) accommodation	0	0	-

One in five local people were in 'other' accommodation (19.1%, n = 26). This included being in their own accommodation (6.6%, n = 9), in a council property (4.4%, n = 6), or staying with family or friends (n = <5). In contrast, Homeless Link found only 3% of people staying in 'other' accommodation at the time of the survey.

Question 5: Do you have any of the following backgrounds? (This helps us to understand how your past experience may have affected your health or services you've been able to access) Tick all that apply.

People were asked about their life experiences related to homelessness. All 137 people responded to this question and were able to select as many options as were relevant to them.

Being admitted to hospital because of a mental health condition (22.1%, n = 50), and spending time in prison (19.5%, n = 44) were the most common life experiences or risk factors relating to homelessness that local people had experienced.

One fifth of people said they had not experienced any of the life experiences or risk factors highlighted (19%, n = 43) (Table 4).

Table 4: Life experiences and risk factors

Background	Count	Wolverhampton (%)	Homeless Link (%)
Admitted to hospital because of a mental health condition	50	22.1%	25%
Spent time in prison	44	19.5%	25%
None of these backgrounds	43	19.0%	-
Been a victim of domestic abuse	35	15.5%	22%
Spent time in local authority care	22	9.7%	14%
Spent time in a secure unit or youth offender institution	15	6.6%	10%
Spent time in the armed forces	6	2.7%	4%
Spent time sex working	6	2.7%	-
Spent time in an immigration detention centre	<5	1.3%	-
Been a victim of trafficking / modern day slavery	<5	0.9%	-

The latest Census data (2021) showed that around 2% of Wolverhampton residents are veterans who previously served.[12] This is lower than the 4.4% (n = 6) of people to the audit who had spent time in the armed services, indicating an overrepresentation of armed forces veterans in the audit sample, albeit the numbers are small.

Question 6: What is your sex?

People were asked to identify their sex. There were 134 responses to this question.

Over three quarters of people (76.9%, n = 103) said that they were male and almost a quarter (23.1%, n = 31) were female.

Question 6a: Is the gender you identify with the same as your sex registered at birth?

People were asked whether the gender they identify with is the same as their sex registered at birth. There were 133 responses to this question.

Almost everyone (98.5%, n = 131) reported that the gender they identify with was the same as their sex registered at birth.

[12] Source: WV Insight (2023) Population - WVInsight (wolverhampton.gov.uk)

Question 6b: What is your gender? Please tick only one.

People were asked to identify their gender. There were 136 responses to this question. Table 5 summarises these responses.

The majority of people identified as male (76.5%, n = 104), 22.8% identified as female (n = 31) and 0.7% identified as transgender male (n = <5). In comparison, just over two thirds of Homeless Link people identified as male (68%), almost a third identified as female (30%) and 1% identified as transgender.

Table 5: Gender

Gender	Count	Wolverhampton (%)	Homeless Link (%)
Male	104	76.5%	68%
Female	31	22.8%	30%
Transgender Male	<5	0.7%	1%
Transgender Female	0	0	
Non-binary	0	0	1%
Other	0	0	0%

Gender is an important factor to understand particularly when considering the experiences people have that have led to homelessness, their experiences whilst homeless and the type of support they may need.

Question 7: Which of the following best describes your sexual orientation? Please tick only one.

People were asked to describe their sexual orientation. There were 136 responses to this question.

The majority of people identified as heterosexual or straight (89.7%, n = 122); concurrent with Homeless Links findings (89%) (Table 6).

Almost 6% were gay or lesbian compared to 4% in Homeless Link's research. Concurrent with Homeless Link's research, 3.7% (n = 5) identified as bisexual; similar to their 4%.

Table 6: Sexual Orientation

Sexual Orientation	Count	Wolverhampton (%)	Homeless link (%)
Heterosexual or Straight	122	89.7%	89%
Lesbian	5	3.7%	4% (gay or lesbian)
Bisexual	5	3.7%	4%
Gay	<5	2.2%	4% (gay or lesbian)
Other	<5 (not specified)	0.7%	1%
Pansexual	0	0	1%

In Wolverhampton, 62% of those owed a homelessness prevention or relief duty identified as heterosexual or straight, 1% identified as gay or lesbian, and 1% identified as 'other' (not specified). More than a third of those owed a duty locally preferred not to say and the sexual orientation of 0.03% was 'not known'[13].

The ability to meaningfully benchmark HHNA findings is challenging when the proportion of missing information is so high within the statutory data both locally (35.8%) and nationally (27.4%), either because people have chosen not to disclose their sexual orientation or because this detail is unknown.

There are specific experiences and challenges faced by people from LGBTQ+ communities that further increase risk of homelessness and barriers to accessing services. According to Crisis[14], one in five LGBTQ+ people have experienced homelessness at some point in their lives, with this being even higher for trans people (25%)[15]. Three quarters of LGBTQ+ young people believe coming out to their parents was the main factor causing their homelessness[16].

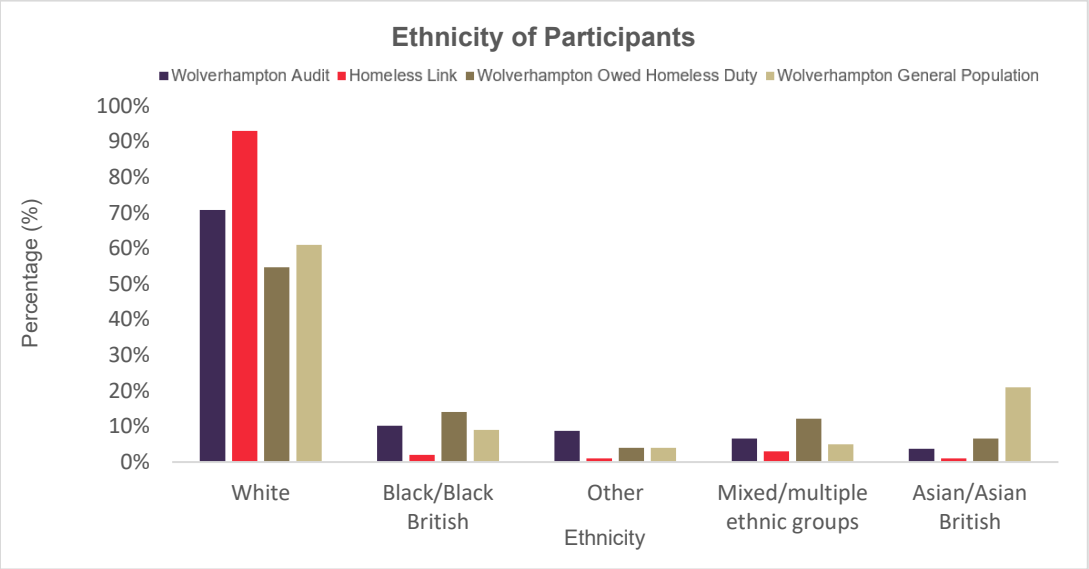
Question 8: What is your ethnic group? Please tick only one.

People were asked to provide their ethnic group. There were 137 responses to this question.

The majority of people were White (70.8%, n = 97), one in ten were Black/Black British (10.2%, n = 14), and 8.8% said their ethnicity was 'Other' (n = 12). 'Other' ethnicities included Lithuanian, Eastern European and Slovakian (all n = <5 respectively). A further 6.6% (n = 9) identified as mixed / multiple ethnicity and 3.7% (n = 5) were Asian / Asian British (Fig. 3).

[13] Source: Gov.uk (2022). Statutory homelessness in England: financial year 2021-22 - GOV.UK (www.gov.uk)
[14] Source: Crisis. LGBTQ+ and Homelessness - Statistics and Support | Crisis UK
[15] Source: Stonewall (2018). lgbt_in_britain_-_trans_report_final.pdf (stonewall.org.uk)
[16] Source: AKT (2023). akt - LGBTQ+ youth homelessness charity

Figure 3: Ethnicity of participants



The difference in ethnicity profile of local people compared to people within the Homeless Link cohort may be in part explained by the difference in geographical areas which have undertaken the Homeless Health Needs Audit to date.

When comparing the HHNA ethnicity profile with local statutory homelessness data, there is an over representation of people from White and Other ethnicities. In Wolverhampton, 54.7% of those owed a homelessness prevention or relief duty identified as White, 14.1% as Black / Black British and 12.2% were of mixed / multiple ethnicities. A further 6.6% of those owed a duty were Asian / Asian British and 4% stated their ethnicity as 'Other'. The ethnicity of almost one in ten (8.8%) owed a homelessness duty was not known[17].

The HHNA profile for Black / Black British and mixed / multiple ethnicities is broadly similar when comparing the ethnicity profile of the Wolverhampton population. People of White and Other ethnicities continue to be overrepresented. People of Asian / Asian British ethnicity are significantly underrepresented when compared to the local population.

Latest Census figures show that 61% of the local population are White, 21% are Asian / Asian British and 9% are Black / Black British. There were 5% of the population who identified as being of mixed / multiple ethnicity and 4% stated their ethnicity as 'Other'[18].

Question 9: What is your immigration status? Please tick only one.

People were asked about their immigration status. There were 135 responses to this question.

[17] Source: Gov.uk (2022). Statutory homelessness in England: financial year 2021-22 - GOV.UK (www.gov.uk)
[18] Source: WV Insight (2023) Population - WVInsight (wolverhampton.gov.uk)

The majority of people were UK nationals (79.3%, n = 107), 11.9% were EEA citizens with settled status (n = 16) and 3.7% were EEA citizens with pre-settled status (n = 5) (Table 7).

UK nationals made up a significantly higher proportion of the Homeless Link cohort profile (92%) than was seen locally. Due to the changes in immigration rights for EEA citizens during the period of the Homeless Link research, data is not available for comparison.

Table 7: Immigration Status

Immigration Status	Count	Wolverhampton (%)	Homeless Link (%)
UK national	107	79.3%	92%
EEA citizen with settled status	16	11.9%	-
EEA citizen with pre-settled status	5	3.7%	-
Indefinite leave to remain/permanent residence	<5	2.2%	2%
Other (please state)	<5	1.5%	1%
Asylum seeker	<5	0.7%	0%
Refugee	<5	0.7%	0%
Limited leave to remain (all other)	0	0	-
Unknown	0	0	1%

People who are experiencing homelessness and who are not originally from the UK face many of the same challenges and barriers as those experiencing homelessness generally. However specific experiences, immigration status and associated entitlements can compound these even further.

Many migrants experience barriers to accessing the healthcare that they need and are entitled to. These are further exacerbated if their immigration status is insecure, and further still if they are experiencing homelessness too.

Question 10: Do you have recourse to public funds? Please tick only one.

People were asked whether they have recourse to public funds. There were 136 responses to this question.

Over three quarters said that they do have recourse to public funds (77.2%, n = 105), 11.8% were unsure whether they did (n = 16) and one in ten people said that they had no recourse to public funds (11%, n = 15).

Primary care consultations and treatment services are free to all people whether registering with a GP as an NHS patient or accessing NHS services as a temporary

patient. Secondary care services are however residence-based, meaning that only people living lawfully in the UK with settled status can access these services free of charge[19]. As a result, some people with restricted or undetermined eligibility may not be able to access all of the health care services they need. This may have significant implications for people locally, with more than one fifth either not having recourse to public funds or being unsure whether they do (22.8%).

Question 11: Do you consider yourself to have a disability? Please tick only one.

People were asked whether they consider themselves to have a disability. There were 133 responses to this question.

Over half considered themselves to have a disability (54.1%, n = 72). This was lower than that found by Homeless Link (63%) but significantly higher than that reported by adults in the general population in Wolverhampton (18%)[20] or nationally (22%)[21].

[19] Source: Gov.UK (2014). NHS entitlements: migrant health guide - GOV.UK (www.gov.uk) (updated 25 August 2023)
[20] Source WV Insight (2023). https://insight.wolverhampton.gov.uk/Home/Report/0e1f5524-eb14-49cc-a879-e19fcb734caa
[21] Source: Department for Work and Pensions (2023). Family Resources Survey: financial year 2020 to 2021 - GOV.UK (www.gov.uk) (updated 12 May 2023)

5. Physical Health

Key Findings

- Almost three quarters of people (73.7%) said they had been told by a doctor or health care professional that they had one or more physical health problems at the time of reporting. Almost four out of five people were living with multiple physical health problems.
- Joint aches / problems with bones and muscles, dental / teeth problems and difficulty seeing / eye problems were the top three most commonly reported physical health problems.
- Locally there was a higher prevalence of TB reported (5.9%) than found by Homeless Link nationally (1.0%). Positively, everyone locally had received treatment for their condition.
- Two fifths of people (40.7%) would like support or treatment for their physical health problem/s, or more help if they already receive some.
- Almost a third (32.6%) said that there was at least one occasion during the last twelve months where, in their opinion, they needed a medical examination or treatment for a physical health problem, but they did not receive it.
- Smoking prevalence was high amongst the audit cohort. Just over three quarters (76.7%) said that they smoked; a third of whom indicated that they would like to stop altogether (30.3%). Just over a quarter of all smokers (26.6%) said they had been offered support by a health professional to stop; half of whom had taken up the offer.

5.1. Purpose of this chapter

The purpose of this chapter is to present a summary of responses to the physical health questions (Q12 – 15b) within the audit.

5.2. Summary of Findings

Question 12: Has a doctor or health care professional ever told you that you have any of the following physical health problems? Please choose the appropriate response for each item.

People were asked to consider a list of physical health problems and highlight

which ones (if any) they were told they had before becoming homeless or after becoming homeless. In total, 135 people responded to this question. Two people chose not to answer any part of this question.

Of the total cohort, almost three quarters (73.7%, n = 101) reported that a doctor or health care professional had identified that they had at least one physical health problem. This is slightly lower than that found by Homeless Link (78%). Around a quarter of people (24.8%, n = 34) did not report having any physical health problems.

People were able to select multiple options. Table 8 ranks the top ten responses from most to least frequently reported.

Table 8: Physical health problem by rank

Physical Health Problem	Wolverhampton Rank (%)	Homeless Link Rank (%)
Joint aches / problems with bones and muscles	1 (41.6%)	1 (37%)
Dental / teeth problems	2 (28.5%)	2 (36%)
Difficulty seeing / eye problems	3 (22.6%)	4 (22%)
Fainting / blackouts	4 (18.2%)	7 (18%)
Stomach problems, including ulcers	5 (16.8%)	5 (20%)
Problems with feet	Joint 6 (16.1%)	6 (18%)
Asthma	Joint 6 (16.1%)	3 (24%)
Chronic breathing problems (bronchitis, emphysema or obstructive airways disease)	7 (14.6%)	9 (13%)
Skin / wound infection or problems	8 (13.9%)	8 (18%)
Heart problems	Joint 9 (11.7%)	10 (13%)
Liver problems	Joint 9 (11.7%)	-
Hearing loss (that affects your day-to-day life)	10 (10.2%)	-

Consistent with national research, most common issues were joint aches / problems with bones and muscles (56.4%, n = 57), and dental / teeth problems (51.5%, n = 52). The third most commonly reported physical health problem locally was difficulty seeing / eye problems (30.7%, n = 31); ranked as the fourth most common by Homeless Link.

Before becoming homeless

People were also asked to indicate whether their physical health problem/s had arisen before or after becoming homeless. Joint aches/problems with bones and muscles were mostly commonly reported as present **prior** to becoming homeless (38.6%, n = 39). This was followed by dental/teeth problems (30.7%, n = 31) and difficulty seeing/eye problems (that affect your day-to-day life) (18.8%, n = 19). The ranking of all three physical health problems was consistent with the overall findings picture.

After becoming homeless

There some slight variation in ranking of physical health problems identified **after** becoming homeless, although the top three problems themselves remained consistent. After becoming homeless, dental/teeth problems was the most frequently reported problem people faced (20.8%, n = 21), followed by joint aches / problems with bones and muscles (17.8%, n = 18) and difficulty seeing/eye problems (that affect your day-to-day life) (11.9%, n = 12).

Responses to 'Other' were varied and included problems such as lower back problems, sleep apnoea and arthritis, all n = <5 respectively.

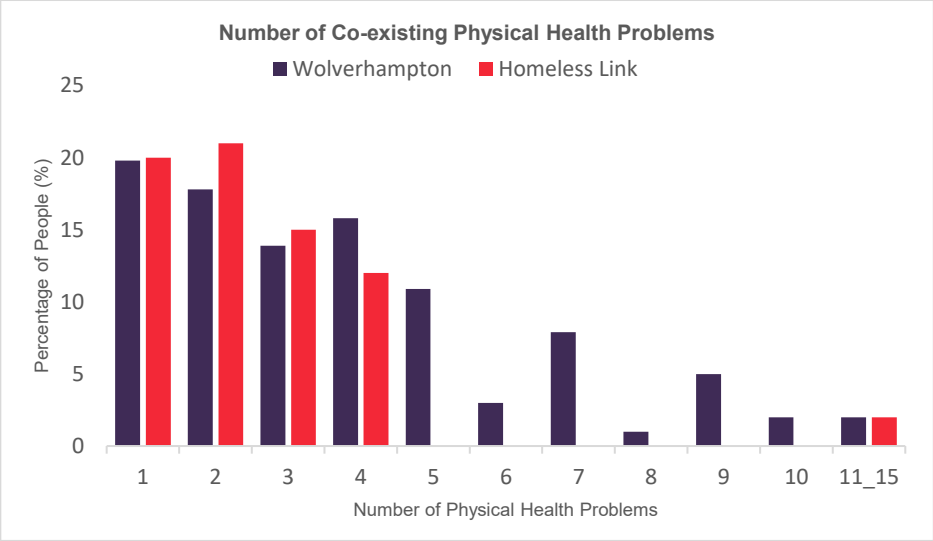
When comparing the top ten physical health problems reported locally with those found by Homeless Link, the problems experienced are the same, although the order in which they are experienced differs slightly (Table 8).

Co-existing physical health problems

For people who said that a doctor or health care professional had told them they had at least one physical health problem, a fifth (19.8%, n = 20) reported having a single problem; concurrent with findings from Homeless Link (20%).

Overwhelmingly, the majority of people responding to this question reported having multiple physical health problems (79.2%, n = 80); again, consistent with Homeless Link findings (80%). The level of co-morbidity experienced by people can be seen in Fig. 4.

Figure 4: Co-existing Physical Health Problems*



* Comparison data for some groupings is absent for Homeless Link due to the way they grouped their responses i.e. the use of a 5 - 10 physical health problems range. Using this method, Homeless Link report that 29% of their people reported having between 5 – 10 identified physical health problems. Applying this grouping methodology to local findings, 29.7% (n = 30) of people reported physical health problems within this range.

Question 13a. If yes to TB, have you received any treatment? Please tick only one.

There were six people who responded to Q12 and reported that they have previously been told by a doctor or health care professional that they had TB (5.9%), higher than that found by Homeless Link (1%).

Everyone that said that they had had TB were then asked whether they have received any treatment for their condition. Positively, all of the people who had TB reported they had received treatment (100%).

Question 13b. If yes to Hepatitis C, have you received any treatment? Please tick only one.

There were seven people who responded to Q12 and reported that they have previously been told by a doctor or healthcare professional that they have Hepatitis C (6.9%), slightly lower than the level identified by Homeless Link (8%).

They were then asked whether they have received any treatment for their Hepatitis C. In total, 85.7% (n = 6) said they had received treatment. The remaining people said they had been offered treatment but did not take it up.

Question 13c: If yes to any physical health needs, are you receiving support / treatment to help you with your physical health problem? Please tick only one.

People who had reported that they had previously been told that they have a physical health condition(s) by a doctor or healthcare professional were asked

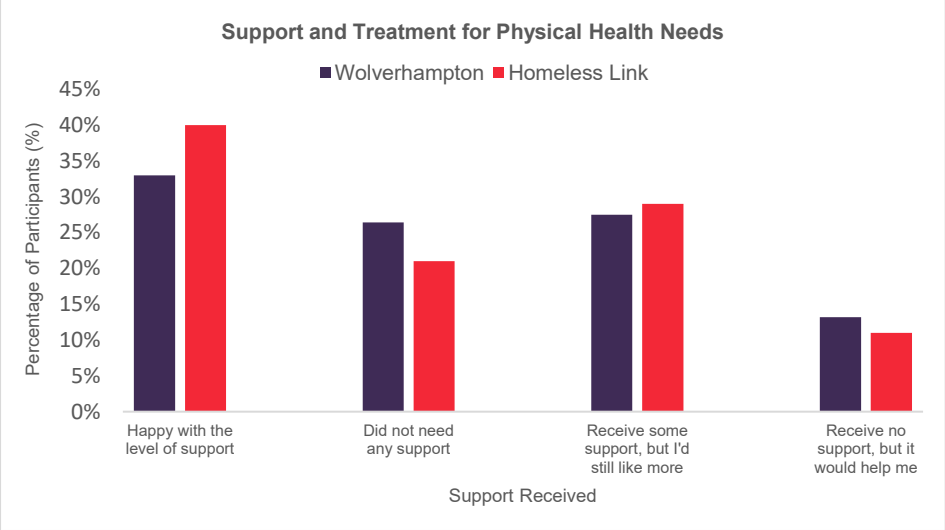
whether they were receiving any support/treatment to help them with their problem. There were 91 responses to this question.

A third of people (33%, n = 30) reported receiving treatment and support and felt as though the support/treatment they received met their needs, compared to 40% of all Homeless Link people (Fig. 5).

Just over a quarter (27.5%, n = 25) said that although they were receiving support / treatment, they felt as though they would still like more help. This was very similar the national findings (29%).

Similar levels reported not receiving any support or treatment for their physical health problems currently, but thought that having some would help them (13.2%, n = 12), again similar to the Homeless Link findings (11%).

Figure 5: Support and Treatment Received for Physical Heath Needs



Locally, 26.4% (n = 24) said they did not receive any support or treatment for their physical health problems and that they did not need any. This was slightly higher than the level found nationally (21%).

Question 14: Was there any time during the past twelve months when, in your opinion you needed a medical examination or treatment for a physical health problem, but you did not receive it? Please tick only one.

People were asked to think back over the last 12-month period and consider whether, in their opinion, they needed an assessment or treatment for a physical health problem, but they did not receive it.

There were 135 responses to this question. A third (32.6%, n = 44) of people reported that this had happened on at least one occasion.

This is slightly higher than Homeless Link's findings where 27% of respondents told them that they had not received a medical examination or treatment for a physical health condition when it was needed at some point within the last 12 months.

Question 14a: If yes to Q14, what was the main reason for not receiving the examination or treatment (the most recent time)? Please tick only one.

People who said 'yes' to Q14 (n = 44), were asked to provide the main reason for not receiving the assessment on the most recent occasion. People were asked to select only one reason.

There were 39 responses to this question. 'Other' was the most frequently reported response (43.6%, n = 17). Within 'Other' most commonly stated was 'there were no appointments available' (15.4%, n = 6) or 'due to Covid-19' (7.7%, n = <5).

'Could not receive treatment because of no address', 'Concerns about judgement from doctor/ reception staff/ examination/ treatment' and 'Wanted to wait and see if problem got better on its own' were the other options selected by people to indicate the main reason why they hadn't received an examination or treatment when, in their opinion, they should have - all 15.4%, (n = 6) respectively.

Question 15: Do you smoke cigarettes, e-cigarettes, cigars or a pipe? Please tick only one.

People were asked whether they smoke cigarettes, e-cigarettes, cigars or a pipe. There were 133 responses to this question.

More than three quarters (76.7%, n = 102) said yes, they do smoke cigarettes, e-cigarettes, cigars or a pipe, consistent with the findings by Homeless Link (76%).

The latest available Health Survey for England (2021) found that 12% of adults within the general population were current cigarette smokers, and 5% were e-cigarette smokers[22]. These figures are included as a helpful indication although a direct comparison with the HHNA findings above cannot be made as it does not include adults who smoke cigars or a pipe.

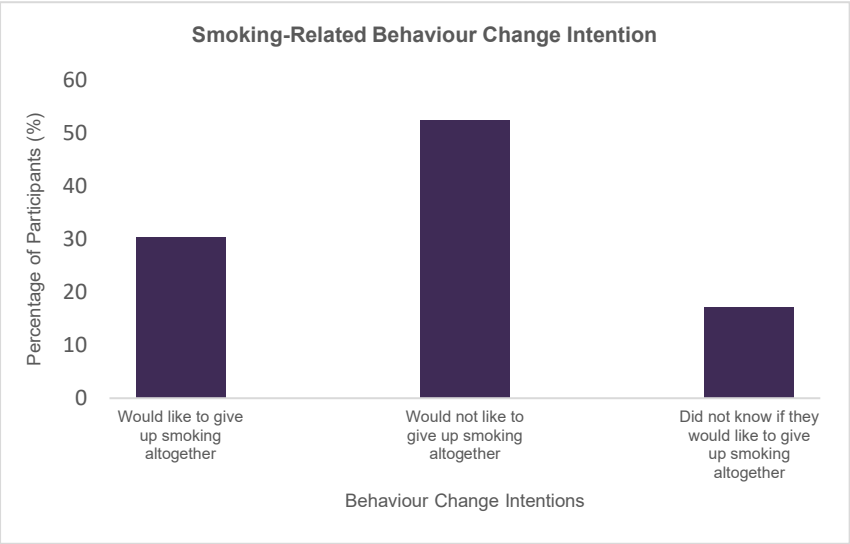
Question 15a. If yes to Q15, would you like to give up smoking altogether? Please tick only one.

People who said 'Yes' to Q15 were asked whether they would like to give up smoking altogether. There were 99 responses to this question.

Almost one third of people who smoke (30.3%, n = 30) said that they would like to give up smoking altogether; a much lower proportion of people than that reported by Homeless Link who found that half (50%) of people that smoked would like to stop (Fig. 6).

[22] Source: Office for National Statistics (2022). https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england/2021/adults-health-related-behaviours

Figure 6: Smoking-related Behaviour Change Intentions



Just over half of people who smoke (52.5%, n = 52) indicated that they did not want to give up smoking and just under one fifth (17.2%, n = 17) said that they did not know.

Question 15b. If yes to Q15, have you been offered help by a health professional to stop smoking? Please tick only one.

People who reported that they do smoke cigarettes, e-cigarettes, cigars or a pipe were asked whether they have been offered help by a health professional to stop smoking. There were 30 responses to this question.

In total, just over a quarter of people reported being offered help to stop smoking (26.6%, n = 8); 13.3% (n = <5) of which had gone on to that the offer up and an equivalent amount reported that they had declined the offer (13.3%, n = <5).

Nearly three quarters of people who smoked (73.3%, n = 22) said that they had not been offered help to stop by a health professional, substantially higher than Homeless Link's findings where 46% of people stated they had not been offered smoking cessation advice or help.

6. Mental Health

Key Findings

- Three quarters of people (77.4%) considered themselves to have one or more mental health conditions, compared to an estimated 12.3% of the population nationally.
- Nine out of ten people said that they experienced depression (91.5%) compared to 16% of adults in Britain.
- Types of support most commonly accessed to help with mental health conditions were medication (60.6%), Specialist Mental Health Workers (42.4%) and talking therapies (31.8%).
- Nearly 40% of people who had a mental health condition would like support or treatment for their condition, or more help if they already received some.
- One in three people felt that there was at least one occasion in the previous year where they needed an assessment or treatment for a mental health condition, but they did not receive it (31.3%). The main reasons cited were difficulty with accessing appointments (48.7%) and drug and alcohol use (23.1%).
- Over a third of people (35.8%) considered themselves to have a cognitive developmental condition(s); learning disability or difficulty being the most commonly reported (69.4%).
- One in ten people with a cognitive condition reported developing dementia **after** they became homeless (12.2%).
- Almost half of the people (48.5%) stated that they use drugs or alcohol to help them cope with their mental health ('self-medicating').

6.1. Purpose of this chapter

The purpose of this chapter is to present a summary of responses to the mental health and cognitive development questions (Q16 – 19) within the audit.

6.2. Summary of Findings

Question 16: Do you consider yourself to have any of the following mental health conditions? Please choose the appropriate response for each item.

People were asked to identify whether they experience any of a listed set of mental health conditions – and if so, whether that condition occurred before or after becoming homeless. One or more options could be selected.

There were 136 people who responded to this question. Only one person chose not to answer any part of this question.

Almost three quarters of people (77.4%, n = 106) reported that they have at least one mental health condition, slightly lower than that reported by Homeless Link (82%) but significantly higher than the NHS GP Patient Survey which was used as a national population comparison (12.3%)[23] – a difference of 65.1 percentage points, highlighting the severe disparity faced by people experiencing homeless.

Just over one in five people (21.9%, n = 30) did not report having any issues with their mental health.

Depression was most commonly reported by people who had one or more mental health conditions, with more than nine out of ten highlighting this as an issue they experience (91.5%, n = 97). In comparison, it is estimated that 16% of adults in the general population in Britain had moderate or severe depressive symptoms[24].

Anxiety disorder or phobia (84%, n = 89) and dual diagnosis (40.6%, n = 43) were the second and third most commonly reported mental health conditions experienced by people, consistent with those found by Homeless Link (Table 9).

Table 9: Prevalence of Mental Health Conditions

Mental health condition	Count	Wolverhampton Rank (%)	Homeless Link Rank (%)
Depression	97	1 (91.5%)	1 (72%)
Anxiety disorder or phobia	89	2 (84%)	2 (60%)
Dual diagnosis	43	3 (40.6%)	3 (25%)
Post Traumatic Stress Disorder	37	4 (34.9%)	4 (22%)
Psychosis	33	5 (31.1%)	5 (20%)
Eating disorder	22	6 (20.8%)	7 (12%)
Personality Disorder	19	7 (17.9%)	6 (15%)
Other	<5	8 (1.9%)	8 (5%)

[23] Source: NHS / IPSOS MORI (2022). NHS GP Patient Survey 2022.pdf
[24] Source: Office for National Statistics (2022). Cost of living and depression in adults, Great Britain - Office for National Statistics (ons.gov.uk)

Before becoming homeless

People were also asked to indicate whether their mental health problem/s had arisen before or after becoming homeless. Depression was most commonly reported as present **prior** to becoming homeless (71.7%, n = 76). This was followed by anxiety disorder or phobia (64.2%, n = 68) and dual diagnosis (28.3%, n = 30), reflecting the overall picture seen.

After becoming homeless

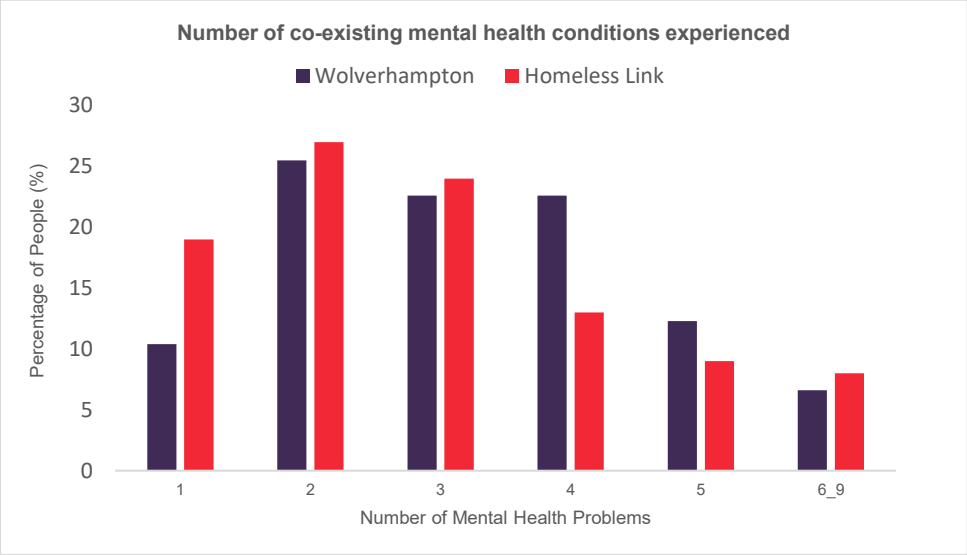
When considering what had happened **after** becoming homeless, the picture was again very similar. Onset of depression and anxiety disorder or phobia (19.8%, n = 21 respectively) were most commonly reported once a person had become homeless, followed by dual diagnosis (12.3%, n = 13).

NHS England suggests that approximately one in four people in the UK experience mental illness.[25] This is significantly lower than findings from the HHNA and similarly Homeless Link; both with around three in four people experiencing a mental health problem.

Co-existing mental health conditions

Almost nine out of every ten people who reported having a mental health condition, reported experiencing two or more conditions (89.6%, n = 95) and nearly one in five reported experiences of five or more (18.9%, n = 20) (Fig. 7).

Figure 7: Co-existing Mental Health Conditions



Question 16a: If YES to any of the mental health conditions, have any of these been diagnosed by a professional?

People who said 'yes', they did consider themselves to have a mental health condition (Q16), were then asked whether they had been diagnosed by a

[25] Source: NHS England. NHS England » Mental health

professional. A discrepancy was noted - whilst 106 people reported having a mental health condition, 111 responded to this question.

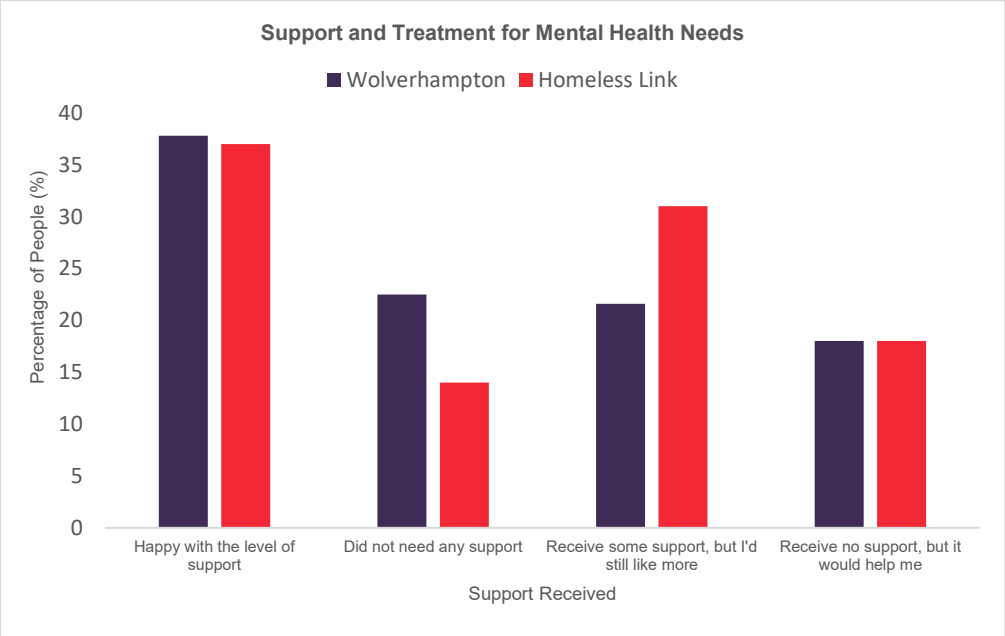
The majority of people said that their condition/s had been diagnosed by a professional (73%, n = 81). Just over a quarter (27%, n = 30) said they had not, indicating a possible group of people experiencing homelessness whose needs are currently unmet.

Question 16b: If YES to any mental health need: are you receiving support/ treatment to help you with your mental health condition? Please tick only one.

People who said 'yes' to Q16 were asked whether they were receiving any support or treatment to help them with their condition. Again, as with Q16a, there were 111 responses to this question.

Just under two thirds of people (60.4%, n = 67) were either happy with the level of support they were receiving (37.8%, n = 42) or did not feel like they needed any support (22.5%, n = 25) - slightly higher than the rate found by Homeless Link where half (51%) had reported this (Fig. 8).

Figure 8: Support and Treatment for Mental Health Needs



Although receiving some support or treatment, one in five people felt as though they would like more help (21.6%, n = 24). In comparison, almost a third of Homeless Link respondents (31%) felt this way.

Almost one in five people (18%, n = 20) reported not receiving any support or treatment for their mental health needs but said it would help them - consistent with Homeless Link's findings (18%).

Question 16c: If YES to Q16b, what type of support are you receiving? Tick all that apply.

People who said 'yes' to receiving support in Q16b, were then asked what type of support they were receiving. A total of 66 people responded to this question. Multiple options could be selected.

The most commonly reported type of support being received by people with a mental health condition was medication that had been prescribed to them (60.6%, n = 40), followed by support from a Specialist Mental Health Worker (42.4%, n = 28) and talking therapies (31.8%, n = 21) (Table 10).

Table 10: Support Received for Mental Health Needs

Support Received	Count	%
Medication that has been prescribed for me	40	60.6%
Support from a Specialist Mental Health Worker – e.g., Community Mental Health team, Community Psychiatric Nurse	28	42.4%
Talking therapies (e.g., counselling, CBT, psychological therapies)	21	31.8%
A service that deals with my mental health and drug/alcohol use at the same time	17	25.8%
Practical support that helps me with my day-to-day life	10	15.2%
Peer support - support from others who have been through a similar experience	9	13.6%
Activities like arts, volunteering or sport	<5	6.1%
Other	<5	6.1%
Training and activities to learn new skills/gain employment	<5	4.5%

Question 16d: If you would like to get help / or more help what support would you like to have? Tick all that apply.

People who reported that they would either like some help, or more help in q16b, were asked what support they would like to have. People had the option to select multiple responses. There were 44 responses to this question.

The responses to this question mirrored that of Q16c. Prescribed medication was reported to be the type of help that they would like or would like more of (63.6%, n = 28), followed by support from a Specialist Mental Health Worker (61.4%, n = 27) and access to talking therapies (56.8%, n = 25) (Table 11).

Table 11: Support Wanted for Mental Health Needs

Support Desired	Count	%
Medication that has been prescribed for me	28	63.6%
Support from a Specialist Mental Health Worker – e.g., Community Mental Health team, Community Psychiatric Nurse	27	61.4%
Talking therapies (e.g., counselling, CBT, psychological therapies)	25	56.8%
A service that deals with my mental health and drug/alcohol use at the same time	22	50%
Practical support that helps me with my day-to-day life	22	50%
Peer support - support from others who have been through a similar experience	19	43.2%
Activities like arts, volunteering or sport	19	43.2%
Training and activities to learn new skills/gain employment	16	36.4%
Other	<5	4.5%

Question 17: Was there a time during the last twelve months when, in your opinion, you personally needed an assessment or treatment for a mental health condition, but you did not receive it? Please tick only one.

People were asked whether in their opinion, in the last twelve months, they personally needed an assessment or treatment for a mental health condition, but they did not receive it. There were 134 responses to this question.

Almost a third of people felt that they needed an assessment or treatment for a mental health condition but did not receive one (31.3%, n = 42), slightly lower than that found by Homeless Link (37%).

Question 17a: What was the main reason for not receiving the assessment (the most recent time)? Please tick only one.

People who responded ‘yes’ to Q17, were then asked what they felt the main reason was for not receiving this support (during the most recent time). People were asked to select only one reason. There were 39 responses to this question. There were three people who chose not to answer this question.

Other was the main reason to have not received an assessment or treatment (48.7%, n = 19). 'Other' reasons included:

- Couldn't get an appointment
- Waiting for an appointment.

Drug and alcohol use was the second most commonly reported reason that people felt they did not get assessed or treated for their mental health condition (23.1%, n = 9), followed by people who 'wanted to wait and see if problem got better on its own' (15.4%, n = 6).

Cognitive Development

Question 18: Do you consider yourself to have any of the following cognitive conditions? Please choose the appropriate response for each item.

People were asked to consider a list of cognitive conditions and highlight which ones (if any) they considered themselves to have - before and after becoming homeless. People had the option to select multiple responses.

There were 131 responses to this question. There were six people who did not answer the question.

Almost 60% said that they did not consider themselves to have any cognitive condition (59.9%, n = 82).

Learning disability or difficulty was most commonly reported by people who considered themselves to have a cognitive condition (69.4%, n = 34) (Table 12). Almost 1 in 4 people (24.8%) reported that they have a learning disability; significantly higher than the estimated 2.2% of adults in the UK thought to have a learning disability[26,27].

Table 12: Cognitive Developmental Conditions

Cognitive developmental condition	Count	%
Learning disability or difficulty	34	69.4%
ADHD / ADD (attention deficit (hyperactivity) disorder)	17	34.7%
Autistic / Asperger's	6	12.2%
Dementia	6	12.2%

ADHD / ADD was the second most commonly reported cognitive condition experienced by people (34.7%, n = 17). This is much higher than the levels acknowledged by National Institute of Health and Care Excellence (NICE)[28] which estimate that ADHD affects around 3 - 4% of adults. This provides insight into the

[26] Source: ONS (2021). Estimates of the population for the UK, England, Wales, Scotland and Northern Ireland - Office for National Statistics (ons.gov.uk)
[27] Source: Public Health England (2015). People with learning disabilities in England 2015: Main report (publishing.service.gov.uk)
[28] Source: NICE (2022). Prevalence | Background information | Attention deficit hyperactivity disorder | CKS | NICE (Last revised in November 2022)

differences experienced by people experiencing homelessness and the general population, however due to differences in study methods, these cannot be directly compared.

One in ten people who said that they had a cognitive condition reported developing dementia **after** they became homeless (12.2%, n = 6).

Most people who reported having a cognitive condition had one of the listed conditions (75.5%, n = 37), one in five had two conditions (20.4%, n = 10) and 4.1% (n = <5) reported having three of the four cognitive developmental conditions listed.

Question 19: Do you use drugs or alcohol to help you cope with your mental health - this can be called 'self-medicating'? Please tick only one.

People were asked whether they self-medicate with drugs or alcohol to help them cope with their mental health. People were asked to select one response. There were 134 responses to this question.

Almost half stated that they used drugs or alcohol to help them cope with their mental health (48.5%, n = 65), similar to that found by Homeless Link (45%).

Almost one third (31.4%, n = 43) self-reported dual diagnosis of co-existing mental health and substance use needs; slightly higher than the 25% found by Homeless Link's research.

7. Drug and Alcohol Use

Key Findings

- Just over half of the people said that they had taken illicit drugs in the last 12 months (55.5%). Cannabis, crack and heroin were most commonly used.
- Nearly a third of people used drugs almost every day (30.1%) and one in three currently had or were in recovery from a drug problem (29.9%). Just under two thirds of people said that their drug use was not problematic (61.3%).
- Nearly half of the people who used drugs were receiving treatment or support and felt as though it met their needs (48.8%). One to one support, prescribed medication and group support were the most commonly accessed.
- Nearly three quarters of people had drank alcohol in the last 12 months (71.5%). When compared to the general population, reported unit volumes and frequency suggest that people experiencing homelessness are less likely to regularly drink to levels that exceed low risk guidelines.
- One in five people (20.4%) said that they have or are recovering from an alcohol problem; 28.6% of whom were accessing support that they were happy with. Advice and information, and counselling or psychological support were most commonly accessed.
- Being unable to get to appointments and waiting too long were common barriers identified in accessing treatment for both drug and alcohol use.

7.1. Purpose of this chapter

The purpose of this chapter is to present a summary of responses to the drug and alcohol use questions (Q20 – QWOL2) within the audit.

7.2. Summary of Findings – Drug Use

Question 20: In the past 12 months have you taken any of the following? Tick all that apply.

People were asked about their drug use (if any) in the past 12 months. People had the option to select all of the answers most relevant to them. There were 131 responses to this question. Six people chose not to answer this question.

In total, 40.2% (n = 55) reported that they have not used any drugs in the last 12 months.

Just over half (55.5%, n = 76) said that they had taken at least one of the listed drugs in the last 12 months, consistent with the findings by Homeless Link (54%) (Table 13). When considering levels of illicit drug use in the general population, this looks considerably different - ONS estimate that 9.2% of adults in the UK reported illicit drug use within the last year[29].

Table 13: Substance Use Over Last 12 Months

Drug	Count	Wolverhampton Rank (%)	Homeless Link Rank (%)*
Cannabis	63	1 (46.0%)	1 (41%)
Crack	35	2 (25.5%)	2 (24%)
Heroin	21	3 (15.3%)	4 (20%)
Cocaine	20	4 (14.6%)	3 (21%)
Medication not prescribed to you (e.g., Benzodiazepines, Codeine, illicit Methadone, Pregabalin)	15	5 (11.0%)	-
Spice/Mamba	9	6 (6.6%)	-
Mephedrone	9	6 (6.6%)	-
Amphetamine	7	7 (5.1%)	5 (8%)
Ketamine	6	8 (4.4%)	-
MDMA / ecstasy	6	8 (4.4%)	-
Other	5	9 (3.6%)	-
Methamphetamine	<5	10 (2.9%)	-

*The ranking list for Homeless Link is shorter due to a smaller number of options being presented to people to choose from. It is likely many of these options are captured by 'Other'.

Cannabis was the most commonly reported drug used by local people (46.0%, n = 63), slightly higher than the 41% of people in Homeless link's research. Nationally, 7.4% of adults aged 16 to 59 years and 16.2% of adults aged 16 to 24 years, reported having used cannabis in the last 12 months[30]. This comparison is presented as a helpful indication rather than a direct comparison due to the slight lower and upper age limit variation between population and HHNA cohorts.

[29] Source: ONS (2022). Drug misuse in England and Wales - Office for National Statistics (ons.gov.uk)
[30] Source: ONS (2022). Drug misuse in England and Wales - Office for National Statistics (ons.gov.uk)

Crack was the second most commonly reported drug used (25.5%, n = 35), followed by Heroin (15.3%).

Question 20a: How often have you used drugs during the last 12 months?

People were asked how often they have used drugs during the last 12 months. There were 73 responses to this question. Interestingly, there were 60 people who did not answer the question. The remaining people indicated 'not at all in the last 12 months' (2.9%).

Nearly a third of people said that they used drugs almost every day (30.1%, n = 22). Using drugs 'once or twice a week' and 'three or four days a week' followed, with one fifth (19.2%, n = 14) of people selecting each option respectively (Table 14).

Table 14: Frequency of Drug Use

Frequency	Count	%
Almost every day	22	30.1%
Once or twice a week	14	19.2%
Three or four days a week	14	19.2%
Once or twice a month	8	11.0%
Once every couple of months	7	9.6%
Five or six days a week	<5	5.5%
Once or twice a year	<5	5.5%

Question 21: How would you describe your relationship with drugs? Please tick only one.

People were asked to describe their relationship with drugs. There were 125 responses to this question. People were asked to select only one response. There were 12 people who chose not to answer the question.

Just over two thirds said that they have no problem with drugs (67.2%, n = 84).

One in five said that they do currently have a drug problem (19.2%, n = 24) and 13.6% said that they are in recovery (n = 17).

Overall, 32.8% (n = 41) said that they have or are recovering from a drug problem locally – slightly lower than that found by Homeless Link (38%).

Support and Treatment for Drug Use

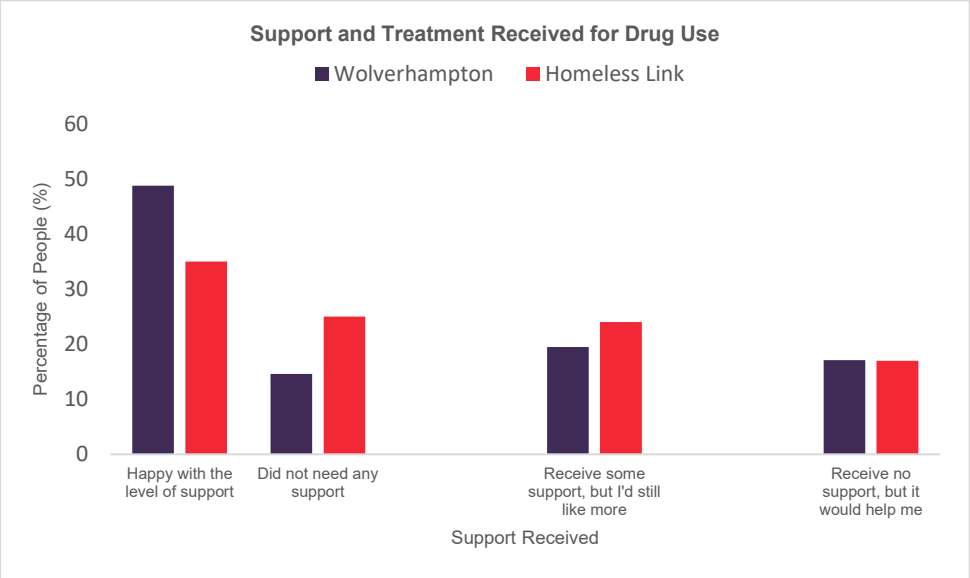
Question 21a: If you have, or are recovering from, a drug problem, are you receiving support/treatment to help you? Please tick only one.

People who said 'yes', they had a drug problem or were in recovery, were then asked whether they are receiving support and / or treatment to help them. People were asked to select only one response. There were 41 responses to this question.

Nearly half reported receiving treatment or support and felt as though the support / treatment they received met their needs (48.8%, n = 20). This was a more positive finding than that of Homeless Link where just over a third of people felt the same way (35%) (Fig. 9).

Around one in five people felt that although they were receiving support / treatment, they would still like more help (19.5%, n = 8); slightly lower than that found by Homeless Link (24%).

Figure 9: Support and Treatment Received for Drug Use



There were some people who did not currently receive any support or treatment for their drug problem but felt that it would help them to do so (17.1%, n = 7), equivalent to findings by Homeless Link (17%).

A small number of people said that they did not receive any support or treatment and that they did not need any (14.6%, n = 6). This was much lower than that found by Homeless Link (25%).

Question 22a: If YES to Q21a, what support are you receiving to help you address your drug use? Tick all that apply.

People who said that they were receiving support to help them to address their drug use, were then asked what support they were receiving. People had the option to select all of the answers that were relevant to them. There were 28 responses to this question – equivalent to the number of people who previously said that they received support.

One to one support was the most common type of support being received by people to help them address their drug use (64.3%, n = 18), followed by prescribed medication (60.7%, n = 17) and group support (17.9%, n = 5) (Table 15).

Table 15: Support Received for Drug Use

Support	Count	%
1-1 support	18	64.3%
Prescribed medication	17	60.7%
Group support	5	17.9%
Support (e.g., counselling, psychology services, aftercare)	<5	10.7%
Community detox/ community rehab	<5	7.1%
Other	<5	7.1%
Needle exchange	<5	3.6%

Question 22b: If you would like support, or more support, what would you like to have? Tick all that apply.

People who reported that they would either like support, or more support, were asked what support they would like to have. People had the option to select all of the answers most relevant to them. There were 15 responses to this question.

One to one support (73.3%, n = 11), prescribed medication (53.3%, n = 8) and group support (33.3%, n = 5) were the most commonly reported support types that people would like to have, or have more of (Table 16).

Table 16: Support Wanted for Drug Use

Support	Count	%
1-1 support	11	73.3%
Prescribed medication	8	53.3%
Group support	5	33.3%
Community detox/community rehab	<5	20.0%
Needle exchange	<5	13.3%
Mutual aid	<5	13.3%
Support (E.g., counselling, psychology services, aftercare)	<5	6.7%

Barriers

QWOL 1: Which of the following, if any, are a barrier to you accessing treatment? Tick all that apply.

People were asked about barriers (if any) to accessing treatment for their drug use. People had the option to select all of the answers most relevant to them. There were 41 responses to this question.

'Other' was most commonly reported as the main barrier to accessing treatment (19.5%, n = 8). Responses noted by people within 'Other' included:

- Finding time
- No information on Amphetamine misuse
- Haven't asked yet
- Relies on alcohol to deal with anxiety

This was followed by not being able to get to appointments (17.1%, n = 7) and waiting lists being too long (14.6%, n = 6) (Table 17).

Table 17: Barriers to Accessing Treatment for Drug Use

Barriers to access	Count	%
Other	8	19.5%
I can't get to appointments	7	17.1%
Waiting lists are too long	6	14.6%
I don't think I can do it alone	5	12.2%
I don't want withdrawal symptoms	<5	9.8%
I don't want to be judged	<5	7.3%
I don't want to right now	<5	7.3%
I don't think they can help me	<5	4.9%
The treatment I want isn't available	<5	4.9%

7.3 Summary of Findings – Alcohol Use

Question 23: How many units do you drink on a typical day when you are drinking? Please refer to flashcard to work this out.

People were asked about their alcohol use including how many units they drink on a typical day when they do drink. A flashcard explaining units was provided for those who were unsure (Appendix F).

There were 119 responses to this question. There were 18 people who chose not to answer the question.

In total, 40.3% (n = 48) of people said that they do not drink alcohol.

Units consumed on a typical day when drinking was clearly identifiable for 85.9% (n = 61) of people who said that they did drink alcohol (Table 18).

Table 18: Units on a Typical Day when Drinking

Units (on a typical day when drinking)	Count	%
1-3	13	10.9%
4-9	23	19.3%
10-19	11	9.2%
20-29	9	7.6%
30+	5	4.2%
Unit value not clear*	10	8.4%

*Unit value unclear for the following reasons: misunderstanding of what the question was asking, unsure of how many units typically consumed, and provision of number of drinks consumed rather than number of units.

People most frequently drank 4 – 9 units on a typical day when they were drinking alcohol (37.7%, n = 23).

To maintain consistency with the methodology used by Homeless Link, the low-risk guidelines for alcohol consumption from the Chief Medical Officer[31] were considered:

'To keep health risks to a low level, it is safest not to drink more than 14 units per week. For adults who drink as much as 14 units per week, it is best to spread this evenly over 3 days or more.'

People were considered to 'routinely exceed safe drinking guidelines' if they routinely consumed more than 14 units of alcohol per week. Regularly exceeding safe guidelines was reported by one in five people (21.9%, n = 30), consistent with findings from Homeless Link (20%), suggesting that people experiencing

[31] Source: Gov.UK (2016). UK Chief Medical Officers' Low Risk Drinking Guidelines (publishing.service.gov.uk)

homelessness are less likely than adults in the general population to regularly exceed safe drinking guidelines (24%)[32].

People were considered to 'exceed safe drinking guidelines when drinks' if they did not drink every week, but drank more than 14 units when they did drink (either once or twice a month, or once every couple of months). Homeless Link found that 3% of people exceeded safe drinking guidelines when they did drink, which was consistent with findings locally (2.9%, n = <5). This is much lower than the general population, where across England and Scotland, it is estimated that just over a quarter of adults (27%) binge drink on their heaviest drinking days[33].

According to the Health Survey for England (2021)[34], adults in the West Midlands (men and women) were the least likely to drink alcohol over the weekly safe drinking guidelines compared to any other region.

Question 23a: How often have you had an alcoholic drink during the last 12 months?

People were asked how often they have had an alcoholic drink during the last 12 months. There were 124 responses to this question.

Four out of five people (79.0%, n = 98) said that they had drank alcohol in the last 12 months, consistent to the levels estimated in the general population (79%)[35]. There is no Homeless Link comparison available for this question.

People who said that they had drank alcohol in the last year, were then asked how frequently they had consumed alcohol during this period (Table 19).

Table 19: Frequency of Drinking Alcohol

Frequency	Count	%
Almost every day	18	18.4%
Five or six days a week	7	7.1%
Once or twice a week	20	20.4%
Once or twice a month	20	20.4%
Once every couple of months	13	13.3%
Three or four days a week	10	10.2%
Once or twice a year	10	10.2%

[32] Source: Gov.UK (2016 – updated 2018). The public health burden of alcohol: evidence review - GOV.UK (www.gov.uk) (updated 10 August 2018)
[33] Source: ONS (2017). Adult drinking habits in Great Britain - Office for National Statistics (ons.gov.uk)
[34] Source: NHS Digital (2021). NHS Digital: Health Survey for England
[35] Source: NHS Digital (2021). NHS Digital: Health Survey for England

People most frequently reported drinking ‘once or twice a week’ and ‘once or twice a month’, both 20.4% (n = 20) respectively. The Health Survey for England (2021) estimated that half of adults in the general population drank alcohol at least once a week (49%)[36] suggesting that they are more likely to drink at that frequency than local people in the HHNA.

Nationally, it is estimated that 8.8% of males and 4.7% females drink alcohol almost every day[37]. In contrast, 18.4% of local people said that they drank at this frequency (n = 18).

Almost a fifth of people stated they had not drunk alcohol at all during this period (21%, n = 26). Nationally it is estimated that 16.6% of women and 12.6% of men do not drink alcohol at all[38]. Although indicative of drinking behaviours within the general population, these figures cannot be compared directly due to the inclusion of people aged 16-17, who were excluded from the local audit.

Question 24: How would you describe your relationship with alcohol?

People were asked to describe their relationship with alcohol. People were asked to select only one option. There were 131 responses to this question and 6 people who chose not to answer.

Just over three quarters of people (78.6%, n = 103) said that they did not have any problem with alcohol use. One in ten (9.9%, n = 13) said that their alcohol use was problematic, and 11.5% (n = 15) said that they were in recovery.

Homeless Link found that 29% reported currently having or being in recovery from problematic alcohol use, higher than the overall picture for people locally (21.4%, n = 28).

Support and Treatment for Alcohol Use

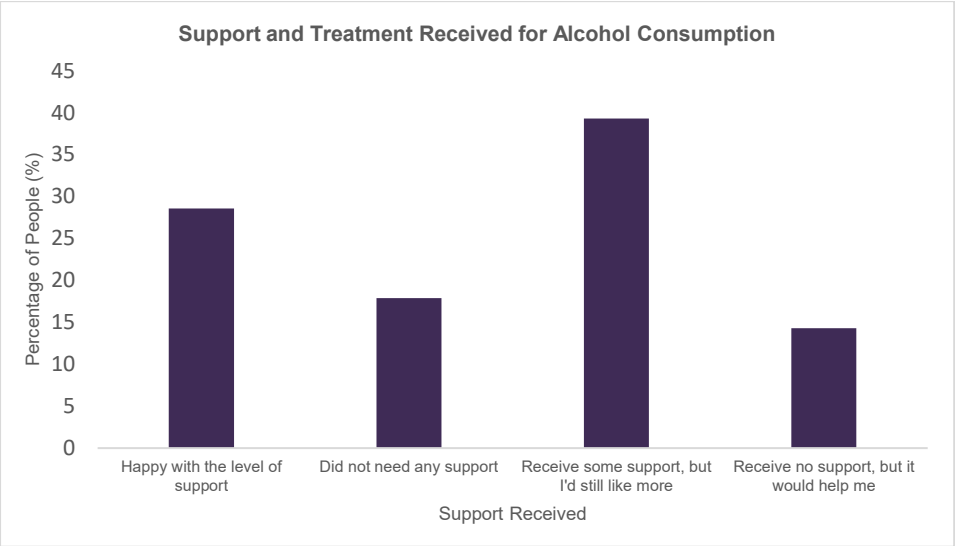
Question 24a: If you have, or are in recovery from, an alcohol problem, are you receiving support or treatment to help you? Please tick only one.

People who said that they either currently have or are recovering from an alcohol problem, were then asked whether they were receiving support or treatment to help them. People were asked to select only one response.

There were 28 responses to this question. More than a quarter said that they were receiving treatment or support and were happy with the level of support they had (28.6%, n = 8). Although receiving some support or treatment, 39.3% felt as though they would still like more help (n = 11) (Fig. 10).

[36] Source: NHS Digital (2021). NHS Digital: Health Survey for England
[37] Source: ONS (2022). UK health indicators - Office for National Statistics (ons.gov.uk)
[38] Source: ONS (2022). UK health indicators - Office for National Statistics (ons.gov.uk)

Figure 10: Alcohol Support and Treatment



A small number of people who were not currently receiving support or treatment, felt that it would help them if they did (14.3%, n = <5) and 17.9% did not receive any support and felt they did not need any (n = 5).

Question 24b: If YES to Q24a, what support are you receiving to help you address your alcohol use? Tick all that apply.

People who were receiving support to help them to address their alcohol use were asked what support they were receiving. People had the option to select all of the answers most relevant to them.

There were 19 responses to this question.

The most common type of support or treatment received was advice and information e.g. from GPs, A&E departments (42.1%, n = 8), followed by counselling or psychological support, reported by 31.6% (n = 6) (Table 20).

Locally, ‘Other’ was the third most common support type (21.1%, n = <5). Typically, ‘Other’ related to people being at the early stages of the process for receiving support or waiting for support to commence.

Table 20: Support Received for Alcohol Use

Support Received	Count	Wolverhampton Rank (%)	Homeless Link Rank (%)
Advice and information (e.g. from GPs, A&E departments)	8	1 (42.1%)	2 (40%)
Counselling or psychological support	6	2 (31.6%)	4 (19%)
Other	<5	3 (21.1%)	-
Community prescribing (drug treatment prescribed as part of a care plan)	<5	4 (15.8%)	7 (7%)
Detox (help with withdrawal as an inpatient)	<5	4 (15.8%)	7 (7%)
Aftercare (support following structured treatment)	<5	4 (15.8%)	6 (9%)
Peer support - support from others who have been through a similar experience	<5	5 (10.5%)	3 (31%)
Mutual Aid e.g. Alcoholics Anonymous	<5	6 (5.3%)	1 (54%)
Attendance at day programmes, delivered in the community	<5	6 (5.3%)	5 (16%)

Interestingly, when comparing these ranks to findings from Homeless Link, there was some variation; Mutual Aid was reported as the most common support type accessed by more than half of people (54%), followed by advice and information (40%) and Peer support (31%).

Question 24c: If you would like support, or more support, to address your alcohol use, what would you like to have?

Where people said that they have support but would like more, or didn't have support but thought it would help, they were then asked what support they would like to have. People had the option to select all of the answers most relevant to them.

There were 15 responses to this question.

The most common type of support requested was advice and information (e.g. from GPs, A&E departments) (73.3%, n = 11), followed by counselling or psychological support (60%, n = 9) and aftercare (support following structured treatment) (53.3%, n = 8) (Table 21).

Table 21: Support Wanted for Alcohol Use

Support Desired	Count	%
Advice and information (e.g. from GPs, A&E departments)	11	73.3%
Counselling or psychological support	9	60%
Aftercare (support following structured treatment)	8	53.3%
Peer support - support from others who have been through a similar experience	7	46.7%
Self-help groups, e.g. Alcoholics Anonymous	7	46.7%
Community prescribing (drug treatment prescribed as part of a care plan)	6	40%
Detox (help with withdrawal as an inpatient)	6	40%
Residential rehabilitation	6	40%
Attendance at day programmes, delivered in the community	<5	26.7%
Other	<5	6.7%

Barriers

QWOL2: Which of the following, if any, are a barrier to you accessing treatment? Tick all that apply.

People were asked about barriers (if any) to accessing treatment for themselves. People had the option to select all of the answers most relevant to them.

There were 28 responses to this question.

Not being able to get to appointments was the most commonly reported barrier faced by people (21.4%, n = 6). Length of time waiting to access treatment, the perception that professionals would not be able to help, and an uncertainty of going to treatment alone were all reflected as equally challenging for people when it came to accessing treatment (all 17.9%, n = 5 respectively) (Table 22).

Table 22: Barriers to Accessing Treatment for Alcohol Consumption

Barriers to treatment	Count	%
I can't get to appointments	6	21.4%
Waiting lists are too long	5	17.9%
I don’t think they can help me	5	17.9%
I don’t think I can do it alone	5	17.9%
I don’t want to right now	<5	10.7%
I don’t want withdrawal symptoms	<5	7.1%
I don’t want to be judged	<5	7.1%
Other	<5	7.1%
The treatment I want isn’t available	<5	3.6%

8. Access to Services

Key Findings

- Positively, most people were registered with a GP in the local area (90.2%). The proportion of people who said they were listed with a dentist was much lower (57.5%).
- There is a considerable difference in people not listed with and being refused access to a dentist, suggesting there may be a group that, despite the prominence of dental / teeth issues, are not engaging with universal dental services. The availability of the Special Care Dental Service locally may offer a positive alternative for some people, although this was not directly explored by the audit.
- People experiencing homelessness were, on average, more than twice as likely to have attended A&E in the past 12 months than the general population; with more than a quarter going on to be admitted to hospital at least once during that period (28.7%).
- Physical health problems or conditions were the most common reason for attending A&E, using an ambulance and being admitted into hospital. Neither drug use or domestic violence were reported as reasons for A&E attendance or ambulance use locally (both 0%) - inconsistent with Homeless Link findings.
- Just over a quarter of people (26.5%) said that they were not asked by hospital staff if they had somewhere suitable to go when discharged.
- Locally people were more likely to be discharged to suitable accommodation than people experiencing homelessness and hospitalised in other areas, however still more than one in five people who had been admitted to hospital (22.6%) were either discharged into accommodation that was not suitable for their needs (12.9%) or discharged to the street (9.7%).

8.1. Purpose of this chapter

The purpose of this chapter is to present a summary of responses to the access to services questions (Q25 – 27d) within the audit.

8.2. Summary of Findings

Primary Health Care

Question 25: Are you registered with these services in your local area? Please choose the appropriate response for each item.

a) General Practice

People were asked whether they were registered with a GP in the local area. There were 132 responses to this question.

Most people (90.2%, n = 119) were registered with a GP in the local area. A small but noticeable number of people (9.8%, n =13) were not registered.

b) Homeless Healthcare Service

People were asked whether they were registered with a Homeless Healthcare Service in their local area. There were 112 responses to this question.

In total, 16.1% (n = 18) were registered with a Homeless Healthcare Service in their local area and 83.9% (n = 94) were not.

Homeless Link's research found that 97% were registered with a GP or Homeless Healthcare Service. These findings may be in some way affected by the Local Authority areas which have previously completed the audit and the service arrangements they have for people experiencing homelessness.

c) Dentist

People were asked whether they were listed with a dentist in their local area. There were 120 responses to this question.

The proportion of people that were listed with a dentist was much lower than GP registration with just over half of people reporting that they were listed with a dentist locally (57.5%, n = 69); similar to the findings from Homeless Link (53%).

It is acknowledged that the general population are also facing challenges in accessing universal dental care at this time. It is however not currently possible to make a direct comparison regarding general population access to a dentist.

Question 26: Have you been refused registration to a GP, homeless healthcare service, or dentist in the past 12 months? Please choose the appropriate response for each item.

a) GP

People were asked whether they had been refused registration to a GP in the past 12 months. There were 134 responses to this question.

A small number of people had experienced this (4.5%, n = 6); similar to the 6% of respondents to in Homeless Link's research who reported having been refused registration to either a GP or homeless healthcare service.

b) Homeless Healthcare Service

People were asked whether they had been refused registration to a Homeless Healthcare Service in the past 12 months. There were 119 responses to this question.

No one reported experiencing this.

c) Dentist

People were asked whether they had been refused access to a dentist in the past 12 months. There were 121 responses to this question.

A small number of people (5.0%, n = 6) had experience of being refused access to dental services, lower than that found by Homeless Link where one in ten people (10%) had been refused access to a dental practice.

Notably the number of people who had been refused access to a dentist was much lower than those not listed which may suggest that there are a group of people who are not engaging with universal dental health care despite the high rate of dental / teeth problems reported in Chapter 5.

The Wolverhampton Special Care Dental Service[39] provides dental care and treatment for special care patients living in the area or with a Wolverhampton GP, who may have difficulty obtaining care in general dental services, including people experiencing homelessness. The availability of this service locally may provide a positive alternative route of access for people although this was not explored directly by the audit survey.

Question 26a: If yes to Q26, why were you refused access?

a) GP

People who had been refused GP registration were asked why. There were 5 responses to this question.

Reasons varied and included:

- Being banned from the surgery
- Not being within the catchment area
- Being unable to obtain their NHS number.

Reasons found by Homeless Link for refusal to register with a GP or a Homeless Healthcare Service also included being outside of the catchment area for the service. Other reasons included:

- No photo ID
- No address.

[39] Source: The Royal Wolverhampton NHS Trust (2023). Wolverhampton Special Care Dental Service (WSCDS) (royalwolverhampton.nhs.uk)

b) Homeless Healthcare Service

There were no responses to this question, consistent with no people reporting that they had been refused access to this type of service in Q26.

c) Dentist

People who reported that they had been refused access to a dentist in their local area were asked why. There were six responses to this question.

All reasons for refusal related to the dentist not taking on new patients. This is consistent with the picture reported by Homeless Link, however they also highlighted:

- Frequently missed appointments
- Having no address.

Utilisation of Health Services

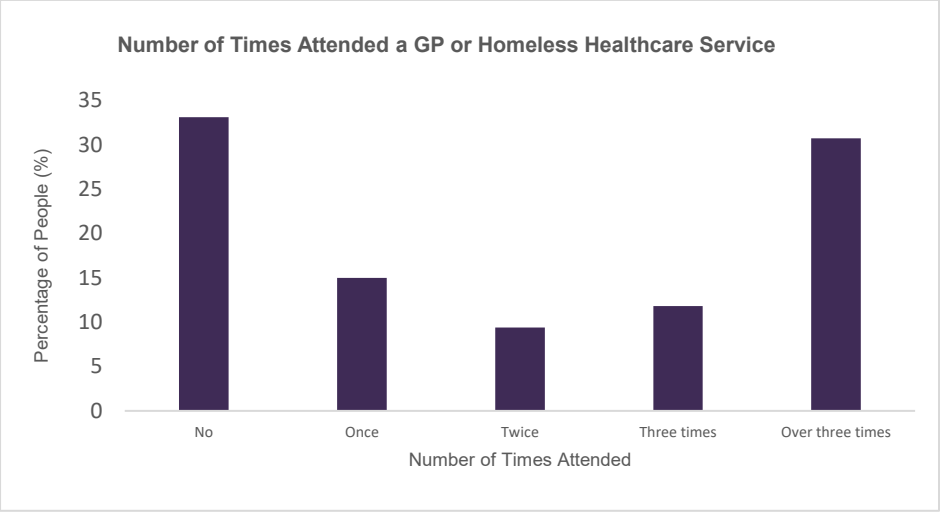
Question 27: In the last 12 months have you been to:

a) GP or Homeless Healthcare Service

People were asked whether in the last 12 months, they had been to a GP or a homeless healthcare service. There were 127 responses to this question.

Two thirds of people had been to a GP or homeless healthcare service at least once in the last 12 months (66.9%, n = 85). Of those, 45.9% (n = 39) had been more than three times during that period. Figure 11 summarises these findings.

Figure 11: Attendance to a GP or Homeless Healthcare Service



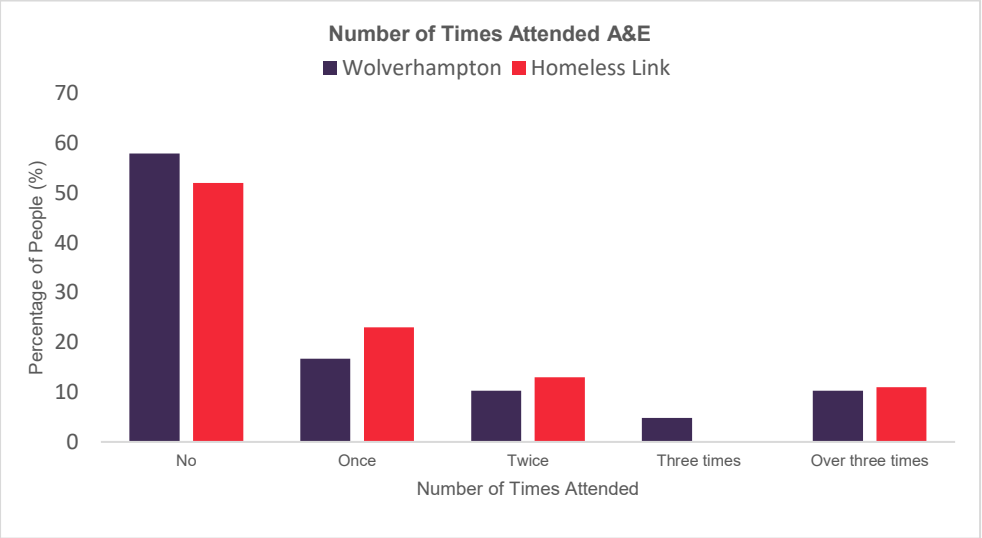
In England, 69% of men and 82% of women had consulted a GP in the last 12 months[40]. With the majority of people in the local cohort being male, these findings could be considered broadly similar.

b) Accident and Emergency

People were asked whether they had been to the Accident and Emergency (A&E) department in the last 12 months. There were 126 responses to this question.

Almost six in ten people had not been to A&E during this period (57.9%, n = 73). However, 42.1% (n = 53) of people had been; of which a quarter had attended more than three times (24.5%, n = 13) (Fig. 12). In comparison, Homeless Link found 48% of people had been to A&E in the last year, 11% of whom had also attended more than three times.

Figure 12: Attendance at A&E



On average, people used A&E services 0.9 times a year; identical to Homeless Link findings and over two times higher than that seen in the general population (0.4)[41]. People experiencing homelessness are known to be more frequent users of A&E services[42], particularly people who are sleeping rough. Practical barriers to access, such as having resources to travel to healthcare services, add to the challenges of getting help before becoming acutely unwell.

For consistency, average use calculations carry forward the assumption made by Homeless Link that everyone who responded 'over three times' used A&E services four times. This could present an underestimation of the average usage of A&E services by people experiencing homelessness.

[40] Source: ONS (2020) Health Survey for England. Main Findings - NDRS (digital.nhs.uk)
[41] Source: NHS Digital (2022). Hospital Accident & Emergency Activity 2021-22 - NDRS (digital.nhs.uk)
[42] Source: Reilly, J.,et al (2020). Accident and emergency department attendance rates of people experiencing homelessness by GP registration: a retrospective analysis - PMC (nih.gov)

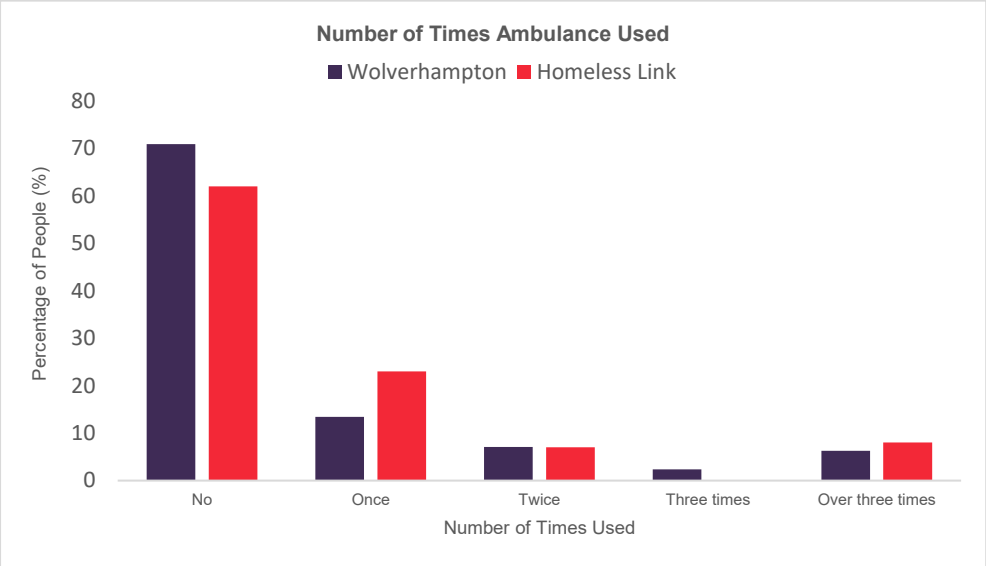
c) Used an ambulance

People were asked whether in the last 12 months, they had used an ambulance. There were 127 responses to this question.

Almost one in three people (29.1%, n = 37) had used an ambulance at least once during the period; lower than that seen by Homeless Link (38%) (Fig. 13).

A small number of people (6.3%, n = 8) had used an ambulance more than three times; again, slightly lower that that found by Homeless Link (8%).

Figure 13: Times Using an Ambulance



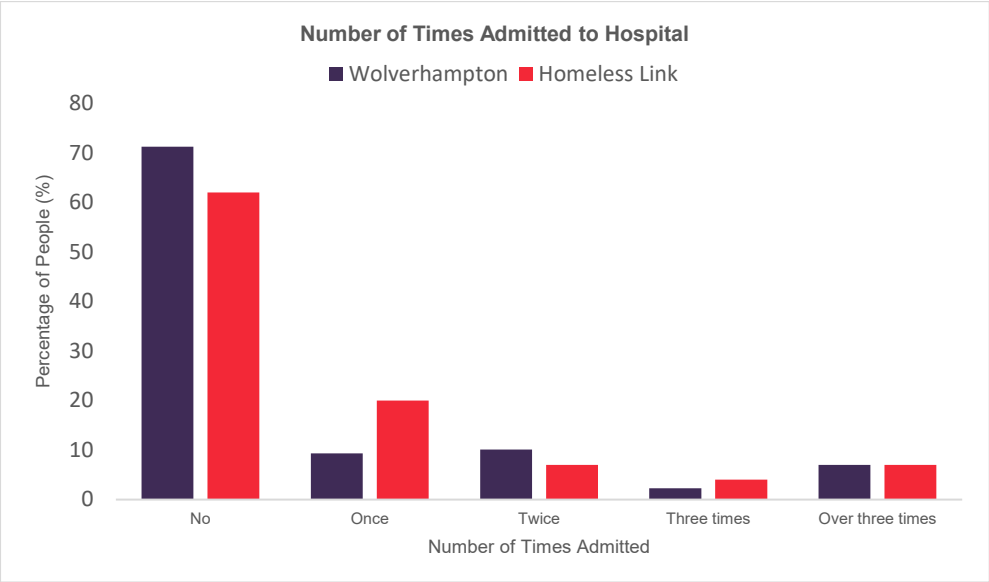
d) Been admitted to hospital

People were asked whether they had been admitted to hospital in the last 12 months. There were 129 responses to this question.

More than a quarter (28.7%, n = 37) had been admitted to hospital at least once in the last 12 months (Fig. 14); lower than that reported by Homeless Link (38%) but considerably higher than that seen nationally. In England, 7.3% of men and 8.5% of women reported being admitted to hospital overnight or longer in the previous 12 months[43].

[43] Source: Office for National Statistics (2022). UK health indicators - Office for National Statistics (ons.gov.uk)

Figure 14: Times Admitted to Hospital



A small proportion of people locally (7.0%, n = 9) and included in Homeless Link's research (7.0%) had been admitted to hospital over 3 times during that period.

Question 27a: If you have used any of A&E, hospital or ambulance in the past 12 months, what was the reason why you last used it? Please select the reason which best fits the primary cause of using the service or use the other box if the reason is not listed.

a) Accident and Emergency

People were asked about their reason for attending A&E in the past 12 months. People were asked to select one reason. There were 37 responses to this question.

Physical health problems or conditions was the most commonly reported reason for attending A&E locally (37.8%, n = 14) and within Homeless Link's findings (32% (Table 23).

Homeless Link saw self harm / attempted suicide (18%) and mental health problems or conditions (14%) follow whereas locally 'Other' was the next most common reason for A&E attendance (21.6%, n = 8). Reasons relating to physical or mental health problems / conditions were most frequently mentioned in 'Other' along with:

- Epilepsy
- Accident / Injury
- Food / supplement poisoning

Table 23: Main Reason for Using A&E

Reason for using A&E	Count	Wolverhampton Rank (%)	Homeless Link Rank (%)
Relating to a physical health problem or condition	14	1 (37.8%)	1 (32%)
Other	8	2 (21.6%)	0%
Self-harm/attempted suicide	<5	3 (10.8%)	2 (18%)
Relating to a mental health problem or condition	<5	3 (10.8%)	3 (14%)
Accident	<5	3 (10.8%)	4 (10%)
Other violent incident or assault	<5	4 (2.7%)	5 (7%)
Relating to alcohol use	<5	4 (2.7%)	5 (7%)
Relating to childbirth or pregnancy	<5	4 (2.7%)	8 (1%)
Relating to drug use	0	-(0%)	6 (6%)
Domestic violence	0	-(0%)	7 (4%)

Locally attendance for self-harm / attempted suicide and mental health problem or condition combined accounted for 21.6% of the total reasons.

Whilst ranking six and seven in the reasons for attendance found by Homeless Link, neither drug use nor domestic violence were highlighted by people locally as reasons for going to A&E (both 0% respectively).

b) Ambulance

People were asked about their reason for using an ambulance in the past 12 months. People were asked to select only one reason. There were 26 responses to this question.

As with A&E attendance, physical health problems or conditions were the most common reported reason for using an ambulance (23.1%, n = 6). Whilst consistent with Homeless Link in terms of rank, the proportion of their respondents stating physical health as the reason was significantly higher (38%) (Table 24).

Table 24: Main Reason for Using Ambulance

Reason for using an Ambulance	Count	Wolverhampton Rank (%)	Homeless Link Rank (%)
Relating to a physical health problem or condition	6	1 (23.1%)	1 (38%)
Other	5	2 (19.2%)	0%
Self-harm/attempted suicide	<5	3 (15.4%)	2 (14%)
Relating to a mental health problem or condition	<5	3 (15.4%)	3 (13%)
Accident	<5	3 (15.4%)	7 (5%)
Other violent incident or assault	<5	4 (3.8%)	5 (9%)
Relating to alcohol use	<5	4 (3.8%)	6 (6%)
Relating to childbirth or pregnancy	<5	4 (3.8%)	8 (1%)
Relating to drug use	0	0	4 (12%)
Domestic violence	0	0	8 (1%)

Whilst not featuring at all in the Homeless Link findings, again 'Other' was the second most common reason for using an ambulance locally (19.2%, n = 5). Other reasons included:

- Food poisoning
- Epilepsy
- Physical or mental health problems/conditions

One in three people needed to use an ambulance because of self-harm / attempted suicide or mental health problems or conditions (30.4%) compared to 27% seen by Homeless Link.

Consistent with the picture seen for A&E attendance, neither drug use or domestic violence featured as a reason for using an ambulance locally but ranked fourth and eighth respectively in findings from Homeless Link.

c) Admission to hospital

People were asked about their reason for being admitted to hospital in the last 12 months. People were asked to select one reason. There were 23 responses to this question.

Physical health problems or conditions were the most common reason for being admitted to hospital (21.7%, n = 5), albeit again a significantly lower rate than that seen by Homeless Link (37%) (Table 25).

Table 25: Main Reason for Hospital Admission

Reason for hospital admission	Count	Wolverhampton Rank (%)	Homeless Link Rank (%)
Relating to a physical health problem or condition	5	1 (21.7%)	1 (37%)
Relating to a mental health problem or condition	<5	2 (17.4%)	2 (15%)
Other	<5	2 (17.4%)	4 (11%)
Self-harm/attempted suicide	<5	3 (13%)	3 (13%)
Accident	<5	4 (8.7%)	8 (3%)
Other violent incident or assault	<5	4 (8.7%)	5 (8%)
Relating to alcohol use	<5	5 (4.3%)	7 (5%)
Relating to drug use	<5	5 (4.3%)	6 (6%)
Relating to childbirth or pregnancy	<5	5 (4.3%)	9 (1%)
Domestic violence	0	0	9 (1%)

Almost one third of admissions (30.4%, n = 7) were either related to a mental health condition or self-harm / attempted suicide compared to just over a quarter of admissions (28%) seen by Homeless Link.

'Other' accounted for 17.4% of reasons for admission (n = <5) and included:

- Overdose on caffeine supplement
- Reasons related to physical and mental health.

Hospital Admission and Discharge

The Homelessness Reduction Act 2017[44] introduced a legal duty on specified public services to refer people they consider may be homeless or threatened with homelessness to a local housing authority.

For health services, this duty particularly focuses on NHS trusts and Foundation Trusts who provide the following NHS health services:

- accident and emergency services in a hospital
- urgent treatment centres
- in-patient treatment (of any kind)[45].

[44] Source: Gov.UK (2017). Homelessness Reduction Act 2017 (legislation.gov.uk)
[45] Source: Department for Health and Social Care (2018). Homelessness: duty to refer – for NHS staff - GOV.UK (www.gov.uk)

In 2020, the Royal College of Emergency Medicine published best practice guidelines for inclusion health in the emergency department; for patients who are homeless or socially excluded[46]. The guidelines make specific reference to the legislation and expectations for emergency department staff.

Nationally, Hospital A&E, Urgent Care Centre and Inpatient Care accounted for 6% of referrals made to Local Authorities[47]. Locally, there were no referrals made to City of Wolverhampton Council in the same way (0%). This difference may be explained in part by the availability of the Hospital Discharge Service commissioned by Black Country Integrated Care Board (Wolverhampton Place) and CWC.

People who had reported being admitted to hospital in the 12 months prior to completing the survey were asked to complete three further questions about their most recent admission.

Question 27b: Did staff ask you if you had somewhere suitable to go when you were discharged? Please tick one only.

People who had been admitted to hospital were then asked whether staff had checked that they had somewhere suitable to go when discharged. There were 34 responses to this question.

More than half (58.8%, n = 20) said that a member of hospital staff had asked if they had somewhere suitable to go when they were discharged; this was a lower proportion than that found by Homeless Link, where 67% of people had been asked if they had somewhere safe and appropriate to go.

Just over a quarter of people (26.5%, n = 9) said they were not asked and the remaining 14.7% (n = 5) could not remember.

Question 27c: When you were discharged from hospital where did you go? Please tick only one.

People who had been admitted to hospital, were asked where they went when they were discharged. There were 31 responses to this question.

Nearly three quarters were discharged into accommodation that was suitable for their needs (74.2%, n = 23); compared to 55% of people in the Homeless Link cohort (Fig. 15).

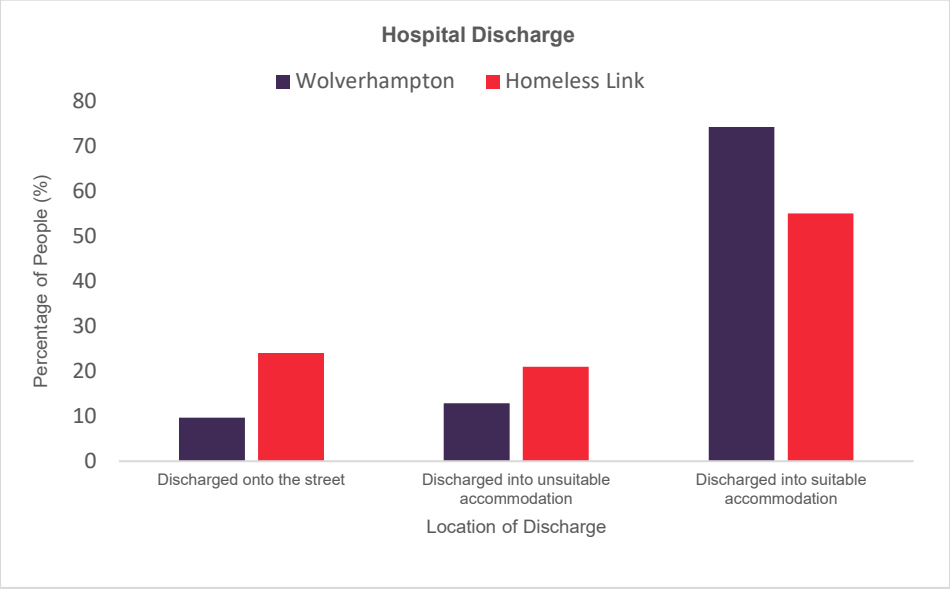
These findings suggest that locally people are more likely to be discharged to suitable accommodation than people experiencing homelessness and hospitalised in other areas, however there are still some people that did not report such a positive experience.

More than one in ten (12.9%, n = <5) said that they were discharged into accommodation that was not suitable for their needs and 9.7% (n = <5) were

[46] Source: The Royal College of Emergency Medicine (2020). Homelessness_and_Inclusion_Health.pdf (rcem.ac.uk)
[47] Source: Department for Levelling Up, Housing and Communities (2022). Statutory homelessness in England: financial year 2021-22 - GOV.UK (www.gov.uk)

discharged to the street; considerably lower than findings from Homeless Link where one in five (21%) people experiencing homelessness were discharged to unsuitable accommodation and almost a quarter were discharged to the street (24%).

Figure 15: Location after Hospital Discharge



Question 27d: After being discharged, were you readmitted within 30 days? Please tick only one.

People who had been discharged from hospital, were asked whether they were readmitted within 30 days. There were 35 responses to this question.

Positively, more than three quarters of people (77.1%, n = 27) had not been readmitted within 30 days of being discharged.

There were a small number of people (14.3%, n = 5) who had been readmitted during that period however this was a considerably lower rate of readmission compared to that seen by Homeless Link where a quarter of people (26%) had been readmitted to hospital within 30 days.

A further 8.6% (n = <5) could not remember.

9. Staying Healthy

Key Findings

- Over a quarter of people (28%) reported that their health was better now when compared to twelve months ago. Almost two in five (39.4%) said it was about the same and a third (32.6%) said it was worse now than it had been previously.
- Close to two thirds of people (60.9%) said that they were currently taking prescribed medication compared to 54% of adults in the most deprived areas in the country.
- Locally, take up of full or partial (at least one) vaccination against Hepatitis B was considerably lower (20.7%) than found by Homeless Link nationally (37%).
- Just under one in five people (19.1%) had had a sexual health check in the 12 months; 27.5% did not know where to access free contraception and around a quarter (24%) did not know where to access sexual health advice.
- For those eligible, just under half (43.8%) said that they had not had a cervical smear and four in five (80%) had not had a breast examination / mammogram within the relevant screening periods.
- The majority of people who required sanitary products had access to them (90.0%).
- There were clear indications of poor nutrition and food insecurity. One in three people said that they ate on average one meal or fewer each day (30%), and two thirds (66.4%) ate one or fewer portions of fruit and vegetables per day.

9.1 Purpose of this Chapter

The purpose of this chapter is to present a summary of responses to the staying healthy questions (Q28 – 43) within the audit.

9.2 Summary of Findings

Question 28: To help people say how good or bad a health state is, we have a scale on which the best state you can imagine is 100 and the worst state you can imagine is marked 0. We would like you to indicate on this scale how good or bad your own health is today, in your opinion? Please do this by saying where on this scale your health state is today.

People were asked to indicate how good or bad their state of health by selecting a number between 0 and 100. There were 127 responses to this question.

The average score people gave their health state on the day of the audit was 57.2 out of 100 (Table 26).

Table 26: Health State Rating of People

Health State Score	Count	%
0 – 30	22	17.3%
31 – 70	64	50.4%
71 – 100	41	32.3%

Locally, 42.1% of Wolverhampton residents described their health as 'very good' and 35.3% as 'good'. Those who described their health as 'bad' equated to 5.4% and 1.6% said their health was 'very bad'[48].

Question 29: Compared to twelve months ago, how would you say your health is now? Please tick only one.

People were asked to compare their health state now to their health 12 months ago. There were 132 responses to this question.

More than a quarter (28%, n = 37) said that their health was better now than it had been 12 months ago whilst 39.4% (n = 52) felt that it was about the same.

One third (32.6%, n = 43) said that their health was worse now than it had been previously.

This information was not reported by Homeless Link so there are no comparisons available.

Medication

Question 30: Are you taking any medication prescribed for you at the moment? This includes medicines, pills, syrups, ointments, puffers or injections. Please tick only one.

People were asked whether they were taking any prescribed medication. There were 128 responses to this question.

[48] Source: Office for National Statistics (2023). How life has changed in Wolverhampton: Census 2021 (ons.gov.uk)

In total, 60.9% of local people (n = 78) said that they were taking some form of prescribed medication at the time of the survey; lower than that seen by Homeless Link (71%) but higher than that found in the general population where 48.9% of men and 56.8% of women had taken some form of prescribed medication in the last two weeks[49]. This higher rate could in part be explained by participants in receipt of methadone script although further investigation is required.

Nationally, people living in the most deprived areas of the country were more likely to be taking some form of prescribed medicines than those living in the least deprived areas (54% vs. 45% respectively)[50]. Overall rates of prescribing, prescribing duration and the rate of prescribing more than one class of medication all increase with higher rates of deprivation[51]. This indicates a strong link between health inequalities and low income, with an even more pronounced effect for people experiencing homelessness where poverty is inextricably linked.

Question 31: Are you able to access your medication?

People were asked whether they are able to access their medication. There were 78 responses to this question.

The majority of people (98.7%, n = 77) said that they were able to access their medication. This is slightly higher than Homeless Link's findings, which found 93% of respondents were able to access their medication.

Question 32: If NO, what is the reason for not being able to access medication? Tick all that apply.

People who said that they were unable to access their medication were asked about the reason for this.

Only 1.3% of people (n = <5) said that they were unable to access their medication, but no reasons were given as to why this was the case.

Vaccinations

Hepatitis B

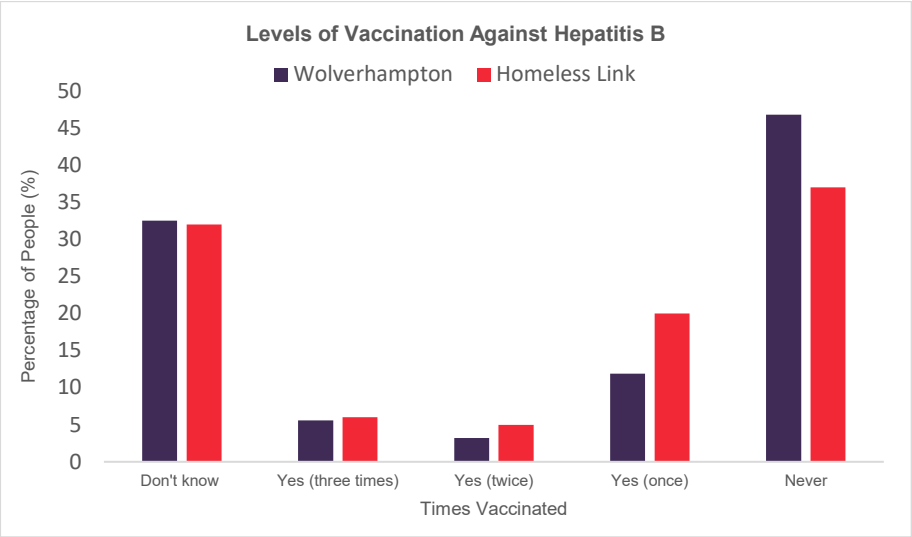
Question 33: Have you been vaccinated against Hepatitis B? Please tick only one.

People were asked whether they have been vaccinated against Hepatitis B. There were 126 responses to this question.

Only 5.6% (n = 7) reported being fully vaccinated against Hepatitis B; concurrent with Homeless Link's research findings (6%). A further 15.1% of people (n = 19) said that they had had at least one Hepatitis B vaccination; a significantly lower rate, in fact half, of that found by Homeless Link (31%) (Fig. 16).

[49] Source: Office for National Statistics (2022). UK health indicators - Office for National Statistics (ons.gov.uk)
[50] Source: NHS Digital (2017 – edited 2021). Health Survey for England, 2016 - NHS Digital
[51] Source: Public Health England (2019). Prescribed medicines review: report - GOV.UK (www.gov.uk)

Figure 16: Levels of Vaccination Against Hepatitis B



Almost half of people (46.8%, n = 59) said they had not been vaccinated against Hepatitis B, almost 10 percentage points higher than found by Homeless Link and around a third (32.5%, n = 41) were unsure if they had been vaccinated at all.

COVID-19

During the COVID-19 pandemic, the Joint Committee on Vaccination and Immunisation (JCVI)[52] advised the UK Government to prioritise people experiencing homelessness for COVID-19, recognising the high level of underlying health conditions which put many at increased risk of poor outcomes as a result of COVID-19 infection.

Question 34: Have you had the COVID-19 vaccination? Please tick only one.

People were asked whether they had been vaccinated against COVID-19. There were 130 responses to this question and seven people chose not to answer.

Almost 60% of people said that they had received one or more COVID-19 vaccinations (58.5%); 35.4% (n = 46) said that they had received at least one vaccination and 23.1% (n = 30) said that they had received their first and second dose and their booster. There were 41.5% of people who had not received any Covid-19 vaccinations (n = 54).

COVID-19 was not reported by Homeless Link so no direct comparisons can be made.

Question 34a: If you have not had the vaccine, why not? Please tick only one.

People who said that they have not had any COVID-19 vaccinations were asked why they have not been vaccinated. There were 54 responses to this question.

[52] Source: Public Health England (2021). JCVI advises prioritising homeless people and rough sleepers for COVID-19 vaccine - GOV.UK (www.gov.uk)

The main reason reported by people was that they did not want the vaccination (83.3%, n = 45).

Other reasons included:

- Not being offered it
- Being offered it but not being able to arrange it
- Related to physical health problems.

Sexual Health

People who experience homelessness are at higher risk of sexually transmitted infections (STIs) and face disproportionately poor reproductive health and adverse pregnancy outcomes[53].

The survey included three questions considering sexual health checks, contraception and advice. It was not possible to determine how many people were / had been sexually active.

Question 35: Have you had a sexual health check in the past 12 months? Please tick only one.

People were asked whether they have had a sexual health check in the 12 months. There were 131 responses to this question.

One in five people (19.1%, n = 25) said that they had had a sexual health check in the past 12 months; slightly lower than that found by Homeless Link (24%).

Over three quarters (77.1%, n = 101) reported that they had not had a sexual health check in the past year and a small number were unsure if they had or not (3.7%, n = 5).

Nationally, attendance at sexual health clinics was highest among people aged 16–24 years (16.6% of men and 22.4% of women) and decreased with age to less than 1.5% of those aged 45-74[54]. The age profile of the people may be a contributing factor to the lower rates of sexual health check uptake found locally (see Chapter 4 for further detail).

Question 36: Do you know where to access free contraception? Please tick only one.

People were asked about accessing free contraception. There were 131 responses to this question.

[53] Source: Paisi, M. et al. (2020). Perceived barriers and facilitators to accessing and utilising sexual and reproductive healthcare for people who experience homelessness: a systematic review | BMJ Sexual & Reproductive Health
[54] Source: Tanton, C. et al. (2018). Sexual health clinic attendance and non-attendance in Britain: findings from the third National Survey of Sexual Attitudes and Lifestyles (Natsal-3) - PubMed (nih.gov)

Almost three quarters (72.5%, n = 95) knew where to access free contraception. However, just over a quarter of people (27.5%, n = 36) did not know where to access free contraception.

Question 37: Do you know where to access advice about sexual health? Please tick only one.

People were asked whether they know where to access advice about sexual health. There were 129 responses to this question.

Around three quarters of people (76%, n = 98) knew where to access advice about sexual health. However, almost a quarter (24%, n = 31) reported that they do not know where to access sexual health advice.

Question 37a: If YES, where would you go? Please tick only one.

People who said that they knew where to access advice about sexual health were asked where they would go to do so. There were 77 responses to this question.

Getting advice from a GP or nurse was the most common response (55.8%, n = 43), followed by GUM / sexual health clinic (28.6%, n = 22). A small proportion of people said that they would speak to homeless / housing staff (7.8%, n = 6) and an equivalent number said that they would seek advice elsewhere (also 7.8%, n = 6). This included:

- Recovery Near You
- Pharmacy
- Housing First worker.

Female Health

People experiencing homelessness are known to have an increased burden of cancer and higher cancer-related mortality compared to the general population. This is due to a variety of factors including experience of barriers to accessing cancer prevention services[55] - for example appointments for routine screening being sent by post however not everyone requiring an appointment may have an address to receive the invitation to.

Question 38: (If answered female at birth and over 25 only). Have you had a cervical smear in the past 3 years, or in the past 5 years if over 49? Please tick only one.

Eligible people were asked about their cervical screening history. There were 16 responses to this question.

Just over half (56.3%, n = 9) said that they had had a cervical smear in the past 3 years, or in the past 5 years if they were over 49 years of age; similar to the findings

[55] Source: Schiffler, T. et al (2022). Barriers to access cancer prevention services for the homeless population in four European countries | European Journal of Public Health | Oxford Academic (oup.com)

from Homeless Link (54%). A further 43.8% (n = 7) said that they had not had a cervical smear during this period.

All women and people with a cervix between the ages are 25 and 64 years old are encouraged to take up cervical screening[56]. In 2022, two thirds of women aged 25 – 49 (67.6%) in England and 63% of women of the same age in Wolverhampton had a cervical screen. Three quarters of women aged 50 – 64 (74.6%) in England and 70.7% of women of the same age in Wolverhampton had had a cervical screen[57].

Question 39: (If answered female at birth and over 50 only). Have you had a breast examination/mammogram in the past 3 years? Please tick only one.

Eligible people were asked about their breast screening history. There were five responses to this question.

The majority (80.0%, n = <5) said that they had not had a breast examination or mammogram within the past three years. Only one in five (20.0%, n = <5) said that they had received an examination / mammogram during this period; lower than that found by Homeless Link (37%).

All people who are registered as female with a GP who are between the ages of 50 and 71 are invited to have an NHS breast screen every three years[58]. Due to the size of the sample responding to this question, caution should be exercised when considering generalisability. As such, the following national and local information is shared for context only.

In 2022, two thirds of the eligible population (65.2%) in England and 58.1% in Wolverhampton had a breast examination / mammogram[59].

Question 40: (If answered female at birth). Do you have access to sanitary products?

Eligible people were asked about access to sanitary products. There were 30 responses to this question.

The majority of people who required access to sanitary products (90.0%, n = 27) said yes, they did have the access they needed.

Nutrition

Poor diet is considered one of the key preventable risk factors to ill health, contributing to lower life expectancy and earlier onset of ill health. Evidence suggests people most at risk of diet-related ill health include people experiencing homelessness[60].

[56] Source: NHS (2020). When you'll be invited for cervical screening - NHS - NHS (www.nhs.uk)
[57] Source: Office for Health Inequalities and Disparities (2022). Public Health Outcomes Framework - Data - OHID (phe.org.uk)
[58] Source: NHS (2021). When you'll be invited for breast screening and who should go - NHS (www.nhs.uk)
[59] Source: Office for Health Inequalities and Disparities (2022). Public Health Outcomes Framework - Data - OHID (phe.org.uk)
[60] Source: UK Parliament (2022) Diet Related Health Inequalities. POST-PN-0686.pdf (parliament.uk)

Question 41: On average, how many meals do you eat a day? If this is difficult, please think about the meals you ate yesterday. Please tick only one.

People were asked how many meals they eat a day on average. People were invited to answer for yesterday i.e., the day prior to the survey being completed, if they were unable to provide an average. There were 129 responses to this question.

One in three people (30%) said that on average they eat one meal or less each day compared to 36% of Homeless Link people.

Most commonly, people said that they ate on average two meals per day (44.5%, n = 61); consistent with findings from Homeless Link (45%) (Table 27).

Table 27: Average Number of Meals Eaten a Day

No. of Meals	Count	Wolverhampton (%)	Homeless Link (%)
0	<5	1.5%	3%
1	39	28.5%	33%
2	61	44.5%	45%
3+	27	19.7%	18%

The Food and Agriculture Organisation of the United Nations defines food insecurity as 'limited access to food…due to lack of money or other resources'[61]. Nationally, almost one in five households (17.7%) had experienced food insecurity and 6.1% reported not eating for a whole day because they couldn't afford or access food. Almost half of households on Universal Credit reported experiencing food insecurity (49%)[62].

Question 42: How many portions of fruit and veg do you usually eat per day? If this is difficult, please think about what you ate yesterday. Please tick only one.

People were asked how many portions of fruit and veg they typically eat per day. There were 131 responses to this question.

Two thirds of people (66.4%, n = 87) said that they ate one or fewer portions of fruit and vegetables per day; consistent with findings from Homeless Link (66%). Just 2.3% of people (n = <5) ate the recommended 5 or more portions of fruit and vegetables a day, almost half of that found by Homeless Link (4%) (Table 28).

[61] Source: Food and Agriculture Organisation of the United Nations (2017). The State of Food Security and Nutrition in the World 2017 (fao.org)
[62] Source: The Food Foundation (2023). Food Insecurity Tracking | Food Foundation

Table 28: Daily Portions of Fruit and Veg

Portions of fruit and veg	Count	Wolverhampton (%)	Homeless Link (%)
0	28	21.4%	41%
Less than 1	36	27.5%	
1	23	17.6%	25%
2	31	23.7%	13%
3	10	7.6%	12%
4	0	0.0%	5%
5+	<5	2.3%	4%

In England, just under a third of adults (32.5%) are consuming the recommended 5 portions of fruit and vegetables per day. In Wolverhampton, this drops to just under one quarter of adults (24.8%)[63].

Nationally, 57% of food insecure households are cutting back on buying fruit and 42% were cutting back on vegetables compared to food secure households (11% and 6% respectively)[64].

Additional Comments About Health and Support

Question 43: Is there anything else you would like to tell us about your health and the support you receive?

'What Works Well?'

People were asked if they had any additional comments about what works well with regards to the health and support that they receive.

The support provided by Homelessness / Housing staff was greatly valued and most commonly referred to by people in response to this question.

The responses from healthcare services such as seeing the GP, Mental Health support and contraception services were also recognised by people as working well locally.

'What could be improved?'

People were asked if they had any additional comments about what could be improved with regards to the health and support that they receive.

[63] Source: Office for Health Inequalities and Disparities (2023). Public Health Outcomes Framework - Data - OHID (phe.org.uk)
[64] Source: The Food Foundation (2023). Food Insecurity Tracking | Food Foundation

Waiting times and referral speeds, numbers of face-to-face GP appointments and spaces for people to register with a dentist were most commonly referred to by people when asked about what could be improved.

10. Conclusion

'Poverty an almost universal, and mental ill health a common, complicating factor.'

Lankelly Chase Foundation (2015)

Homelessness is much more than a housing problem. It is a complex, multifaceted issue that must be understood more clearly for improvements in health outcomes to be achieved.

It has been long since evidenced that homelessness has a significant impact on life expectancy – on average 30 years less than the general population. This stark inequality should stand on its own as a call to action for all professionals who work with people experiencing homelessness.

This audit sought to gain a deeper understanding of the health needs of people experiencing homelessness in Wolverhampton, and the barriers that they face in accessing healthcare services locally.

The findings, and those of audits conducted in other areas supported by Homeless Link, shine a light on the high levels of morbidity that people experiencing homelessness live with and manage daily. Whilst not specifically tested, it would be fair to suggest that already stark inequalities would undoubtedly widen further when taking quality of life and years lived without disability into account.

Locally, it is clear that people experiencing homelessness have high health needs and there are challenges faced in finding help to stay well and accessing timely support should health begin to decline. There are however areas of positive practice where people feel supported and are able to get the help that they need in a way that works for them. The principles driving these provisions should be celebrated, built upon and embedded consistently wherever possible.

Homelessness is a health issue – and we must respond accordingly.

Homeless Link (2022)

11. Recommendations

Overarching

- Agree an all-partner commitment to undertake the NG214 - Integrated health and social care for people experiencing homelessness self-assessment to identify good practice and respond to areas for further development.

- Consider the introduction of an integrated commissioning response involving health, social care and accommodation services, informed by people with lived experiences of homelessness.

- Establish a Wolverhampton Health Inclusion steering group (or equivilent) as a subgroup of the One Wolverhampton and Homelessness Prevention strategy governance structures.

Profile of Participants

- Ensure effective general practice registration in line with NHS England guidance for people experiencing homelessness. This should also include the localisation of the Groundswell ‘My Right to Healthcare’ yellow cards for use across all Wolverhampton Primary Care Networks.

- Promote the message that everyone is welcome in dental and general practice utilising key resources such as the Primary Care Network Health Inclusion Planning Toolkit, Doctors of the World Safe Surgeries Toolkit, and the Everyone Welcome in General Practice Campaign.

- Develop and deliver a Rights and Entitlements training programme for healthcare professionals who work with people experiencing homelessness, particularly those who have no recourse to public funds, or whose immigration status is uncertain.

- Work with DWP, CWC and the local voluntary and community sectors to better understand the barriers to accessing employment, education and training and design solutions that ensure people experiencing homelessness are supported to be economically active.

- Consider the introduction of an inclusive apprenticeship offer for people with lived experience of homelessness.

Professionals

- Building on the summary findings from the professionals' survey, gain a more detailed understanding of the views and experiences of healthcare professionals working with people experiencing homelessness.

Physical Health

- Introduce an annual health check offer (including health action plan) to encourage people experiencing homelessness to access primary care to help them stay well, identify any problems early, and review any medication / treatment.

- Test a tailored, brief intervention smoking cessation support offer delivered by specialist support and accommodation providers. This could be supported by an information campaign to raise awareness of the universal smoking cessation offer available in the city.

Mental Health

- Co-design and implement a model of mental health peer support delivered by peers with experience to improve engagement with mental health services and support wellbeing.

- Work with One Wolverhampton Adult Mental Health Strategic Working Group to improve access to targeted support for people experiencing homelessness who have co-existing substance misuse and mental health problems.

Drug and Alcohol Use

- Undertake further investigation into reported alcohol consumption levels amongst people experiencing homelessness.

- Develop and implement a fast-track pathway for people who are homeless and require specialist drug and/or alcohol treatment (including aftercare).

Access to Services

- Secure additional funding for the Healthier Hostel pilot to ensure continuation of in-reach delivery whilst the evaluation is completed, and recommendations are made.

- Work with NHS England Specialist Commissioning, Black Country ICB and Royal Wolverhampton Trust (RWT) Specialist Dental Service to investigate the low level of dental access reported by people experiencing homelessness, to better understand barriers faced and how these can be addressed.

- Undertake a review of homeless hospital discharge pathways from RWT New Cross Hospital and BCHT Penn Hospital, along with any associated process / protocols, to ensure that patients are discharged into suitable accommodation.

- Ensure that the local end to end process for Duty to Refer is effective and efficient, enabling specified public authorities to identify and refer a person who is homeless or may be threatened with homelessness, to a local housing authority of their

choice, and where Wolverhampton is the receiving authority, that a timely and appropriate response is in place.

- Pilot the introduction of specialist navigator capacity into RWT New Cross Hospital Emergency Department, alongside the High Intensity User Service, to work with people experiencing homelessness who frequently attend emergency care and whose needs could be better met elsewhere, and to reduce repeat attendances.

Staying Healthy

- Ensure equitable access to screening services, providing targeted promotion and support for people experiencing homelessness to make an informed choice about participation.

- Provide cancer screening promotion training to organisations who work with people experiencing homelessness in Wolverhampton.

- Explore the possibility of trailing access to the third-party ordering system to increase access to and uptake of bowel screening for people experiencing homelessness.

- Expand the current provision of cooking and food preparation courses to other specialist homeless support service providers in the City.

- Introduce targeted engagement within the forthcoming sexual health services consultation to ensure the voices of people experiencing homelessness (and other inclusion health groups) are reflected and are representative.

- Work with CWC and RWT Embrace to enhance the sexual health outreach offer for people experiencing homelessness.

Appendix A: Homeless Health Audit Survey

A few questions about you

1. How old are you?

2. Which of these categories best describes you at present? Please tick **only one**.

- ☐ Going to school or college
- ☐ Working
- ☐ On an apprenticeship
- ☐ Doing unpaid or voluntary work
- ☐ Not working
- ☐ Other (Please state)

3. Have you ever (in your lifetime) done any of the following? Tick **all** that apply.

- ☐ Stayed at a hostel, foyer, refuge, night shelter or B&B (for emergency housing), or any other type of homelessness service
- ☐ Stayed with friends or relatives because had no home of own ('sofa surfed')
- ☐ Experienced sleeping rough
- ☐ Applied to the council as homeless
- ☐ Squatted (occupy an uninhabited building or settle on a piece of land)
- ☐ Slept in a tent, car (or other vehicle) or public transport
- ☐ None of the above
- ☐ Client did not answer

4. Where are you currently sleeping? (if this frequently changes, please say where you slept last night). Please tick **only one**.

- ☐ Rough sleeping
- ☐ In a hostel or supported accommodation (supported accommodation only for clients experiencing homelessness)
- ☐ Squatting (occupying an uninhabited building or settling on a piece of land)
- ☐ Sleeping on somebody's sofa/floor
- ☐ In NASS accommodation
- ☐ In emergency accommodation e.g. night shelter, refuge
- ☐ In B&B or other temporary accommodation
- ☐ Vehicle or caravan on the side of the road or in a car park
- ☐ Other (please state)_____
- ☐ Client did not answer

5. Do you have any of the following backgrounds? (This helps us to understand how your past experience may have affected your health or the services you've been able to access). Tick **all** that apply.

- ☐ Spent time in prison
- ☐ Spent time in a secure unit or youth offender institution
- ☐ Spent time in local authority care
- ☐ Spent time in the armed forces
- ☐ Spent time sex working
- ☐ Spent time in an immigration detention centre
- ☐ Admitted to hospital because of a mental health condition
- ☐ Been a victim of domestic abuse
- ☐ Been a victim of trafficking / modern day slavery
- ☐ None of these backgrounds

6.*What is your sex?

- ☐ Male
- ☐ Female

6a.* Is the gender you identify with the same as your sex registered at birth?

- ☐ Yes
- ☐ No

6b.* What is your gender? Please tick **only one.**

- ☐ Male
- ☐ Female
- ☐ Transgender male
- ☐ Transgender female
- ☐ Non-binary
- ☐ Other_____
- ☐ No answer

7. Which of the following best describes your sexual orientation? Please tick **only one**

- ☐ Heterosexual or straight
- ☐ Gay
- ☐ Lesbian
- ☐ Bisexual
- ☐ Pansexual
- ☐ Other_____

8. What is your ethnic group? Please tick **only one**.

White
- ☐ English / Welsh / Scottish / Northern Irish / British
- ☐ Irish
- ☐ Gypsy or Irish Traveller
- ☐ Other white

Mixed / Multiple ethnic groups
- ☐ White & Black Caribbean
- ☐ White & Black African
- ☐ White & Asian
- ☐ Other mixed

Asian/Asian British
- ☐ Indian
- ☐ Pakistani
- ☐ Bangladeshi
- ☐ Chinese
- ☐ Other Asian

Black/Black British
- ☐ African
- ☐ Caribbean
- ☐ Other black

Other
- ☐ Arab
- ☐ Any other ethnic group (please state)_____

9. What is your immigration status? Please tick **only one**.

- ☐ British citizen
- ☐ EEA citizen with settled status
- ☐ EEA citizen with pre-settled status
- ☐ Asylum seeker
- ☐ Refugee
- ☐ Limited leave to remain (all other)
- ☐ Indefinite leave to remain / permanent residence
- ☐ Unknown
- ☐ Other (please state) _____

10. Do you have recourse to public funds? Please tick **only one**.

- ☐ Yes
- ☐ No
- ☐ Don't know

11.* Do you consider yourself to have a disability? Please tick **only one**.

- ☐ Yes
- ☐ No
- ☐ Client did not answer

Some questions about physical health

12.* Has a doctor or health care professional ever told you that you have any of the following physical health problems? Please choose the appropriate response for each item.

	Yes, after I became homeless	Yes, before I became homeless	No	No answer
Heart problems (heart attack, angina, endocarditis or abnormal health rhythm)	☐	☐	☐	☐
Chronic breathing problems (bronchitis, emphysema, obstructive airways disease)	☐	☐	☐	☐
Asthma	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Joint aches / problems with bones and muscles	☐	☐	☐	☐
Difficulty seeing / eye problems (that affect your daily life)	☐	☐	☐	☐
Skin / wound infection or problems	☐	☐	☐	☐
Problems with feet that affect your day to day life	☐	☐	☐	☐
Fainting / blackouts	☐	☐	☐	☐
Urinary problems / infections / incontinence	☐	☐	☐	☐
Circulation problems / blood clots	☐	☐	☐	☐
Liver problems	☐	☐	☐	☐
Stomach problems including ulcers	☐	☐	☐	☐
Dental / teeth problems	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐

	Yes, after I became homeless	Yes, before I became homeless	No	No answer
Tuberculosis (TB)	☐	☐	☐	☐
Hepatitis C	☐	☐	☐	☐
Hearing loss (that affects your day to day life)	☐	☐	☐	☐
Brain injury including blackouts and seizures	☐	☐	☐	☐
Traumatic brain injury	☐	☒	☐	☐
HIV	☐	☐	☐	☐
Other (please state):	☐	☐	☐	☐

13a. If yes to TB, have you received any treatment? Please tick **only one**.

- ☐ Yes
- ☐ No, offered but didn't take it up
- ☐ No, not offered any

13b. If yes to Hepatitis C, have you received any treatment? Please tick **only one**.

- ☐ Yes
- ☐ No, offered but didn't take it up
- ☐ No, not offered any

13c. If yes to any physical health needs, are you receiving support / treatment to help you with your physical health problem? Please tick **only one**.

- ☐ Yes, and it meets my needs
- ☐ Yes, but I'd still like more help
- ☐ No, but it would help me
- ☐ No, I don't need any

14. Was there any time during the past twelve months when, in your opinion you needed a medical examination or treatment for a physical health problem but you did not receive it? Please tick **only one**.

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

14a. If yes to Q14, what was the **main reason** for not receiving the examination or treatment (the most recent time)? Please tick **only one**.

- ☐ Could not receive treatment because of no address
- ☐ Too far to travel / no means of transportation
- ☐ Concerns about judgement from doctor / reception staff
- ☐ Wanted to wait and see if the problem got better on its own
- ☐ Was refused treatment / examination
- ☐ Concerns about seeking healthcare due to immigration status
- ☐ Other (please state)_____

15.* Do you smoke cigarettes, e-cigarettes, cigars or a pipe Please tick **only one**.

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

15a. If yes to Q15, would you like to give up smoking altogether? Please tick **only one**.

- ☐ Yes
- ☐ No
- ☐ Don't know

15b. If yes to Q15, have you been offered help by a health professional to stop smoking? Please tick **only one**.

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

Some question about mental health and cognitive development

16.* Do you consider yourself to have any of the following mental health conditions? Please choose the appropriate response for each item.

	Yes, after I became homeless	Yes, before I became homeless	No	No answer
Depression	☐	☐	☐	☐
Anxiety disorder or phobia	☐	☐	☐	☐
Psychosis (incl. schizophrenia or bipolar disorder)	☐	☐	☐	☐
Post-Traumatic Stress Disorder (PTSD)	☐	☐	☐	☐
Personality disorder	☐	☐	☐	☐
Eating disorder	☐	☐	☐	☐
Dual diagnosis – a mental health condition alongside drug or alcohol use	☐	☐	☐	☐

16a. If yes to any of the mental health conditions, have any of these been diagnosed by a professional?

- ☐ Yes
- ☐ No

16b. If yes to any mental health conditions, are you receiving support or treatment to help you with this? Please tick **only one**.

- ☐ Yes, and it meets my needs
- ☐ Yes, but I'd still like more help
- ☐ No, but it would help me (*go to Q16d*)
- ☐ No, I don't need any (*go to Q17*)

16c. If yes to Q16b, what type of support are you receiving? Tick **all** that apply.

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

16d. If you would like to get help or more help, what support would you like to have? Tick **all** that apply

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

17. Was there any time during the past twelve months when, in your opinion, you personally needed an assessment or treatment for a mental health condition but you did not receive it? Please tick **only one**.

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

17a. If yes to Q17, what was the **main reason** for not receiving the examination or treatment (the most recent time)? Please tick **only one**.

- ☐ Due to my drug or alcohol use
- ☐ Have been banned from the service
- ☐ Too far to travel / no means of transportation
- ☐ Concerns about judgement from doctor / reception / examination / treatment staff
- ☐ Wanted to wait and see if the problem got better on its own
- ☐ Was refused treatment / examination
- ☐ Concerns about seeking healthcare due to immigration status
- ☐ Other (please state)_____

18. Do you consider yourself to have any of the following cognitive developmental conditions? Please choose the appropriate response for each item.

	Yes, after I became homeless	Yes, before I became homeless	No	No answer
Learning disability or difficulty	☐	☐	☐	☐
Dementia	☐	☐	☐	☐
Autism / Asperger's	☐	☐	☐	☐
ADHD / ADD (attention deficit (hyperactivity) disorder)	☐	☐	☐	☐

19. Do you use drugs or alcohol to help you cope with your mental health – this can be called 'self-medicating'? Please tick **only one**.

- ☐ Yes
- ☐ No

Some questions about drug and alcohol use

Q20.* In the past 12 months have you taken any of the following? Tick **all** that apply.

- ☐ Heroin
- ☐ Crack
- ☐ Cocaine
- ☐ Cannabis
- ☐ Spice/Mamba
- ☐ Ketamine
- ☐ MDMA/ecstasy
- ☐ Mephedrone
- ☐ Amphetamine
- ☐ Methamphetamine
- ☐ GHB/GBL
- ☐ Fentanyl
- ☐ Medication not prescribed to you (such as benzodiazepines, codeine, illicit methadone, pregabalin)
- ☐ Other (please state)_____
- ☐ I have not used in the last 12 months (go to Q21)

Q20a.* How often have you used drugs during the last 12 months?

- ☐ Almost every day
- ☐ Five or six days a week
- ☐ Three or four days a week
- ☐ Once or twice a week
- ☐ Once or twice a month
- ☐ Once every couple of months
- ☐ Once or twice a year
- ☐ Not at all in the last 12 months
- ☐ Client did not answer

Q21. How would you describe your relationship with drugs? Please tick **only one**.

- ☐ I currently have a drug problem
- ☐ I am in recovery from a drug problem
- ☐ No problem (*go to Q23*)
- ☐ Client did not answer

Q21a. If you have, or are in recovery from, a drug problem, are you receiving support or treatment to help you? Please tick **only one**.

- ☐ Yes, and it meets my needs
- ☐ Yes, but I'd still like more help
- ☐ No, but it would help me (*go to Q22b*)
- ☐ No, I do not need any help (*go to Q23)*

Q22a. If yes to Q21a, what support are you receiving to help you address your drug use? Tick **all** that apply.

- ☐ Group support
- ☐ 1-1 support
- ☐ Prescribed medication
- ☐ Needle exchange
- ☐ Mutual aid
- ☐ Community detox / community rehab
- ☐ Support (such as counselling, psychology services and aftercare)

Other (please state)_____

Q22b. If you would like support, or more support, what would you like to have? Tick **all** that apply.

- ☐ Group support
- ☐ 1-1 support
- ☐ Prescribed medication
- ☐ Needle exchange
- ☐ Mutual aid
- ☐ Community detox / community rehab
- ☐ Residential detox / rehab
- ☐ Support (such as counselling, psychology services and aftercare)

Other (please state)_____

QWOL1. Which of the following, if any, are a barrier to you accessing treatment? Tick **all** that apply

- ☐ The treatment I want isn't available
- ☐ Waiting lists are too long
- ☐ I can't get to appointments
- ☐ I don't think they can help me
- ☐ The service doesn't respect my religious/ethical/cultural beliefs
- ☐ I don't want withdrawal symptoms
- ☐ I don't want to be judged
- ☐ I don't think I can do it alone
- ☐ I don't want to right now
- ☐ Other (please state) _____

Q23.* How many units do you drink on a typical day when drinking? Please refer to flashcard to work this out.

Q23a.* How often have you had an alcoholic drink during the last 12 months?

- ☐ Almost every day
- ☐ Five or six days a week
- ☐ Three or four days a week
- ☐ Once or twice a week
- ☐ Once or twice a month
- ☐ Once every couple of months
- ☐ Once or twice a year
- ☐ Not at all in the last 12 months
- ☐ Client did not answer

Q24.* How would you describe you relationship with alcohol?

- ☐ I currently have an alcohol problem
- ☐ I am in recovery from an alcohol problem
- ☐ No problem (*go to Q25*)
- ☐ Client did not answer

Q24a. If you have, or are in recovery from, an alcohol problem, are you receiving support or treatment to help you? Please tick **only one**.

- ☐ Yes, and it meets my needs
- ☐ Yes, but I would still like more help
- ☐ No, but it would help me (*go to Q24c*)
- ☐ No, I do not need it

Q24b. If yes to Q24a, what support are you receiving to help you address your alcohol use? Tick **all** that apply.

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

Q24c. If you would like support, or more support, to address your alcohol use, what would you like to have?

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

QWOL2. Which of the following, if any, are a barrier to you accessing treatment? Tick **all** that apply

- ☐ The treatment I want isn't available
- ☐ Waiting lists are too long
- ☐ I can't get to appointments
- ☐ I don't think they can help me
- ☐ The service doesn't respect my religious/ethical/cultural beliefs
- ☐ I don't want withdrawal symptoms
- ☐ I don't want to be judged
- ☐ I don't think I can do it alone
- ☐ I don't want to right now
- ☐ Other (please state) _____

Some questions about your access to services

Q25.* Are you registered with these services in your local area? Please choose the appropriate response for each item.

	Yes	No	No answer
GP	☐	☐	☐
Specialist homeless healthcare specialist	☐	☐	☐
Dentist	☐	☐	☐

Q26. Have you been refused registration to a GP, homeless healthcare service or dentist in the past 12 months? Please choose the appropriate response for each item.

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

Q26a. If yes to Q26-GP, why were you refused access?

Q26b. If yes to Q26-homeless healthcare service, why were you refused access?

Q26c. If yes to Q26-dentist, why were you refused access?

Q27.* In the past 12 months have you:

	No	Once	Twice	3 times	Over 3 times	Client did not answer
Been to a GP or homeless healthcare service	☐	☐	☐	☐	☐	☐
Been to A&E	☐	☐	☐	☐	☐	☐
Used an ambulance	☐	☐	☐	☐	☐	☐
Been admitted to hospital	☐	☐	☐	☐	☐	☐

Q27a. If you have used any of A&E, hospital or ambulance in the past 12 months please answer these questions. What was the reason why you last used:
please select the reason which best fits the primary cause of using the service, or use the other box if the reason is not listed.

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

If you were admitted into hospital, please answer questions 27b – 27D about your most recent admission.

Q27b. Did staff ask you if you had somewhere suitable to go when you were discharged? Please tick **one only**.

- ☐ Yes
- ☐ No
- ☐ I can't remember

Q27c.* When you were discharged from hospital where did you go? Please tick **only one**.

- ☐ I was discharged onto the street
- ☐ I was discharged into accommodation, but it was *not* suitable for my needs
- ☐ I was discharged into accommodation, and it *was* suitable for my needs
- ☐ I can't remember
- ☐ Client did not answer

Q27d.* After being discharged, were you readmitted within 30 days? Please tick **only one**.

- ☐ Yes
- ☐ No
- ☐ I can't remember
- ☐ Client did not answer

Some questions about staying healthy

Q28. To help people say how good or bad a health state is, we have a scale on which the best state you can imagine is 100 and the worst state you can imagine is marked 0. We would like you to indicate on this scale how good or bad your own health is today, in your opinion. Please do this by saying where on this scale your health state is today.

Q29. Compared to twelve months ago how would you say your health is now? Please tick **only one**.

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

Q30. Are you taking any medication prescribed for you at the moment? This includes medicines, pills, syrups, ointments, puffers or injections. Please tick **only one**:

- ☐ Yes
- ☐ No

Q31. Are you able to access your medication?

- ☐ Yes (*go to Q33*)
- ☐ No

Q32. If no, what is the reason for not being able to access your medication? Tick **all** that apply.

- ☐ Not registered with a GP service
- ☐ Cannot afford the medication (prescription charge)
- ☐ Considers to be self-medication
- ☐ Other (please state)_____

Q33. Have you been vaccinated against Hepatitis B? Please tick **only one**.

- ☐ Yes (once)
- ☐ Yes (twice)
- ☐ Yes (three times)
- ☐ No

☐ Don't know

Q34. Have you had the COVID-19 vaccination? Please tick **only one**.

☐ Yes, I have had my first dose
☐ Yes, I have first and second dose
☐ Yes, I have my first, second and boosters
☐ No, I haven't been vaccinated

Q34a. If you have not had the COVID-19 vaccine, why not? Please tick **only one**.

☐ I have not been offered it
☐ I have been offered it but haven't been able to arrange it
☐ I don't want the vaccination
☐ Other (please state)_____

Q35. Have you had a sexual health check in the past 12 months? Please tick **only one.**

☐ Yes
☐ No
☐ Don't know

Q36. Do you know where to access free contraception? Please tick **only one.**

☐ Yes
☐ No

Q37. Do you know where to access advice about sexual health? Please tick **only one.**

☐ Yes
☐ No (*go to Q36*)

Q37a. If yes to Q37, where would you go? Please tick **only one**.

☐ GP or nurse
☐ GUM/sexual health clinic
☐ Homeless/housing staff
☐ Other (please state)_____

Q38. (If answered female at birth and over 25 only). Have you had a cervical smear in the past 3 years, or in the past 5 years if over 49? Please tick **only one**.

☐ Yes
☐ No
☐ Don't know

Q39. (If answered female at birth and over 50 only). Have you had a breast examination / mammogram in the past 3 years? Please tick **only one**.

☐ Yes
☐ No
☐ Don't know

Q40. (If answered female at birth). Do you have access to sanitary products?

☐ Yes
☐ No
☐ This is not (currently) relevant for me

Q41. On average, how many meals do you eat a day. If this is difficult, please think about the meals you ate yesterday. Please tick **only one**.

☐ None
☐ One
☐ Two
☐ Three or more

Q42. How many portions of fruit and veg do you usually eat per day? If this is difficult, please think about what you ate yesterday. Please tick **only one**.

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

Q43. Is there anything else you would like to tell us about your health and the support you receive?

What works well?

What could be improved?

Any other comments?

Thank you for completing the survey

Appendix B: Pilot Feedback Checklist

Homeless Health Needs Audit Pilot Feedback

Could you comment on…	Comments
…recruiting participants?	
…identifying an opportunity to complete the survey?	
… identifying a staff member to complete the survey with the participant?	
… the information sheet and consent form in terms of providing satisfactory information to the respondent?	
…the respondents' understanding of the questions being asked?	
…the time it took to complete one survey?	
…how many sessions it took to complete one survey?	
…whether the survey was completed or left incomplete?	
Any other comments or thoughts?	

Appendix C: Consent Form

Homeless Health Needs Audit

Printable version of the survey

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

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

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

Introduction

Before you get started, please ask the client to confirm that they understand how their data will be used and that they have not already completed a survey for the current audit.

Participant Consent

I have been provided with a copy of the Homeless Health Needs Audit – information for participant's sheet.

I understand that:

- City of Wolverhampton Council is carrying out an audit of the health needs of people experiencing homelessness.
- The aim is to understand more about local homeless health services and to address gaps in services, and to give people experiencing homelessness a voice in this process.
- The charity Homeless Link would also like to use the information gathered as part of the audit to carry out further research into the health needs of people experiencing homelessness across the country. Homeless Link will always make sure that all personal information is removed before any research is published.

I consent to City of Wolverhampton Council using my personal information in order to carry out the health needs audit.	

I consent to Homeless Link using my personal information for research to understand national health needs.	

You can withdraw your consent at any time by contacting City of Wolverhampton Council: Stephanie.Taylor2@wolverhampton.gov.uk or Homeless Link: research@homelesslink.org.uk

Name: .....

Date: .....

Appendix D: Participant Information Sheet

Schedule 2

Client Information Sheet

Health Needs Audit

Information for participants

1. **What is the Health Needs Audit?**

The main aim of this Health Needs Audit is to find about the health needs of people with experience of homelessness in the local area. This information is used to help improve services and remove any barriers to access.

The City of Wolverhampton Council is carrying out this audit and they have asked [NAME OF LOCAL PARTNER] to contribute. Homeless Link is a charity that provides the tools to carry out the audit. You can find contact details for all of these organisations at the end of this information sheet.

2. **What does it involve?**

If you take part in the Health Needs Audit, a member of staff will ask you some questions about your health needs, what health services you use, how good the services are in your local area, and whether you get the help you need. This should take around 30 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.

3. **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 needed to help improve health services for homeless people in your local area.

Participants across the country have already taken part in a Health Needs Audit for their area and there have been a range of improvements as a result including:

- better links between hospitals and homelessness services
- greater access to universal services like GPs and dentists
- improved screening for vaccinations against things like TB.

4. **What personal information will I be asked to give?**

As part of the audit, you will be asked to give:

- Your name

You do not have to give us all of this information if you don't want to, but it will help us if you can answer the questions as fully as you can. If you'd rather pass on a question, just let the interviewer know.

We only use the personal information you give to us. We don't combine this with any other information held about you elsewhere and none of the information you provide will affect any of the services you are already receiving.

5. **How will my personal information be used?**

We will always ask for your consent to go ahead with the audit and we will keep a record of your name to show that you agreed to take part. You can withdraw your consent at any time by speaking to a member of staff or contacting us (contact details are at the end of this information sheet).

Any information or reports produced from the Health Needs Audit will be anonymous and no one will be able to identify you or anyone else who has taken part.

6. **Who will access my information?**

One named person at the City of Wolverhampton Council will be authorised to access your personal information. Homeless Link will also have access to your information in order to administer the Health Needs Audit.

With your permission, Homeless Link will use your personal information (and information from similar audits carried out across the country in aggregate form) to better understand the health needs of people who are homeless across England. Homeless Link will use the results of this research to campaign for national change.

Everyone who accesses your personal information will be subject to a duty of confidentiality.

7. **How will my personal information be stored?**

We have put in place security measures to prevent your personal information from being accidentally lost, used or accessed in an unauthorised way, altered, or disclosed.

Your personal information will be kept on a secure server. No information is transferred outside Europe.

8. **How long will you keep my information?**

We will keep your personal information for two years to fulfil the purposes described in this information sheet.

Anonymous data (i.e. information that it can no longer be associated with you) can be kept indefinitely.

9. **Your legal rights**

You have the right to:

Request access to your personal information (also known as a subject access request). This enables you to receive a copy of the personal information we hold about you and to check that we are lawfully processing it.

- **Ask us to correct personal information** that we hold about you which is incorrect, incomplete or inaccurate.

Ask us to erase your personal information from our files and systems where there is no good reason for us continuing to hold it.

Ask us to restrict or suspend the use of your personal information, for example, if you want us to establish its accuracy or our reasons for using it.

Ask us to transfer your personal information to another person or organisation.

Withdraw your consent to us using your personal information. Once we have received notification that you have withdrawn your consent, we will no longer process your personal information and, subject to our retention policy, we will dispose of your data securely.

If you want to exercise any of these rights, please contact [NAME/POSITION AND CONTACT DETAILS].

You have the **right to make a complaint** at any time to the Information Commissioner's Office (ICO), the UK supervisory authority for data protection issues (www.ico.org.uk). We would, appreciate the chance to deal with your concerns before you approach the ICO so please contact us in the first instance.

10. **Contact details**

Thank you for taking part in the Health Needs Audit. If you have any further questions, please ask a member of staff or contact:

Stephanie Taylor, Senior Public Health Specialist, City of Wolverhampton Council
Stephanie.Taylor2@wolverhampton.gov.uk

[CONTACT DETAILS FOR THE LOCAL PARTNER]

Homeless Link: research@homelesslink.org.uk

Appendix E: Professionals' Survey Questions

The questions that were asked of professionals were the following:

Professionals' Questions

1. What are the barriers to accessing healthcare for people with multiple complex needs?
2. What is working well locally?
3. What could be improved or enhanced?
4. Case study example of client healthcare experience (optional)
5. What is your organisation? (optional)

Appendix F: Alcohol Prompt Card

The alcohol prompt card is a simple tool you can use to calculate unit measurements for alcohol consumption, if you're not already familiar with them. It's designed to be used in a one-to-one session with participants. You'll find the card to share with your client on the next page.

Some participants may be reluctant to disclose information if they feel it could impact on their support or treatment plans, so always make it clear that the audit will not affect the support they receive. Arranging for the interview to be carried out by a member of staff with no personal connection to the participant, or by a volunteer or peer researcher, can help to overcome this.