OXFORDSHIRE
COUNTY COUNCIL

A health needs assessment of the adult street homeless population in Oxfordshire.

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Acknowledgments

Executive summary

People experiencing homelessness die younger than those living in stable, appropriate housing. In fact, they have a lower life expectancy than the average person living in the poorest, least healthy countries on the planet. In Oxfordshire, the tragic deaths of several people experiencing homelessness in the winter of 2018-2019 has brought these issues into sharp relief.

Whilst this report focusses on services available to people who are currently homeless, it is important to acknowledge that by the time someone becomes homeless, the wider societal system has already failed. The vital public health principle of prevention should not be neglected. Prevention of homelessness is a broad and complex issue that requires societal attention and the same forces that shape homelessness – for example the availability of appropriate, affordable housing; strength of communities; accessibility of appropriate services; unequal distribution of wealth – shape the wellbeing of all of us.

Homelessness is not a simple issue. People become homeless for myriad, overlapping reasons – including poor health – and health is exacerbated and worsened in many complex ways through being homeless. The homeless population is difficult to see and measure, and represents a broad group with a diverse set of needs. This report is therefore not designed to be definitive: it gathers what we *do* know and *can* measure about this difficult-to-access group, and highlights what we don't know. It is hoped this report serves as a starting point for further work to better understand the needs of this population, rather than being treated as the final word.

Because of the complexity of the issue, this report does not give simple answers and identifies relatively few 'off-the-shelf' policies that should to be implemented – it is for others to decide which policies to implement and how. Instead the report aims to give an indication of the needs of the homeless population, a flavour of what services are working well in Oxfordshire and takes an honest approach to identifying gaps in knowledge and services.

For the first time in Oxfordshire, this report combines local quantitative data from various healthcare service providers and housing teams, as well as qualitative data from focus groups and questionnaires conducted with people experiencing homelessness in this area, to provide estimates of the homeless population across the county and their health needs. These local data are supplemented with national data to fill in information gaps and place the situation in Oxfordshire in a wider context.

Main health needs

The main health issues identified will be familiar to people experiencing homelessness and many people working with this population. Mental health is once again flagged as an important health need, substance misuse is very prevalent in this population and some specific physical health issues (e.g. blood borne infections) as well as more general physical health issues (e.g. cardiovascular disease) cause death and disease. Crucially, these very often overlap. The increasing proportion of female people experiencing homelessness – whilst still a minority – raises specific issues around domestic violence and sexual and reproductive health.

What is currently working well?

There are many examples of where services are well-designed and well-run, and really meet the needs of the homeless population. For example, services for people with substance misuse issues – run through Turning Point – appear to be excellent. Primary care for people experiencing homelessness in Oxford City – provided by Luther Street Medical Centre – is exemplary. There is some great work happening in the John Radcliffe Hospital, Oxfordshire's largest hospital, to care for people experiencing homelessness – often led by passionate and driven individuals.

What could work better?

However, there are also areas for improvement. Seven of these are highlighted below.

Firstly, services for people with very complicated needs are mainly concentrated in Oxford City. One example is Luther Street Medical Centre, the only specialist GP for people experiencing homelessness in the county. Whilst Oxford City is where the largest number of people experiencing homelessness currently live, at least some have been attracted there because of services. Many have left support networks of friends and family in other parts of the county to access the services they need. Others are unable to reach Oxford-based services because they are too far away and too expensive to reach. This has the potential to worsen inequalities within this already very vulnerable and disenfranchised group, and the resulting influx of people experiencing homelessness from other parts of the county may place additional strain on the already-overburdened wider system of care within Oxford City. This situation is not the fault of the existing (often excellent) services in Oxford City, but they may have creative solutions to meet the need for services around the county, and should be consulted early in the process. For example, clinicians at Luther Street Medical Centre currently provide training on homelessness to GPs-in-training and may be able to provide similar training to upskill to primary care providers outside Oxford City.

Secondly, whilst there is some innovative work around housing for people with extreme levels of mental health need, services targeting less severe mental illness may need to be strengthened. In focus

groups, questionnaires and semi-structured interviews, people experiencing homelessness and service providers expressed a feeling that current services – particularly those for mild-moderate mental health issues – do not meet the very high level of need in this population. Given the extraordinarily high burden of mental health issues amongst the homeless, further work should be undertaken to fully understand these needs; to identify the data required to evaluate access; and to compare current service provision for mild-moderate mental illness against best practice.

Third, the linear housing pathway does not work for everyone. In some instances, the pathway from rough sleeping, through homeless hostels and onto 'move-on' accommodation may entrench people within a homeless community, hinder recovery and jeopardise peoples' health – all at a very high financial cost to councils. Alternative housing models, including Housing First, may be more beneficial for health and may save money across the entire system through reductions in the use of healthcare and other services. Health organisations should advocate for Housing First to be formally considered when recommissioning the adult single homeless pathway in Oxfordshire.

Fourth, whilst there are some great examples of partnership working across the county (such as clinicians from Luther Street Medical Centre accompanying street outreach workers, and the joint clinics between Turning Point and the Oxfordshire Mental Health Partnership for those experiencing both substance misuse and mental health issues), more is still needed. Many people experiencing homelessness have extremely complicated, overlapping and interrelated needs which cannot be addressed by one service – these patients may require a level of multi-disciplinary working beyond current levels. Previously, there have been regular meetings where various providers come together to discuss a few homeless people experiencing particularly high level of needs, but these are not currently happening and could be reinstated.

Fifth, to design policy grounded in fact and to structure services to meet the evolving needs of the homeless population, timely, accurate data is required. Data availability is currently patchy (and this report highlights specific gaps) but databases, managed by skilled analysts, are available in some areas of the county. The best example is OxTHINK. In addition to informing evidence-based policy, a universal data system would improve the experience of homeless people accessing services; many that were consulted for this report were exasperated at having to constantly repeat their story. A concerted effort to develop a county-wide database will require careful considerations around data sharing and consent, but these should not be impediments to what would be an incredibly useful tool.

Sixth, too often, people experiencing homelessness are discharged from hospital without fully exploiting links to other appropriate services. Front-line clinicians cannot be expected to appropriately coordinate all aspects of the discharge for this group – instead specialist support from housing officers

or clinicians experienced in the housing system is likely to be required. Conversations about the coordination of hospital discharge in the John Radcliffe Hospital have already begun, led by compassionate and driven clinicians.

Seventh, the increasing proportion of female people experiencing homelessness raises particular health issues, particularly around sexual and reproductive health. This report could not answer all the relevant questions, and further work may be required to fully understand these needs and how services meet them, or fall short.

What needs to happen next?
This report identifies 10 recommendations, but how these fit in with wider plans to combat homelessness is a question beyond the scope of this report. Therefore, the tenth recommendation is that this report is discussed at an upcoming meeting of the Housing Support Advisory Group, for senior policy-makers to decide which recommendations to adopt, monitor and implement over the coming years.

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Contents

Definitions

Wherever possible, this report uses unambiguous terms and, where necessary, definitions are outlined in the text. A few

key terms are defined below.

Street homeless: People experiencing street homelessness are those who routinely find themselves on the streets during the day with nowhere to go at night. Most of these will be sleeping rough or in a temporary institution or shelter. The street homeless population is focus of this report[i].

Need[ii]:   This report attempts to identify the need for services. Thus need is defined as "the capacity to benefit" to from services. This is a combination of a lack of ill-health and, crucially, the ability of services – if they were present – to remedy the ill-health.

Felt need: Felt needs are those perceived by an individual. They are limited by an individual's perceptions and knowledge of services. For example, a person experiencing homelessness and struggling with alcohol misuse may feel they need assistance in overcoming their addiction. That would be a felt need. However, if they did not know such services could exist, they may not feel they have a need that could benefit from services.

Expressed need: Expressed needs are felt needs that have become actions. For example, the person experiencing homelessness who is struggling with alcohol misuse may attend an alcohol cessation service, or demand detox at a hospital.

Normative need: Normative need is that defined by experts. These may or may not correlate with felt or expressed needs. For example, someone struggling with alcohol addiction may not feel they have a problem, but a doctor might still feel they require an alcohol misuse service.

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[i] Shelter. 2006. Street Homelessness.
https://england.shelter.org.uk/__data/assets/pdf_file/0011/48458/Factsheet_Street_Homelessness_Aug_2006.pdf
[ii] All definitions of need are based upon Bradshaw, J. 1972: Taxonomy of social need. In: McLachlan, Gordon, (ed.) Problems and progress in medical care : essays on current research, 7th series. Oxford University Press , London , pp. 71-82.

1.   Background

1.1 Homelessness

Homelessness means not having a safe home to live in. It includes rough sleeping (sleeping without a shelter of any kind); sleeping in a temporary institution or shelter (like a hostel, night shelter, temporary supported housing service or bed and breakfast); living in insecure housing (being threatened with eviction due to insecure tenancies, staying with friends or family or experiencing domestic violence) and living in inadequate housing (overcrowding/unfit housing, or caravans on illegal campsites)[1]. People experiencing street homelessness are those who routinely find themselves on the streets during the day with nowhere to go at night. Most of these will be sleeping rough or in a temporary institution or shelter. The street homeless population is the focus of this report, as they have amongst the highest levels of health needs[2].

The number of people in England experiencing homelessness has increased in recent years. In 2017, 153,000 people were experiencing some form of homelessness, compared to 120,000 in 2010 (an increase of 28%)[3].

The increase in the numbers of rough sleepers has been particularly acute – 4,677 slept on the streets on one night across England in 2018, a 165% increase on the 1,768 rough sleepers counted in 2010[4].

The National Audit Office[5], the homelessness charity Crisis[6] and even government Ministers[7] have implicated the rising cost of private rented accommodation (which, across England, has increased three times faster than earnings), and government policies (including freezing the Local Housing Allowance and the rollout of Universal Credit) in the increasing rates of homelessness.

Reacting to this "national crisis"[8], high-profile policies such as the Government's Rough Sleeping Strategy[9] have recently been announced. Ambitious targets have followed, the government now hopes to halve rough sleeping by 2022 and end it altogether by 2027. Together with the passage of the Homelessness Reduction Act 2017[10], promising measures announced in the 2018 Budget[11] and the additional £30 million to meet the needs of rough sleepers announced in the NHS 10-year plan[12], these may signify a window of opportunity for reducing homelessness across the UK.

Section 1: Background.

1.2 Health and homelessness

Being homeless is bad for health and wellbeing.

The links between poor housing and poor health are well documented[13]. People experiencing homelessness are more likely to have serious and multiple health problems[14], including infectious diseases, mental health disorders and drug and alcohol misuse and have much higher mortality rates[15].

Rough sleepers die, on average, between age 43[16] and age 47[17] – more than 30 years earlier than the general UK population. The life expectancy of rough sleepers in the UK is lower than the life expectancy in the poorest country on earth[18]. Housing is clearly a crucial social determinant of health, on a par with the availability of health services in the well-recognised Dahlgren and Whitehead model of the social determinants of health[19].

Figure 1.1. The Dahlgren and Whitehead model of social determinants of health. (Housing highlighted)

Poor health can also cause homelessness.

There are many examples of ill health leading to homelessness. For example, uncontrolled mental health issues could contribute to a relationship breakdown, or a long hospital admission could lead to someone losing employment, both common triggers for homeless. Health services and health professionals therefore have a role in the prevention of homelessness, as well as maintaining health during a period of homelessness and ensuring ill-health is not a barrier to re-entering settled housing.

It can be difficult to meet the needs of people experiencing homelessness.

Barriers can arise from the way services are structured and provided (such as inflexibility of services and appointment systems, difficulty registering or receiving follow up for services without a fixed address, negative staff attitudes) or difficulties with people experiencing homelessness themselves (such as chaotic behaviour or drug and alcohol problems which affect engagement with services)[20]. People experiencing homelessness therefore often require additional effort to receive an equitable share of resources.

These forces combine to cost society large amounts in the provision of healthcare for people experiencing homeless. People experiencing homelessness are less likely to be registered with a GP[21], more likely to attended hospital emergency departments[22], stay longer in hospital and consume around four times more acute hospital services than the general population[23].

Section 1: Background.

1.3   Homelessness in Oxfordshire

Oxford is the least affordable city in the UK for housing, and house prices across the county continue to increase faster than earnings[24]. Unsurprisingly, homelessness is particularly acute here, and loss of private rented accommodation is now the primary cause of homelessness across Oxfordshire[25].

Routes out of homelessness are heavily dependent on social housing. Families and those in priority need are offered temporary accommodation from their local City or District Council, before moving into a more permanent tenancy in social housing when available. For single homeless people without priority needs, the general route involves rough sleeping, entering Oxfordshire's Adult Single Homeless Pathway and then receiving support to apply for more permanent accommodation through social housing. However, the proportion of social housing stock has reduced across Oxfordshire, and the cost of social housing here is a fifth higher than the national average[26]. The high cost of private sector housing and scarcity of social housing combine to form a significant challenge in Oxfordshire.

The health of the homeless population has been high on the agenda within Oxfordshire for some time, though a recent spate of deaths in rough sleepers has rightly brought additional media attention and public scrutiny[27]. Since 2015, Oxfordshire's Joint Health & Wellbeing Strategy has recognised "preventing homelessness and tackling the broader determinants of health through better housing" as one of eleven key priorities[28] and every subsequent annual report from the Director of Public Health has reported on levels of homelessness within Oxfordshire[29]. Given the high levels of need and political commitment, the Ministry of Housing, Communities & Local Government awarded Oxfordshire £890,000 to fund the Trailblazer project aimed at preventing homelessness[30]. Oxford City Council were awarded over £1 million from the government's Rough Sleeping Initiative to fund activities in 2018-19 and 2019-20[31], and Oxford City Council was recently announced as an 'early adopter' to receive further government funding as part of the Rapid Rehousing Pathway[32].

However, there has never been a systematic, evidence-based assessment of the health needs of the street homeless population across Oxfordshire. This report aims to fill the gap by:
1. Estimating the size, location and demographics of street homeless adults in Oxfordshire (Section 3),
2. Examining the health needs of this population (Section 4),
3. Mapping current services available to the street homeless population (Section 5),
4. Highlighting gaps between health needs and currently-available services (Section 6), and
5. Recommending ways to improve the provision of services for the street homeless population in Oxfordshire (Section 7).

Section 1: Background.

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2.   Methods (in brief)

The methods employed for this health needs assessment are outlined in detail in Section 7.

Briefly, various data sources were used to assess the size and demographics of this population as well as their health needs. No single data source was able to comprehensively provide all the data that was required, and each data source comes with limitations. Therefore, where possible, multiple data sources have been combined to triangulate information. Routinely and previously collected data were collated for this report, and some data were specifically collected for this health needs assessment.

Data specifically collected for this health needs assessment:

- *The HomelessLink Health Needs Audit* is a detailed, lengthy questionnaire that has been used nationally to assess the health needs of people experiencing homelessness. 22 questionnaires were administered in Oxfordshire between March and April 2019, and the responses were compared to 3,355 responses from across the UK. (Appendix 1).
- *Focus groups with people experiencing homelessness* were conducted in Banbury and Oxford City. Each of the two focus groups had five participants, one was all-female to capture issues specific to the female homeless population. (Appendix 2).
- *Discussions with experts and providers* of services to the homeless population, covering the health needs of people experiencing homelessness, service mapping and an assessment of what works well and what could improve, were held between February and June 2019.
- *A workshop on homeless health* was held in June 2019. Many service providers gathered to hear early findings of the report and discuss creative solutions.

Routinely/previously collected data analysed for this report:

- *The Oxford Tackling Homelessness Information Network (OxTHINK)* is a multi-agency database that records information on rough sleepers in Oxford City and anyone in supported accommodation across Oxfordshire.
- *An audit of homeless attendances to the John Radcliffe Hospital* was conducted between April 1st 2017 and March 31st 2018. The John Radcliffe Hospital is Oxfordshire's largest hospital. The audit recorded all attendances from people experiencing homelessness across 12 months, including general demographics, discharge diagnoses and their registered GP.
- *Service utilisation data* from specific providers:
    - Luther Street Medical Centre (a specialist homeless GP practice)
    - Turning Point (drug and alcohol service)
- *Housing information* from district/city councils in Oxfordshire

3.   The street homeless population

3.1   How many people are street homeless in Oxfordshire?

No formal estimates exist for the size of the street homeless population in Oxfordshire.

To provide an overall estimate, the numbers of people sleeping rough and of people living in supported accommodation are estimated below and combined. Sofa surfers may also be considered part of the street homeless population, but numbers of sofa surfers were not available.

Households in temporary accommodation are also homeless, but are not street homeless. Some information on households in temporary accommodation is included below for information.

This is the first attempted estimate of the overall homeless population in Oxfordshire, and quite methodologically simplistic. It should be treated only as a 'best guess', not an absolute number.

Section 3: The street homeless population.

Rough sleepers

The best guess of the number of rough sleepers at any one time comes from estimates based on street counts[iii]. On one night in November 2018, an estimated 119 people were sleeping rough in the county:

94 in Oxford City	(79.0% of all estimated rough sleepers in the county)
11 in Cherwell	(9.2%)
9 in Vale of the White Horse	(7.6%)
3 in South Oxfordshire	(2.5%)
2 in West Oxfordshire	(1.7%)

Over the course of one year[33] (April 2018 to the end of March 2019), the number of people sleeping rough in different parts of the county were:

441 in Oxford City

78 in Cherwell

110 in South Oxfordshire and Vale of the White Horse (who maintain a joint database)

30 in West Oxfordshire.

Clearly, there is some missing data. These data can be approximately imputed with some basic calculations. Across Oxford City, South and Vale and West Oxfordshire, 659 people were counted sleeping rough in the course of the year, 5.4 times as many people as were counted on one night (117).

Based on the limited data available, it is estimated that 600-700 people sleep rough somewhere in Oxfordshire in the course of a year[iv], with 100-150 sleeping rough somewhere in the county on any one night.

[iii] Rough sleeping counts/estimates are mandated by central government and follow a prescribed methodology: https://www.homeless.org.uk/connect/blogs/2018/sep/20/rough-sleeping-counts-and-estimates-all-you-need-to-know

[iv] It is worth noting that these estimates assume each District has a separate rough sleeping population with no overlap. This is inaccurate; many people spoken to for this report mentioned sleeping rough in more than one District. This would mean the above numbers are overestimates, though the size of this error is unknown. Conversely, these estimates assume that street counts and annual databases capture every rough sleeper and miss no-one. This is also likely to be inaccurate, and would result in the above numbers being underestimates. For simplicity, the unquantified net effect of these two counterbalancing errors has been ignored.

Section 3: The street homeless population.

People in supported accommodation

Each night, around 300 adults sleep in supported accommodation provided by the voluntary sector (see Table 3.1). Roughly half these (141/305, 46.2%) are part of the adult single homeless pathway, which is publicly funded. For more details on the Adult Single Homeless Pathway in Oxfordshire, see Section 5.4. Local charities accommodate approximately 80 further people (Table 3.2).The current total number of beds available between the public sector (305, 79.0%) and the voluntary sector (81, 21.0%) is 386.

It is therefore estimated that between 350-400 homeless adults sleep in some form of supported accommodation each night.

Between April 2018 and the end of March 2019, 513 different adults were accommodated in supported accommodation provided by the public sector[34]. Based on the proportion of beds split between the public and voluntary sector, 136 additional people may be expected to be accommodated in supported accommodation provided by the voluntary sector in the course of a year (therefore totalling 649 people across the two sectors). However, some may move on from public sector accommodation into voluntary sector accommodation so there is probably overlap between these.

Around 600 to 650 homeless adults are therefore accommodated in some form of supported accommodation in the course of a year, with around 350-400 people sleeping in supported accommodation each night.

Section 3: The street homeless population.

Sofa surfers

Sofa surfers are perhaps the most difficult group of people experiencing homelessness to count. Sofa surfers often stay with friends or family and therefore have an address, they may not self-identify as homeless and may avoid services aimed at "the homeless" (e.g. by maintaining registration with their previous GP).

There are some reasons to believe the health of sofa surfers is unlikely to be as bad as people who are more visibly homeless – for example, they are not rough sleeping so are less likely to be subject to health issues related to exposure to the elements, hygiene or vulnerability to abuse and may still be benefiting from the material support of social networks.

Nevertheless, they may have particular issues that complicate health and healthcare. If they do not have an address they can use for post, coordinating care and arranging follow-up is difficult. Sometimes, a place to stay is not offered freely and instead "exchanged". Such situations (which are often not explicit or arranged in advance) may involve exchanging sex, drugs or conducting illegal activities on behalf of their 'landlord' (such as shop-lifting or dealing drugs), on whom the sofa surfer is dependent. This dependency also creates unique vulnerabilities, including to threatened or actual violence. Sofa surfing may therefore carry associated, particular health issues.

Although this group is very difficult to measure, it appears there is significant overlap between sofa surfers and rough sleepers – unfortunately, many sofa surfers become rough sleepers for a period of time. Qualitative research from the Nuffield College's Centre for Social Investigation exploring the life course of people's homeless journeys has revealed considerable transitions between sofa surfing and rough sleeping (as well as other forms of homelessness)[v]. In the HomelessLink Health Needs Audit conducted for this report, 20/22 respondents (90.9%) reported rough sleeping at some point in their lives, of which 17 (85.0%) also reported sofa surfing, usually around the same age. Many also reported staying in hostels. In focus groups, street homelessness and sofa surfing were commonly referred to together, with little difference between them. Thus whilst the group may be difficult to count, it is hoped some of their health needs may be captured in the assessment of health needs of homeless groups who are more visible.

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[v] Dr Elisabeth Garratt & Dr Jan Flaherty (Centre for Social Investigation, Nuffield College, University of Oxford), personal communication, June 2019

Section 3: The street homeless population.

Overlap between these groups

In the course of a year, some rough sleepers enter supported accommodation, some people in supported accommodation may sofa surf, and some sofa surfers may sleep rough. There is therefore overlap between the number of rough sleepers and the numbers of people in supported accommodation (and the number of sofa surfers, though this number is not known) and individual estimates of the different population cannot simply be combined to provide an overall estimate. From OxTHINK, it is known that 170 rough sleepers in Oxford City entered publicly funded supported accommodation at some point between April 2018 and the end of March 2019. It is not known how many rough sleepers from other parts of the county entered publicly funded supported accommodation, or how many rough sleepers entered supported accommodation not supported by public funds (that accommodation is not currently captured by OxTHINK). 170 is therefore probably most, but not all, of the overlap between these groups.

By combining annual estimates of rough sleepers (~600-650) and those in supported accommodation (~600-650), and discounting the overlap between these groups (~200-300), it is estimated that **around 1,000 homeless adults sleep rough or in supported accommodation in the course of a year. Around 500 homeless adults sleep rough (~100-150) or in supported accommodation (~350-400) on any given night.**

To reiterate, these numbers are very approximate and should not be considered final, but they hopefully give some idea of the size of this population and the scale of the issue facing organisations seeking to provide services for homeless adults.

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Table 3.1: Approximate numbers of beds in supported accommodation funded by the public sector across Oxfordshire. Data may not be 100% accurate as complete information is difficult to obtain and verify, and the system is in constant flux to try to respond to the most urgent needs.

	Geographically located within Oxford										Located outside Oxford				Total
	O'Hanlon House	Simon House[vi]	Project 41	Connection	May Day	Acacia	Housing first	Women's house	Pre-drug recovery	Post-drug recovery (Sapling)	Banbury	Witney	Vineyard (Abingdon)	Mind (Abingdon)	
Oxford City	28	22	41	31	30	5	5	5	5	-	-	-	-	-	172
Cherwell	11	10	-	-	-	-	-	-	-	-	13	-	-	-	34
West	5	10	-	-	-	-	-	-	-	-	-	6	-	-	21
South	6	-	-	-	-	-	-	-	-	-	-	-	7	4	17
Vale	6	-	-	-	-	-	-	-	-	-	-	-	7	4	17
Open to all districts	20-30[vii]	10	-	-	-	-	-	-	7	7	-	-	-	-	44
Total	76	52	41	31	30	5	5	5	12	7	13	6	14	8	305

Table 3.2: Additional beds for people experiencing homelessness or recovering from homelessness, with various levels of support. Data may not be complete, but is the most up-to-date information available at the time of writing.

Provider	Beds
Emmaus	28
Compass (run by Homeless Oxfordshire)	18
Reconnect (run by Homeless Oxfordshire)	14
Edge	13
ACT	8
Total	**81**

[vi] Simon House is closing soon. In its place, a new 37-bed hostel will open in Rymers Lane (East Oxford) to serve those with a City connection. Cherwell District Council has commissioned 10 beds in shared houses in East Oxford to be managed by Homeless Oxfordshire to make up their shortfall. Neither Rymers Lane nor the Cherwell accommodation in East Oxford are included in this table as Simon House was still open at the time of writing.

[vii] O'Hanlon House also accommodates 20 people per night in 'sit-up' accommodation (these are verified rough sleepers who are given some bedding and a space on the floor to sleep. 10 additional rough sleepers can be accommodated during severe weather as part of the severe weather emergency protocol (SWEP). The 20 sit-up 'beds' are included in the total for O'Hanlon House as they are used every night so these people would not be counted in rough sleeping estimates. The 10 SWEP 'beds' are not included in the total to avoid double counting – as they are only available for some nights, and therefore the same people may be counted as rough sleepers.

Section 3: The street homeless population.

3.2 Trends in homeless population in Oxfordshire

The number of rough sleepers is increasing (Figure 3.1). Figures for 2019 will likely be available in November or December 2019.

Figure 3.1: Number of people sleeping rough, by District, 2010-2018. Data are intelligence-based estimates based on street counts, following a national methodology developed by HomelessLink[35].

	2010	2011	2012	2013	2014	2015	2016	2017	2018
Oxford	11	8	12	19	43	56	47	89	94
Cherwell	0	0	2	14	14	21	17	9	11
South	1	0	0	5	3	5	7	2	3
Vale	0	0	0	5	5	5	8	10	9
West	1	5	5	2	3	3	0	7	2
Total	**13**	**13**	**19**	**45**	**68**	**90**	**79**	**117**	**119**

The number of people in temporary housing is more static (the same is true of supported accommodation but the numbers are not available). This is largely because these units are often at capacity and constructing/identifying additional accommodation space takes time. As increases in the population of people experiencing homelessness outstrip increases in the provision of supported accommodation and temporary housing, more people will likely sleep rough.

Section 3: The street homeless population.

3.3   Where are the people experiencing homelessness in Oxfordshire?

Across the county, the largest numbers of rough sleepers, people in supported accommodation and people in temporary accommodation are all in Oxford City.

It is well recognised that Oxford City has the largest homeless population. Most of the beds in the adult single homeless pathway are therefore located in Oxford City (108/141, 76.6%), and the county's only specialist homeless GP service is in Oxford City.

However, there are significant numbers of people experiencing homelessness in Oxfordshire outside Oxford City. As demonstrated in Section 3.1, almost 200 people slept rough in Cherwell, South Oxfordshire or Vale of the White Horse in the course of a year. An audit of people experiencing homelessness attending the John Radcliffe Hospital (itself within Oxford City and likely to overrepresent people living nearby) found over 30% were registered with GPs outside Oxford City[viii].

Additionally, even those *in* Oxford City are not necessarily *from* Oxford City. Of 61 rough sleepers in Oxford City in a street count in 2017 for whom the connection was recorded, only 6 (9.8%) had a local connection to Oxford City. Some (13, 21.3%) had a connection to another part of Oxfordshire, but the remainder had no local connection.

Clearly, there are people experiencing homelessness in Oxford City who are originally from other parts of the county, or even outside Oxfordshire. There are probably many reasons for this:

* Service providers, convened at a recent workshop to discuss health and homelessness, felt people experiencing homelessness may be choosing to move to Oxford City, to be part of a larger homeless community or to earn more money by begging in a large, well-touristed urban centre.
* In focus groups, people experiencing homelessness mentioned travelling to Oxford City because of the availability of specialist services (e.g. healthcare, including the John Radcliffe Hospital and Luther Street Medical Centre).
* The vast majority of beds in the adult single homeless pathway (and all hostel beds, most often used for people with the highest level of need) are in Oxford City. People experiencing homelessness are therefore often moved from across the county to Oxford City for accommodation.

[viii] 320 homeless people attended the emergency department, 69 (21.6%) were not registered with a GP and the remaining 251 patients were registered at 101 different general practices. 79 of these practices were outside Oxford City, and 52 of these were outside Oxfordshire County. (The data do not permit calculations of the number of people registered outside Oxford City, though it is at least one per practice, therefore even the most conservative estimates are that at least 31.5% (79/251) of GP-registered people in this audit were registered with a GP from outside Oxford City, and at least 20.7% (52/251) were registered with a GP outside of Oxfordshire). Within Oxfordshire, general practices in Banbury and Bicester (both in Cherwell District) saw significant numbers of their patients included in the audit.

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3.4   Who is homeless in Oxfordshire?

Gender

Around 80% of homeless adults are male, but the proportion of women has increased in recent years.

The proportion of males is broadly consistent across:

*   OxTHINK data from April 2018 to the end of March 2019 (621/776, **80.0%**)

*   Turning Point service users in June 2019 with no fixed abode (234/289, **81.0%**)

*   Homeless adults presenting to the Emergency Department at the John Radcliffe between April 2017 and the end of March 2018 (255/320, **79.7%**).

*   And registration with Luther Street Medical Centre in March 2019 (370/464, **79.7%**)

However, several providers mentioned the increasing number of female people experiencing homelessness in recent years. The proportion of females in OxTHINK data has increased from 12.8% in 2012 to 20.3% in 2019 (Figure 3.3).

Figure 3.3: Proportion of females recorded in the OxTHINK database, 2012-2019. Data provided by Dr Lan Nguyen. Numbers on chart reflect percentages of females recorded on OxTHINK database.

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Age

Most homeless adults are aged between 30 and 50, but the proportion of young people has increased in recent years.

59.4% (461/776) of all those recorded on OxTHINK between April 2018 and the end of March 2019 and 54.0% (250/464) of those registered with Luther Street Medical Centre in March 2019 were aged between 30 and 50. The median age of people experiencing homelessness attending the Emergency Department at the John Radcliffe was 41, and the median age recorded in OxTHINK was 40.

Figure 3.4: Population pyramid for people recorded in OxTHINK between April 2018 and the end of March 2019. Data provided by Dr Lan Nguyen. Numbers of on chart reflect absolute numbers of people, by gender and age bracket.

Section 3: The street homeless population.

In the calendar year 2012, 6.4% of people recorded in OxTHINK were under 30. In calendar year 2018 (the last year with full data), the proportion had more than tripled to 20.0% (Figure 3.5).

Figure 3.5: Age profile of people recorded on OxTHINK, calendar years 2012-8. Data and figure provided by Dr Lan Nguyen.

Prison leavers
High proportion of people leaving prison do so to No Fixed Abode (NFA), particularly if on remand or short sentence. They would therefore fit within the definition of having no secure place to live. This report does not include a specific measure of this population, but this could be considered in the future.

Section 3: The street homeless population.

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[35] Oxford City Council. 2018. Councils release annual estimate of rough sleeper numbers in Oxfordshire. URL: https://www.oxford.gov.uk/news/article/958/councils_release_annual_estimate_of_rough_sleeper_numbers_in_oxfordshire

4.   Health needs of the homeless population

"Long term homelessness is characterised by 'tri-morbidity' – the combination of mental ill health, physical ill health and drug or alcohol misuse." Hewett et al. 2012. *British Medical Journal.*

Each of these three areas are detailed below with reference to Oxfordshire's homeless population.

Section 4: Health needs of the homeless population

4.1   Mental health

"Mental health issues can lead onto being homeless, but also, if you don't have mental health issues when you become homeless, they can certainly develop, like anxiety and depression. It's like a vicious circle." Participant, focus group for people experiencing homelessness, May 2019

Felt need

Mental health is an important issue amongst people experiencing homelessness nationally and internationally, and Oxfordshire is no exception. In focus groups with people experiencing homelessness in Banbury and Oxford City, mental health issues were identified overwhelmingly as the most common and important health conditions faced by participants. Figure 4.1, below, shows the responses when homeless participants were asked to put a sticker by the most serious health issue that they face (anxiety was voted as the most important health issue 13 times, and depression was voted most important 12 times across the two focus groups, compared to just one vote for cancer across the two focus groups).

Of the 21 respondents who completed the relevant sections of the HomelessLink Health Needs Audit all but two (19/21, 90.4%) reported having been diagnosed with a mental health issue, of which 14 had been an issue within the last year. Depression (18/19, 94.7%) and anxiety (14/19, 73.7%) were again the most frequent, but respondents had also been affected by psychosis, personality disorder and eating disorders. This is very similar to the national picture – 86% of 2,697 respondents across the country reported a mental health issue, and again depression was the most common.

Figure 4.1: During focus groups, people experiencing homelessness placed a star by the health issue they felt most seriously affects them.

Anxiety and depression were recognised as the most important health issues in both focus groups.

Section 4: Health needs of the homeless population

Expressed need

Mental health needs are amongst the most commonly expressed need recorded on OxTHINK, where an extraordinary three quarters of people (383/518, 73.9%) report a mental health issue[ix].

Unfortunately, the Oxfordshire Mental Health Partnership do not record the housing status of patients attending their services, so the data is not available to estimate how much these reported needs translate into demand for mental healthcare. However, in the recent audit of homeless attendances to the John Radcliffe Hospital (see Section 8.6), the most common primary diagnoses at discharge for homeless patients were mental health/behavioural issues due to alcohol (18.7% of all discharge diagnoses), mental health and emotional instability (5.9%) and poisoning with paracetamol (3.2%), which is overwhelmingly due to deliberate self-harm. Even these relatively imprecise codes account for over a quarter of all attendances of people experiencing homelessness to the emergency department, indicating a high level of expressed need.

Normative need

As mentioned above, mental health issues were recorded as a support need for 73.9% of people on OxTHINK, and accounted for a significant proportion of all emergency department attendances of people experiencing homelessness. Data from Luther Street Medical Centre reiterates the high level of normative need for mental health conditions – 13.2% of active patients (61 out of 463 people who had had contact with Luther Street Medical Centre in the last year) were registered as having a severe long-term mental illness, and 15.7% (73/463) had a personality disorder (from the summary data available, it was not possible to ascertain the overlap between these groups). In line with the felt need, in the year from April 2018 to March 2019, over a third of users had sought care for depression (117/463, 38.2%) and a quarter had been diagnosed with anxiety (111/463, 24.0%).

Nationally, mental health issues are not just a significant cause of morbidity amongst the homeless population. According to the Office for National Statistics[x], around 15% (412/2627) of the deaths in homeless adults between 2013 and 2017 were due to suicide[36].

However, there is some debate about the relative importance of suicide as a cause of death in people who are homeless. A recent well-designed study found that deaths by suicide made up a much smaller

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[ix] This is almost certainly an underestimate, as these support needs are often recorded after an initial verification with a member of the local outreach team. Understandably, people may not report mental health issues on a first meeting in the street, or they may be reported but not recorded.

[x] These are Experimental Statistics based on death certification data mainly of people sleeping rough or using emergency accommodation such as homeless shelters and direct access hostels around the time of death. The methodology remains in development and estimates have yet to be assessed against the rigorous quality standards of National Statistics. See: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/methodologies/deathsofhomelesspeopleinenglandandwalesqmi

proportion (9/600, 1.5%) of all homeless deaths, and this proportion was similar to the proportion amongst the housed comparison group (22/2512, 0.9%)[37]. Part of this discrepancy is likely due to the different methodologies employed, and the true number is likely to be somewhere between these two estimates. There were 175 deaths by suicide recorded by in the Oxfordshire Suicide Surveillance System in 2014, 2016 and 2017 (the years with available data), and none recorded homelessness as a risk factor[38].

Nevertheless, local data – GP-practice data, Emergency Department data, registers of support needs, the HomelessLink Health Needs Audit and focus groups with people experiencing homelessness – as well as national data all identify mental health issues as amongst the most common and important health problems faced by the homeless population in Oxfordshire.

High levels of mental health issues probably contribute to the development of other health needs, particularly substance misuse and addiction. For example, over two-thirds of all respondents to Oxfordshire's HomelessLink Health Needs Audit (15/22, 68.2%) reported using drugs or alcohol to help cope with their mental health.

Section 4: Health needs of the homeless population

4.2   Substance misuse

Felt need

The people experiencing homelessness who were consulted for this report felt that substance misuse was a major issue, and often trumped all other health concerns. One focus group participant said: "you don't go to your doctors' appointments, you don't give a f*** about your health, so it deteriorates – because you're a druggie or you're an alcoholic". As mentioned in Section 4.1, several focus group participants also reported using drugs to self-medicate for under-treated mental health issues. 17/22 (77.2%) people completing the HomelessLink Health Needs Audit reported either having or recovering from a drug problem.

Expressed need

Nationally, 20% of people in treatment for drug and alcohol issues have a housing problem, either rough sleeping or being at serious risk of homelessness. This proportion of those with housing issues rises to around 30% for opiate users and around 60% for users of opiates and synthetic cannabinoids[39].

In Oxfordshire, between April 2017 and the end of March 2018, 80 out of 220 (36.4%) newly presenting opiate users were in a perilous housing situation[40]. This places a significant demand on services: in June 2019, 294 out of 2,666 (11.0%) of all people using Turning Point services (see Section 4.2) were registered with no fixed abode. The proportion of people with no fixed abode was highest in the Oxford (13.2%) and Banbury (13.4%) hubs, and the absolute number of homeless clients was highest in Oxford City (165) then Banbury (80) (Table 4.1).

Table 4.1: Number and proportion of clients with no fixed abode, by Turning Point hub. Data provided by Turning Point.

Hub location	District	Total number of clients	Number of clients with no fixed abode	Proportion of clients with no fixed abode (%)
Oxford	Oxford City	1,251	165	13.2
Banbury	Cherwell	596	80	13.4
Didcot	South	566	35	6.18
Witney	West	253	14	5.53
Total	**Oxfordshire**	**2,666**	**294**	**11.0**

Normative need

On OxTHINK, 367 of 460 (79.8%) for whom relevant support needs were recorded had either a alcohol misuse or drug misuse issue (263, 50.0%, were recorded as misusing alcohol and 299, 59.0%,

were recorded as misusing other substances). Data from Luther Street Medical Centre corroborates the high levels of substance misuse needs – 208/463 active patients (44.9%) had a recorded drug dependency[xi].

Unsurprisingly, these high levels of need in outreach and primary care translate into secondary care usage. Research from Oxford University revealed substance misuse as the leading cause of hospital admission amongst homeless adults across England[41]. (It is difficult to estimate hospital admission rates for substance misuse specifically within Oxfordshire, though conversations with staff at the John Radcliffe Hospital and the Oxfordshire Mental Health Partnership at the recent providers' workshop anecdotally suggest this is not uncommon).

Furthermore, this high level of substance misuse amongst people experiencing homelessness causes deaths. According to the Office for National Statistics, opiate, alcohol and poisoning with other drugs claimed the lives of almost 1,000 homeless adults between 2013 and 2017, constituting over one third of all deaths (944/2627, 35.9%). Drug poisoning has been implicated in some of the recent deaths amongst people experiencing homelessness in Oxfordshire[42].

[xi] This data only reflects people who had sought care related to these issues at Luther Street Medical Centre, whereas OxTHINK is a multi-agency database where multiple providers can report support needs. OxTHINK may therefore represent a higher, and more accurate, prevalence of these issues than the Luther Street data.

Section 4: Health needs of the homeless population

4.3   Physical health

Felt need

Whilst substance misuse and mental health issues rightly garner a lot of attention, physical health issues should not be neglected. However, physical health issues appear to feature low down on the list of priorities faced by people experiencing homelessness. One focus group participant summed up her priorities whilst living on the streets: "When you're on the drugs, you don't care about yourself. To go to the doctors seems like such a mission. You just take more drugs to block it out.".

Across the two focus groups, when asked which health issues are the most serious facing them, a combination of cancer, diabetes, heart disease, high blood pressure or high cholesterol, liver disease, infections like hepatitis or HIV and lung disease received a total of five votes between them (whilst depression and anxiety received 25 votes between them).

Expressed need

Perhaps consequently, physical health issues have very mixed levels of expressed need.

Primary prevention (preventing a disease before it ever occurs) for chronic conditions is an example of low levels of expressed need. For example, approximately 90% of people experiencing homelessness smoke tobacco (415/463 (89.6%) of people seen at Luther Street Medical Centre in the last year, and 18/20 (90.0%) of respondents to the HomelessLink Health Needs Audit). However, despite eight of the 18 smokers who responded to the HomelessLink Audit reporting either asthma, chronic obstructive pulmonary disorder (COPD) or both (and the majority of those reporting being offered assistance from a healthcare professional to quit smoking), only three expressed a desire to stop smoking and just two had taken up the offer of assistance to quit. Additionally, most respondents in the HomelessLink Health Needs Audit (15/22, 68.2%) ate one piece of fruit or less each day, and just 3/22 (13.6%) met national guidelines for exercising (11/22, half of all respondents, never exercised).

However, there are very high levels of expressed need for acute physical health issues. The 463 active patients at Luther Street Medical Centre between April 2018 and March 2019 had 7,898 appointments between them, an average of over 17 appointments per person (for comparison, the combined number of face-to-face consultations, telephone consultations and home visits for each member of the general population is less than 4[43]). People experiencing homelessness also often attend the Emergency Department more than the general population[44]. Between April 2017 and March 2018, 320 homeless patients accounted for 667 attendances to the Emergency Department at the John Radcliffe, an average of 2.1 attendances to the Emergency Department per homeless attendee per year, compared to

Section 4: Health needs of the homeless population

0.11 Emergency Department attendances across the entire Oxfordshire population per year[xii]. This may also be an under-representation as some patients may give an address where they have been placed in supported housing, and therefore the system may not pick them up as homeless, despite this only being a short-term accommodation solution.

Normative need

In many cases, these attendances to the Emergency Department did result in admission – homeless patients were admitted to the John Radcliffe 219 times between April 2017 and March 2018, indicating high levels of normative need[xiii]. Of the 103 admissions under clinical teams other than the Emergency Department, the majority (55/103, 53.4%) were under general medicine, with a significant minority admitted under general surgery teams or the infectious disease team (both 14/103, 13.6% each). A few (5/103, 4.9%) were admitted under the hepatology team, who manage liver conditions.

One liver condition that appears to be a significant health issue amongst people experiencing homelessness in Oxfordshire is Hepatitis C. 6/22 (27.3%) respondents in the HomelessLink Health Needs Assessment reported having had Hepatitis C virus at some point in their lives, which is similar to the national picture (240/974, 24.6%)[xiv]. This lifetime estimate is expectedly higher than the prevalence of current infection in London[45] or in Birmingham[46], and a little higher than the measure of lifetime exposure in a further London-based study[47]. (Alcohol misuse, which – as detailed in section 4.2 – is very common amongst people experiencing homelessness, is also a common cause of liver damage, but the prevalence of alcoholic liver disease in this population could not be estimated with data that is currently available).

[xii] Approximate calculation based on 76,684 attendances to Emergency Departments (ED) run by Oxford University Hospitals in 2016/17, against a population of Oxfordshire of 682,444 in 2017. Comparing this number of attendances per person per year to the number of attendances *of people who attended ED at least once*, as done above for homeless people – is problematic because people who attend ED once are more likely to attend again. Comparing the rate of 2.1 attendances per homeless person per year with the rate of 0.11 attendances per person per year for the entire population may thus artificially inflate the attendances from homeless people relative to the general population, and has only been done because of the difficulties in calculating a denominator for the homeless population. However, even taking the population estimate from Section 3.1.3 (approximately 1,000), the ED attendance rate would still be 667/1000 – six times the rate for the entire population. Furthermore, the 667 ED attendances recorded in the hospital audit is likely to be an underestimate due to the strict criteria used to define homelessness (see Section 8.6), and only attendances at one hospital is captured for the homeless population, whereas the figure for the general population captures all Oxfordshire hospitals.

[xiii] As noted in Section X, many of these admissions may not have been for a strictly "physical health" issue [in this context, meaning not a substance misuse or mental health issue]. However, whilst the majority of admissions (116/219, 52.9%) were under the Emergency Department, where care is provided across a broad spectrum of illnesses probably including substance misuse and mental health, 55 (25.1%) were under general medicine, and therefore much more likely to be a "physical health" issue, whilst the remaining 48 (21.9%) were under medical and surgical specialties which are very likely to limit their care to those with "physical health" issues.

[xiv] At least some of the questionnaire responses were from Turning Point, the drug and alcohol service, which may over represent intravenous drug users who are more likely to have blood-borne viruses than the general population. The prevalence of Hepatitis C in this survey may therefore not reflect the prevalence of Hepatitis C in people experiencing homelessness across the county.

Section 4: Health needs of the homeless population

Despite the high prevalence of substance misuse and mental health issues, according to a large recent study by Aldridge et al[48], the causes of death amongst people experiencing homelessness may be more similar to the housed population, and therefore more based around 'physical' health issues, than previously thought (Figure 4.2). For example, in that study, cancer; ischaemic heart disease; respiratory disease (e.g. COPD); liver disease and lower respiratory tract infections (e.g. pneumonia) were the leading causes of death amongst 600 people experiencing homelessness admitted to hospitals in England. People experiencing homelessness in Oxfordshire are not immune from these same chronic conditions – for example, over a quarter of active patients registered at Luther Street Medical Centre (125/463, 27.0%) had high cholesterol, a risk factor for cardiovascular disease)[xv]. 4.5% (21/463) had been diagnosed with COPD compared to 4.9% of homeless people nationally[49][xvi]. It should be noted, however, that substance misuse issues, as well as homelessness, can influence treatment compliance for physical health conditions, thereby this may be linked to exacerbation of chronic conditions in this population.

Importantly, one third of the deaths in the Aldridge study were from conditions amenable to healthcare and which may have been prevented, with proper and timely care. It is therefore crucial that people experiencing homelessness seek appropriate care for these chronic conditions, and thus the low demand for primary prevention of chronic conditions in Oxfordshire (as evidenced by the large numbers of smokers experiencing homelessness who have not taken up offers to help stop smoking) is concerning.

[xv] This figure is for a very crude measure of high cholesterol, a total cholesterol above 5.0mmol/L (or a diagnosis of raised cholesterol). Actual cardiovascular risk is dependent on many factors, including the use of lipid-lowering therapy to bring the cholesterol down, which was not investigated here.

[xvi] COPD is commonly underdiagnosed, especially in homeless populations. One US study examining this phenomenon found that whilst only 4% of homeless people reported a diagnosis of COPD, the prevalence when testing lung function was 15% (Snyder, L. & Eisner, M. 2004. Obstructive lung disease among the urban homeless. *Chest*). Prevalence estimates from other UK providers (14.0% in one London-based study [Lewer, D. et al. 2019. Health-related quality of life and prevalence of six chronic diseases in homeless and housed people: a cross-sectional study in London and Birmingham, England. *BMJ Open*]) are more consistent with the US experience, and it is likely both the Oxfordshire figure and the national estimate reported above are underestimates.

Figure 4.2: Causes of death in people experiencing homelessness versus the housed population.
Figure adapted from Aldridge, R. et al. 2019. Causes of death among homeless people: a population-based cross-sectional study of linked hospitalisation and mortality data in England. *Wellcome Open Research.*

Underlying cause of death
- All other causes
- Chronic lower respiratory diseases
- Other forms of heart disease
- Mental and behavioural disorders due to psychoactive substance use
- Influenza and pneumonia
- Malignant neoplasms
- Ischaemic heart diseases
- Diseases of liver
- Suicides
- Accidents

As well as suffering mortality from chronic conditions, people experiencing homelessness in Oxfordshire experience high levels of morbidity from acute health conditions. For example, 21.8% (101/463) of active patients registered at Luther Street Medical Centre sought care for an injury between April 2018 and March 2019. Some of these injuries are likely due to assault: rough sleepers are 17 times more likely to be victims of violence than the general public[50]. Skin infections (65/463, 14.0%), venous thromboembolism (e.g. deep vein thrombosis/DVT, 64/463, 13.8%), and dental caries (54/463, 11.7%) were also common presenting complaints.

Despite a high incidence of tuberculosis (TB) detected in other parts of the country, a register of TB cases in Oxfordshire in the preceding three years show no cases amongst people with a housing issue.

There are also some particular health needs amongst the growing proportion of women experiencing homelessness. In focus groups, women highlighted sexual and reproductive health and violence as important, gendered issues. "It's dangerous out there, of course it is." Another said: "It's hard. As a woman on the streets, it's hard to even go to the toilet on the streets." Some focus group participants had been involved in commercial sex work whilst living on the streets, a phenomenon also observed elsewhere in the UK[51]. Furthermore, whilst not disclosed by any people experiencing homelessness in Oxfordshire[xvii], nationally a quarter of female rough sleepers have been sexually assaulted whilst sleeping on the streets[52]. In addition, the Local Government Association acknowledges that young people are also "at more risk of sexually transmitted infections and unwanted pregnancies, and can come under pressure to exchange sex for food, shelter, drugs and money."[53] As the size of both the

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[xvii] Sexual assault was not discussed in focus groups or asked about in the HomelessLink Health Needs Audit as neither were deemed appropriate forums for intimate discussions without follow-up.

young and female homeless populations increase, sexual and reproductive health needs are likely to grow in importance.

4.4   Multiple comorbidities

Any one of mental ill health, physical ill health or substance misuse whilst homeless is a complicated issue to resolve. The complexity is multiplied when these issues co-exist. SM, who died in January 2019 after many years spent homeless in Oxford, summed it up in a quotation to The Guardian: "I've always wanted to get clean, but it's not as simple as that if you've got mental health issues and you're living like this, being pushed from pillar to post." Both being homeless[54] and having mental health issues[55] both significantly reduce the likelihood of successful completion of treatment for substance misuse[56].

Felt and expressed need

Multiple comorbidities are common amongst the homeless population of Oxfordshire. As SM's quotation illustrates, people experiencing homelessness intuitively understand the complexity of multiple comorbidities. In focus groups, people experiencing homelessness highlighted their desire for more multi-agency working, and their appreciation of services that do this well (e.g. Turning Point, which was positively referred to as a "one-stop shop"). One participant said: "The agencies need to work more closely together, more coherently, rather than working separately and against each other…". Another stated: "The left hand doesn't know what the right hand is doing. When they do operate together sometimes, they seem to be conflicting. You're told to do one thing by one and the other says 'oh, no, you can't do that'. When faced with that all you want to do is isolate yourself."

Normative need

People experiencing homelessness have very high levels of overlapping needs. Fewer than a fifth of homeless people are not experiencing more than one of either physical health issues, mental health issues, alcohol misuse or another substance misuse (Figure 4.3). This is in line with experience across the UK[57]: one author writing about the health of people experiencing homelessness writes: "Because of multimorbidity, homeless people are at risk of fragmentation of care. Diversification of services under one roof, preventive services, and multidisciplinary care are imperative.".

Figure 4.3: Numbers, proportions, and overlap between support needs, as recorded on OxTHINK. Data and figure from Dr Lan Nguyen.

Support need	Alcohol misuse	Physical health issues	Mental health issues	Other substance misuse
n	263	299	383	299
Proportion of those with need recorded (%)	50	57	74	57

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[36] Office for National Statistics. 2019. Deaths of homeless people in England and Wales – local authority estimates, 2013 to 2017.

[37] Aldridge, R. et al. 2019. Causes of death among homeless people: a population-based cross-sectional study of linked hospitalisation and mortality data in England. *Wellcome Open Research*

[38] Culmer, S. 2018. Oxfordshire Suicide Surveillance: Summary of findings for calendar year 2017. *Oxfordshire County Council*

[39] Public Health England. 2019. National Drug Treatment Monitoring System. URL: https://www.ndtms.net/ViewIt/Adult

[40] Public Health England. 2019. National Drug Treatment Monitoring System. URL: https://www.ndtms.net/ViewIt/Adult

[41] McCormick, B. and White, J. 2016. Hospital care and costs for homeless people. *Clinical Medicine.*

[42] Booth, R. 2019. Spike in deaths of Oxford rough sleepers rocks community. *The Guardian.*

[43] Hobbs, R. et al. 2016. Clinical workload in UK primary care: a retrospective analysis of 100 million consultations in England, 2007-14. *The Lancet.*

[44] Bowen, M. et al. 2019. Multimorbidity and emergency department visits by a homeless population: a database study in specialist general practice. *British Journal of General Practice.*

[45] Aldridge, R. et al. 2018. High prevalence of latent tuberculosis and bloodborne virus infection in a homeless population. *Thorax.*

[46] Bowen, M. et al. 2019. Multimorbidity and emergency department visits by a homeless population: a database study in specialist general practice. *British Journal of General Practice.*

[47] Aisyah, D. et al. 2018. Hepatitis C among vulnerable populations: A seroprevalence study of homeless, people who inject drugs and prisoners in London. *Journal of Viral Hepatitis.*

[48] Aldridge, R. et al. 2019. Causes of death among homeless people: a population-based cross-sectional study of linked hospitalisation and mortality data in England. *Wellcome Open Research.*

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5.   Services available to the homeless population, and gaps in service provision

People experiencing homelessness are legally able to access all health services available to the general population, including choosing their GP and presenting to any hospital, though these may not always be welcoming or appropriate for the homeless population.

There are also additional, specialist health services which serve homeless populations, for example Luther Street Medical Centre (see section 5.3.1).

Additionally, several hubs across the county provide a space for relevant services to come together. There are hubs in Bonn Square, Oxford City (operated by Oxford City Council); Hart Place, Bicester, Cherwell District (operated and hosted by the Salvation Army, with input from Connection Support and Turning Point); and St Mary's Centre, Banbury, Cherwell District (The Beacon, part funded by Cherwell District Council).

Additionally, outreach teams across the county identify and engage with people sleeping rough in order to link them to appropriate services (which sometimes accompany outreach workers).

Section 5: Services available to the homeless population and gaps in provision

5.1 Mental health

Most mental health services in the county are provided through the Oxfordshire Mental Health Partnership. One partner, Oxford Health NHS Foundation Trust, are rated as good by the CQC (other partners are not primarily health organisations and so are not inspected by the CQC). The Oxfordshire Mental Health Partnership runs a range of mental health services, including:

- Psychological therapies for mild mental ill-health such as mild/moderate depression or anxiety. These include talking therapy and cognitive behavioural therapy. In Oxfordshire, these are run by TalkingSpace Plus. People can self-refer online/by phone or be referred by their GPs, and services may be online, by phone or in-person (either group sessions or 1:1) across the county.

- Community (outpatient) psychiatric treatment, administered by adult mental health teams. Adult mental health teams are based across the county, one team covering Oxford City, another North and West, and another South Oxfordshire. Adult mental health teams manage the outpatient psychiatric care of people with psychiatric conditions or severe depression/anxiety.

- Safe Haven: an out-of-hours, non-clinical 'safe space' for people in mental health crisis, offering crisis support, signposting, safety planning and listening support over weekends.

- Emergency Department Psychiatric Services, available 24 hours a day, providing assessments and organise follow-up for people presenting to the Emergency Department at the John Radcliffe Hospital in mental health crisis.

- Inpatient psychiatric care at Littlemore Mental Health Centre (165 beds) and Warneford Hospital (75 beds) for people with severe mental health issues requiring inpatient care and supervision.

- Social workers at inpatient facilities to assist people experiencing severe mental health issues.

- Mental health housing pathway: Oxfordshire Mind and Response offer supported accommodation to people experiencing mental health issues. Prioritisation for these accommodation-based services is based on ensuring effective clinical care, and therefore often this accommodation is provided to people on discharge from an acute inpatient psychiatric ward to prevent them remaining in hospital inappropriately. As such, it is not designed specifically for people experiencing homelessness, but is available and useful for people experiencing homelessness if they have no stable accommodation to be discharged to.

- Some people have such severe mental illness that they are unable to sustain a tenancy even within the mental health housing pathway. Oxfordshire Mental Health Partnership are tackling this population through an innovative trial of microhomes for a small number of people with severe mental health diagnoses.

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The Oxfordshire Mental Health Partnership and Turning Point also collaborate to provide services for people experiencing both substance misuse and mental health issues, including regular meetings between Turning Point staff and members of the adult mental health teams and monthly joint assessment clinics where staff from both services are available. Additionally, a consultant psychiatrist attends Turning Point once a month for clinical reviews. A consultant psychiatrist also runs a clinic once a month at Luther Street Medical Centre and discusses individual cases with other clinicians.

Luther Street Medical Centre also have a permanent mental health worker (separate to the Oxfordshire Mental Health Partnership) who manages patients and sometimes accompanies the Oxfordshire Street Population Outreach Team (OxSPOT) on outreach visits. The adult single homeless pathway also includes five beds in supported accommodation specifically provided for people experiencing mental ill-health.

Gaps:
The largest gap in service provision appears to be in community mental health support.

In the HomelessLink Health Needs Audit, half of respondents (10/20) felt they were not receiving the mental health support they need[xviii]. In focus groups with people experiencing homelessness, TalkingSpace Plus received mixed reviews – participants felt the group sessions or online support were not sufficiently flexible and sometimes inappropriate for their needs. Several participants had been told they could not access TalkingSpace Plus whilst suffering from substance misuse[xix].

In discussions with providers, it was felt that the very high levels of depression and anxiety in the homeless population may not be adequately met through group sessions with the housed population (where the causes of and treatments for this level of mental health need might be very different) or online/telephone consultations, which may pose a barrier to the homeless population.

Some service providers felt the shortage of mental health support in the community went beyond TalkingSpace Plus and identified a gap in service provision for many people experiencing homelessness whose mental health issues are not severe enough to require admission to inpatient facilities under the Mental Health Act, but who are also not well enough to engage with services such

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[xviii] In answer to the question "If yes to any mental health need, are you receiving support/treatment to help you with your mental health problem?", four people answered "Yes, but I'd still like more help"; six answered "No , but it would help me". Six people replied "Yes, and it meets my needs" and four respondents replied "No, I do not need any". Two people did not have a mental health need so did not respond to this question.

[xix] It was difficult to verify the exact criteria for accessing TalkingSpace Plus, but it seems that people actively under the influence of alcohol or other drugs cannot attend services, though people in recovery would be permitted to access services. Either way, the perception amongst the people experiencing homelessness consulted for this report was that these services were not open and welcoming to them if they were suffering substance misuse issues.

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as the Adult Mental Health Teams. One senior manager of an outreach team said: "With many clients, we're just waiting for a dip in their mental health so that they can be admitted". Another senior manager of a housing provider felt "the threshold for access [to mental health services] is too high". This is a view shared by people experiencing homelessness: one focus group participants asked: "Have I got to be on top of a multi-story car park before someone will take me seriously? Have I got to be stood by a canal with rocks in my pockets, or at the train station ready to throw myself onto the tracks?". The high level of attendances to the Emergency Department with mental health issues may reflect this perceived gap in community mental health care.

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5.2   Substance misuse

At the time of writing, Turning Point are the main providers of drug and alcohol services in Oxfordshire. They operate four hubs around Oxfordshire, one in each of Oxford City, Banbury (Cherwell District), Didcot (South Oxfordshire District) and Witney (West Oxfordshire District), and are rated outstanding by the CQC.

Turning Point hubs are open to anyone, and people can seek care of their own accord or be referred by a professional (e.g. a GP or homeless outreach worker). There is a large crossover between Turning Point's population and the homeless population. In June 2019, Turning Point had 2,666 active patients, of whom 294 (11.0%) were recorded as having no fixed abode.

In addition to the four hubs, Turning Point provide outreach to services used by the homeless population. In total, Turning Point operate from tens of satellite locations each week: drug and alcohol workers from Turning Point work at Luther Street Medical Centre four days per week, at the homeless hub in Bonn Square three days per week, at O'Hanlon House two days per week, Simon House one day per week (the arrangements for the soon-to-open Rymer's Lane are not yet finalised) and at the hubs in Banbury and Bicester. A Turning Point worker sometimes accompanies OxSPOT on their morning outreach rounds in Oxford City.

Turning Point also attempt to reduce the harm resulting from drug use, for example by distributing foil to heroin users to encourage them to smoke rather than inject (which reduce overdoses and transmission blood-borne viruses) and by offering sterile needle exchange (to reduce transmission of blood-borne viruses). Both approaches also help to build therapeutic relationships with people not currently engaging in the full treatment process, often including people experiencing homelessness.

Turning Point also offer dried blood spot testing for blood borne viruses (Hepatitis B, Hepatitis C and HIV), and in Oxford City nurses from the hepatology service are present two days per week to perform further testing where indicated – so far over 100 people have completed hepatitis C treatment through these specialist nurses based at Turning Point.

Additionally, Turning Point hubs provide pregnancy tests and sanitary products as needed. In Oxford City, they are located in the same building as a sexual and reproductive health service and have referred homeless patients directly there when needed. "Turning Point's"[xx] ability to meet some

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[xx] In focus groups, some people grouped the services on Rectory Road (Turning Point and the sexual health clinic above) together and referred to it as Turning Point. This is because Turning Point were good at recognising need and signposting or accompanying clients to the sexual health clinic, even though the sexual health service is commissioned separately and run by a different provider.

sexual/reproductive health was appreciated by people experiencing homelessness, particularly in Oxford City.

Turning Point were highly appreciated by the people experiencing homelessness consulted for this report. One said: "Turning Point are brilliant. They are there for you. They guide you in the right direction.". Another said: "They just help, there's always someone to talk to there." A third person appreciated the lived experience of some Turning Point staff: "They've been through it. A lot of people in Turning Point have had history of drugs or alcohol. So they don't judge you, they know what you're going through, they know how hard it is to come off it. And that's why it's such a nice place."

Separate to Turning Point, the public health team commissions a needle exchange service across the county, the Sterile Works for Oxfordshire Premises (SWOP) scheme. 42 sites including hospitals and pharmacies, and one homeless hostel (O'Hanlon House), also distribute large numbers of sterile needles and associated equipment.

Gaps:
On the whole, Turning Point was well-received by providers and service users and the data suggest they are doing a very good job of providing appropriate services for people experiencing homelessness.

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5.3   Physical health

5.3.1   Primary care

Luther Street Medical Centre is a General Practice providing healthcare to adults (16 and over) experiencing homelessness (rough sleeping and vulnerable housing) in Oxford City. The service is run by Oxford Health NHS Foundation Trust and rated outstanding by the CQC.

The practice works with partners from a range of voluntary and statutory organisations to provide co-ordinated care to patients who find it difficult to register at other GPs and may otherwise not be able to access the care and treatment they require. Additionally, as the primary care provider for most people in the single homeless pathway, Luther Street healthcare professionals liaise extensively with patients' link workers to ensure holistic, joined-up care across services.

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

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- In addition, Luther Street provides training opportunities for medical and nursing students and for doctors and nurses in training.
- Patients can also access the award-winning PATHS (Promoting Access To Health Scheme), helping patients to attend hospital appointments, though this is dependent on volunteer support and therefore intermittent.
- The practice can also help by coordinating post.

Luther Street Medical Centre received positive reviews from every person consulted from this report, including service users who were consulted in focus groups conducted independently of the practice. One homeless person said: "I'm a massive fan, I've got the best GP in the world.". Another said: "I can't complain about Luther Street Medical Centre. I think Luther Street is absolutely brilliant. They would see you and they would listen.". A third particularly appreciated the accessibility of appointments and the level of care from the staff: "Luther Street are right on the door of the night shelter. You could walk in that morning without an appointment and get one. The doctors and staff have experience of working with people in that lifestyle, so they've got an understanding of your needs. They don't judge, they're there to listen and take their time. A service provider referred to Luther Street Medical Centre "somewhere we know our clients will be treated well".

Beyond their demonstrable clinical expertise, Luther Street Medical Centre do a good job of overcoming structural barriers to care by providing flexible appointments (e.g. walk-ins), cultivating a non-judgemental atmosphere, co-locating commonly needed services and offering longer-than-average appointment times. The key ingredients of their excellence seems to be:
- Clinical expertise and experience with this patient group
- Long-term therapeutic relationships
- Non-judgemental atmosphere
- Flexible appointments, e.g. walk-ins
- Co-located services
- Longer appointment times

Luther Street Medical Centre, in addition to O'Hanlon House, Turning Point, Aspire Oxfordshire and other providers, distribute sanitary products to women free of charge. Turning Point also distribute a kit for commercial sex workers, including condoms, gloves, dams and lubricating jelly and – separately – run group sessions for women experiencing domestic violence. As well as using reproductive health services available through primary care, women experiencing homelessness reported accessing services at the sexual health clinic co-located with the Oxford Turning Point hub.

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Gaps:

If someone attends Luther Street Medical Centre, they appear to receive an exceptionally high standard of care. However, at a recent workshop, one service provider identified the need to "take great services out of their box", and Luther Street Medical Centre was given as an example. For instance, only 72 out of 320 (22.5%) of homeless patients audited attending the Emergency Department at the John Radcliffe Hospital were registered with Luther Street Medical Centre. A similar proportion of patients (69, 21.6%) were not registered with any GP.[xxi] Of the estimated ~1,000 street homeless people in Oxfordshire, around half are registered with Luther Street Medical Centre (505 patients were registered at Luther Street Medical Centre in April 2019). Thus a significant proportion of people experiencing homelessness in the county are either not registered with a GP or seek care at mainstream GP practices. In focus groups, people experiencing homelessness reported feeling judged by administrative staff or patients at mainstream practices, having difficulties accessing appointments when they needed them, and feeling dismissed by clinicians who 'blamed' all their current health conditions on previous chaotic health behaviours (e.g. intravenous drug use) even if they were in recovery.

This lack of access to specialist primary care is particularly acute outside Oxford City. This is not the fault of the excellent primary care provider within Oxford City, nor is the issue limited to primary care. Some quotations about this from people experiencing homelessness are shown in Box 5.1.

Box 5.1: Quotations from people experiencing homelessness outside of Oxford City.

"You're not too bad if you live in the big cities like Oxford and Banbury, [but outside of these] there are absolutely no services for the homeless unless it's voluntary."

"If you're street homeless or sofa-surfing, it's extremely chaotic. If you can't even put a roof over your head, how are you expected to get to appointments that are miles away, that aren't even in your home town?"

"I'm from Bicester. To access the services for homelessness, whether it's healthcare or the night shelter, I was taken away from all my support networks. I'm very grateful but I've had to sacrifice my support networks and family back in Bicester… I can't afford the train fare so I'm extremely isolated and with the mental health issues I've got, it's really, really not helping. It's making me even worse. My mental health is the worse now than it's ever been."

"I had to travel [to access services]. I suffer from high anxiety, I can't travel on public transport! Or, I can, but if I freak out and have a panic attack on a train or on a bus, that's me arrested and almost sectioned, just because I'm forced to travel."

"Having to travel long distances for appointments makes people who are already anxious second guess themselves and they have more chance to back out."

[xxi] Many attenders to the Emergency Department were from out of county – the proportion of homeless people registered with an Oxfordshire GP registered with Luther Street Medical Centre is higher.

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Whilst specialist primary care is not the only service that could be strengthened outside of Oxford City, it is amongst the most important. Given the mismatch between the felt need for physical health and normative need for physical health in this population, it is particularly important that primary care services – the entry-point for physical health medical care – is accessible with as few barriers as possible.

In addition, the increasing proportion of women experiencing homelessness raises specific issues around violence and sexual and reproductive health. Although some service providers meet some specific reproductive health needs, a full evaluation of the extent of these health needs and the extent to which they are currently met was beyond the scope of this report. However, this population is likely to become increasingly important in the coming years, and attention should be payed to specifically gendered health issues.

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5.3.2 Secondary care

The John Radcliffe Hospital, the Churchill Hospital and the Nuffield Orthopaedic Centre are large hospitals based in Oxford City, and the Horton General Hospital is located in Banbury. The John Radcliffe Hospital is the largest hospital in Oxfordshire. These hospitals are run by Oxford University NHS Foundation Trust, which is rated by the CQC as "requires improvement".

In addition to routine secondary care services provided by these hospitals, Oxfordshire County Council commissions a Community Safety Practitioner who works primarily in the Emergency Department of the John Radcliffe Hospital (though sometimes also in the Horton General Hospital) to provide support to those with safeguarding concerns, including people experiencing homelessness. This role also acts as a crucial link between primary and secondary care, allowing ongoing liaison with GPs when patients with housing issues attend the Emergency Department. Furthermore, Oxford University Hospitals NHS Foundation Trust (who manage Oxfordshire's main hospitals) and Oxford Health NHS Foundation Trust (who provide the majority of mental health support) have worked together to develop a 'frequent attenders programme', with monthly meetings aimed at enhancing joint working between the trusts and directly case-managing complex cases[58].

As part of the Trailblazer homelessness prevention programme, a housing support worker is also based in the John Radcliffe Hospital, to provide advice and guidance to people at risk of becoming homeless. (This prevention work was funded through a grant from central government, and is currently only scheduled to continue until August 2019. Work is ongoing to assess whether this programme can continue to be supported in the future.

Additionally, in the winter of 2018-2019, a four-bed emergency stepdown service was opened to provide short-term (two week) accommodation to homeless patients who were medically fit for discharge from the John Radcliffe Hospital but had no safe accommodation to which to be discharged. In the time they spend in this step-down accommodation, support workers are available to facilitate access to local accommodation-based services or reconnection to another area. This project was funded from hypothecated "winter pressures" money provided to the NHS, though there are indications that this service will continue.

Turning Point staff reported good communication with secondary care providers, and regularly provide telephone advise about specific patients who are known to services, for example to maintain consistent opiate substitution prescriptions during an inpatient admission, or to arrange follow-up after an admission. Additionally, the hepatology service provide a nurse-led diagnosis and treatment clinic for hepatitis C co-located at Turning Point hubs, which have so far managed over 100 cases.

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Gaps:

The most pressing gap in secondary care services seems to be around the discharge of patients. Of the six respondents to the HomelessLink Health Needs Audit who reported being discharged from hospital in the past year, four (66.7%) reported being discharged to the street. Discharges to the street also appear to be increasing nationally[59]. GPs and nurses at Luther Street Medical Centre reported three inappropriate and unsafe discharge of patients experiencing homelessness in the fortnight before they were consulted for this report. GPs at Luther Street Medical Centre regularly complete incident reporting forms to raise concerns about unsafe discharges, and often speak to individual clinicians to follow-up. Staff at a large hostel in Oxford City also reported receiving people after discharge from hospital who still appeared unwell, and often people attended the hostel after discharge being told they had accommodation secured which had not been arranged. Some had to be returned to hospital.

In fact, a very high proportion of people experiencing homelessness reattend the Emergency Department at the John Radcliffe Hospital soon after leaving the hospital. Of all 667 attendances from people experiencing homelessness in one year in a recent audit, 100 (15.0%) were reattendances within 72 hours, and 194 (29.1%) were reattendances within two weeks (Table 5.1).

Table 5.1. Reattendances from people experiencing homelessness at the John Radcliffe Hospital, by time since leaving the hospital.

Re-attendance	Number (% of all attendances)
Within 24 hours	31 (4.6)
Within 48 hours	81 (12.1)
Within 72 hours	100 (15.0)
Within 7 days	147 (22.0)
Within 14 days	194 (29.1)
Within 30 days	229 (34.3)
Within 12 months	348 (52.2)

This may not be because they have received insufficient or inappropriate clinical care, but may be because they are not able to access follow up through regular channels due to their housing situation or because they are seeking care inappropriately for a chronic condition. Nevertheless, taken together with the experiences of healthcare providers and housing providers, it appears at least some hospital discharges for people experiencing homelessness are inappropriate or insufficiently supported.

Dr Nigel Hewitt, a GP and the medical director of Pathway (a homeless health charity), outlined possible reasons for difficulties coordinating the discharge of people experiencing homelessness: "Hospitals don't generally want to discharge people to the streets, but often lack the skills and

contacts to negotiate the system." [60] It is not expected that front-line clinicians know the intricacies of the housing system, however, there are approaches that could ameliorate the situation.

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5.4   Accommodation-based support

According the Royal College of General Practitioners: "the best way to improve the health of homeless people is to provide appropriate and secure housing"[61]. This eminent group of clinicians is acknowledging that the single most important intervention in improving the health of the homeless lies outside of the health sector.

In recognition, numerous agencies – including the Association of Directors of Public Health, the Local Government Association, Department of Health, Public Health England and NHS England – have signed a Memorandum of Understanding to support joint action on improving health through the home which includes a recommendation for "including housing and homelessness in key strategy and planning processes for health, social care and local government at both a national and local level"[62]. Accommodation-based support in Oxfordshire is therefore an important component of this health needs assessment, and an important consideration for providers of health-oriented bodies.

As outlined in Section 3.1, there are around 300 beds in supported accommodation across the county provided by the public sector. In recognition of the vital role accommodation plays in determining the health of the homeless, the Adult Single Homeless Pathway is part funded by the Clinical Commissioning Group.

Most homelessness services in the UK – including the Adult Single Homeless Pathway in Oxfordshire – take a 'staircase' or linear approach to housing people experiencing homelessness, whereby people progress through a series of accommodation and treatment services until they are 'housing ready' and can access independent housing[63]. In Oxfordshire, the linear Adult Single Homeless Pathway is designed to progress from rough sleeping to an independent tenancy. It is designed around the understanding that when people enter the Adult Homeless Pathway, they often have multiple, overlapping, complex needs but – with support – these needs can be met with appropriate services and they can exit the pathway able to sustain a tenancy either in social housing, in the private rental sector or in a community such as those provided by several charities across Oxfordshire (Figure 5.1).

The Pathway has changed shape in recent years and will continue to evolve. For example, Simon House in Oxford City, which provides accommodation for around 50 people with high levels of need, will soon be replaced by new supported accommodation in Rymers Lane. A new complex in Floyds Row will within the next year and provide up short term emergency accommodation for up to 60 people who may or may not have a local connection[64].

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Figure 5.1: An illustration of the linear model of housing, as employed by the majority of public-sector supported accommodation in Oxfordshire.

Accommodation	Rough sleeping →	Sit up at O'Hanlon →	O'Hanlon or to another hostel →	"Move on" accommodation →	Independent tenancy in social housing or private rental sector
Level of need	High level needs in multiple areas, e.g. active substance misuse, poorly controlled mental health issues, poor physical health and using inappropriate services (e.g. A+E)		Moderate levels of need in several areas, e.g. in substance misuse recovery, regularly seeing Luther Street GPs	Low-moderate levels of need, e.g. in substance misuse recovery, less dependent on GP	Low levels of need, e.g. no longer actively using drugs, well-controlled mental health issues
Engagement with services	Little to no engagement with services	Some engagement with services tailored to homeless people, e.g. outreach/inreach	Good, active engagement with services tailored to the homeless and some mainstream services		Not dependent on services tailored to the homeless

Gaps:

Whilst adding emergency accommodation to the 'front end' of the Adult Single Homeless Pathway may seem an obvious solution to the very visible of issue of street homelessness in Oxford City, solutions exploring the 'back end' are equally important. A bottleneck anywhere in the pathway means people are stuck in accommodation that may not be appropriate. For example, someone recovering from substance misuse 'stuck' in a complex needs bed in a hostel may regularly encounter active drug users, placing their recovery at risk as well as costing more than accommodation for someone with less acute needs. Staff at hostels within Oxfordshire reported people who were not dependent on drugs or alcohol entering the Adult Single Homeless Pathway, being exposed to significant peer pressure and readily-available drugs and alcohol, and becoming dependent.

Additionally, the linear model necessitates regular moves. For example, a person experiencing homelessness in West Oxfordshire would be required to move to Oxford City to access hostel services, but as they progressed through the Adult Single Homeless Pathway, they would be expected to move back supported accommodation to West Oxfordshire (though not necessarily the area they are from). The regular moves can have implications for mental health and support networks. When asked if depression or anxiety was in issue for them, one focus group participant replied: "It wasn't, but because I've been taken away from my support network – which was family – you feel isolated. If it's not depression that gets you, loneliness gets you." Others also found the constant moving a barrier to establishing health relationships: "You're in limbo, too. You know you're only going to be there for six-nine months so you don't want to go out and make friends and that."

5.5   Multiple overlapping needs

Multiple services collaborate with each other in order to provide joined-up services. For example, Luther Street Medical Centre hosts staff from Turning Point several days a week, and host regular clinics with a consultant psychiatrist from the Oxfordshire Mental Health Partnership. Turning Point run joint clinics with the Oxfordshire Mental Health Partnership. Staff from both Turning Point and Luther Street Medical Centre sometimes accompany OxSPOT on street outreach visits.

In addition to these collaborations, St. Mungo's OxSPOT team recently recruited a pathway navigator and people within the Adult Single Homeless Pathway have a support worker, to facilitate access to the many services that people experiencing homelessness often require. Some of these were very well regarded by people experiencing homelessness. Connections Support were singled out for playing an exceptional role in the recovery of several people experiencing homelessness: one focus group participant said "they treat you like a proper person and not a second class citizen". Another said: "Connections have been absolutely fantastic" and a third added: "key workers go above and beyond".

Gaps:

Despite some examples of impressive collaboration between providers, the extent of multidisciplinary working still does not meet the multiple, overlapping needs of many people experiencing homelessness.

Previously, in Oxford City, multiple agencies met at a fortnightly Client Share Meeting to discuss people experiencing homelessness with multiple issues that were proving difficult to resolve. This seems to have lapsed recently, partly due to reductions in funding as it had been provided informally, above and beyond contracted responsibilities.

5.6 Other services that promote health and well-being

The World Health Organisation defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"[65]. Well-being integrates mental health and physical health in a holistic approach to disease prevention and health promotion[66]. Due to the high levels of disease and infirmity in the homeless population in Oxfordshire, the majority of this report focusses on acute health issues. However, the importance of well-being cannot be overstated and should not be ignored. It is often closely linked with acute health issues (including both physical and mental health) and is intrinsically linked with self-esteem and resilience, both positive attributes for people struggling to overcome homelessness[67].

Factors associated with improved wellbeing include: positive social relationships, access to basic resources, stability and routine, exercise, a healthy diet, a sense of purpose and enjoyable activities. The NHS publicised five steps to wellbeing: connecting with people and building relationships; being physically active; learning new skills; giving or volunteering; being mindful[68]. Stress, loneliness, inactivity, lack of sleep can all negatively impact wellbeing[69]. It is easy to see how homelessness denies people of opportunities for activities associated with positive wellbeing but ample opportunities for negative activities.

There are several organisations that provide services for people experiencing homelessness within Oxfordshire that are likely to enhance wellbeing. Some are listed below, but there may be others.

Aspire	aspireoxfordshire.org
Crisis Skylight	crisis.org.uk/get-help/oxford
Elmore	elmorecommunityservices.org.uk
Emmaus	emmaus.org.uk/oxford
Foodbanks, e.g.	oxfordfoodbank.org.uk
Mayday Trust	maydaytrust.org.uk
The Porch	theporch.org.uk
The Gatehouse	oxfordgatehouse.org

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[69] Mind. 2019. How to improve your wellbeing. URL: https://www.mind.org.uk/information-support/tips-for-everyday-living/wellbeing/#.XOPLSI5Kjcs

6. Recommendations

Gaps in service provision can be viewed as opportunities – providing additional services in these areas has the capacity to greatly benefit the health of people experiencing homelessness in Oxfordshire. Some recommendations to address these gaps are listed below. These are by no means exhaustive, and aim to start the conversation rather than provide definitive guidance.

Section 6: Recommendations

6.1   Services outside of Oxford City (including primary care)

Primary care for homeless people within Oxford City, largely provided by Luther Street Medical Centre, appears to be exemplary. However, the provision of primary care for the significant proportion of people experiencing homelessness within Oxfordshire who are not registered with Luther Street Medical Centre is unlikely to be as consistent or as accessible. The issue is not limited to primary care, but also includes secondary and tertiary care (Oxfordshire's largest hospitals, mental health inpatient beds and specialist units are all within Oxford City) and – crucially – accommodation services (all of the county's hostel beds are located within Oxford City), though of these primary care may be the easiest to address in the short to medium term[xxii]. High quality, accessible primary care with as few barriers as possible is particularly important given the very low levels of felt need for physical health services within the homeless population.

Recommendation 1:   Commissioners of primary care services in Oxfordshire should build provision of care outside of Oxford City into future tendering processes.

Various policy options are available to ensure access to appropriate, skilled primary care for all people experiencing homelessness, including those outside Oxford City (this does not necessarily involve establishing specialist primary care services in every district of Oxfordshire):

- Ensuring anyone experiencing homelessness who attends a hospital is registered with a GP, preferably Luther Street Medical Centre.

- Providing outreach from existing providers (e.g. with a nurse practitioner) by piggybacking onto existing services, such as Turning Point's hubs and satellite sites, or accompanying Connection Support as they conduct street outreach outside Oxford City. (Some secondary and tertiary services, such as hepatology, already provide outreach through the Turning Point network).

- Training clinicians outside Oxford City in the healthcare of people experiencing homelessness. (GPs at Luther Street Medical Centre already teach all GP-trainees within the local NHS deanery, and may be well placed to provide a similar package to other practices).

- A formalised referral/advice phone-line. (GPs at Luther Street Medical Centre already provide informal advice to other GPs when called, though anecdotally several GPs across the county were unaware that this kind of support was available, or how to access it).

[xxii] The availability of accommodation for those with multiple, overlapping needs outside Oxford City is related to the availability of services – at the very least, the perception that specialised services are concentrated in Oxford City has been mentioned as a reason for not trying to locate people with high support needs in areas remote from Oxford City, even if that would be beneficial for other aspects of their life (e.g. being closer to friends and family, as mentioned in the focus groups). Thus ensuring high quality primary care across the county could provide impetus to change the structure of the housing pathway.

Section 6: Recommendations

- The development of primary care networks supports collaboration between practices within a network and encourages them to use their pooled resource to manage health needs. A primary care network in an area with high levels of homelessness may be able to provide a suitable primary care offering. This could be supported by the primary care network contract which recognises and provides funding for meeting the needs due to inequalities.

The clinicians and allied healthcare professionals currently caring for homeless populations may have more creative and practical ideas for how this unmet need could be addressed, and should be consulted early in the process. Whilst commissioning any new services, care should be taken not to erode the high standard of care currently provided to people experiencing homelessness in Oxford City.

Section 6: Recommendations

6.2   Mental health care in the community

Mental health problems are amongst the most common and most serious issues facing the homeless population. However, recent years have seen a huge surge in demand for community mental health services across the board (including a ~30% increase in demand for adult mental health teams in the last few years[xxiii]). In this context, the increasing size of the street homeless population places additional complex demands on an already overstretched system.

Nevertheless, the needs of this vulnerable population must be understood and met and there is a lack of mental health services that people experiencing homelessness feel is accessible and appropriate. Some areas of good work do make mental health care more accessible, such as the collaborations with Turning Point to meet the needs of people with overlapping substance misuse and mental health issues, and the mental health worker and consultant psychiatrist provided through Luther Street Medical Centre. However, the most acute area of unmet need remains mild/moderate, outpatient mental health issues. Tackling this is likely to have knock-on benefits on other parts of the system, most notably substance misuse.

It is very possible that this broad health needs assessment has missed important work addressing the mental health of people experiencing homelessness. Therefore:

Recommendation 2:   **A thorough audit of community mental health services for the homeless could be a valuable method of evaluating current local mental health provision against best practice, and should be considered before any future commissioning cycle**.

Measuring how successfully community mental health services meet the needs of people experiencing homelessness will necessitate monitoring service uptake amongst the homeless. Therefore:

Recommendation 3:   **The housing status of patients seeking mental health care should be recorded in clinical systems.**

[xxiii] Personal communication, Oxford Health NHS Foundation Trust.

Section 6: Recommendations

6.3   Housing

As a crucial determinant of health, it is entirely appropriate that organisations with health as their primary mandate are involved in the design, funding and commissioning of accommodation-based services for people experiencing homelessness (for example, the CCG's contributions to the pooled housing budget is necessary and welcomed).

As noted by the Royal College of General Practitioners, the best way to improve the health of the homeless is to provide them with appropriate and secure housing. At times, for some people, the Adult Homeless Pathway in Oxfordshire is unfortunately neither appropriate nor secure; the linear housing model does not appear to work for everyone. People are often 'stuck' in accommodation that is inappropriate for their needs and costly for the commissioners. Therefore, rather than focus exclusively on building new housing provision for rough sleepers, increasing move-on options would be very beneficial in allowing progression and flow through the housing pathway.

Alternative models of accommodation-based support, particularly Housing First, should also be considered. Housing First provides permanent or long-term housing to people experiencing homelessness with high support needs, effectively bypassing the linear model to directly place people in their own tenancy – with appropriate support. People who have used Housing First are 50% more likely to sustain housing than those who have been through a linear model[70]. There are also considerable health benefits: 63% of Housing First users in England reported better general health and 66% reported improved mental health[71]. In 2018, the Government announced £28 million for three Housing First pilot schemes for homeless adults (in West Midlands, Manchester and Liverpool)[72]. A senior manager within a large provider of Oxfordshire's hostels – at the front-line of the linear model – described Housing First as "a much better way of working, for those with multiple and complex needs". Oxfordshire has just five housing first beds and this small unit has secured 10 successful long-term tenancies, effectively ending homelessness for those people, compared to two evictions. Whilst the Housing First model is somewhat more costly than the linear model, recent evidence suggests that when system-wide benefits are accounted for (such as a reduction in health service utilisation, contact with the police and criminal justice system), "Housing First models for homeless individuals with complex needs returns £3.60 for every £1 spent"[73]. Expanding the Housing First offer in Oxfordshire has the potential to improve the health of the homeless more than most changes to the health system, and should be considered a key health intervention.

Recommendation 4:   Housing First should be explicitly reviewed as one option in the recommissioning of the Adult Homeless Pathway, expected in 2020.

Section 6: Recommendations

Health bodies (e.g. the CCG, Oxfordshire County Council Public Health Team) should use the influence from their financial contributions and technical expertise to push for an expansion to the number of Housing First units available in Oxfordshire, with rigorous evaluation of the system-wide impacts of any Housing First offer.

Section 6: Recommendations

6.4   Coordination of care for people with multiple, overlapping needs

The majority of people experiencing homelessness in Oxfordshire do not have just one issue that affects their health. Currently, each of these issues is addressed largely in isolation by specialist services which, by and large, do a good job in their specialist area. There are some good examples of collaborative working between two, or occasionally three, services. However, someone with complex physical health issues, mental health issues and substance misuse may need to regularly see their GP, hospital specialists, their community mental health worker, a psychiatrist and a drug and alcohol worker – all in addition to housing officers and others supporting their attempts to get into permanent accommodation. Collaborative working is intuitive, but also has proven benefits across the system[74], and an approach of getting "everyone in the room" to discuss clients and ensure joined up working between multiple services has paid dividends in Wrexham[75].

Co-locating services in various hubs around the county has improved this, but coordination of care could be further improved. Previously in Oxford City, there was a fortnightly Client Share meeting for different services to come together to discuss individuals with overlapping needs and identify ways forward but this is no longer running.

Recommendation 5:   Reinstate regular multi-disciplinary case conferences to enhance joint working and identify people who require additional, coordinated support. To recognise the value of this, participation in these multi-disciplinary meetings should be explicitly included in contracts when recommissioning services.

Re-establishing a regular, client-focussed multi-disciplinary meeting where a rotating 'top 10' of those chronic rough sleepers with multiple comorbidities could be discussed may improve coordination and unlock creative solutions. Representation could include outreach workers; clinicians (from Luther Street Medical Centre and or the John Radcliffe); Turning Point; mental health workers; housing officers; community safety and resilience team members; police; probation and other services as necessary.

Section 6: Recommendations

6.5   Data and monitoring

In order to provide appropriate, timely services commissioners must have accurate, up-to-date data on the issues they are trying to address. The homeless population is one that is difficult to get relevant information on for a wealth of reasons: they are less likely to be registered with a GP, they do not have a permanent address, some deliberately avoid contact with services, others may give inconsistent accounts of their support needs and the sensitive nature of some of the needs disclosed means data sharing needs to considered within strict data-protection frameworks.

However, the homeless population also utilise many services (and therefore lots of data is available even if it is currently dispersed across agencies). People experiencing homelessness consulted for this report were willing to have relevant information shared across services in order to receive better care. Whilst there are examples of excellent, multi-agency data management systems emerging, some organisations are maintaining their own databases in different formats, which creates major challenges of analysis to inform evidence-based policy making (not least, the different data structures often prohibit matching individuals across datasets).

Recommendation 6:   **A county-wide database of people experiencing homelessness and their support needs should be developed.**

OxTHINK is probably the best framework on which to build this, and the team managing OxTHINK have the technical skills to make an incredibly successful county-wide resource, with the right financial and organisational support.

Any county-wide system will require buy-in from all stakeholders, including service users, providers and the District and City councils. Consideration should also be given to collecting information regarding recent prison leavers. Informed consent for the sharing of important information across relevant partners should routinely be sought from homeless services users. The strength of a database relies upon the reliability of the information entered into it – all organisations entering data should receive appropriate training on how to input and update records, as well as why the accuracy of this data is important. Commissioners should build assessments of the quality and completeness of data entry into performance-management aspects of contracts with providers. Automated or semi-automated reports (including details on the number of people experiencing homelessness, key demographics and headline figures of their support needs) should be circulated on a regular basis to senior contacts within the county council, District and City councils and partner organisations, and regularly discussed at the Housing Support Advisory Group (HSAG) and other relevant, high-level meetings.

Section 6: Recommendations

6.6   Discharge from hospital

Homeless patients in Oxfordshire are frequent attenders at hospitals. Attendances represent moments of particularly acute need within an already vulnerable population. A lengthy admission may also be a trigger for homelessness. These attendances are therefore opportunities to target people in need.

Despite this, too often people are discharged without fully exploiting links to appropriate services. Hostels in Oxfordshire reported examples of people being discharged to their accommodation, with no notice and therefore no bed reserved. GPs at Luther Street Medical Centre also mentioned recent inappropriate discharges without adequate communication. It is well-recognised that hospital staff are under extraordinary pressures. Support services available for people who are homeless are complex. Therefore, expecting front-line clinicians to appropriately coordinate all aspects of the discharge of this group is unrealistic. The impact of the Trailblazer Housing Officer in the hospital was well recognised by hospital staff and community services. Recognising the important public health principle of prevention, and the particular moment of vulnerability that a hospital visit may represent:

Recommendation 7:   The Trailblazer Housing Officer in the John Radcliffe Hospital should continue to be funded.

Recommendation 8:   The coordination of hospital discharges for people experiencing homelessness must improve.

Several options are available to improve hospital discharge for those experiencing homelessness.

- A Pathway-style team in acute hospitals in Oxfordshire. Pathway (pathway.org.uk) is a model of integrated healthcare for single homeless people and rough sleepers. A part-time GP and specialist nurse form hospital-based teams, often with multidisciplinary input (e.g. housing, social work) either directly or through routine multiagency coordination meetings[76].
- An individualised care coordinator, similar to that employed by some mental health trusts.
- Regular visits from the OxSPOT team, at least to the Emergency Department, to ensure that every attendee is registered with a GP and linked to appropriate services.

Conversations about the coordination of hospital discharge in the John Radcliffe Hospital have already begun, led by compassionate and driven clinicians. Some are also working to improve access to homelessness-specific resources on the hospital intranet, to provide the information required for hospital staff to navigate the complex housing system. These efforts should be encouraged and institutionalised.

Section 6: Recommendations

6.7 Sexual and reproductive health services, particularly for women

People experiencing homelessness are more likely to suffer sexual abuse and to engage in commercial sex work than the housed population. As the numbers of female homeless people and homeless people under the age of 30 increase (Section 3.4), these issues are likely to become increasingly important. Whilst some providers which are used by people experiencing homelessness provide some sexual and reproductive health services (e.g. contraception, sanitary products), the full extent of sexual and reproductive health needs amongst the homeless population – and whether these are being met – is beyond the scope of this report. To understand this growing need:

Recommendation 9: **A rapid assessment of the sexual and reproductive health needs of the growing female homeless population should be undertaken.**

Section 6: Recommendations

[70] Johnsen, S. and Teixeira, L. 2010. Staircases, elevators and cycles of change: 'Housing First' and other housing models for homeless people with complex support needs. *Herriot Watt University Research Gateway.*

[71] Bretherton, J. and Pleace, N. 2015. Housing First in England An Evaluation of Nine Services. *Centre for Housing Policy.*

[72] Fitzpatrick, S. 2017. Bright spot in the budget: UK Government backs housing first for vulnerable homeless people. *UK Collaborative Centre for Housing Evidence.*

[73] Public Health Wales. 2019. Making a Difference: Housing and Health – a Case for Investment.

[74] Sheikh, S. and Teeman, D. 2018. A rapid evidence assessment of what works in homelessness services. *Social Care Institute for Excellence.*

[75] 2019. £88k funding boost for Wrexham's Community Care Hub to help provide "innovative and person-centred support to Wrexham's homeless". URL: http://www.wrexham.com/news/88k-funding-boost-for-wrexhams-community-care-hub-to-help-provide-innovative-and-person-centred-support-to-wrexhams-homeless-162906.html

[76] Hewett, N. et al. 2012. A general practitioner and nurse-led approach to improving hospital care for homeless people. *The BMJ.*

7.   Summary of recommendations

In order to maximise the utility of this report to policy makers, the nine recommendations above are summarised below. To ensure the messages from this report receive appropriate attention, whilst remaining balanced with competing funding priorities, an additional recommendation is included:

Recommendation 10:   Discuss report at the next Housing Support Advisory Group meeting, decide which recommendations are appropriate to take forward and continue to monitor progress against them at six-monthly intervals.

Topic	#	Recommendation	Responsibility
Services outside Oxford City	1	Build provision of primary care for people experiencing homelessness outside of Oxford City into future tendering processes.	Clinical Commissioning Group (CCG)
Mental health	2	Audit community mental health services for people experiencing homelessness against best practice.	Oxford Health / CCG / Oxfordshire County Council (OCC) Public Health team
	3	Consider recording the housing status of patients using mental health services on clinical systems.	Oxfordshire Mental Health Partnership
Housing	4	Press for Housing First to be reviewed as an option in the recommissioning of the Adult Homeless Pathway.	CCG and OCC Public Health
Care coordination	5	Reinstate regular multi-disciplinary case conferences to enhance joint working, and explicitly build multi-disciplinary working into future contracts.	City and District Councils
Data	6	Develop a county-wide database of people experiencing homelessness and their support needs	Ideally OxTHINK team, with appropriate funding and support.
Secondary care	7	The Trailblazer Housing Officer in the John Radcliffe Hospital should continue to be funded.	To be decided
	8	The coordination of hospital discharges for people experiencing homelessness must improve.	Oxford University Hospitals NHS Foundation Trust
Sexual health	9	Undertake a rapid assessment of the reproductive health needs of the female homeless population.	OCC Public Health
This report	10	Discuss this report at the next HSAG, decide which recommendations are appropriate and monitor progress against them at six-monthly intervals.	Housing Support Advisory Group

8.   Detailed methods

8.1   The HomelessLink Health Needs Audit

The Health Needs Audit, designed by HomelessLink, was developed in partnership with the Department of Health and nine pilot areas across England in 2010. In 2015, with funding from Public Health England, HomelessLink updated the audit to take into account changes to local commissioning environments and other relevant reforms impacting on homelessness and health. It has been used in 27 local authorities to assess the health needs of people experiencing homelessness and contains information from 3,355 total respondents.

In Oxfordshire, the survey was sent around various providers of services for people experiencing homelessness, and ran between early March and early May. 22 responses were collected either online (10) or in paper form (12). The full questionnaire is included in Appendix 1. The sample size was too small to provide accurate estimates of every condition of interest (and responses are non-random so prevalence estimates should be treated with caution), however, it is a valuable resource when applied to the national dataset to show how Oxfordshire differs (or doesn't) from the national homeless population.

8.2   Focus groups with people experiencing homelessness

Two focus groups were conducted, one in Banbury (Cherwell District) and one in Oxford City. The Oxford City group was all female. Both focus groups had five participants, so there were 10 total participants, six female and four male. The focus groups were led by Dr Jan Flaherty, a postdoctoral qualitative researcher from the Centre for Social Investigation at Nuffield College, University of Oxford, who also works on a separate project examining homelessness pathways in Oxford and the role of support services in a local context. They were organised by Appy Reddy from the Clinical Commissioning Group. The focus groups followed a specification designed by Dr Isaac Ghinai, a public health registrar at Oxfordshire County Council, which is included in Appendix 2.

Section 8: Detailed methods

8.3   Discussions with experts and providers

This report draws on the insights of many experts and providers (below, alphabetically by surname).

Alison Adkins, Cherwell District Council
Rob Aldridge, University College London
Angela Barnett, Oxfordshire County Council
Alex Bax, Pathway
Charlotte Blake, Homeless Oxfordshire
Caroline Bradley, Luther Street Medical Centre
Amanda Bremble, Turning Point
Sam Casey-Rerhaye, Oxfordshire County Council
Anne Clarke, Oxfordshire Mental Health Partnership
Kiren Collison, Oxfordshire Clinical Commissioning Group
Ele Crichton, Joint Commissioning, Oxfordshire County Council
Amy Delisser, Connection Support
Nigel Deakin, Banbury Beacon
Emily Dobell, Oxford School of Public Health
Jan Flaherty, University of Oxford
Elisabeth Garratt, University of Oxford
Jaffa Holland, South and Vale District Councils
Carrie Hartwell, Oxford University Hospitals
David Hurst, Mayday Trust
Sue Jackson, St Mungo's
Kate King, Oxfordshire Clinical Commissioning Group
Natalia Lachkou, Oxfordshire County Council
Jac Lawler, Luther Street Medical Centre
Brendan Lewis, Oxford City Council
Stephen Moore, Luther Street Medical Centre
Shafik Nasser, Luther Street Medical Centre
Rebecca Nelson, Mayday Trust
Mark Nightall, Connection Support Oxfordshire
Lan Nguyen, Oxford City Council
Ela Oriciari, Luther Street Medical Centre
James Porter, Luther Street Medical Centre
Cath Power, Luther Street Medical Centre
Will Pearson, Bicester Salvation Army
Paul Reid, Aspire Oxford
Sarah Roberts, Oxfordshire County Council
Jayne Rogers, Turning Point
Christine Rolls, Aspire Oxford
Rob Schafer, Luther Street Medical Centre
Di Scott, Luther Street Medical Centre
Helen Shaw, Public Health England
Rob Shaw, Oxford University Hospitals
Ted Sheppard, Turning Point
Sheetal Tanna, Oxford City Council
Daniel Tooke, South and Vale District Councils
Mark Thompson, Connection Support
Chris Walkling, Oxfordshire Clinical Commissioning Group
Emma Warren, Luther Street Medical Centre
Jackie Wilderspin, Oxfordshire County Council
Ethan Williams, The Kings Fund

Section 8: Detailed methods

8.4   The Oxford Tackling Homeless Information Network (OxTHINK)

OxTHINK is a multi-agency database that records information on people experiencing homelessness in Oxford City. It was designed by RealSystems at St. Mungo's, has been in operation since 2012 and is maintained by Dr Lan Nguyen at Oxford City Council. Data is input by providers that have been commissioned to provide client-facing services (e.g. the Oxford Street Population Outreach Team (OxSPOT) run by St Mungo's or supported accommodation providers, such as Homeless Oxfordshire who run O'Hanlon House). The database includes personally identifiable information (such as name and age) as well as data on support needs (such as alcohol dependency or physical health issues).

It includes data on:
- Anyone found sleeping rough in Oxford City by OxSPOT.
- Anyone using any publicly funded supported accommodation across Oxfordshire county.
- People that are discharged from institutions (such as prison, hospital, care) that require accommodation to stop them from sleeping rough.

It does not include data on:
- Anyone found sleeping rough in Cherwell District, South Oxfordshire, Vale of the White Horse or West Oxfordshire, where outreach is conducted by Connection Support. [Some of these districts (South Oxfordshire and Vale of the White Horse) maintain their own database of rough sleepers and these were used for these populations.]
- Anyone in temporary accommodation, sofa surfing, or other accommodation that does not spend time on the streets.

The data is input by trained staff but is still subject to several potential biases and errors. In some cases, the data is gathered during an initial meeting on the street, and people may be understandably reluctant to share personal information such as their mental health history with a stranger, in public. This may lead to underestimates of support needs. Conversely, some people may exaggerate their support needs in order to try to access more intensive support, which could lead to an overestimate of support needs. In particular, health data is usually recorded in OxTHINK as it was reported to the member of staff and is not automatically verified by a trained healthcare professional or with healthcare records, so may reflect perceived health need rather than measured health need. Again, this may lead to over or underestimates of the prevalence of various conditions. Finally, data entry relies on members of staff accurately recording or updating a client's record alongside their other front-line duties. In the past, inconsistencies in compliance across providers have been detected, but this is

improving. The relative importance of these sources of bias and error are difficult to quantify, and their net effect on estimates of health needs is unknown.

Nevertheless, OxTHINK data is very valuable as it contains a variety of holistic information (such as demographics, housing situation, physical health issues, mental health issues, degree of drug/alcohol dependency) that is rarely collated in one database. Additionally, the ability to track patients through the system (and, in the future, even across databases) by matching on personally identifiable information makes this a powerful source of data. As compliance improves, longitudinal data accumulates and other datasets (including records from other districts) are merged, this resource will only grow in value.

Section 8: Detailed methods

8.5   Audit of homeless attendances to the John Radcliffe Hospital

Dobell, E. August 2018. Homeless Patient Care: OUH clinical evaluation.

Information below are summarised from the Aims, Methods and Results sections of the above report.

This audit described:

- Emergency Department (ED) attendances, re-attendances and non-elective admissions between March 31st 2017 and March 31st 2018 amongst patients who are homeless
- The experiences of:
    - Staff working in the ED at Oxford University Hospitals NHS Foundation Trust
    - Patients registered at Luther Street Medical Centre
- [The Dobell Report also contained information from a separate audit investigating all inpatient admissions amongst patients who were homeless between August 2017 and February 2018 completed by Dr Anna Seeley and Dr Tamsin Cargill.]

Methods

'Homelessness' was identified by any one of the following:

- Registration with Luther Street Medical Centre (LSMC)
- Address containing 'NFA', 'N.F.A' or 'No Fixed A' [No Fixed Abode]
- ICD10 code Z590 for homelessness
- An address of a local homeless hostel/charity or LSMC

The OUH Information Team provided data on all ED presentations amongst homeless patients aged 18 and over between March 31st 2017 and March 31st 2018. This included Medical Records Number, NHS number, gender, ethnicity, age, postcode, GP, referral source, presenting complaint, length of time in ED, ED disposal (where the patient went next), length of inpatient stay, discharging specialty and consultant, discharging diagnosis, primary procedure and inpatient tariff.

Exclusions were made for those incorrectly identified as homeless (n=31) by reviewing records for those patients who were registered with a GP other than Luther Street, had an address other than NFA and did not have a homelessness ICD 10 code. Those who had no mention of housing concerns in their records were also excluded.

To explore the interface between primary and secondary care and to quantify the use of healthcare services, the audit extended to a review of LSMC data. For those patients who were also registered at LSMC, information was collected on type of homelessness; past medical history; most recent presenting complaint; number of GP appointments, out of hours appointments and additional hospital admissions within the same 12-month period; liaison between OUH and LSMC during admissions; timeliness of discharge letters, interaction with other community services and issues arising during

access to healthcare services. CaseNotes and ED discharge summaries were reviewed for those patients not registered with a GP to identify potential follow up issues and safeguarding concerns.

To understand the issues faced by those accessing or providing services, informal interviews were carried out with ED staff and patients at LSMC. Additional information was gathered via meetings with Oxford City Council's Trailblazer and Housing teams, OUH Safeguarding and Discharge team colleagues, the Pathway charity and those involved in local homelessness research.

Results

Between March 31st 2017 and March 31st 2018, 320 patients identified as homeless attended the ED department (65 women & 255 men). Of these, 149 (47%) were admitted to hospital via ED.

Amongst the patients identified as homeless there was an average of 2.1 ED attendances per person resulting in a total of 667 ED attendances and 219 hospital admissions via ED. 448 ED attendances did not lead to admission (67%). 18 patients had died by the time of data collection in April 2018.

Figure 8.1. Most commonly-registered GP practices amongst homeless patients attending ED

Patients were registered at 101 different general practices. Luther Street Medical Centre was the most commonly recorded general practice amongst registered patients (72 patients, 23% of total). 69 patients (22%) had no GP registration recorded. 49 of the GP practices recorded were in Oxford or Oxfordshire (22 and 27 respectively), 14 were in neighbouring counties and 38 were in counties further afield. This last category accounted for 42 patients, 13% of total. Figure 8.1 demonstrates the location of the most commonly recorded practices.

The most common category of presenting complaint was injury (including assault), followed by alcohol (including withdrawal), generally 'unwell', mental health (including self-harm), chest pain and overdose.

Over a third of patients attended ED more than once during the 12-month period (121, 38%) whilst 19 (6% of patients) attended more than five times. The presenting complaints amongst patients attending most frequently were similar to those seen amongst patients overall. All of the most frequently attending patients were registered with a GP, mostly at Luther Street Medical Centre (11 patients, 58%) or within Oxfordshire (16, 84%). Two patients were registered with a specialist homeless general practice in London (The Doctor Hickey Surgery).

Section 8: Detailed methods

8.6   Service utilisation data

Service utilisation data were available from Turning Point and Luther Street Medical Centre.

For Turning Point, the data included the number of people using Turning Point services, the proportion of those that had no fixed abode, each broken down by hub/district. These data were triangulated with national and regional data from the National Drug Treatment Monitoring System, maintained by Public Health England.

Data from Luther Street Medical Centre were extracted from EMIS by the Commissioning Support Unit (CSU) at the Clinical Commissioning Group, in collaboration with the practice manager from Luther Street Medical Centre. Data included the prevalence of a number of conditions (e.g. from disease registers) and an approximation of the clinical burden of some conditions, estimated from the frequency of use of certain clinical codes over the last year. This was supplemented with discussions with various staff at Luther Street Medical Centre (three GPs, three nurses, one mental health practitioner, one receptionist and the practice manager). (There were concerns from some clinicians that some of the CSU data did not reflect their clinical practice, due a difference in coding. Where there were disagreements that could not be clarified, these data were dropped and alternative sources of data to answer the underlying question were sought).

Data on the housing status of patients using the Adult Mental Health Partnership were sought, but were unavailable at the current time.

Other smaller sources of data included the Sterile Works for Oxfordshire Programme (SWOP), which provided information about needle exchange programmes; data from the Community Safety Practitioner about the Emergency Departments of major Oxfordshire hospitals; and data on selected infectious diseases run by the Thames Valley Health Protection Team.

Appendix 1: HomelessLink Health Needs Audit

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

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

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

INTRODUCTION

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

- ☐   I (the client) understand how this information will be used and am happy to go ahead
- ☐   I have not previously undertaken this survey

A FEW QUESTIONS ABOUT YOU

1*   **HOW OLD ARE YOU?** ……………………………………………………………………………………………..

- O   No answer

2   **WHICH OF THESE CATEGORIES BEST DESCRIBES YOU AT PRESENT?** Please tick only one:

- O   Going to school or college full-time (including on vacation)
- O   In paid employment or self-employment (or away temporarily)
- O   On a Government scheme for employment training
- O   Doing unpaid work or voluntary work
- O   Waiting to take up paid work already obtained
- O   Looking for paid work or a Government training scheme
- O   Intending to look for work but prevented by temporary sickness or injury (CHECK MAX28 DAYS)
- O   Permanently unable to work because of long-term sickness or disability (USE ONLYFOR MEN AGED 16-64 OR WOMEN AGED 16-59)
- O   Unemployed and not looking for work
- O   Other (please state)……………………………………………………………………………………….

3*   **HAVE YOU EVER (IN YOUR LIFETIME) DONE ANY OF THE FOLLOWING? IF YES, PLEASE INDICATE THE AGE AT WHICH THIS FIRST OCCURRED.** Tick all that apply:

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

4* **WHERE ARE YOU CURRENTLY SLEEPING?** (if this frequently changes, please say where you slept last night). Please tick **only one**:

- O   Sleeping rough on streets/parks
- O   In a hostel or supported accommodation O Squatting
- O   Sleeping on somebody's sofa/floor
- O   In emergency accommodation, e.g. nightshelter, refuge O In B&B or other temporary accommodation
- O   Housed - in own tenancy
- O   Other (please state)…………………………………………………………………….. O   No answer

5 **THINKING ABOUT THE MOST RECENT TIME YOU BECAME HOMELESS, WHAT WAS THE MAIN REASON FOR THIS?** Please give **one primary** reason and **one secondary** reason if applicable.

	Primary reason	Secondary reason
Parents / care-givers no longer able or willing to accommodate	O	O
Other relatives or friends no longer able or willing to accommodate	O	O
Non-violent relationship breakdown with partner	O	O
Abuse or domestic violence	O	O
Overcrowded housing	O	O
Eviction or threat of eviction	O	O
Rent or mortgage arrears	O	O
Other debt-related issues	O	O
End of tenancy (social housing)	O	O
End of tenancy (private rented sector)	O	O
Financial problems caused by benefits reduction	O	O
Unemployment	O	O
ASB or crime	O	O
Drug or alcohol problems	O	O
Mental or physical health problems	O	O
Leaving institutional care (e.g. hospital, prison, care etc.)	O	O
Other (please state)………………………………………………………..	O	O

6 **DO YOU HAVE ANY OF THE FOLLOWING BACKGROUNDS?** (This helps us to understand how your past experience may have affected your health or services you've been able to access**). Tick **all** that apply:
- ☐   Spent time in prison
- ☐   Spent time in a secure unit or young offender institution
- ☐   Spent time in local authority care
- ☐   Spent time in the armed forces
- ☐   Admitted to hospital because of a mental health issue
- ☐   Been a victim of domestic violence
- ☐   None of these backgrounds

7* **WHAT IS YOUR GENDER?** Please tick **only one**:
- O   Male
- O   Other (please state)…………………………………………
- O   Female
- O   No answer

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

Please tick **only one**:

- O   Heterosexual or straight
- O   Bi-sexual
- O   Gay or lesbian
- O   Other (please state)……………………..

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9* **WHAT IS YOUR ETHNIC GROUP?** Please tick **only one:**

White				Mixed/Multiple ethnic groups				Asian/Asian British					Black/Black British			Other ethnic group	
English / Welsh / Scottish / Northern Irish / British	Irish	Gypsy or Irish Traveller	Other white	White & Black Caribbean	White & Black African	White & Asian	Other mixed	Indian	Pakistani	Bangladeshi	Chinese	Other Asian	African	Caribbean	Other black	Arab	Any other ethnic group
O	O	O	O													O	Please state: ....

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

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

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

O Yes   O No   O Don't know

12* **DO YOU HAVE ANY LONG-STANDING ILLNESS, DISABILITY OR INFIRMITY?** By long-standing

I mean anything that has troubled you over a period of time or that is likely to affect you over a period of time. Please tick **only one:**

O Yes   O No   O No answer

SOME QUESTIONS ABOUT YOUR PHYSICAL HEALTH

13* **HAS A DOCTOR OR HEALTH PROFESSIONAL EVER TOLD YOU THAT YOU HAVE ANY OF THE FOLLOWING PHYSICAL HEALTH PROBLEMS?** Please choose the appropriate response for each item:

	Yes, in past 12 months	Yes, 12 months + ago	No	No answer
Heart problems (heart attack, angina, murmur or abnormal heart rhythm)	☐	☐	☐	☐
Chronic breathing problems (bronchitis, emphysema, obstructive airways disease)	☐	☐	☐	☐
Asthma	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐
Joint aches/problems with bones and muscles	☐	☐	☐	☐
Difficulty seeing/eye problems	☐	☐	☐	☐
Skin/wound infection or problems	☐	☐	☐	☐
Problems with feet	☐	☐	☐	☐
Fainting/blackouts	☐	☐	☐	☐

Physical health problems continued	Yes, in past 12 months	Yes, 12 months + ago	No	No answer
Urinary problems/ infections/ incontinence	☐	☐	☐	☐
Circulation problems/blood clots	☐	☐	☐	☐
Liver problems	☐	☐	☐	☐
Stomach problems, including ulcers	☐	☐	☐	☐
Dental/teeth problems	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Epilepsy/seizures	☐	☐	☐	☐
HIV	☐	☐	☐	☐
Tuberculosis (TB)	☐	☐	☐	☐
Hepatitis C	☐	☐	☐	☐
Other (please state)…………………………………	☐	☐	☐	☐

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

O   Yes   O   No, not offered any

13b   *IF YES TO HEPATITIS C*, **HAVE YOU RECEIVED ANY TREATMENT?** Please tick **only one**:

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

13c   *IF YES TO ANY PHYSICAL HEALTH NEED*, **ARE YOU RECEIVING SUPPORT/ TREATMENT TO HELP YOU WITH YOUR PHYSICAL HEALTH PROBLEM?** Please tick **only one**:

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

14   **WAS THERE ANY TIME DURING THE PAST TWELVE MONTHS WHEN, IN YOUR OPINION, YOU NEEDED A MEDICAL EXAMINATION OR TREATMENT FOR A PHYSICAL HEALTH PROBLEM BUT YOU DID NOT RECEIVE IT?** Please tick only one:

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

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

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

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

O   Yes   O   No (*go to Q16*)   O   No answer

15a   *IF YES TO Q15*, **WOULD YOU LIKE TO GIVE UP SMOKING ALTOGETHER?** Please tick **only one**:

O   Yes   O   No   O   Don't know

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

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

SOME QUESTIONS ABOUT MENTAL HEALTH AND DEVELOPMENT

16* **HAS A DOCTOR OR HEALTH PROFESSIONAL EVER TOLD YOU THAT YOU HAVE ANY OF THE FOLLOWING MENTAL HEALTH OR BEHAVIOURAL CONDITIONS?** Please choose the appropriate response for each item:

	Yes, in past 12 months	Yes, 12 months + ago	No	No answer
Depression	☐	☐	☐	☐
Anxiety disorder or phobia	☐	☐	☐	☐
Psychosis (incl. schizophrenia or bipolar disorder)	☐	☐	☐	☐
Personality disorder	☐	☐	☐	☐
Post traumatic stress disorder (PTSD)	☐	☐	☐	☐
Eating disorder	☐	☐	☐	☐
Dual diagnosis - a mental health problem alongside drug or alcohol use	☐	☐	☐	☐
ADHD (attention deficit hyperactivity disorder)	☐	☐	☐	☐
Learning disability or difficulty	☐	☐	☐	☐
Autism/Asperger's	☐	☐	☐	☐
Other (please state)……………………..........................	☐	☐	☐	☐

16a *IF YES TO ANY MENTAL HEALTH NEED,* **ARE YOU RECEIVING SUPPORT/ TREATMENT TO HELP YOU WITH YOUR MENTAL HEALTH PROBLEM?** Please tick **only one**:

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

16b *IF YES TO Q16a,* **WHAT TYPE OF SUPPORT ARE YOU RECEIVING?** Tick **all** that apply:

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

17. **WAS THERE ANY TIME DURING THE PAST TWELVE MONTHS WHEN, IN YOUR OPINION, YOU PERSONALLY NEEDED AN ASSESSMENT OR TREATMENT FOR A MENTAL HEALTH PROBLEM BUT YOU DID NOT RECEIVE IT?** Please tick only one:

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

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

O   Couldn't get an appointment

O   Waiting list

O   Have been banned from the service

O   Due to my drug or alcohol use

O   Too far to travel/no means of transportation

O   Fear of doctor/hospitals/examination/ treatment

O   Wanted to wait and see if problem got better on its own

O   Was refused treatment/examination

O   Other (please state)………………………………………………………………………………

18. **DO YOU USE DRUGS OR ALCOHOL TO HELP YOU COPE WITH YOUR MENTAL HEALTH – this can be called 'self-medicating'?** Please tick only one:

    O   Yes   O   No

SOME QUESTIONS ABOUT DRUG AND ALCOHOL USE

s

19* **IN THE PAST 12 MONTHS HAVE YOU TAKEN ANY OF THE FOLLOWING?** Tick all that apply:

- ☐ Heroin
- ☐ Crack
- ☐ Cocaine
- ☐ Cannabis/weed
- ☐ Amphetamines/speed
- ☐ Tranquilisers, such as benzodiazepines/benzos, not prescribed for you
- ☐ Any other prescription drugs, not prescribed for you
- ☐ New Psychoactive Substances (also known as legal highs)
- ☐ IV drugs (drugs you inject)
- ☐ No drug use in the past 12 months
- ☐ Other (please state)………………………………………………………………………….
- ☐ No answer

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

Please tick **only one**:

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

21* **DO YOU HAVE OR ARE YOU RECOVERING FROM A DRUG PROBLEM?** Please tick only one:

O Yes, I have a drug problem   O Yes, I am in recovery   O No *(go to Q22)*

21a *IF YES TO A DRUG PROBLEM,* **ARE YOU RECEIVING SUPPORT/TREATMENT TO HELP YOU WITH YOUR DRUG PROBLEM?** Please tick **only one**:

O Yes, and it meets my needs   O Yes, but I'd still like more help
O No, but it would help me *(go to Q22)*   O No, I do not need any *(go to Q22)*

21b *IF YES TO Q21a,* **WHAT SUPPORT ARE YOU RECEIVING TO HELP YOU ADDRESS YOUR DRUG USE?** Tick **all** that apply:

- ☐ Advice and information (e.g. from GPs, A&E departments)
- ☐ Harm reduction services, such as needle exchange
- ☐ Self-help groups (often called Mutual Aid), e.g. Narcotics Anonymous
- ☐ Community prescribing (drug treatment prescribed as part of a care plan)
- ☐ Counselling or psychological support
- ☐ Attendance at day programmes, delivered in the community
- ☐ Detox (help with withdrawal as an inpatient)
- ☐ Residential rehabilitation
- ☐ Aftercare (support following structured treatment)
- ☐ Peer support - support from others who have been through a similar experience
- ☐ Other (please state)………………………………………………………………………….

22* **HOW OFTEN HAVE YOU HAD AN ALCOHOLIC DRINK DURING THE PAST 12 MONTHS?**

Please tick **only one**:

- O   Almost every day
- O   Five or six days a week
- O   Three or four days a week
- O   Once or twice a week
- O   Once or twice a month
- O   Once every couple of months
- O   Once or twice a year
- O   Not at all in the past 12 months (*go to Q24*)
- O   No answer

23* **HOW MANY UNITS DO YOU DRINK ON A TYPICAL DAY WHEN YOU ARE DRINKING?** (Please refer to flashcard to work out a numerical figure).

……………………………………………………………………………………………………..

- O   No answer

24* **DO YOU HAVE OR ARE YOU RECOVERING FROM AN ALCOHOL PROBLEM**? Please tick

only one:

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

24a *IF YES TO AN ALCOHOL PROBLEM,* **ARE YOU RECEIVING SUPPORT/TREATMENT TO**

HELP YOU WITH YOUR ALCOHOL PROBLEM? Please tick **only one**:

- O   Yes, and it meets my needs
- O   No, but it would help me (*go to Q25)*
- O   Yes, but I'd still like more help
- O   No, I do not need any (*go to Q25)*

24b *IF YES TO Q24a*, **WHAT SUPPORT ARE YOU RECEIVING TO HELP YOU ADDRESS YOUR ALCOHOL**

USE? Tick **all** that apply:

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

SOME QUESTIONS ABOUT YOUR ACCESS TO SERVICES

25* **ARE YOU REGISTERED WITH THESE SERVICES IN YOUR LOCAL AREA?** Please choose the

appropriate response for each item:

	Yes	No	No answer
GP or homeless healthcare service	☐	☐	☐
Dentist	☐	☐	☐

26 **HAVE YOU BEEN REFUSED REGISTRATION TO A GP/ HOMELESS HEALTHCARE SERVICE OR**

DENTIST IN THE PAST 12 MONTHS? Please choose the appropriate response for each item:

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

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

....

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

....

27* **IN THE PAST 12 MONTHS HAVE YOU-:** Please choose the appropriate response for each item:

	No	Once	Twice	3 Times	Over 3 times	No answer
Been to a GP or homeless healthcare service?	☐	☐	☐	☐	☐	☐
Been to A&E?	☐	☐	☐	☐	☐	☐
Used an ambulance?	☐	☐	☐	☐	☐	☐
Been admitted to hospital?	☐	☐	☐	☐	☐	☐

27a **IF YOU HAVE USED <u>ANY</u> OF A&E, HOSPITAL OR AMBULANCE IN THE PAST 12 MONTH PLEASE ANSWER THESE QUESTIONS: What was the reason why you last used:** *Please select the reason which best fits the primary cause of using the service, or use the other box if the reason is not listed.*

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

IF YOU WERE ADMITTED INTO HOSPITAL, PLEASE ANSWER QUESTIONS 27b-27d ABOUT YOUR MOST RECENT ADMISSION:

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

    O   Yes   O   No   O   I can't remember

27c* **WHEN YOU WERE DISCHARGED FROM HOSPITAL WHERE DID YOU GO?** Please tick only **one**:

    O   I was discharged onto the street
    O   I was discharged into accommodation, but it was *not* suitable for my needs
    O   I was discharged into accommodation, and it *was* suitable for my needs
    O   I can't remember
    O   No answer

27d* **AFTER BEING DISCHARGED, WERE YOU READMITTED WITHIN 30 DAYS?** Please tick only **one**:

    O   Yes   O   No   O   I can't remember   O   No answer

SOME QUESTIONS ABOUT STAYING HEALTHY

28* **BY PLACING A TICK IN ONE BOX IN EACH GROUP BELOW, PLEASE INDICATE WHICH STATEMENTS BEST DESCRIBE YOUR OWN HEALTH STATE TODAY:**

MOBILITY Please tick **only one**:
- O I have no problems in walking about
- O I have some problems in walking about
- O I am confined to bed
- O No answer

SELF-CARE Please tick **only one**:
- O I have no problems with self-care
- O I have some problems washing or dressing myself
- O I am unable to wash or dress myself
- O No answer

USUAL ACTIVITIES Please tick **only one**:
- O I have no problems with performing my usual activities
- O I have some problems with performing my usual activities
- O I am unable to perform my usual activities
- O No answer

PAIN/DISCOMFORT Please tick **only one**:
- O I have no pain or discomfort
- O I have moderate pain or discomfort O I have extreme pain or discomfort O No answer

ANXIETY/DEPRESSION Please tick **only one**:
- O I am not anxious or depressed
- O I am moderately anxious or depressed O I am extremely anxious or depressed O No answer

28a* 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.** (please rate by giving a number 0 and 100)

……….
- O No answer

29. **COMPARED TO TWELVE MONTHS AGO, HOW WOULD YOU SAY YOUR HEALTH IS NOW?**

Please tick **only one**:
- O My health is better than it was 12 months ago
- O My health is about the same as it was 12 months ago
- O My health is worse than it was 12 months ago

30. **ARE YOU TAKING ANY MEDICATION PRESCRIBED FOR YOU AT THE MOMENT?** This includes medicines, pills, syrups, ointments, puffers or injections. Please tick only one:
- O Yes   O No

31. **HAVE YOU BEEN VACCINATED AGAINST HEPATITIS B?** Please tick only one:
- O Yes (once)   O Yes (twice)   O Yes (three times)
- O Never   O Don't know

32. **HAVE YOU BEEN VACCINATED AGAINST FLU?** Please tick **only one**:
- O Yes (in the last year)   O Yes (more than a year ago)
- O Never   O Don't know

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

    ○ Yes   ○ No   ○ Don't know

34. HAVE YOU HAD A SEXUAL HEALTH CHECK IN THE PAST 12 MONTHS? Please tick only one:

    ○ Yes   ○ No   ○ Don't know

35. DO YOU KNOW WHERE TO ACCESS FREE CONTRACEPTION? Please tick only one:

    ○ Yes   ○ No

36. DO YOU KNOW WHERE TO ACCESS ADVICE ABOUT SEXUAL HEALTH? Please tick only one:

    ○ Yes   ○ No (*go to Q37)*

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

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

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

    ○ Yes   ○ No   ○ Don't know

38. *FEMALE CLIENTS OVER 50 ONLY*: HAVE YOU HAD A BREAST EXAMINATION/ MAMMOGRAM IN THE PAST 3 YEARS? Please tick **only one**:

    ○ Yes   ○ No   ○ Don't know

39. ON AVERAGE, HOW MANY MEALS DO YOU EAT A DAY? If this is difficult, please think about the

meals you ate yesterday. Please tick only one:

    ○ None   ○ One   ○ Two   ○ Three or more

40. HOW MANY PORTIONS OF FRUIT AND VEG DO YOU USUALLY EAT PER DAY? If
this is difficult, please think about what you ate yesterday. Please tick only one:

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

**41. HOW OFTEN PER WEEK DO YOU EXERCISE FOR 30 MINS OR MORE? (Activity
that raises your heart rate and makes you breathe faster).** Please tick **only one**:

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

42. IS THERE ANYTHING ELSE YOU WOULD LIKE TO TELL US ABOUT YOUR HEALTH & THE SUPPORT YOU RECEIVE?

What works well?...
...............…………………..

What could be improved?..
....…….

Any other comments:…………………………………………………………………………….………
……..
…...……………………………….…………………………………………………………………………
.

Thank you for completing this survey.

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Appendix 2: Focus group specification

Format: Ideally three focus groups with 6-8 people, each lasting 1.5 hrs

Below is a draft script (with instructions in italics). Whilst it would be good to cover these areas, a moderator does not have to stick rigidly to the script and can be guided by the focus group participants.

Welcome and topic

- Introduce moderator +/- assistant
- Our topic is your health, and the healthcare services available to you.
- The results will be used for an assessment of the health of homeless people in Oxfordshire. Some of the results will inform which services we provide in the near future.
- You were selected because you're in Oxfordshire, using some of the services aimed at homeless people.

Guidelines

- No right or wrong answers, only differing points of view, everyone can have different opinions
- We're tape recording, one person speaking at a time
- We're on a first name basis
- You don't need to agree with others, but please listen respectfully as others share their views
- My role as moderator will be to guide the discussion
- Talk to each other
- You don't have to tell us any information you wouldn't want other people to know
- Outside this room, please don't share anything that is discussed – what is shared in the room stays in the room

Questions
Introduction (15 minutes)

1. Tell us the name you would like us to use and what comes to mind when I say the word "**health**"?

Health needs (15 minutes)

2. Now I'd like to talk about serious health issues you face today. What health issues are you most worried about?
 2a. <u>Women</u> – *have there been any health issues relating to you as <u>**women**</u>? Probe pregnancy, period problems, contraception and menopause.*

Before this session, we made up a list of what we thought would be the most serious health issues. Here is a list of what we came up with (flip chart 1). Based on what you told us, I'm going to add a few more categories.

Add any points that were raised that are not on the list.

In front of you, you have five (5) dots with which I'd like you to vote on the MOST serious health issues you face. You can put one dot on five different categories, or you can put more than one dot on a single category.

Allow participants to "vote" with their dots and probe on which ones received the most dots. Probe specifically on the mental health categories.

Health Services (20 minutes)

3. What health services have you had contact with whilst you've been homeless?
Probe about GP practices, including Luther Street Medical Centre, experience with hospitals, drug and alcohol services, mental health services, sexual health etc.

For O'Hanlon House, probe about needle exchange:
   a. There has been a change in the way we provide clean needles at O'Hanlon House – we noticed that some people were only using one or two needles from the large packs of needles, so now we are giving out individual, single clean needles in smaller, more discrete packets. How do you feel about this?
   b. With the smaller packets, we have stopped providing the condoms that we give out with the larger packets. How do you feel about this?
   c. We have found lots of needles – some used and some not used – discarded loose and not in sharps' bins around Luther Street and Gloucester Green. How do you feel about this? Is there anything you think we could do better to make sure the needles are disposed of properly?

4. Which services do you think have been provided well? What is it about these services that has been good?

5. Which services do you think have not been provided well? What is it about these services that have not been good? Can you think of any ways that these could be improved?
6. Can you think of any services we DON'T provide that you would find useful?

Probe about Hepatitis C:
   a. We are exploring the possibility of a new testing service for Hepatitis C. This is because the treatment for hepatitis C has got so much better in recent years – and so has the testing. Now, with just a swab from your mouth, they can immediately tell you if you are likely to have hepatitis C or not, and we want to enable pharmacists to offer tests to people who come in for clean needles and offer some support on getting treated. How would you feel about this?

Difficulties reaching health needs (15 minutes)

7. Lots of people in Oxfordshire have trouble meeting their health needs. For instance, you might not want to attend all the meetings/appointments you have been given, or you might find it difficult to find a doctor or hospital where you feel welcome, or all of the services might be quite far away from where you are staying. *Ask* - have you or a friend that you know has been in this situation.

8. Let's talk about this. In your experience, what are the biggest areas of trouble in meeting their health needs?

Probe on why people have unmet health needs. Specifically probe if they have felt any hostility towards homeless people, and where they have felt his (e.g. in hospital or at the GP).

Making health-related decisions (15 minutes)

9. If you felt unwell or were concerned about your health, where would you go?
Try to differentiate between primary care (chronic issues and emergency issues).

10. How do you make decisions about where to go to receive health care?

   Before this session, we made up a list of what we thought would be the major factors in deciding where to go to receive health care. Here is what we came up with: (flip chart 2)
Add any points that were raised that are not on the list.

   In front of you, you have three (3) dots with which I'd like you to vote on the TOP factors in deciding where your family goes to receive health care. You can put one dot on three different categories, or you can put more than one dot on a single category.
Allow participants to "vote" with their dots and probe on which ones received the most dots.

Summary (10 minutes)

11. *Provide summary of major points discussed.*
    Did I correctly describe what was said?

12. Is there anything you would have liked to talk about but didn't?

Flip chart 1 – health issues (listed in alphabetically order)

Alcohol dependency

Anxiety

Being overweight or obese

Being underweight or too thin

Blood clots in the leg (deep vein thromboses)

Cancer

Depression

Diabetes

Drug dependency

Heart disease, high blood pressure or high cholesterol

Injuries

Illness related to the cold, like frostbite

Infections, like hepatitis or HIV, that you can get from sharing needles

Liver disease

Lung disease, like lung damage from smoking, or chronic infections like TB

Oral health, like problems with your teeth

Psychiatric issues like schizophrenia, bipolar or personality disorders

Self-harm

Sexual health/pregnancy-related

Skin problems, like skin infections or burns or leg ulcers

Smoking

Stroke

Other

Flip chart 2 – how do you decide where to go to receive healthcare?

Clinicians making you feel welcome

Doesn't take too much time to attend

Proximity to where you're staying

Quality of care

Referred by a friend/family

Visible in your community

Other