Dec 2022

People Experiencing Homelessness in Bristol Health Needs Analysis

Bristol Public Health

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Summary

Strong governance systems and leadership are needed across the city to fulfil Bristol's commitment to improve health outcomes for people who have or are experiencing homelessness.

From the perspective that this report has taken, two broad areas have been identified for action. Addressing these will help prevent ill health and improve outcomes for people experiencing homelessness. They should also result in improved efficiency within the health and care system.

Themes for improvement are:

1. **Access to effective healthcare**

Early diagnosis and treatment could prevent multiple and complex conditions developing. This requires improved access to healthcare and especially routine access to primary care services for people in Bristol experiencing homelessness.

Primary care providers can be supported to ensure they allow access without proof of ID or address, immigration status or an NHS number. This can be amplified via the national NHS England campaign resources such as shown in figure 14 and monitored at a local level.

People experiencing homelessness face stigma and discrimination which can lead to a lack of trust and engagement with health services. Supporting a cultural shift towards trauma informed practice can help to address this. Effective behaviour change interventions can be explored and implemented.

Many people experiencing homelessness cannot access services using current models based on the need to attend a specific location at a specific time. Opportunities to increase outreach work and drop-in sessions can be identified and more inclusive models explored and implemented.

Care leavers and younger people experiencing homelessness have been identified as needing improved access to preventative healthcare and protection from exploitation. Access to current healthcare services and models for improvement can be explored.

2. Data and intelligence

Homelessness is a health issue; a condition that results in poor physical health which must be considered as we would any other public health concern. Homelessness is both a result and cause of poor health and the impact of cold and damp have been highlighted as concerns locally.

A limited range of data sources were identified which allow analysis by accommodation status for health outcomes and risks.

There is a lack of access to health surveillance data sources such as primary care activity and a lack of consistency and completeness in identifying people experiencing homelessness in available data sources. This needs to improve.

There is also an absence of identification/inclusion of those experiencing homelessness in some regular surveys such as Quality of Life and Census, as well as a lack of a regular bespoke homelessness-focussed health survey in Bristol.

People experiencing homelessness are impacted by intersections of inequality and differences have been found in recorded health needs depending on age, gender identity, sexuality, ethnicity, and disability.

Services can continue to monitor, develop, and improve health equity only with good quality data. Data for equality groups varied in completeness and can be improved.

Advisors have raised topic areas such as sexual health, social care needs and serious mental illness. Potential data sources can be identified to explore these further.

To report more fully on the health needs of people experiencing homelessness, access is needed to health surveillance data which is both complete and consistent. Methods to overcome identified issues can be explored.

Opportunities can be explored to improve recording and reporting of data and analysis and support and encouragement for more 'screening' and recording of homelessness within routine NHS datasets.

Consistency can be sought in definitions of patients/clients subject to homelessness to be used in local data sources.

Identification of residents who have experienced / who are experiencing homelessness can be added to routine data collection / survey processes where this does not occur at present.

The creation of bespoke primary health data collection for the cohorts of interest can be considered.

Opportunities can be explored for further data analysis to prevent, manage, and treat conditions of concern.

The Housing Support Register (HSR) is a rich source of data for analysis of health needs and can be more regularly examined and reported on.

The increased speed at which data can be accessed means that analysis can occur more frequently, and a refresh of this document can be planned before the end of 2024 to monitor progress.

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Forward by the Director of Public Health

In the last 12 months 840 people experiencing rough sleeping have had contact with the Outreach Team in Bristol. All these individuals are at higher risk of poor health and early death. Many have experienced considerable lifetime trauma and have complex mental and physical health needs which may be compounded by substance use. A high proportion of people sleeping rough have as children been in contact with the care system then as adults experience the paradox of being at once displaced, excluded and unseen at the same time as having a higher-than-average visibility within the criminal justice system and emergency and unplanned health care.

As a city we want and need better health outcomes for people who experience rough sleeping. It takes resilience and courage to survive on the street and whether a person has a home or not, they deserve dignity, care, and respect. During the *Everyone In* initiative which was put in place during the COVID-19 lockdown, we witnessed increased numbers of people moving into recovery, managing their addiction, and moving into more permanent accommodation. This was as a direct result of the provision of clean, safe accommodation and of wrap around personalised health and care services. These outcomes need to be the norm, rather than the exception.

The purpose of this report is to support the city to achieve these better outcomes by informing future planning, alignment, and commissioning of services in Bristol. Drawing on a range of data and information sources, including lived experience, the report provides an analysis of the different physical and mental health needs and challenges of people experiencing homelessness and rough sleeping.

The report firstly looks at the national policy context and evidence and then looks at who is homeless and rough sleeping in Bristol and what their health needs are. Most importantly, in chapter 10 the report concludes with several key recommendations for improvement and action.

Produced as part of ongoing work to address health inequalities in Bristol, this report forms a significant step towards this commitment.

Christina Gray

Director for Communities and Public Health, Bristol City Council

Terminology and Categories

Wherever possible, person-centred language such as "People Experiencing Homelessness" and "People Experiencing Rough Sleeping" has been used to frame homelessness as an experience and not an identity.

ICD-10 Codes are referred to which are the International Classification of Diseases (ICD) 10th revision codes and are used for entry onto clinical databases such as those used in hospital.

The Housing Support Register is sometimes referred to as 'HSR' in this document and holds information which is self-reported by the client and recorded by Bristol City Council staff to determine accommodation and support need.

The four homelessness prevention accommodation pathways for people aged 22 and over, without dependent children in Bristol are sometimes referred to in this document as Pathways 1-4:

- Pathway 1: men only
- Pathway 2: mixed gender
- Pathway 3: women only
- Pathway 4: substance misuse preparation and in-treatment housing

Bristol City Council's equality terms guide has been consulted but where data has been collected using specific terms, these has been used, such as in graphs and tables.

This report will focus on the health needs of single individuals who are either sleeping rough, in emergency accommodation, hostels or temporary accommodation.

National Context

Homelessness is described by Shelter as not having a home and includes those who do not have permission to stay where they are or live in unsuitable housing (Shelter, 2022).

A pragmatic tool - European Typology on Homelessness and Housing Exclusion (ETHOS) has been proposed to help describe different types of homelessness (European Commission, 2007). This report will focus on operational categories 1 to 3 as highlighted in green in table 1 (column 1, cells 1 to 3).

Table 1: homelessness operational categories from ETHOS Light (European Commission, 2007)

Operational Category	Living situation	Definition
1. People Sleeping rough	1. Public spaces/external spaces	Living on the streets or public spaces without shelter that can be defined as living quarters.
2. People in emergency accommodation	2. Overnight shelters	People with no place of usual residence who move frequently between various types of accommodation.
3. People living in accommodation for people experiencing homelessness	3. Homeless Hostels 4. Temporary accommodation 5. Transitional supported accommodation 6. Women's shelters or refuge accommodation	Where the period of stay is time-limited and no long-term housing is provided.
4. People living in institutions	7. Health care institutes 8. Penal institutions	Stay longer than needed due to lack of housing. No housing available prior to release.
5. People living in non-conventional dwellings due to lack of housing	9. Mobile homes 10. Non-conventional buildings 11. Temporary structures	Where accommodation is used due to a lack of housing and is not the person's usual place of residence.
6. People living temporarily in conventional housing with family and friends (due to lack of housing)	12. Conventional housing, but not the person's usual place of residence	Where accommodation is used due to a lack of housing and is not the person's usual place of residence.

Table 1 is adapted from ETHOS Light *(European Commission, 2007)*

The recent national strategy "Ending Rough Sleeping for Good" (Department for Levelling Up, Housing and Communities, 2022) includes a vision for rough sleeping to be:

"Prevented wherever possible, and where it does occur (ensure) it is rare, brief, and non-recurrent."

The national strategy described rough sleeping as a highly complex issue and suggests that an understanding of the routes into rough sleeping is vital.

Referenced in the strategy, a survey of people who had slept rough within the last year (Ministry for Housing, Communities and Local Government, 2020) found that at least half of respondents first slept rough over 5 years ago and at least 39% of respondents first slept rough over 10 years ago. Before rough sleeping, most respondents had not been in stable accommodation. This included 'sofa surfing', being in a hostel, prison, or hospital. 72% had experienced time in care as a child, been permanently excluded from school, regularly truanted from school, left school before age 16 or a mixture of more than one of these (Aldridge RW, 2018).

The homelessness monitor is a longitudinal study and the most recent showed a change in the profile of applicants which reflected pandemic related homelessness drivers, such as added pressure within the home, putting those in informal "sofa surfing" arrangements and those in domestic abuse situations at great risk (Crisis, 2022).

People who are eligible for assistance and threatened with homelessness are owed the 'prevention duty'. This duty is owed regardless of priority need, intentional homelessness or local connection. It requires that the applicant and the local authority take reasonable steps to secure that accommodation does not cease to be available and that any accommodation secured has a reasonable prospect of lasting for at least six months (Department for Levelling Up, Housing and Communities, 2018).

The latest statistics released as part of the statutory homelessness annual report (Department for Levelling up, Housing and Communities, 2022) show the number of single households in England that were either threatened with homelessness or already homeless and owed a

prevention duty was 77,090 in 2021-22. This was a 3.8% increase from 2020-21 and a 9.6% decrease from 2019-20.

Routes into homelessness

Identifying that the causes of individual factors are influenced by wider determinants such as unemployment and poverty, a more "upstream" lens can be applied to divide into structural and individual factors (Public Health England, 2019) See figure 1.

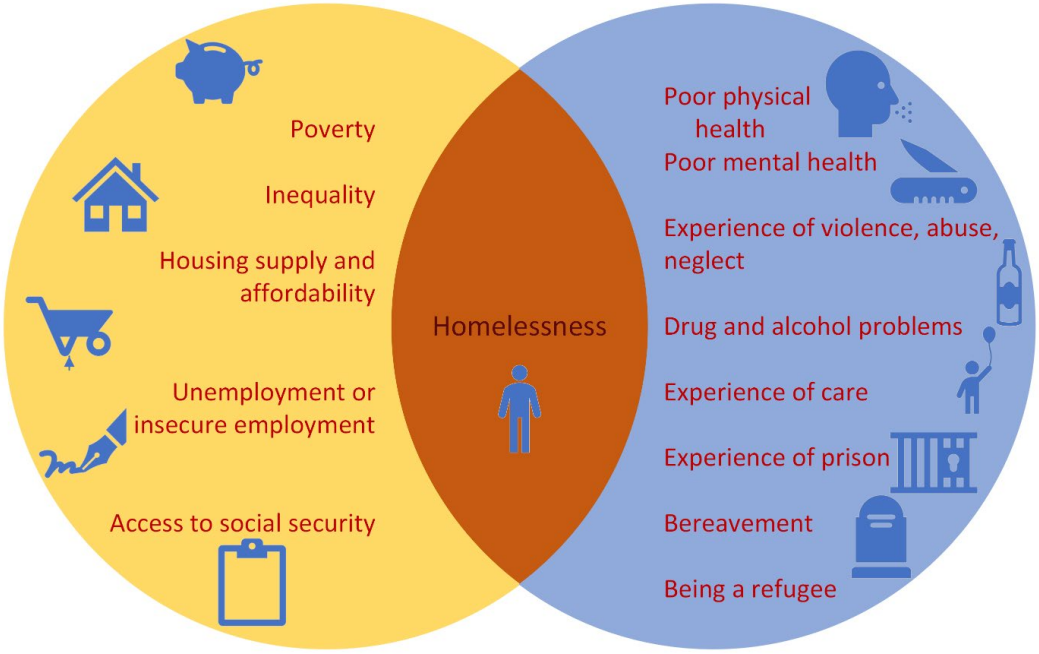


Figure 1: Causes of Homelessness: Structural, Individual, adapted from (Public Health England, 2019)

Research on routes into homelessness demonstrates a high prevalence of childhood trauma, including exposure to abuse, neglect, domestic violence, and parental mental ill-health and substance use disorders with the highest risks found in low-income populations (Luchenski, 2018).

Care leavers, prison leavers and survivors of domestic violence have been identified as most at risk of homelessness (All-Party Parlimentary Group for Ending Homelessness , 2017).

For young people with care experience, the transition to living independently is a key pressure point (Sanders. M, 2021)

Preventing homelessness

A five-part typology was developed in policy deliberations towards the national rough sleeping strategy which identified Universal, Targeted, Crisis, Emergency and Recovery prevention. (Fitzpatrick.S, 2019) (Department for Levelling Up, Housing and Communities, 2022).

A review of evidence on the prevention of homelessness concluded that there is need for more research to assess the relative effectiveness of different approaches (Centre for Homeless Impact, 2021).

COVID-19

In concluding this section, it would be remiss to not mention the COVID-19 pandemic. In March 2020 in response to this, the UK government announced that all people experiencing homelessness in the UK should be supported into accommodation (Ministry for Housing Communities and Local Government, 2020).

Early modelling around six months later suggested that the "everyone in" initiative (as it became known) may have prevented over 20,000 infections and 266 deaths amongst people experiencing homelessness and rough sleeping in England (Lewer. D, 2020).

Summary of Current Evidence

This section reviews the prevalence and incidence of health conditions for people who experience rough sleeping and/or homelessness in the UK, using research studies published in the last 5 years.

A scoping literature review was conducted to gain a broad understanding of the health needs and conditions commonly experienced by this population.

People who experience homelessness have poorer health than people of the same age in the general population (Public Health England, 2019).

Although people who experience homelessness may have a range of conditions, most prescribing activities in specialist GP services have been found to relate to mental health and substance use, possibly suggesting under diagnosis and under treatment of other long term health conditions (Khan A, 2022).

(Field, 2019) found that the most recorded diagnosis at admission to hospital for people experiencing homelessness were mental and behavioural disorders, external causes and their consequences. Mental and behavioural disorders included alcohol intoxication or withdrawal, self-harm, suicidal ideation, or depression. External causes and their consequences included assault, road traffic collisions, poisoning, head injuries and fracture.

The following highlights particular areas of health where outcomes are worse in people experiencing homelessness compared to the wider population.

Health Behaviours

Health behaviours which reduce risk of non-communicable diseases such as (most) cancer and cardiovascular diseases include not smoking and being physically active. These health behaviours have been found to be lower in people who have experienced homelessness compared to those who have not. One study found that physical activity levels were significantly lower amongst participants who had experienced at least one month of homelessness, with 30.7% being classed as inactive compared to 23% in those participants who had not experienced homelessness. The

study also found higher levels of smoking amongst those who had experience of homelessness (Smith L, 2019)

Higher rates of smoking were also found amongst those surveyed by Homeless Link in their most recent review of homeless health audits for years 2018-21. This review found that 76% of respondents reported they smoke cigarettes, cigars, or a pipe. Over half of respondents (54%) reported they had used drugs in the last 12 months (Homeless Link , 2022).

People experiencing homelessness have been found to consume lower amounts of fruits and vegetables as well as higher amounts of fat and alcohol when compared to housed individuals (Huang. C, 2022).

Over half (54%) of people experiencing homelessness report having used drugs in the last year which is far higher than estimates for the general population (8%). Dual diagnosis of mental health and a drug or alcohol problems are common amongst people experiencing homelessness and 45% of respondents to the latest health needs audits nationally reported using drugs or alcohol to help them cope (Homeless Link , 2022).

Treating drug dependence as a long- term condition has been recommended (Department of Health and Social Care, 2021).

Long term medical conditions

There is a higher prevalence and incidence of cardiovascular disease as well and risk factors for people experiencing homelessness in the UK compared to people who are housed (Banerjee. A. Nanjo. A, 2020).

Whilst it is widely understood that those in deprived areas of the UK experience poorer health outcomes than those in less deprived areas, a study of people living in London and Birmingham, found the reported prevalence of several chronic diseases is far higher for people experiencing homelessness. As shown in graph take from the study (figure 2), asthma, COPD, epilepsy, heart problems and stroke were reported to be significantly higher amongst those experiencing homelessness compared to the housed population, including those living in the most deprived areas (Lewer. D, 2019).

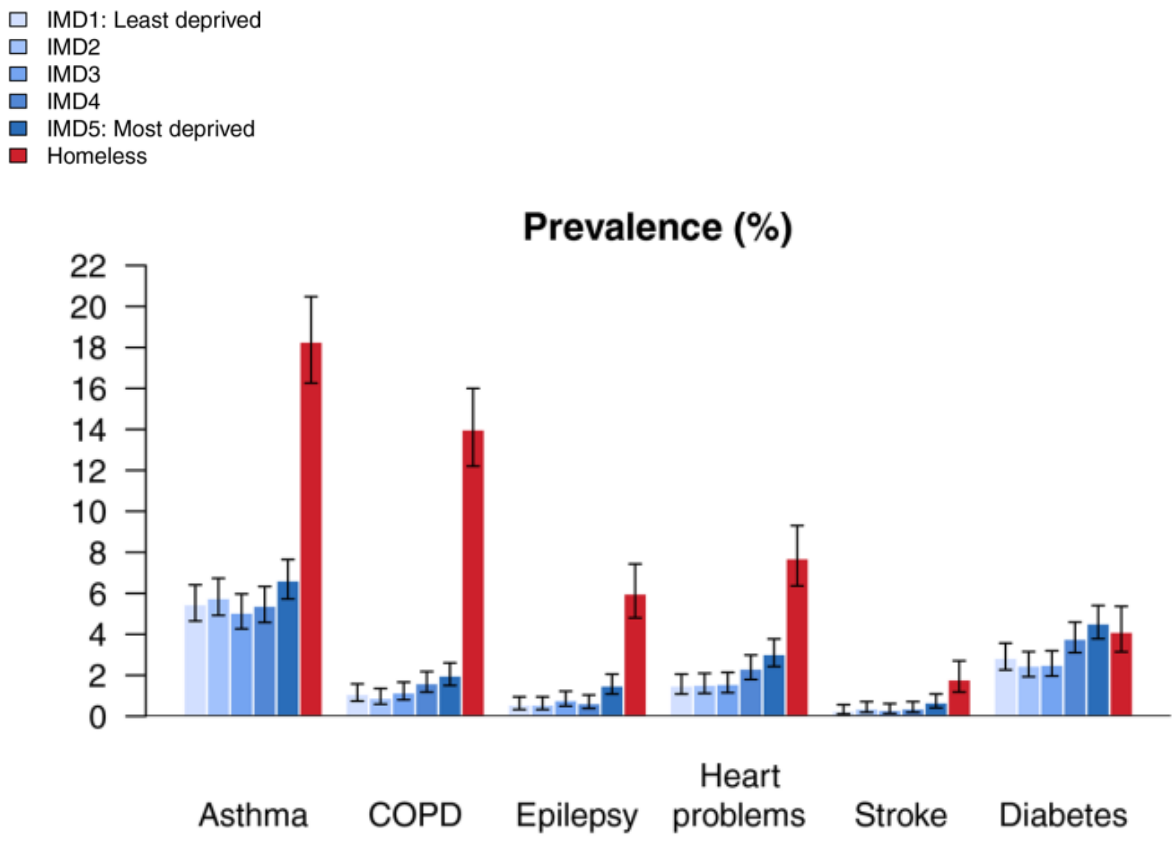


Figure 2: Prevalence of Long-Term conditions (Lewer. D, 2019)

The ten most common health problems reported by people experiencing homelessness nationally (Homeless Link , 2022) are:

- Joint aches/problems with bones and muscles
- Dental/teeth problems
- Asthma
- Difficulty seeing/eye problems
- Stomach problems, including ulcers
- Problems with feet
- Fainting/blackouts
- Skin/wound infection or problems
- Chronic breathing problems

- Heart problems

Dental and Oral health

People experiencing homelessness have been found to have greater need for oral healthcare than the general population (NHS England and NHS Improvement, 2021). Oral health varies across the national population and disproportionately impact socially disadvantaged groups and individuals such as those experiencing homelessness (Public Health England, 2022).

Peer led research in London found that the experience of homelessness has a negative impact on a person's oral health and the oral health of participants in the study was significantly worse than the general population (Groundswell, 2018). 30% of those in the study were currently experiencing dental pain with bleeding gums, holes in teeth and abscesses common. 17% had lost teeth following acts of violence and 15% had pulled out their own teeth. 27% had used alcohol to help them deal with dental pain and 28% had used other drugs.

Liver Disease

The British Liver Trust explains that risk factors for liver disease include alcohol use and Hepatitis C and there has been found to be a high burden of chronic liver disease amongst people who experience homelessness (British Liver Trust, 2022), (Hashim, 2021).

Liver disease has been found to account for a higher percentage of deaths (13.8%) amongst people experiencing homelessness when compared to people living in the most deprived areas (2.7%) (Aldridge RW, 2019).

Infectious diseases

There is an increased risk of HIV and hepatitis C virus among people who inject drugs (PWID) who are or have recently experienced homelessness or unstable housing when compared with PWID who are more stably housed (Arum C, 2021).

Despite initial fears in March 2020, there is general agreement that the rate of COVID-19 infections was not as high as anticipated amongst people experiencing homelessness with an estimated 13 deaths involving COVID-19 registered in 2020 (Office for National Statistics, 2022).

People experiencing homelessness in the UK have been found to have higher rates of latent tuberculosis (TB) (Aldridge RW, 2018) and an association has been found between people who have experienced homelessness and higher TB risk (Nguipdop-Djomo P, 2020).

Data on TB in England is collected on the presence or absence of four social risk factors (SRF) which are known to increase the risk of TB and these include experiencing homelessness. 2020 data showed a reduction in the number of people reported with TB overall. Available data for 2016-2019 showed a rise in the percentage of cases that were recorded in those experiencing homelessness although this dropped again in 2020 (UK Health Security Agency, 2021).

Globally, homeless shelters have been found to be a common site of exposure to group A streptococcus (GAS) (Avire NJ, 2021).

Mental Health

In one study, people experiencing homelessness were more than twice as likely to report problems with anxiety, compared to those who were housed in the most deprived areas (Lewer. D, 2019).

The latest Homeless Health Audit data found that 82% of respondents reported they have a mental health diagnosis – a rise from 45% in a previous audit (Homeless Link , 2022). This appears to be much higher than the general population as identified via a survey of GP patients nationally in which 12.3% reported they have a mental health condition (NHS England, 2022).

Analysis of data from the National Confidential Inquiry into Suicide and Safety in Mental Health found that people experiencing homelessness, who died by suicide between 2000 and 2016, who had recent contact with mental health services, were more likely to have acute and chronic substance use than patients in stable accommodation. They were also younger, more likely to be male and less likely to be supported by a crisis team (Culatto P, 2021).

Of deaths registered in 2020 in people experiencing homelessness, deaths from suicide fell by about a third from 112 in 2019 to 74 in 2020 (Office for National Statistics, 2022).

Brain injury

There is an association between Traumatic Brain Injury (TBI) and poorer reported health as well as suicidality and suicide risk (Stubbs J. L., 2020) and the lifetime prevalence of moderate to severe TBI has been found to be around ten times higher amongst people experiencing homelessness, than is estimated for the general population.

Mortality

A recent study (Aldridge RW, 2019) investigated the causes of death for a large group of people admitted to hospital in 17 sites across England (Aldridge RW, 2019). It was found that whilst external causes of death such as drugs, alcohol and suicide are considerably more prevalent in the homeless population than for those living in socially deprived areas this was also the case for deaths from respiratory, cardiovascular and digestive system diseases.

A study of "Pathway" teams in the UK which offer specialist hospital care coordination for people experiencing homeless found that many deaths of homeless individuals are due to treatable conditions such as heart disease, pneumonia, and cancer (Field, 2019). Fifty reviewed patients died within one year of discharge with an average age of 52 years at the time of their death.

Analysis of data from the national child development study and 1970 British cohort study provides further evidence that exposure to any type of homelessness in early adult life can increase the risk of overall mortality (White.J, 2021).

Homelessness in Bristol

The main reason given to Bristol City Council for homelessness in Bristol is due to private rented sector eviction. Other reasons for homelessness reported to the Homelessness Prevention Service include domestic abuse, loss of social rent tenancy and non-violent end of relationship (Bristol City Council, 2021).

Current services

Services provided in Bristol which are available to support the health of people experiencing homelessness include (but are not limited to):

1. Mainstream NHS and other health specific services in such as GPs, secondary care (hospital), primary care, social care – although access issues raised.

2. Health and well-being support and help to access healthcare are provided by various non health services. These include commissioned homelessness services, and third sector and other support services such as faith groups, charities, small groups and individuals. Peer support from people with relevant lived experience is included within some of these.

3. Targeted services provided to address the specific health and care needs of people experiencing rough sleeping and homelessness:

    a. Homeless Health service based at Jamaica street which provides drop-in sessions with a doctor or nurse as well as three wet Clinics per week in outreach locations (wet clinics allow access to healthcare without the need to stop drinking and allow alcohol on site). Previously commissioned by the Clinical Commissioning Group and recommissioning now led by the Integrated Care Board.

    b. Out of Hospital Care Model offering enhanced primary care services, holistic assessment and discharge planning, step down floating support service and virtual multi-disciplinary team. Current pilot funded until end of Q3 2022.

    c. Social care Homeless Move on Team (HMO) set up in 2020, initially to support the assessment of people accommodated through “everyone in”. This service carries out assessment of

care and support needs under Section 9 of the Care Act (UK Government , 2014) for people experiencing homelessness and who present with multiple complexity.

d. Changing Futures programme which is prioritising working with people experiencing homelessness to better understand and address the system change issues people experience in relation to health, social care, housing and the criminal justice system.

4. Substance treatment services – collectively known as ROADs. Whilst not exclusively for people experiencing homelessness and rough sleeping, access is provided with people who experience multiple disadvantage in mind. Some healthcare services cover wider health needs than substance only. Services include needle exchange, respiratory and renal health, hepatitis B and C treatment and vaccination, detox – inpatient and detox community. Includes ADDER.

5. Community Dental Services (CDS) and Special Care dental services provide dental care services through referral for people who cannot be seen in general practice (University Hospitals Bristol NHS Foundation Trust , 2022). These are provided at sites to serve the BNSSG and BANES area including at Charlotte Keel Health Centre in Bristol. There is also an out of hours dental service for which an NHS number and address is required in order to access.

People rough sleeping or in temporary accommodation in Bristol

The latest annual single night count recorded **58** people sleeping rough on that night in Bristol in November 2022.

The number of people who had slept rough at any time within a three month period as reported by Bristol Street Outreach service for October to December 2021 as **175**, rising to **200** in April to June 2022. This is shown in figure 3.

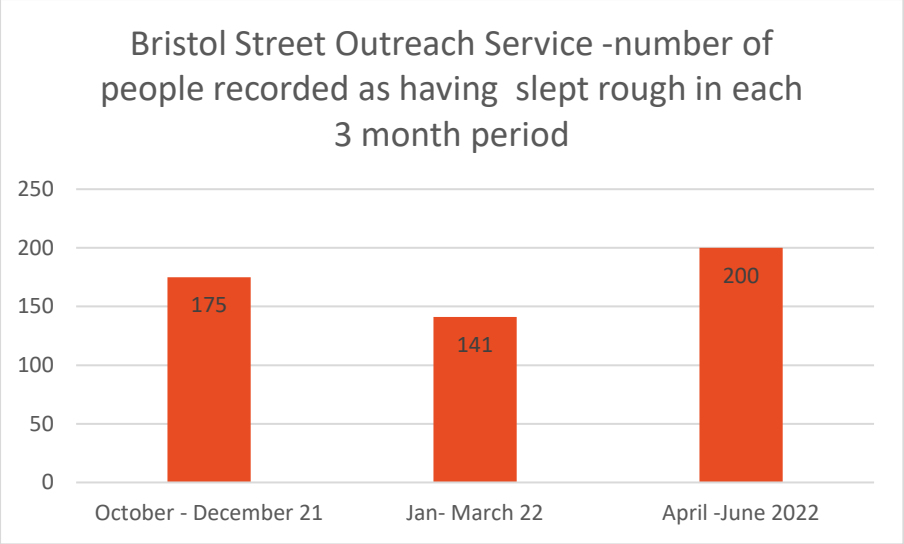


Figure 3: Number of people recorded as having slept rough in each 3 month period

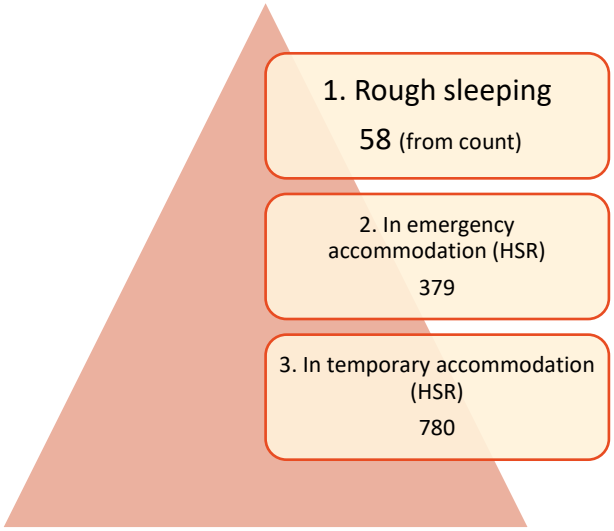


Figure 4: Diagram to illustrate quantity of people experiencing each type of homelessness in Bristol

People may move from one type of accommodation to another or be hidden because they are temporarily living with someone, be in prison or move in and out of the city. Figure 4 provides an illustrative snapshot of the number of people known to homelessness services.

Analysis of the health of people experiencing homelessness in Bristol

GP utilisation

A priority in addressing health and homelessness is to ensure that everyone experiencing homelessness has access to and is registered with a GP. The Homeless Health Service is a specialist service which includes doctors, nurses, health link workers and support staff who provide confidential health advice and treatment to people experiencing homelessness in Bristol. Services are based at The Compass Centre in Stokes Croft, Bristol, with several outreach clinics around the city.

The Homeless Health Service does not hold a GP list and all clients are encouraged and supported to register with local practices.

142 patients were coded as "homeless" at Bristol practices; however, it is not clear whether this code is used consistently or what type of homelessness this describes.

Given the importance of access to primary care, along with the high utilisation of acute and emergency services, there is considerable scope for strengthening both the data available and the services offered.

Dental and Oral Health

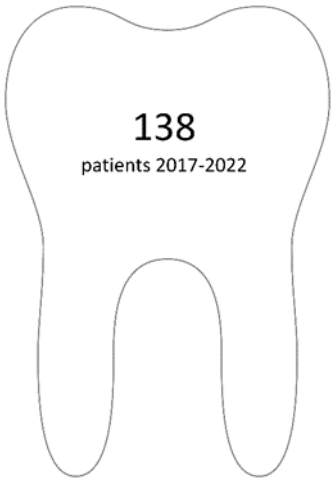
Several frontline professional working across Bristol's homelessness system have raised the issue of dental and oral health for the clients and patients they work with.

Email feedback from local professional

In theory, people experiencing homelessness can access dental care in a variety of ways, including high street dental service providers, and via community dental services. However, these individuals may experience significant difficulties in accessing high street dental care, and this has been exacerbated by Covid.

Current triage processes (that use telephones); long waiting lists; and system complexities in accessing dental treatment generate additional barriers to accessing dental care, as evidenced by the data on the poor uptake of NHS general dental practice services in lower socio-economic

groups. Furthermore, these individuals are not always considered eligible for care via the Community Dental Services, in the absence of certain acceptance criteria.



Very little data is readily available about the oral and dental health of people experiencing homelessness in Bristol. Working with UHBW primary care dental service, potential sources were explored and patients were identified who had used these services and given their postcode as one of 7 of the largest hostels in Bristol. This showed that over a 5 year period, 138 individual patients were seen by these dental services who have their address at one of these 7 hostels.

Whilst limited conclusions can be drawn from this information, it indicates that some people experiencing homelessness in Bristol are able to access Community Dental and out of hours services in Bristol and provides a basis for future analysis.

Hospital utilisation

Working with Hospital Episode Statistics, all admissions of Bristol residents coded 'Z590' (within the ICD-10 coding schema) indicating problems relating to homelessness were identified. Admissions data was also identified for patients of the Homeless Health Service.

The following pages present three cohorts for comparison:

1. Patients coded with 'Z590' indicating 'problems relating to homelessness'.

2. Patients NOT coded with 'Z590' indicating 'problems relating to homelessness.

3. Patients registered using the practice code for the Homeless Health service.

During the five-year period 2017-2022 there were 623,081 admissions recorded to Bristol hospitals. Very low percentages were identified from either "homeless" cohort:

- 0.2 % (1,258) of these were recorded as having 'problems relating to homelessness'
- 0.07% (441) were recorded as patients of Homeless Health service

Of these, most admissions for those 'problems relating to homelessness' and those registered as Homeless Health patients were emergency rather than elective (planned), accounting for **94%** and **88%** and of admissions in these groups respectively compared to **38%** for patients where records did not indicate 'problems relating to homelessness'. The ratio of emergency to planned care was more than 20 times larger for admissions recorded as 'having problems relating to homelessness' compared to those without this recorded.

Emergency admissions and their causes, provide a useful guide to the incidence of health issues that require hospital care within the population, and for those conditions that can be managed or pre-empted through community-based care, a measure of the effectiveness of that sort of intervention between groups within the population. Comparing the most commonly recorded diagnoses for these admissions between the homelessness cohorts and the rest of the admissions for the Bristol population provides some clues to those health issues more prevalent within the homelessness cohorts than the general population.

This does not give us an understanding of multiple conditions or 'comorbidities' experienced by people in each cohort. Self-reported comorbidities were identified through examination of data from the Housing Support Register.

To aid interpretation of the data presented in graphs and tables, Table 2 provides examples of the conditions within each ICD-10 chapter code diagnosis which are mentioned.

Table 2: Examples of conditions for ICD-10 codes identified

ICD-10 code	**Examples of conditions**
Mental and behavioural disorders due to psychoactive substance use	This includes mental and behavioural disorders due to substances such as alcohol, opioids, cannabinoids, sedative hypnotics, cocaine, stimulants, and solvents.

ICD-10 code	Examples of conditions
Poisoning by drugs, medicaments and biological substances	This includes poisoning by substances such as systemic antibiotics, nonopioid analgesics, antipyretics and antirheumatics, narcotics and hallucinogens, anaesthetics and therapeutic gases, psychotropic drugs, diuretics and other and unspecified drugs.
Injuries to the head	This includes superficial injury of head, open wound of head, fracture of skull and facial bones, dislocation, sprain and strain of joints and ligaments of head, injury of eye and orbit crushing.
Symptoms and signs involving cognition, perception, emotional state and behaviour	This includes somnolence (drowsiness), stupor and coma signs involving cognitive functions and awareness dizziness disturbances of smell and taste emotional state appearance and behaviour.
General symptoms and signs	This includes headache, pain, malaise and fatigue, symptoms and signs concerning food and fluid intake and other general symptoms and signs.
Symptoms and signs involving the circulatory and respiratory systems	This includes abnormalities of heart beat, cardiac murmurs and other cardiac sounds, abnormal blood-pressure reading, without diagnosis, haemorrhage from respiratory passages, cough, abnormalities of breathing and pain in throat and chest.
Infections of the skin and subcutaneous tissue	This includes staphylococcal scalded skin syndrome, impetigo, cellulitis and other local infections.

ICD-10 code	Examples of conditions
Chronic lower respiratory diseases	This includes bronchitis, not specified as acute or chronic, emphysema, other chronic obstructive pulmonary disease and asthma.
Influenza and pneumonia	This includes various types of influenza and pneumonia.
Episodic and paroxysmal disorders	This includes Epilepsy and recurrent, Migraine, Other headache syndromes, Transient cerebral ischemic attacks and related vascular syndromes of brain in cerebrovascular diseases sleep disorders.
Schizophrenia, schizotypal and delusional disorders	This includes Schizophrenia, Schizotypal disorder, Persistent delusional disorders, Acute and transient psychotic disorders, Induced delusional disorder, Schizoaffective disorders, Other nonorganic psychotic disorders, Unspecified nonorganic psychosis.

Figure 5 and table 3 both present the percentages for the 11 most common causes of emergency admission (by ICD-10 diagnosis code chapter) recorded for patients with 'problems relating to homelessness' for a 5 year period 2017 to 2022.

Also shown for comparison are the percentages for the same causes for those NOT recorded as having 'problems relating to homelessness' and for patients of Homeless Health services.

Whilst very low numbers of people experiencing homelessness were recorded in data for those with emergency admissions to hospital, for those that do the diagnostic profile appears to show several differences compared to housed people:

- Both '**Mental and behavioural disorders due to psychoactive substance use'** and '**Poisoning by drugs, medicaments and**

biological substances' can be identified as far more prevalent in the data for people with 'problems relating to homelessness' than for other admissions.

- **Influenza and pneumonia** diagnosis codes were used for over twice the percentage of the 'homeless' cohort compared to admission of other patients.

- Although very low percentages and numbers, '**Episodic and paroxysmal disorders**' and '**Schizophrenia, schizotypal and delusional disorders**' can also be identified as far more prevalent in the cohort of patients identified as having problems relating to homelessness.

- Patients recorded as patients of the Homeless Health service have noticeably higher percentage of '**injuries to the head'** and '**Infections of the skin and subcutaneous tissue'** recorded.

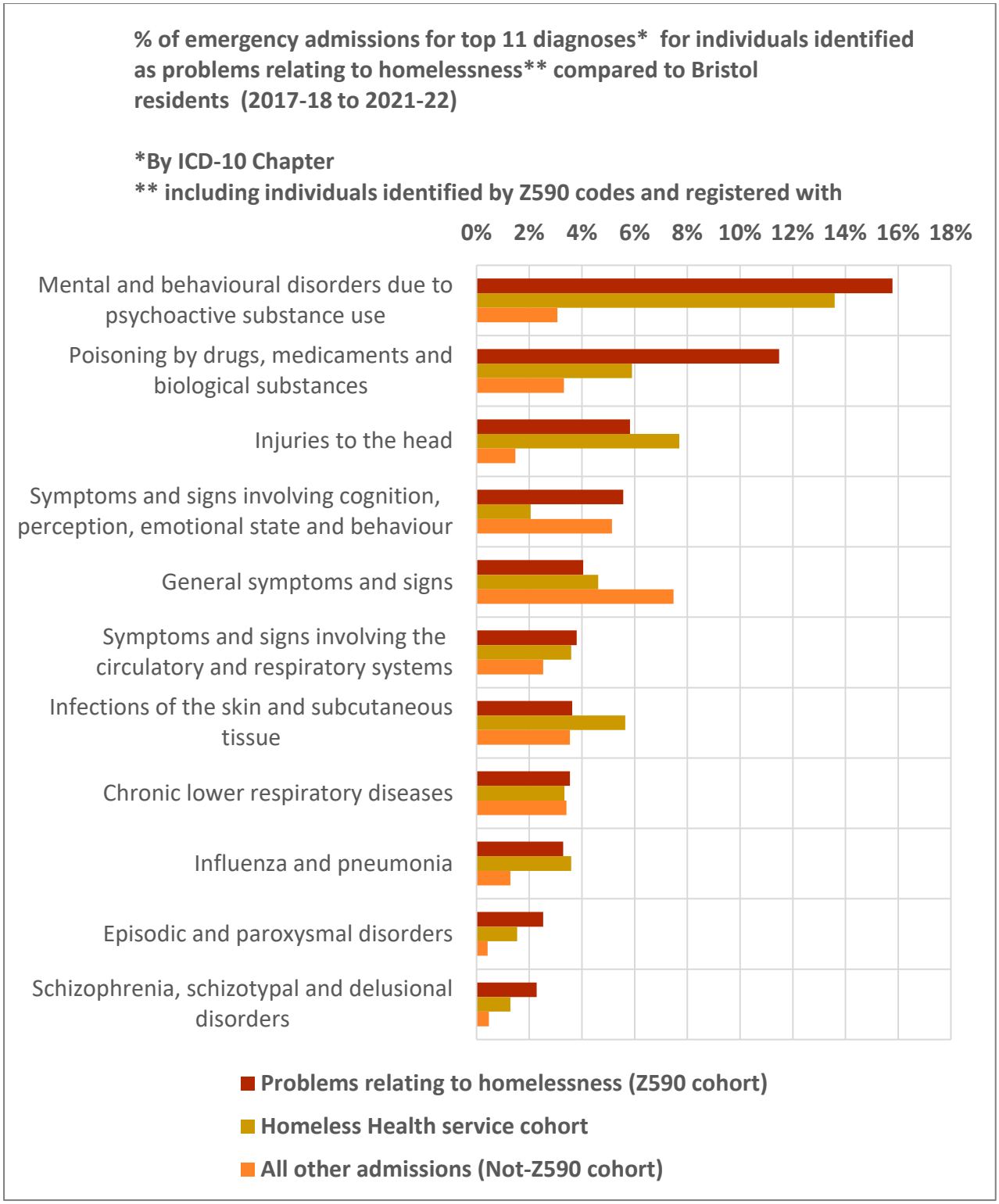


Figure 5: percentage of emergency admissions for top 11 diagnoses* by individuals identified for problems relating to homelessness** compared to Bristol residents (2017-18 to 2021-22).

* By ICD-10 Chapter

** including individuals identified by Z590 codes and registered with Homeless Health Service (Compass Health).

ICD-10 chapter	Problems relating to homelessness (Z590 cohort)	Homeless Health service cohort	All other admissions (Not Z590 cohort)
Mental and behavioural disorders due to psychoactive substance use	15.8%	13.6%	3.1%
Poisoning by drugs, medicaments and biological substances	11.5%	5.9%	3.3%
Injuries to the head	5.8%	7.7%	1.5%
Symptoms and signs involving cognition, perception, emotional state and behaviour	5.6%	2.1%	5.1%
General symptoms and signs	4.1%	4.6%	7.5%
Symptoms and signs involving the circulatory and respiratory systems	3.8%	3.6%	2.5%
Infections of the skin and subcutaneous tissue	3.6%	5.6%	3.5%
Chronic lower respiratory diseases	3.5%	3.3%	3.4%
Influenza and pneumonia	3.3%	3.6%	1.3%
Episodic and paroxysmal disorders	2.5%	1.5%	0.4%
Schizophrenia, schizotypal and delusional disorders	2.3%	1.3%	0.5%

Table 3: percentage of emergency admissions for top 11 diagnoses for individuals identified as problems relating to homelessness compared to Bristol residents (2017-18 to 2021-22)

Infectious Diseases

Data obtained from UK Health Security Agency (UKHSA) for the South West Of England is shown in Table 4.

Table 4: count of selected infections within the South West between 31 October 2021 and 31 October 2022 within homeless settings

Infection	Count
Hepatitis C	<5
iGAS (Invasive Group A Streptococcal) infection	9
Tuberculosis	<5
Hepatitis B	0
COVID-19	<5

Cases were extracted and analysed based on data entered onto Health Protection Zone between 31 October 2021 and 31 October 2022 with 'Homeless accommodation' as principle contextual setting. Only cases reported to UKHSA are included, absolute numbers should be interpreted with caution. Reporting practice is known to vary with time and geography.

There is no longer a requirement to report single cases of COVID-19 and testing has changed over time. This will impact the number of cases of COVID-19 which can be identified.

Whilst low numbers of these infectious diseases have been reported to UKHSA, this is unlikely to represent all cases in Bristol amongst people experiencing homelessness.

Another potential sources of infectious disease data was identified and initial analysis performed to explore further.

Hepatitis C data, substance use services

Hepatitis C is a blood borne infection with a variety of potentially serious health outcomes and complications for the infected individual if left

untreated. As Hepatitis C is a potential risk from injecting drugs if equipment is shared or not clean and therefore it is of particular interest to substance use treatment services. Comparing the incidence of Hepatitis C recorded for the individuals in the substance use treatment dataset, between those identified as 'mainly rough sleeping' and all others in the dataset can give us an indication of the additional risk of infection for the population experiencing homelessness.

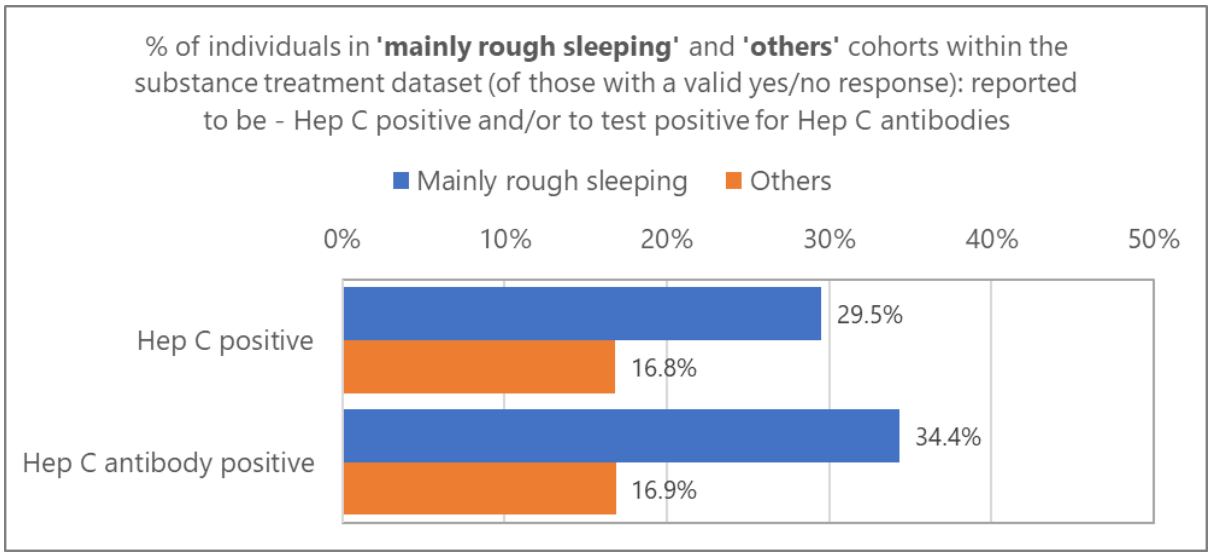


Figure 6: Hep C prevalence

Figure 6 indicates that the prevalence of Hepatitis C is roughly double in the cohort identified as 'mainly rough sleeping' compared to other clients of the substance use service/s. Just over a third of those 'mainly rough sleeping', in contact with the services were recorded as positive for Hepatitis C antibodies.

It should be borne in mind that given that the data for this analysis has been sourced from services designed to treat individuals with substance use problems, and injecting drugs is a known risk factor for infection with Hepatitis C, it is likely that the scale of infection prevalence reported here will differ from that for the population not in contact with such services. However, it is true to say that in this cohort, rough sleeping appears to be associated with an increased risk of Hepatitis C infection.

COVID-19 Vaccination

Data is collected on the number of COVID-19 vaccinations administered at clinics specifically set up to provide access to people experiencing

homelessness within the Bristol, North Somerset, and South Gloucestershire (BNSSG) area. The data shown in figure 7 suggests there has been lower take up of second dose and booster dose amongst people experiencing homelessness across the wider BNSSG geographic area.

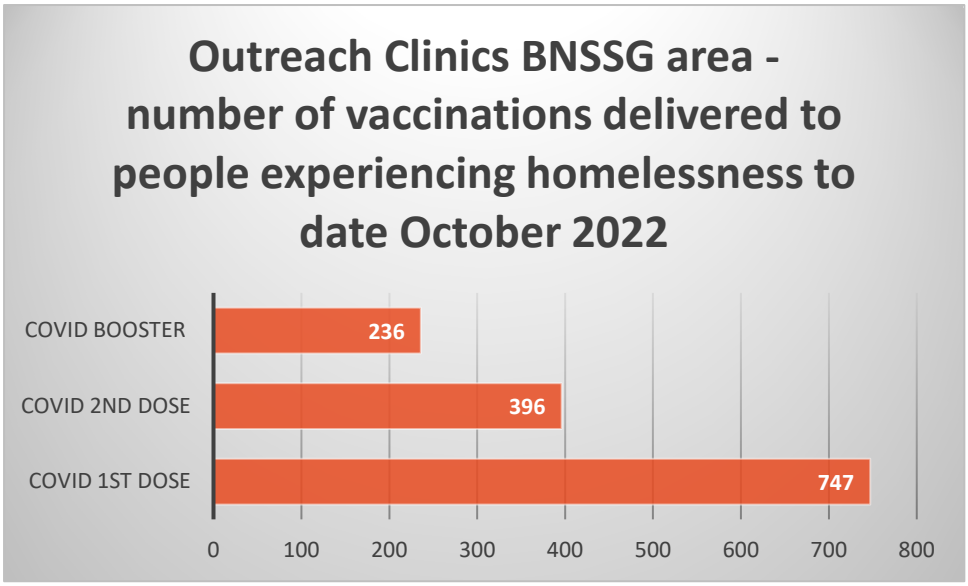


Figure 7: Number of COVID-19 Vaccinations delivered at specialist clinics

Mental Health

Several mental health diagnoses were found to be more prevalent amongst the two 'homeless' cohorts with emergency admission to hospital.

Table 5 shows data with percentages for each mental health diagnoses by ICD-10 chapter for those with emergency admission to hospital for the 5 year period from 2017 to 2022 (as previously shown in figure 5 and table 3).

For 'Mental and behavioural disorders due to psychoactive substance use', 15.8% of the 'problems relating to homelessness' cohort had this recorded and 13.6% of homeless health patients. This compared to just 3.1% for those who were not part of the 'problems relating to homelessness' cohort.

The following ICD-10 chapters were referenced in far higher percentages for emergency admissions in those experiencing homelessness

- **Mental and behavioural disorders due to psychoactive substance use -** This includes mental and behavioural disorders due to substances such as alcohol, opioids, cannabinoids, sedative hypnotics, cocaine, stimulants, and solvents.

The difference between the percentages for homeless and non-homeless cohorts was the highest in this category with non-cohort admissions at 3.1% and the homeless cohorts 4 to 5 times higher. This was also the highest percentage of all emergency admissions for the homeless cohorts (see figure 5 and table 3).

- **Schizophrenia, schizotypal and delusional disorders -** Schizophrenia, Schizotypal disorder, Persistent delusional disorders, Acute and transient psychotic disorders, Induced delusional disorder, Schizoaffective disorders, Other nonorganic psychotic disorders, Unspecified nonorganic psychosis

Whilst percentages are very low for this ICD-10 code, the homeless cohort percentages are 2 to 5 times as high as the non-homeless cohort.

The following was found at similar or lower percentages in those experiencing homelessness

- **Symptoms and signs involving cognition, perception, emotional state and behaviour -** somnolence (drowsiness), stupor and coma signs involving cognitive functions and awareness dizziness disturbances of smell and taste emotional state appearance and behaviour.

Table 5: percentage of emergency admissions, diagnoses by ICD-10 chapter for Z590-coded admissions, 5 year total, 2017/18 to 2021/22: Bristol residents excluding Z590 admissions, Z590 admissions and Compass Health registered patients

ICD-10 chapter	**Z590** cohort	Compass Health	**Not-Z590** cohort	**Higher percentage for emergency admissions for people experiencing homelessness?**
Mental and behavioural disorders due to psychoactive substance use	15.8%	13.6%	3.1%	✓ Yes
Symptoms and signs involving cognition, perception, emotional state and behaviour	5.6%	2.1%	5.1%	✗ No
Schizophrenia, schizotypal and delusional disorders	2.3%	1.3%	0.5%	✓ Yes

Data for those triaged to substance use treatment in Bristol were analysed.

Clients are asked whether they feel they have a mental health treatment 'need'. 61% of those identified as 'mainly rough sleeping' reported a mental health treatment need compared to 50% of those identified as 'other' suggesting a higher need for mental health support amongst people experiencing homelessness within this cohort.

Self reported mental health needs are also covered further on in this report where Housing Support Register (HSR) records are examined.

Alcohol and other drugs

Alcohol-caused hospital admissions

The Office for Health Improvement & Disparities publish a range of alcohol-harm related indicators as part of their 'Local Alcohol Profiles for England' (Office for Health Improvement and Disparities, 2022).

One of these employs a list of agreed diagnoses codes to identify admissions deemed to be wholly attributable to alcohol consumption.

Using this list of diagnoses codes, it is possible to identify what proportion of hospital admissions for a given population are wholly due to alcohol consumption. Figure 8 shows that a very large proportion of all admissions within the 5 year period 2017/18 to 2021/22 for the homelessness cohorts identified in this analysis, can be attributed directly and wholly to alcohol consumption. This proportion is many times larger than the equivalent proportion for admissions not coded with the Z590 'problems relating to homelessness' code, and largest for male patients in all patient cohorts.

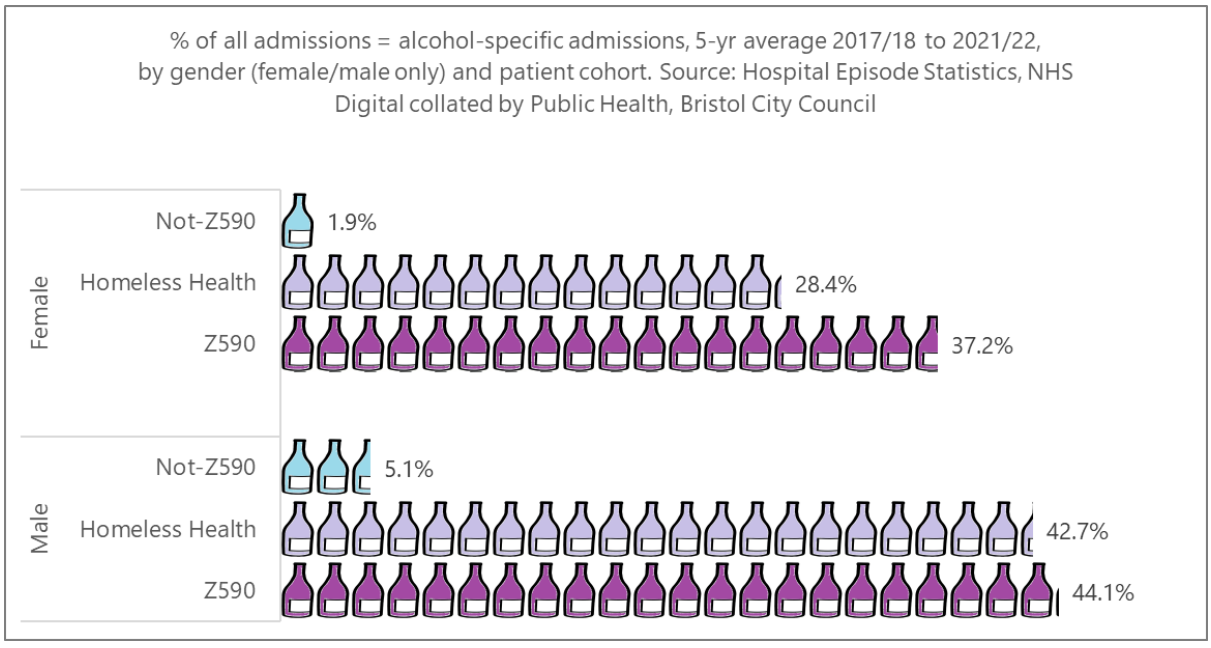


Figure 8: Alcohol Specific Admissions

The most numerous alcohol-specific admission causes for the homelessness cohorts are mental and behavioural disorders, alcohol poisoning, alcoholic liver disease, alcohol-induced acute/chronic

pancreatitis and alcoholic gastritis. These diagnoses were much more common amongst the homelessness cohort patients than the comparator group.

Substance use services data

Data for individuals who were first triaged into substance use services between 01/04/2021 and 31/03/2022 was examined. During this 12 month period, there were 2863 recorded clients with a triage by any of the service providers. Of these, 614 or 21%, aligned with categories chosen to represent people experiencing categories 1 to 3 homelessness and this is shown in figure 9.

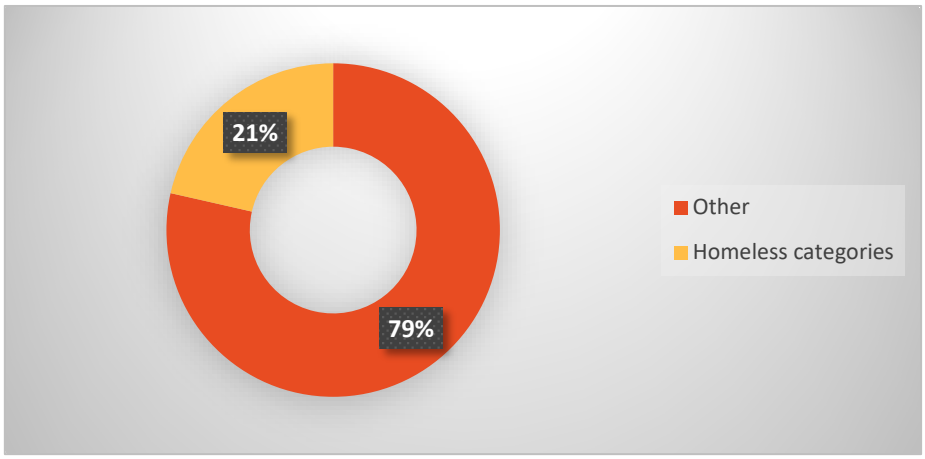


Figure 9: Clients triaged to ROADs services in a one year period 2021 to 2022

Mortality

Figure 10: Number of reported deaths

Whilst figure 10 shows **reported** deaths of people experiencing homelessness, estimations from ONS suggest that the true figures are higher (Office for National Statistics, 2022).

Cause of death information was not available in time for this report for the deaths shown in figure 10. A homeless deaths audit is underway in Bristol.

Nationally, 35% of deaths of homeless people registered in 2021 were related to drug poisoning. Alcohol-specific causes and suicide accounted for 9.6% and 13.4% of estimated deaths of homeless people registered in 2021 respectively. Together these three causes accounted for an estimated 57.9% of homeless deaths registered nationally in 2021 (Office for National Statistics, 2022).

Voices of clients and professional

Housing Support Register (HSR) self-reported health data

The Housing Support Register (HSR) holds information which is self-reported by the client and recorded by Bristol City Council staff to determine accommodation and support need.

Using the operational categories in figure 1 (European Commission, 2007), data analysis was conducted for categories 1 to 3. Further detail is given in Table 6 of the data records which were made available for this analysis.

Table 6: Number of records examined

Ethos light operational category	Accommodation Status	Date range of data examined	Number of records
1	Rough Sleeping	One month period to 02/09/2022	114
2	Emergency Accommodation	All current and open records on 02/09/2022	379
3	Short -term accommodation	All current and open records on 02/09/2022	781

Table 7 shows the percentage of reported health and support needs which were self-reported by clients from each category.

Complexity and comorbidity

Analysis of the percentages for mental health, physical health, substance use, and self-harm and suicide attempts for each category suggests complex and multiple health for those in each cohort.

To note:

- Category 1: Rough sleeping. 70% identified mental health need and 69% identified drug support need which indicates an overlap between these.
- Category 2: Emergency accommodation. 77% identified mental health need and 61% physical health need which indicates overlap between these.
- Category 3: Short term accommodation. 84% identified mental health need, 58% physical health need and 74% substance use which indicates overlap between these.

Initial examination of text records for categories 2 and 3 further indicates multiple and complex physical and mental health needs.

Table 7: Percentage of client records indicating each support need

Ethos light operational category	Accommodation Status	Percentage who answered yes to question on mental health	Percentage identified with physical health need	Percentage identified with substance use/ support need	Percentage identied with history of self harm and/ or suicide attempts
1	Rough Sleeping	70%	42%	Drugs 69% Alcohol 39%	Not recorded
2	Emergency Accommodation	77%	61%	49%	40%
3	Short -term accommodaton	84%	58%	74%	42%

Mental health

People who are recorded as rough sleeping are asked about their support needs whereas those records for those in emergency or short- term accommodation indicate self reported concerns about mental and wellbeing, and if they are trying to improve their mental health at the moment.

The results from analysis of these records are presented in Table 7 and indicate that in all three categories, at least 70% of clients reported mental health support needs or concerns.

Analysis was conducted on text contained in 1,160 HSR records for those in Category 2 (emergency accommodation) and Category 3 (short- term accommodation) where self-reported information is recorded. This was not available for Category 1 (rough sleeping).

The most commonly identified terms found in the text via initial analysis were 'depression' and 'anxiety'. The terms 'PTSD' and 'Trauma' were both identified as words present in more than 10% of records.

Mental health of the wider Bristol population

Whilst not directly comparable, data from the Quality-of-Life survey indicates that **20%** of respondents from the wider population reported they experience below average mental wellbeing, suggesting that levels of poor mental health and mental health support needs are higher amongst those experiencing homelessness (Bristol City Council, 2022).

Self-harm, suicide, and suicidal ideation

The most recent national data on the causes of death of people experiencing homelessness indicates that 13.4% of deaths in this population registered in 2021 were estimated to be through suicide (Office for National Statistics, 2022)

Of 1,160 records for operational categories 2 and 3, the percentage of those who answered 'yes' to a question on self-harm and suicide is shown in Table 7. This data is not recorded on the HSR for category 1 (rough sleepers).

Self-harm in the wider Bristol population

The latest JSNA data profile indicates that were 1,717 emergency admissions for self-harm in Bristol in 2020/21. The rates of self-harm admissions in Bristol were higher than the England average for both men and women and the 2020/21 rate of admissions has increased by 6% comparing to the previous year. The self-harm admissions rate for those living in in the most deprived areas of Bristol is 2.7 times higher than in the least deprived (Bristol City Council, 2022).

Suicide amongst the wider Bristol Population

The latest JSNA data profile indicates that there were 142 deaths from suicide and injury of undetermined intent between 2018 and 2020 in Bristol – a slight increase since the last reporting period. The suicide and injury of undetermined intent mortality rate for 2018-2020 in Bristol is 12.3 per 100,000 population aged over 10 which is slightly higher than but statistically similar to England average of 10.4 (Bristol City Council, 2022).

Alcohol and other drugs

Data was examined from self-reported use of or support needs for alcohol and other drugs.

This data for category 1, rough sleeping is gathered in a slightly different way to that for categories 2 and 3.

In Bristol, operational category 3 (Short-term accommodation) includes a substance use pathway which may impact the number of individuals who reported use.

Detailed analysis of HSR records for substance use

Further insight into which substances clients reported using was gained through analysis of the text contained in 1,160 records for operational categories 2 and 3. The results from this analysis is shown in Table 8.

For those in emergecny accommodation, alcohol was the most commonly mentioned substance identified and this was the second most common for those in short term accommodation. The most common substance mentioned in records for those in short-term accommodation was heroin.

Table 8: Percentage of HSR records which use each of the words for substances listed

Word identified in text	**Percentage of records identified as containing this word – Emergency accommodation**	**Percentage of records identified as containing this word – Short-term accommodation**
Heroin	25%	40%
Alcohol	33%	38%
Crack	27%	36%
Cannabis	29%	33%
Cocaine	21%	20%
Spice	6%	16%
Weed	7%	4%

Professionals

Summary Points

A wide range of medical conditions were identified with comorbidities and complexity reported.

- Respiratory conditions such as asthma and COPD were identified and thought to be linked to cold, damp conditions as well as smoking.
- Brain injury and epilepsy were identified.
- Chronic untreated infections.
- Infected wound and abscesses as well injection sites were reported.
- Early aging – people who look 20 to 30 years older than they really are.
- Poor oral and dental health was reported as a concern.
- Problems linked to substance use such as acute illnesses a result of intravenous drug use.

Several mental and social health concerns were raised

- Mental health was identified including Trauma, PTSD, dual diagnosis, isolation, self-neglect self-harm and suicide attempts.
- Discrimination and stigma.
- Isolation and lack of trust.
- Self-medication to counter the effects of trauma that they have experienced.

Healthcare and social care access and provision

- Access to healthcare was raised as an issue including mainstream services – not just specialist or homeless health.
- Issues with hospital discharge was identified where people have nowhere to go and have ongoing support needs.

- Discrimination and stigma encountered in attempting to access primary and secondary care services.

Suggestions

- Tailored approach for hospital discharges that require a Care Act Assessment.
- Better understanding and training for health professionals of the needs of these clients.
- Dual diagnosis service in AWP.
- Services flexing to accommodate people who struggle to make appointments, have no phone, can't afford to travel etc., may present as challenging or under the influence and need engagement.
- Homeless-specific/on-street mental health team (AMHP, CPNs, psychiatrists).
- Integrated mental health and substance misuse services.
- More flexible appointment slots/drop-ins at community GP.
- More outreach work.
- Services need to be tailored to the needs of this client group and go where they feel comfortable and link to the services that they engage with.
- Mental health outreach workers who are proactively out on the streets looking to support homeless people.
- More support to access mainstream services.
- Prevention services should be the focus.
- Work with Homeless services to provide them with appropriate accommodation, then provide support to address their health needs.
- We need to get better at using data.

Local professionals: health issues and homelessness

Local professionals working in the homelessness sector in Bristol were asked what health issues came to mind when they thought of homelessness and what they saw in their working life. The following quotes are replies from a survey to which they responded in November 2022.

GP Lead for Homeless Health

Patients who look 20 to 30 years older than they really are. Severe mental health and substance misuse problems. Untreated chronic disease of many different types. Learning disabilities, all parts of the autistic spectrum. Untreated epilepsy and brain injury. Acute illnesses a result of IVDU, self-neglect, cold weather, violence and trauma, accidents of all sorts. Chronic untreated infections.

Bristol Professional

Isolation, deprivation and substance misuse are extremely common. There isn't a community of rough sleepers. Most people in those conditions will mistrust others and will be particularly careful at not appearing too vulnerable. There are several relationships that lack intimacy and affection and are based around dependency and abuse.

Bristol Professional

Poor nutrition, unmet health needs, physical health issues related to substance use, mental health needs, respiratory issues, problems accessing inflexible health and mental health services, health complications due to sleeping in cold and wet conditions.

Bristol Professional

Respiratory illness, issues relating to cold and damp, mental ill health and substance misuse.

Bristol Professional

It must be incredibly hard for both those rough sleeping and the hidden homeless communities to stay healthy both physically and mentally. Some have addictions and many have mental health issues, the insecurity of this sort of lifestyle.

Bristol Professional

They are struggling and need help. They need support to be removed from the street, into a suitable accommodation in order to provide the support to address their health needs.

Street Intervention Service Coordinator

Abscesses from poor injecting practice, undiagnosed/treated mental health conditions, COPD caused by prolonged crack use, poor dental health.

Commissioning Manager (Homelessness), Bristol City Council

Generally, people who are rough sleeping for long periods have multiple physical health issues exacerbated by self-medication - to counter the effects of trauma that they have experienced - compounded by lack of access to services. People often have health related issues with joints, respiratory issues, their feet, stomach problems, infected wounds, heart, liver and kidney issues. Poor oral health and sight are also very common due to lack of access to dentists and opticians. Additionally, people also experience poor mental health that often goes undiagnosed. People often only access services in Crisis.

Outreach drug and alcohol worker

Their health is normally poor and there is also a lot of self-neglect so they do not normally take care of themselves.

Service manager, St Mungo's outreach team, Bristol

Complex! Both physical and mental health needs are substantial in our clients. The resilience of our clients astounds me as a lot of their health needs remain unaddressed. Generally I would say there is poor engagement with health services due to discrimination and stigma that they receive from these services and difficulty sticking to appointments. Having worked in the hospital, I was shocked by the stigma that homeless patients faced institutionally. The care was not person-centred or trauma informed. There was very poor knowledge of the needs of these clients across the board.

High rates of hepatitis C, respiratory illnesses (COPD), unaddressed chronic mental health and complex trauma and injecting injuries and

infections. Dual diagnosis is really common but there are no services that support this - psych teams will not work with people that use substances, which is hugely problematic. Clients struggle to engage with healthcare, particularly in the hospital setting where they are faced with rules and restrictions and cannot control their own medication. The rigidity of primary health settings is challenging as well.

Local professionals: barriers to access and how to improve health outcomes for people experiencing homelessness

Local professionals were also asked about barriers to access and ideas on how to improve health outcomes for people experiencing homelessness in Bristol. The following are quotes from a survey which they responded to in November 2022.

Outreach drug and alcohol worker

Normally the clients I work with can access health care through services that are set up for people that are homeless but it is a little more difficult for them to access mainstream services due to their addiction. In my role I often support them with this.

Bristol Professional

Services flexing to accommodate people who struggle to make appointments, have no phone, can't afford to travel etc., may present as challenging or under the influence and need engagement. Also factoring in dual diagnosis which the NICE guidelines suggest is by having a 'no wrong door' approach.

Bristol Professional

At times, people have reported being unable to register with a GP as they are of no fixed abode, but this can generally be resolved with some support.

Bristol Professional

They need to build trust with public servants, and support providers, suitable accommodation to address their support needs. They cannot be expected to comply with support services or health services as other people with no complex needs.

Bristol Professional

Work with Homeless services to provide them with appropriate accommodation, then provide support to address their health needs. Without appropriate accommodation, they will not contemplate addressing their health needs.

Street Intervention Service Coordinator

I would like to see mental health outreach workers who are proactively out on the streets looking to support homeless people.

The population are well aware of the Compass Health Centre and use that a lot. Unfortunately, people that have an addiction often put their own health far behind sustaining that addiction. I also know that the outreach nurses are well used and having a St Mungo's point of contact in the hospitals is very beneficial.

GP Lead for Homeless Health

We need to get better at using data.

At the moment even though patients registered at the Homeless Health Service may have had complex medical histories recorded by us, these are invisible to the Emergency Departments & wards of both UHBW and NBT. Hospital staff are simply unable to see crucially important information, putting homeless patients' safety at risk.

Bristol Professional

I am aware of the GP service provided which is good but hours of service are limited and unsure if the service is widely advertised to the entire homeless community. I am unsure if the "hidden homeless" could interact with it.

Bristol Professional

Integrated mental health and substance misuse services.

GP Lead for Homeless Health

We do have the Homeless Health Service but that is not a GP practice - it is a temporary service until people register with a GP Practice. There is much improved engagement with health services since Everyone in. People find it difficult and intimidating to access mainstream services, so services need to engage with people more effectively. This is made more

difficult to achieve when health services are so badly underfunded. If the general population can no longer register with an NHS dentist because of lack of capacity, what hope is there for people who are the most excluded?

Service Manager, St Mungo's Outreach

Tailored approach for hospital discharges that require a Care Act Assessment.

Better understanding and training for health professionals of the needs of these clients. Understanding of trauma-informed approaches and complex trauma. Dual diagnosis service in AWP. Homeless-specific/on-street mental health team (AMHP, CPNs, psychiatrists). More flexible appointment slots/drop-ins at community GP.

We have great homeless health services in Bristol that really understand the needs of our clients and this is available for people rough sleeping. When people move into accommodation, however, they move into general community general practice and engaging them with this is very challenging as a flexible approach to appointments is much more beneficial. The drop-ins and wet clinics that Homeless Health run work really well - Compass Health is massively oversubscribed though.

The Homeless Support Team at the BRI are doing fantastically at improving health outcomes and positive discharges for homeless clients. Discharges that require adult social care input is hugely problematic as the Discharge 2 Assess model does not work (they have nowhere to be discharged to for assessment) and there are huge barriers here. The team there have to go through a number of hoops to get a Care Act Assessment whilst receiving a lot of pressure from the site managers on why their patients are still in hospital. They need their own social worker - they used to have this but it got taken when ASC left the hospital.

Bristol Professional

Prevention services should be the focus. Unfortunately, once rough sleeping becomes the norm for an individual, the barriers and challenges will make it so that any intervention becomes costly and challenging.

Commissioning Manager (Homelessness), Bristol City Council

Services need to be tailored to the needs of this client group and go where they feel comfortable and link to the services that they engage with.

Bristol Professional

I think they may have to be signposted to be able to get help which requires significant outreach work to support people who are homeless. I think that from my conversations with people working directly with this population - a lot of it is about lack of awareness about where to go and how to get help.

Bristol Professional

More investment in outreach work, sorting out accommodation and housing issues. Investing in getting people off the streets, into housing and giving them an opportunity to rebuild their lives.

Bristol Professional

I am aware of the GP service provided which is good but hours of service are limited and unsure if the service is widely advertised to the entire homeless community. I am unsure if the "hidden homeless" could interact with it.

CEO, 1625 Independent People

For young people and care leavers in the homelessness pathway, because they are often physically fit and have yet to see the effects of an unhealthy lifestyle, they often do not see health as a priority among other challenges. Additionally young people cannot safely access the health services provided for the older cohort where presenting needs are higher and the young people are often at risk of exploitation from some others in attendance. What is really needed is a nurse outreach in youth homelessness settings, where young people can learn how to avoid major health risks and improve their health in a preventative way so that they can avoid some of the health issues seen in older homeless cohorts. This physical health support should be in addition to mental health wellbeing services, which are currently trust funded for young homeless people in Bristol and should be considered for mainstream health funding.

Equality groups

This section provides analysis of the health needs of people experiencing homelessness in Bristol by Age, Gender, Sexuality, Ethnicity and Disability.

Summary points

Age

- An association between increasing age and increasing use of alcohol was identified.
- An assosiation between increased age and increased prevalence of Hep C was identified.
- The majority (just under 80%) of those experiencing homelessness with an unplanned admission to hospital are in the range 25 to 54 years, in contrast with the general population where age range is broader.
- Mental health concerns are most likely to be reported by individuals at the younger end of the age range.
- Younger people were more likely to report self-harm and suicide attempt.
- Professionals have described people experiencing homelessness as looking 20-30 years older than their biological age and the proportion of the Bristol adult population requiring the housing support in any of these categories increases with age to approximately 40 years of age before declining to a very low level by around 70 years of age.
- This absence of those over 70 may be due to lower life expectancy and early death but may also be partly accounted for by the additional support systems which become available as people age resulting in improved access to accommodation and care.
- Need for bespoke and prevention health for care leavers and younger people experiencing homelessness.

Gender

- Men are much more likely to be part of the cohort represented by the HSR datasets than women, around 3 times more likely on average.
- Association between gender and reported mental health concerns/need varied between the cohorts analysed.
- Drug use is more commonly reported by female respondents.
- Higher Hep C prevalence was found in women compared to men.

Sexuality

- Heterosexual respondents were more likely to report substance use.
- Self Harm and suicide attempts were considerably more likely to be reported by non heterosexual respondents than heterosexual respondents.
- Data completeness was poor for this cohort.

Ethnicity

- Black residents are particularly overrepresented in homelessness cohorts.
- Clients of white or mixed ethnicity were the most likely to report substance use.
- The prevalence of self-reported disability was higher for individuals of white ethnicity, compared to all other ethnic groups combined.

Disability

- Three out of the four possible data sources for the population experiencing homelessness provided estimates for the presence of a disability much larger than that proportion in the general population.
- In HSR data, women were more likely to describe themselves as disabled than men.

- In substance use data, men were more likely to describe themselves as disabled than women.

Age

The age-distribution of individuals included in the Housing Support Register (HSR) for the three different accommodation status categories is as follows.

Category 1

Of the **114** individuals included in the 'rough sleeping' dataset, ages ranged from 20 to 67 years of age. The majority (more than 80%) are aged between 20 and 54 years of age.

Category 2

Of the **379** individuals included in the 'Emergency Accommodation' dataset ages ranged from 17 to 77 years of age. The majority (more than 80%) are aged between 20 and 59 years of age.

Category 3

Of the **781** individuals included in the 'Pathways 1-4' dataset, ages ranged from 20 to 74 years of age. The majority (more than 80%) are aged between 25 and 54 years of age.

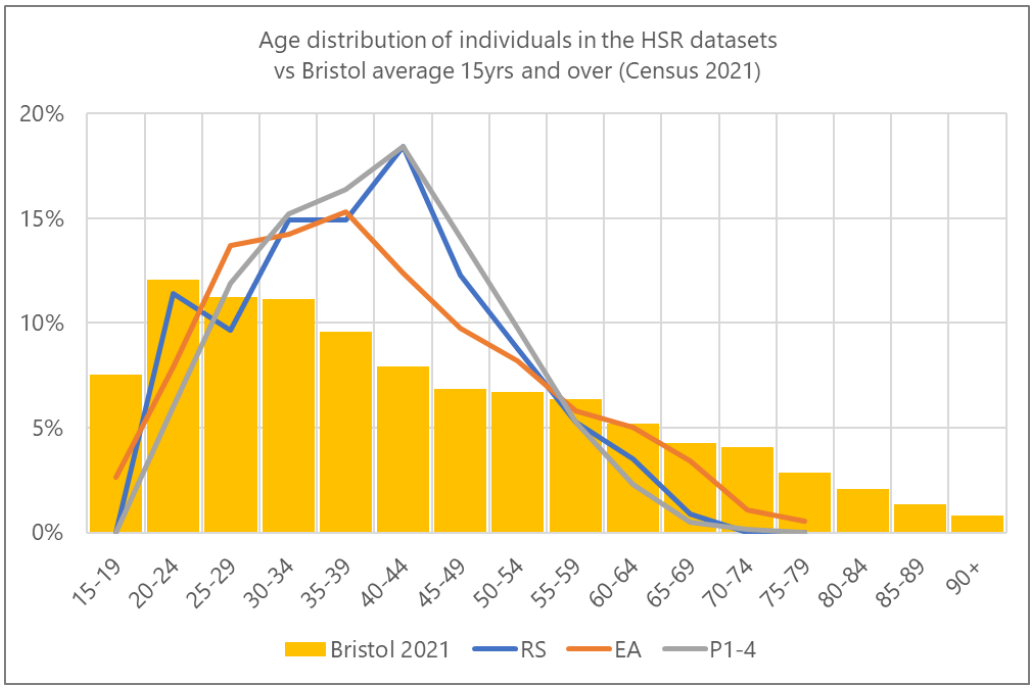


Figure 3: Bristol 2021 Population age distribution vs. individuals on the HSR data set for Rough Sleeping (RS), Emergency Accommodation (EA) and in those in temporary accommodation (P1-4).

Figure 11 presents a comparison to the Bristol population average (for over 15s). The proportion of the Bristol adult population requiring the support in any of these categories increases with age to approximately 40 years of age before declining to a very low level by around 70 years of age.

It is possible that the differences in age distribution between housed and homeless cohorts may be partly understood by considering that services are in place to care for children and for elder adults and these individuals would not therefore appear in this data.

Age - Mental health

Mental health concerns are most likely to be reported by individuals at the younger end of the age range for each of the homelessness cohorts analysed within the HSR. For all cohorts, reported mental health concern levels were highest for those aged between 20 and 49 years of age, before generally diminishing with age. The relationship with age was similar in the analysis of those 'mainly rough sleeping' in the substance use treatment data.

Those in the category 2 and 3 cohorts of the HSR data answer an additional question on self-harm and suicide. Around 40% of respondents answered 'yes' to this question. The proportion was highest for individuals aged under 30 years of age, and diminished with increasing age but represented a notable proportion at all ages.

Age – Alcohol and other drugs

Within category 1 (rough sleeping) of the HSR there appears an association between increasing age and increasing use of alcohol; approximately 30% of respondents aged less than 40 years report alcohol use in this group, the proportion is almost 50% for those aged over 40 years. There are no such clear indications of a similar association for reported drug use in this group.

There is no discernible or consistent association between age and reported substance use within the category 2 (emergency

accommodation) cohort, although the indicator for this dataset combines alcohol and drug use.

Within category 3 the level of substance use reported is highest, and the association between this and age is not entirely consistent but there are indications of greater use amongst older respondents; 82% for those aged 40 years and over, 68% for those younger. This result is closer to that seen for alcohol use within the 'rough sleeping' cohort but as previously noted, category 3 HSR data includes that for individuals within a substance use treatment pathway.

Age - distribution of individuals in Substance use services

Based on information recorded on clients triaged to substance use services, individuals were grouped within this dataset as 'mainly rough sleeping' or 'others'.

There were **628** individuals included in the 'mainly rough sleeping' cohort with ages ranging from 17 to 69. The majority (more than 80%) were aged between 25 and 54 years of age, and the age-distribution for the cohort is presented in figure 12. This distribution apparent is somewhere between that reported for the emergency accommodation and rough sleeping datasets derived from the Housing Support Register (HSR).

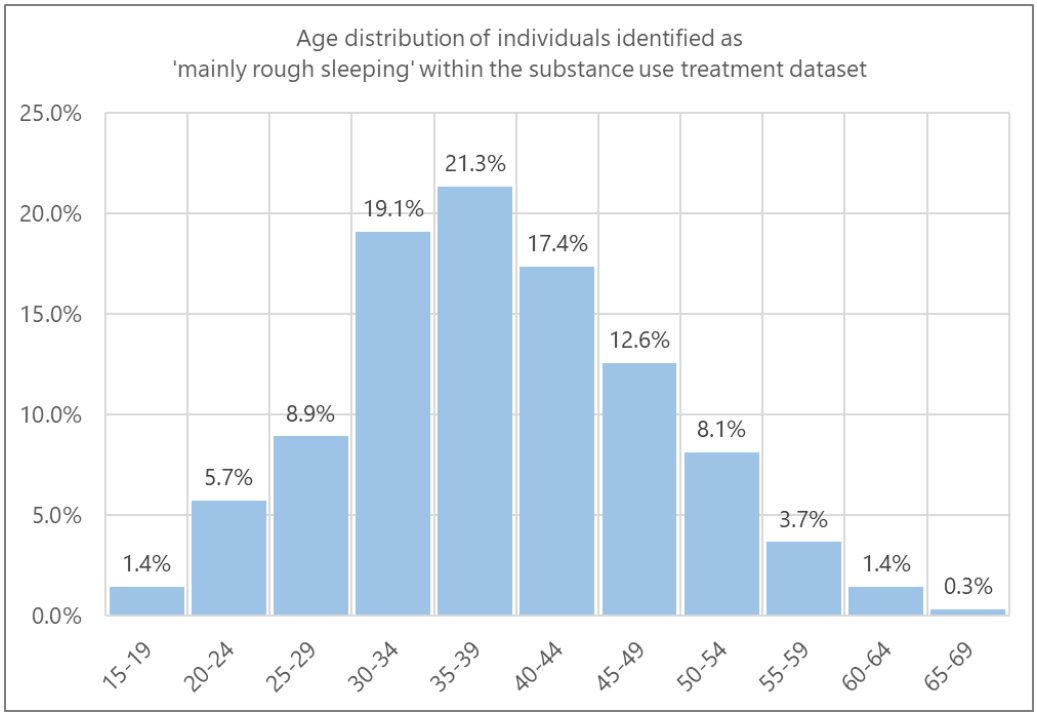


Figure 12: Age-structure of individuals included in the dataset of individuals triaged to treatment for substance use (April 2019 to March 2020)

Age and hospital utilisation

Working with Hospital Episode Statistics, all emergency admissions of Bristol residents coded 'Z590' (within the ICD-10 coding schema) indicating problems relating to homelessness were identified and used to flag admissions as relating to patients experiencing homelessness.

There were **1,185** admissions for **739** individuals identified via the Z590 code as experiencing homelessness, over the five-year period used. Their ages ranged from 0 to 84 years of age, and the majority (90%) are aged between 20 and 59 years of age. The age-distribution for the cohort is presented in figure 13.

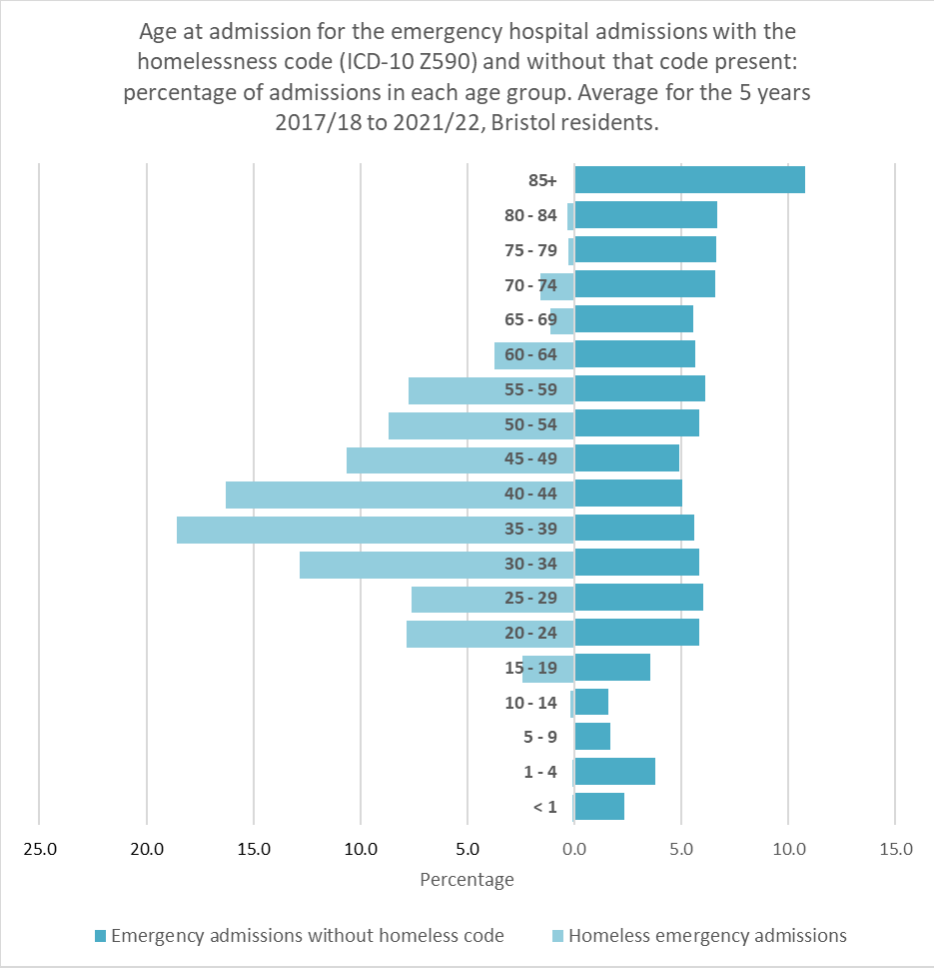


Figure 43: Age at admission for the emergency admissions with the homelessness code (ICD-10 Z590) and without that code present: percentage of admissions in each age group. Average for the 5 year 2017/18 to 2021/22

Admissions were also identified for patients registered to the Compass Health homelessness health service. This practice tends to have only a relatively small number of patients registered at any one time (typically 30 – 50), and often sees patients only temporarily registered to them so this analysis is likely to include just a proportion of their typical patients. There were **390** admissions for **195** individuals identified for this group over the five-year period used. The age-distribution, peaks in the 40 to 44 years age-group and the majority (just under 80%) are in the range 25 to 54 years.

Age - infectious disease

There is some evidence from the substance use dataset, that the risk of Hepatitis C infection increases with age, most likely an indication of the time spent at potential exposure to the risk of infection. Just under 20% of those identified at 'mainly rough sleeping' (with a known antibody status) tested positive for Hepatitis C antibodies within the 20- 24 year age group. That proportion grows to just over 50% for those 'mainly rough sleeping' in the age group 45 to 49 years of age.

Gender

Gender is relevant to the experiences that cause homelessness, the kind of homelessness experienced, and type of support needed, including support with reproductive and maternity health (Homeless Link , 2022).

A gender identity was recorded for 87% of 'rough sleepers' in the HSR dataset, 97% of those in the emergency accommodation dataset and 98% of those in the pathways 1 to 4 dataset. Less than 0.5% of individuals were recorded as transgender which provides inadequate numbers of cases to analyse in a more widely representative fashion and therefore the analysis of gender is restricted by necessity to female and male gender identities only.

Men are much more likely to be part of the cohort represented by the HSR datasets than women, around 3 times more likely on average.

Statistics from all the local data sources reviewed showed consensus with an estimated 21% to 29% female, and corresponding estimate for males of between 71% and 79%.

Gender - mental health

Association between gender and reported mental health concerns/need varied between the cohorts analysed.

For those in the HSR identified as rough sleepers, and those identified as 'mainly rough sleeping' in the substance use treatment data, there was a distinct difference with more female respondents reporting concerns/need than male respondents.

For those in the category 2 and 3 cohorts of the HSR data, experiencing a different form of homelessness, the responses were more similar and the direction of difference not consistent between them.

Amongst those identified as 'mainly rough sleeping' in the substance use treatment data, there was a similar gender-orientated difference in the proportion reporting they were receiving mental health treatment for men and women (56% and 66% respectively).

Gender – alcohol and other drugs

For category 1, reported use of alcohol is approximately the same for men and women but drug use is more commonly reported by female respondents (81% women vs 65% men).

There is more consistency between categories 2 and 3 when analysing the variation in reported substance use by gender. In both cohorts, men were much more likely to report substance use than women; 54.3% men vs 36% women in category 2, and 78.1% men vs 65.4% women in category 3.

Gender – Infectious disease

Just under a quarter of the cohort identified as 'mainly rough sleeping' were women, but there is sufficient data to calculate that the overall prevalence of Hepatitis C infection in women within the 'mainly rough sleeping' cohort is considerably higher than that for the men in that group; of those with a known status the statistics are 45% (women) and 32% (men).

Sexuality

Sexual orientation was recorded for 50% of 'rough sleepers' in the HSR dataset, and 74% of those in categories 2 and 3. In the two HSR datasets where data completeness was better, gay, lesbian, bisexual individuals and those describing their sexuality as 'other' were recorded. In category 2, 7% of those with a record were recorded in this way. In category 3, the total was 8%. Data for the Bristol population to compare this to from census 2021 is not yet available.

Sexuality - Mental health

Only categories 2 and 3 within the HSR data offer any ability to analyse for variation by sexuality, and due to low numbers, this is only possible for a comparison of heterosexual with all other sexual identities with the data available. Within the category 2 (emergency accommodation) cohort there is no apparent difference between these two sexual identity groups in respect of reported mental health concerns, the proportions are close to identical. In category 3 (temporary accommodation) there is a small difference with a slightly higher proportion with mental health concerns amongst respondents with a sexual identity other than heterosexual.

The differences are much clearer between these groups in respect of the question asked around self-harm and suicide. In both categories, non-heterosexual respondents were considerably more likely to answer yes to this question than heterosexual respondents. For category 2 (emergency accommodation) the proportion of heterosexual respondents was 40%, the value for those with other sexual identities was 56%. For category 3 (temporary accommodation) the statistic for heterosexual respondents was 42%, the value for those with other sexual identities was 62%.

None of the other local datasets used for analysis in provided any further data or comparisons within the cohort 'experiencing homelessness' based on sexuality.

Sexuality and use of alcohol and other drugs

There is consistency between categories 2 and 3 when analysing the variation in reported substance use by sexuality. In both cohorts, heterosexual respondents were more likely to report substance use.

Ethnicity

An ethnicity was recorded for 86% of 'rough sleepers' in the HSR dataset, 91% of those in the category 2 accommodation and 93% of those in category 3 accommodation. In terms of comparator data to the Bristol population, the equivalent from the 2021 Census is expected shortly.

The relatively small numbers and poorer level of recording completeness and detail in the 'rough sleeper' dataset makes interpretation highly speculative.

Individuals from a wide range of Bristol's minority ethnic communities are among those recorded in categories 2 and 3. Residents from minority non-white ethnic groups are overrepresented within those HSR homelessness-affected cohorts; accounting for a share around twice their proportion of the city population based on 2011 Census estimates for the city. Similar findings exist comparing all not white British residents to white British residents.

Drilling down into further detail for these comparisons suggest that black residents are particularly overrepresented in these homelessness cohorts, but this may not be the case for Asian residents, and residents of mixed heritage or of other non-white ethnicity. However, with a significant proportion of records uncoded and these groups being relatively small for more detailed analysis the interpretation for all but the black population is highly tentative.

Ethnicity of individuals included in the HSR dataset – Comparisons to other datasets

In contrast to the results from the Housing Support Register, there is not a similar over-representation of residents from minority non-white ethnic groups within the 'mainly rough sleeping' cohort identified within the substance use treatment dataset, or the data collected on patients admitted to hospital and coded with 'problems related to homelessness', when they are analysed in terms of two aggregated ethnic categories.

Analysing ethnicity in more detail, some similarities do emerge between the cohorts. Although their proportional share of the cohort is smaller in the substance use treatment and hospital admissions datasets is smaller than it is the Housing Support Register, it is apparent that there is a greater representation of black and mixed heritage residents than there is

Asian residents, in all of the datasets used for this analysis, even if it is to a lesser extent in the admissions and substance use treatment datasets.

Those in contact with and recorded by the substance use treatment service, and those admitted to hospital with the appropriate 'problems relating to homelessness' coding, are subsets of the greater population experiencing homelessness and there could well be differences between those that are part of those subsets and those that are not; who engages with these services and who does not, who tends to be recorded more completely than others and who does not. These data sources would not be expected to coincide in all respects.

Ethnicity - Mental health

There was no ethnic group within the cohorts with a low proportion of respondents with mental health concerns. For category 2 (emergency accommodation) the average was 77%, the lowest ethnic group associated value was 56.5%. For category 3 (temporary accommodation) the average was 84%, the lowest ethnic group associated value was 71%.

For both categories (2 and 3), the proportion of white respondents reporting mental health concerns was more than 10% higher than the equivalent proportion for respondents of all other non-white ethnicities combined. Whether this disparity is related to a 'real' difference in mental health or relates to differences in the willingness and ability to report, it is not possible to tell.

A similar analysis of the mental health need responses from the cohort identified as 'mainly rough sleeping' in the substance use treatment data, provides very similar trends to those observed in the HSR data. 62% of white respondents reported a mental health need, compared to 57% of those of

Ethnicity and use of alcohol and other drugs

For categories 2 and 3, numbers of responses available for an analysis of variation by individual ethnic groups were not large, but is possible to generalise from the data that in both cohorts, those of white or mixed ethnicity were the most likely to report substance use. Once the ethnic groups are aggregated to allow for a more robust statistical comparison, a clear and significant difference can be observed whereby respondents of white ethnicity are much more likely on average to report substance use, around 40% more likely in both cohorts.

This difference and the direction of association is similar in the responses to the question around self-harm and suicide and the difference between white and non-white respondents larger than that observed for mental health concerns.

The largest variations in reported substance use within this cohort appear to relate to ethnicity. White British respondents are more than three times more likely to report drug and/or alcohol use than respondents of other ethnicities in this cohort.

Ethnicity and infectious disease

Overall, the presence of Hepatitis C antibodies was slightly more prevalent for those identified as 'mainly rough sleeping' and of white ethnicity, than the aggregated grouping of all other ethnicities. The numbers of individuals within the specific ethnic groups recorded were too small to analyse separately in this respect.

Disability

The Housing Support Register and substance use treatment datasets include a record of individuals responding to a question on whether they consider themselves disabled. Approximately 60% of the individuals in the HSR dataset had a valid response to this question. Reporting completeness was a little better in the substance use treatment dataset (77%). This leaves a large margin of potential error in any estimates from this data and therefore all results reported here should be seen as indicative only.

Our best comparator statistic for the wider Bristol population comes from the Census (2011), where 16.7% of residents are estimated to have a disability or long-term health condition that limits their day-to-day activities. Three out of the four possible data sources for the population experiencing homelessness provided estimates for the presence of a disability much larger than that proportion. The large proportion of individuals with an unknown response to this question, and potential differences in the meaning of the indicators between the Census statistic, and the self-reported disability question in these datasets cast some doubt over the validity of whether this means that disability is more prevalent in our local population experiencing homelessness. However, the size of the disparity for three of these data sources, and the fact that the population experiencing homelessness has already been shown to have a younger age-structure than the city overall, would indicate that these are higher prevalence statistics than might be expected.

The proportion of individuals describing themselves as disabled within the three cohorts identified in the HSR vary considerably, but in all instances the proportion is higher for females than males. This is not the case for the individuals identified as 'mainly rough sleeping' in the substance use treatment dataset where there is a smaller difference in the opposite direction with a higher prevalence for men than women. As this latter cohort is in effect a small subset of the wider population experiencing homelessness it is possibly a peculiarity of the cohort requiring and receiving treatment for substance use issues and does not necessarily invalidate the skew seen in the HSR datasets.

In all three datasets where the analysis was possible, the prevalence of self-reported disability was higher for individuals of white ethnicity, compared to all other ethnic groups combined.

Developments Next 12 Months

Dental and Oral Health

Findings from the Southwest Oral Health Needs Assessment (NHS England , 2021) identified the needs of those experiencing homelessness. Following this, NHS England have committed to fund a regional pilot programme which will aim to provide access to dental care for people experiencing homelessness and other adults who have a high level of need and find it difficult to access services NHS England, Access Working Group 2022, 2022).

Substance use

A health needs analysis for substance use will be published in 2023.

In recognition of the strong association between rough sleeping and substance misuse additional funding streams have been made available for the next two – three years as part of the governments Combatting Drugs Strategy. Both grants aim to provide additional funding to people who have a drug or alcohol treatment need and are vulnerably housed, or at risk of homelessness. These areas of national focus were highlighted in the 2021 Dame Carol Black review of drugs (Department of Health and Social Care, 2021), which stated:

"Drug dependence can be both a cause and consequence of homelessness and rough sleeping. MHCLG has estimated that almost two-thirds of people who sleep rough have a current drug or alcohol problem. PHE's drug treatment data shows that one-fifth of adults starting treatment in 2019 to 2020 reported a housing problem, increasing to one-third of people in treatment for opiates."

Grants include:

1. Rough sleeper drug and alcohol treatment grant – This grant, first launched in 2020, aims to support people rough sleeping, or at risk of rough sleeping to access drug and alcohol treatment. It aims to provide specialist, targeted treatment services to reduce the harms of drug and alcohol use, including those with co-occurring mental health needs. Bristol received around £750,000 per year over the last two years, with one final year of the grant remaining.

2. Housing support grant: This grant will go live from January 2023 and will aim to prevent people who are vulnerably housed, who have a drug or alcohol treatment need, from losing their tenancy due to their impacts of drug use. While the aims of this grant overlap somewhat with the Rough Sleeper Drug and Alcohol Treatment Grant – this grant aims to work with people upstream of the rough sleeping cohort, working with people who may be privately renting, or in other supported accommodation across the city. Bristol will receive £600,000 per year from 2023-2025.

Integrated Care System (ICS)

Partnerships between NHS organisations, local authorities and others have been formed and are known as Integrated care systems (ICSs) These are intended to take collective responsibility for planning services, improving health and reducing inequalities across geographical areas and there are 42 ICSs across England (The King's Fund, 2022).

Locally, a programme of work to enable delivery of next steps and objectives is underway. Equity of healthy life expectancy is one of several objectives relevant to the work to improve outcomes for people experiencing homelessness.

Domestic Abuse

A Bristol Domestic Abuse Needs Assessment will be published in 2023 which includes analysis of domestic abuse and homelessness locally.

Homeless Health Service

The ICB are leading the recommissioning process which is underway for the new contract to start in September 2023.

Changing Futures

As part of the Changing Futures Programme an assessment will be produced which considers the intersecting needs for people who experience 3 or more of the following factors: mental illness, criminal justice involvement, domestic violence and abuse, substance misuse and homelessness. This work will consider peoples' experiences through a trauma informed and an equalities perspective to inform the development of a multiple disadvantage strategy for Bristol.

Cost of Living

The local cost of living crisis plan (Bristol One City, 2022) sets out the One City approach to support communities and individuals likely to be affected. As part of this, an impact assessment is currently underway.

Preventing deaths of people experiencing homelessness

Linked to this report and currently underway in Bristol, is a review of deaths of people experiencing homelessness.

This will:

- Deliver an audit of deaths related to homelessness that have occurred since surveillance of these deaths commenced in April 2020.
- Develop recommendations to improve the surveillance system for deaths related to homelessness.

Summary and Recommendations

This report has included analysis of data and evidence from a range of sources. It is acknowledged there is more to explore, learn and action than can be covered by this report alone.

Call to action

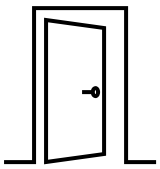
Strong governance systems and leadership are needed across the city to fulfil Bristol's commitment to improve health outcomes for people who have or are experiencing homelessness.

From the perspective that this report has taken, two broad areas have been identified for action. Addressing these will help prevent ill health and improve outcomes for people experiencing homelessness. They should also result in improved efficiency within the health and care system.

Themes for improvement are:

1. Access to effective healthcare
2. Data and intelligence

Access to effective healthcare (mental and physical health)



Early diagnosis and treatment could prevent multiple and complex conditions developing. This requires improved access to healthcare and especially routine access to primary care services for people in Bristol experiencing homelessness.

Take Action:

- Primary care providers can be supported to ensure they allow access without proof of ID or address, immigration status or an NHS number. This can be amplified via the national NHS England campaign resources such as shown in figure 14 and monitored at a local level.

- People experiencing homelessness face stigma and discrimination which can lead to a lack of trust and engagement with health services. Supporting a cultural shift towards trauma informed practice can help to address this. Effective behaviour change interventions can be explored and implemented.

- Many people experiencing homelessness cannot access services using current models based on the need to attend a specific location at a specific time. Opportunities to increase outreach work and drop-in sessions can be identified and more inclusive models explored and implemented.

- Care leavers and younger people experiencing homelessness have been identified as needing improved access to preventative healthcare and protection from exploitation. Access to current healthcare services and models for improvement can be explored.

Data and intelligence

Homelessness is a health issue; a condition that results in poor physical health which must be considered as we would any other public health concern. Homelessness is both a result and cause of poor health and the impact of cold and damp have been highlighted as concerns locally.

A limited range of data sources were identified which allow analyse by accommodation status for health outcomes and risks.

There is a lack of access to health surveillance data sources such as primary care activity and a lack of consistency and completeness in identifying people experiencing homelessness in available data sources. This needs to improve.

There is also an absence of identification/inclusion of those experiencing homelessness in some regular surveys such as Quality of life and census as well as a lack of a regular bespoke homelessness-focussed health survey in Bristol.

People experiencing homelessness are impacted by intersections of inequality and differences have been found in recorded health needs depending on age, gender identity, sexuality, ethnicity, and Disability.

Take Action:

- Services can continue to monitor, develop, and improve health equity only with good quality data. Data for equality groups varied in completeness and can be improved.
- Advisors have raised topic areas such as sexual health, social care needs and serious mental illness. Potential data sources can be identified to explore these further.
- To report more fully on the health needs of people experiencing homelessness, access is needed to health surveillance data which is

both complete and consistent. Methods to overcome identified issues can be explored.

- Opportunities can be explored to improve recording and reporting of data and analysis and support and encouragement for more 'screening' and recording of homelessness within routine NHS datasets.

- Consistency can be sought in definitions of patients/clients subject to homelessness to be used in local data sources.

- Identification of residents experienced / experiencing homelessness can be added to routine data collection / survey processes where this does not occur at present

- The creation of bespoke primary health data collection for the cohorts of interest can be considered.

- Opportunities can be explored for further data analysis to prevent, manage, and treat conditions of concern.

- The Housing Support Register (HSR) is a rich source of data for analysis of health needs and can be more regularly examined and reported on.

- The increased speed at which data can be accessed means that analysis can occur more frequently, and a refresh of this document can be planned before the end of 2024 to monitor progress.

Conditions

A range of health conditions have been identified via data and/or raised as concerns through the voices of professionals and people with lived experience of homelessness.

People experiencing homelessness in Bristol often experience several conditions at once. Complexity and comorbidity have been identified across mental health, substance use and physical health.

Progress on the themes already identified of 'access to effective healthcare' and 'data and intelligence' are intended to address health inequalities across a range of conditions.

The following are examples of specific conditions which have been highlighted.

Mental Health & Trauma

Higher levels of emotional distress are experienced by those living rough or in temporary accommodation. Trauma may have been acquired during childhood and throughout life. However, the eligibility threshold for specialist mental health services is often not reached.

Developing trauma informed approaches is likely to be effective, with rapid access to tailored mental health expertise, including managing addiction.

Investigate the prevalence of severe mental illness in people experiencing homelessness.

Substance use including alcohol

Given higher levels of trauma experienced by people experiencing homelessness as well as ongoing discrimination, stigma and unmet physical and mental health needs, the use of alcohol and other drugs may be understood as a way of coping.

Although there is emphasis on substance use amongst people experiencing homelessness, this often focuses on the use of illegal drugs. Analysis of local data identified that alcohol plays a large part in poor health outcomes for people experiencing homelessness and interventions to reduce harm can be explored.

Improvements are needed to allow access to mental health services for those with continued use of substances and encouragement of a 'no wrong door' attitude.

Opportunities can be explored to improved links between mental health and substance treatment services.

Models of good practice for outreach via on street engagement by mental health teams can be explored and developed for implementation locally.

Infectious diseases

Issues such as lack of access to toilets, running water, places to wash and dry clothes, sharing of cigarettes, drinks and needles means increased opportunities for spread of viruses and bacteria. This results in people experiencing homelessness being at higher risk from infectious diseases.

Higher rate of Hepatitis C have been identified amongst people experiencing homelessness. Cases of iGAS (Invasive Group A Streptococcal) infection were identified and local understanding suggests that this is a concern locally.

Improvements are needed to data collection and reporting systems to improve understanding of prevalence of infectious diseases.

Improvements to vaccination access and uptake can also help to reduce risk of poor health outcomes.

In addition to infectious disease other health protection concerns have been raised including scabies, skin diseases, care of infected wounds, abscesses, and injection sites.

Asthma and respiratory conditions

Cold, damp conditions, smoking cannabis, crack, and tobacco as well as pollution from motor vehicles and businesses in central Bristol are likely contributary factors in asthma and other respiratory conditions identified amongst people experiencing homelessness.

Inequalities could potentially be reduced by improving access to 'support to stop' and substance use services for cannabis, crack, and tobacco as well as pulmonary rehabilitation services.

Support can be given to the clean air zone and other measures to reduce air pollution especially in central Bristol.

Other conditions

Oral and dental health was raised as a concern and access to treatment is limited.

Traumatic brain injury and head injuries were identified via both data and professionals who have raised concerns.

Inclusion Health Populations

The term “Inclusion Health” has been identified to help improve health outcomes for traditionally excluded populations, including people experiencing homelessness, forced migrants and refugees, Roma and traveller communities, those with substance and alcohol use difficulties, people involved with the criminal justice system and sex workers. This report has been produced as part of ongoing work to address health inequalities in Bristol and is intended to form part of a series of publications.

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