Brighton & Hove Homeless Health Needs Audit

February 2014

NHS

Brighton & Hove City Council

Brighton and Hove
Homeless Health Needs Audit

Contents

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Special thanks go to the homeless services who gave their time and effort to administer the questionnaires and to the service users who completed the survey. A full list of services recorded as participating in the audit is included in appendix 5.

Thanks to all of the providers and commissioners who commented on the original survey and to Helen Mathie of Homeless Link.

The project was overseen by a steering group with membership of:

Alistair Hill	Brighton and Hove City Council
Barbara Hardcastle	Brighton and Hove City Council
Jenny Knight	Brighton and Hove City Council
Linda Harrington	Brighton and Hove Clinical Commissioning Group
Stephen Woodbridge	Brighton YMCA
Russell Carter	Brighton and Hove City Council

In addition acknowledgements also go to the following colleagues in Public Health, Brighton and Hove City Council for contributing their time, views and expertise:

Stephen Nicholson
Clare Mitchison
Kate Gilchrist
Liz Tucker
Ellie Katsourides

This document has been written by:

Russell Carter
Public Health Specialist Trainee
Public Health Intelligence Team, Brighton & Hove City Council

Introduction

Homelessness and rough sleeping have been increasing nationally in recent years and health and wellbeing needs are high among rough sleepers and people living in insecure accommodation. In particular, there is a high prevalence of mental ill-health, drug and alcohol dependency and physical health needs. The Joint Strategic Needs Assessment for 2013 highlighted that housing and homelessness have a high impact on health and wellbeing in Brighton & Hove.[1]

A new Brighton & Hove Homeless Strategy will be published in 2014 and there is an opportunity to consider how services can be improved to improve health outcomes in this vulnerable group. Therefore the health and wellbeing Board agreed that this audit would be conducted as part of the Joint Strategic Needs Assessment programme. This report complements the Rough Sleeper and Single Homeless needs assessment (available at http://www.bhlis.org/resource/view?resourceId=1442)

The Homeless Health Audit was originally developed by Homeless Link with funding from the Department of Health and is a questionnaire designed to be completed by service users with help from a support worker. The principal aim of conducting the audit was to increase local knowledge on the health needs of the homeless population while increasing the involvement of homeless people and homeless services in local commissioning processes.

The targeted population for this audit was the single homeless population, many of whom the Council has no statutory responsibility to house. Further information on Local Authority legal obligations for housing is available in the Rough Sleeper and Single Homeless Needs Assessment 2013.[2] The questionnaire was completed in homeless services across Brighton & Hove using a non-random sampling strategy which aimed to include as many homeless clients as possible. Services for homeless people in Brighton & Hove are provided in an integrated support pathway which categorises services into five bands. Band one provides the most intensive support to those with often the highest levels of need through to band five which provides the least intensive support to people otherwise living independently. The bands are summarised below:

Band 1: Provides outreach and floating support for rough sleepers and those in emergency placement accommodation (including temporary B&B accommodation). Rough sleepers are likely to have the most intensive health needs of the homeless population.

Band 2: Hostels which are staffed 24 hours a day, seven days a week.

Band 3: Supported accommodation with support provided during office hours.

[1] http://www.bhlis.org/jsna2013
[2] http://www.bhlis.org/resource/view?resourceId=1442

Band 4: Low level floating support for people living in their own tenancy.

Band 5: Crisis response and peer support for people otherwise independent of services. These clients are likely to have the least intensive health needs of the homeless population.

It is important to note that this pathway does not include homeless people with severe mental health conditions who are usually placed in mental health accommodation. This is likely to impact on the type and severity of mental health needs in the sample. Similarly most over 65 year olds are usually placed in sheltered housing or other older people services meaning there are relatively few people in this age group in the integrated support pathway.

The questionnaires were completed by clients in 4 out of the 5 bands with 80 completed in band one services, 125 in band two, 68 in band three and 4 in band five. Some questionnaires did not report the service where they were completed. No band four services were asked to participate in the audit because these services were piloting a screening tool during the period when the Homeless Health Audit was being carried out. The full integrated support pathway is displayed in appendix 1.

Data for the local and national general populations is presented for comparison throughout the report where available although caution should be taken when comparing many of these figures directly with different surveys often using very different methodologies. Nevertheless they often provide a useful point of reference for the size of the challenge facing services in meeting the needs of a group whose health is among the poorest in our communities.

Where possible, data from the audit in Brighton & Hove is also compared to data from a national pilot of the audit questionnaire which included a sample of 727 people across nine NHS Primary Care Trust areas in England in 2009/10. However, due to the non-random nature of both samples and a lack of information on response rates and the makeup of the national sample, comparisons between the two surveys should be treated with some caution. In total, over 3000 homeless people have now completed the audit nationally and further data from this sample is due to be published in March 2014 which will allow for further comparison with the Brighton & Hove sample.

Methods

The questionnaire was developed by Homeless Link and consisted of a total of 34 questions in six sections:

- Demographics
- Access to health services
- Health behaviours
- Health and wellbeing (including aspects of mental and physical health)
- Substance misuse
- Screening and immunisations

The delivery of the survey was overseen by a steering group which included representation from Public Health, Housing, Brighton and Hove Clinical Commissioning Group and Brighton YMCA as a provider representative.

The Homeless Link survey was circulated to service providers and commissioners for comment in advance and based on responses received some of the generic content was tailored to local circumstances. The survey was completed over a period of six weeks in summer 2013.

Before completing the survey clients were asked to confirm that they understood how the information would be used and that they had not previously completed the survey at another venue. The questionnaire was anonymous with no personal details recorded and took approximately 20 minutes to complete.

Clients of participating services were approached by frontline staff and asked to complete a questionnaire with their assistance. This approach was designed to obtain as large a sample as possible in the absence of an adequate sampling frame from which to take a random selection.

The data was analysed using SPSS v19 and findings were presented to and discussed by a steering group of local stakeholders. Recommendations were agreed by this group and communicated widely to other stakeholders in homeless health in Brighton & Hove.

Section 1: Demographic information

Sample size

In total 302 people completed the Homeless Health Audit questionnaire in services across Brighton & Hove between July and August 2013. The initial target number of responses was 304, which was estimated to be approximately 40% of all single homeless people accessing services in the City.

Age

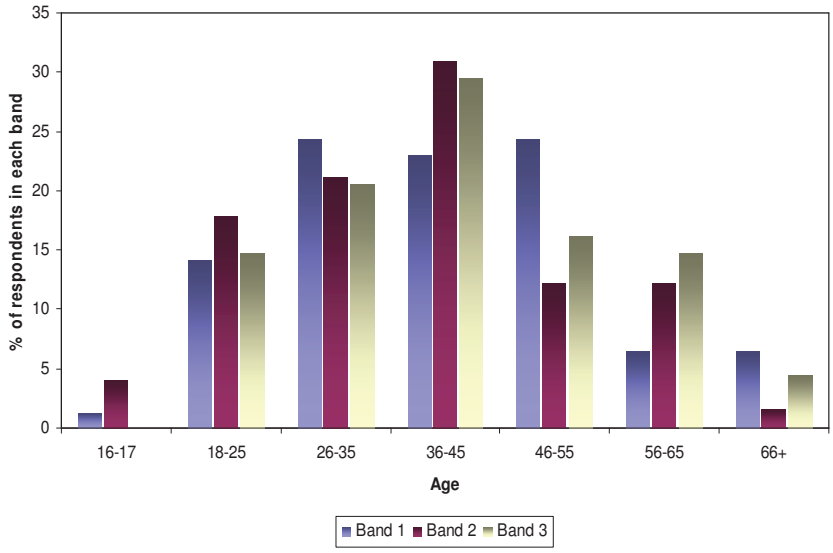
A total of 296 people (98%) provided their age during the audit. There was a wide spread of ages in the sample although only 2% were under 18 years and only 3% were over 65 years. This highlights that there are fewer people over 65 years of age in this population compared to the general population in Brighton & Hove, with 2011 mid-year estimates suggesting 13% of people in the City are in this age band. As stated previously this would be expected as many people over 65 years of age are placed in sheltered housing or other older people services meaning there are relatively few people in this age group in the integrated support pathway.

Table 1. Breakdown of respondents by age

Age range	Count	%
16-17	6	2%
18-25	55	19%
26-35	62	21%
36-45	80	27%
46-55	50	17%
56-65	33	11%
66+	10	3%
Total	**296**	**100%**

The age spread was also similar in bands 1, 2 and 3 (the number of band 5 respondents was too small to display).

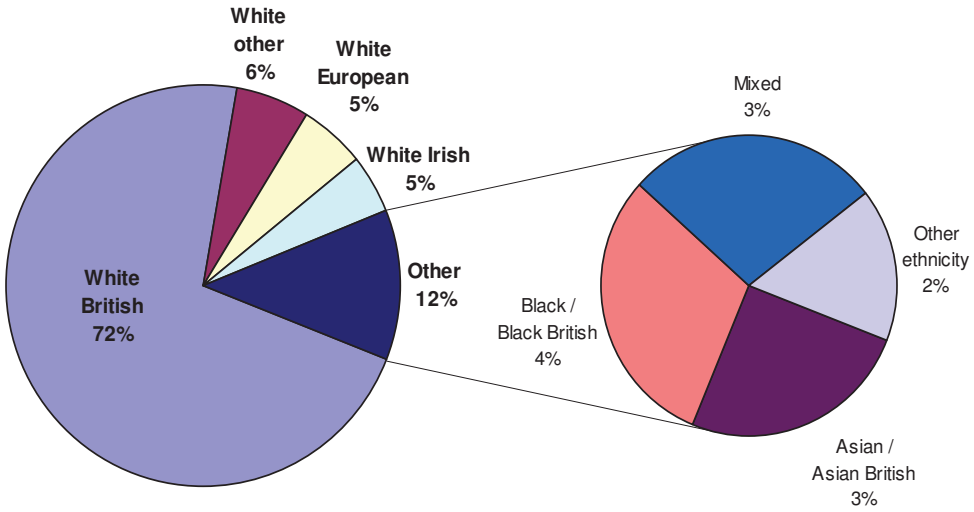
Figure 1. Age of respondents by service band



Ethnicity

A total of 296 people (98%) indicated their ethnicity during the audit. Out of these 212 were White British (72%) and 84 were from Black and Minority Ethnic (BME) groups (28%) which includes all individuals who classified their ethnic group as something other than White British.

Figure 2. Breakdown of respondents by ethnic group



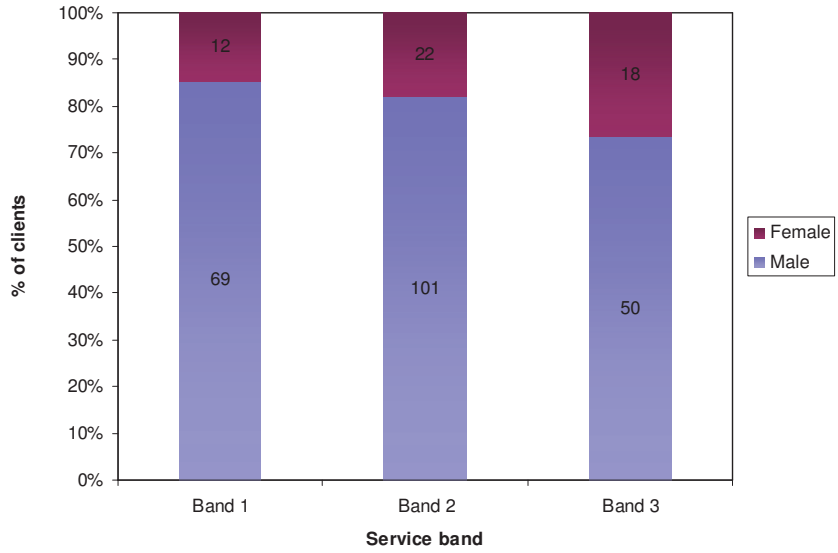
These figures suggest that the homeless population is more ethnically diverse than the general population in Brighton & Hove with 2011 mid-year estimates suggesting 80.5% of people in the City are White British.

Gender

A total of 294 people (97%) indicated their gender during the audit. Out of these 78% were male and 22% female. This is markedly different to the general population in Brighton & Hove which mid-2011 estimates suggest is equally split at 50% males and 50% females.

The proportion of females was lowest in the band one clients (15%) and increased in bands 2 and 3 (18% and 26% respectively).

Figure 3. Proportion of males / females by service band.

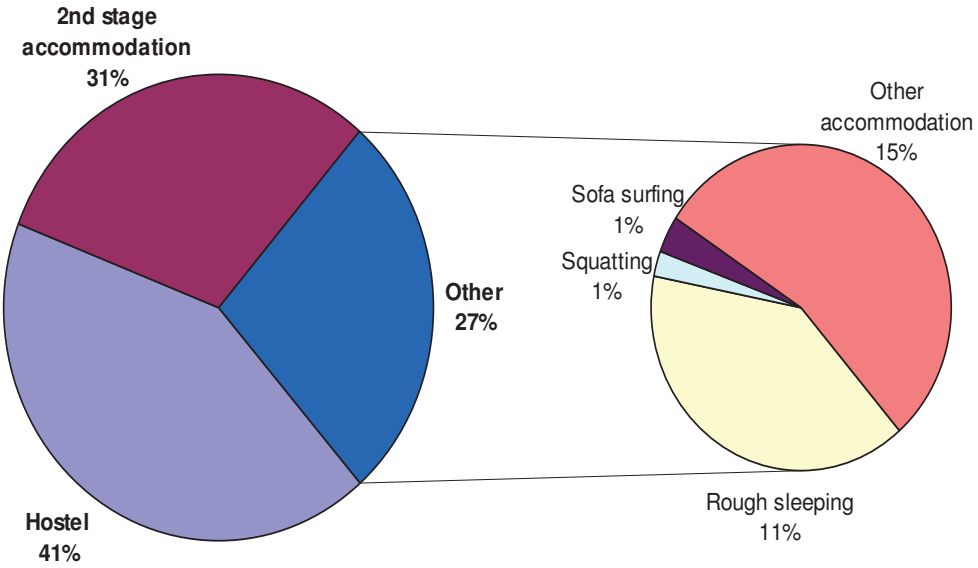


An additional question was asked about whether clients identify themselves as transgender and five out of 260 people (2%) indicated that they did (42 people did not provide a response to the question).

Accommodation status

A total of 299 (99%) people indicated where they were currently sleeping during the audit. The clients were predominantly hostel residents or living in second stage or supported accommodation. Smaller proportions were rough sleeping, squatting or sofa surfing.

Figure 4. Breakdown of respondents by accommodation status



Background of clients

Out of the 302 people that completed the survey, 22 (7%) indicated that they had left care services for young people in the last five years while 27 (9%) indicated that they were currently employed.

Twenty-one people (7%) indicated that they had left prison within the last 12 months while 55 (18%) indicated that they had left prison more than 12 months ago meaning a quarter of the sample had been in prison at some point. This is to be expected as the integrated support pathway for homeless people incorporates a pathway for offenders including hostels that have beds specifically for people on probation.

Figures five and six display the number of people indicating their current employment and offending situations.

Figure 5. Breakdown of employment status

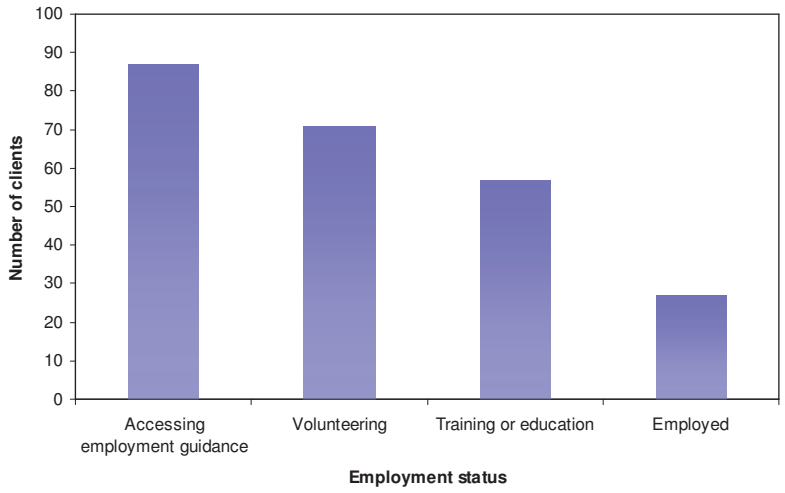
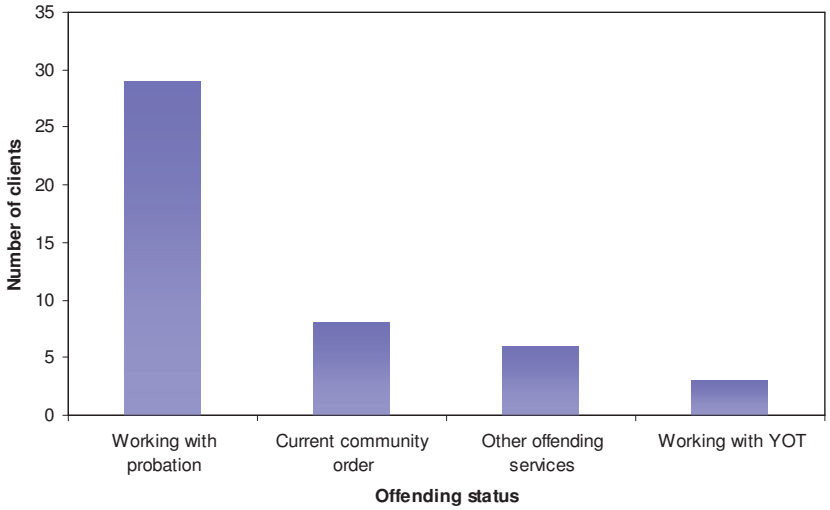


Figure 6. Breakdown of offending status



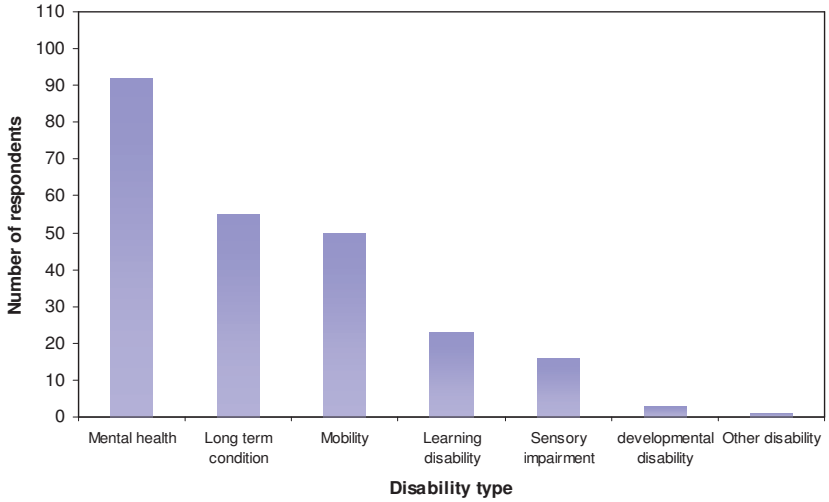
A total of 291 people (96%) indicated their migration status during the audit and 268 (89%) of these indicated they are UK residents, 6 (2%) that they are A10

nationals[3] and 11 (4%) that they are other EU nationals. A small number of people (below five) were currently seeking asylum in the UK.

Disability

A total of 289 people (96%) answered the question on whether they have one or more disabilities and 145 (50%) indicated that they do. Figure seven indicates the number of these people who stated they have each type of disability:

Figure 7. Type of disabilities reported.



Sexual orientation

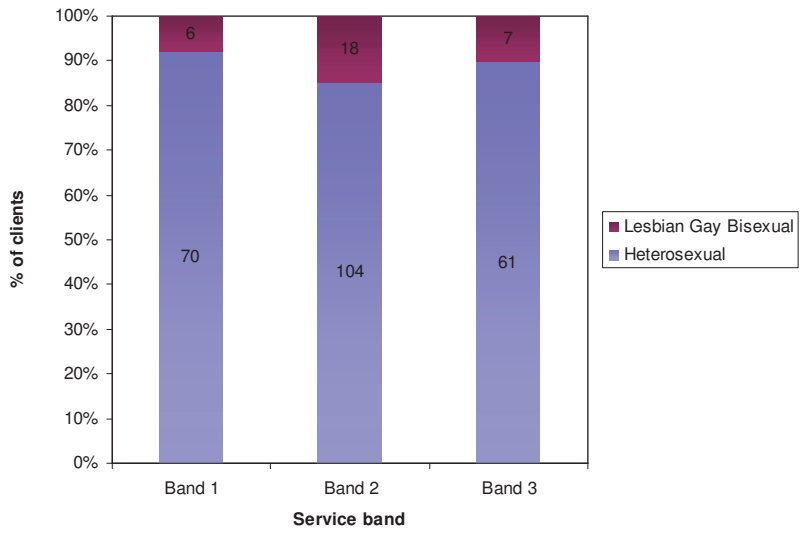
A total of 279 people (92%) provided information on their sexual orientation with 244 (88%) identifying as heterosexual, 10 (4%) as gay men, 5 (2%) as gay women/lesbian and 20 (7%) as bisexual.

There is no definitive research into the number of lesbian, gay, bisexual (LGB) people who live in Brighton & Hove and the recent 2011 Census did not include a question on sexual orientation. However, local estimates suggest that approximately 15-16% of the city's population are in lesbian, gay, bisexual or transgender groups. This is slightly higher than the homeless sample at 12% although it should be noted that this figure doesn't include transgender people.

Figure eight indicates the proportion of clients in bands 1-3 identifying as heterosexual or LGB out of those who provided a response.

[3] Ten countries joined the EU in 2004 and together these are known as A10 countries. These are Poland, Slovakia, the Czech Republic, Slovenia, Hungary, Latvia, Lithuania and Estonia, Malta and Cyprus.

Figure 8. Sexuality by service band.



Representativeness of the sample

As stated previously, the sample of homeless people who completed the questionnaire was not random and represented a convenience sample of service users. This means that it is particularly important to look at the demographics of the sample and compare with estimates of the local homeless population including service user statistics to determine if the sample appears to be different in any substantial way.

Data on homeless service users in Brighton & Hove has been presented in a recent Rough Sleeper and Single Homeless Needs Assessment and if these figures are taken as a proxy for the homeless population as a whole then comparisons suggest that the audit sample is generally a representative one.

For example, the audit sample had a similarly low number of people aged 16-17 and over 65 as those recorded as using band 2 or 3 accommodation in 2011/12 although there were slightly less people aged 18-45 in the audit (67%) compared to 18-44 in the service users (78%). The ethnic breakdown of the sample was very similar to the service user statistics for band 2 and 3 accommodation in 2011/12 while the proportion of lesbian, gay and bisexual people was slightly higher in bands 1-3 in the audit sample as was the proportion of females. The higher LGB proportions were due to a greater proportion of bisexual clients in the audit sample although a breakdown of these figures is not presented due to the small numbers involved. Overall the sample does not appear to be substantially different to recent local service user statistics.

The table in appendix two presents a comparison of the audit sample and service user statistics for Brighton & Hove in 2011/12.

Key Points

- The audit sample can be considered a representative sample of the homeless population in Brighton & Hove and therefore provides useful information on the health needs of this group.

- The sample suggests that the homeless population differs from the general population in Brighton & Hove in a number of important ways:
    - The sample was younger than the general population with fewer people aged 65 and over.
    - The sample was more ethnically diverse than the general population with only 72% of the sample identifying as White British compared to 80.5% of the general population.
    - There was a much larger proportion of males in the audit sample compared to the general population, 78% compared to 50%.
    - A quarter of the sample had been in prison at some point in their lives.
    - The sample had a similar proportion of LGB people as estimates for the general population in Brighton & Hove. This was 12% in the audit sample compared to 15-16% (including transgender people) in the general population.

Section 2: Access to health services

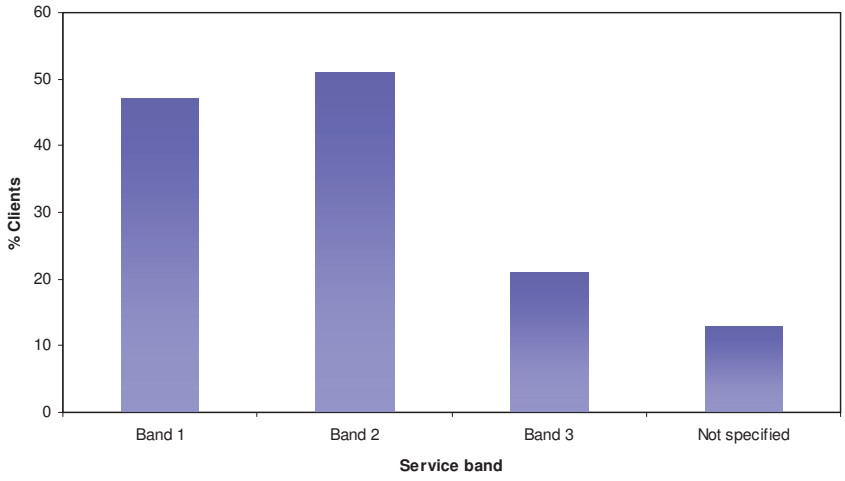
Registration with health services

The findings showed that there was a high level of GP registration with 279 (92%) clients stating they were registered with a GP either temporarily or permanently (95% Confidence Interval: 88.9% to 95.1%). This is higher than the corresponding figure in the national homeless audit sample of 85%.

In Brighton & Hove Morley Street Homeless Health provide GP services to the homeless population and a small number of clients indicated that they are registered with both the Morley Street clinic and another GP. A small proportion of the sample (7%) also said that they had been refused registration to a GP or dentist in the last 12 months with reasons given including not having sufficient photo ID, due to violence and not accepting people on benefits (all less than five respondents per reason).

The proportion of people registered with Morley Street was similar in bands one and two (47% and 51% respectively) but lower in band three (23%) and people who didn't specify the service they were accessing (13%). The lower level of registration would be expected in band three as this accommodation is more geographically dispersed and suggests that clients with the highest level of need (i.e. bands one and two) are registered with the Morley Street practice.

Figure 9. Proportion of clients registered with Morley Street Practice by service band.



There was a much lower proportion of people (38%) who were registered with a dentist (95% CI: 32.5% to 43.5%). This finding reflected a recent study by Pathway[4] which found 44% of a sample of 158 homeless people in London in 2013. The study highlighted the difficulties faced by homeless people in accessing dental services and the need to raise awareness of the benefits of regular dental care including awareness of entitlement and practicalities of access among homeless people and services.

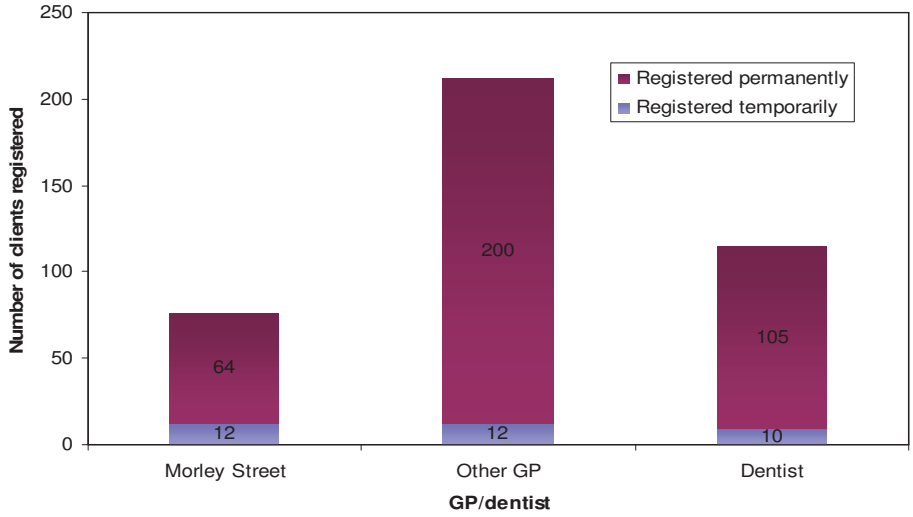
The proportion of clients registered permanently with a GP and a dentist varied widely between different homeless services from 100% of clients to 50% for GP

[4] http://www.pathway.org.uk/wp-content/uploads/2013/10/final-final-edh.pdf

registration and from 64% to 15% for dentist. Tables showing the proportion of clients registered for individual services is included in appendix four. Only services with a minimum of ten questionnaires providing responses to this question were included in these analyses.

The majority of GP and dentist registrations were permanent (92%).

Figure 10. Morley Street, 'other' GP and dentist registration.

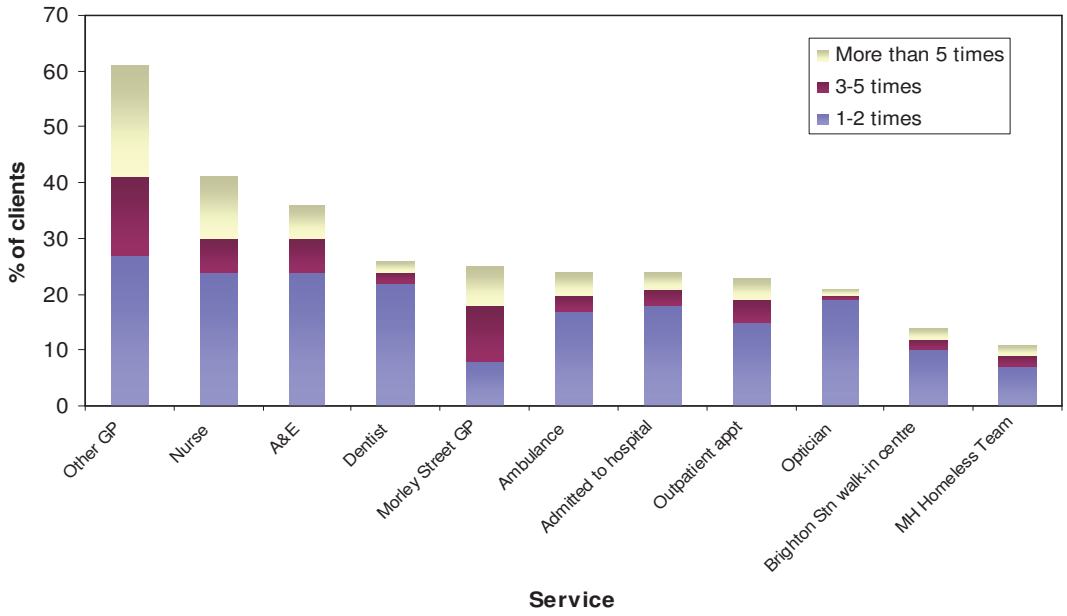


Use of health services

Figure 11 shows the proportion of clients who used health services 1-2 times, 3-5 times or more than five times in the last six months. The GP was the service most used with 61% having visited a GP other than Morley Street and a further 25% having visited Morley Street – 86% in total. The GP was also the service most likely to have been used multiple times with 59% of those who had visited a GP having done so three or more times.

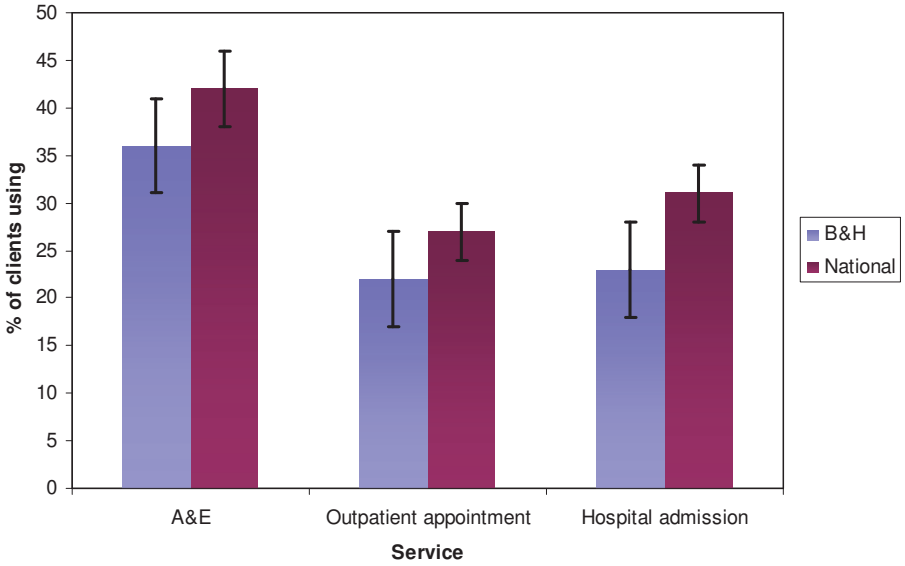
Service usage figures in the audit sample were considerably higher than for the general population. For example, over a 12 month period it is estimated that only 7% of the general population will have an inpatient hospital stay which compares to 25% of the audit sample who had been admitted to hospital at least once *in the last six months*. Furthermore, national data suggests that 13.5% of the general population attend A&E or an outpatient appointment in a three month period (the data does not distinguish between the two) which compares to 39% of the Brighton & Hove audit sample who had attended A&E or an outpatient appointment *in the last six months*.

Figure 11. Proportion of clients using services in the last 6 months.



The data also showed that clients in the Brighton & Hove audit were less likely to have used A&E, hospital outpatient appointments and have been admitted to hospital in the last six months compared to the national homeless audit sample although these differences were not statistically significant. The proportion of clients using key services in the last six months in Brighton & Hove and the national audit sample are displayed in figure 12.

Figure 12. Brighton & Hove and national audit comparison of service usage.



The clients in the audit who had been admitted to hospital in the past six months had a self-reported average length of stay of 3.2 days (95% CI: 2.3% to 4.2%) based on their most recent admission. This is higher than the figure for the national general population estimated by the Department of Health of 2.1

days. [5] However it is considerably lower than findings from the national homeless audit sample where an average length of stay of 7.2 days was observed and lower than the figure reported by a Department of Health study which found an average length of stay of 6.2 days for homeless people. [1]

Reasons for service use

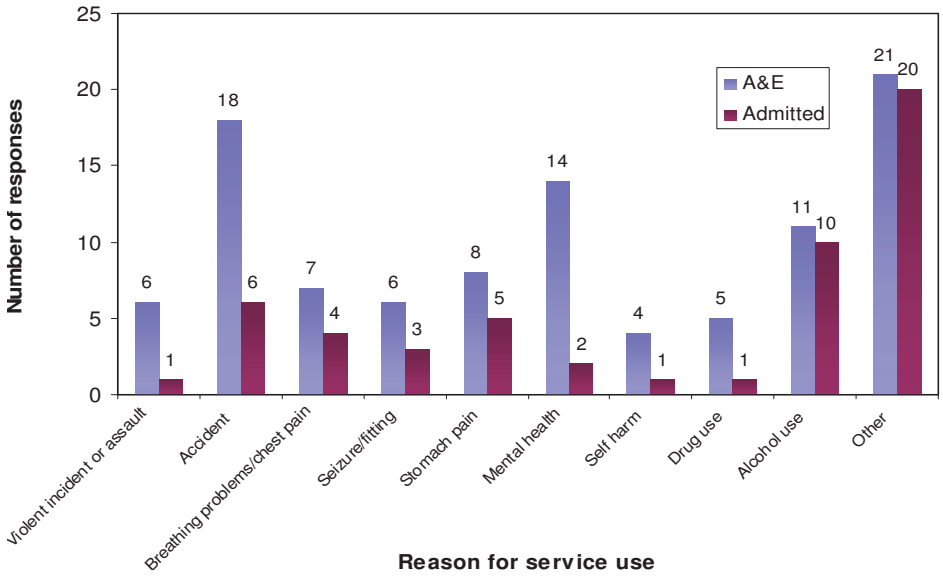
Out of 110 clients who had been to A&E in the last six months, the most common reasons given for the visit were accidents, mental health and alcohol use whereas out of 70 clients who had been admitted to hospital, the most common reasons given were alcohol use, accidents and stomach pains. Figure 13 displays these results.

Discharge planning

The Department of Health states that all acute hospitals should have admission and discharge policies ensuring homeless people are identified on admission and linked into services on discharge.[6] The audit found that out of the people who had been admitted to hospital in the past six months, 78% stated that hospital staff had ensured they had somewhere suitable to go when discharged.

This figure compares favourably with the national homeless audit where only 27% of clients stated they had help with their housing before they were discharged. This is likely to have been due to the Pathway project in Brighton & Hove which has been implemented by Brighton and Sussex University Hospitals NHS Trust and aims to provide somewhere to stay for every homeless person who attends hospital.

Figure 13. Reasons reported for A&E visits and hospital admissions.



[5] Healthcare for single homeless people, DH, 2010
[6] Discharge from hospital; pathway, process and practice, DH, 2003

Information about health services

Respondents were asked if they have been given information about health services they can use by their housing or homelessness project and 288 provided a response. Out of these, 242 stated that they had been given information (84%) and 210 stated that they had found it useful (87%).

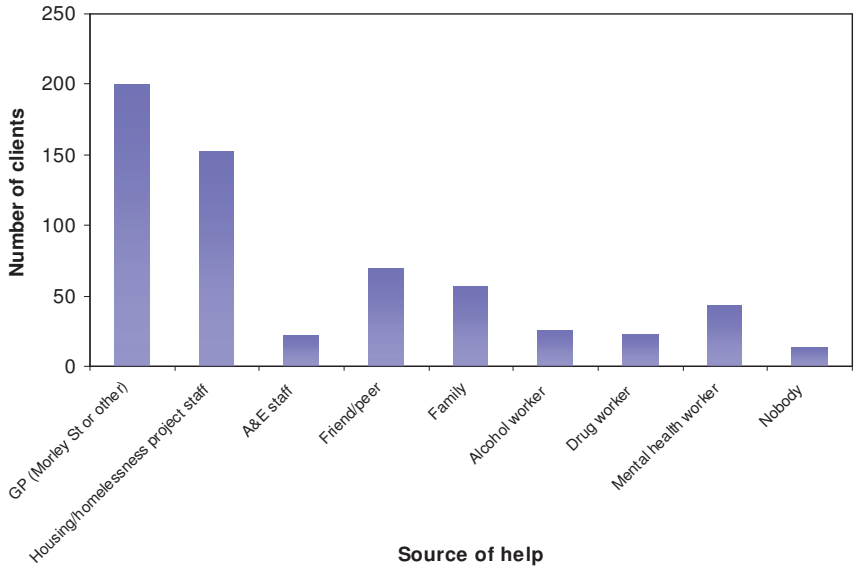
Clients were also asked who they thought helped them most with their health in general and the responses are displayed in figure 14 (multiple responses were possible). The GP was the most common response.

Clients who are registered with the Morley Street GP Practice were somewhat more likely than those registered with other GPs to identify their GP as a useful source of help when it comes to their health (76% compared to 68%). However, this was not a statistically significant difference.

Table 2. Proportion agree "GP helps most with my health" by Morley St / other GP registration

	% agree	Count	Total	Significance
Registered at Morley Street	76%	52	68	NS
Registered at another GP Practice	68%	136	203	NS
Total	69%	188	271	---

Figure 14. Individuals reported to help most with clients' health

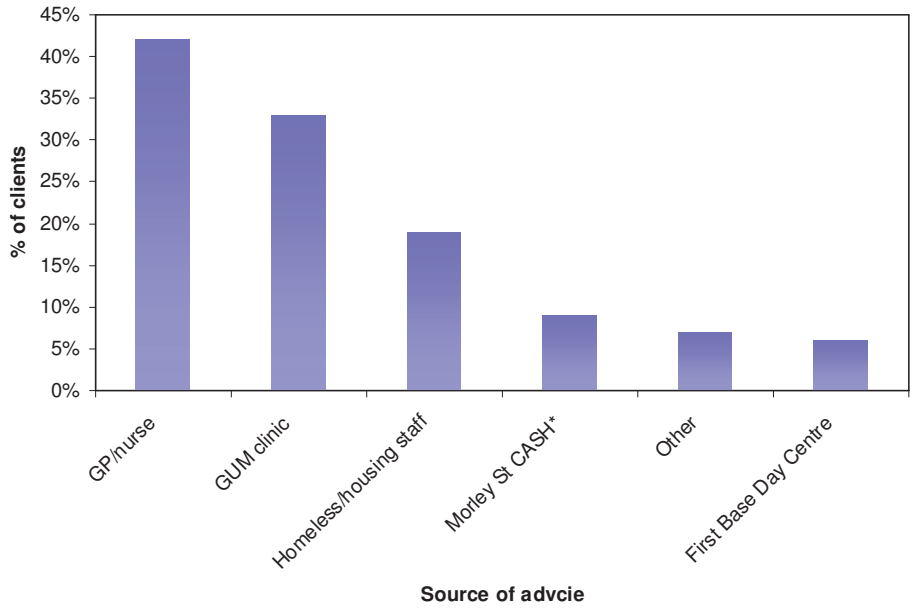


Sexual health advice

Clients were also asked if they knew where to access advice about sexual health and there was a high level of awareness reported with 87% of 284 people who responded stating that they did know. Again, the GP was the most

common response with 42% identifying this as the place they would go for this advice. Figure 15 shows the sources of advice clients indicated they would go to.

Figure 15. Source of sexual health advice identified.



**** CASH: Contraception Advice and Sexual Health clinic at Morley Street.***

Population subgroups and access to services

In addition to analysing the sample as a whole, reported use of A&E, ambulance and admission to hospital in the last six months were analysed within various subgroups of the sample. Chi Squared tests were performed to determine if the results in each sub-group were significantly different from the rest of the sample and key findings include:

- White British clients had a higher self-reported use of all three of these services in the last six months compared to those in BME groups although none of these findings were statistically significant which may be due to the relatively small number of BME clients in the sample.

- Females had higher self-reported use of A&E and ambulance in the last six months compared to males, although only the findings for ambulance use was statistically significant. Again, this may be due to the relatively small number of females in the sample.

- Clients aged 46 years and over had the lowest self-reported use of all three services and the A&E result was statistically significant.

- Clients aged 26-45 years had the highest rates of A&E use and admission to hospital and the second of these findings was statistically significant.

- Lesbian, gay and bisexual clients had higher self-reported use of all three services but none of these were significantly different to the rest of the sample and again this may be due to the relatively small number of LGB clients in the sample.

Full results tables for these analyses are presented in tables A1, A2 and A3 in appendix three.

Key Points

- The audit found a high rate of GP registration in the homeless population (92%) with about a quarter of these registrations at the Morley Street Practice.

- The proportion registered with a dentist was much lower at 38%.

- GP and dentist registration levels vary considerably between different homeless services.

- Use of services including A&E and hospital inpatient and outpatient services was higher in the audit sample than estimates for the general population.

- The self-reported hospital length of stay was 3.2 days which is higher than estimates for the general population but considerably lower than estimates for other homeless populations including the national homeless audit which found an average of 7.2 days.

- A large proportion of those that had been admitted to hospital stated that hospital staff had found somewhere suitable for them to go after discharge (78%). This was considerably higher than the national audit and is likely to represent a positive impact of the local Pathway project.

Recommendations

1. Target interventions to increase rates of registration with GPs and dentists at services with the lowest levels.

2. Increase rates of dental registration and consider evidence and recommendations from recent Pathway research in addition to this audit to improve access to dental services for the homeless population.

3. NHS Commissioners provide advice to GPs to ensure that homeless people have equitable access to primary care (including advice on photo ID).

4. NHS Commissioners to consider the evidence that discharge planning is working relatively effectively (probably as a result of the Pathway service) in the development of future services. Consider how this can be improved further.

5. NHS commissioners and Brighton & Sussex University Hospitals NHS Trust to consider the proportion of A&E visits by homeless people that are genuinely required and whether service redesign could reduce inappropriate use of hospital services.

Section 3: Health behaviours

Information on the health status and behaviours of the general population in Brighton & Hove is collected in a local survey called Health Counts. In Health Counts 2012 a random sample of 2.5% of the population aged 18 years or over drawn from GP registration database was surveyed with a response rate of 45%. This survey provides data for comparison with the homeless health audit results.

Smoking

In the Brighton & Hove audit, 219 clients or 73% (95% CI: 68.0% to 78.0%) indicated that they smoke. According to Health Counts these figures are far higher than in the general population in Brighton & Hove where 23% smoke and also nationally where only 20% of people smoke. The national homeless audit sample had a higher smoking prevalence than the Brighton & Hove audit at 77%. Appendix four gives the smoking prevalence reported in each individual participating service.

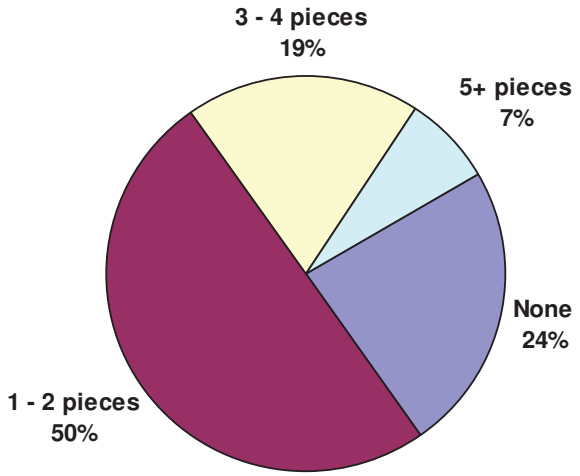
Out of the smokers in the Brighton & Hove audit, 56% had been offered help to stop (which is similar to the national audit figure of 55%) and 46% stated that they would like to stop smoking.

Diet

The audit data also highlighted the poor diets many homeless people have with 36% (95% CI: 30.6% to 41.4%) stating that on average they do not eat two meals a day. Only 7% of the sample (95% CI: 4.1% to 9.9%) stated that they eat five portions of fruit and vegetables a day and 24% (95% CI: 19.1% to 28.9%) do not eat any at all. According to the Health Counts survey, the proportion of the general population in Brighton & Hove eating five portions a day is far higher at 52%.

The findings are similar to the figures from the national homeless audit which also found 7% eating five portions a day and about one third not eating any at all.

Figure 16. Fruit and vegetable consumption in Brighton & Hove homeless sample



Physical activity

A total of 146 clients (51%) stated that they exercise at least twice a week (95%CI: 45.4% to 56.6%). Out of those that stated they do not exercise twice a week, 62% stated that they would like to. Again, appendix four gives the proportion of clients exercising two times a week in each individual participating service.

Population subgroups and health behaviours

Key findings from the subgroup analyses include:

- None of the subgroups analysed were significantly more or less likely to eat two meals a day compared to the rest of the sample. However, this may be due to fairly small numbers in some of the subgroups it is worth noting that:
    - a higher proportion of BME clients ate two meals a day compared to White British clients.
    - a higher proportion of clients aged 46 years or older ate two meals a day compared to younger age groups.
    - a higher proportion of clients living in supported accommodation ate two meals a day compared to those sleeping rough or in hostels.
- White British clients and those living in hostels were both significantly more likely to smoke than the rest of the sample.
- it is also worth noting that:
    - a higher proportion of males smoked compared to females
    - a lower proportion of 16-25 year olds smoked compared to older age groups.

Full results tables for these analyses are presented in tables A4 and A5 in appendix three.

Key Points

- The audit found a very high smoking prevalence at 73%. This is considerably higher than the general population in Brighton & Hove at 23%.
- Almost half of smokers stated that they would like to stop but only 56% said that they had been offered help to do so.

- A third of the sample were not eating two meals a day and only 7% reported eating 5 portions of fruit and vegetables which is considerably lower than the general population in Brighton & Hove at 52%.

- Only half of the sample reported exercising two or more times a week while 62% of those not exercising two or more times reported that they would like to.

- There was considerable variation in smoking prevalence, fruit and vegetable consumption, eating two meals a day and exercise levels between clients accessing different homeless services.

- Little variation in health behaviours was found between population groups although White British clients were significantly less likely to smoke as were those living in hostels.

Recommendations

1. Review provision of Stop Smoking Services for the homeless population in Brighton & Hove. All smokers should be encouraged and offered support to quit.

2. Ensure homeless people are included in healthy eating and physical activity programmes and that they are meeting their needs.

3. Target these health promotion programmes at services identified with the highest levels of need to achieve maximum impact.

4. Providers and commissioners to note the findings of low levels of exercise and poor diet relating to fruit and vegetable consumption and eating two meals a day, and ensure these are prioritised.

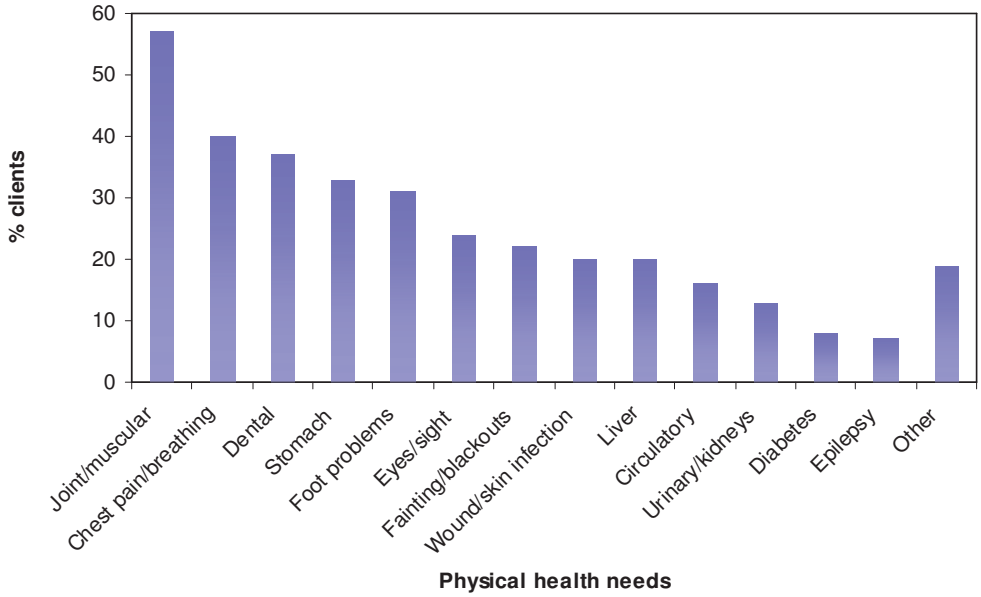
Section 4: Health and wellbeing

Physical health

In Brighton & Hove, 84% of clients stated that they have at least one physical health problem (95% CI: 79.9% to 88.1%) and 33% of these indicated that they had had it for 12 months or longer. This is similar to the national homeless audit where it was reported that 82% of clients had one or more physical health problem. The range of conditions reported are displayed in figure 17.

Out of the 248 clients who had a physical health need, 25 (10%) stated that they were not currently receiving any support or treatment to help with the problem but would like some and 74 (29%) stated that they were receiving help but still wanted more.

Figure 17. Physical health needs reported (figures exceed 100% as respondents could select multiple needs)



Only half of the clients who reported dental health problems were registered with a dentist but there was no statistically significant difference between those registered and not registered with a dentist in terms of whether they reported dental problems.

Table 3. Proportion reporting dental health problems by registration with a dentist

	%	Count	Total	Significance
Registered with a dentist	42%	43	103	NS
Not registered with a dentist	34%	43	127	NS
Total	37%	86	230	---

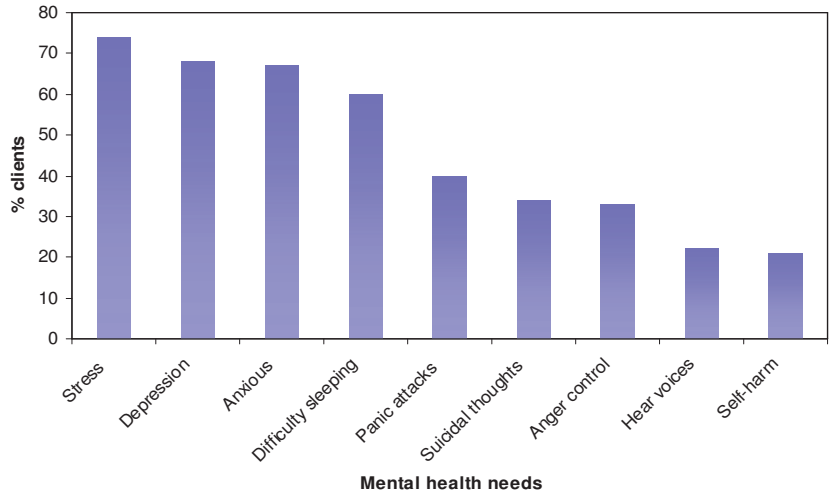
Again, appendix four gives the proportion of clients reporting a physical health need in each individual participating service.

Mental health

In Brighton & Hove, 85% of clients stated that they have at least one mental health issue (95% CI: 81.0% to 89.0%) while it is estimated that only one in six adults nationally will have a mental health problem at any time.[7] The figure for the Brighton & Hove audit sample was also higher than the national homeless audit figure of 72% of clients stating they had at least one mental health issue.

Out of those who had a mental health issue, 73% indicated that they had had it for 12 months or longer. The range of mental health issues reported is displayed in figure 18.

Figure 18. Mental health needs reported (figures exceed 100% as respondents could select multiple needs)

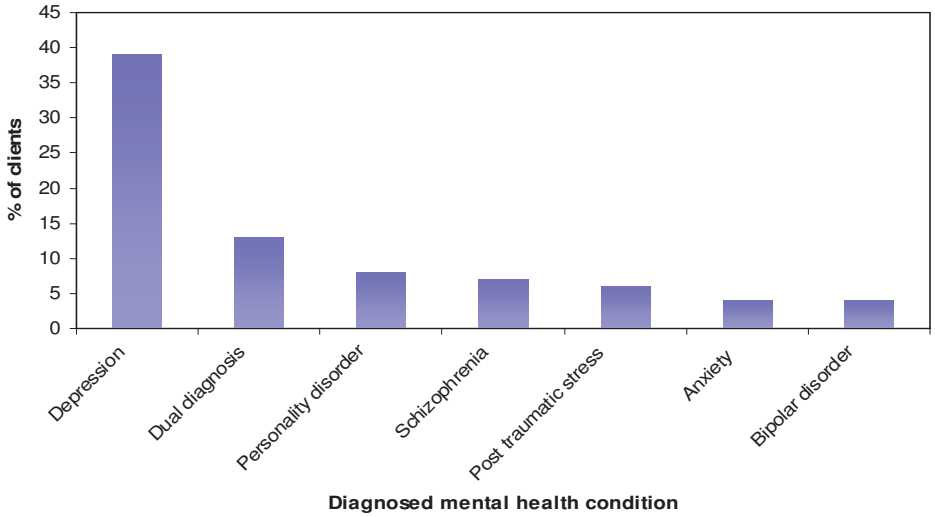


Despite the high proportion of clients who stated they had a mental health issue, only 53% said they had been diagnosed by a health professional with a mental health condition. This figure compares to 12.7% of the adult population in Brighton & Hove who are on GP registers for common mental health problems and 11.7% nationally. As stated previously, homeless people with severe mental health conditions are likely to be accessing specific mental health services and therefore would not be represented in this sample. Figure 19 displays the diagnosed mental health conditions reported.

Out of the 251 clients who had a mental health issue, 38 (15%) stated that they were not currently receiving any support or treatment to help with the problem but that they would like some and 55 (21%) stated that they were receiving help but still wanted more.

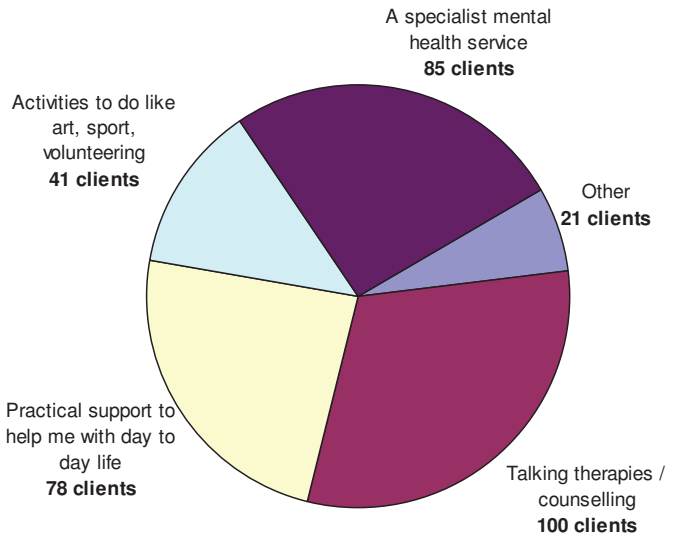
[7] No Health Without Mental Health, DH, 2011

Figure 19. Diagnosed mental health conditions reported



Clients were also asked what kind of support helps, or would help, them with their mental health needs) and the responses are presented in figure 20.

Figure 20. Type of support clients identified as currently helping or would help them.



Population subgroups and health and wellbeing

Key findings from the subgroup analyses include:

- 16 - 25 year old clients were significantly less likely to have either a physical health problem or a diagnosed mental health condition compared to the rest of the sample.

- Clients aged 46 years or over were significantly more likely to have a physical health problem compared to the rest of the sample while clients aged 26 - 45 years were significantly more likely to have a mental health condition compared to the rest of the sample.

- LGB clients were significantly more likely to have a physical health problem and a diagnosed mental health problem compared to the rest of the sample.

- Although it was not a statistically significant finding, it is also worth noting that a higher proportion of females had a physical health problem than males.

Full results tables for these analyses are presented in tables A6 and A7 in appendix three.

Key Points

- The audit found high levels of both physical health and mental health needs with 84% and 85% reporting at least one of these needs respectively.

- The audit found that many clients felt these needs were not being adequately met. Over a third of the clients who had at least one physical health need and about a third of the clients who had at least one mental health need reported that they would like more support for it.

- Depression was the most common diagnosed mental health condition reported and the second most common mental health difficulty experienced after stress.

- Talking therapies/counselling was the most common type of support identified as most useful for dealing with mental health problems.

- LGB clients were significantly more likely to have a physical health problem and a diagnosed mental health problem compared to the rest of the sample.

Recommendations

1. Work with homeless health services in the City to ensure they are meeting the physical and mental health needs of the homeless population.

2. Ensure training for staff in hostels and other homeless services in identifying mental and physical health needs and signposting to appropriate services.

3. Investigate whether current projects are addressing the high levels of physical and mental health needs in the LGB homeless population.

Section 5: Substance misuse

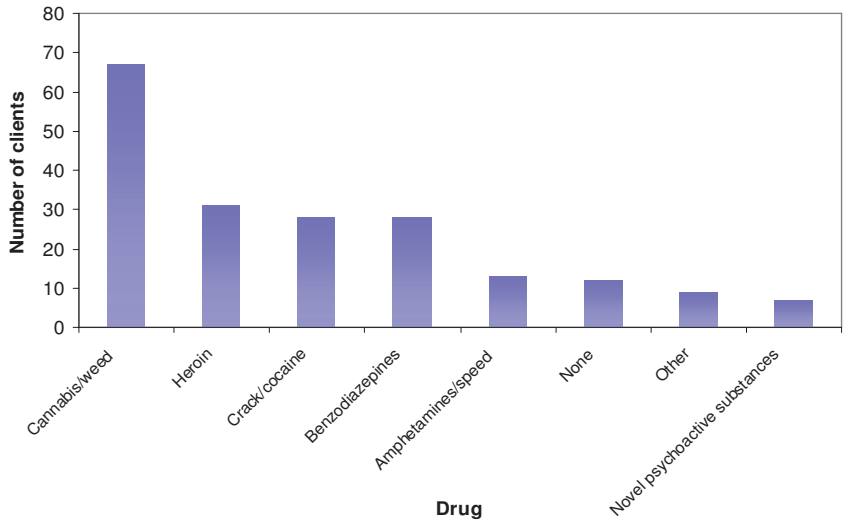
Drug use

In the Brighton & Hove audit, 40% of clients indicated that they currently take drugs or are recovering from a drug problem (95%CI: 34.5% to 45.3%). This is considerably higher than the general population where 9% of 16-59 year olds report having taken one or more illicit drug in the last year (2011/12).

The Brighton & Hove figure is lower than the national homeless audit sample where 52% of clients stated they are currently taking drugs or are recovering from a drug problem.

Figure 21 shows drugs reported to have been used in the last month (not including prescribed drugs) and shows that cannabis was the most commonly used drug in the audit sample, reported by 67 clients (22%), followed by heroin, reported by 31 clients (10%). Participants could indicate use of more than one substance.

Figure 21. Type of drug use reported



Eighteen clients also stated that they currently inject drugs (6%), although 64% of the sample declined to answer this question. Out of these people, less than five stated that they usually or sometimes share their injecting equipment with others while 16 of the 18 clients stated that they knew about a needle exchange scheme they could use.

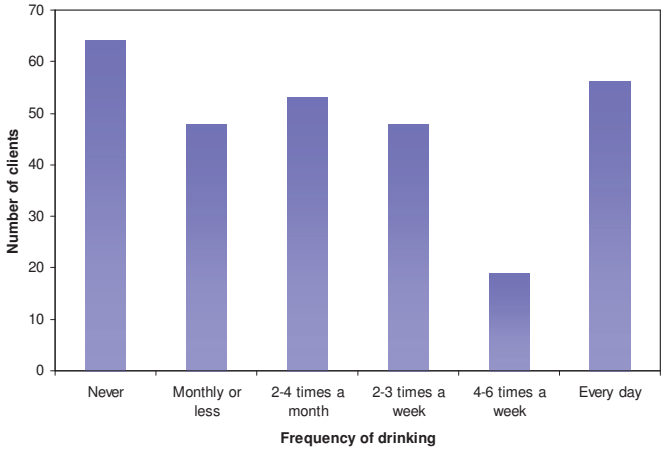
Out of the 114 clients who stated that they take drugs, 55 (48%) indicated that they are receiving help to address their drug use and most felt that this met their needs. Despite this, 21% of clients taking drugs stated that they would still like more help.

Alcohol use

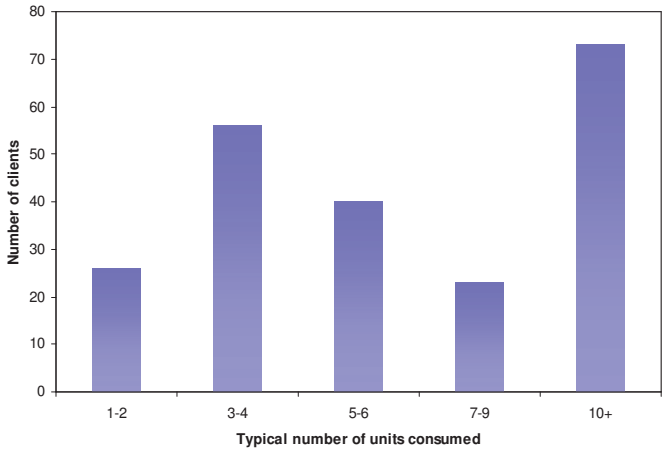
In the Brighton & Hove audit, 26% of clients indicated that they drink four or more times a week (95% CI: 21.1% to 31.0%) which is the frequency considered harmful by the Department of Health.

Out of the clients that stated they drink four or more times a week, 59% said they consume 10 or more units each time they drink which suggests very harmful levels of alcohol consumption. Overall 32% of clients stated that they have or are recovering from an alcohol problem. Figures 22 and 23 display the frequency and amount of alcohol consumption in the Brighton sample.

Figures 22. Frequency of alcohol consumption.



Figures 23. Typical number of units consumed in a session.



The proportion of clients in the national homeless audit who drank four or more times a week was slightly lower than in Brighton & Hove at 20% and considerably less of these said that they consume 10 units or more on a typical drinking day.

Out of the 95 clients who stated that they have or are recovering from an alcohol problem, 57 (60%) indicated that they are receiving help to address it and most felt that this met their needs. However, 36 (38%) stated that they would still like more help.

Population subgroups and substance misuse

Key findings from the subgroup analyses include:

- White British clients were significantly more likely than BME clients to be currently taking drugs or recovering from a problem compared to the rest of the sample.

- Clients aged 46 years and over were significantly less likely to be taking drugs or recovering compared to the rest of the sample, while clients aged 16 - 25 years were significantly less likely to be drinking four or more time a week and 26-45 year olds significantly more likely.

- Clients in a hostel were significantly more likely to be taking drugs than the rest of the sample and those in supported accommodation significantly less likely.

Full results tables for these analyses are presented in tables A8 and A9 in appendix three.

Key Points

- The audit found high levels of drug use with 40% of clients currently taking drugs or recovering from a drug problem although this was less than found nationally.

- Cannabis was the most common drug used (22% of the sample) followed by heroin (10% of the sample). Six percent of the sample also reported that they currently inject drugs.

- About a fifth of those taking drugs or recovering stated that they would like to receive more help with their problem.

- One third of the sample stated that they have or are recovering from an alcohol problem and over a third of these stated they would like to receive more help with it.

- White British people were significantly more likely to take drugs or be recovering from a drug problem than BME people while those aged over 45 years were significantly less likely than younger age groups.

- Clients in a hostel were significantly more likely to be taking drugs than the rest of the sample. This may be a consequence of the characteristic of the population sampled with clients in band 2 potentially less likely to have achieved recovery/abstinence.

Recommendations

1. Share audit findings with the local Drug and Alcohol service commissioners and the Drug and Alcohol Action Team (DAAT) for their consideration to support re-commissioning.

2. Ensure provision of stop smoking services for the homeless population adequately incorporates cannabis use in addition to regular cigarettes.

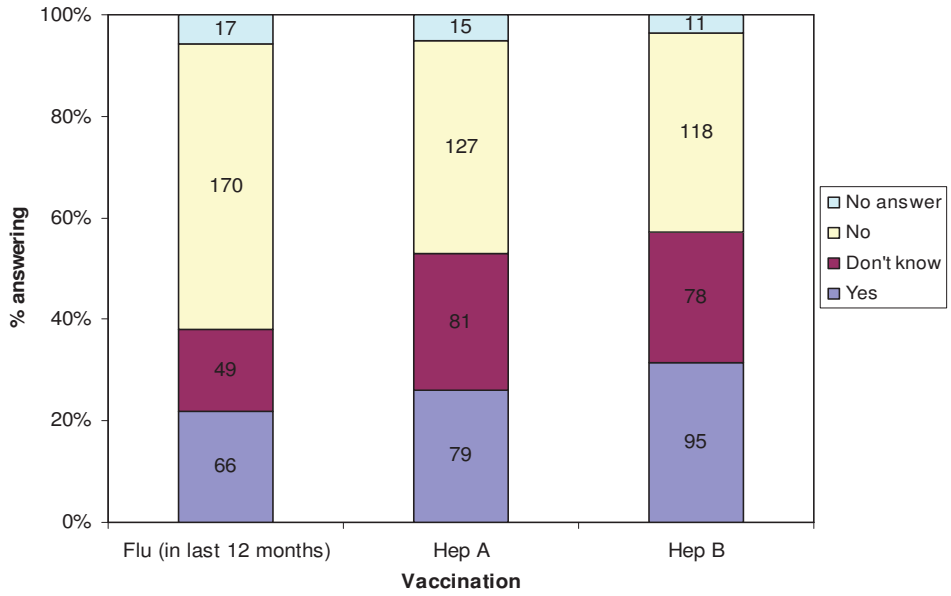
3. There was a good level of awareness of local needle exchange services among injecting drug users (IDUs) and relevant services should ensure this is maintained.

Section 6: Screening and immunisations

Vaccinations

Clients completing the audit were asked about their history of vaccination for hepatitis A, B and flu and figure 24 displays the responses. No data is available from the national homeless audit for comparison on this question.

Figure 24. Flu, hep A and hep B vaccination status.



Hep A, B and flu vaccines are not specifically recommended for homeless people. However there are a number of groups that are recommended for these vaccines that are represented in the homeless population.

Flu: The flu vaccine is recommended, and provided free of charge, for people with a long term health condition who are at risk of serious complications from the illness. While there is not a definitive list of these conditions and clinical decisions are made on a case by case basis, the NHS Choices website recommends that people with a number of conditions should be offered a vaccine.[8] These include liver conditions, kidney conditions, diabetes and HIV. People aged 65 years and over are also eligible for a free flu vaccine. Table 10 gives the proportion of clients vaccinated in some of these key groups and suggests that although more people in each of these groups are receiving the vaccine than the sample as a whole, many are still going unvaccinated placing them at risk of serious complications from the virus.

Table 4. Proportion vaccinated in key risk groups: flu

Vaccine indicator	% vaccinated	Count	Total
Aged 65+	50%	5	10
Liver condition	30%	15	50
Diabetes	45%	9	20
HIV+	38%	5	13
All respondents	22%	66	302

[8] http://www.nhs.uk/conditions/vaccinations/pages/who-should-have-flu-vaccine.aspx

Hepatitis A: Hepatitis A vaccine is recommended for IDUs and people with chronic Hep B or C infection and milder forms of liver disease.[9] Table 5 gives the proportion of clients vaccinated in these groups and again suggests that many are still going unvaccinated placing them at risk of infection.

Table 5. *Proportion vaccinated in key risk groups: Hep A*

Vaccine indicator	% vaccinated	Count	Total
Injecting drug user	33%	6	18
Liver condition	40%	21	53
All respondents	26%	79	302

Hepatitis B: Hepatitis B vaccine is also recommended for IDUs and people with any form of liver disease. [10] Table 6 gives the proportion of clients vaccinated in these groups and again suggests that many are still going unvaccinated placing them at risk of infection.

Table 6. *Proportion vaccinated in key risk groups: Hep B*

Vaccine indicator	% vaccinated	Count	Total
Injecting drug user	33%	6	18
Liver condition	43%	23	53
All respondents	31%	95	302

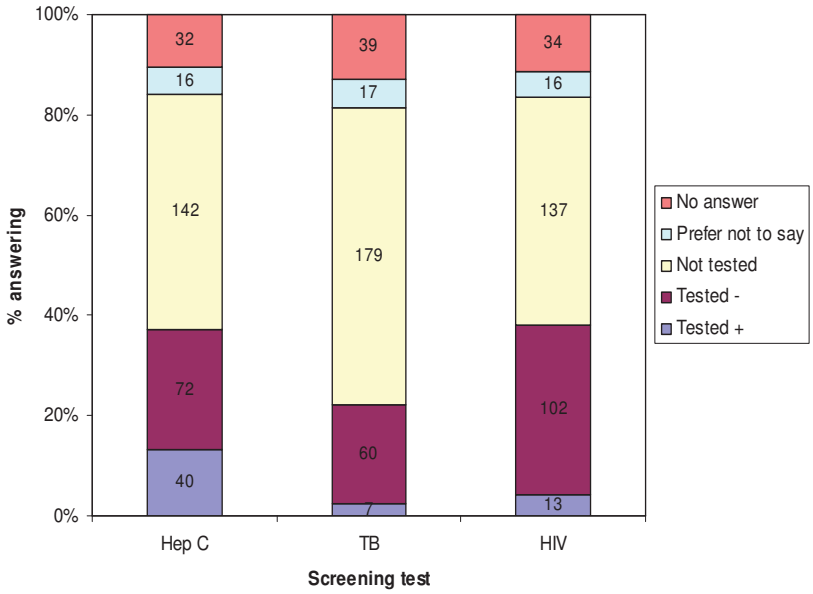
Caution should be applied when interpreting the figures in tables 4-6 as the numbers in some of the groups are small meaning formal statistical analysis was not possible and the health needs are self-reported and may not indicate the need for a vaccination to a health professional. It is also important to note that there is no information available on how many clients had been offered vaccinations which may be considerably higher than the number accepting and receiving them.

[9] http://www.nhs.uk/Conditions/Hepatitis-A/Pages/Vaccination.aspx
[10] http://www.nhs.uk/Conditions/vaccinations/Pages/hepatitis-b-vaccine.aspx

Screening

Clients completing the audit were asked about their history of screening for hepatitis C, TB and HIV and figure 25 displays the responses. Again, no data is available from the national homeless audit for comparison on this question.

Figure 25. Hep C, TB and HIV screening status.



Some people who reported that they had tested positive for Hep C, TB and HIV stated that they were not offered treatment although this is not a validated finding.

TB: National Institute for Health and Clinical Excellence (NICE) guidance for the "*Clinical diagnosis and management of tuberculosis, and measures for its prevention and control*" state that:

> *Active case finding should be carried out among street homeless people (including those using direct access hostels for the homeless) by chest X-ray screening on an opportunistic and/or symptomatic basis. Simple incentives for attending, such as hot drinks and snacks, should be considered.*

Only 67 (22%) respondents stated that they had ever been tested for TB which may suggest that this guideline is not being implemented fully in Brighton & Hove. However it should be noted that none of the hostels in the audit are open access and the sample included people living in supported accommodation which are not included under these guidelines.

Hepatitis C: NICE guidelines recommend testing for hepatitis C for anyone who has ever injected drugs and anyone living in a hostel for the homeless or sleeping on the streets.[11] Table 7 gives the proportion of clients tested for hepatitis C in these groups in the audit sample and suggests that while testing

[11] http://publications.nice.org.uk/hepatitis-b-and-c-ways-to-promote-and-offer-testing-to-people-at-increased-risk-of-infection-ph43/recommendations#whose-health-will-benefit

of IDUs is quite high, those in hostels and rough sleeping are not being routinely tested.

Table 7. Proportion tested for hepatitis C			
Testing group	**% tested**	**Count**	**Total**
Injecting drug user	78%	14	18
Rough sleepers and hostel dwellers	44%	62	142
All respondents	37%	112	302

HIV: The British HIV Association (BHIVA) guidelines for HIV testing[12] recommend offering testing to all patients reporting a history of injecting drug use. Out of the 18 IDUs in the sample, 12 had been tested for HIV (67%).

Again it is important to note that there is no information available on how many clients had been offered testing for these infections which may be considerably higher than the number accepting and receiving them.

Sexual health: Clients were asked if they had had a sexual health check in the last 12 months and 34% of 274 clients who answered the question stated that they had. Female clients were also asked whether they had received a cervical smear in the last three years and 23 out of 65 (35%) women in the sample stated that they had had a smear test.

Key Points

- Despite higher vaccination rates in key risk groups for flu, hepatitis A and B than the sample as a whole, 50% or more of the clients in these risk groups were unvaccinated.
- Some people who reported that they had tested positive for Hep C, TB and HIV stated that they were not offered treatment although this is not a validated finding.
- Only 22% of the sample reported that they had been tested for TB.
- The proportion of IDUs who had been tested for hepatitis C and HIV was high at 67% and 78% respectively but this still means that substantial numbers had not been tested.

Recommendations

1. Ensure all homeless people in risk groups are offered the appropriate vaccinations and screening tests. Consider providing these at drop-in sessions where health assessments are conducted. This is particularly important for TB which all rough sleepers and open access hostel dwellers should be offered testing for.
2. Ensure that local pathways for TB, HIV and hepatitis C are working effectively.

[12] http://www.bhiva.org/documents/Guidelines/Testing/GlinesHIVTest08.pdf

Summary of recommendations

The following recommendations have been made throughout the document.

Section 2: Access to health services

1. Target interventions to increase rates of registration with GPs and dentists at services with the lowest levels.

2. Increase rates of dental registration and consider evidence and recommendations from recent Pathway research in addition to this audit to improve access to dental services for the homeless population.

3. NHS commissioners to provide advice to GPs to ensure that homeless people have equitable access to primary care (including advice on photo ID).

4. NHS commissioners to consider the evidence that discharge planning is working relatively effectively (probably as a result of the Pathway service) in the development of future services. Consider how this can be improved further.

5. NHS commissioners and Brighton & Sussex University Hospitals NHS Trust to consider the proportion of A&E visits by homeless people that are genuinely required and whether service redesign could reduce inappropriate use of hospital services.

Section 3: Health behaviours

1. Review provision of Stop Smoking Services for the homeless population in Brighton & Hove. All smokers should be encouraged and offered support to quit.

2. Ensure homeless people are included in healthy eating and physical activity programmes and that they are meeting their needs.

3. Target these health promotion programmes at services identified with the highest levels of need to achieve maximum impact.

4. Providers and commissioners to note the findings of low levels of exercise and poor diet relating to fruit and vegetable consumption and eating two meals a day, and ensure these are prioritised.

Section 4: Health and wellbeing

1. Work with homeless health services in the City to ensure they are meeting the physical and mental health needs of the homeless population.

2. Ensure training for staff in hostels and other homeless services in identifying mental and physical health needs and signposting to appropriate services.

3. Investigate whether current projects are addressing the high levels of physical and mental health needs in the LGB homeless population.

Section 5: Substance misuse

1. Share audit findings with the local Drug and Alcohol service commissioners and the Drug and Alcohol Action Team (DAAT) for their consideration to support re-commissioning.

2. Ensure provision of stop smoking services for the homeless population adequately incorporates cannabis use in addition to regular cigarettes.

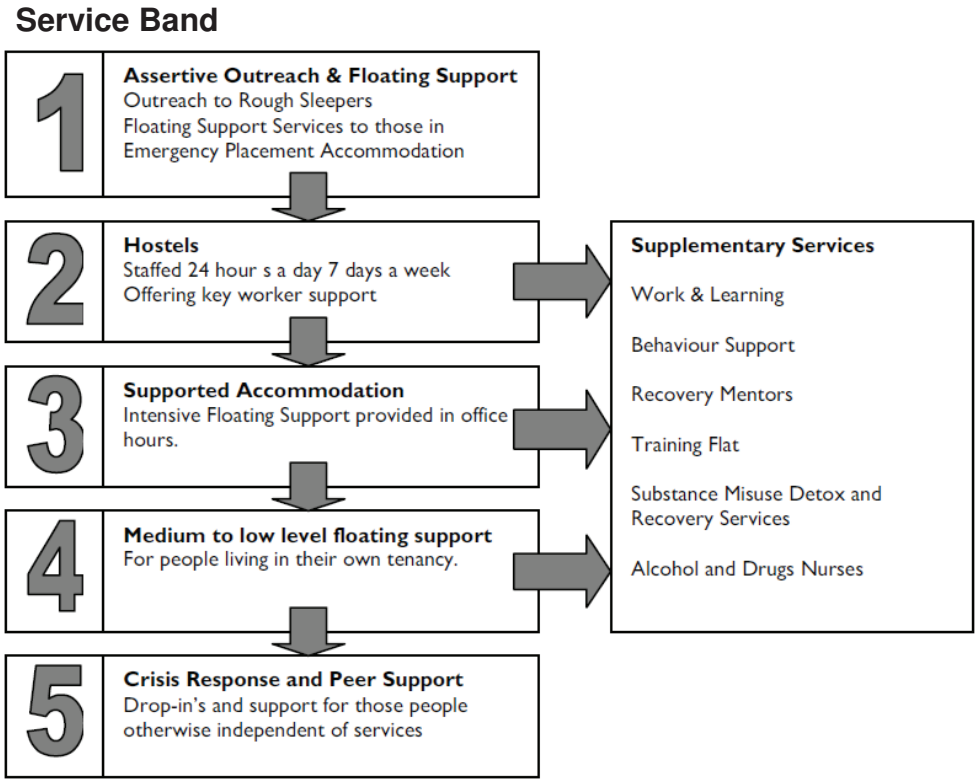
3. There was a good level of awareness of local needle exchange services among injecting drug users (IDUs) and relevant services should ensure this is maintained.

Section 6: Screening and immunisations

1. Ensure all homeless people in risk groups are offered the appropriate vaccinations and screening tests. Consider providing these at drop-in sessions where health assessments are conducted. This is particularly important for TB which all rough sleepers and open access hostel dwellers should be offered testing for.

2. Ensure that local pathways for TB, HIV and hepatitis C are working effectively.

Appendix 1. *Integrated support pathway*



Appendix 2. *Comparison of audit sample with service user statistics*

Table 8. Demographics of audit sample and band 1, 2 and 3 service users for 2011/12.

	Band 1 services		Band 2 services		Band 3 services	
	Audit sample	**2013 needs assessment figures***	**Audit sample**	**2013 needs assessment figures**	**Audit sample**	**2013 needs assessment figures**
Age						
16-17	--	--	3%	0%	0%	0%
18-25	--	--	17%	22%	18%	26%
26-34**	--	--	22%	24%	21%	20%
35-44**	--	--	32%	32%	32%	33%
45-64**	--	--	24%	21%	29%	21%
65+**	--	--	2%	1%	4%	0%
Ethnicity						
White British	--	--	82%	85%	79%	82%
BME	--	--	18%	15%	21%	18%
Gender						
Male	85%	89%	82%	83%	74%	80%
Female	15%	11%	18%	17%	26%	20%
Sexuality						
Heterosexual	88%	76%	83%	79%	90%	83%
LGB	8%	7%	14%	9%	8%	5%
Unsure / no answer	4%	17%	3%	12%	2%	12%

* Figures given for band 1 services are First Base Day Centre user statistics

** Caution is required when comparing age distributions due to different age bands used in the Homeless Audit questionnaire. Age bands are different by 1 year.

Appendix 3. *Subgroup analysis results tables*
Chi Squared tests were used to determine if each subgroup result is significantly different from the rest of the sample who answered the relevant questions. Not every client answered each question meaning the total varies. All results are based on statistical significance with a 95% confidence level. Results of these significance tests are denoted by:

- SigHigh: significantly higher than the rest of the sample
- NS: not significantly different to the rest of the sample
- SigLow: significantly lower than the rest of the sample

Table A1. *A&E use in the last six months by population group*

	% used A&E	Count	Total	Significance
Ethnicity				
White British	43%	84	196	NS
BME	30%	20	67	NS
Gender				
Male	37%	78	212	NS
Female	48%	30	62	NS
Age group				
16-25	46%	28	61	NS
26-45	51%	56	110	NS
46+	29%	25	85	SigLow
Sexual orientation				
Heterosexual	34%	84	244	NS
Lesbian, gay, bisexual	49%	17	35	NS
All respondents	**39%**	**110**	**280**	**--**

***Table A2**. Admitted to hospital in the last six months by population group*				
	% admitted to hospital	**Count**	**Total**	**Significance**
Ethnicity				
White British	24%	51	212	NS
BME	21%	15	72	NS
Gender				
Male	24%	54	228	NS
Female	24%	16	66	NS
Age group				
16-25	19%	12	64	NS
26-45	30%	42	142	SigHigh
46+	17%	16	90	NS
Sexual orientation				
Heterosexual	23%	56	244	NS
Lesbian, gay, bisexual	31%	11	35	NS
All respondents	**25%**	**70**	**283**	**--**

Table A3. *Used an ambulance in the last six months by population group*				
	% used ambulance	**Count**	**Total**	**Significance**
Ethnicity				
White British	26%	56	212	NS
BME	19%	14	72	NS
Gender				
Male	21%	48	228	SigLow
Female	36%	24	66	SigHigh
Age group				
16-25	28%	18	64	NS
26-45	27%	39	142	NS
46+	18%	16	90	NS
Sexual orientation				
Heterosexual	25%	60	244	NS
Lesbian, gay, bisexual	26%	9	35	NS
All respondents	**26%**	**73**	**276**	**--**

Table A4. *Eat two meals a day by population group*				
	% eat 2 meals	**Count**	**Total**	**Significance**
Ethnicity				
White British	58%	124	212	NS
BME	66%	57	87	NS
Gender				
Male	60%	137	228	NS
Female	62%	41	66	NS
Age group				
16-25	53%	34	64	NS
26-45	58%	82	142	NS
46+	70%	63	90	NS
Sexual orientation				
Heterosexual	61%	149	244	NS
Lesbian, gay, bisexual	54%	19	35	NS
Accommodation status				
Rough sleeping	56%	18	32	NS
Hostel	56%	71	126	NS
Supported accommodation	64%	59	92	NS
All respondents	**64%**	**183**	**285**	**--**

Table A5. *Current smoker by population group*				
	% smoke	**Count**	**Total**	**Significance**
Ethnicity				
White British	76%	162	212	SigHigh
BME	63%	55	87	SigLow
Gender				
Male	74%	169	228	NS
Female	64%	42	66	NS
Age group				
16-25	64%	41	64	NS
26-45	75%	106	142	NS
46+	74%	67	90	NS
Sexual orientation				
Heterosexual	74%	180	244	NS
Lesbian, gay, bisexual	69%	24	35	NS
Accommodation status				
Rough sleeping	69%	22	32	NS
Hostel	80%	101	126	SigHigh
Supported accommodation	71%	65	92	NS
All respondents	**73%**	**219**	**299**	**--**

***Table A6**. At least one physical health problem by population group*				
	% have a physical health problem	**Count**	**Total**	**Significance**
Ethnicity				
White British	83%	176	212	NS
BME	80%	70	87	NS
Gender				
Male	80%	183	228	NS
Female	88%	58	66	NS
Age group				
16-25	71%	47	66	SigLow
26-45	81%	115	142	NS
46+	89%	80	90	SigHigh
Sexual orientation				
Heterosexual	81%	197	244	NS
Lesbian, gay, bisexual	94%	33	35	SigHigh
Accommodation status				
Rough sleeping	84%	27	32	NS
Hostel	83%	105	126	NS
Supported accommodation	88%	81	92	NS
All respondents	**84%**	**248**	**297**	**--**

Table A7. Diagnosed mental health condition by population group				
	% have a mental health problem	**Count**	**Total**	**Significance**
Ethnicity				
White British	50%	106	212	NS
BME	52%	45	87	NS
Gender				
Male	51%	117	228	NS
Female	50%	33	66	NS
Age group				
16-25	28%	18	64	SigLow
26-45	61%	86	142	SigHigh
46+	50%	45	90	NS
Sexual orientation				
Heterosexual	49%	119	244	NS
Lesbian, gay, bisexual	69%	24	35	SigHigh
Accommodation status				
Rough sleeping	38%	12	32	NS
Hostel	58%	73	126	SigHigh
Supported accommodation	50%	46	92	NS
All respondents	**53%**	**153**	**287**	**--**

***Table A8**. Take drugs or recovering from a drug problem by population group*				
	% take drugs/ recovering	**Count**	**Total**	**Significance**
Ethnicity				
White British	43%	91	212	SigHigh
BME	25%	22	87	SigLow
Gender				
Male	39%	90	228	NS
Female	30%	20	66	NS
Age group				
16-25	45%	29	64	NS
26-45	43%	61	142	NS
46+	23%	21	90	SigLow
Sexual orientation				
Heterosexual	39%	94	244	NS
Lesbian, gay, bisexual	37%	13	35	NS
Accommodation status				
Rough sleeping	28%	9	32	NS
Hostel	48%	61	126	SigHigh
Supported accommodation	29%	27	92	SigLow
All respondents	**40%**	**114**	**284**	**--**

***Table A9**. Drink more than 4 times per week by population group*				
	% drink 4 times or more	**Count**	**Total**	**Significance**
Ethnicity				
White British	26%	55	212	NS
BME	23%	20	87	NS
Gender				
Male	27%	62	228	NS
Female	17%	11	66	NS
Age group				
16-25	8%	5	64	SigLow
26-45	31%	44	142	SigHigh
46+	29%	26	90	NS
Sexual orientation				
Heterosexual	27%	66	244	NS
Lesbian, gay, bisexual	14%	5	35	NS
Accommodation status				
Rough sleeping	28%	9	32	NS
Hostel	30%	38	126	NS
Supported accommodation	23%	21	92	NS
All respondents	**26%**	**75**	**288**	**--**

Appendix 4. *Breakdown of figures by individual service*

Services with 10 or more clients providing responses were included in these analyses.

Proportion of clients registered permanently with a GP by service		
Relative position	**Service**	**% permanently registered with a GP**
Highest	Brighton Housing Trust RSI	100%
	Fred Emery Court	100%
	Phase One Hostel	100%
	West Pier	100%
	William Collier House	93%
	George Williams Mews	92%
	Glenwood Lodge	89%
	Housing Support Service*	89%
	Stanley Court	88%
Average	**Brighton & Hove**	**85%**
	St Patrick's Hostel	75%
	First Base Day Centre	67%
Lowest	Rough Sleeper Team	50%

Proportion of clients registered with a dentist by service (temporarily or permanently)		
Relative position	**Service**	**% registered with a dentist**
Highest	Fred Emery Court	64%
	Brighton Housing Trust RSI	63%
	George Williams Mews	55%
	William Collier House	46%
Average	**Brighton & Hove**	**45%**
	Stanley Court	41%
	Rough Sleeper Team	38%
	Housing Support Service	30%
	Phase One Hostel	29%
	St Patrick's Hostel	25%
	Glenwood Lodge	22%
Lowest	First Base Day Centre	15%

Proportion of clients currently smoking		
Relative position	**Service**	**% currently smoke**
Highest	Glenwood Lodge	95%
	Phase One Hostel	95%
	William Collier House	83%
	West Pier Hostel	81%
	Rough Sleeper Team	81%
	St Patrick's Hostel	77%
	Stanley Court	76%
	George Williams Mews	75%
Average	**Brighton & Hove**	**73%**
	Brighton Housing Trust RSI	67%
	Fred Emery Court	64%
	First Base Day Centre	61%
Lowest	Housing Support Service	54%

Proportion of clients exercising two times a week		
Relative position	**Service**	**% exercising twice a week**
Highest	Rough Sleeper Team	80%
	William Collier House	67%
	Brighton Housing Trust RSI	67%
	Stanley Court	53%
Average	**Brighton & Hove**	**51%**
	George Williams Centre	50%
	Fred Emery Court	43%
	West Pier Hostel	40%
	First Base Day Centre	35%
	Phase One Hostel	35%
	St Patrick's Hostel	31%
	Housing Support Service	24%
Lowest	Glenwood Lodge	18%

Proportion of clients reporting a physical health need		
Relative position	**Service**	**% reporting a physical health need**
Highest	Phase One Hostel	100%
	First Base Day Centre	94%
	Fred Emery Court	93%
	St Patrick's Hostel	92%
	West Pier Hostel	91%
	Stanley Court	88%
Average	**Brighton & Hove**	**84%**
	Glenwood Lodge	79%
	William Collier House	76%
	Housing Support Service	75%
	George Williams Mews	75%
	Rough Sleeper Team	69%
Lowest	Brighton Housing Trust RSI	44%

* Housing Support Service is a Brighton & Hove City Council team supporting vulnerable people in emergency placement (B&B) accommodation.

Appendix 5. *Full list of homeless services recorded as participating in the audit*

Service
Brighton Housing Trust - Rough Sleeper Initiative
Brighton YMCA - George Williams Centre
Brighton YMCA - William Collier House
Chris Batten House
Clock Tower Sanctuary
Eaton Place
First Base Day Centre
Fred Emery Court
Friends First Supported House
Gareth Stacey House
Glenwood Lodge (BHCC)
Goldstone Villas
Housing Support Service
Justlife
Leslie Best House
New Steine Mews Hostel
Peer 2 Peer
Phase One Hostel
Rough Sleeper Team
Southdown Housing Association
St Patricks Hostel
Stanley Court
Stopover Supported Housing
Sussex Central YMCA
West Pier project
YMCA Lansworth House