Hastings Homeless Service
End of Year Report 2020

Improving access to health care and support for homeless and vulnerably housed people

CONTENTS

INTRODUCTION

"If the founding principles of what we're doing and the values are right, we're not frightened to fail."[1]

The effects of the Covid-19 pandemic on mental health and routine healthcare are well known, with many people experiencing intense feelings of isolation and/or unable to access the healthcare they need.

For those who are homeless or have multiple complex needs, these challenges are potentially lethal.

The above quote from the 2020 King's Fund report, Delivering health and care for people who sleep rough speaks of the innovation and freedom to break new ground which so often defines services that effectively meet the needs of homeless people and those with complex needs.

The Hastings Homeless Service is no exception, as we responded to the pandemic with major service adaptations in line with our long-held ethos of flexibility and accessibility.

This report describes the steps we took in 2020, including a shift to mobile outreach and remote health-related support, to ensure that the physical and mental health needs of those experiencing homelessness, exclusion from mainstream healthcare and/or social isolation due to Covid restrictions were effectively met.

Our Service User Survey, undertaken in the Autumn, is also summarised here. The survey responses, which were even more positive than in previous years, threw a spotlight on the appreciation clients have for the service precisely because of its accessibility and friendliness.

Despite the challenges thrown at service users and services alike, this report demonstrates the incredible resilience of our clients, with some remarkable case studies of recovery and health improvements seen during this *annus horribilis*.

Writing this report has been an opportunity for my own personal reflection on 2020 and fills me with pride for both our team and service users.

Roger Nuttall
Nurse Co-ordinator

[1] Delivering health and care for people who sleep rough (King's Fund, 2020)

HASTINGS HOMELESS SERVICE: OVERVIEW

St John Ambulance Homeless Services – Mission Statement:

"To provide an accessible, holistic and continuous, person-centred, primary and urgent health care service, in order to promote the health and wellbeing of homeless and vulnerable communities."

The above mission statement was created in September 2020 at a meeting of volunteers and staff from St John Ambulance (SJA)'s homeless services across the country.

In exciting developments of recent years, SJA has adopted a new community focus and is establishing new homeless services in a number of regions across England.

The Hastings Homeless Service (HHS) was established in 2003, as one of three arms of St John Ambulance Sussex Homeless Service. Further information about the Brighton Homeless Service and the Homeless Training Service can be obtained through the contacts listed at the end of this report.

Homeless Service provision in Hastings & St Leonards includes:

- Accessible, person-centred, nurse-led, primary healthcare for homeless and vulnerably housed people and those with complex needs, who often find the normal difficulties associated with accessing mainstream healthcare systems considerably exacerbated by their circumstances and needs;
- Advocacy and support to help clients access mainstream health, housing and other services;
- A non-judgmental, empathic service that promotes hope and motivation through social support and active listening, and that recognises the value of treating people holistically, dealing with health, housing and other life issues together rather than in isolation: often achieved through close multi-agency working;
- Taking every opportunity for proactive health promotion within healthcare consultations;
- Close partnership working with a wide range of statutory and voluntary agencies, many of whom are named at the end of this report.

"Without SJA I would be dead. Their emotional support has saved my life."

From Service User Survey 2020

SERVICE CHANGES 2020

Along with businesses and agencies everywhere, the Hastings Homeless Service (HHS) has had to radically change its *modus operandi* in response to the pandemic.

Mobile clinics

While our longstanding partnership with Seaview remains a strong and vital asset to the service, we have been unable to operate out of their Southwater Road premises for most of the year due to their Covid risk assessments. Previously we were running 4 clinics / week in the treatment-room there.

However, in early 2020, as a result of long-term efforts to secure an outreach vehicle, we finally took possession of a mobile treatment centre, which was swiftly put into action as a wound care clinic for the clients we had been seeing regularly for leg ulcer care.

The service then rapidly received referrals for other homeless or ex-homeless clients with leg ulcers who had disengaged with services and/or who had found GP services even harder to access than usual due to Covid-19 restrictions.

We quickly developed into a roving health outreach service, going to people where they are: whether to rough sleepers at their sleep sites or to other vulnerable individuals at locations suitable for them, while also parking outside Seaview for ad hoc consultations as needed (with all appropriate Covid screening measures and precautions in place).

Case Study (name changed):

Jack was referred by A&E after a suicide attempt, was still rough sleeping despite “Everyone In” measures, and hadn’t seen a nurse or GP for at least two years, despite having chronic bilateral leg ulcers.

The Hastings Homeless Service took the vehicle to Jack twice/week to dress his ulcers. He engaged well, was enabled to build a good rapport with the team, and as a result we were able to link him in with housing and substance misuse services. He settled into temporary accommodation, his mental health improved and he achieved his goal of going back on to a methadone script instead of using heroin.

Jack continues to be seen regularly by the service, the leg ulcers are healing well, and he is being supported with longer-term goals.

By adopting a proactive, innovative and person-centred approach, a turnaround from complete disengagement to full engagement with services was achieved, with the client’s own goals being successfully attained.

At time of writing (March 2021), Jack has recently moved into permanent housing, his mental and physical health have vastly improved, and he is aiming to enter rehab.

"*The service has been brilliant. You listen to what people say, and if you say you're going to do something, you do it. The support has been brilliant*." (Jack)

Saturday evening outreach sessions with the vehicle parked outside Hope Kitchen took place on a number of occasions, but have been limited both by depleted volunteer availability and the restrictions on Hope Kitchen itself.

Weekday sessions have been every Tuesday and Friday, and alternate Thursdays, with a nurse at every session. Specialist foot care is provided on Tuesdays by the Service Podiatrist, Christine Bolt, and on alternate Thursdays by Judith Wynn, Volunteer Nurse with extended foot care qualifications.

The mobile approach was found to add a significant extra dimension to our existing person-centred ethos, enabling the service to develop from a mainly static one into an assertive outreach service with even greater flexibility and accessibility.

While we look forward to returning to our treatment-room with the space, light and equipment that it affords, we will also continue to maximise this new outreach element of the service.

Despite the many terrible effects of the pandemic, this is a positive development that has emerged from it all.

Remote support

The other major change for the service was a move to remote support provision. In anticipation of the first lockdown, we updated phone numbers for as many clients as possible and offered them regular telephone support. Many accepted this offer, while others declined, positively asserting their independence.

For those who did accept support, two of the team's volunteers, Claire Finn (General Support Volunteer) and Sandy Collver (Volunteer Lead Nurse), took on this role, with some ongoing advocacy, healthcare consultations and prescribing also being provided remotely by Roger Nuttall.

Sandy and Claire have shaped the role into an invaluable, deeply empathic and holistic service that clients prize highly, as so much of the social interaction and other support that they valued was stripped away by Covid, leaving many in an awful state of physical, psychological and social isolation.

Volunteers and clients alike have found that this new service has facilitated a new depth of interaction and support, with some amazing recovery outcomes being seen, as in the case study on page 6.

Again, this new initiative born out of the pandemic struggles has proven to be a positive learning experience which is likely to continue in some form long after Covid restrictions have ended.

Street Sheet

From May, following discussion with Public Health East Sussex in response to the constant, rapid changes across local services, we started to collate updates from local agencies and disseminate a weekly update as an extension of our normal (twice-yearly) Street Sheet production.

This has been very well received and has now moved to an ad hoc basis, as the pace of change to local service provisions has slowed down.

REFLECTIVE ACCOUNT ON PROVIDING REMOTE SUPPORT

The following account of providing telephone support to homeless clients has been written by Sandy Collver, Volunteer Lead Nurse with St John Ambulance Hastings Homeless Service:

As a Nurse Practitioner, I am accustomed to examining and treating clients by hands-on examinations and by listening to them face-to-face. All good, until COVID-19 steamrolled its way into all of our lives. As I am shielding a relative at home, I was unable to see people face-to-face in the usual manner. However, I realised from the beginning there was so much support that was needed to help people live through the present public health crisis that could be done by other methods, primarily over the phone or by talking face to face at a socially distant space out of doors.

A colleague and I drew up a list, with our manager Roger Nuttall, of people we felt needed telephone support. Some people we talked to surprised us and needed little support. People who have lived and survived on the streets and had traumatic pasts often show remarkable resiliency – a fact that always amazes me. Others that seemed to be coping well often were not. It was this dedicated phone support that brought some of those needs to the surface. Unlike a shorter clinic session where often there can be interruptions for emergencies, phones ringing or people knocking on the door asking for help, this was dedicated time with no interruptions and truly dedicated patient centred care. A much more holistic service.

Many books have been written on the mind / body connection and holistic care. I interpret that type of care as one where we must explore with the client all of the factors that influence getting them to a better place in their lives. Sometimes that means sorting out a purely physical complaint, other times it is one of providing mental health support, and more often it is both. Holistic care requires us to dig a bit deeper into the hows and whys of patient concordance. Often the time to investigate all of the reasons that block a person's road to recovery cannot be fully realised in a clinic appointment. By giving people a safe space in which to talk about anything that is on their mind empowers them to seek out solutions. It increases behavioural concordance and when that happens, we see more positive outcomes.

One of our clients, who I will call Jill, lived in a terrible run-down rented room. It was infested with bedbugs, causing her to seek out our clinic for a face-to-face appointment for treatment of the bug bites. Our manager, who has continued to run a mobile treatment centre throughout this pandemic, saw the client there and treated her with a prescription for creams to alleviate the bites she had sustained. The housing officer at Seaview (the local charity we work in partnership with) together with the Council helped Jill secure better accommodation.

But in the in-between period, before moving to better accommodation, Jill needed mental health support to deal with her depression exacerbated by lockdown and the terrible living conditions, as well as monitoring of her skin complaint. All of this left her with feelings of despair especially during the first (full) lockdown period. I contacted her and she readily requested weekly telephone support to help her cope with her current situation.

Jill has now moved into more suitable accommodation, which has lifted her spirits substantially. She still requests a weekly session with me to have a chat and discuss her week and how it has gone. She also has asked advice about an orthopaedic complaint. I referred her to one of our volunteers who is a physiotherapist and saw her in the mobile treatment centre for an assessment. Jill will also be seeing an orthopaedic consultant in future.

All the while the continuous thread running through this is that she can give me a call at any time when she feels she needs to get advice or have a chat. Often our clients describe our service as a *lifeline* and are most appreciative that this has been made available during the pandemic.

I am not sure that this type of service will come to an end when COVID-19 disappears one day as it has proved so successful in supporting people in a very person-centred, dedicated manner. It is a client's "me time."

Their time to talk freely about any and all issues that concern them, physical, mental, even spiritual. Whatever is on their mind.

Sandy with her 500 hours certificate
(over 500 hours volunteered in 2019)

Case Study (name changed):

Seb (not his real name) is a man in his 50s with a long history of injecting drug use and a background that includes both childhood and adult trauma, as is often the case for Homeless Service clients.

Seb has been supported by Claire, chiefly by phone, throughout the pandemic, following on from an effective rapport built between him and the Hastings Homeless Service team previously. Although known to the service for several years, Seb started to open up to the team about a number of complex psychological, social and physical health issues that he was experiencing towards the end of 2019.

During 2020 Seb made some incredible, positive strides forwards in his recovery journey, which at time of writing (March 2021) continue to progress:

- he successfully reduced his drug use without specialist support (which he declined), until finally attaining his goal of abstinence;
- completed Hepatitis C treatment;
- re-initiated contact with his GP to address his mental health, and consequently restarted antidepressants, in order to support his recovery from substance use;
- has proactively improved his nutritional intake (a vital factor in the recovery journey);
- made real progress in coming to terms with deep-seated family issues.

Seb periodically received antibiotic prescriptions from the Service's nurse prescriber for injecting-related skin infections, but these problems became few and far between as his drug use reduced, and have now stopped with his abstinence.

Such remarkable progress is testament to the flexible, whole-person ethos of the service, expressed to a new depth through the remote support provision given by Claire and Sandy.

Seb is adamant that he would not have survived this long without this support, as he summed up here:

"*The caring support I have been getting from St Johns has been fantastic. I cannot thank them enough. And that's from the heart. If it hadn't have been for Sandy at the start, and then Claire, I wouldn't be here*."

Claire comments: "*Just shows what can happen when you can afford someone time and a safe holding space in which to chat*."

VOLUNTEERS AND STAFFING

Volunteers

As Covid guidance was released, many volunteers had to shield due to their own health conditions or of others in their households.

Some team members have had to take a complete break from the service, while others have been able to provide remote support from home, and others still have continued to provide face-to-face care and support with the new mobile service.

We are very grateful to all who have been able to continue volunteering in one form or another, while completely understanding that this has not been possible for many others.

A few new volunteers were recruited during the year. We are indebted to new volunteers Pierluigi Vullo and Christine Catt who conducted our annual Service User Survey in Nov/Dec 2020, and to Pierluigi for compiling such an informative, thoughtful and high-quality report on the survey (more details later).

At the end of 2020 there were 3 active volunteer nurses and 7 general support volunteers on the Hastings Homeless Service team, with others expected to return later in 2021.

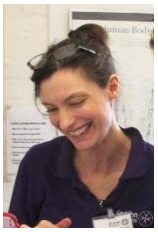
"*Please would you extend thoughts of gratitude to all, whom, at this time are braving it on the frontline in order to be able to continue providing a vital service to all of us – tis much appreciated. You are all amazing!! THANK YOU ALL!*"

Received by text from a client who was being supported with healthcare, prescribing and advocacy in person prior to the pandemic and continued to receive the same support remotely after the start of the first lockdown.

Staff

Sharon Agnew has been in post as Sussex Homeless Service Manager since January 2019.

The day-to-day running of the Hastings Homeless Service has been managed by Nurse Co-ordinator, Roger Nuttall, since its launch in 2004.



Nancy Jones left her role as staff Podiatrist with the Hastings Homeless Service in September 2020.

Christine Bolt, Brighton Homeless Service Podiatrist, extended her hours from October 2020 to join the Hastings Homeless Service team and now works every Tuesday with us.

Sophia Reeks has been the Hastings Homeless Service Administrator since April 2019.

“WHAT WE DO BEST”

There have been two opportunities in particular this year to reflect on what we do especially well: the Hastings Homeless Service’s annual Service User Survey; and discussions between the Sussex Homeless Service and the wider organisation about SJA’s plans to roll out new homeless services across the country.

The survey, which for the first time was carried out entirely by phone, elicited glowing responses that were possibly even more positive than in previous years. This is testament to the whole team’s ability to adapt and respond to changing needs of clients and services, particularly during the pandemic when people have been in even greater need of empathic, accessible support than ever before.

The survey concludes with the following **Key Benefits** of the service:

- Continued care: Three quarters of clients access HHS multiple times in a year, with more than 50% visiting its premises on a monthly or weekly basis.

- Podiatry and General Help: Footcare is reported as the most widely used service among its users, whilst general support and advice is the single most common reason for visiting our premises.

- Improved lifestyle: The benefits to our clients’ health are also observed in an improvement of their lifestyle across several areas, including footcare, mental health, alcohol and drug use and the ability to access other services independently.

- Friendliness: A friendly, non-judgemental and understanding environment was mentioned by 100% of the participants of this study when describing their experiences with HHS staff.

- Emotional Support: The practical help seems to go hand in hand with the emotional support which they receive from our staff. It is worth mentioning that several participants broke down in tears during their interview, highlighting the need for an empathic and understanding rapport when liaising with our clients.

Other conclusions of the survey include the following points on **Accessibility and Pandemic**:

- Access: In terms of accessibility, almost two thirds of respondents mentioned ease of access as the primary advantage of HHS, citing the absence of long waiting lists as well as the lack of complex bureaucratic forms as the main benefits.

- Location: Almost 60% mentioned the central and easy to reach locations of HHS premises as a real plus point and more than 75% cited the friendly and understanding attitude of our staff as a prime motivator to keep using us.

- COVID-19: Unsurprisingly, nearly 75% of respondents reported a negative impact of the pandemic to their mental health with several of them expressing real fears of catching the virus. Most respondents reported social isolation and inability to access support services as a direct consequence of the pandemic.

The full survey report, which can be accessed here provided us with invaluable qualitative data that will inform and reinforce our own service provision and help to guide the formation of new SJA homeless services.

In our 2019 End of Year Report we reported on new pilot sessions with CGL/STAR (the local substance misuse service) and with Surviving the Streets (STSUK), which continued into early 2020.

Although Covid then changed all potential plans, both pilots helped pave the way for the direction of the service over the rest of the year.

The trial outreach sessions with STSUK formed part of a needs assessment that helped inform the way in which we conducted health-related outreach once we had received the mobile treatment centre: for example adopting an informal and gentle approach, slowly and carefully building rapport with new clients.

L-R: Amanda Rudnick, Roger Nuttall (with cheque from Asda) and Ann Love

Although it was no longer possible to deliver clinics on CGL's premises at Thrift House due to Covid, our relationship with the service has continued to grow, with the majority of referrals in 2020 being received from CGL/STAR (with other referrals coming principally from Seaview, Conquest A&E and Adult Social Care).

The nature of referrals received, the survey responses and the discussions around extending SJA homeless services all helped us to distil the Hastings Homeless Service's unique contribution to local service provision, or "what we do best."

It can be summed up in two statements, the first of which is:

Delivering holistic healthcare to people with multiple complex needs including unmet physical health needs, and re-engaging them with services.

In other words, it is not so important whether clients are homeless or not (although many are homeless, ex-homeless, in temporary accommodation or vulnerably housed), but what stands out is our ability to re-engage those with complex needs who had formerly disengaged with healthcare; meeting their healthcare needs; and in many cases successfully supporting them to re-engage with NHS and other services.

The survey results present a stark picture of the difficulties encountered by vulnerable people in trying to access mainstream health services and their contrasting experience with the Hastings Homeless Service, with self-reported outcomes ranging from "*They helped me get off the street, so I am no longer homeless*" and "*I stopped drinking*" to "*They literally saved my life."*

The other facet of our unique contribution as a service pertains not so much to the Hastings service alone but to its role within the wider Sussex Homeless Service.

Together with the Homeless Training Service, we provide a complete "journey of care" from first aid, harm reduction and first aid training for service users, through primary healthcare, to whole-person recovery and reintegration.

In the service's earlier years, it could be said that we took a holistic approach in order to attain better physical health outcomes (e.g. wound healing), whereas now we are more interested in whole person recovery, of which physical health goals are seen as just one part.

This subtle shift in emphasis can be attributed to our ongoing learning and development as a whole team, with the adoption of important evidence-based principles such as inclusion health and trauma-informed care, and can be seen in some of the case studies and survey responses detailed in this report.

The complete "journey of care" described means that, for some, we are available for simple first aid or primary care, such as footcare or general health advice, while for others, these physical treatments will form part of a raft of long-term support and care towards whole-person recovery.

> *"I am humbled by their dedication. Their integrity is beyond anything. They are lifesavers and if I won the Lottery, I would give the money to them as they are truly wonderful people*."
>
> From Service User Survey 2020

CLIENT INTERACTION STATISTICS

During 2020 the Hastings Homeless Service had 1195 client interactions, including face-to-face and remote contacts: an unsurprising reduction by 20% on 2019.

Over each of the last few months of the year, remote contacts comprised about half of all client interactions, as this form of support and advocacy became a growing part of the service.

Service user demographics

Similarly to previous years, just under three-quarters of our client contacts were with men (73.4% male, 24% female, 2.5% non-binary).

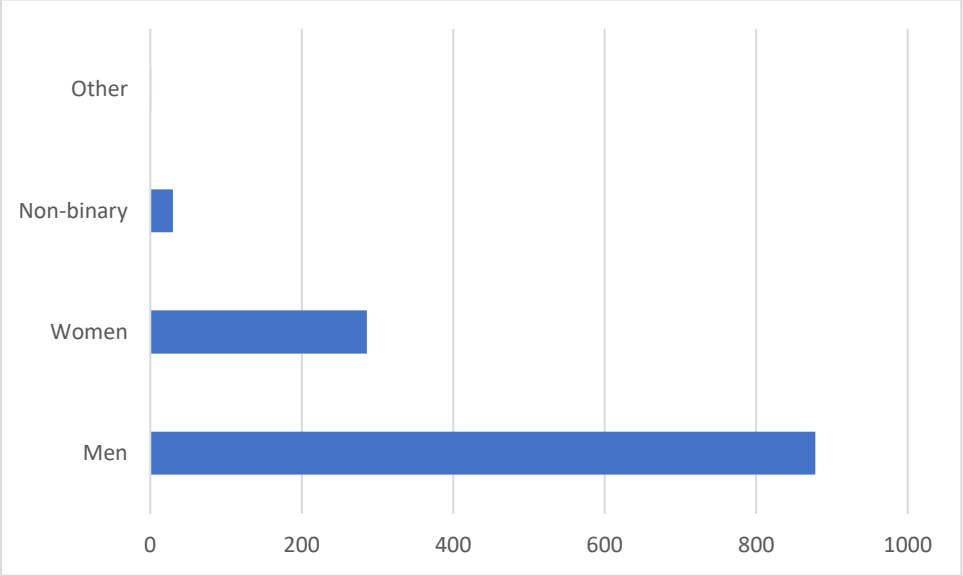


Chart 1: Gender of service users (numbers of client interactions), 2020

As in previous years, the most prevalent age groups of our service users in 2020 were 35-44 and 45-54 (31% and 28% respectively). See Chart 2.

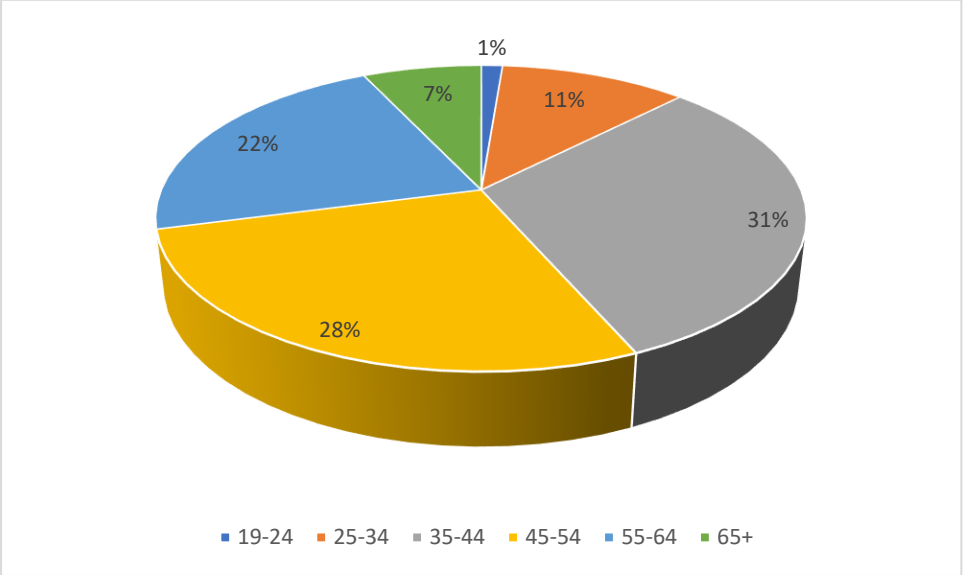


Chart 2: Age groups of service users (client contacts), 2020, by percentage

The majority of the client group identify their ethnicity as White British / Irish / Other. See Table 1 for breakdown of ethnicities.

Ethnicity	Percentage of total client contacts
White British / Irish / Other	**94.9%**
Eastern European	**2.5%**
Mixed White & Black African / Black Caribbean	**1.4%**
Middle Eastern	**0.6%**
Mixed Other	**0.3%**
Black African / Caribbean / Other	**0.2%**
Mixed White & Asian	**0.1%**
Other	**0.1%**

Table 1: Ethnicity of clients seen by HHS during 2020, by percentage

All client monitoring figures for 2020 and previous 4 years for comparison, including demographics and housing status, are given in full in the Appendix, *although it should be borne in mind that all client contact figures are reduced this year due to Covid restrictions*.

L-R: Amanda Rudnick, Ann Love, Roger Nuttall, Iain Brooke-Bennett (SJA National Community Response Lead), on Iain's visit to the service in October

Housing and homelessness

The application of the Government's "Everyone in" measures by Hastings Borough Council and the Rough Sleeping Initiative have been very effective in Hastings, with rough sleeper numbers greatly reduced.

Due to this, as well as the closure of our clinics at Seaview for much of the year, our contacts with rough sleepers were down by 39% compared with 2019.

However, we still saw 35 people who were sleeping rough when we first met them: a reduction of just 20% (although many of these would have been subsequently housed).

Tents on St Leonards seafront, Summer 2020

	2016	2017	2018	2019	2020
New contacts	52	55	51	56	35
Recurring contact	206 (+ Snowflake: 44)	358 (+ Snowflake: 38)	184 (+ Snowflake: 20)	204 (+ Snowflake: 13)	111 (+ Snowflake: 20)
Total contacts	302	451	255	273	166

Table 2: Nos. of new, recurring and total contacts with rough sleepers in 2019 (with previous 4 years for comparison)

NB: The opening of winter night shelters was prohibited at the end of 2020 by Covid. The 20 contacts with Snowflake (winter night shelter) guests referred to in the table all relate to the early part of 2020.

As in previous years, the greatest proportion of our clients are in private rented or housing association accommodation. Many of these have been homeless and/or are in poor accommodation and have many of the same complex needs that previously led them to homelessness. See Table 3 for details.

The role of the Hastings Homeless Service in supporting this broad client group complements well those services that are more directed to people experiencing street homelessness.

Year:	2016	2017	2018	2019	2020
Sleeping Out / Winter Night Shelter / Tents / Vehicle	22% (302)	29% (451)	18% (255)	19% (273)	12% (146)
Friend's Floor	10% (134)	11% (169)	8% (108)	11% (165)	6% (67)
Conquest Hospital	2% (27)	0% (0)	0% (0)	0% (0)	0% (0)
Supported Accommodation	11% (151)	5% (71)	11% (145)	9% (124)	6% (70)
B&B / Hotel	5% (72)	5% (71)	2% (31)	3% (45)	6% (75)
Squat	0% (0)	0% (0)	0% (0)	0% (0)	0% (1)
Private Rented	33% (460)	29% (456)	29% (401)	26% (378)	34% (397)
Care Home	3% (45)	2% (38)	1% (20)	1% (21)	1% (8)
Housing Association	11% (158)	14% (214)	24% (326)	26% (375)	28% (329)
Owner occupier	3% (39)	5% (77)	6% (84)	5% (65)	4% (52)
Other	0% (3)	0% (0)	0% (3)	0% (2)	0% (0)

Table 3: Housing status of clients seen in 2020 (with previous 4 years for comparison), to the nearest whole percentage (client contact numbers in brackets)

Case study (name changed):

At the start of the first lockdown, the majority of rough sleepers were given temporary accommodation through the Government's "Everyone in" measures.

Some individuals find it hard to settle within four walls; and it can be difficult for services to find appropriate accommodation for some. One of those people is Joe, a young man with the common co-morbidity of a mental health disorder and substance misuse, who continues to sleep rough.

Joe presented to the mobile clinic with what he believed to be a broken foot. He was examined by one of our general support volunteers who works professionally as a physio – in conjunction with the nurse. His foot was assessed as not fractured but having a soft tissue injury, possibly caused by an injury during his long walks. Advice and treatment were given, including follow-up advice and a prescription for oral anti-inflammatory painkillers.

Further discussion took place around the prescribing for his mental health and he was put in touch with his mental health worker, who arranged for a medication review.

This case study provides an example of the types of acute conditions that the service can assist with in caring for the physical and mental health needs of rough sleepers; the broader, opportunistic support that is often afforded by the presentation of a physical health need; and the incredible value and skill mix of a team drawn from such a variety of professional backgrounds and life experiences.

Health and care issues

All health and social care issues addressed in each client interaction are monitored, forming our monthly and annual monitoring statistics, which can be seen in full for 2020 and the previous 4 years for comparison, in the Appendix.

This year, these figures include issues addressed in both face-to-face and remote contacts.

In 2020 Mental Health and Wound Care were the health issues most frequently recorded by the service, followed by Drug Use.

The following pages give a little more detail on these three areas.

Chart 3 shows the five areas of health most commonly addressed during 2020.

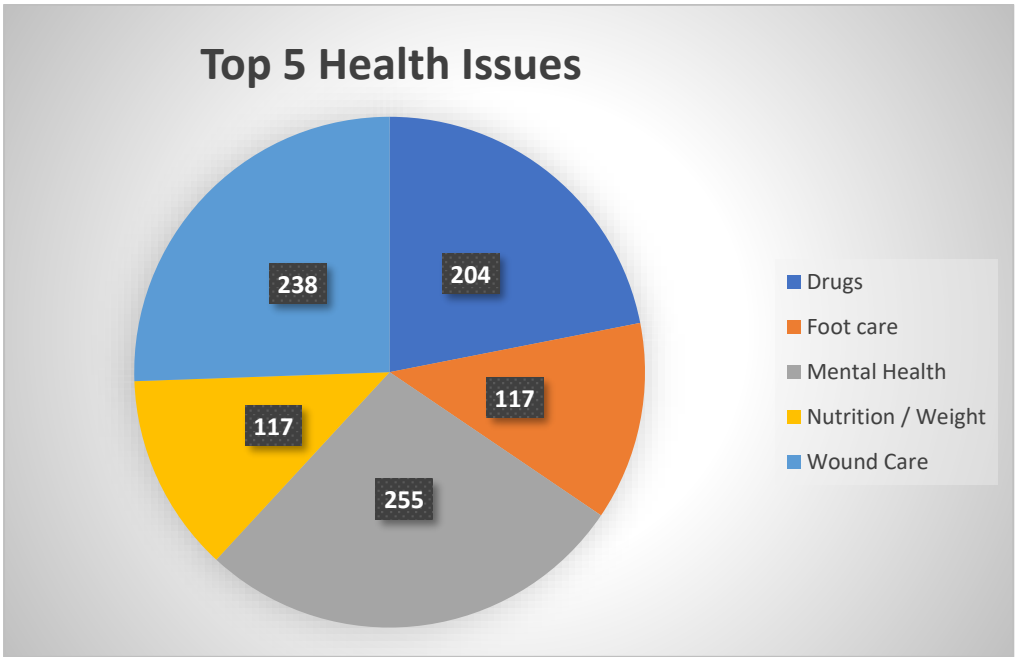


Chart 3: Five most commonly addressed health issues (with nos. of interactions), 2020

Mental health

Mental health support is sometimes the main focus of a client consultation or phone call; while at other times, psychological and emotional issues are addressed as part of a broader, holistic interaction in which a physical health complaint was the presenting issue.

In 2020, despite the big reduction in client interactions, recorded instances of mental health support were up by 63% compared with 2019, highlighting the detrimental effects of the pandemic on mental health and the significant part this element of care played in remote support provision.

It is clear from the Service User Survey results that mental health support is one of the most important, *if not the most important*, element of our service to clients.

The Survey quotes in the box below illustrate this and the effectiveness of the service's "psychologically informed" approach, defined as:

"*One that takes into account the psychological make-up – the thinking, emotions, personalities and past experience - of its participants in the way that it operates. It's an approach to supporting people out of homelessness, in particular those who have experienced complex trauma or are diagnosed with a personality disorder.*

It also considers the psychological needs of staff: developing skills and knowledge, increasing motivation, job satisfaction and resilience."[2]

> *"They are really good listeners. I have used mental health in other places but SJA is much better. I don't feel judged by them".*
>
> *"I have regular support from SJA almost every week for my depression, mental health issues, addiction and general health."*
>
> *"They helped me regain trust in people"*
>
> A selection of quotes from Service User Survey 2020

Although none of the HHS volunteers or staff are qualified mental health professionals, there is a range of mental health training and experience amongst the team, including Mental Health First Aid, suicide alertness, personality disorders and motivational interviewing. The team will refer on to more specialist mental health services whenever needed.

Wound care

Wound care, especially leg ulcer treatment, has continued to play a prominent role in Homeless Service provision, with new referrals being received during the year for leg ulcers and abscesses for people with complex needs who have been finding it harder than ever, with Covid restrictions, to access healthcare.

20% of client interactions this year were for wound care.

The mobile treatment centre has proved invaluable, offering a clinical treatment space that can be taken to a variety of locations, both for those who are homeless and others who are in temporary or permanent housing.

The case study described earlier ("Jack") highlights the importance of this facility and the holistic approach that does not simply aim for wound healing but also supports the client towards recovery from the background factors that led to the ulcer or wound.

We continue to enjoy and benefit from our working relationship with East Sussex Healthcare NHS Trust's Tissue Viability Nurse team, who provide specialist advice and support whenever needed.

[2] Creating a Psychologically Informed Environment - 2015.pdf (homeless.org.uk)

Drug use

This year's monitoring figures reveal that support around drug use featured in exactly *three times as many client contacts* than in 2019. This is largely attributable to the regular, intensive nature of the remote support that has proven to be so beneficial to service users' recovery, as exemplified in some of the case studies detailed earlier.

Two clients in particular have achieved their goal of abstinence, and we are very proud of all clients and volunteers at the heart of these successes.

To quote Claire Finn again: "*Just shows what can happen when you can afford someone time and a safe holding space in which to chat*."

Injecting drug use is a key factor in the aetiology of many of the leg ulcers and other wounds seen by the service, and again our collaborative working with CGL/STAR has been essential to the effective support given to many clients over this year.

Nurse prescribing

Prescribing is a vital element of the service, provided by Nurse Co-ordinator, Roger Nuttall, as a Nurse Independent Prescriber, through a service level agreement with East Sussex Clinical Commissioning Group (CCG).

Table 4 gives the 10 areas most frequently prescribed for during 2020.

	Areas of prescribing	No. of items
1.	**Wound care** (chiefly leg ulcer care)	143
2.	**Analgesics** (including topical and oral NSAIDs)	25
3.	**Topical skin products** (e.g. for dry/allergic skin conditions, fungal and bacterial infections, insect bites)	25
4.	**Antibiotics for wound & skin infections** (e.g. cellulitis, abscesses)	25
5.	**Flu vaccines**	23
6.	**Nutritional supplements** (for those with concomitant leg ulcers and malnourishment, and in palliative care)	20
7.	**Gastro-intestinal** (e.g. for reflux disease, diarrhoea, constipation)	7
8.	**Anti-histamines** (for various allergic conditions, including hay fever and reactions to insect bites for those sleeping rough)	7
9.	**Compression hosiery** (prevention and treatment of leg ulcers)	6
10.	**Stop Smoking support** (nicotine replacement products, Champix)	5

Table 4: Ten most frequent areas of prescribing in 2020

While we have had an outreach element to our flu vaccination delivery for some years, having the mobile treatment centre meant that we were able to take flu jabs to more people and places in Autumn 2020 than ever before.

Inside the mobile treatment centre

Case study (name changed):

During the pandemic Mark successfully underwent detox and rehab from substance use. During this time he was diagnosed with Type 2 diabetes and experienced hyperglycaemic episodes. Although medications were initiated for this by the GP assigned to him during rehab, due to Covid restrictions Mark received almost no dietary advice or other information about the condition. He returned to Hastings to realise he was no longer registered with a local GP and had almost run out of his diabetes medications.

The Homeless Service team swiftly supported Mark to register with a new GP. While his registration process was pending, the nurse prescriber, guided by Mark's glucose levels (monitored over several consultations) and the initial medications given during rehab, issued prescriptions for Mark's diabetes, titrating doses safely to minimise any risk of hypoglycaemia.

Although we would normally avoid prescribing for chronic disease management, exception was made in this case due to the importance of reducing glucose levels, the exceptional circumstances and the prescriber's own personal and recently updated knowledge of diabetes.

An information pack on Type 2 diabetes was printed from an NHS site, which we gave to Mark (after assessment of his literacy skills) and talked through with him. Having had virtually no information previously, he was extremely grateful for the pack which he read through avidly and immediately started making appropriate changes to his diet. His blood glucose levels stabilised and was soon able to see the new GP for ongoing diabetes management.

Although Mark is housed, this case study illustrates the vital role the Hastings Homeless Service plays in preventing ill health of a wider cohort than those experiencing homelessness. Many service users are vulnerable in a number of ways and would otherwise fall through the cracks in statutory health systems. This fact has been accentuated by the pandemic, which has made access to primary care even harder than usual.

Support issues

In addition to health needs, support issues are monitored.

Advocacy remains the most common factor recorded, as volunteers and staff assist clients to access health, housing and other social support agencies. Although, with Covid restrictions, there was less scope to provide advocacy in person with clients than in previous years, there were still 11 occasions on which clients were accompanied to appointments in 2020.

Housing was by far the most common social issue addressed, followed by help with GP registration, which we gave more frequently than in the previous 4 years. A number of new clients seen were street homeless individuals from out of area who wanted to register with GP services.

Despite the lower numbers of client interactions overall this year, our referrals to GPs were 50% higher than in 2019 as people struggled more than ever to access health services.

Bereavement, domestic violence and abuse, and issues around police and crime were some of the other primary issues, as seen in Chart 4.

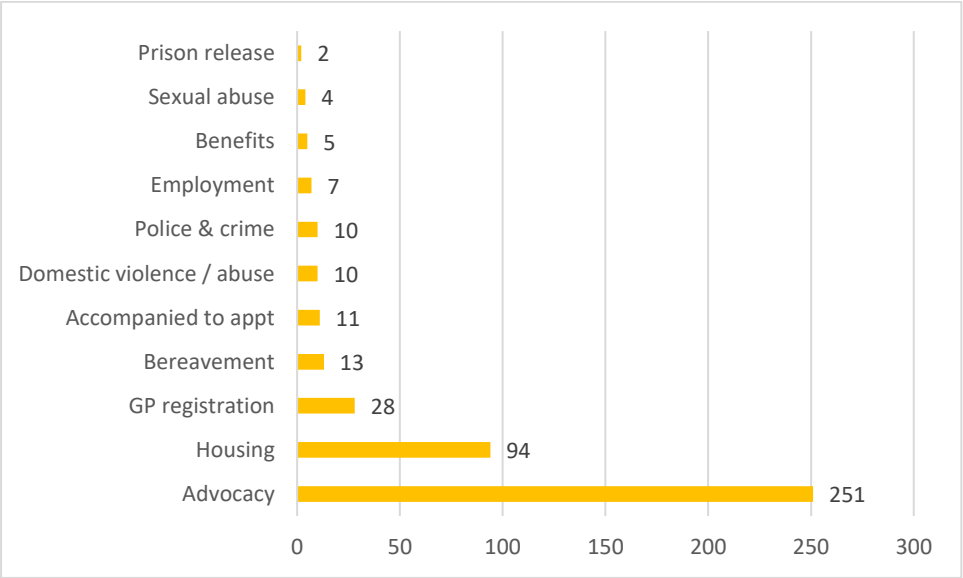


Chart 4: Incidence of support issues addressed during client contacts in 2020

> *"I don't know how I would manage in life without the help I get from Seaview and St. Johns. I just want you to know I really appreciate all of the kindness shown to me and it helps me a lot*."
>
> Phone message from a client

PUBLICITY AND FUNDRAISING

An excellent interview with Sandy Collver, conducted earlier in the year, was broadcast on BBC Radio 4's Woman's Hour on 2nd June and is available here:

BBC Radio 4 - Woman's Hour, Talking to kids about the US protests; Trouper Sandy Collver; Dating after lockdown

On Sunday 19th July, Sussex Homeless Service team members, between them, walked from Hastings to Brighton to raise funds for SJA and to highlight homelessness in the two areas.

Over £3000 was raised, with some good publicity, and a good time was had by all!

The case study ("Jack") described earlier was published as a blog on the Queen's Nursing Institute (QNI) site here:
Hastings Homeless Health Service – The Queen's Nursing Institute (qni.org.uk)

In 2020 the Hastings Homeless Service contributed to the ground-breaking new "Guidelines for health related street outreach to people experiencing homelessness", published by the London Network of Nurses and Midwives Homelessness Group and endorsed by the QNI, the Royal College of Nursing, Pathway and other professional healthcare bodies.

The guidance is expected to be an invaluable tool for SJA in its initiative to establish new homeless health services across the country.

In October the service had a visit from Andrew Blackman, High Sheriff of East Sussex, who subsequently wrote the following letter to the HHS team:

"*It was a pleasure to meet you on Tuesday, along with Ann, Sophia and Christine – thanks to all of you for making me so welcome and for taking the time to explain your work to me.*

What an extraordinary, compassionate, generous resource the Hastings Homeless Service is for some of the most marginalised and neglected members of our community – I was so impressed by your obvious commitment, approachability and professionalism, and admire all of you enormously. Your work is a much-needed reminder of the very best that human nature can be – warmest thanks for all that you do.

I very much hope our paths will cross again soon – please keep in touch."

L-R: Sophia Reeks, Ann Love, Andrew Blackman, Roger Nuttall

As part of the longstanding relationship between the Hastings Homeless Service and Conquest A&E, we provide a regular supply of homeless 'discharge packs', containing toiletries, information sheets, socks, space blanket, snacks and drinks, to give to patients presenting at A&E.

Following Sophia Reeks' appeal to local stores for their assistance with this, Asda St Leonards kindly donated isotonic drinks and cereal bars for the discharge packs.

A £10 gift card was also gratefully received from Sainsbury's St Leonards.

Roger Nuttall and Amanda Rudnick with donations from Asda

HOPES AND PLANS FOR 2021

Firm plans remain somewhat hard to make, as changes depend not only on easing of Covid restrictions but also on the return of volunteers as and when they are ready.

However, we hope to gradually reinstate our healthcare delivery in Seaview and at Hope Kitchen, while also retaining the outreach sessions.

Having tested, developed and discovered the benefits of both mobile clinics and remote health-related support over this year, these will both continue in some form in the year to come.

We aim to achieve a healthy and therapeutic balance of:

- static and mobile clinics;
- planned appointments and ad hoc consultations;
- face-to-face and remote health-related support.

We and the rest of the Sussex Homeless Service are delighted to see SJA's roll-out of homeless services in other areas of the country and to be contributing our experience not only to this but also to wider national homeless health networks.

We are anticipating doing more of this in 2021, including sharing our learning in relation to:

- homelessness and learning disabilities / difficulties, which has been the focus of some recent study by Roger Nuttall;
- health inclusion and wound care.

Details of these opportunities to follow in reports during 2021.

THANKS

The Hastings Homeless Service would like to thank the following individuals and organisations for their input and support during 2020:

All volunteers and staff:

Volunteers:

Amanda Rudnick
Antonia Berelson
Ann Love
Christine Catt
Claire Finn
Debbie Hutchinson
Debbie Thomson
Delia Elliman
Drusilla Relf
Hannah Wilkinson
Judith Wynn
Judy Walker
Liezl Rebalde
Lynne Mercer
Mick Petrie
Mo McColl
Pennie McMichael
Pierluigi Vullo
Robert Mulligan
Sandy Collver
Simon Tyler-Murphy
Tony Pilton
Zena Malapitan

Staff:

Sharon Agnew (Sussex Homeless Service Manager)
Roger Nuttall (Nurse Co-ordinator)
Nancy Jones (Podiatrist, outgoing)
Christine Bolt (Podiatrist, incoming)
Sophia Reeks (Administrator)

Funding / Donors

- Asda
- Burdett Trust for Nursing
- The Chapman Charitable Trust
- Charlotte Marshall Charitable Trust
- The Francis and Eric Ford Charity Trust
- The Ian Askew Charitable Trust
- Isabel Blackman Foundation
- The Magdalen and Lasher Charity
- Morrisons Foundation
- Sainsbury's
- St John Ambulance
- Many other donors of socks, shoes and other items.

Partner agencies

The following list includes many local agencies with which the Hastings Homeless Service has worked in partnership during 2020, and/or to whom clients have been referred, or who have referred clients to the Homeless Service.

The list is not exhaustive, but the partnership and support of all agencies who work with the Service is truly appreciated.

- Adult Social Care
- All local GP practices
- Sanctuary Supported Living
- CGL (Change Grow Live) / STAR
- Conquest Hospital
- East Sussex Healthcare NHS Trust
- Emmaus
- Fulfilling Lives
- Hastings Borough Council
- Hastings Food Bank
- Health in Mind
- Home Works
- Hope Kitchen
- Rough Sleepers Initiative
- Safehaven Men / Safehaven Women
- Seaview Project
- St John Ambulance Hastings Division
- Snowflake – winter night shelter
- Street Pastors
- Surviving the Streets
- Sussex Partnership NHS Foundation Trust
- Sussex Police
- Surviving Christmas
- Transom Trust
- Warming Up The Homeless.

CONTACT DETAILS

St John Ambulance Hastings Homeless Service can be contacted at:

St John Ambulance HQ
Bohemia Road
Hastings
TN34 1ET

Telephone: 01424 435358
E-mail: roger.nuttall@sja.org.uk

St John Ambulance Brighton Homeless Service:

16 Crowhurst Road
Brighton
BN1 8AP

Telephone: 01273 371539
E-mail: katy.matthews@sja.org.uk

St John Ambulance Sussex Homeless Service:

16 Crowhurst Road
Brighton
BN1 8AP

Telephone: 01273 371541
E-mail: sharon.agnew@sja.org.uk

St John Ambulance London & South:

St John Ambulance
Tindal Road
Aylesbury
Bucks
HP20 1HR

Telephone: 0303 003 0101

St John Ambulance National Headquarters can be contacted at:

27 St John's Lane
Clerkenwell
London
EC1M 4BU

Telephone: 020 7324 4000
E-mail: enquiries@sja.nhq.org.uk

APPENDIX: SUMMARY OF MONITORING STATISTICS

Some explanatory notes on the way the following statistics are recorded are given at the end of this section.

Year-on-Year Totals for Comparison: *(N/A = Not Applicable. NR = Not Recorded)*	**2020**	**2019**	**2018**	**2017**	**2016**
Gender					
Men	878	1071	1069	1101	917
Women	286	422	330	491	513
Transgender	0	NR	NR	NR	NR
Non-binary	31	NR	NR	NR	NR
Total	1195	1493	1399	1592	1430
Age					
Under 16	0	0	0	0	0
16-18	0	3	0	4	2
19-24	15	15	12	23	42
25-34	133	244	165	287	366
35-44	370	391	402	422	271
45-54	328	400	403	456	369
55-64	84	202	205	263	257
65+	2	237	208	137	118
Unknown		1	4	0	5
Ethnicity					
1. White British / Irish / Other	1134	1391	1302	1509	1302
2. Eastern European	30	35	38	37	35
3. Black African / Caribbean / Other	2	4	12	8	8
4. Mixed White & Black African / Black Caribbean	17	49	27	19	79
5. Bangladeshi / Indian / Pakistani	0	0	0	1	2
6. Chinese / Other Asian	0	0	1	1	0
7. Mixed White & Asian	1	3	2	0	0
8. Middle Eastern	7	0	11	17	3
9. Mixed Other	3	5	3	0	1
10. Other	1	6	3	0	0
Contact Type					
New Contact	74	128	110	102	113
Known to Service	1121	1362	1287	1489	1315
Unknown	0	3	2	1	2
Accommodation Status					
Sleeping Out/Tents/Vehicle	146	260	235	413	258
Winter night shelter	20	13	20	38	44
Friend's Floor	67	165	108	169	134
Conquest Hospital	0	0	0	0	27
Squat	1	0	0	0	0
B&B/Hotel	75	45	31	71	72
Supported accommodation	70	124	145	71	151
Private rented	397	378	401	456	460
Care Home	8	21	20	38	45
Housing Association	329	375	326	214	158
Owner occupier	52	65	84	77	39
Unknown	0	45	26	45	39
Other	0	2	3	0	3

	2020	2019	2018	2017	2016
Local Connection					
Hastings	1119	1412	1278	1446	1316
Rother	7	10	30	31	30
Other	57	63	77	107	75
Unknown	12	8	14	8	9
Rough Sleepers Contacts					
Sleeping Out/New Contact	35	56	51	55	52
Sleeping Out/Recurring Contact	111	204	184	358	206
Health & Care Issues					
Alcohol	53	42	41	68	70
Circulatory / cardiovascular	85	71	81	80	76
Dental	19	28	29	30	35
Diabetes / endocrine	23	30	38	24	27
Drugs	204	68	53	83	88
Ear, nose & throat	17	33	59	49	43
Eyes	8	25	22	9	22
First Aid given	10	15	22	16	27
Flu vaccine given	23	15	23	25	19
Footcare	117	244	273	270	192
Gastro-Intestinal	46	57	99	81	65
Headache	6	34	21	25	35
Hepatitis	8	2	12	9	4
HIV	0	1	4	3	3
Medication advice	64	108	92	153	126
Medication / wound care products prescribed	166	177	152	161	126
Mental Health	255	156	219	254	231
Musculo-Skeletal	105	118	110	171	191
Neurological	7	17	18	20	28
Nutrition / Weight	117	72	90	87	123
Pregnancy & Gynae	12	23	7	39	61
Pregnancy test	3	4	2	6	9
Respiratory	87	60	58	77	47
Self-harm	5	16	8	12	10
Sexual Health / Contraception	6	11	11	10	9
Skin Disorders & Infestations	99	106	110	113	86
Smoking	16	13	46	28	13
Suicidality	8	9	32	20	19
Urology	21	17	6	18	15
Wound Care	238	411	270	237	197

	2020	2019	2018	2017	2016
Other Support Issues					
Accompanied to appt	11	12	30	26	16
Advocacy	251	154	218	216	186
Asylum seeker / refugee	0	0	1	1	0
Benefits	5	1	19	24	12
Bereavement	13	11	21	16	16
Domestic violence / abuse	10	5	6	10	5
Employment	7	1	5	7	6
Ex-armed forces	0	1	0	3	2
Gambling	2	0	0	0	0
General social issues	726	913	883	1081	825
GP registration	28	26	23	17	17
Housing	94	82	100	138	136
Police & crime	10	14	13	17	17
Prison release	2	3	13	9	9
Sexual abuse	4	1	0	4	7
Referrals Made					
A&E	4	12	15	10	15
Conquest Podiatry	0	0	2	1	1
Conquest – Other	21	5	14	3	11
Dentist	0	0	4	2	0
GP	92	61	98	117	56
Hastings Borough Council Housing Services	6	5	10	15	3
Health in Mind / NHS Mental Health Services	9	8	19	12	7
Home Works	0	2	4	5	4
Seaview Drop-In Staff	12	10	19	19	2
Seaview Housing / Outreach Services	23	17	23	37	5
Sexual Health	1	2	2	1	0
Social Services	2	4	3	11	9
STAR (Substance Misuse Service)	21	3	3	5	1
Tissue Viability Nurse	4	4	2		
Number of People Seen					
Nurse	921	1254	1212	1388	1256
Podiatrist	78	145	186	197	154
General Volunteer	227	136	94	76	78
Visiting Professional	3	2	4	6	17

Explanatory notes

Contact Type:

New contact refers to a consultation or conversation between the Homeless Service team and a client for the first time.

Known to Service refers to clients who have been seen by the service before.

Unknown is recorded if the team members on duty are unsure whether the client is new to the service or not.

Local Connection:

Local Connection is recorded for every client seen. A client has a local connection with Hastings if they have had settled accommodation in the Borough for 6 out of the last 12 months or 3 out of the last 5 years, if they have permanent employment in the area, or if they have a parent, (adult) child, brother or sister who has been living in the area for at least 5 years.

Local Connection is one of the legal housing tests applied by Local Authority housing services. The Local Authority has no duty to give housing assistance to a client without a local connection to the area, although it does have a duty to give everyone housing *advice*, regardless of local connection.

Rough Sleepers Contacts:

Sleeping Out / New Contact refers to a consultation or conversation between the Homeless Service team and a street homeless client for the first time. (If the client is known to the Homeless Service but this is the first time the service has had contact with him/her since s/he became homeless, the client is recorded as Sleeping Out / Recurring Contact).

Sleeping Out / Recurring Contact indicates that the client is sleeping rough and is already known to the Homeless Service, whether s/he was previously known as a rough sleeper or as someone with housing.

NB: The monitoring system, while detailed and providing much information, does not give the total numbers of individual rough sleepers seen over a given period.

Health & Care Issues and Other Support Issues:

These categories refer to issues addressed during each client consultation or interaction, whether with a nurse, podiatrist or general volunteer. The issues are only recorded if they have been addressed, not simply if they are a current issue in the client's life.

However, on many occasions, several categories are recorded, as client consultations and conversations often cover a number of health and social issues.

Health & Care Issues:

Medication advice refers to occasions when advice is given in relation to medication that a client is already taking, and does not include times when a client is given a prescription by the Homeless Service's Nurse Independent Prescriber.

Medication / wound care products prescribed refers to the number of times clients received nurse prescriptions from the Homeless Service, not to the number of items prescribed.

Other Support Issues:

Accompanied to appt refers to times when clients have been supported at GP, housing or other appointments by a Homeless Service nurse or volunteer for support and/or advocacy.

Advocacy refers to advocacy given by the Homeless Service on behalf of clients to a range of health or housing agencies, either by phone, letter, or in person.

Asylum seeker / refugee refers to the number of contacts with clients who either are seeking asylum or have attained refugee status, whether this is addressed in the client consultation or conversation or not.

Ex-armed forces: The Homeless Service records client consultations and conversations in which a client discusses having been in the armed forces. This is thought to be under-recorded.

General social issues covers a wide range of social issues that are discussed in client consultations and conversations and which may not fit into other categories. General social support given by all members of the team (volunteers, nurses, podiatrists) is an essential aspect of the work of the Homeless Service, forming part of the holistic service given.

Referrals Made:

These are only recorded if a client is referred directly by the Homeless Service team to another agency, not if a client is simply 'signposted' or advised to attend a particular agency.

Home Works: new referrals can now only be made to Home Works or STEPS by local authorities such as Hastings Borough Council Housing Services or Social Services. The small number of referrals recorded here represent some of the liaison made with Home Works regarding their existing clients.

STAR (substance misuse service): new referrals are seldom made to STAR, as it is usually preferable for clients to present themselves to agencies dealing with substance misuse and addiction, in order to demonstrate motivation. Referrals recorded usually entail liaison regarding clients who are already engaging with STAR.

Number of People Seen:

The primary professional dealing with a client is recorded here. In some cases two professionals are recorded for one client consultation, for example, when a client is seen by a nurse and podiatrist simultaneously.

General Volunteer refers to those occasions when a client is supported solely by a general volunteer without a health professional.