Office for Health Improvement & Disparities

Inclusion Health Groups in Hampshire and the Isle of Wight ICS:

An overview of available data and published evidence

Office for Health Improvement and Disparities (OHID) South East &

South East Local Knowledge and Intelligence Service

December 2023

How to use the datapack

This datapack is intended to provide a one-off summary of available data and evidence for inclusion health groups in the South East at an ICB level. It was developed to complement the Spotlight tool, which includes mainly national level data and where new data is currently being added.

It presents an initial overview to support systems to understand need in their area and provide a resource including data and summaries that can be taken out and used as required, as well as be further developed by local Systems.

For each inclusion health group, the key messages for systems are presented, followed by an overview of health issues and available data. The end of each section includes links to further resources and organisations.

Each slide includes a link back to the main contents page for ease of navigation and the contents page for each section includes links to key slides.

For each summary, there are links to websites in the text with references to published papers included in the notes section.

For data slides, notes and further information is included in the notes section of each slide.

It is recommended that the datapack is used in conjunction with the newly published National Framework for NHS Action on Inclusion Health.

If you have any feedback on this datapack, please contact: OHIDSEBST@dhsc.gov.uk

Reflections on data

The purpose of this resource is to provide systems with local data relating to inclusion health groups in their area. One of the challenges for these populations is that they are often not represented in routinely collected data.

This makes it difficult for local integrated care systems to both fully understand the health need of their inclusion health populations, but also to evaluate the outcomes and impact of interventions.

While the Spotlight tool provides an overview on inclusion health groups at a national level, the aim of this resource is to understand what data exists at a local level, which will potentially also be captured by Spotlight in the future.

Data sources for this datapack include publicly available data from the Office for National Statistics (ONS), OHID Fingertips, Local Government data, data from the Home Office, Department for Levelling up, Housing and Communities (DLUHC) and experimental analysis using Hospital Episode Statistics.

Further sources explored included screening and immunisations data, health and justice data, police data as well as other sources. A recurrent theme was that data was often not available broken down by inclusion health groups, particularly for preventative interventions, or data was either not collected in a robust manner, or not publicly available.

Therefore, we know that data outlined in this datapack will often be an under-representation of the need or impact for these populations.

Acknowledging and outlining the challenges in compiling data at an ICS level for this resource is hoped to encourage local systems to review their data collection processes and to look beyond routinely available data, working creatively with all residents and groups to seek wider sources of information.

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Overview

Inclusion health describes population groups who are socially excluded, who typically experience multiple overlapping risk factors for poor health and are often not accounted for in electronic records. This includes people who experience homelessness, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system, those with drug and alcohol dependence and victims of modern slavery but can also include other socially excluded groups.

People in inclusion health groups often face barriers to accessing primary and preventative care, relying on emergency services to manage acute health needs. This can both further exacerbate health inequalities, but also come at a greater use of emergency services and subsequent financial cost. It has been estimated, for example, that preventing homelessness for one year would result in a reduction in public expenditure of £9,266 per person, through costs otherwise resulting from a much higher than typical contact with the NHS, mental health services and criminal justice system[1].

This resource aims to highlight the needs and challenges faced by inclusion health groups within an ICS area and therefore help improve understanding of the issues that people face. Due to the nature of these groups, there is not always a large amount of data available. However, we have aimed to use the best possible data available and included latest evidence to outline the challenges and health needs for these groups. This also highlights gaps in the system and provides an indication of where more needs to be done to collect data on these groups to identify and address inequality.

Inclusion health groups face extreme health inequity and addressing this will require intensive cross-sectoral policy and service action. Everyone across an Integrated Care System (ICS) has a role and responsibility to take action to improve outcomes for inclusion health groups to address the systematic health inequalities they face.

People in inclusion health groups often experience stigma and discrimination with frequent barriers in access to healthcare.

Individuals may belong to more than one inclusion health group, experiencing multiple and overlapping risk factors for poor health including poverty, adverse childhood experiences, violence, substance use, mental illness and complex trauma. This results in very poor health outcomes, often much worse than the general population and a lower average age of death.

It is important to note that these are not a homogenous group though, with different health and social care needs both within and between different inclusion health groups and these must be understood and responded to appropriately.

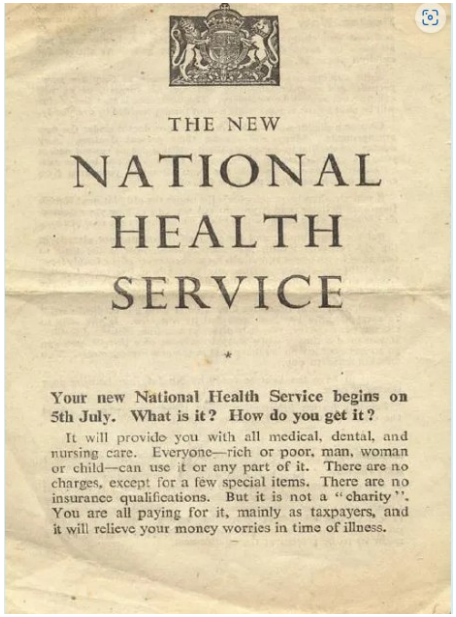
Addressing the needs of inclusion health groups is fundamental to promoting health equity and addressing health disparities among marginalised and vulnerable populations.

The statutory duties placed on public bodies

The NHS Constitution states that the NHS has a duty to "…pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population".

This is reflected in the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012 and 2022), which introduced for the first-time legal duties to reduce health inequalities.

NHS England and Integrated Care Boards (ICBs) have a legal duty to have regard to reducing inequalities associated with access to and outcomes from NHS services. This means that health inequalities must be properly and seriously considered when making decisions or exercising functions, including balancing those needs against any other challenging factors. ICBs and NHS trusts must also provide annual narrative for progress to address inequalities.


THE NEW
NATIONAL
HEALTH
SERVICE

Your new National Health Service begins on 5th July. What is it? How do you get it?

It will provide you with all medical, dental, and nursing care. Everyone—rich or poor, man, woman or child—can use it or any part of it. There are no charges, except for a few special items. There are no insurance qualifications. But it is not a "charity". You are all paying for it, mainly as taxpayers, and it will relieve your money worries in time of illness.

ICBs have statutory duties to support partnership working, where this would help to tackle inequalities.

The **Homelessness Reduction Act 2017** places several duties on local authorities to assess, prevent and relieve homelessness.

- Duty of every local authority in England to provide advisory services
- Duty to assess every eligible applicant's case and agree a plan
- Duties to those who are homeless or threatened with homelessness
- Duty on public authorities in England to refer cases (A guide to the duty to refer)

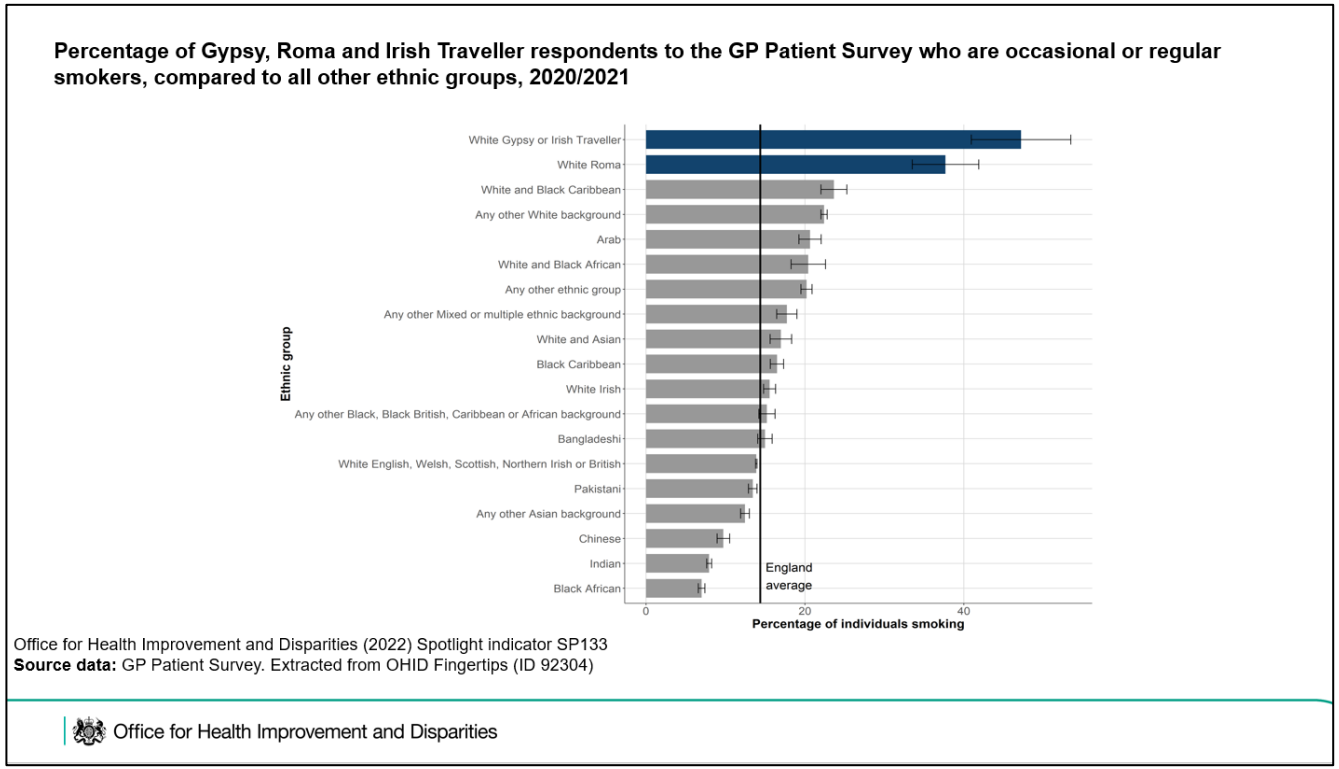
SPOTLIGHT: Improving Inclusion Health Outcomes

Spotlight is a data dissemination platform produced by the Office for Health Improvement and Disparities (OHID). It collates and presents key statistics related to the public health outcomes of inclusion health groups across the following themes:

- access to and utilisation of health care;
- preventative care;
- health outcomes; and
- wider determinants of health.

The aim of Spotlight is to improve accessibility and visibility of data and evidence related to inclusion health populations.

Spotlight and instructions on how to use it can be found here.



Example of data as provided within the Spotlight tool

Kings Fund Pockets of Excellence

The King's Fund has led a shared learning programme of work with Pathway and with Groundswell, looking at:

- developing consistently good services across the whole inclusion health cohort
- how to scale up from examples of good practice in a given neighbourhood to achieve system wide success.

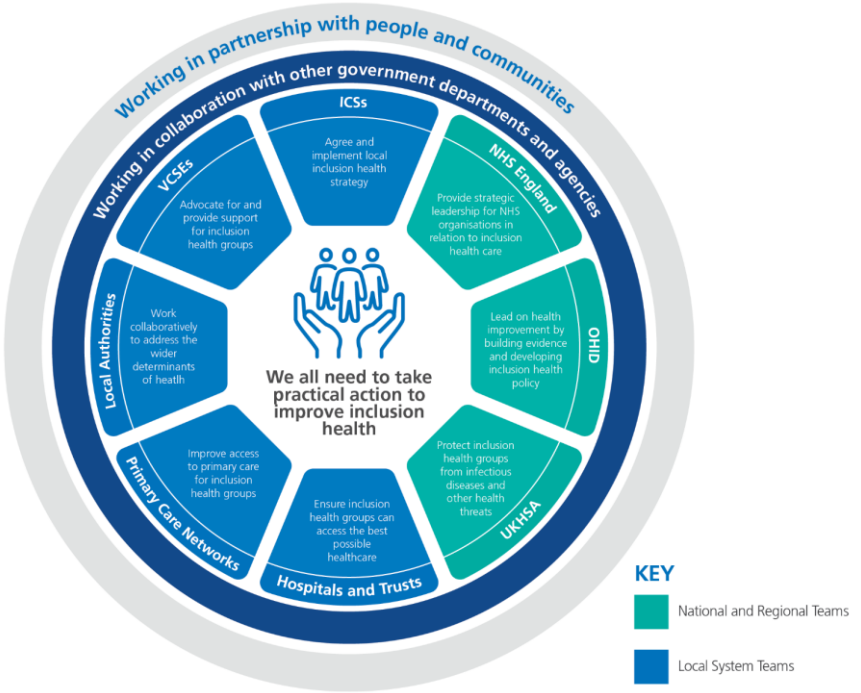
Two ICS areas in the South East were part of this first cohort – Hampshire & the Isle of Wight and Sussex.

Findings from the programme provide senior NHS and ICS system leaders with the case for inclusion health and describes a strategic better service road map for inclusion health groups.

There is also shared learning from programme participants who considered what good services should look like and identifies some of the levers and enablers that participants thought from their experience can help systems to create the conditions for success.

Pockets of Excellence Report

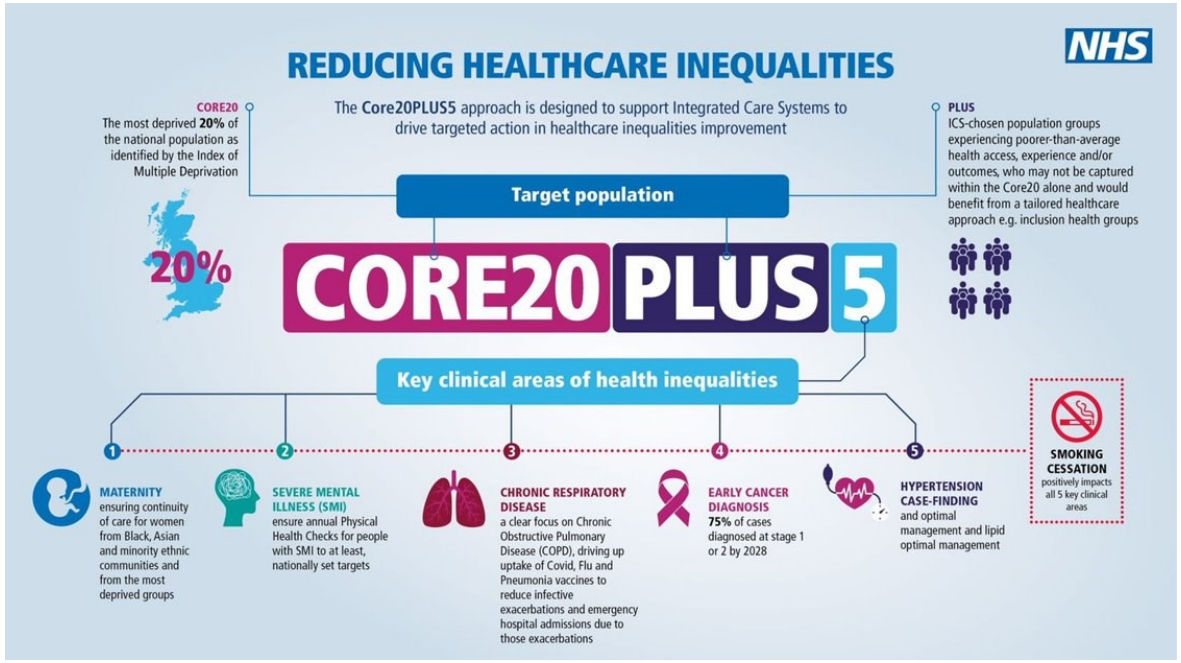
National Framework for NHS - Action on Inclusion Health



The national framework for NHS - action on inclusion health was published in October 2023. It is intended to support systems to plan, develop and improve health services to meet the needs of people in inclusion health groups. The framework is based on five principles for action on inclusion health, outlining actions to address issues which are common across inclusion health groups. The framework focuses on the role that the NHS plays in improving healthcare, highlighting the importance of working in partnership across sectors and with other members of the Integrated Care System.

NHS England » A national framework for NHS – action on inclusion health

Reducing healthcare inequalities: Core 20+5



Core 20+5 is a national NHS England approach to inform action to reduce healthcare inequalities at both national and system level. Initially focused on adults, it was later expanded to include reducing healthcare inequalities for children and young people. Core20 refers to the most deprived 20% of the national population – as identified by the Index of Multiple Deprivation (IMD). "Plus" population groups are identified at an ICS level, identifying those within their population who are experiencing poorer than average health access, experience and/or outcomes. Inclusion health groups are expected to form part of the "plus" population groups, as action to address healthcare inequalities experienced by these groups is fundamental in order to reduce healthcare inequalities across the whole population.

Integrated Care Board (ICB) Boundaries

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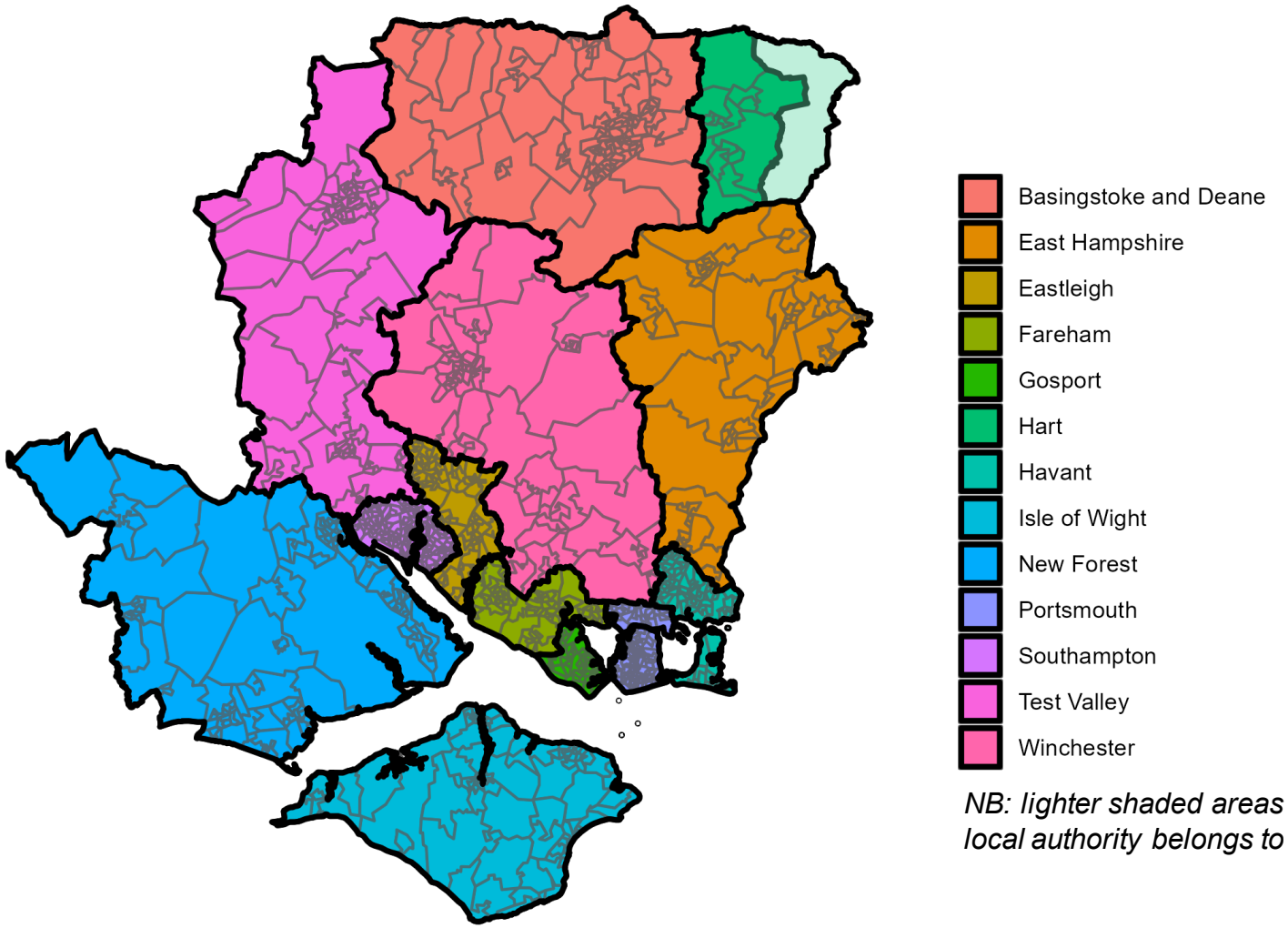
NHS Hampshire and the Isle of Wight HIOW ICB

As ICB boundaries are often not co-terminous with their local authority boundaries, the table below describes the population and percentage of each local authority area included in the ICB. The following map outlines the geographical boundary of Hampshire and the Isle of Wight ICB. Data throughout this pack is often only available at local authority level and so ICB values are calculated from local authority figures using the PHE aggregations method where possible.

Local Authority	Total local authority population	Total of local authority population in HIOW ICB	Total HIOW ICB population	Proportion of HIOW ICB from local authority (%)	Proportion of local authority in HIOW ICB (%)
Basingstoke and Deane	177,760	177,760	1,831,473	9.7	100
East Hampshire	123,838	123,838	1,831,473	6.8	100
Eastleigh	135,520	135,520	1,831,473	7.4	100
Fareham	116,338	116,338	1,831,473	6.4	100
Gosport	84,679	84,679	1,831,473	4.6	100
Hart	97,608	24,402	1,831,473	1.3	25
Havant	126,339	126,339	1,831,473	6.9	100
Isle of Wight	142,296	142,296	1,831,473	7.8	100
New Forest	179,649	179,649	1,831,473	9.8	100
Portsmouth	214,692	214,692	1,831,473	11.7	100
Southampton	252,872	252,872	1,831,473	13.8	100
Test Valley	127,163	127,163	1,831,473	6.9	100
Winchester	125,925	125,925	1,831,473	6.9	100

NHS Hampshire and Isle of Wight Integrated Care Board



NB: lighter shaded areas indicate where part of the local authority belongs to an adjoining ICB area.

Open Geography Portal (https://geoportal.statistics.gov.uk)

Homelessness and Rough Sleeping

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Homelessness and Rough Sleeping: Contents

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- Adult Safeguarding Reviews
- Experimental data analysis: Homelessness and Hospital admissions in the South East
- Homelessness - Households owed a relief duty under the Homelessness Reduction Act
- Homelessness - Temporary Accommodation
- Homelessness – Mental Health
- Homelessness – Deaths
- Homelessness Resources/Organisations

Homelessness definitions

Homelessness: a household that has no home in the UK or anywhere else in the world available and reasonable to occupy (legal definition). This includes:

- **Rooflessness**: without a shelter of any kind, sleeping rough
- **Houselessness**: with a place to sleep, but temporary in institutions or a shelter
- **Living in insecure housing**: threatened with severe exclusion due to insecure tenancies, eviction, domestic violence, or staying with family and friends ("sofa-surfing")
- **Living in inadequate housing**: in caravans on illegal campsites, in unfit housing, in extreme overcrowding.

Temporary Accommodation: Households might be placed in temporary accommodation pending the completion of inquiries into an application, or they might spend time waiting in temporary accommodation after an application is accepted, until suitable secure accommodation becomes available.

Homelessness and Rough Sleeping: Key messages

- Homelessness is more than rough sleeping. It includes people living in sheds, garages and other unconventional buildings; sofa surfing; hostels and unsuitable temporary accommodation, such as B&Bs. It places people at a high risk of social exclusion, exacerbating or resulting in poor health, limiting education and personal development and may also contribute to people being excluded from general service provision or more specialist support services.

- People experiencing homelessness have far worse health and social care outcomes than the general population. The average age of death for people experiencing homelessness is 43 for women and 45 for men.

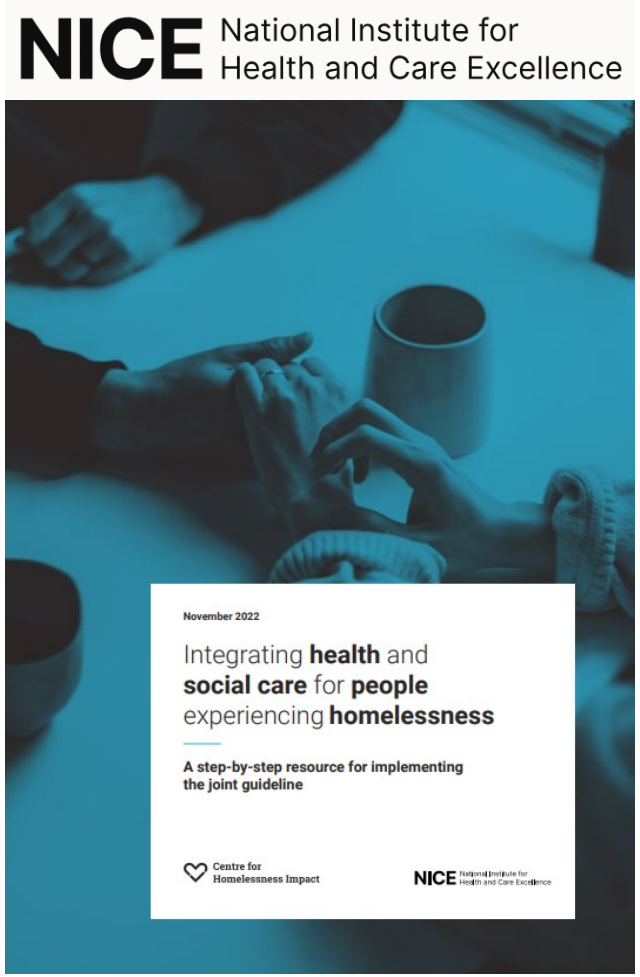
- The costs of homelessness to society are significant. NICE guidance suggests most interventions that address homelessness are likely to be cost effective or even cost saving from the wider public sector perspective.

NICE Guidance 214: Integrated health and social care for people experiencing homelessness

Research has shown that people affected by homelessness often experience poor healthcare and social care. Mainstream services are largely not geared to provide accessible and trauma informed care for those experiencing rough sleeping and homelessness. The National Institute for Health and Care Excellence (NICE) and the Centre for Homelessness Impact (CHI) have developed new guidance which covers providing integrated health and social care services for people experiencing homelessness. It aims to improve access to and engagement with health and social care, and ensure care is coordinated across different services.

A step by step implementation manual is available which highlights the main recommendations, presents the evidence base and provides practical suggestions and checklists.

A series of short awareness films are being developed by CHI for the front line workforce in health, social care, and for commissioners and managers.



Duty to refer

The Homelessness Reduction Act 2017 (HRA) places a statutory duty on Hospital Trusts, NHS walk-in centres and Accident and Emergency departments. They are required to refer (with consent) any patient who is homeless, or at risk of homelessness in the next 56 days. Referrals without consent may be made to safeguard children or vulnerable adults, in accordance with safeguarding procedures. For patients, this means they can recover in appropriate accommodation and can access health and social care services for ongoing support. For hospitals, it is the chance to break the cycle of costly repeat admissions.

Homelessness may include patients residing in hostels or unsuitable accommodation, people in insecure accommodation or people sleeping rough. Helpful guidance is available.

The Faculty for Homeless and Inclusion Health has produced Standards For Commissioners and Service Providers and offers advice and best practice in the care of excluded patients.

Royal College of Physicians guidance advises that hospitals supporting 30 or more homeless patients each year develop specific responses, and those supporting more than 200 homeless patients per year consider developing a Pathway homeless hospital team to ensure timely discharge and reduced readmission. Contact Pathway for advice on developing a team.

A new report from Crisis and Pathway, Beyond the Ward – Exploring the Duty to Refer in Hospital Settings, highlights examples of good practice where the integration of services across organisations have been developed.

Health outcomes for people experiencing homelessness 1/2

The latest national official figures show a 26% increase in rough sleeping and the highest rates of people living in temporary accommodation on record.[1]

Homelessness is associated with poor health outcomes, with mortality risks of three to six times higher than for the general population[2,3]. People experiencing homelessness have substantially increased risk of death due to respiratory and cardiovascular diseases[4]. Some studies have shown the increased risk of mortality is also present for those sofa surfing and squatting[5]. Studies excluding these more prevalent forms of homelessness, and use of low-cost hotels, may have underestimated their impact on mortality.

There are few studies of morbidity among homeless people. Most research has focused on infections and mental health problems and found high relative and absolute prevalence[4]. Those studies which have looked at broader outcomes have found that respiratory diseases, dental problems, headaches and skin diseases are also more common among homeless people than the general population.

Increasingly, frailty and premature aging is being seen in the homeless population. Research by Pathway, the Marie Curie Palliative Care Research Department and Institute of Epidemiology & Health Care at UCL, involved the first exploration of premature aging among people experiencing homelessness in the UK. Although the average age of participants was 56 years (range 38-74), the levels of frailty were comparable to 89-year-olds in the general population. Conditions usually associated with old age were common, with more than half experiencing falls, visual impairment, low grip strength, and mobility impairment. Cognitive impairment was also found to be prevalent but under recognised and rarely diagnosed. In addition, all participants had more than one long-term health condition, with an average of 7 long-term conditions identified per person. This is greater by far than even the oldest people in the general population[6].

Health outcomes for people experiencing homelessness 2/2

In 2022, Homeless Link published The Unhealthy State of Homelessness. The findings from 31 Homeless Health Needs Audits (HHNAs), representing 2,776 individuals showed:

- People experiencing homelessness suffer from worse physical and mental health than the general population and on many measures, the situation has worsened since the first HHNA in 2014.
- Nutrition presents a big challenge with a third of respondents reporting that on average, they eat only one meal a day.
- 76% (378) of respondents reported that they smoke cigarettes, cigars or a pipe, compared to 13.8% of adults in the general population who are either 'occasional' or 'regular' smokers.
- Between 2018–2021, 63% of respondents reported they had a long term illness, disability or infirmity.
- The number of people with a mental health diagnosis has increased substantially from 45% in 2014 to 82% in 2018–2021.
- 45% of respondents reported they are self-medicating with drugs or alcohol to help them cope with their mental health.
- Barriers in accessing needed support for physical and mental health means people experiencing homelessness are over reliant on emergency health care services, with 48% of respondents having used A&E services in the last year: three times more than the general population.
- Between 2018 - 2021 a total of 38% of respondents had been admitted to hospital in the 12 months before participating in a Homeless Health Needs Audit. The most common reason for hospital admission related to a physical health condition (37%), and 28% related to either a mental health condition or self-harm or attempted suicide.
- For those who had been admitted to hospital nearly a quarter (24%) had been discharged to the streets.

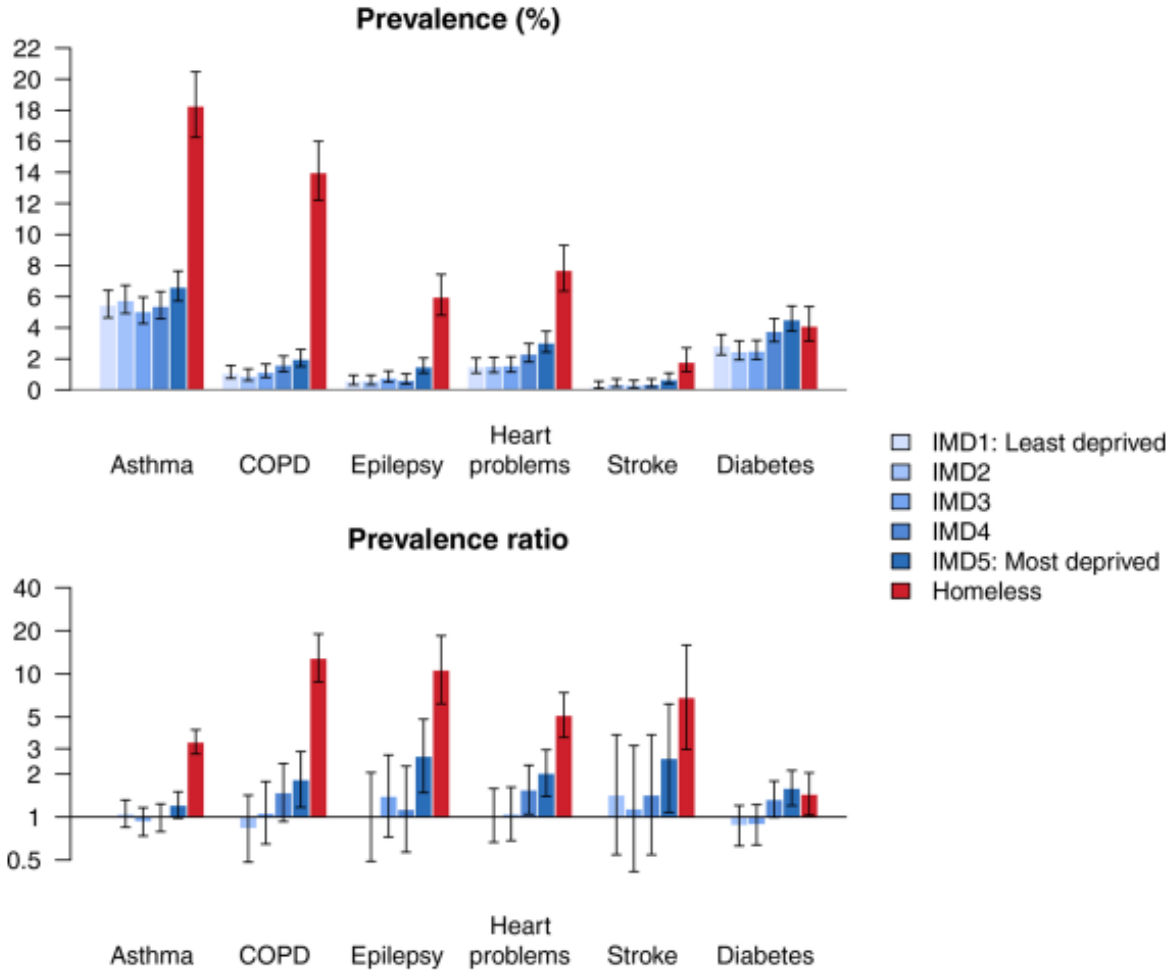
Prevalence of long-term conditions by deprivation and homelessness

Research has found that homeless people report substantially worse health than those in stable accommodation and are three times more likely to report a chronic disease[1].

The chart opposite demonstrate prevalence and prevalence ratios of different long-term conditions compared to deprivation and homelessness in homeless and housed people in London and Birmingham[1].

When comparing some of the health conditions, that are identified in CORE 20+5, across deprivation quintiles (blue), there is a "slope" in health outcomes, but factor in homelessness (red) and the inequalities are significantly greater for conditions such as Chronic Obstructive Pulmonary Disease (COPD), Cardiovascular Disease (CVD), asthma and epilepsy.

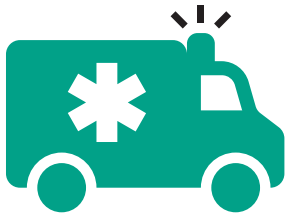
The same study also found that homeless people report worse quality of life and are more than twice as likely to report problems with anxiety[1].



A person who is homeless is:

- 34X more likely to have tuberculosis
- 50X more likely to have Hepatitis C
- 12X more likely to have epilepsy
- 6X more likely to have heart disease
- 5x more likely to have a stroke
- 2.5x more likely to have asthma

People who are homeless (compared with the general population):



Attend A&E 6x as often

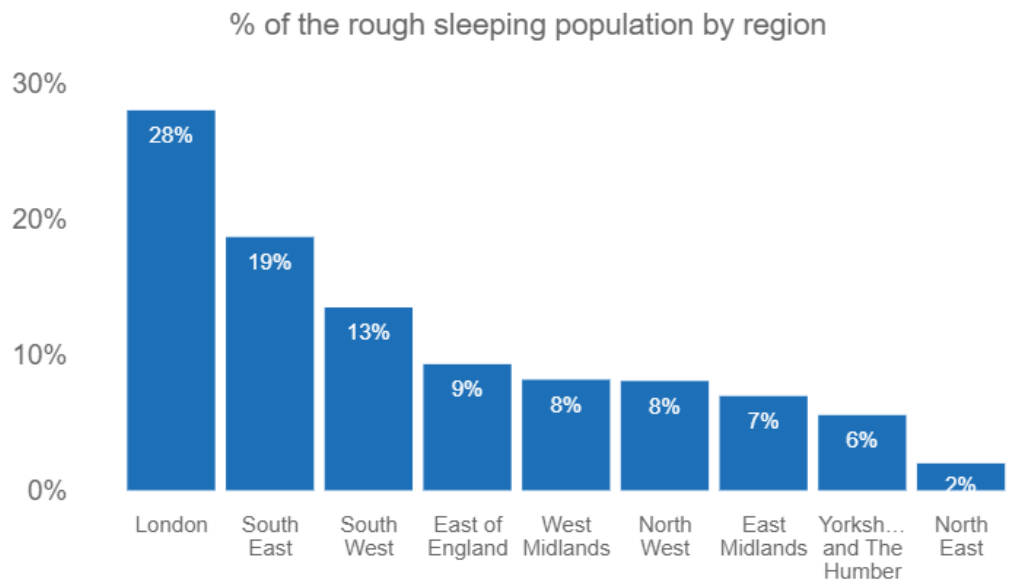
Are admitted to hospital 4X as often

Stay 3X as long

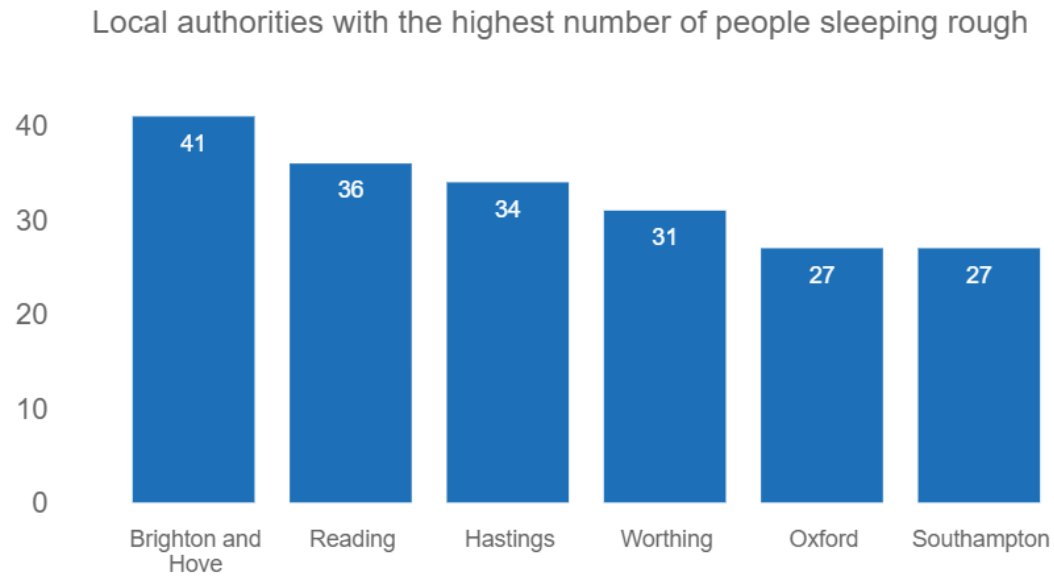
Taken from Pathway

Rough Sleeping Snapshot in England: Autumn 2022

The number of people sleeping rough in England, on a single night in autumn 2022 was estimated to be 3,069 which was the first increase in four years. This number is lower than in 2019, before the Covid-19 pandemic, but is higher than 2010 when the snapshot was first introduced. In the South East, there was an estimated 572 people sleeping rough on a single night. Data by local authority area can be found on the interactive map.



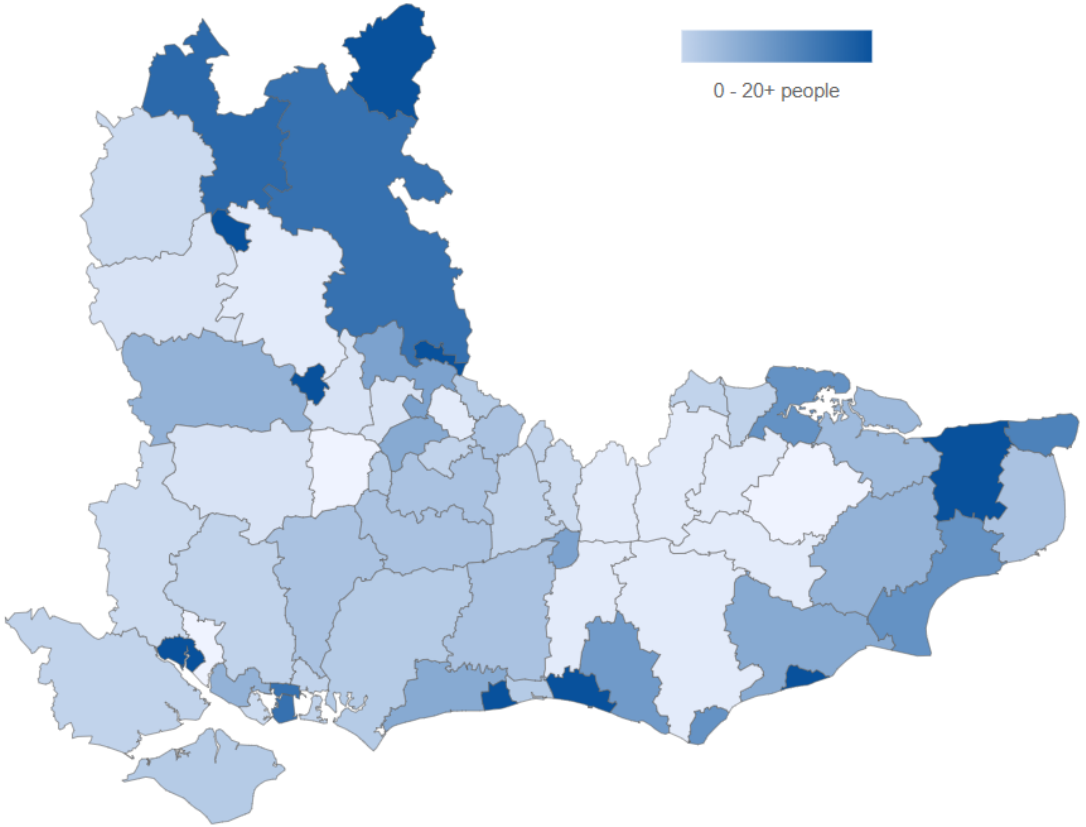
The South East has the second highest proportion of people sleeping rough on a single night, almost 20%, with only London having a higher proportion.

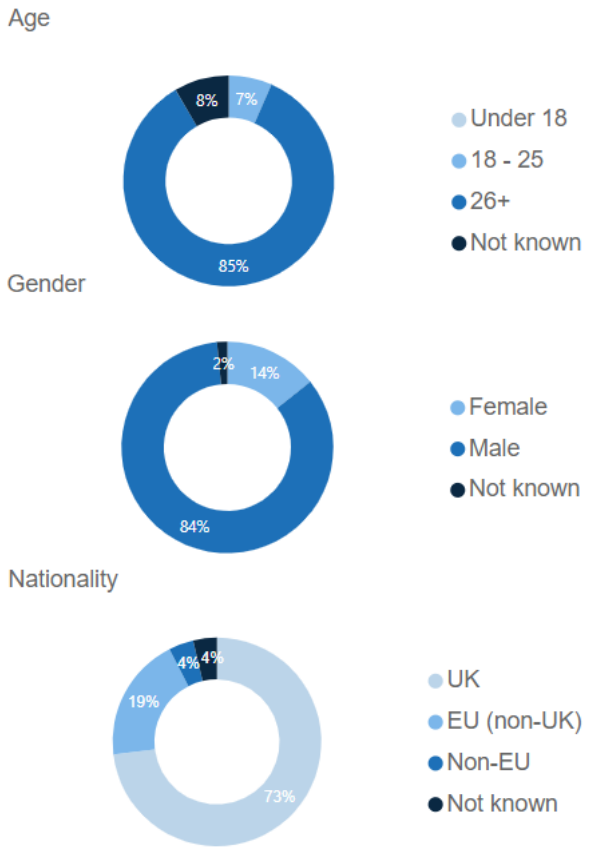


In the South East, Brighton and Hove had the highest number of people sleeping rough, following by Reading and then Hastings.

Source: Department for Levelling Up, Housing & Communities

Number of people sleeping rough in the South East on a single night in autumn 2022





This map demonstrates the spread of rough sleeping across the South East, as measured by the rough sleeping snapshot in autumn 2022, along with the breakdown by age, gender and nationality.

Source: Department for Levelling Up, Housing & Communities

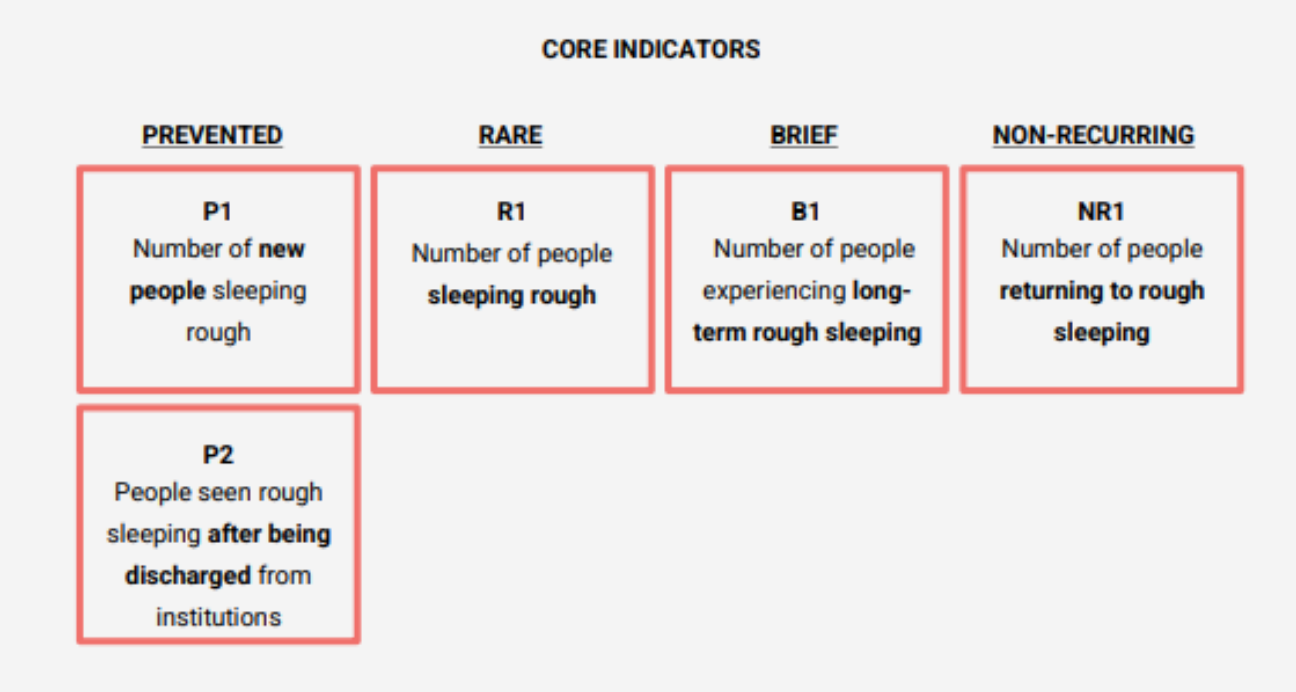
The Rough Sleeping Data Framework

The new Rough Sleeping Data Framework was launched in 2023 to help local authorities to identify and address the specific needs of their local areas.

The framework was created collaboratively by the Centre for Homelessness Impact (CHI) and the Department for Levelling Up, Housing and Communities (DLUHC) to provide a new national data-led approach to measure progress towards ending rough sleeping.

The Framework consists of five core indicators (see picture) enabling every local area to understand what is needed, to track the progress they are making and to be held accountable locally. Nationally, DLUHC is using the data to support cross-government work and better understand local challenges.

The Ending Rough Sleeping Data Framework Dashboard includes the first round of framework data, published in November 2023.



The single night count reflects trends but does not capture the complexity of rough sleeping and homelessness, which the Framework seeks to address.

A guide on how to use the Framework is available.

Adult Safeguarding Reviews

Rough sleeping and multiple disadvantage is a safeguarding issue. The government's Rough Sleeping Strategy highlights The Care Act 2014 and the responsibility of local authorities and partners to provide assurance that local safeguarding arrangements are acting to help and protect adults with care and support needs who they suspect are at risk of abuse or neglect (including self-neglect).

In line with the recommendations of the National Institute for Health and Care Excellence (NICE) guidelines, both DLUHC and DHSC strongly recommend that every Safeguarding Adult Board(SAB) has a named member advocating for people sleeping rough, whom experience the most severe disadvantage and multiple and complex needs. Safeguarding Adult Boards should also ensure, in their partnerships with housing teams, that there is clear accountability for people sleeping rough.

SABs have an absolute duty to conduct a SAR where an adult with care and support needs has died as a result of abuse and/or neglect, including self-neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the person. There is a comparable absolute duty where the person has experienced serious abuse and/or neglect but survived. In these circumstances a review is mandatory.

Twenty-five cases in the first national analysis of SARs in England (Learning from Safeguarding Adult Reviews, 2021) involved individuals who were or had experienced homelessness. This represented 11% of the sample. An earlier thematic review contained 14 reviews where homelessness was a factor[1].

Experimental data analysis: Homelessness and Hospital admissions in the South East 1/2

People experiencing homelessness are less likely to access both preventative and primary healthcare, with studies showing that homeless patients use hospital services at a higher rate than those who are not homeless[1,2]. In view of this, experimental data analysis was undertaken by OHID SE to identify numbers of hospital admissions for people experiencing homelessness at an ICB level in the South East. In addition, the reasons for admission were also explored.

This data has been calculated using Hospital Episode Statistics (HES) available through UKHSA's Data Lake. HES contains details about inpatient admissions, outpatient appointments and Accident and Emergency attendances at NHS hospitals in England. It is a record based system that covers all NHS Trusts in England, and covers all medical specialities and:

- NHS patients treated in NHS Trusts
- NHS patients treated in private hospitals
- Private patients treated in NHS hospitals

Definition of admission for a homeless person used in this analysis

The analysis contained in this section covers inpatient admissions for homeless people/people of no fixed abode in NHS Trusts in the South East. There is no current agreed methodology within OHID for identifying admissions for homeless people and so the approach taken in this analysis is therefore experimental.

An admission episode for a homeless person is defined is an episode with an ICD-10 code of homelessness, Z59.0, in the secondary diagnosis position. An admission episode for a person of no fixed abode is defined as an episode where the current local authority district of residence of the patient is "No fixed abode" (RESLADST_ONS = "U"). Hereinafter, an admission that meets either of these definitions is referred to as an admission for a homeless person.

Experimental data analysis: Homelessness and Hospital admissions in the South East 2/2

Attributing an admission to an ICB

Episodes were counted towards an ICB by treatment area according to where the NHS Trust is situated. Please note that this represents a departure from the usual approach to allocating episodes to place, which uses the patient's usual place of residence via the Lower Layer Super Output Area (LSOA). This approach is precluded for admissions for homeless people because of the large proportion of missing LSOA values for these admissions. Counts for ICB are aggregated to form the counts for NHS South East. Counts between 1 and 7 have been suppressed and all other counts are rounded to the nearest 5.

Analysis of data for 2022/23

In order to provide a recent view of admissions for homeless people, this analysis includes admissions data for 2022/23, which has been generated from monthly HES data for 2022/23.

It should be noted that no HES data was available for Frimley Health NHS Foundation Trust from mid-June 2022 to March 2023. As this Trust is situated within the NHS Frimley ICB boundary, this will have impacted on counts for this ICB as well as the counts for South East.

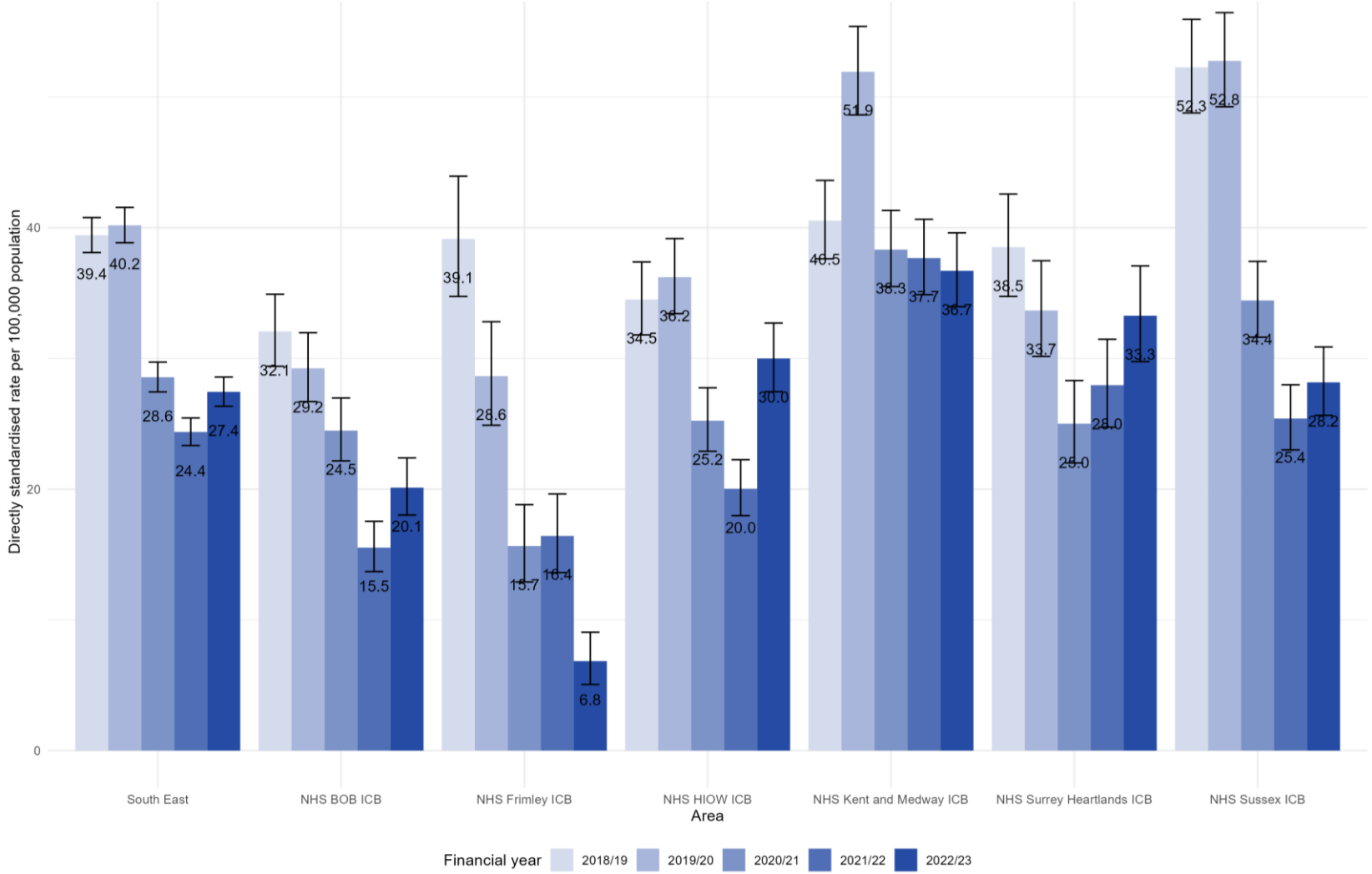
Additional points to note

This analysis is based on finished admission episodes. An examination of the data has found that for some episodes, the ICD-10 code of homelessness, Z59.0, is not present on the admission episode but is present on subsequent episodes within the spell. These episodes will therefore not be included in this analysis, leading to the potential of undercounting. Work is underway to quantify the number of subsequent episodes that contain the Z59.0 code where it is not present in the admission episode. The footnotes attached to each analysis provide additional caveats to aid interpretation.

Admissions for homeless people, directly standardised rate per 100,000 population: South East and NHS ICBs 2018/19 to 2022/23

This graph demonstrates the trend in those identified as homeless among hospital admissions, for both the South East and each individual ICB from 2018/19 to 2022/23. There are some limitations to the data as described in the notes.

Most ICB areas showed a decline in rates of homeless people being admitted to hospital from 2020/21 to 2021/22, although numbers appear to be increasing again in the most recent data. Kent & Medway and Sussex ICBs had the highest rate of admissions for homeless people in 2019/20, compared to the other ICBs in the South East.



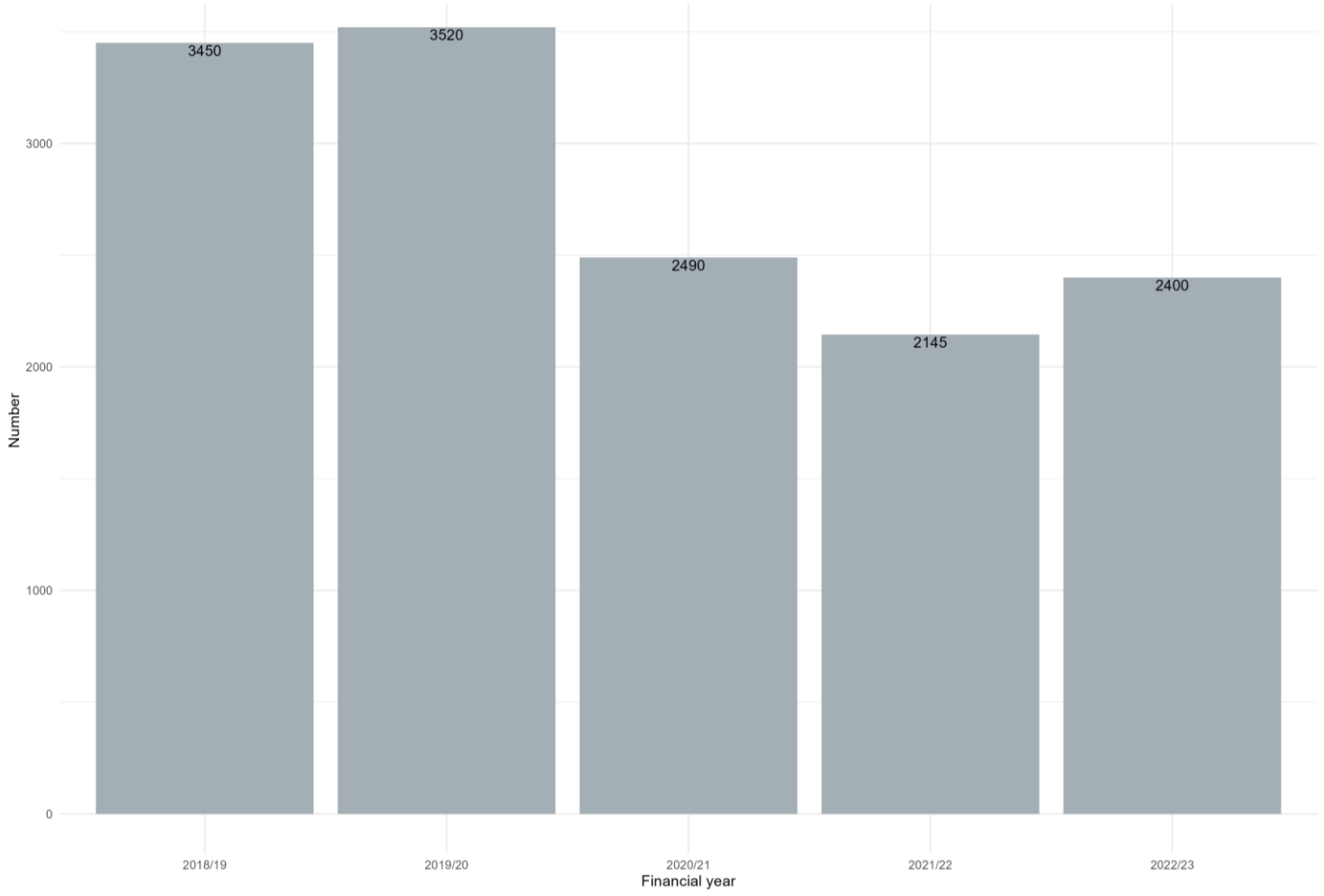
Hospital admissions: Number of people identified as homeless - South East 2018/19 – 2020/23

The number of people identified as homeless among those admitted to hospital in the South East between 2018/19 and 2020/23 is demonstrated in this chart. The highest number was in 2019/20, when 3520 people admitted to hospital were identified as being homeless.

The number reduced to 2490 in 2020/21, which may in part be due to the Covid-19 pandemic and the national "Everyone In" initiative which aimed to support those experiencing homelessness and accommodate them, ensuring that as few as people as possible returned to life on the streets.

Numbers were at their lowest in 2021/22 with 2145 people admitted to hospital in the South East being identified as homeless.

Of note, no admissions data was available for Frimley NHS Foundation Trust from mid-June 2022 to March 2023, which will impact numbers for the South East.



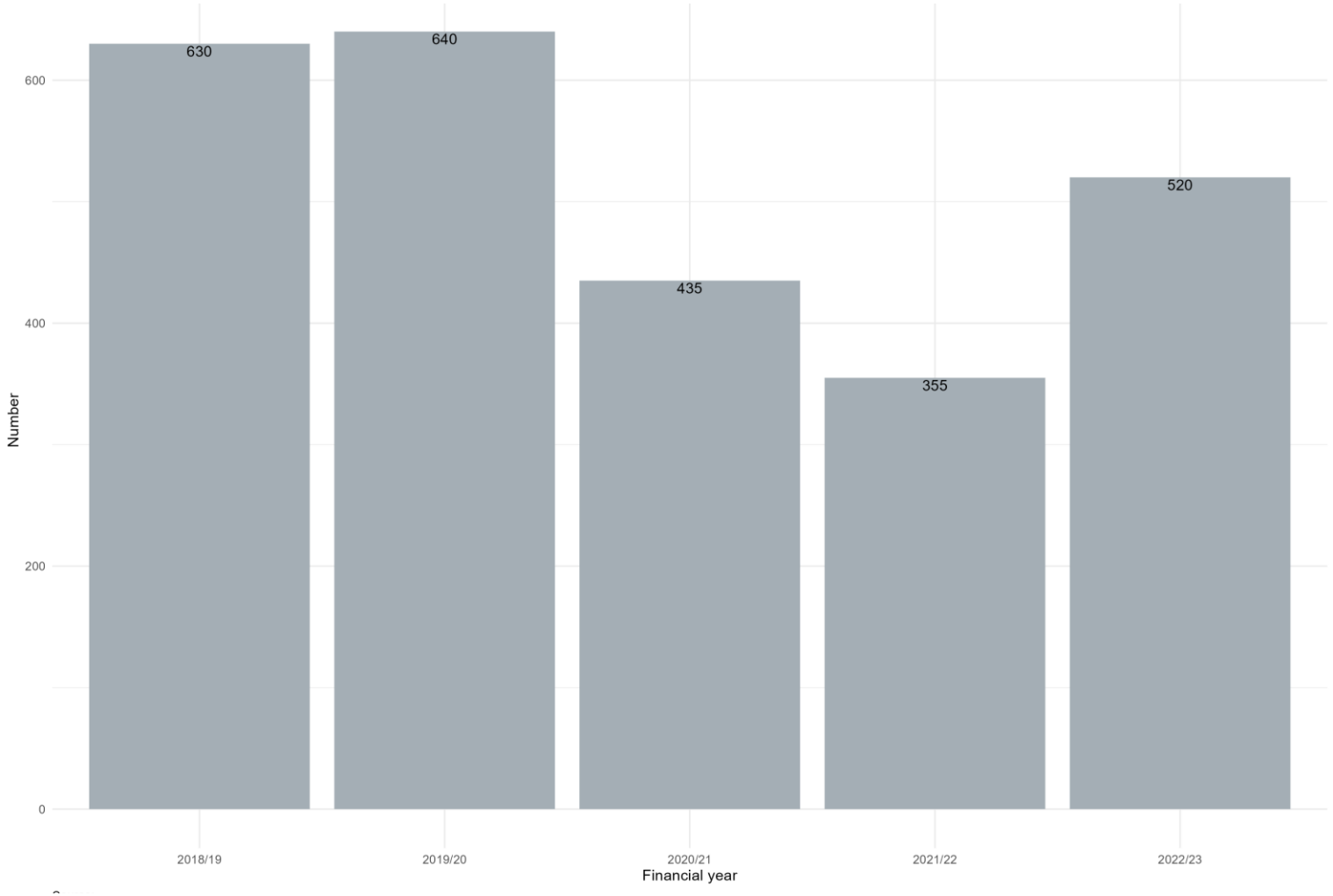
Source: Hospital Episode Statistics Admitted Patient Care (APC) Copyright © 2023

Hospital admissions – number of people identified as homeless: NHS HIOW ICB 2018/19 – 2022/23

Numbers of people admitted to hospital who were identified as homeless across Hampshire and Isle of Wight ICB from 2018/19 to 2022/23 follows a similar pattern to that seen across the South East with a peak seen in 2018/19, but more recent values starting to increase again.

While relatively small numbers, people experiencing homelessness are likely to have complex physical and mental health issues – often either undiagnosed, or under-treated. The higher use of the Emergency Department represents a high cost and resource intense environment.

In addition, these numbers are likely to be an underestimate due to the methodology challenges and data at an ICB level will mask inequalities seen across the system and at a Place level.



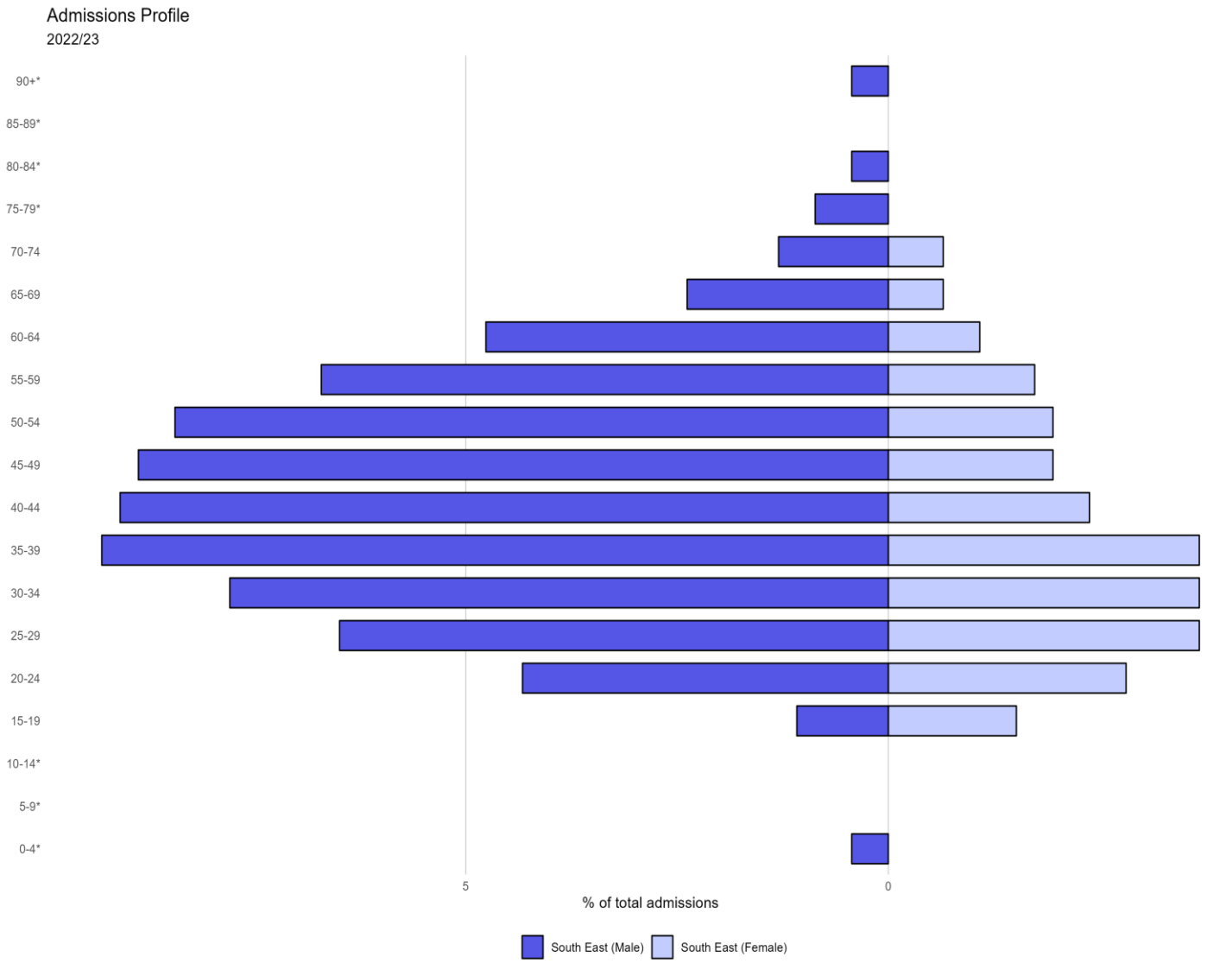
Source: Hospital Episode Statistics Admitted Patient Care (APC) Copyright © 2023

Homeless Admissions profile in the South East: 2022/23

This population pyramid demonstrates the percentage of hospital admissions among those identified as homeless, by age and gender.

Across the South East in 2022/23, most of those identified as homeless population were men with the highest percentage of being in the 35–39 age group. For females, the highest percentage of admissions across the 25–39 age range.

Data from the Office of National Statistics has previously identified that 8 out of 10 people sleeping rough are male. However, homelessness encompasses more than rough sleeping. Although this pyramid gives a snapshot of those admitted to hospital and identified as homeless by age and gender, it does not enable us to describe who within the homeless population may be at a higher risk of admission.



Notes:
There were 2,360 admissions for homeless people/people of no fixed abode in the South East in 2022/23. 95 (4%) had a SEX that was not specified or not known and/or did not have a valid STARTAGE. They have therefore been excluded from thepopulation pyramid calculations
* Values in these age groups have been suppressed as the admission count is between 1 and 7

Homeless admissions: Reason for admission in the South East by count and percentage (2022/23)

The table outlines the primary cause for admission among those identified as homeless in the South East in 2022/23.

The most common reason for admission was due to mental and behavioural disorders (21.7%), followed by “not elsewhere classified” (20.2%) and “injury, poisoning and certain other consequences of external causes” (18.1% of admissions).

Admissions in this table are only classified on the basis of their primary diagnosis code and it is acknowledged that patients may have a number of co-occurring medical conditions, which are not reflected in this analysis.

ICD-10 chapter	Count	Percent
Mental and behavioural disorders	520	21.7
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	485	20.2
Injury, poisoning and certain other consequences of external causes	435	18.1
Diseases of the digestive system	145	6
Pregnancy, childbirth and the puerperium	105	4.4
Diseases of the respiratory system	105	4.4
Diseases of the circulatory system	105	4.4
Diseases of the skin and subcutaneous tissue	85	3.5
Diseases of the musculoskeletal system and connective tissue	80	3.3
Endocrine, nutritional and metabolic diseases	60	2.5
Certain infectious and parasitic diseases	60	2.5
Factors influencing health status and contact with health services	55	2.3
Diseases of the genitourinary system	50	2.1
Diseases of the nervous system	35	1.5
Neoplasms	35	1.5
Codes for special purposes	15	0.6
Diseases of the eye and adnexa	10	0.4
Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	-	-
Diseases of the ear and mastoid process	-	-
Certain conditions originating in the perinatal period	-	-
Congenital malformations, deformations and chromosomal abnormalities	-	-
Total	**2400**	**100**

Notes:
The primary diagnosis code, which represents the main condition treated or investigated during the episode, has been used to allocate the episode to the ICD-10 chapter
Counts have been rounded to the nearest 5. "-" indicates suppressed count as the number of episodes is between 1 and 7

Reasons for admission: Homeless admissions compared to South East resident admissions 2022/23 (all ages)

Table 1: ordered by SE homeless admissions	SE homeless admissions		SE resident admissions	
ICD-10 chapter	Count	%	Count	%
Mental and behavioural disorders	520	**21.7**	16,215	**0.9**
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	485	**20.2**	253,520	**13.3**
Injury, poisoning and certain other consequences of external causes	435	**18.1**	126,455	**6.6**
Total	2,400	**100**	1,902,625	**100**

For those admitted to hospital in the South East, who were identified as being homeless, the most common cause of admission was mental and behavioural disorders. This accounted for 21.7% of admissions, compared to 0.9% of admissions among the overall South East resident population in 2022/23.

This ICD code can be broken down further and for those experiencing homelessness, the most common cause of admission within the mental and behavioural disorders chapter, was due to alcohol – which accounted for 10.2% of total admissions for this population group. However, alcohol only accounted for 0.2% of admissions for the overall South East resident population. This was followed by “symptoms and signs involving emotional state (5.5% of admissions) which contributed to the “symptoms, signs and abnormal clinical and laboratory findings not elsewhere classified” chapter. In comparison, this only accounted for 0.2% of admissions for the overall South East resident population.

Homelessness – Households Owed a Relief Duty

Under section 189B of the 1996 Homelessness Reduction Act, the "Relief duty" requires housing authorities to help people who are homeless to secure accommodation. The duty applies when the housing authority is satisfied that the applicant is both homeless and eligible for assistance and requires an authority to "take reasonable steps to help the applicant to secure suitable accommodation with a reasonable prospect that it will be available for their occupation for at least six months".

The charts on the following slides look at the scale of the issue of homelessness by capturing the number of households owed a relief duty under the Homelessness Reduction Act as crude rate.

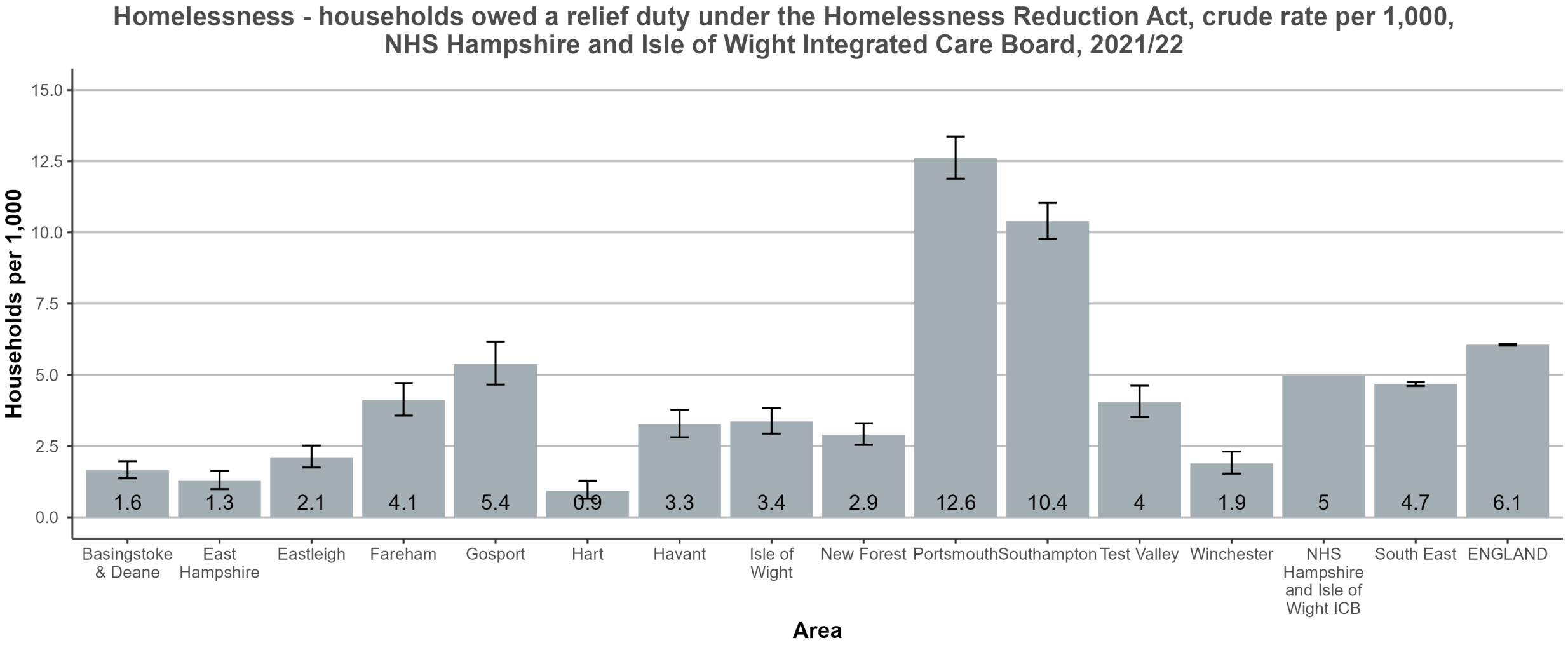
Rates are shown per 1,000 households. For example, on the following slide, the South East has a value of 4.7, this implies that in the South East, 4.7 households out of 1,000 households are owed a relief duty.

The data is broken down at a local authority level; where no figure is shown for a local authority this implies that the source data for that local authority is missing.

ICB values have been calculated from local authority figures using the PHE aggregations method where possible. The data for any LA, which is only partly in an ICB, is for the whole LA and not for the part within the ICB. The proportion for the ICB (where available) is aggregated from the data for each LA which has been weighted for the part of the population within the ICB. In cases where a local authority value is missing, the ICB value cannot be calculated. Confidence intervals for ICBs cannot be calculated where local authority geographies used to build up to the ICB geography are overlapping (further details are outlined in the Technical Guidance for the aggregation method).

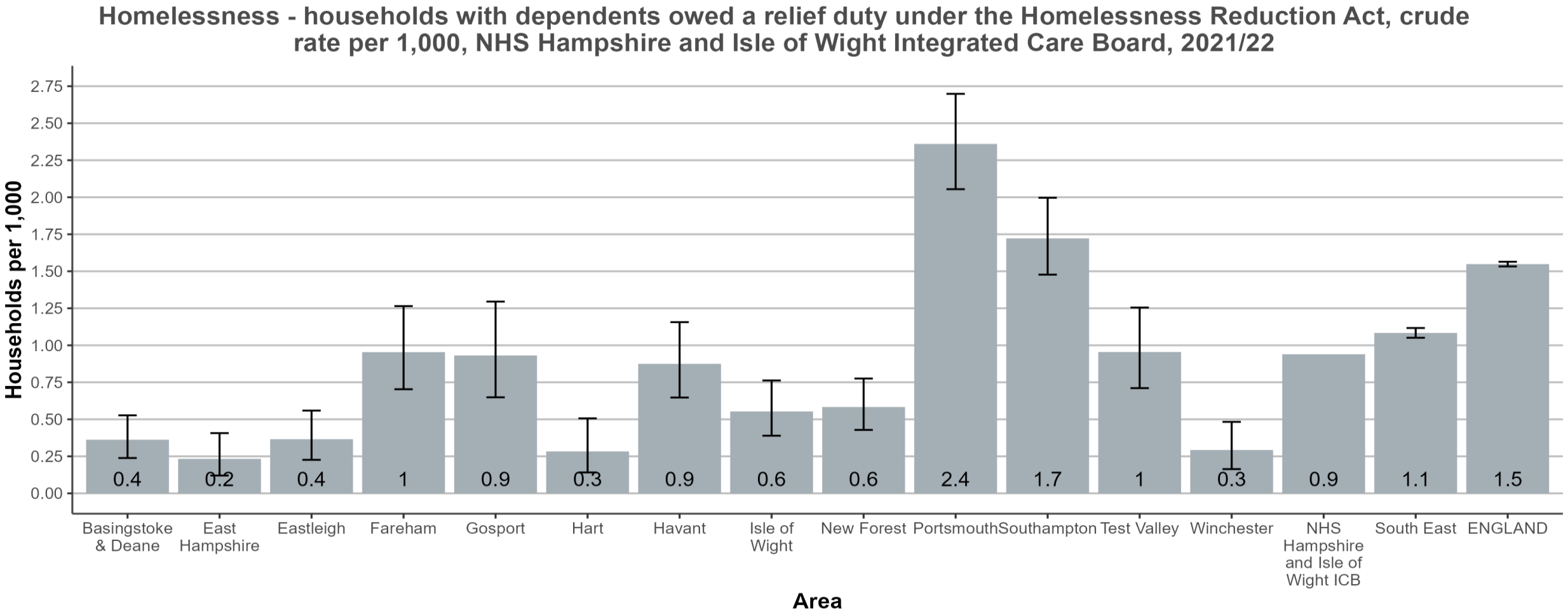
Full details on numerator and denominator definitions are provided in the notes on each slide.

Households owed a relief duty under the Homelessness Reduction Act - NHS Hampshire and Isle of Wight ICB



Source: ONS Statutory homelessness in England: financial year 2020-21, ONS 2018-based household projections for mid-2022, ONS mid-year population estimates 2020

Households with dependents owed a relief duty under the Homelessness Reduction Act - NHS Hampshire and Isle of Wight ICB



Source: ONS Statutory homelessness in England: financial year 2020-21, ONS 2018-based household projections for mid-2022, ONS mid-year population estimates 2020

Homelessness – Temporary Accommodation

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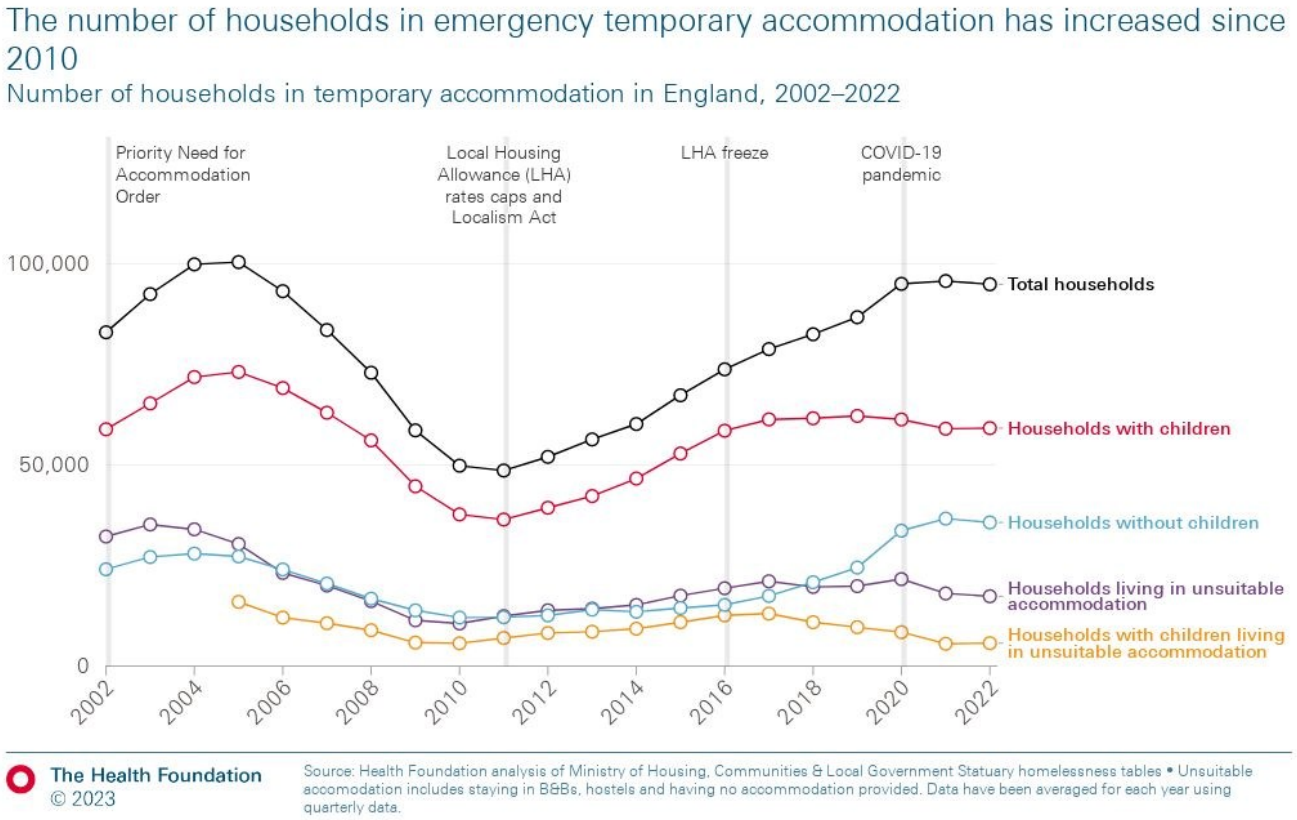
Households in emergency temporary accommodation in England

Temporary accommodation (TA) is a broad term given to the housing which local authorities provide for people who are deemed as being in priority need (mostly families with children, pregnant women, or people with disabilities) and eligible (dependent on immigration status), when the authority does not have anywhere suitable straight away. It can include B&Bs, hostels, hotels, private rented houses or flats, and council or housing association properties.

The chart shows the number of households that have been placed in temporary accommodation in England since 2002 – people who have been classed by their local authority as being, or becoming, homeless and in need. The overall number of households in temporary accommodation has risen by 95% since 2011 (The Health Foundation).

On 31 March 2023, 104,510 households were in temporary accommodation, up 10.0% from the same period in 2022. The most common length of time for households with children to be in temporary accommodation was for 2 to 5 years accounting for 26.3% of households with children (Statutory homelessness in England 2022-2023).



Health Impacts of Temporary Accommodation

Data from Shelter in 2022 revealed two-thirds of families living in Temporary accommodation have been there for more than 12 months (more than four-fifths for those in London). Two in three people report temporary accommodation as having a negative impact on their physical or mental health with 71% reporting that their stress or anxiety had worsened because of their living situation (Shelter). A significant proportion of people in temporary accommodation have physical health problems but, like other types of homelessness, they often experience barriers to accessing health services, particularly primary and preventative healthcare.

Growing up in temporary accommodation can have a profound effect on the health outcomes of children and young people[1], in particular those under the age of five years[2]. It can affect their life chances by limiting access to universal healthcare, e.g. immunisation; disrupting education; and loss of social and family support if the family is placed "out of area". One evidence review found children who have been in temporary accommodation for more than a year are over three times more likely to demonstrate mental health problems such as anxiety and depression than non-homeless children. They were also at greater risk of infections and accidents[3].

A 2023 report by the All Party Parliamentary Group for Households in Temporary Accommodation, reviewed child deaths in the National Child Mortality Database reported between 1 April 2019 and 31 March 2022. They found there were at least 200 individual records where homelessness or living in temporary accommodation were recorded as present in the child's mother, child, or child's family life at some stage. In the finalised case reviews, 34 cases had homelessness and temporary accommodation recorded by the independent child death overview panel as factors that may have contributed to the child's vulnerability, ill health or death. In a further 39 child death reviews, overcrowding, threats/enforcement of evictions, and extended family accommodation were recorded as factors that may have contributed to the child's vulnerability, ill health or death. Most of the children were under the age of 1 year.

Homelessness – Households in Temporary Accommodation

The charts on the following slides look at scale of the issue of homelessness by capturing the number of households in temporary accommodation as of June 30th 2022.

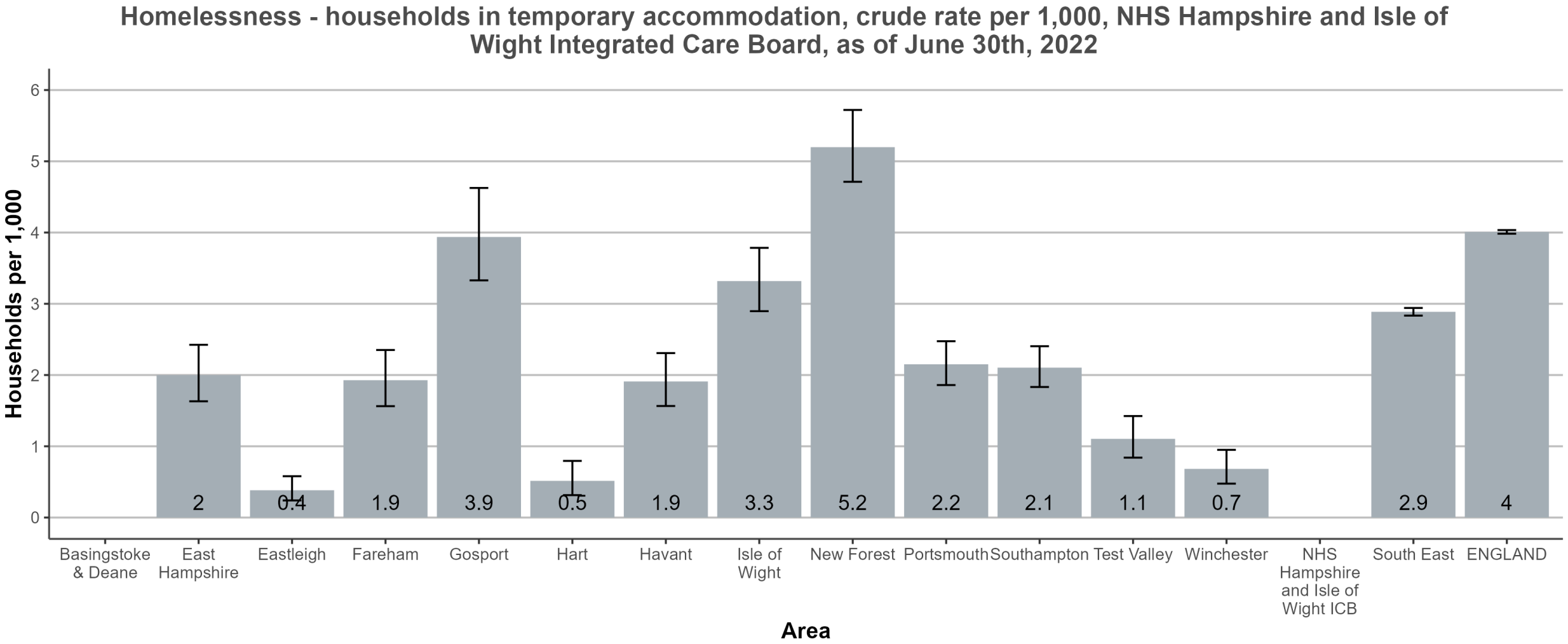
Rates are shown per 1,000 households. For example, on the following slide, the South East has a value of 2.9, this implies that in the South East, 2.9 households out of 1,000 households are owed a relief duty.

The data is broken down at a local authority level; where no figure is shown for a local authority this implies that the source data for that local authority is missing.

ICB values have been calculated from local authority figures using the PHE aggregations method where possible. The data for any LA, which is only partly in an ICB, is for the whole LA and not for the part within the ICB. The proportion for the ICB (where available) is aggregated from the data for each LA which has been weighted for the part of the population within the ICB. In cases where a local authority value is missing, the ICB value cannot be calculated. Confidence intervals for ICBs cannot be calculated where local authority geographies used to build up to the ICB geography are overlapping (further details are outlined in the Technical Guidance for the aggregation method).

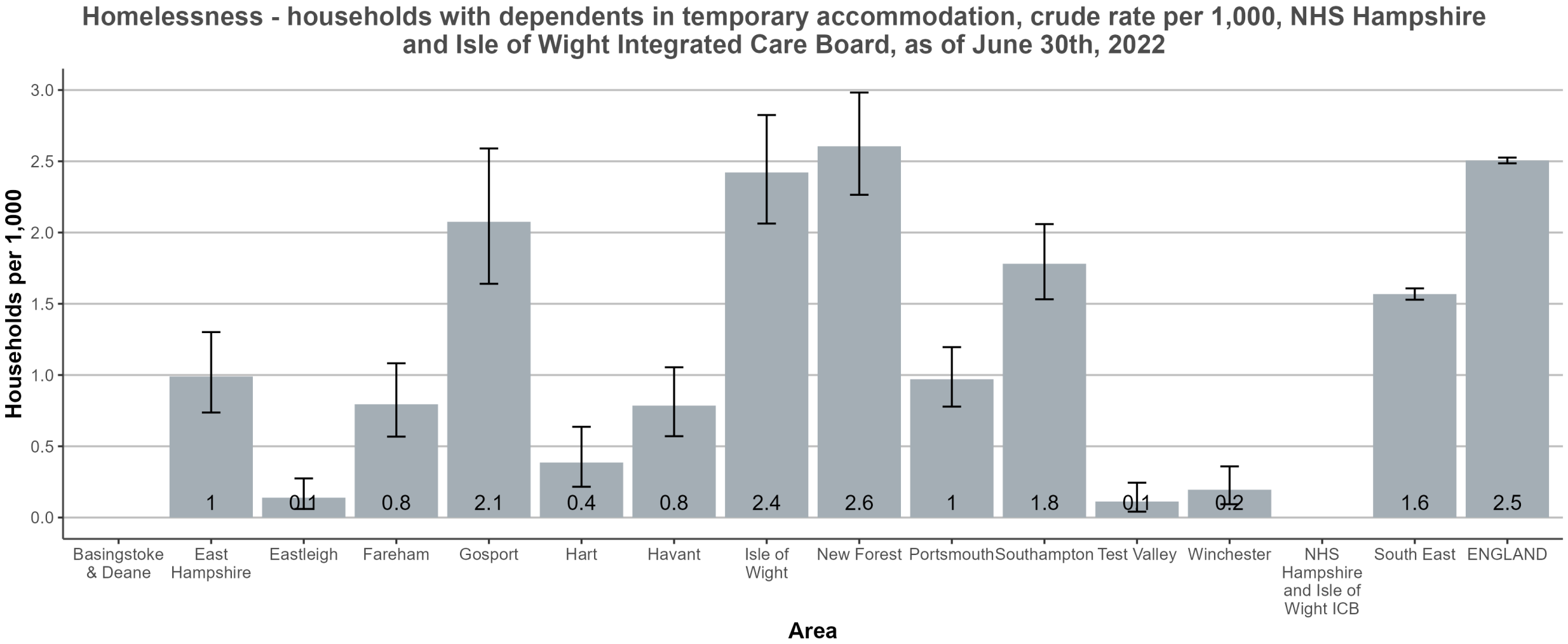
Full details on numerator and denominator definitions are provided in the notes on each slide.

Households in temporary accommodation - NHS Hampshire and Isle of Wight ICB



Source: ONS Statutory homelessness in England: April to June 2022, ONS 2018-based household projections for mid-2022, ONS mid-year population estimates 2020

Households with dependents in temporary accommodation - NHS Hampshire and Isle of Wight ICB



Source: ONS Statutory homelessness in England: April to June 2022, ONS 2018-based household projections for mid-2022, ONS mid-year population estimates 2020

Homelessness – Mental Health

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Homelessness – Households with Mental Health Problems

In the latest Homeless Link Homelessness Health Needs Assessment, the number of people with a mental health diagnosis had increased substantially from 45% in 2014 to 82% in 2018 – 2021[1]. The most frequently reported mental health conditions were depression, anxiety disorder or phobia, and dual diagnosis with a drug or alcohol problem. Serious mental health issues such as schizophrenia, bipolar and post traumatic stress disorder (PTSD) are far more common amongst homeless people. In 2021, alcohol specific causes and suicide accounted for 9.6% and 13.4% of estimated deaths of homeless people (ONS 2022).

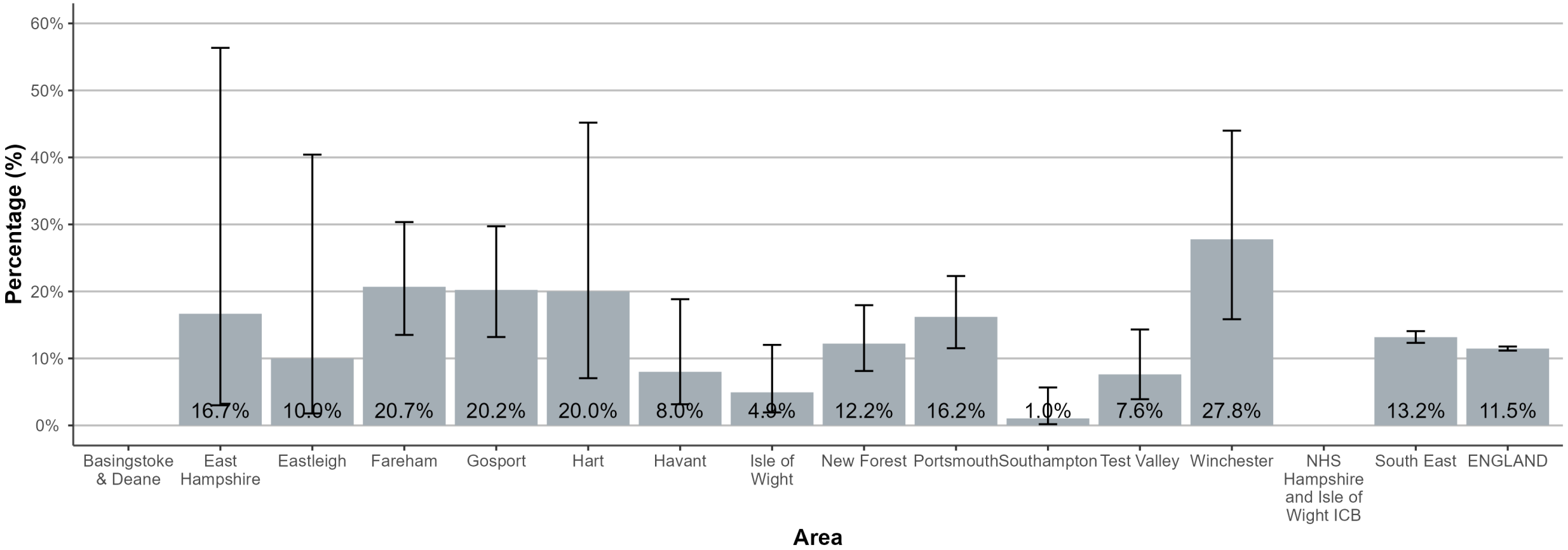
NHS England has funded a number of outreach services, providing co-ordinated efforts to ensure that rough sleepers have better access to NHS mental health support, joining up care with existing outreach, accommodation, drug and alcohol and physical healthcare services.

The charts on the following slides show the proportion of households owed a main duty where one or more members of the household suffer from mental health problems. This is presented as a percentage of the total number of households owed a main duty. For example, the South East has a value of 13.2%, this implies that in the South East, 13.2% of households owed a main duty have a member of the household with mental health problems.

The data is broken down at a local authority level; where no figure is shown for a local authority implies that the source data for that local authority is missing. ICB values have been calculated from local authority figures using the PHE aggregations method where possible. The data for any LA, which is only partly in an ICB, is for the whole LA and not for the part within the ICB. The proportion for the ICB (where available) is aggregated from the data for each LA which has been weighted for the part of the population within the ICB.

Households with mental health owed a main duty: NHS Hampshire and Isle of Wight ICB

Proportion of households owed a main duty with a vulnerable household member suffering from mental health problems as a percentage of total households owed a main duty, NHS Hampshire and Isle of Wight Integrated Care Board, 2021/22



Source: ONS Statutory homelessness in England: financial year 2020-21, ONS mid-year population estimates 2020

Homelessness – Deaths

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Deaths whilst experiencing homelessness: National data

In 2021, there were an estimated 741 deaths of homeless people in England and Wales. Although this was statistically similar to the estimated number of deaths during 2018 – 2021, the estimate in 2021 is significantly higher than the estimates for the period 2013 to 2017, indicating an upward trend. The estimate for 2021 was 53.7% higher than the first estimate in 2013, representing an additional 259 deaths.

The main causes of death in 2021 were as follows:

- Drug poisoning – 35% of deaths
- Suicide – 13.4% of deaths
- Alcohol specific deaths – 9.6% of deaths
- Related to coronavirus – 3.5% of deaths

The vast majority of deaths (87.3%) were amongst men, consistent with findings in previous years. The mean age of death was 45.4 years for men and 43.2 years for women.

Of note, the definition used here relies on information provided on death certificates and does not align with official statistics on homelessness produced by public bodies. For example, these statistics do not use the same definition of homelessness as rough sleeper counts or statutory homelessness. In addition, statistics are based on the year of death registration, not necessarily when the death occurred.

See further information on Safeguarding Adult Reviews.

Source: Source: Deaths of homeless people in England and Wales - Office for National Statistics (ons.gov.uk)

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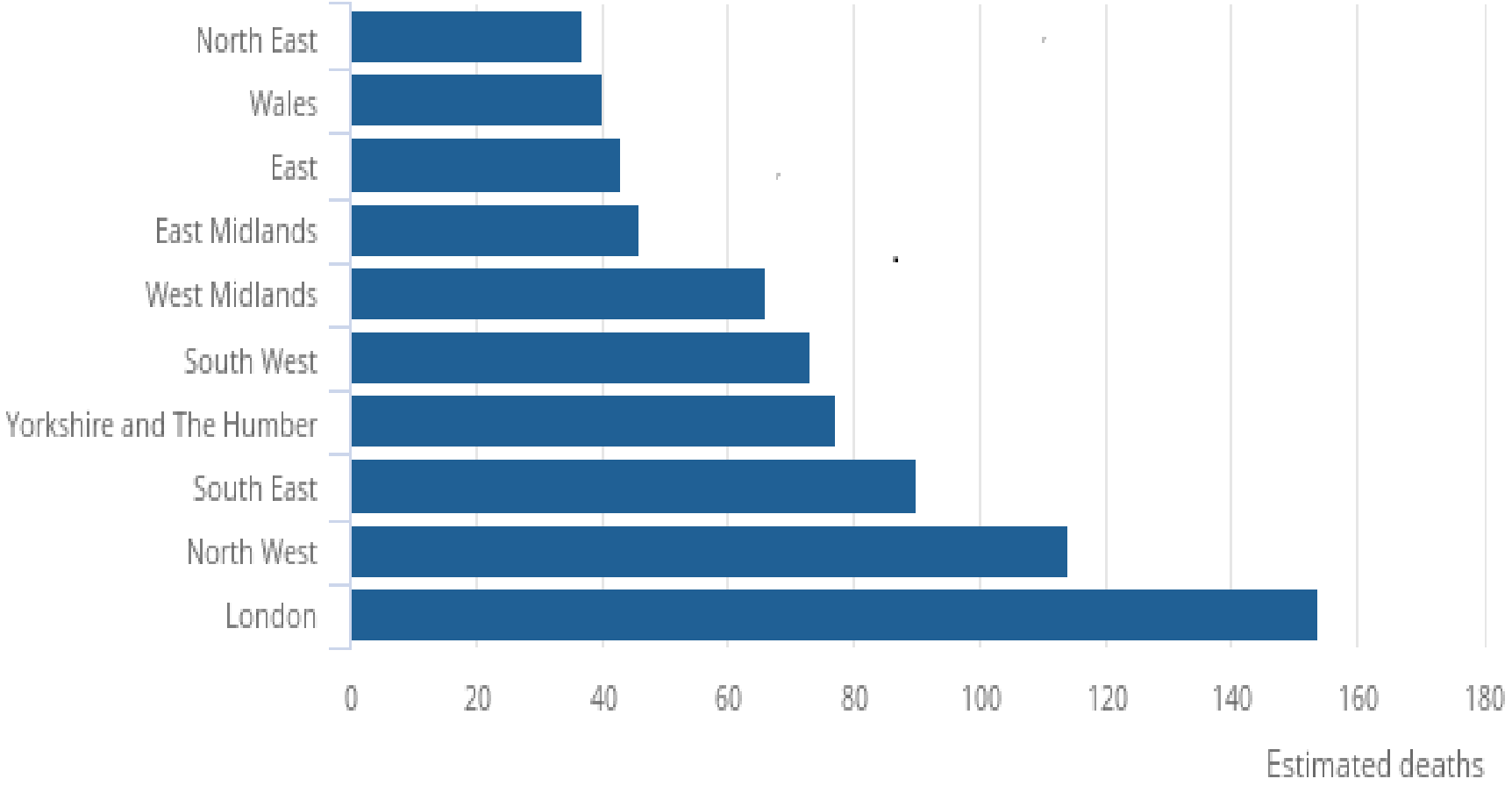
Numbers of deaths of homeless people in English region and Wales, deaths registered in 2021

In 2021, the South East region had the third highest number of estimated deaths of homeless people in England.

It should be noted that there is significant variation across the region.

The ONS figures reported here are the total estimated numbers, except for identified records. The method used provides a robust but conservative estimate, so the real numbers may still be higher.



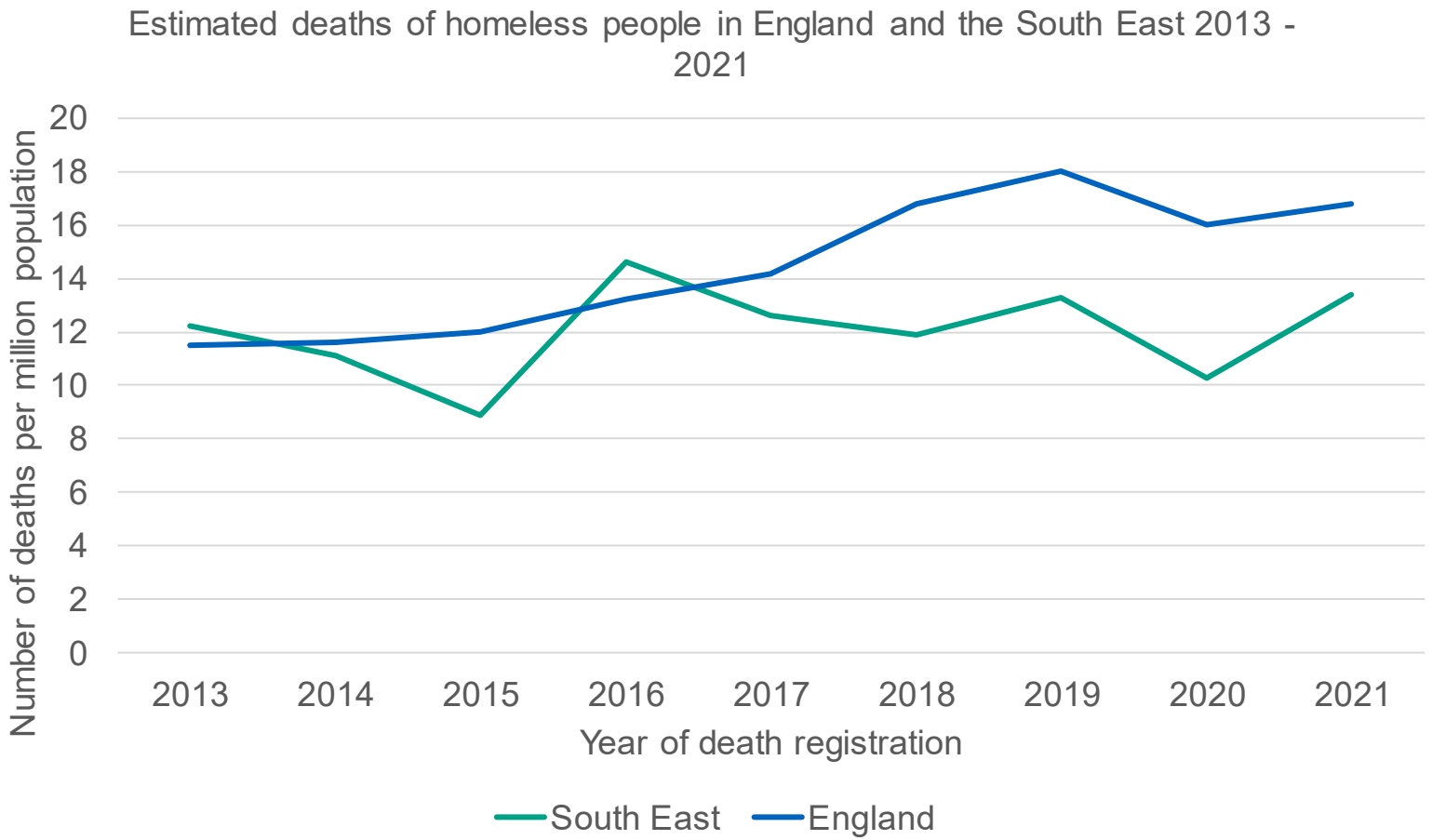
Deaths of homeless people in England and Wales - Office for National Statistics (ons.gov.uk)

Deaths of homeless people per million population: 2013 - 2021

This chart demonstrates the trend in estimated deaths of homeless people for both England and the South East from 2013 – 2021.

Deaths are identified from death registration records held by ONS and allocated to the year of death registration. This is likely to be an under-estimate of the actual numbers.

On the following slide, data is presented at ICB level, describing the number of deaths occurring in people experiencing homelessness in 2021



Source: Deaths of homeless people in England and Wales - Office for National Statistics (ons.gov.uk)

Deaths occurring in people experiencing homelessness (2021): NHS Hampshire and Isle of Wight ICB

Area Name	Identified deaths	Estimated deaths	Estimated deaths per million total population
Portsmouth	4	0	36.3
Southampton	2	0	15.4
Isle of Wight	1	2	
Basingstoke and Deane	0	0	
East Hampshire	0	0	
Eastleigh	1	2	
Fareham	1	2	
Gosport	1	2	
Hart	0	0	
Havant	0	0	
New Forest	0	0	
Test Valley	1	2	
Winchester	0	0	

Source: Source: Deaths of homeless people in England and Wales, Office for National Statistics.
Available from Deaths of homeless people in England and Wales - Office for National Statistics (ons.gov.uk)

Homelessness Resources & Organisations

Resources

- Homelessness: applying All Our Health
- NICE Guideline 214 – Integrated health and social care for people experiencing homelessness
- Homeless and Inclusion Health standards for commissioners and service providers
- Guidance on the duty to refer
- Beyond the ward: Exploring the Implementation of the Duty to Refer in Hospital Settings
- Homeless and Inclusion Health Programme – The Queen's Nursing Institute
- Supporting people experiencing homelessness in an accident and emergency setting
- Citizens Advice cost-of-living data dashboard
- Ending rough sleeping for good
- Better than cure? | Crisis UK

Organisations

- Homeless Link
- Pathway
- Crisis
- Groundswell

Gypsy, Roma, Travellers

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Gypsy, Roma Travellers: Contents

- Gypsy, Roma Travellers: Key messages
- Gypsy, Roma Travellers: an overview
- Inequalities experienced by Gypsy, Roma Travellers
- Gypsies' and Traveller's lived experiences, overview in England and Wales
- Gypsy, Roma Traveller populations (2021 Census data)
- Number of traveller caravans on authorised sites in the South East
- Count of Traveller caravans by site type
- Gypsy, Roma Travellers: Organisations

Gypsy, Roma Travellers: Key messages

- Gypsy, Roma Traveller communities are among the most disadvantaged minority groups in the UK with life expectancies 10 – 25 years shorter than the general population.

- They face significant discrimination and stigma, resulting in lower access to both preventative services and healthcare, leading to worse health outcomes across a range of measures, including an infant mortality rate which is 3 times higher than that of the general population[1].

- Despite being an available ethnic category within NHS services, Gypsy, Roma Travellers are often not recognised in the data. As a result, healthcare services are often unaware of the severe inequalities that exist and are unable to measure progress against tackling them.

Gypsy, Roma, Travellers: an overview

The 2021 census identified 63,443 Gypsy or Irish Travellers in England and Wales, with over 100,000 people identifying as Roma[1]. This is likely to be an underestimate with the biannual Traveller caravan count and school roll figures suggesting there are around 200,000 – 300,000 Romany Gypsy and Traveller people living in England and Wales.

Gypsy, Roma and Traveller communities are among the most disadvantaged minority groups in the UK. They are vulnerable to a range of negative health outcomes, created through a combination of health conditions, delayed healthcare seeking and barriers to accessing healthcare. They can experience challenges to registering with a GP surgery, with subsequent barriers to accessing screening and preventative healthcare.

Issues relating to stigma and discrimination may mean that individuals are less likely to self-declare as being a member of this community, resulting in this population often not being recognised in data sets. Therefore, local data is often lacking on health outcomes. Services often fail to recognise and account for the premature onset of typically age-related conditions in this community. The average health of a Romany or Traveller person in their 60s is comparable to that of a White person in their 80s[1], meaning a much younger onset of conditions such as frailty, falls and dementia.

Inequalities experienced by Gypsy, Roma Travellers

The suicide rate for Irish Traveller women is 6 times higher than the general population and seven times higher for Irish Traveller men[1].

Romany and Traveller people face life expectancies between 10 and 25 years shorter than the general population[2].

In 2016 – 2017, Gypsy or Irish traveller people aged 65 and over had the lowest health related quality of life of all ethnic groups[3].

At all key stages, Gypsy, Roma and Irish traveller pupil's attainment was below the national average[3].

Children from Irish Traveller families are over 3 times as likely to be eligible for free school meals than White British Children[4].

Infant mortality rate among the Irish Traveller population is 3.5 times that of the general population with 10% of Traveller children dying before their second birthday[5].

Gypsies, Travellers and Roma are less likely to access immunisation with barriers cited including language, low literacy, discrimination and low trust[6].

Gypsies and Travellers are three times as likely to suffer from anxiety and twice as likely to suffer from depression compared to the general population[7].

42% of Gypsies and Travellers are affected by a long-term condition, compared to 18% of the general population[8].

Gypsies' and Travellers' lived experiences: England and Wales 2022

In November 2021, the Office for National Statistics (ONS) commissioned Derbyshire Gypsy Liaison Group to collaborate on a research project into the experiences, priorities and needs of Gypsy and Traveller communities in England and Wales.

Key findings included:

- The importance of close-knit family and social groups and of shared moral values was described as fundamental to Gypsy and Traveller culture, communities and wellbeing
- Participants' living situations varied greatly from houses or flats, to chalets on private land and large sites owned and managed by the local authority. The lack of authorised stopping places was described, along with an apprehension of being moved on by Police.
- Barriers to employment include a lack of skills, education or formal qualifications and perceived discrimination from employers, colleagues and the settled community
- A range of health conditions was described, along with delayed healthcare seeking and barriers to accessing healthcare which were highlighted as potentially creating vulnerability to negative health outcomes. Particular challenges included:

  - Environmental factors including site locations and standards
  - Challenges in registering with a GP surgery without a fixed address
  - Delays in diagnosis and treatment along with delayed access to screening and preventative care
  - Perceived discrimination and derogatory attitudes of healthcare providers
  - Familiarity, understanding and open communication with trusted health practitioners were described as supportive to access and engagement with healthcare.

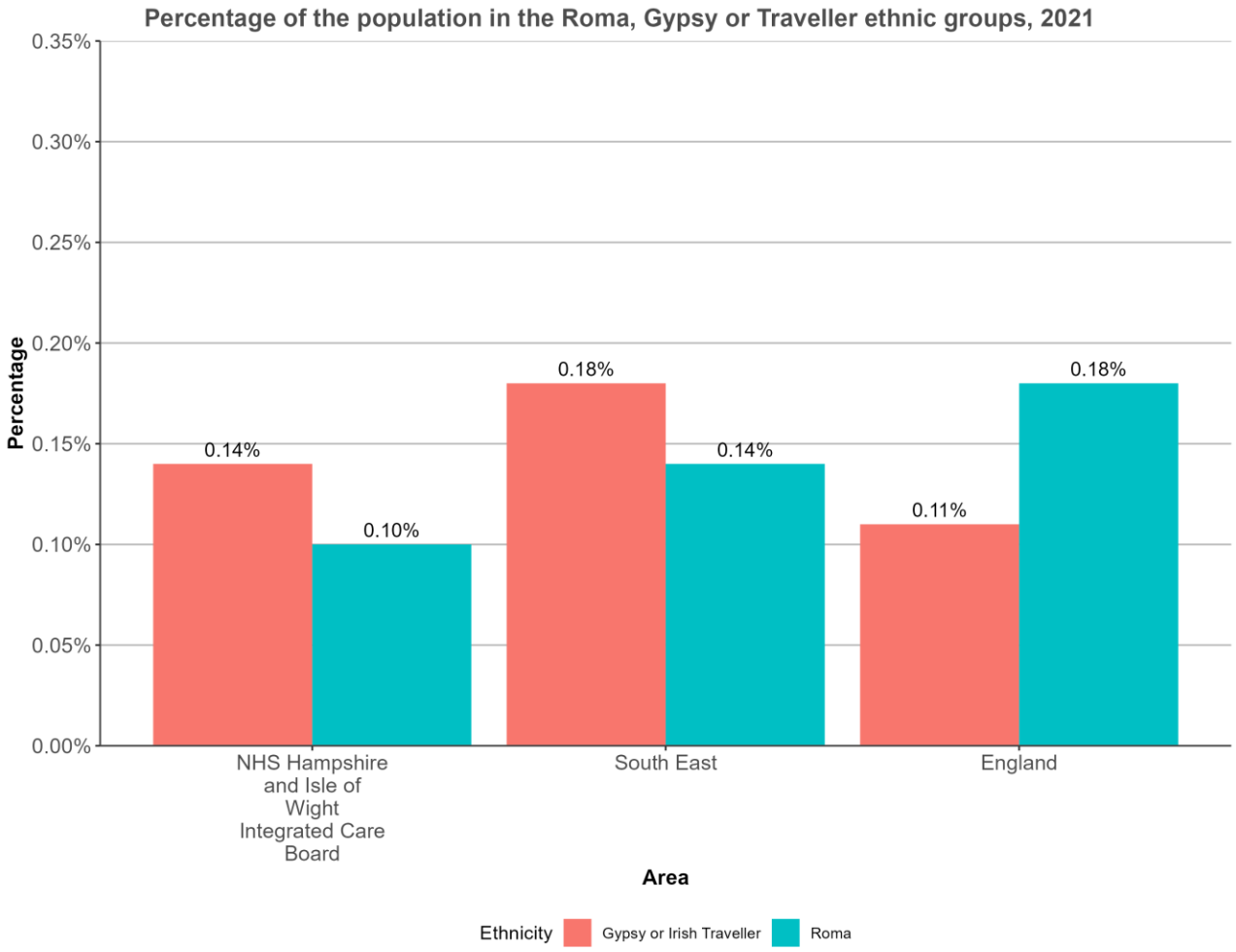
Gypsies' and Travellers' lived experiences, overview, England and Wales (ONS)

Roma, Gypsy and Irish Travellers: NHS Hampshire and Isle of Wight ICB

0.1% (1,858) of the population of NHS Hampshire and Isle of Wight Integrated Care Board identify as Roma. This can be compared to 0.14% (12,202) for the South East and 0.18% (99,102) for England

Similar figures are seen for the Gypsy or Irish Traveller group where 0.14% (2,574) of the population of NHS Hampshire and Isle of Wight Integrated Care Board identify as Gypsy or Irish Traveller. Compared to 0.18% (16,598) for the South East and 0.11% (64,214) for England

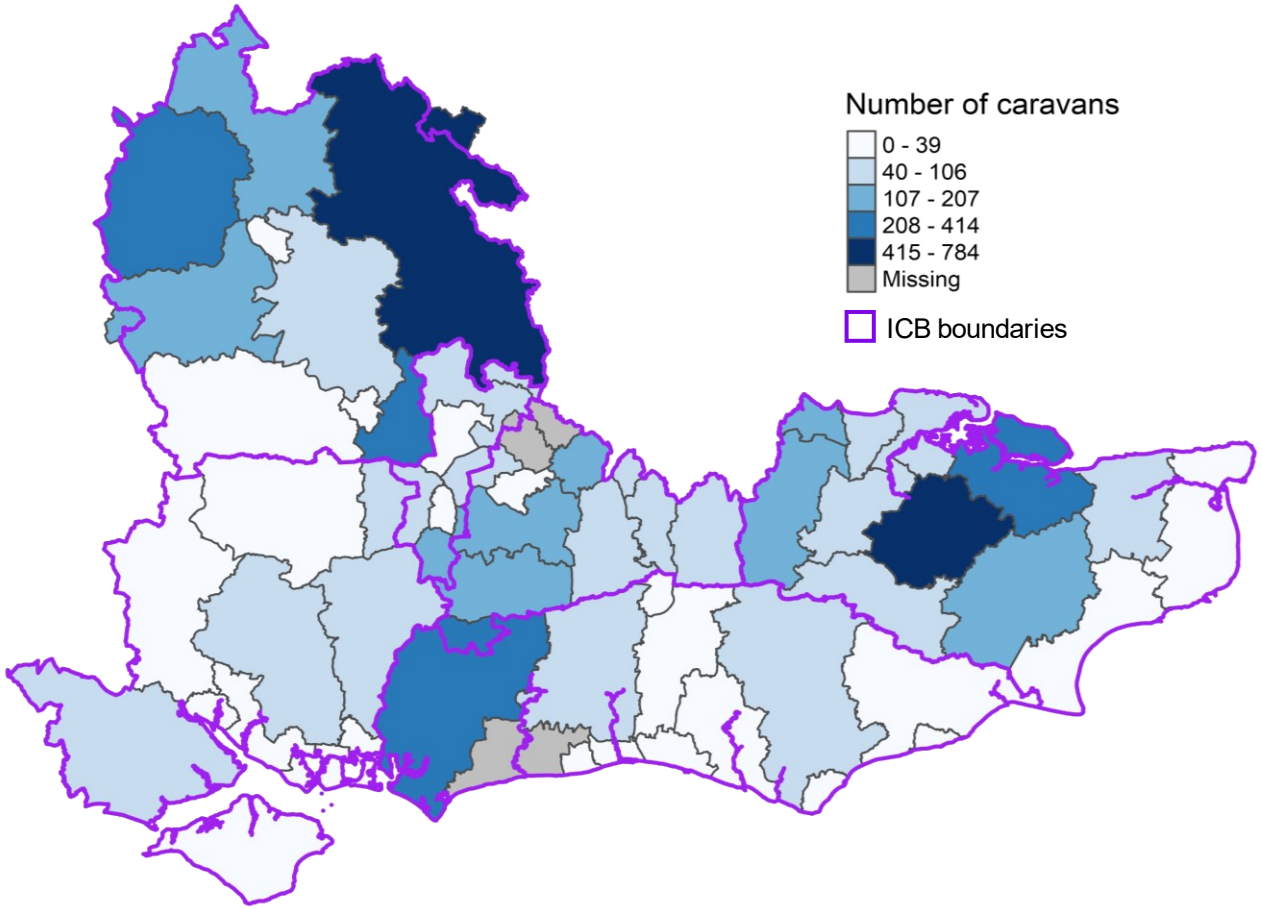
Due to the nature of these groups, very limited data is available when looking at health inequalities and breakdowns.



Souce: Census 2021

Source: 2021 Census. Available from [Nomis - Official Census and Labour Market Statistics (nomisweb.co.uk)]

Number of traveller caravans on authorised sites in the South East, by lower tier local authority, July 2022



Buckinghamshire and Maidstone had the highest number of traveller caravans on authorised sites in the South East in July 2022 (784 and 608 caravans respectively)

Source: Count of Traveller Caravans, Department for Levelling Up, Housing & Communities (2022). Available from Traveller caravan count - GOV.UK (www.gov.uk)

Count of Traveller caravans by site type – South East, July 2022 (excluding Milton Keynes)

	Number of Traveller caravans, July 2022	Percentage of total caravans, July 2022
Caravans on authorised sites (with planning permission)	5,415	86.5%
Socially rented caravans	1,154	18.4%
Private caravans	4,261	68.1%
Temporary planning permission	178	2.8%
Permanent planning permission	4,083	65.3%
Caravans on unauthorised sites (without planning permission)	842	13.5%
Caravans on sites on Travellers' own land	775	12.4%
Tolerated	222	3.5%
Not tolerated	553	8.8%
Caravans on sites not on Travellers' own land	67	1.1%
Tolerated	20	0.3%
Not tolerated	47	0.8%
Total all Traveller caravans	**6,257**	**100.0%**

Source: Count of Traveller Caravans, Department for Levelling Up, Housing & Communities (2022). Available from Traveller caravan count - GOV.UK (www.gov.uk)

Count of Traveller caravans by site type – NHS Hampshire and Isle of Wight ICS, July 2022

	Caravans on authorised sites (with planning permission)			Caravans on unauthorised sites (without planning permission)			
Local Authority	Socially rented caravans	Private caravans	Total caravans on authorised sites	Caravans on Traveller's own land	Caravans on sites not on Travellers' own land	Total unauthorised caravans	Total traveller caravans
Portsmouth	0	0	0	0	0	0	0
Southampton	19	0	19	0	0	0	19
Isle of Wight	0	0	0	15	0	15	15
Basingstoke & Deane	0	6	6	11	0	11	17
East Hampshire	0	60	60	0	0	0	60
Eastleigh	0	28	28	8	0	8	36
Fareham	0	12	12	0	0	0	12
Gosport	0	0	0	4	0	4	4
Hart	31	60	91	0	0	0	91
New Forest	0	69	69	0	0	0	69
Test Valley	0	23	23	0	0	0	23
Winchester	0	53	53	87	0	87	140

Source: Count of Traveller Caravans, Department for Levelling Up, Housing & Communities (2022). Available from Traveller caravan count - GOV.UK (www.gov.uk)

Gypsy, Roma Travellers: Organisations

- Friends, Families & Travellers
- The Traveller Movement
- Margaret Clitherow Trust
- Leeds Gate Gypsy & Traveller Exchange
- Pavee Point: Traveller and Roma Centre
- Roma Support Group

Sex workers

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Sex workers: Contents

- Sex workers: Key messages
- Sex workers overview
- Sex workers and the law
- Visual representation of the various "sectors" of sex work
- Exploring the Health and Wellbeing (HWB) needs of Sex Workers in two English Regions
- Sex workers: demographics
- Health outcomes for sex workers
- Sex workers: Resources and organisations

Sex workers: Key messages

- Studies have shown that the population of sex workers is diverse and rapidly changing but there is a lack of data and insight which makes analysis difficult. Whilst routine data does not exist at national, regional or local level, this does not mean that addressing the health and care needs of sex workers are not important.

- Many sex workers experience a syndemic, where a multitude of social problems, such as poverty, violence and homelessness, combine to negatively impact on health in a way that is more severe than if they were affected by just a single social issue.

- Sex work is associated with high levels of social stigma. Fear of stigmatisation and of criminalisation result in reduced contact with health and other support services, compounding health issues and leading to greater social exclusion.

Sex workers overview 1/2

Limited data was found regarding sex workers in the UK. A systematic review and meta-analysis of four inclusion health populations found that sex workers were the least well investigated[1]. The NIHR is currently offering funding as part of the Public Health Research Programme to look at what interventions improve health outcomes for sex workers[2]. The lack of data is in part due to the following reasons[3]:

Criminalization: Sex work is largely criminalized in the UK, which means that sex workers often operate underground and may be reluctant to share information about their work. This can make it difficult to gather accurate data.

Stigma: There is a significant social stigma attached to sex work, which can make sex workers hesitant to reveal their identities or provide information about their work. This can lead to underreporting and inaccurate data.

Methodological challenges: Conducting research on sex work can be methodologically challenging. For example, it can be difficult to obtain a representative sample of sex workers, as they may be dispersed across different locations and may be difficult to identify. It can also be challenging to develop questions that are sensitive to the experiences of sex workers and that will elicit accurate and meaningful responses. One study, which surveyed sex workers aged 19 years or older, found 37% of participants did not disclose their occupation to healthcare providers[3].

The lack of routinely collected data means this pack does not include data at an ICB level. It is however recognised that local data may be available as part of bespoke pieces of work or needs assessments. While routine data does not exist at national, regional or local level, this does not mean the issue is not important.

Sex workers overview 2/2

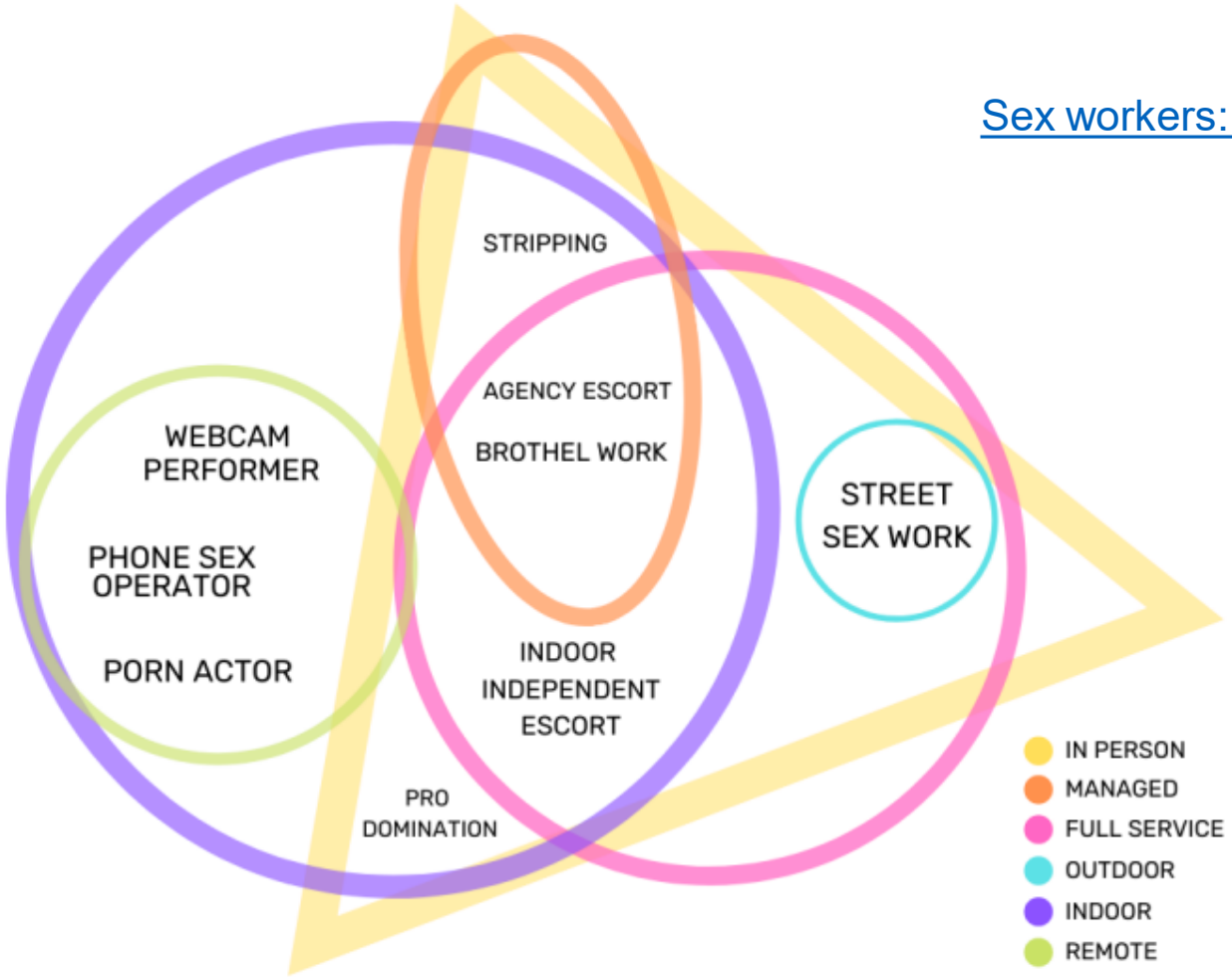
"Sex work lies in the intersection of a broad range of health inequalities. The complexity of the issue and morality politics cannot stand in the way of recognising the health risks sex workers face. It is time to put the health and safety of sex workers at the forefront of policy decisions and crucial to offer a structure for the implementation of effective policy interventions, protection, and research."
The Lancet editorial, February 2023

Sex workers are a diverse population, based on the type of services they provide, so their health and wellbeing needs vary. In the UK, sex work is associated with a number of poor health outcomes and sex workers are disproportionately at risk of poor physical and mental health. Street-based sex workers are highly marginalised, facing face disproportionate health inequities and harms related to: substance use; blood borne viruses, such as HIV, hepatitis B, and hepatitis C; and sexually transmitted infections (STIs)[1,2,3].

Sex workers can encounter high rates of physical, verbal, and sexual violence from intimate partners, with perpetrators posing as clients[1]. Reporting these offences is largely dependent on the quality of local relationships with police[5]. Some sex workers encounter additional stigma, for example, people who are from gender or sexual minority populations. The changing nature of sex work means that increasingly, work is being carried out in off the street and online environments, using digital platforms for engagement[4]. Not all sex work is experienced in the same way with the type of sex work and the entry and exit points into the work varying significantly. It, therefore, may be difficult to distinguish sex workers from other patients.

It is important to recognise that the varied type of sex work means there is a broad range of occupational experiences. This population group reflects the intersectionality with other inclusion health groups, such as homelessness, modern slavery, drug and alcohol dependence and contact with the criminal justice system.

Visual representation of the various "sectors" of sex work



[Sex workers: A guide for professionals (2021)]

Sex workers and the law

The exchange of sexual services for money is legal in the UK (apart from in Northern Ireland where it's illegal to pay for sex). 'Sex work' can be prostitution, stripping or lap dancing, performing in pornography, phone or internet sex, or any other sexual services in return for money, goods, or other agreed items.

The National Ugly Mugs charity defines sex work as "the exchange of sexual services for money or resources. This definition incorporates a range of different modes of sex work, including, but not limited to: street sex work, brothel work, escorting, adult film, stripping, professional BDSM services, phone sex and camming".

The following activities are illegal under the Sexual Offences Act 2003:

- soliciting (trying to get clients) on the street or other public place, including someone in a vehicle
- paying for the services of a sex worker who is forced or threatened into it
- owning or managing a brothel (any premises which is used by more than one person for sex work)
- pimping (someone who has control over sex workers and the money they earn)
- advertising sexual services, including putting cards in phone boxes.

Exploring the Health and Wellbeing (HWB) needs of Sex Workers in two English Regions

UK Health Security Agency

Georgina Wilkinson, Shahin Parmar: UK Health Security Agency, 61 Colindale Avenue, London NW9 5EQ

Cathie Railton: Office for Health Improvement and Disparities, Quarry House, Quarry Hill, Leeds, LS2 7UA

INTRODUCTION

As an inclusion health group, sex workers often experience the most extreme health inequalities (Figure 1). This population is however largely unidentified (even within broader inclusion health work) due various factors including stigma and the hidden - often transient - nature of sex work.

METHODS

Work was initiated in two English regions (East of England and Yorkshire and Humber) for different reasons. The East of England saw an increase in syphilis in a group of sex workers whilst Yorkshire and Humber recognised that sex workers were not considered in broader inclusion health work. Scoping work was undertaken to better understand the needs, scale, range, and distribution of sex worker populations across both regions.

OUTCOMES and SUMMARY

Figure 2 highlights the common findings and outcomes of investigations from each area.

Sex workers are not being recorded within health datasets and can therefore be absent from service developments and strategic planning. Effective partnership working, and strong relationships need to be established across health, public health, local government, third sector, and police to address this complex and sensitive issue.

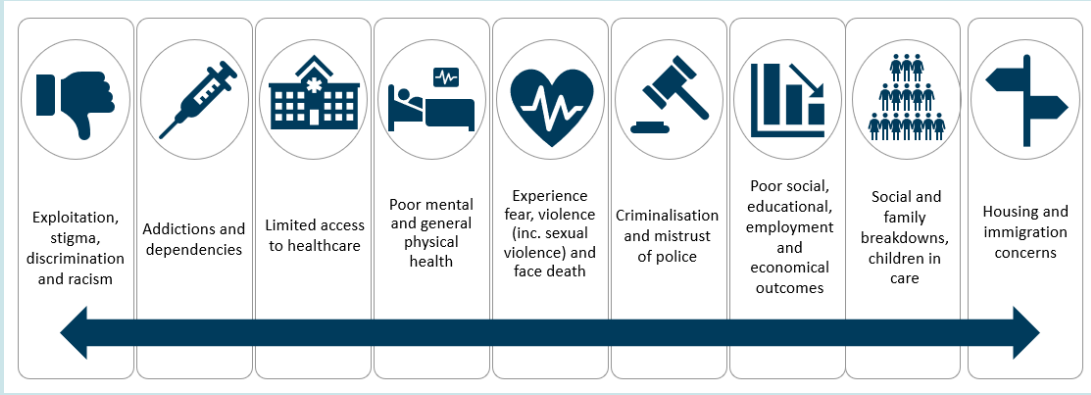


Figure 1: Inequalities experienced by sex workers

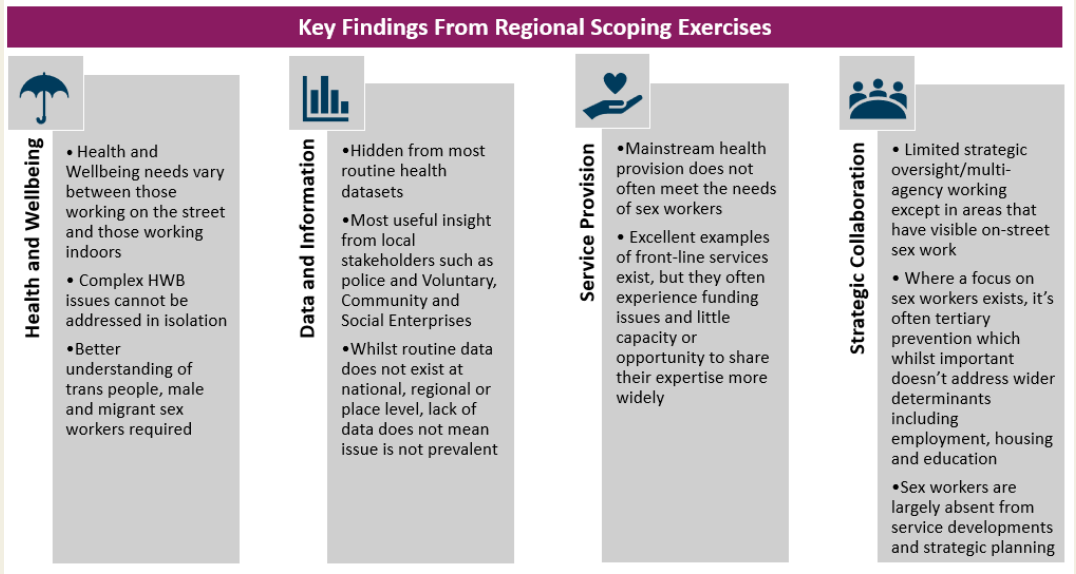


Figure 2: Common findings from each regional scoping exercise

FURTHER WORK

Work is ongoing to respond to the issues identified from the scoping exercises:

- Multi-agency steering group, including lived experience representation, established to take Yorkshire and Humber work forward
- Development of a public health approach to sex work resource
- Research proposal submitted for a multi-sited evaluation of third sector-led health interventions for street sex workers in the North of England
- Self-assessment tool aimed at all key partners
- Introduction of *Law Enforcement Public Health* tool for frontline police officers
- Case study template for local government, service providers, the police and voluntary sector
- Sex worker *Ladder of Interventions* produced to determine if a measure is deemed acceptable or not
- Library of research, policy and best practice via open access Knowledge Hub platform

ACKNOWLEDGEMENTS

We would like to acknowledge all stakeholders and people with lived experiences across both regions who have contributed towards work to date and for their ongoing support.

Sex workers: demographics

Studies indicate a diverse and rapidly changing population but lack of data and information makes analysis difficult.

The exact number of sex workers in the UK is unknown but the general consensus suggests the population is between 50,000 and 80,000[1]

Population surveys in the United Kingdom have documented an increase in the number of men paying for sex from 5.6% in 1990 to 8.8% in 2000[3].

It is estimated that around 37% of UK commercial sex workers are migrants with as many as 52% of migrants coming from Eastern Europe[1].

Women make up the majority of the sex work population, estimated around 85-90% [2]

The remaining population is made up of men and transgender sex workers

Sex workers can come from diverse socio-economic backgrounds[4]

Many factors drive entrance into sex work: financial factors (debt, poverty, cost of living), homelessness and/or insecure housing, drug and alcohol dependence, violence, family breakdown/leaving care, low education, mental health[4];

Health outcomes for sex workers 1/2

Studies show sex workers experience poor mental health, with increased rates of anxiety, depression, loneliness, post-traumatic stress disorder, self-harm, and suicide[1].

Many sex workers face large barriers to accessing health and social care, despite their need. There are few specialist services for this community, and mainstream services are often unaware of sex working and are not tailored to sex workers' needs. A study showed that sex workers have access to high-quality care through the GUM clinic network, but there is evidence of geographical inequality in access to these services[2].

Despite high rates of chronic disease, reproductive health need, respiratory disease and health problems related to substance misuse, most clinical services for Street Sex Workers (SSW) predominantly focus on sexual health[2]. There is an absence of high-quality evidence for effective healthcare provision for SSWs[3] but research has described the main challenges in providing healthcare to SSWs as services being inflexible, poorly-resourced services and services not being trauma-informed.

In addition to their high burden of unmet health need[4], sex workers face severe, complex social inequity, which can often contribute to their many health issues, such as homelessness or insecure housing, unemployment, adverse childhood experiences, gender and racial inequality, poverty, sex work criminalisation, violence and exploitation, and the setting of sex work[3].

During and post-Covid, reports have shown how sex workers were often excluded from government health protection and financial support resources. A recent report from the UK national charity, National Ugly Mugs, highlighted the experiences of sex workers facing the cost-of-living crisis, with workers saying they are facing fewer clients and having to "offer riskier and more emotionally draining services“.

Health outcomes for sex workers 2/2

- Female sex workers are twice as likely to be diagnosed with chlamydia and 3 times more likely to be diagnosed with gonorrhoea than other female sexual health clinic attendees in England [1].

- Sexually Transmitted Infection (STI) risk is estimated to be higher in street based sex workers, who are at greater risk of unsafe sex and less likely to access sexual health services[2].

- More than two thirds (68%) of female sex workers meet the criteria for post-traumatic stress disorder (PTSD)[3]. The more types of violence reported (childhood physical and sexual abuse, rape and physical assault while working), the greater the severity of PTSD symptoms.

- A study of female sex workers in London, found their mortality rate was 12 times higher than women from the general population[4].

Sex Workers: Resources and groups

Resources:

- Sex Workers a guide for professionals
- Mental Health Resources: Mental Health Resources – National Ugly Mugs
- A scoping to understand the health and wellbeing needs of sex workers in Yorkshire and the Humber Sex Work (yhphnetwork.co.uk)

Organisations:

- National Ugly Mugs: There is organisation membership for practitioners doing front-line work with sex workers. It is free to join: Information for Practitioners – National Ugly Mugs
- Beyond the Streets
- English Collective of Prostitutes

Vulnerable migrants

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Vulnerable migrants: Contents

- Vulnerable migrants: Key Messages
- Vulnerable migrants: An overview
- Health outcomes for vulnerable migrants
- Unaccompanied Asylum Seeking Children (UASC)
- Safe and legal routes for refugees to come to the UK
- South East Migration Schemes Data Explorer
- Health Intelligence Pack for Migrant Health
- Asylum applications over time: including breakdown by nationality
- Migrant Statistics (Totals)
- Percentage of live births to mothers born outside of the UK
- Supported Asylum seekers: Section 95 support
- Immigration Groups: England, South East and Local Authorities
- Number of visa applications, visas issued and arrivals in the UK by sponsor location
- Vulnerable migrants: Resources

Vulnerable migrants: Key messages

- Vulnerable migrants can have a range of physical and mental health issues related to their previous experiences, which may then be exacerbated by the asylum process and experience of insecure housing, barriers to accessing healthcare, discrimination and stigma, among many other challenges.

- Unaccompanied Asylum Seeking Children currently account for 9% of Looked After Children in England, and present with particular challenges such as dental health, emotional disorders including sleep difficulty and issues associated with navigating a new culture, language and education system.

- Front line services, who incorporate the principles of psychological first aid and implement culturally competent, trauma informed practice, are key to providing support and addressing barriers to accessing health and other services.

Vulnerable migrants: An overview

Although many migrants come to the UK to work or study and so are young and healthy, some groups of migrants may have increased health needs associated with their experiences either before, during or after migration which can make them particularly vulnerable to potential health needs. This includes the following groups:

- Asylum seekers: a person who has applied for permission to stay in the UK
- Refugees: a person given permission to stay in the UK
- Unaccompanied children
- People who have been trafficked: someone who has been moved to the UK to be exploited through forced labour, slavery or prostitution
- Undocumented migrants (those living in the UK with no legal status)
- Low paid migrant workers.

The OHID Migrant Health Guide includes comprehensive advice and guidance for healthcare practitioners on the health needs of migrant patients in relation to access to healthcare, assessing and treating patients, communicable and non-communicable disease, outbreak management and nutrition in relation to migrant patients.

Specialist support may be required for some refugees and asylum seekers due to their experience of violence and trauma. Language barriers can make it difficult to engage and access safe and effective healthcare.

Health outcomes for vulnerable migrants

Vulnerable migrants can experience a wide range of health needs including:

- Communicable diseases
- Incomplete vaccination history
- Non-Communicable diseases
- Malnutrition and nutrient deficiencies
- Anaemia
- Oral diseases
- Sexually transmitted infections
- Female Genital Mutilation
- Psychological disturbance due to violence and trauma

On arrival to the UK, vulnerable migrants may have to navigate a new culture and language, along with an often complex legal immigration process. They may have vulnerabilities from their experiences which along with uncertainty for the future and resettlement can lead to an increased risk of psychological distress and suicide[1]. This can be exacerbated by experiences including trauma, exposure to detention settings and social isolation.

Refugees and asylum seekers are often subject to inequalities under the wider determinants of health, which impact both physical and mental health. They are likely to experience poorer socio-economic status on arrival in a new country, with potentially limited access to services and welfare support. Restricted opportunities for employment can impact food and housing security, as well as the ability to settle in a supportive community[2] along with delayed access to education for their children. They may experience a loss of identify and status with challenges to integration, a lack of family and community support along with racism and discrimination. There are often barriers to accessing healthcare, including through both through language and digital exclusion.

All of these factors can exacerbate vulnerability, leaving people at risk of exploitation.

Unaccompanied Asylum Seeking Children (UASC) (1/2)

The Home Office defines an Unaccompanied Asylum Seeking Child (UASC) as an individual who is under 18 when the asylum application is submitted, is not being cared for by an adult who by law has responsibility to do so, is separated from their parents and has applied for asylum in the United Kingdom in their own right. They are not a homogenous group but vary by age and background with a range of experiences of trauma, separation and loss, both before and during their asylum process.

Unaccompanied children are entitled to care and protection under the provisions of the Children Act 1989 (as amended by the Children and Young Persons Act 2008). The responsibility for these children is devolved to local authorities and once they reach 18 years old, the duty is held within the Care Planning and Care Leavers Regulations 2010 (amended in 2014 to take account of unaccompanied asylum seeking children). UASC represent 9% of all Looked After Children in England with the numbers of UASC increasing by 42% since pre-pandemic 2019 figures (Children Looked After in England).

Statutory guidance exists for local authorities on the Care of unaccompanied migrant children and child victims of modern slavery, including the requirement for an initial health assessment with a plan setting out how the local authority intends to meet the child's health needs. This assessment should be carried out within 28 days of the child being registered with the local authority. In addition, NICE guidance for Looked-after children and young people refers to UASCs and includes recommendations on positive relationships, placement stability, safeguarding as well as health and wellbeing acknowledging the impact of trauma and the need for language and culturally sensitive care needs along with the danger of going missing.

Unaccompanied Asylum Seeking Children (UASC) (2/2)

- These children and young people can have significant physical and mental health needs including tooth decay, continence issues, emotional problems, sleep difficulty, body pain and injuries, unknown vaccination history and potential sexual abuse during their journey along with post-traumatic stress and mood disorders[1,2,3].

- They can face challenges entering education in the UK following a potentially fragmented previous experience of education, while also navigating a change in culture and language.

- Unaccompanied children are at high risk of mental illness, with post-traumatic stress disorder (PTSD), mood disorders and agoraphobia being among the most commonly reported conditions. These may be due to the stressors they have been exposed to either in their home country (for example war) and upon arrival (due to uncertainty over status and discrimination)[4.] The sustained lack of a parental figure increases their vulnerability to mental health issues.

- These children and young people are at increased risk of exploitation due to their circumstances and may have arrived as an UASC due to trafficking.

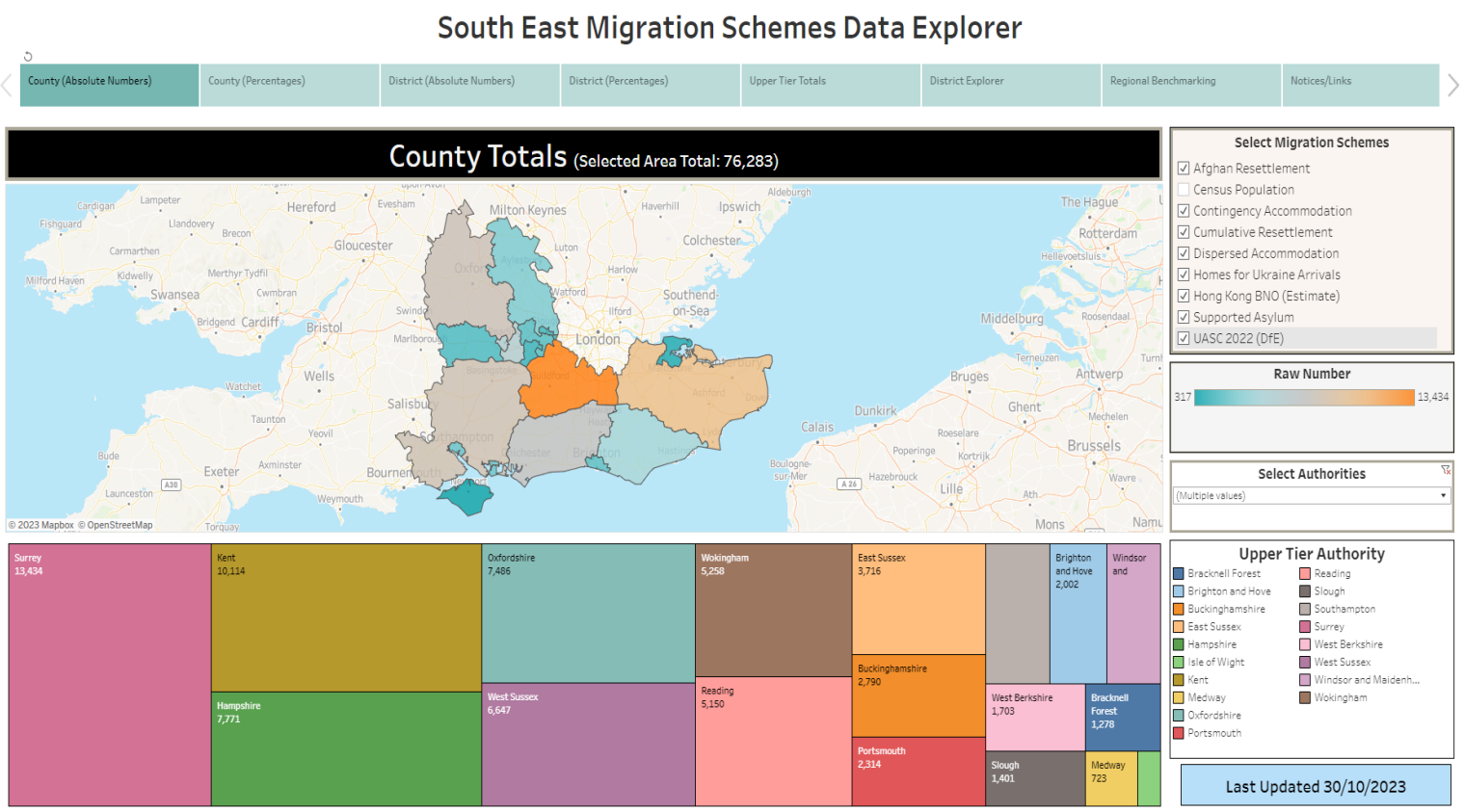
- These children and young people require extensive support along with stability to enable them to adapt to their new environment, recognising their particular needs and vulnerabilities.

Safe and legal routes for refugees to come to the UK

Scheme	Description	Length of leave granted	How long until settlement	Refugee status?	Application process
UK Resettlement	There are three different general resettlement schemes in partnership with the UN Refugee agency (UNHCR) and the UK government. Full details are in the UK Refugee Resettlement Policy guidance and include the UK resettlement scheme, Community Sponsorship and Mandate Scheme.	Six months LOTR	ILR granted on arrival	Yes	No
Family reunion	Where a person has refugee status and has not naturalised as a British citizen, they are entitled to bring their partner and children to the UK where they meet the requirements.	In line with refugee sponsor	In line with refugee sponsor	No	Yes
Hong Kong	The Hong Kong British National (Overseas) Visa was announced in July 2020 and the Appendix Hong Kong British National (Overseas) was introduced in January 2021. The scheme is covered in detail here.	2.5 or 5 years	After continuous residence in UK of 5 years	No	Yes (£)
ARAP	The Afghan Relocation and Assistance Policy (ARAP) was announced in August 2021 for Afghan citizens who worked for or with the UK Government in exposed or meaningful roles and may include an offer of relocation to the UK for those deemed eligible by the Ministry of Defence and who are deemed suitable for relocation by the Home Office.	6 months LOTR	ILR granted on arrival	No	Can submit request for eligibility
ACRS	The Afghan Citizens Resettlement Scheme was opened in January 2022 and prioritises those who have assisted the UK efforts in Afghanistan and vulnerable people including women and girls at risk and members of minority groups at risk.	6 months LOTR	ILR granted on arrival	No	No
Homes for Ukraine	The Homes for Ukraine Sponsorship scheme is open to Ukrainian nationals who were resident in the Ukraine prior to January 2022, enabling those with a named eligible sponsor in the UK, who can provide accommodation, to apply for a visa.	3 years	N/A. settlement is not available	No	Yes
Ukraine Family Scheme	The Ukraine Family Scheme enables individuals to come to the UK if they are a family member of a British citizen, someone with permission to settle in the UK or someone with refugee status or humanitarian protection in the UK.	3 years	N/A. Settlement is not available.	No	Yes

Safe and legal routes - GOV.UK (www.gov.uk)

South East Migration Schemes Data Explorer



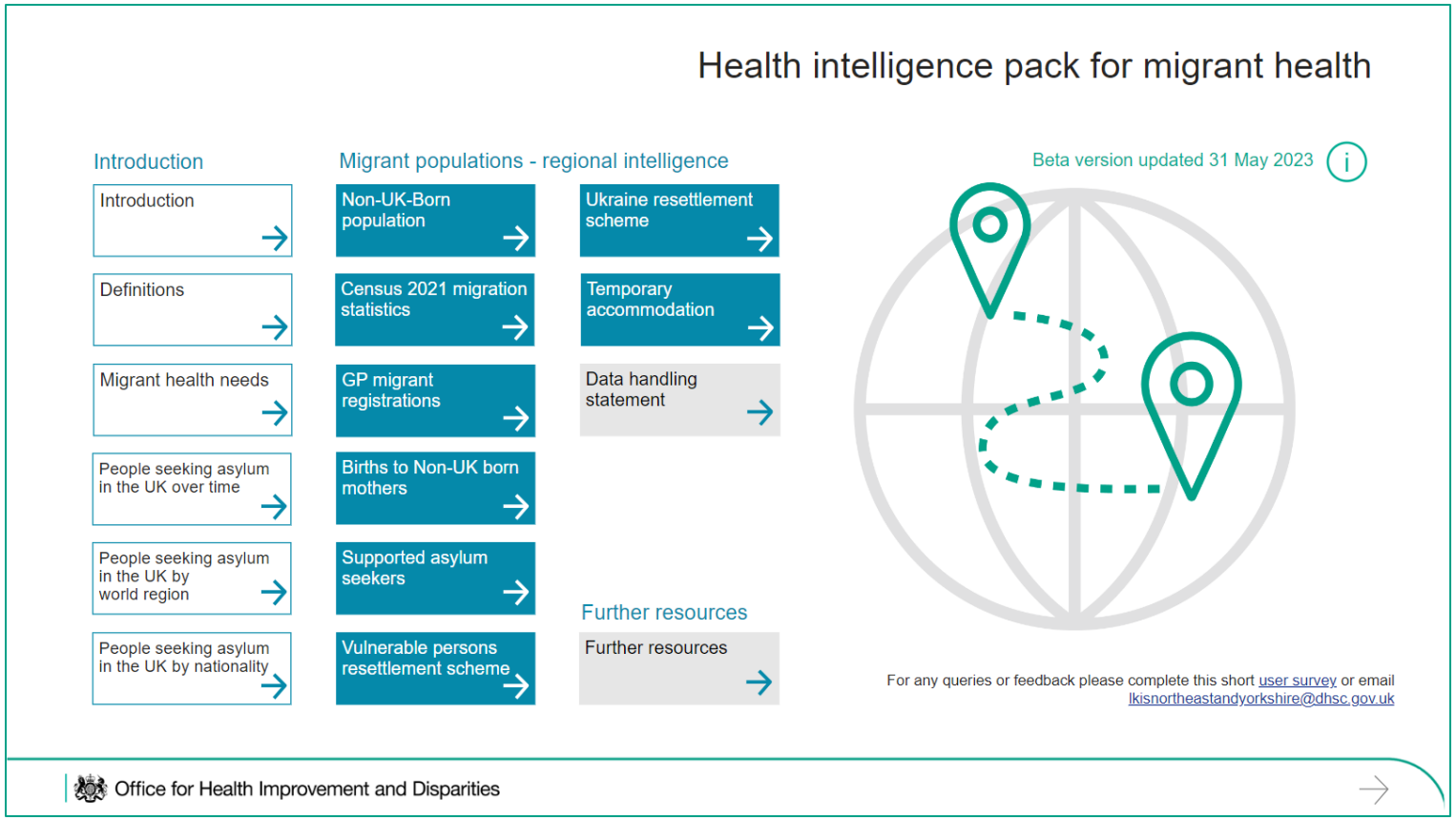
The South East Migration Schemes Data Explorer is a tool which brings together data sources on migration to outline the numbers of individuals under each migration scheme at County and District level.

The tool has been produced by the South East Strategic Partnership for Migration (SESPM) which provides a leadership, co-ordination and advisory function for migration in the South East. They are hosted by South East Councils and provide support to all 70 South East local authority areas.

Health Intelligence Pack for Migrant Health

The OHID Local Knowledge and Intelligence Service (LKIS) have recently published the Health Intelligence Pack for Migrant Health. This presents the latest available data on migrant populations intended to support regional and local stakeholders. The pack includes a range of indicators relevant to migrant populations, available at a regional and local authority level.

Routinely collected health data on migrants is lacking, both in the UK but also globally. Where migration data exists, it is often not linked with health data. The OHID national Inclusion Health Intelligence team are working on improving the reporting and collection of data on migrant health.

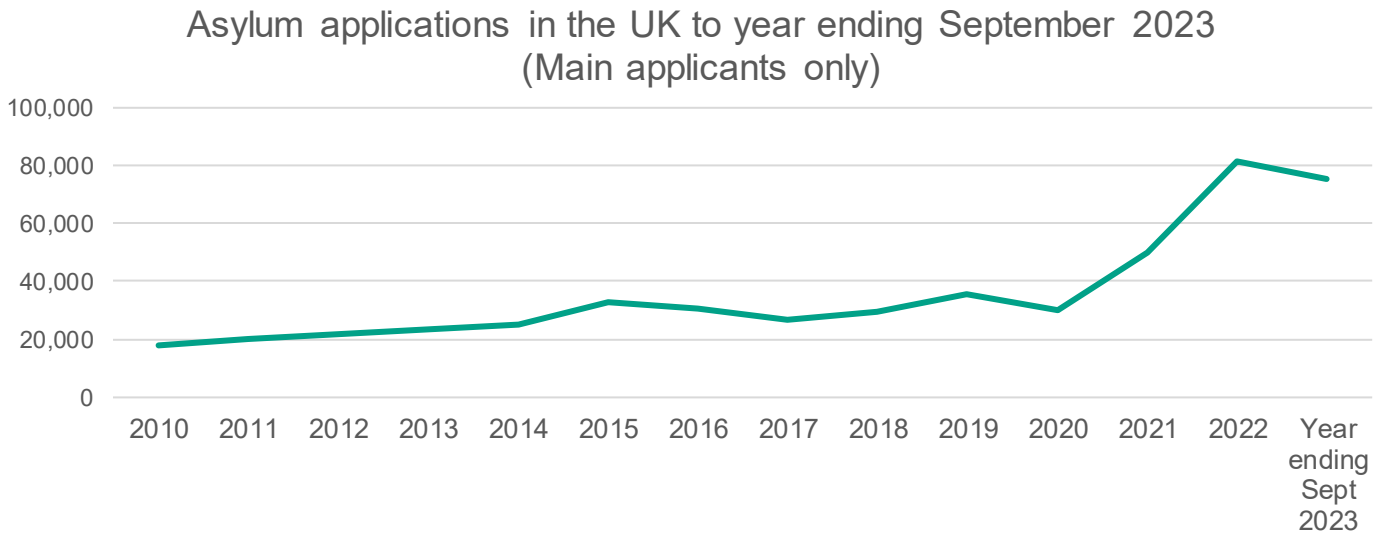


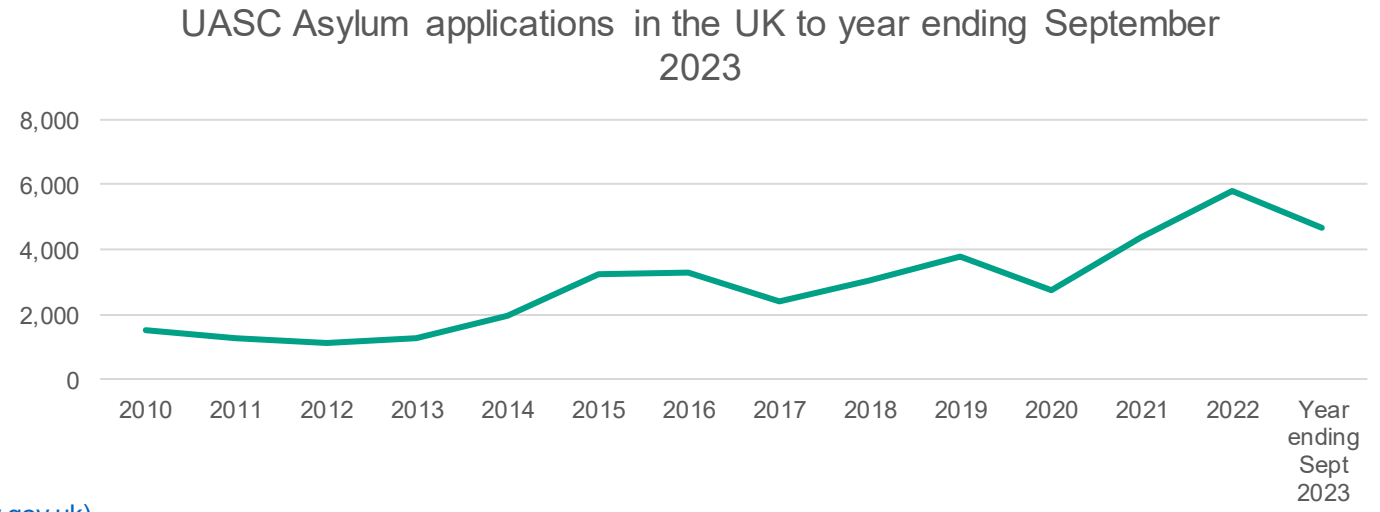
Asylum applications over time

The Home Office produces quarterly and annual statistics relating to those: coming to the UK, extending their stay, gaining citizenship, applying for asylum and being detained or removed as well as immigration for work, study and family reasons.

In the year ending September 2023, there were 75,340 asylum applications (main applicants only) in the UK. This was similar to the year ending September 2022 but lower than the previous peak in 2002 of 84,132 applications.

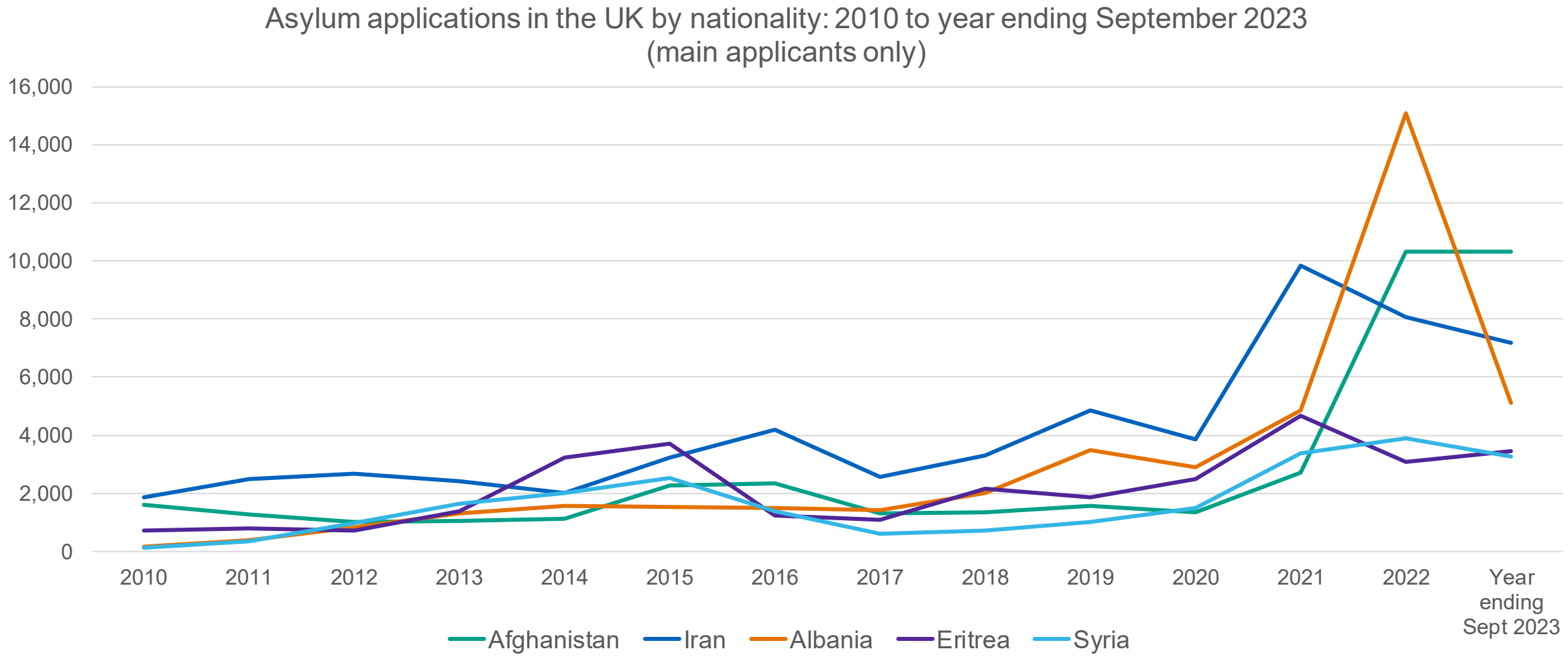
For the most recent data (released in November 2023), the final data point includes the year up to September 2023. In the year ending September 2023, there were 41, 858 initial decisions made on asylum applications. This is higher than the pre-pandemic levels of decisions (20,766 in 2019).





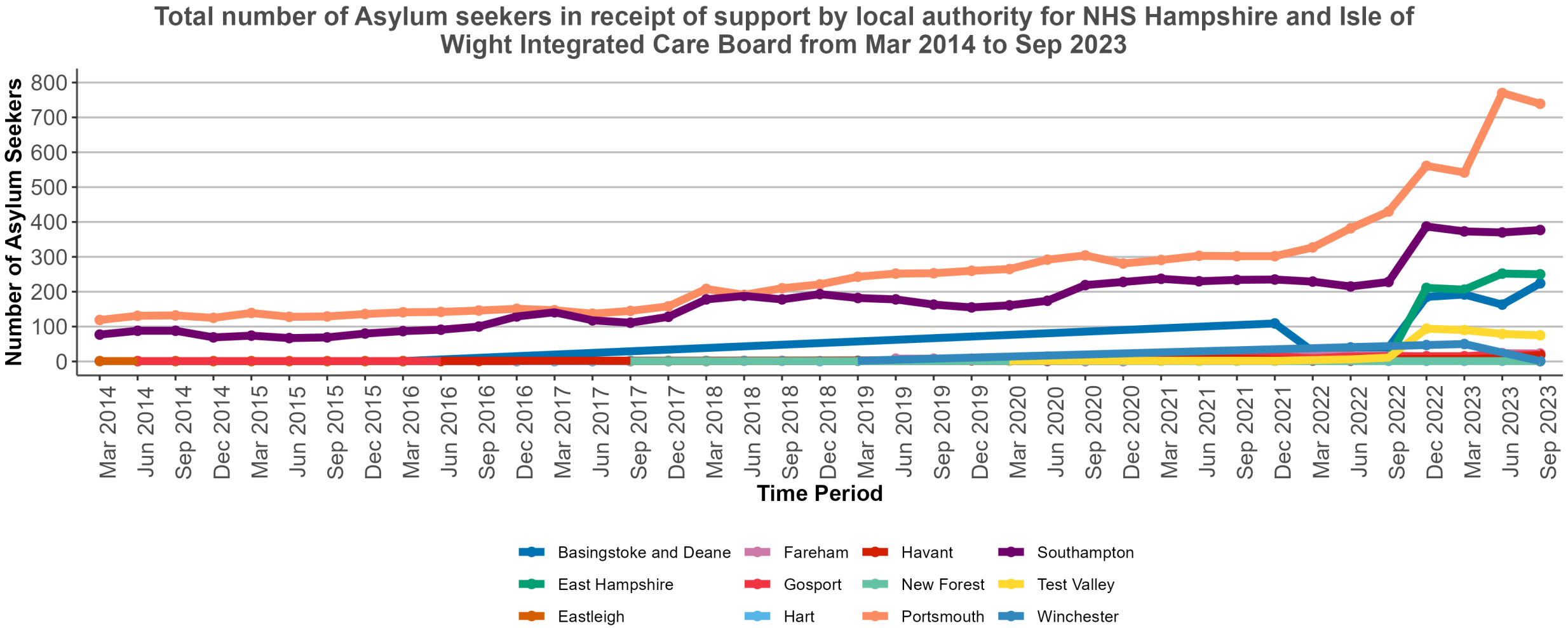
Source: Immigration statistics, year ending September 2023, Home Office
Available from Immigration system statistics, year ending September 2023 - GOV.UK (www.gov.uk)

Breakdown by Nationality



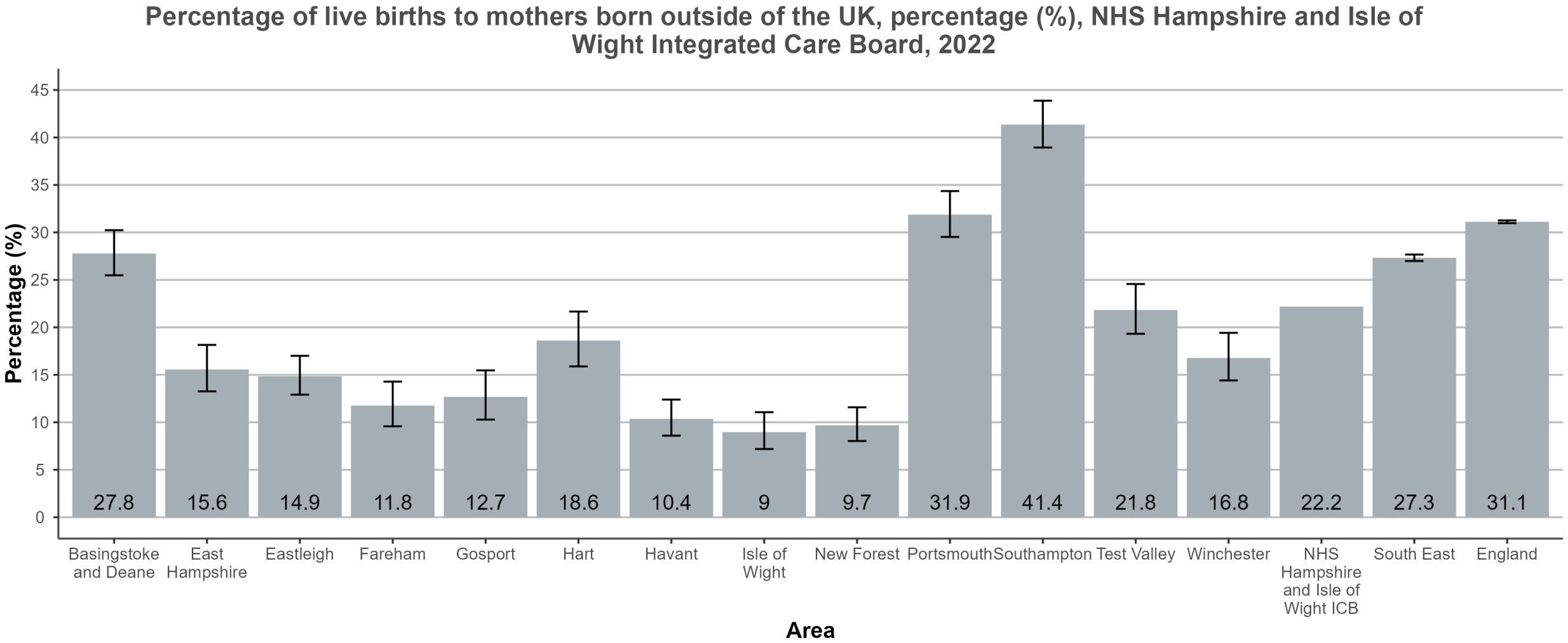
Source: Immigration statistics, year ending September 2023, Home Office
Available from Immigration system statistics, year ending September 2023 - GOV.UK (www.gov.uk)

Migrant Statistics (Totals) - NHS Hampshire and Isle of Wight Integrated Care Board



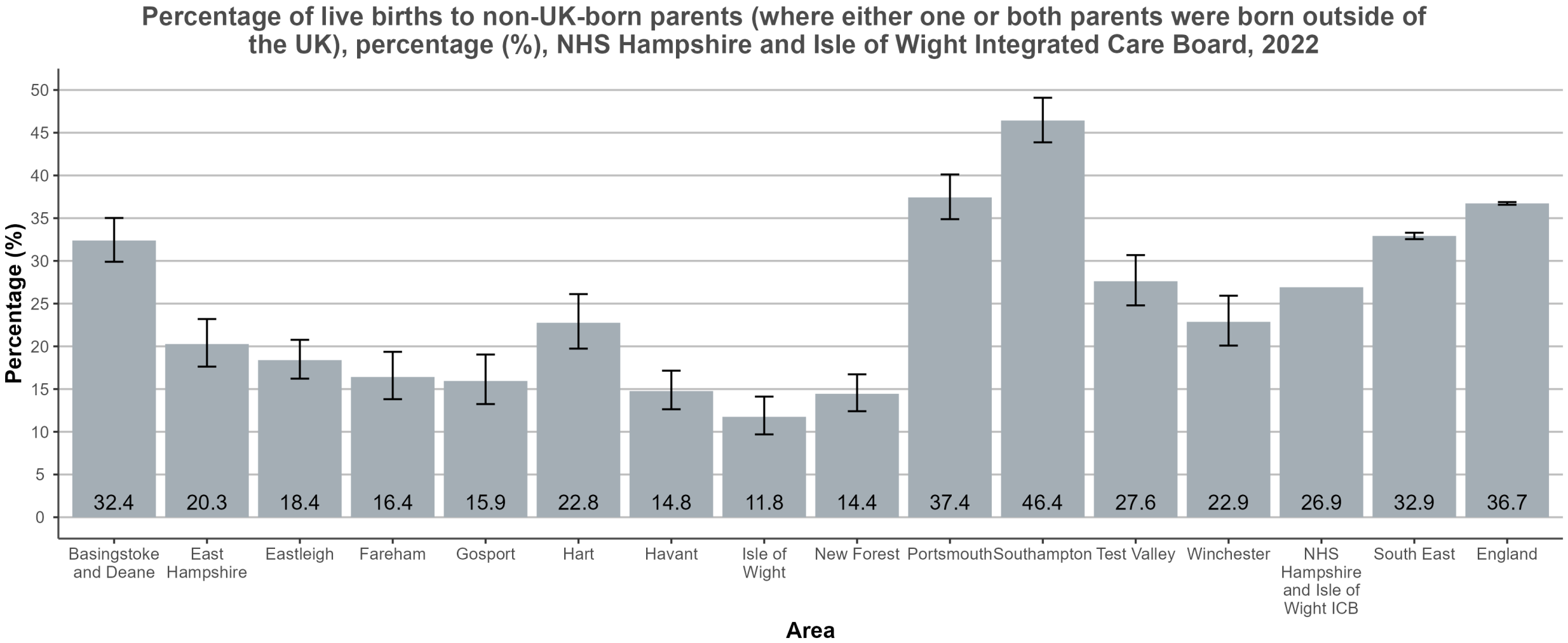
Source: Home Office - Immigration System Statistics, Crown copyright © 2023 Available from: Immigration system statistics data tables

Percentage of live births to mothers born outside of the UK - NHS Hampshire and Isle of Wight ICB



Source: Office for National Statistics. Births by parents' country of birth, England and Wales: 2022. © Crown copyright 2023

Percentage of live births to non-UK-born parents - NHS Hampshire and Isle of Wight ICB



Source: Office for National Statistics. Births by parents' country of birth, England and Wales: 2022. © Crown copyright 2023

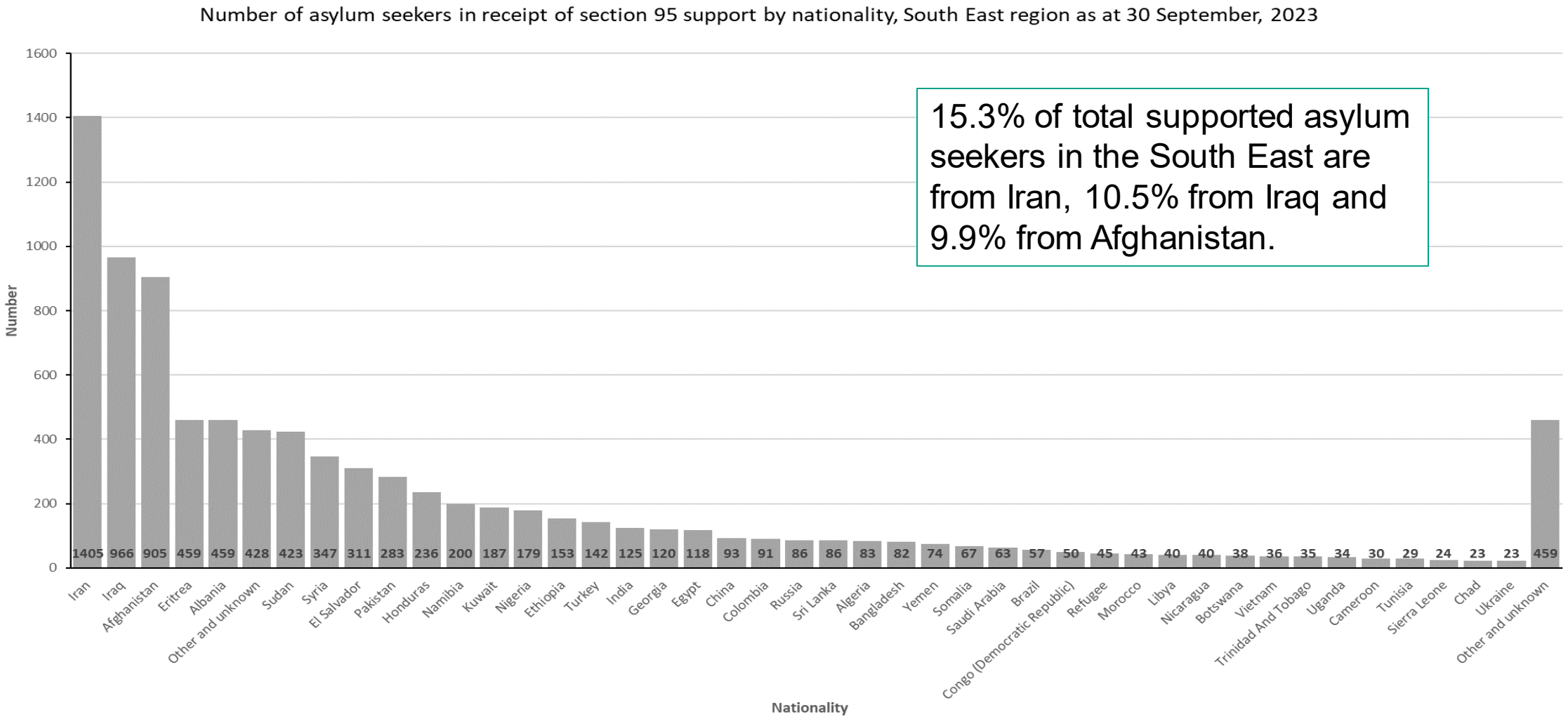
Asylum Support

Section 95 Support: This refers to support provided by the government under Section 95 of the Immigration and Asylum Act 1999. It consists of accommodation and financial support and is available to those who have made an asylum claim and do not yet have a decision on their case. In order to qualify for this support, an asylum seeker would also need to demonstrate that they do not have adequate accommodation or enough money to meet living expenses for themselves and any dependents (the destitution test).

Section 98 support: This is emergency support for those who appear to be destitute and who are awaiting a decision on their application for Section 95 asylum support.

Section 4 support: This is available for some groups of asylum seekers who have previously made unsuccessful asylum claims. In order to meet the eligibility criteria for this support, an asylum seeker must be destitute and meet one of the five criteria, which includes for example being unable to leave the UK because of a serious medical problem which prevents taking a flight to their country of origin.

Supported asylum seekers: Section 95 support

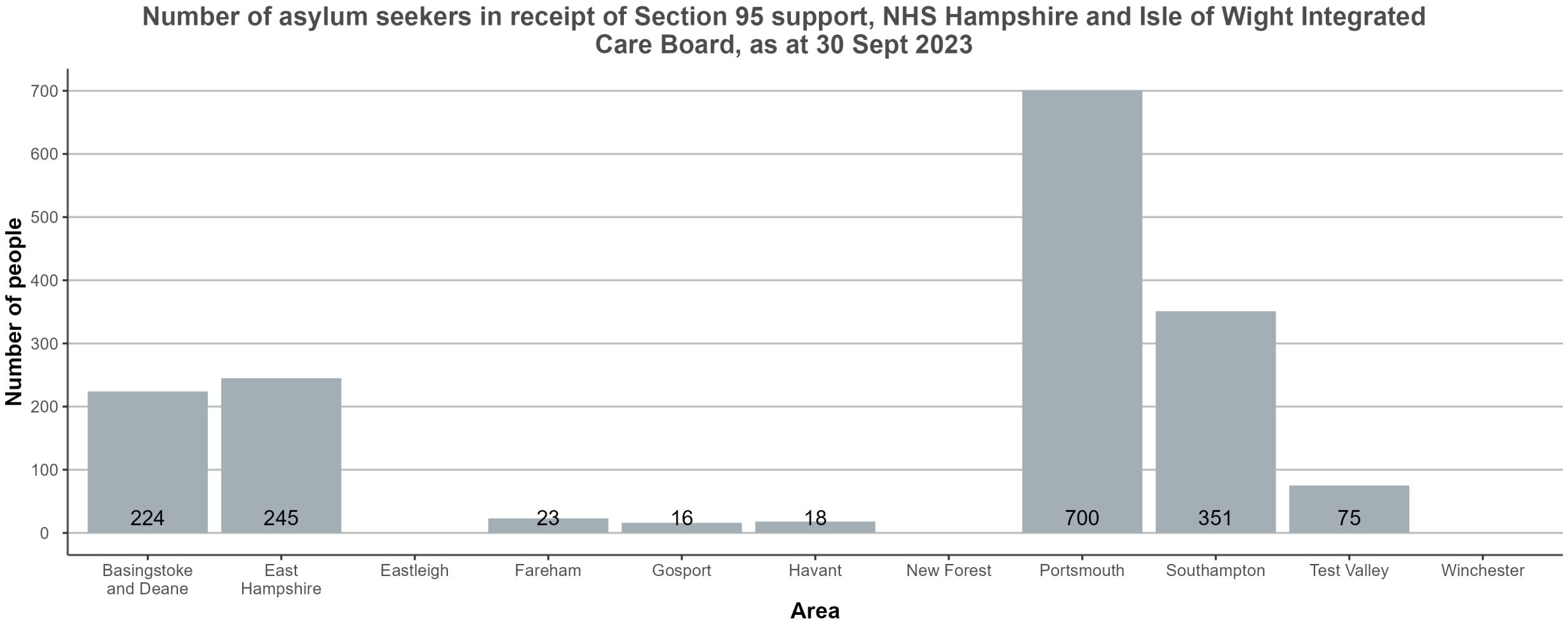


15.3% of total supported asylum seekers in the South East are from Iran, 10.5% from Iraq and 9.9% from Afghanistan.

Source: Immigration statistics quarterly release (Sept 2023): Asylum seekers in receipt of support, detailed datasets. Home Office, Crown copyright © 2023.
Nationalities with a count <20 are included in the 'Other and unknown' group.

Source: Immigration statistics, year ending September 2023

Supported asylum seekers: Section 95 support NHS Hampshire and Isle of Wight ICB



Source: Immigration statistics quarterly release (Sept 2023): Asylum seekers in receipt of support by Local Authority, 2014 Q1 to 2023 Q3 - dataset. Home Office, Crown copyright © 2023. Counts of < 10 have been suppressed.

Source: Immigration statistics, year ending September 2023

Immigration groups year ending 30 September 2023: England and the South East

	England	South East
Homes for Ukraine (arrivals)	**99,686**	**22,240**
Afghan Resettlement Programme (population)	**13,968**	**2,557**
of which - bridging accommodation	1,368	721
of which - settled in LA housing	9,817	1,496
of which - settled in PRS housing	2,783	340
Supported Asylum population	**111,089**	**9,169**
of which - initial accommodation	1,845	-
of which - Dispersed accommodation	48,858	2,135
of which - Contingency accommodation	55,918	6,671
of which - Subsistence only	4,339	363
All 3 pathways (total)	**224,743**	**33,966**
Population	**56,536,419**	**9,005,822**
Per Capita	**0.40%**	**0.38%**

Source: Immigration system statistics quarterly release - GOV.UK (www.gov.uk)

Immigration groups for local authorities in NHS Hampshire and Isle of Wight ICB as of 30th September 2023

Area Name	South East Region	NHS Hampshire and Isle of Wight ICB	Basingstoke and Deane	East Hampshire	Eastleigh	Fareham	Gosport	Hart	Havant	Isle of Wight	New Forest	Ports-mouth	South-ampton	Test Valley	Winch-ester
Homes for Ukraine (arrivals)	22,240	3,650	401	418	244	147	110	250	143	259	389	193	263	492	528
Afghan Resettlement Programme (population)	2,557	354	15	3	10	30	27	10	15	7	2	92	113	14	23
of which - bridging accommodation	721	-	-	-	-	-	-	-	-	-	-	-	-	-	-
of which - settled in LA housing	1,496	276	15	3	10	30	27	10	15	7	2	92	36	14	23
of which - settled in PRS housing	340	77	-	-	-	-	-	-	-	-	-	-	77	-	-
Supported Asylum (population)	9,169	1,729	224	250	1	23	20	-	18	-	1	739	377	75	1
of which - Initial Accommodation	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
of which - Dispersed Accommodation	2,135	848	3	9	-	22	18	-	15	-	-	605	176	-	-
of which - Contingency Accommodation	6,671	819	216	241	-	-	-	-	-	-	-	119	170	73	-
of which - Subsistence only	363	62	5	-	1	1	2	-	3	-	1	15	31	2	1
All 3 pathways (total)	**33,966**	**5,732**	**640**	**671**	**255**	**200**	**157**	**260**	**176**	**266**	**392**	**1,024**	**753**	**581**	**552**
Population	**9,005,822**	**1,825,884**	**185,656**	**126,199**	**136,974**	**114,993**	**82,178**	**100,293**	**124,470**	**140,889**	**176,262**	**206,828**	**257,256**	**131,190**	**127,916**
Per Capita (%)	**0.38%**	**0.31%**	**0.34%**	**0.53%**	**0.19%**	**0.17%**	**0.19%**	**0.26%**	**0.14%**	**0.19%**	**0.22%**	**0.50%**	**0.30%**	**0.44%**	**0.43%**

Source: Operational data, Home Office (HO) and Department for Levelling Up, Housing and Communities (DLUHC

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Number of visa applications, visas issued and arrivals in the UK by sponsor location for upper tier local authorities in the NHS Hampshire and Isle of Wight ICB as at 21 November 2023

Area Name	Number of visa applications	Number of visas issued	Number of arrivals in the UK by sponsor location
England	152,120	123,466	102,945
South East Region	31,236	26,900	22,806
NHS Hampshire and Isle of Wight ICB	4,893	4,257	3,598
Hampshire	4,498	3,955	3,333
Isle of Wight	364	319	264
Portsmouth	280	230	197
Southampton	420	320	272

Source: Operational data, Home Office (HO) and Department for Levelling Up, Housing and Communities (DLUHC

Vulnerable migrants: Resources

- OHID Migrant Health Guide
- NHS entitlements: migrant health guide - GOV.UK (www.gov.uk)
- BMA refugee and asylum seeker health resource
- Doctors of the World: Safer Surgeries Toolkit
- Unaccompanied Asylum Seeking Children Toolkit
- Asylum seeker and refugee mental health | Royal College of Psychiatrists (rcpsych.ac.uk)
- City of Sanctuary UK

Victims of modern slavery

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Victims of modern slavery: Contents

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- Types of exploitation
- Victims of modern slavery: Healthcare issues
- Victims of modern slavery: Health outcomes
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- Indicators of modern slavery relating to children
- National Referral Mechanism (NRM) and Duty to Notify
- Referrals by exploitation type
- NRM referrals by nationality
- Referrals by broad type and age group
- Trend in NRM referrals flagged as county lines, UK
- NRM referrals by Police Force and age at exploitation in Police Force areas covering the South East, all persons, 2022
- Victims of modern slavery: Resources and Organisations

Victims of modern Slavery: Key messages

- Modern slavery is a violation of human rights and has severe consequences for health and wellbeing at an individual and population level.

- Modern slavery is largely viewed as a law enforcement issue in terms of policy, practice and research. This approach limits the approaches required to meet the needs of survivors and address the serious individual and population health impacts.

- There are opportunities to make a difference, with those in a position to influence statutory and third sector engagement talking about modern slavery and raising public awareness. Workforce training and development in statutory organisations can help with the identification and support for victims.

Victims of modern slavery: Overview

Modern slavery is a complex crime that covers all forms of slavery, trafficking and exploitation. Trafficking includes transporting, recruiting or harbouring an individual with a view to them being exploited. Modern slavery crimes may involve, or take place alongside, a wide range of abuses and other criminal offences such as grievous bodily harm, assault, rape or child sexual abuse.

Victims of modern slavery can be men, women and children of any age across the world. There is an assumption that victims of modern slavery are often trafficked to the UK from other countries, but residents of the UK are also among the victims that are exploited in the UK and other countries.

There were 16,938 potential victims of modern slavery referred to the Home Office in 2022, a 33% increase compared to 2021 (Home Office, 2023). This increase may have been driven by increased referrals from government agency first responders. The Home Office also received 4,580 reports of adult potential victims via the Duty to Notify (DtN) process, the highest annual number since the DtN began.

Modern slavery is not the same as people smuggling. People smuggling is an offence against the state, involving moving people illegally with their consent. Modern slavery and human trafficking are crimes against the individual, involving moving people without their consent.

Types of exploitation

There are five main types of exploitation that victims of modern slavery may experience:

- **labour exploitation**: victims are forced to work for nothing, low wages or a wage that is kept by their owner; work is involuntary, forced and/or under the threat of a penalty, and the working conditions can be poor. For example: rural work, farms and agricultural work, factories, construction, food processing, hospitality industries, plantations, fishing, beauty industry, shops.
- **sexual exploitation**: victims are exploited through non-consensual abuse or another person's sexuality for the purpose of sexual gratification, financial gain, personal benefit or advantage, or any other non-legitimate purpose
- **domestic servitude**: victims are domestic workers who perform a range of household tasks (for example, cooking and cleaning); some live with their employers and have low pay, if any at all
- **criminal exploitation**: victims are forced to work under the control of criminals in activities such as forced begging, shoplifting, pickpocketing, cannabis cultivation, drug dealing and financial exploitation
- **organ harvesting**: living or deceased victims are recruited, transported or transferred, by threat or force for money, for their organs

Victims of modern slavery: Healthcare issues

As this population group is largely hidden, data is very limited. Victims of modern slavery may only come to an organisation's attention when seriously ill or injured, or with an injury or illness that has been left untreated for a while. Health care issues may include:

- evidence of long term multiple injuries
- indications of mental, physical and sexual trauma
- sexually transmitted infections
- pregnant, or a late booking over 24 weeks for maternity care
- disordered eating or poor nutrition
- evidence of self-harm
- dental pain
- fatigue
- non-specific symptoms of post-traumatic stress disorder
- symptoms of psychiatric and psychological distress
- back pain, stomach pain, skin problems; headaches and dizzy spells

Royal College of Nursing (2020) Modern Slavery and Trafficking | Royal College of Nursing (rcn.org.uk)

Victims of modern slavery: Health outcomes

There is limited research and data available on the health outcomes for those who have experienced enslavement. However, studies have found physically demanding forced labour combined with long working hours, in poor, unsafe, working conditions, can result in a high incidence of physical injury; and sexual exploitation brings with it a high prevalence of sexually transmitted infections and trauma.

Research carried out by the Helen Bamber Foundation, on behalf of the Freedom Fund, found that modern slavery, in all its forms, has a "profound and devastating impact on human lives". The critical evidence review looked at the mental health impact of enslavement and the efficacy of specific mental health interventions. The review found mental health problems including depression, anxiety and Post-Traumatic Stress Disorder (PTSD) occur frequently in survivors, irrespective of the form of slavery to which they have endured. There was limited evidence to demonstrate the efficacy of specific treatment interventions. An integrated approach to care for survivors was likely to be more effective. Information is limited on the risk factors which increase the likelihood of major mental health consequences and on factors which may protect survivors from developing serious mental health problems.

Public Health England previously championed a call to action for: leaders in public health to influence statutory and third sector engagement by talking about modern slavery (for example, with housing associations, schools and allied health professionals) and by raising public awareness; and health professionals and other frontline staff to have a central role in better identifying and supporting victims.

Indicators of modern slavery, both for adults and children

- Distrustful of authorities
- Malnourished and unkempt
- Wears clothes unsuitable for type of work
- Expression of fear or anxiety, avoiding eye contact
- Signs of psychological trauma
- Acts as if instructed by another
- Injuries apparently a result of assault or controlling measures
- Evidence of control over movement, either as an individual or as a group
- Found in or connected to a type of location likely to be used for exploitation
- Restriction of movement and confinement to the workplace or to a limited area
- Passport or documents held by someone else
- Limited social contact and contact with family
- Unable, or reluctant to give details of accommodation or details such as work address
- Perception of being bonded by debt
- Money is deducted from salary for food or accommodation
- Threat of being handed over to authorities
- Threats against the individual or their family members
- Being placed in a dependency situation
- Gives vague information, reluctant to explain how the injury occurred or provide a medical history
- Accompanied by someone who appears controlling, who insists on giving information and speaking for them
- No or limited access to bathroom or hygiene facilities or medical care

Source: Royal College of Nursing, 2020

Indicators of modern slavery relating to children

Entered the country illegally	Possesses money or goods not accounted for	Accompanied by an adult who insists remaining with the child at all time	Has a prepared story very similar to those that other children have given	Exhibits maturity not expected in a child of such age
Shows signs of physical or sexual abuse, and/or has contracted a sexually transmitted infection or has an unwanted pregnancy	Has a history with missing links and unexplained moves	Among a number of unrelated children found at one address	Known to beg for money	Performs excessive housework chores and rarely leaves the residence
Quality of the relationship between the child and their adult carers is not good	Not been registered with or attended a GP practice, or enrolled in school	Children dropped off/ picked up in private cars or taxis at unusual times and in places where it isn't clear why they'd be there.	Relationships which don't appear right – e.g. has adult boyfriend/girlfriend who provides money or gifts	Known to frequent various locations where Child Sexual Exploitation is a risk or moves between various locations with adults

Source: Royal College of Nursing, 2020

National Referral Mechanism and Duty to Notify

The National Referral Mechanism (NRM) was introduced in April 2009. It is a framework for identifying and referring potential victims of modern slavery and ensuring they receive the appropriate support. The difference between an NRM referral and a Duty to Notify (DtN) referral relates to the consent of the adult involved.

Guidance on how to refer can be found on the government website: National referral mechanism guidance

Child victims

If the potential victim is under 18, or may be under 18, an NRM referral must be made, children cannot be referred in using a DtN referral. Child victims do not have to consent to be referred into the NRM and must first be safeguarded and then referred into the NRM process.

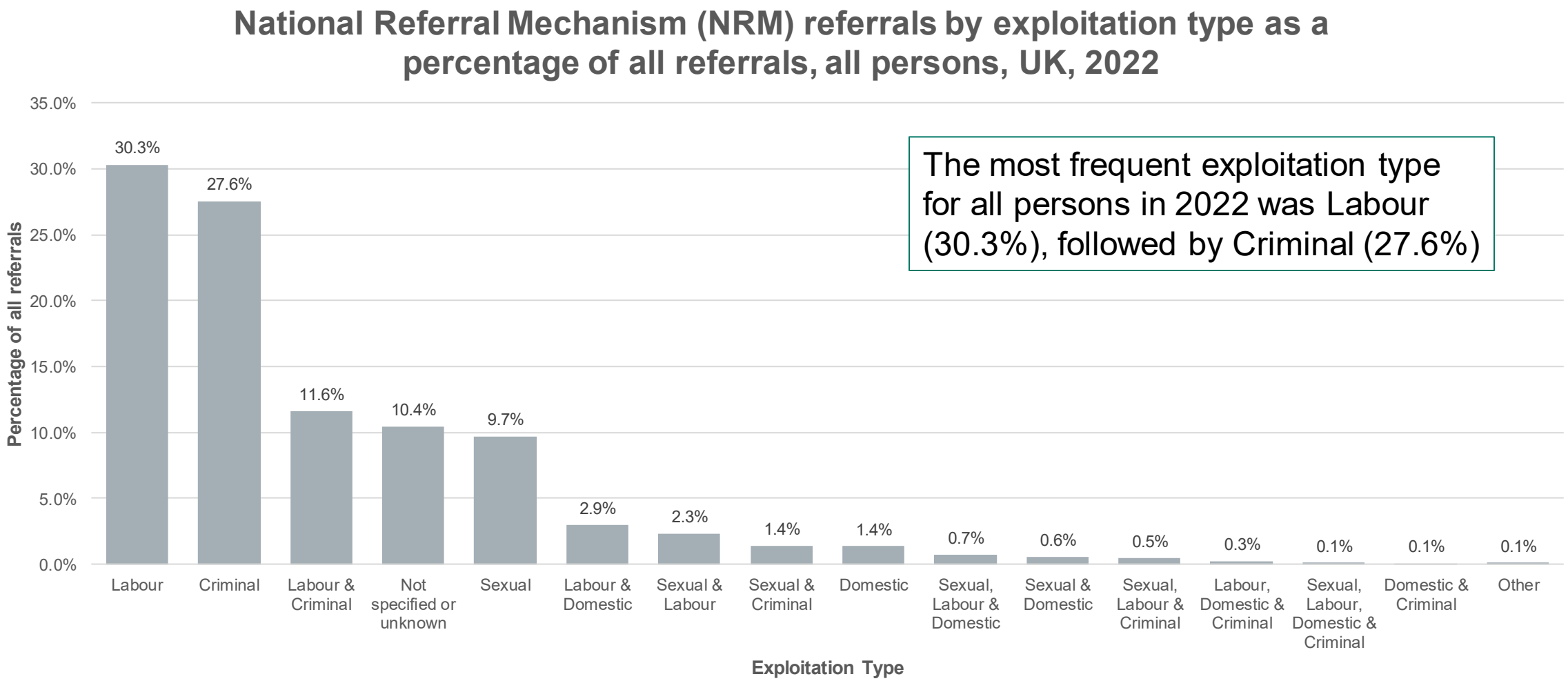
Duty to Notify

From November 2015, specified public authorities are required to notify the Home Office about any potential victims of modern slavery they encounter in England and Wales. Adult cases whereby consent is not provided to be referred into the NRM process automatically become DTN referral.

The NHS is not required to report under the Modern Slavery 2015 Act, which means there is a lack of consistency in the health system in respect of awareness and training. However, the CEO of NHS England sets out clear expectations of staff in terms of prevention of Modern Slavery and the protection of the health of survivors.

There were 16,938 potential victims of modern slavery referred to the Home Office in 2022, a 33% increase compared to 2021 (Home Office, 2023). This increase is driven by increased referrals from government agency first responders which could be linked to the increase in detections at the border and the large increase in small boats arrivals.

Referrals by exploitation type

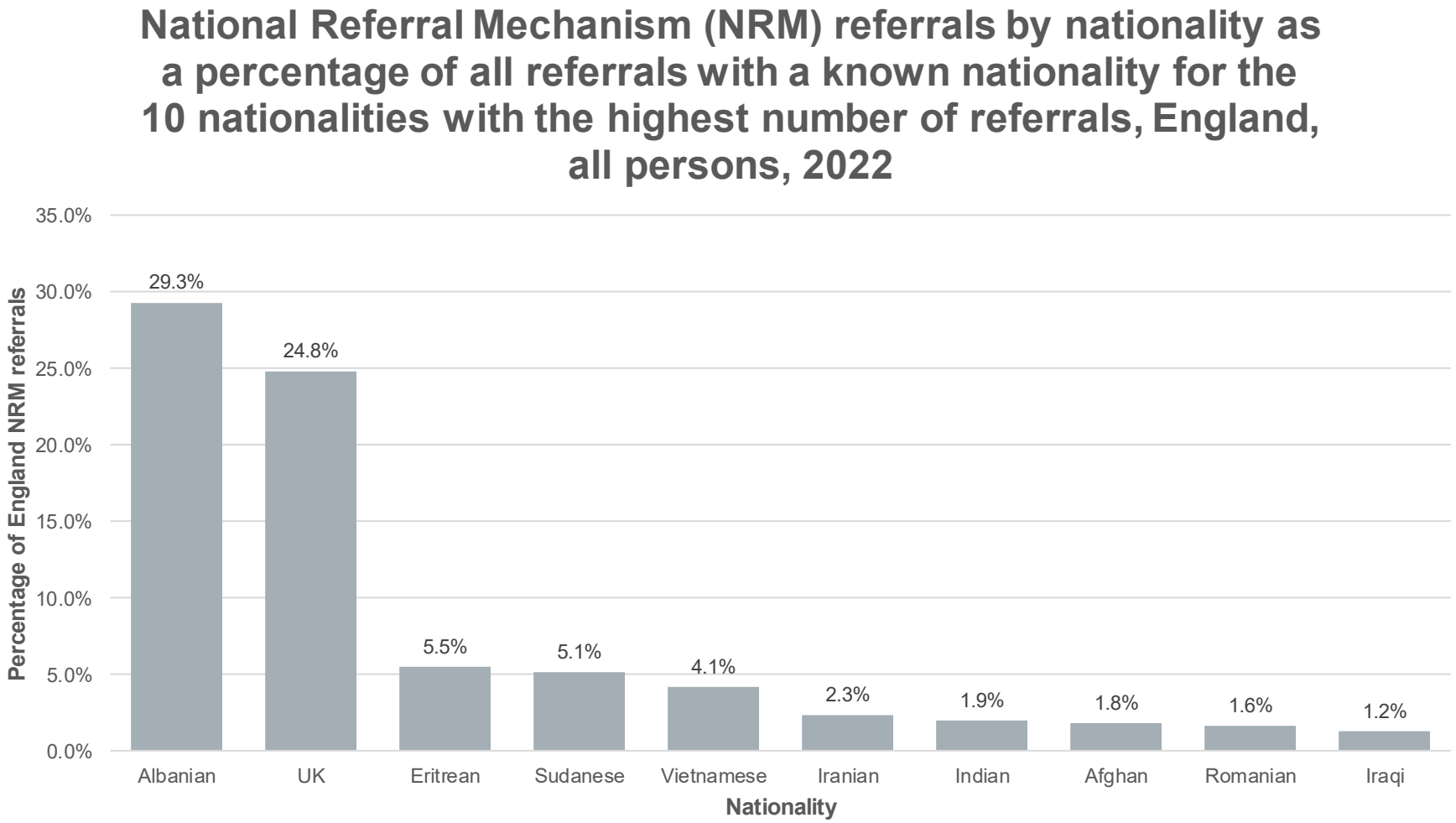


The most frequent exploitation type for all persons in 2022 was Labour (30.3%), followed by Criminal (27.6%)

Source: Modern Slavery: National Referral Mechanism and Duty to Notify Statistics UK, end of year summary 2022, Home Office – Table 5
Available from: Modern Slavery: National Referral Mechanism and Duty to Notify statistics UK, end of year summary 2022 - GOV.UK (www.gov.uk)

NRM referrals by nationality

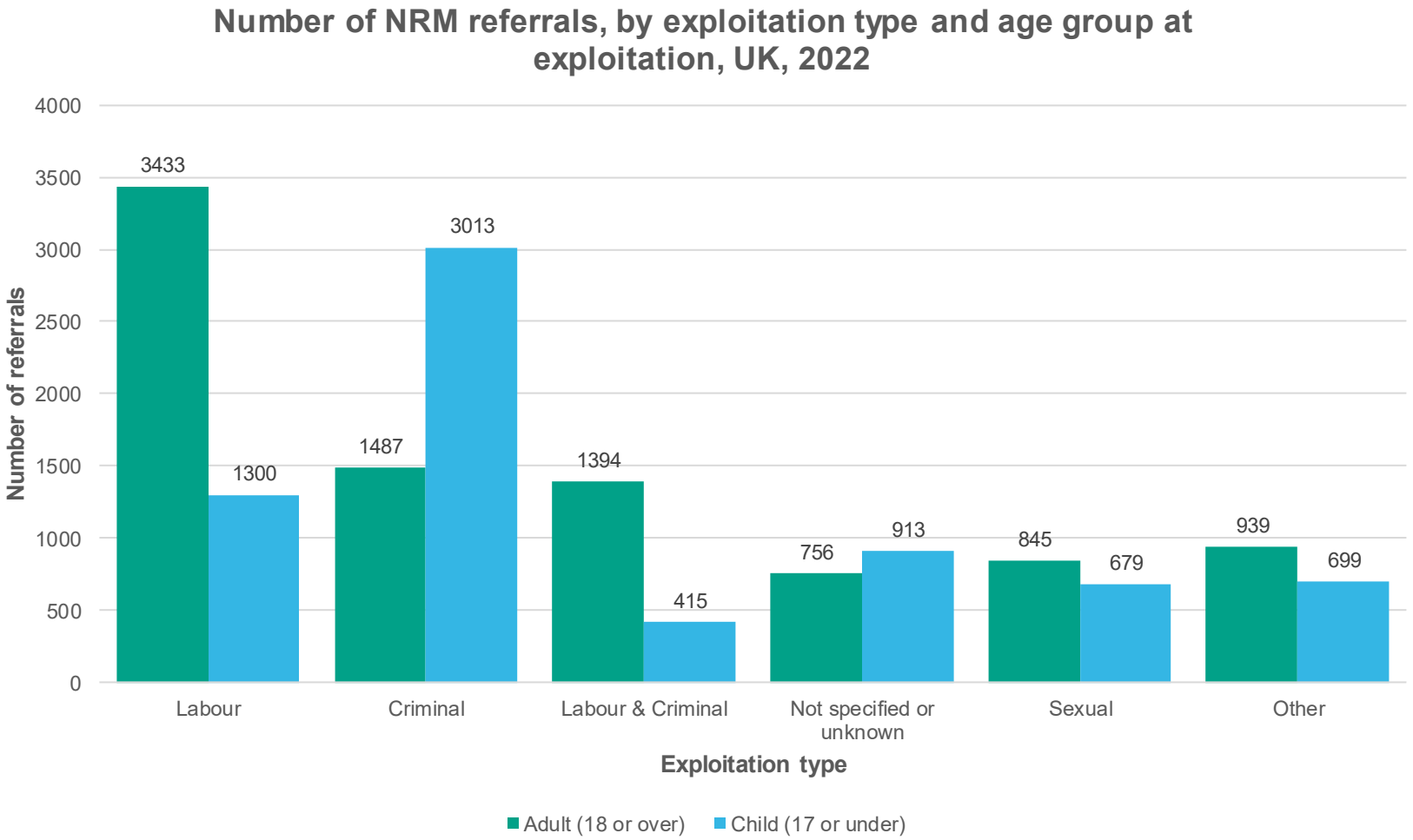
- In 2022, Albanian nationals overtook UK nationals as the most commonly referred nationality (4,454) in England.
- Albanian nationals represent 29.3% of the total referrals with a known nationality.



Source: Modern Slavery: National Referral Mechanism and Duty to Notify Statistics UK, end of year summary 2022, Home Office – Table 5
Available from: Modern Slavery: National Referral Mechanism and Duty to Notify statistics UK, end of year summary 2022 - GOV.UK (www.gov.uk)

Referrals by broad type and age group

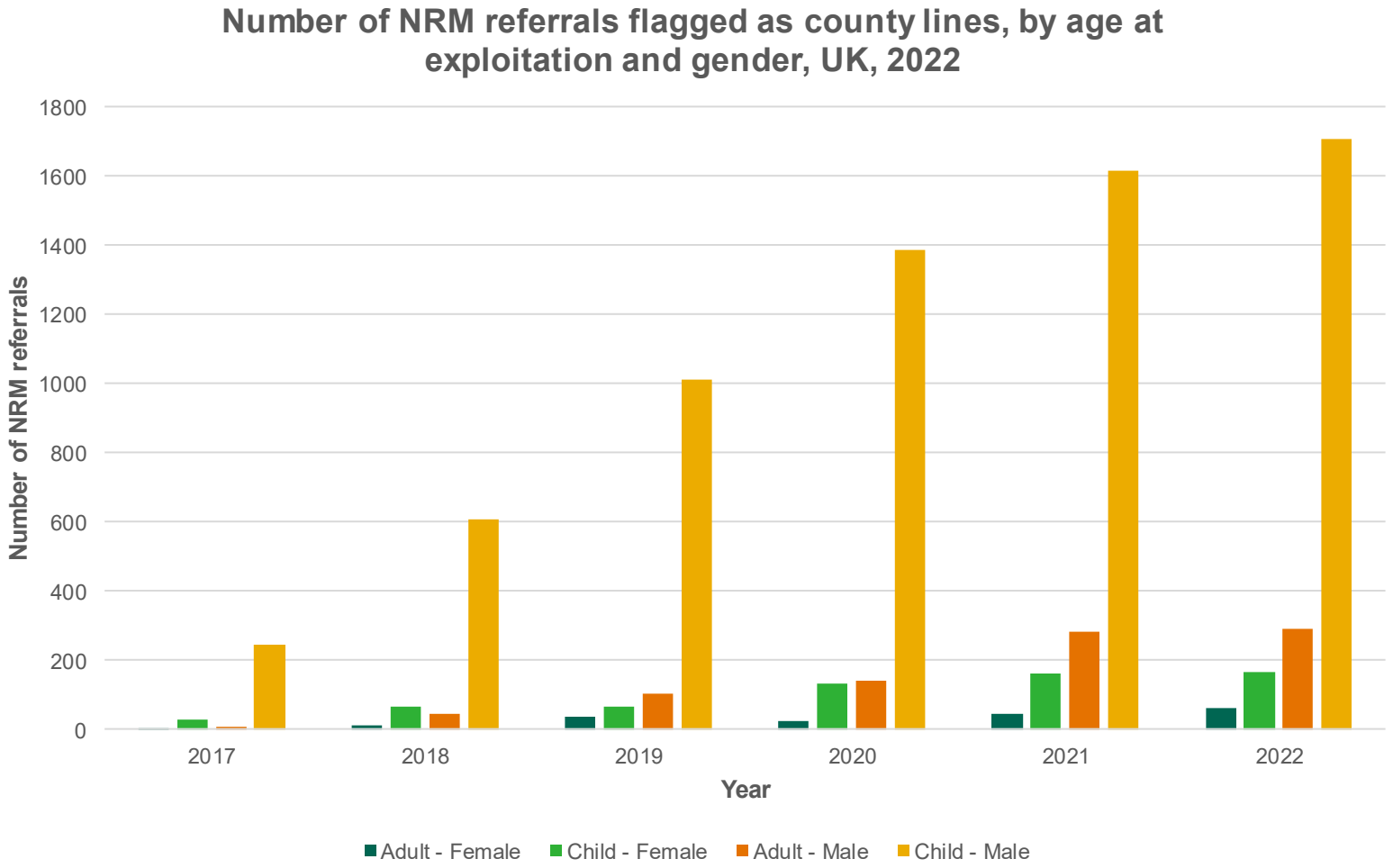
- 55.8% referrals were adults and 44.2% were children aged 17 or under in 2022.
- For adults 78% were male and 22% female; for children, 80% were male and 20% female
- Child victims were most often referred for criminal exploitation. This links to increases in the number of 'county lines cases'



Source: Modern Slavery: National Referral Mechanism and Duty to Notify Statistics UK, end of year summary 2022, Home Office – Table 4
Available from: Modern Slavery: National Referral Mechanism and Duty to Notify statistics UK, end of year summary 2022 - GOV.UK (www.gov.uk)

Trend in NRM referrals flagged as county lines, UK

- In 2022, 2,281 county lines referrals were flagged.
- The majority, 75%, were for male children (17 years or under).
- County Lines is where illegal drugs are transported from one area to another, usually by children or vulnerable adults, often coerced by gangs.



Source: Modern Slavery: National Referral Mechanism and Duty to Notify Statistics UK, end of year summary 2022, Home Office – Table 15
Available from: Modern Slavery: National Referral Mechanism and Duty to Notify statistics UK, end of year summary 2022 - GOV.UK (www.gov.uk)

NRM referrals by Police Force and age at exploitation in Police Force areas covering the South East, all persons, 2022

	Adult (18 or over)	Child (17 or under)	Not specified or unknown	Total	% of Grand Total
Sussex Police	572	238	57	867	34.9%
Kent Police	295	372	50	717	28.9%
Thames Valley Police	223	239	30	492	19.8%
Hampshire Constabulary	93	119	6	218	8.8%
Surrey Police	99	81	7	187	7.5%
Total	**1282**	**1049**	**150**	**2481**	**100.0%**

Source: Modern Slavery: National Referral Mechanism and Duty to Notify Statistics UK, end of year summary 2022, Home Office – Table 8
Available from: Modern Slavery: National Referral Mechanism and Duty to Notify statistics UK, end of year summary 2022 - GOV.UK (www.gov.uk)

Victims of modern slavery: Resources & organisations

Resources

- Identifying and supporting victims of modern slavery: guidance for health staff
- Modern Slavery - elearning for healthcare
- Child exploitation disruption toolkit
- Trafficking Toolkit
- A public health approach to modern slavery opportunities and challenges
- NHS England modern slavery and human trafficking statement
- Preventing modern slavery: the role of the NHS
- Royal College of Nursing: Modern Slavery and Trafficking
- Interim guidance for Independent Child Trafficking Guardians
- Public Health England: Modern slavery and public health

Organisations

- Support Services — Human Trafficking Foundation
- Helen Bamber Foundation | Strength to Fly
- Home - Unseen (unseenuk.org)

People in contact with the criminal justice system

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- People in contact with the criminal justice system: Overview
- Health needs of people in contact with the criminal justice system
- Sexual health and people in prison
- Health outcomes for women in prison
- Young people in young offender institutions and prisons
- England prisons
- Prisons in the South East
- Prisons in NHS Hampshire and Isle of Wight ICB area
- People in contact with the Criminal Justice System: Resources

People in contact with the criminal justice system: Key messages

- People in contact with the criminal justice system are some of the most marginalised, vulnerable population groups in any community, often experiencing multiple complex health and social care needs, with poor access to health services and a background of poverty, unemployment, indebtedness, substance misuse, poor education and homelessness.

- Considering and tackling health inequalities for this group includes both those within prisons and those being supervised by probation services. All of those in prison have come from the community and almost all will return to their community following their sentence, with the proportion of offenders being supervised by probation services outnumbering those currently serving by around three to one at any one time.

- Integrated Care Systems are ideally placed to help improve health outcomes for those in prison, by supporting prisons to understand what their health needs are and start working with them towards meeting those needs within the community.

People in contact with the criminal justice system: Overview

People in contact with the criminal justice system encompasses both those who are currently serving a sentence in prison and those who are under supervision of probation services. Data indicates that 27% of the prison population identify as an ethnic minority, compared with 13% in the general population. The prison population is aging, with the proportion of people aged over 50 years in prisons increasing from 7% in 2002, to 17% in March 2020[1].

People in prison are more likely to have been taken into care, or have experienced abuse as a child, been homeless or been unemployed. They are more likely to engage in high-risk behaviours, often do not manage their existing health issues effectively, have limited contact with primary care services and as such, are over-represented in their use of emergency services. It is estimated that around 80% of prisoners smoke on arrival to prisons[2], compared to just under 13% of the general population[3]. They experience some of the most extreme health inequalities resulting in an average age of death for people dying in prison of 56 years, compared to 81 in the general population[4].

Transition from prison, to probation services and back to the community is a fundamental time to ensure continuity of care, particularly for those individuals with ongoing health needs or who are engaging with substance misuse, health or social care services.

Health and offending are often interrelated. Health issues such as substance misuse or mental health problems can lead to contact with the criminal justice system. Addressing the health needs of this group can reduce reoffending and have a positive impact on the overall health of their communities.

Health needs of people in contact with the criminal justice system (1/2)

- 1/3rd of people in contact with the criminal justice system have a learning disability or difficulty with 57% of adult prisoners having literacy levels below those expected of an 11 year old[1]
- It is estimated that at least 1 in 3 people have neurodivergent needs, compared to 15% of the general population[2].
- Up to 90% of prisoners aged 50 or more have at least one moderate or severe health condition, and over 50% have three or more[3].
- 71% of women and 47% of men in contact with the criminal justice system experience mental health problems[4].
- A review of hospital admissions[5] found injury and poisoning were the most common reasons for prisoners being admitted to hospital and that 40% of hospital outpatient appointments for prisoners were not attended, a rate double that of the general population.
- Older people in prison are vulnerable to experiencing frailty due to the prevalence of multiple long-term conditions and the challenge of the prison environment itself[6].

Health needs of people in contact with the criminal justice system (2/2)

- The prevalence of Hepatitis C virus antibody (indicating either past or current infections) is approximately 6% among those in prisons, compared to 0.7% in the general community[6].

- There is a complex link between substance misuse and crime but evidence shows that both drug and alcohol use are risk factors for re-offending with general re-offending being highest among drug users[7]. Data collected by NHS England under the Liaison and Diversion Programme showed that over 55% of service users in contact with the criminal justice system and identified with mental health need also had problem with drug use, alcohol use or both.

- The main causes of death while in prison are cardiovascular disease (43%) followed by cancer (32%) however the Independent Advisory Panel on deaths in custody has suggested that many deaths are preventable[8].

- Between 2008 and 2019, the risk of male prisoners dying by suicide was 3.9 times higher than the general male population[9].

Sexual health & people in prison

- People in prison are more likely to experience poor sexual health, often due to social deprivation and engaging in higher levels of risk taking behaviours (including condomless sex). They are at higher risk of blood borne viruses (BBV) and sexually transmitted infections (STI), and more likely to have complex support needs for sexual assault or abuse[1,2].
- According to 2019/20 Hospital Episode Statistics (HES) data, diseases of the genitourinary system were among the top five most common reasons why PIP require admission to hospital in England[3].
- Although people in prison are deprived of their liberty, their right to access healthcare remains unchanged and should have equivalent access to healthcare services as the general population[4]. However, there are well documented inequalities that limit access to care. It is estimated that 30-40% of health appointments are unattended[5,6].
- There are known barriers to accessing condoms in prison that limit their uptake and use amongst prisoners[7,8].
- A recent inspection of UK prisons revealed that support for lesbian, gay, bisexual and transexual (LGBT) prisoners is often lacking, with most establishments offering no formal consultation or community organisation links for these groups[9].
- Female estates can also provide a timely opportunity to address reproductive health including pregnancy testing, cervical screening and access to contraception.
- These, along with other structural challenges and wider inequalities[5], contribute to the poorer sexual health outcomes observed among people in prison.

Health outcomes for women in prison

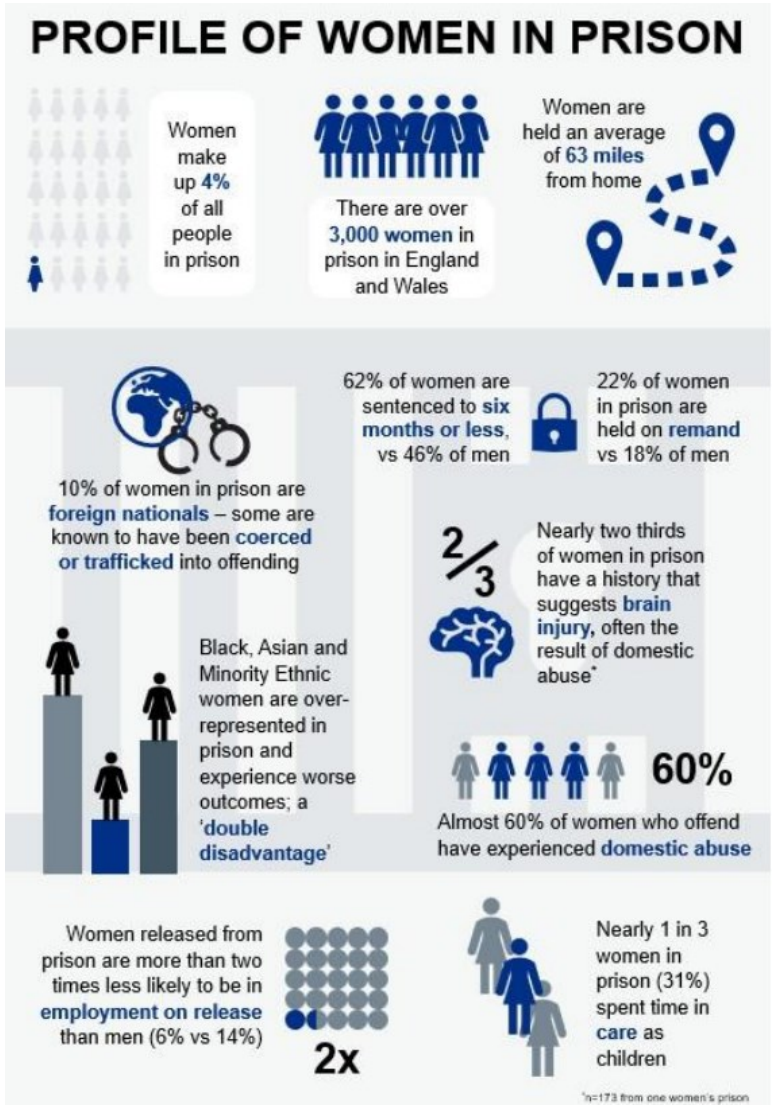
Women make up less than 4% of the prison estate but face disproportionately higher levels of health and social care needs than their male counterparts. A third of the adult female prisons are in the South East[1].

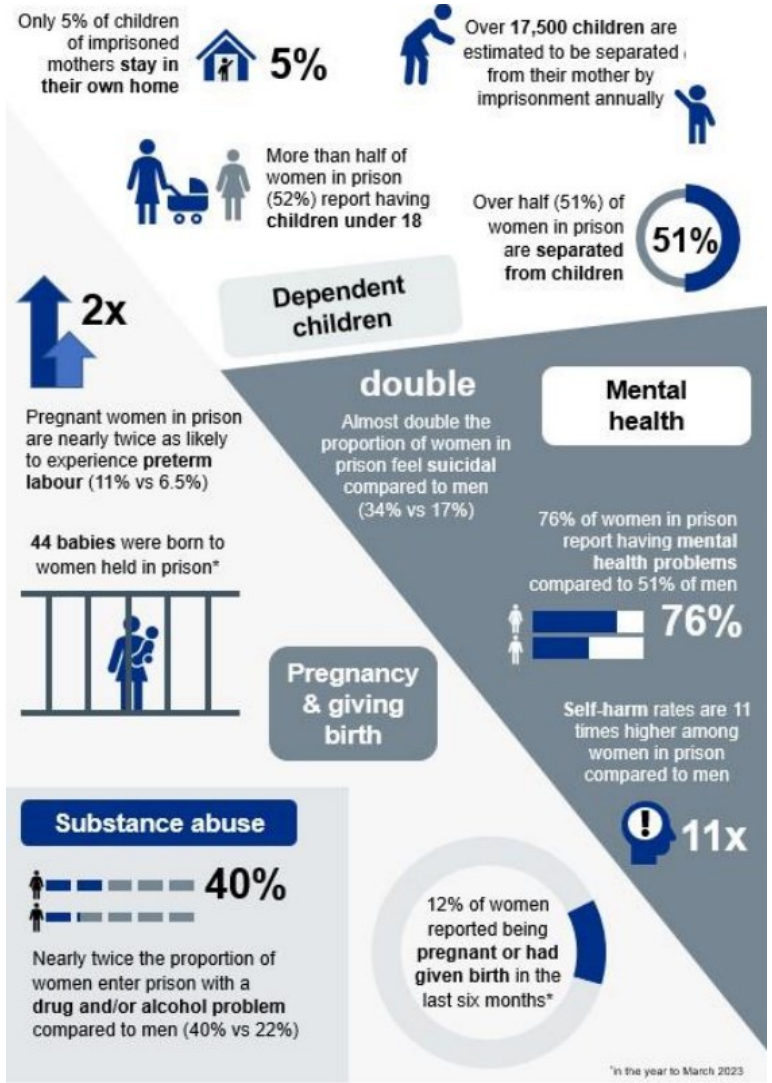
There is currently limited data or research on the health and social care needs, services and outcomes for women in prison, however, it is known that these women have often experienced trauma and substance abuse. Hospital Episodes Statistics (HES) data in 2019/20 showed that just under 30% of inpatient admissions by women in prison had a diagnosis of substance misuse[2].

A review by NHS England[3] found that health and social care services across women's prisons are inconsistent, not always gender specific or sensitive to women with protected characteristics. Acutely mentally ill women are still being sent to prison. There is a gap in mental health services across the range of needs including primary mental healthcare and specialist interventions for women who have experienced trauma, including sexual and domestic violence. Women may have been subject to experiences within domestic abuse which can directly impact their health, for example admissions for acute brain injury.

Women in prison often experience challenges and barriers around accessing health and care services including missed midwifery appointments due to lack of available escort staff, and a lack of understanding around sexual and reproductive health care needs including menopause. Pregnant women are more likely to experience preterm birth with 11% going into pre-term labour, compared to 6.5% of births among the general population[2]. For women who give birth in prison, the consequences of maternal separation on physical and mental wellbeing can be significant, highlighting the need to align work on supporting families with healthcare provision.

Health profile of women in prison





A review of health and social care in women's prisons (england.nhs.uk)

Young people in young offender institutions and prisons

Monthly statistics are produced on the population in custody of children and young people within secure children's homes (SCH), secure training centres (STCs) and young offender institutions (YOIs). In September 2023, there were 441 children and young people aged under 18 in the Children and Young People's Secure estate (613 when including those aged 18 years and older).This has been reducing over time, from a peak of 3654 children and young people (including over 18) in July 2002. The majority are boys (606) and the most common age is 17 years (235)[1].

Analysis of routinely collected hospital data by the Nuffield Trust[2] highlighted serious challenges with the health and care of children and young people in custody, particularly around self-harm and violence.

- 42% of hospital admissions involving young adult males in custody had a primary diagnosis of injury or poisoning, significantly higher than the 16% among the adult prisoner population.
- 60% (n=55) of hospital admissions for young adult males in prison where a diagnosis of attention deficit hyperactivity disorder (ADHD) was flagged had a primary diagnosis of injury or poisoning.
- Boys detained in young offender institutions had a higher proportion of outpatient appointments cancelled on their behalf (18%) than both young adult males (14%) and other adult males (13%) in prison.

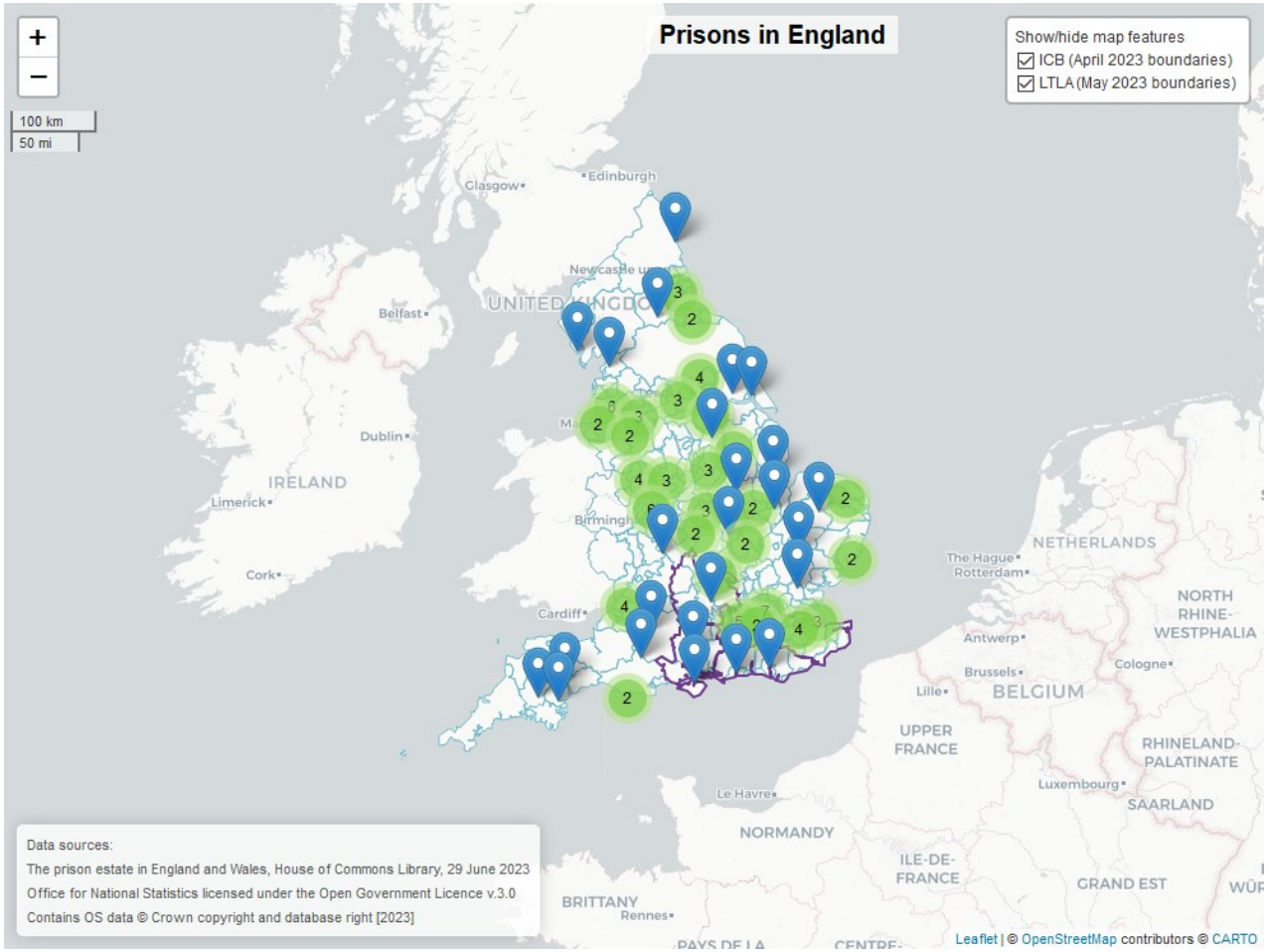
A literature review conducted by the Centre for Mental Health highlighted that girls in the secure estate are often highly vulnerable, having been exposed to multiple traumatic events such as sexual abuse, victimisation and gender based violence[3].They are also more likely to have co-existing mental and physical health needs, which may have been overlooked, as well as higher levels of neurodiversity.

England Prisons

The total adult prison population in England and Wales is 87,576 as of September 2023. 84,006 adult prisoners are male while 3,570 prisoners are female.

HM Prison and Probation Service (HMPPS) is responsible for running an estate of 120 prison and Young Offenders institutions and one Secure Training Centre.

More information and an interactive map with prison populations can be found here.

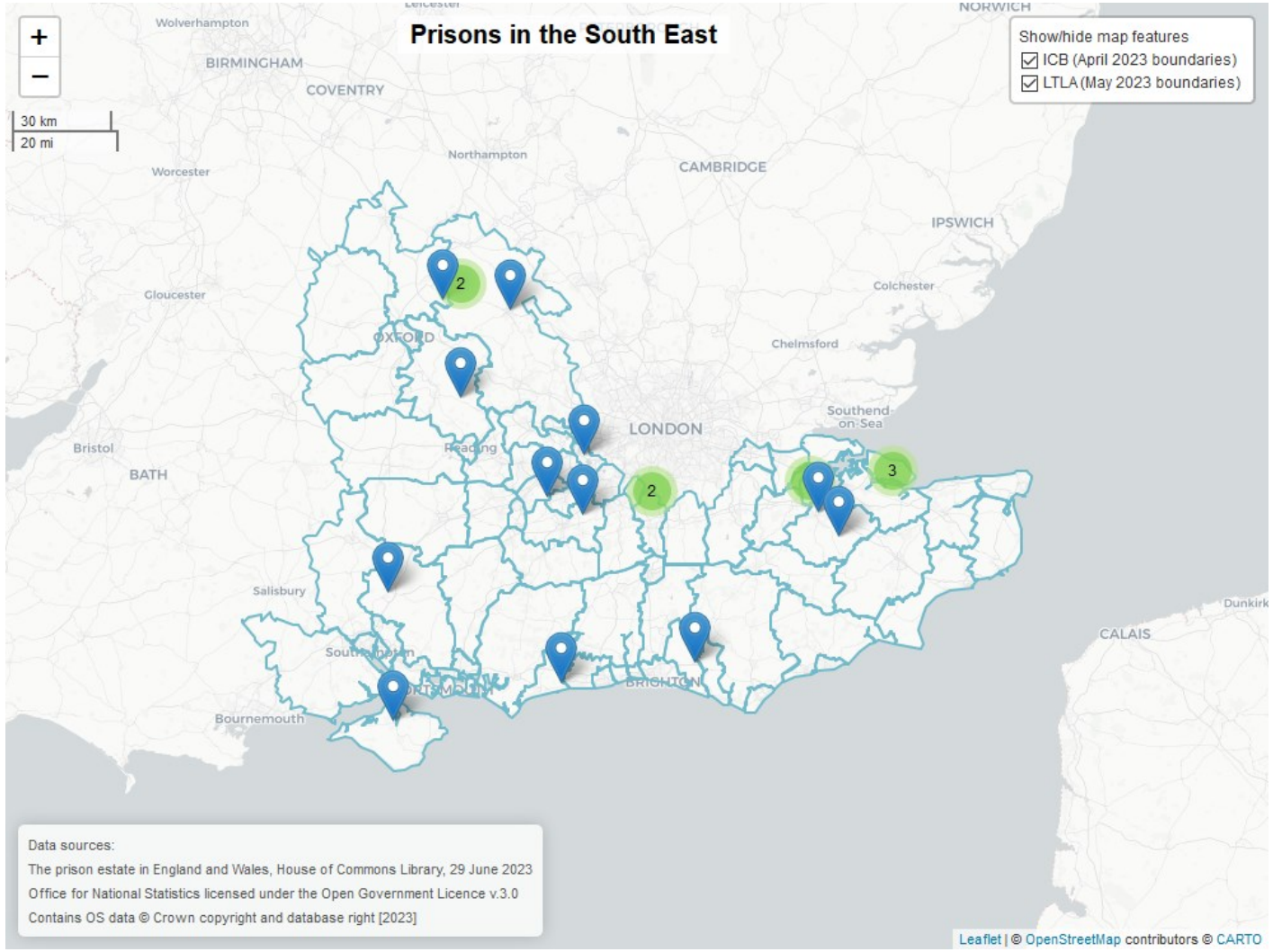


Source: Offender management statistics (Prison population: September 2023), Ministry of Justice and HM Prison and Probation Service.
Available from Offender Management Statistics quarterly: April to June 2023 - GOV.UK (www.gov.uk)

Prisons in the South East

The total adult prison population in the South East is 11,515 as of September 2023. 10,413 adult prisoners are male while 1102 prisoners are female.

A total of 20 prison institutions are shown on the map. Woodhill prison and Oakhill Secure Training Centre, both in Milton Keynes, are not included as they fall outside the South East health geographies.

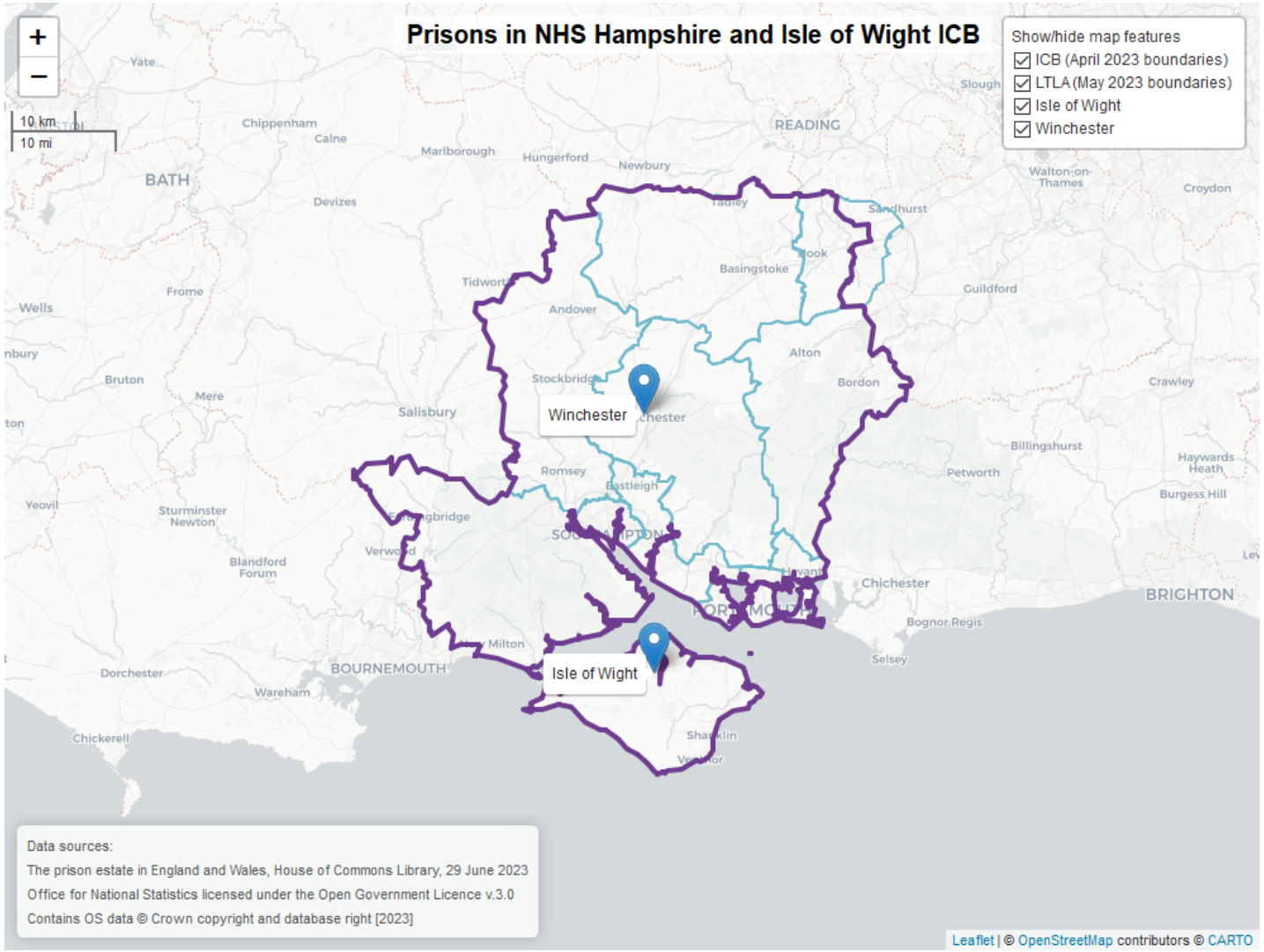


Source: Offender management statistics. Prison Population September 2023. Ministry of Justice and HM Prison and Probation Service. Available from Offender Management Statistics quarterly: April to June 2023 - GOV.UK (www.gov.uk)

Prisons in NHS Hampshire and the Isle of Wight Integrated Care Board area

The total adult prison population in Hampshire and the Isle of Wight ICB is 1,758 as of September 2023. All prisoners in this ICB are male.

A total of 2 prison institutions are shown on the map.



Prison	British Nationals	Foreign Nationals	Nationality not recorded	Total Population
Isle of Wight	968	129	1	1,098
Winchester	566	93	1	660
	1534	222	2	1,758

Source: Offender management statistics (Prison population: September 2023), Ministry of Justice and HM Prison and Probation Service.
Available from Offender Management Statistics quarterly: April to June 2023 - GOV.UK (www.gov.uk) Population_30Sep2023.ods (live.com)

People in contact with the Criminal Justice System: Resources

- The Health and Justice Framework for integration 2022 – 2025
- National Partnership Agreements:
  - National Partnership Agreement for Health and Social Care for England
  - Health and Justice Children Programme national partnership agreement 2023 – 2025
  - National partnership agreement for immigration removal centre (IRC) healthcare in England 2022 - 2025
- Rebalancing Act A resource for Directors of Public Health, Police and Crime Commissioners and other health and justice commissioners, service providers and users.
- RECONNECT: a holistic care after custody service which seeks to ensure that individuals with identified health needs who are leaving prison or an IRC receive access to ongoing care and support.
- Homelessness Reduction Act: Duty to refer policy framework
- Shelter Legal England - Homelessness referrals for prisoners and people on probation - Shelter England

People with drug and alcohol dependence

People with drug and alcohol dependence: Contents

- People with drug and alcohol dependence: Key messages
- Health outcomes: Drug dependence
- Prevalence estimates of illicit opiate and/or crack cocaine use
- Drug dependence data
- Health outcomes: alcohol dependence
- Prevalence estimates of alcohol dependence
- Alcohol dependence data
- Drug and alcohol dependence: Guidance and Resources

People with drug and alcohol dependence: Key messages

- There is a significant overlap of populations experiencing severe multiple disadvantage including alcohol and drug dependence, homelessness, offending behaviours and mental ill health.

- Stigma remains a significant issue both for people affected by drug and alcohol dependence and their families and communities. This impacts on engagement with services and recovery.

- Education, prevention and early intervention is necessary to reduce harm and prevent both hospital admissions and drug and alcohol related deaths. Therefore, a key focus is for systems to identify need and refer to effective treatment.

Health outcomes: Drug dependence

Over the past 10 years, drug use in the South East has gone from 8.8% in 2011/12 to 9.1% of 16–59 year olds using any drug in the last year in 2019/20. Drug use in the South East region is at a similar level to England (9.1% and 9.2% respectively) in 2021/22 (ONS, 2022).

In 2019/20, there were 7,027 hospital admissions for drug-related mental and behavioural disorders in England, 5% fewer than the previous year. More men (73%) were admitted than women. Admissions were around 5 times more likely in the most deprived areas, compared to the least deprived areas (NHS Digital).

Drug use is associated with a range of health-related problems. These include mental health problems (anxiety, depression, psychosis, personality disorder and suicide), cardiovascular disease, blood borne viruses, liver damage from undiagnosed or untreated hepatitis C virus to sexual risk taking and associated sexually transmitted infections, as well as poor vein health and arthritis or mobility problems among those who inject drugs (OHID).

There is a significant overlap between those dependent on drugs and other levels of disadvantage, with the most deprived local authorities having the highest prevalence of problematic drug users. Drug dependence is associated with relationship breakdown and difficulty in maintaining social links. There is also a strong relationship between drug dependence and crime and between April 2022 and March 2022, there were 45,096 adults in alcohol and drug treatment in prisons and secure settings. Of these, 74% started treatment during the year and nearly of third of people starting treatment were identified as having a mental health need (OHID, 2023). The pattern of drug use has changed over time with new psychoactive substances, image and performance enhancing drugs and misuse of medication producing areas of concern. The rise in psychoactive substances within criminal justice settings can contribute to health related and behavioural problems.

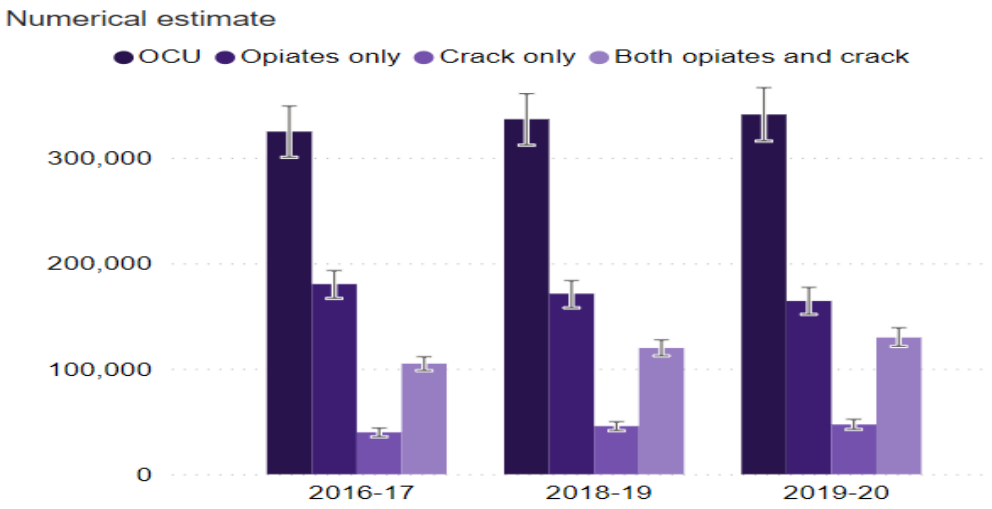
Prevalence estimates of illicit opiate and/or crack cocaine use (OCU) - England

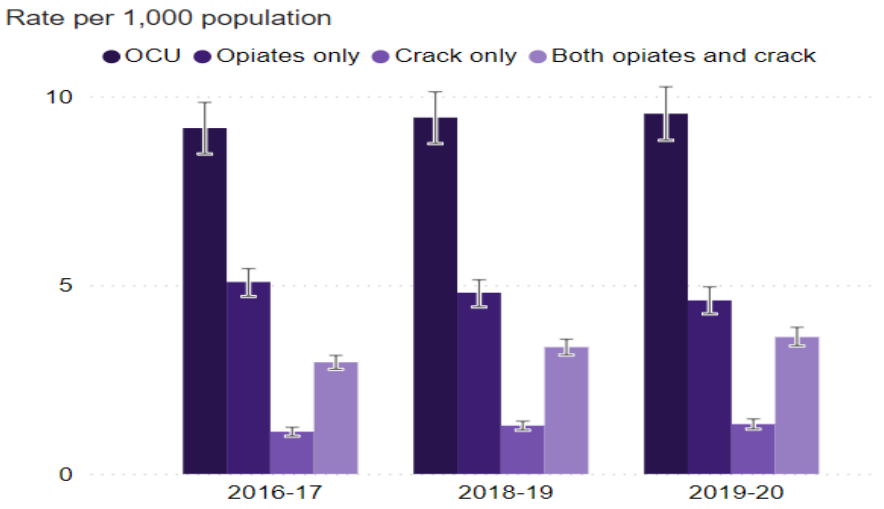
England
2019-20

Substance group	Numerical estimate	Estimate lower bound	Estimate upper bound	Population estimate (15-64)
OCU	341,032	315,864	366,547	35,741,156
Opiates only	164,279	151,542	177,081	35,741,156
Crack only	47,168	42,483	52,026	35,741,156
Both opiates and crack	129,584	121,143	138,804	35,741,156

England
2019-20

Substance group	Rate per 1,000 population	RPT lower bound	RPT upper bound	Population estimate (15-64)
OCU	9.5	8.8	10.3	35,741,156
Opiates only	4.6	4.2	5.0	35,741,156
Crack only	1.3	1.2	1.5	35,741,156
Both opiates and crack	3.6	3.4	3.9	35,741,156





Prevalence estimates of illicit opiate and/or crack cocaine use are shown as both numerical estimates and rates per 1,000 population for England. The above bar charts demonstrates the trend from 2016/17 to 2019/20.

Source: Opiate and crack cocaine use: prevalence estimates - GOV.UK (www.gov.uk)

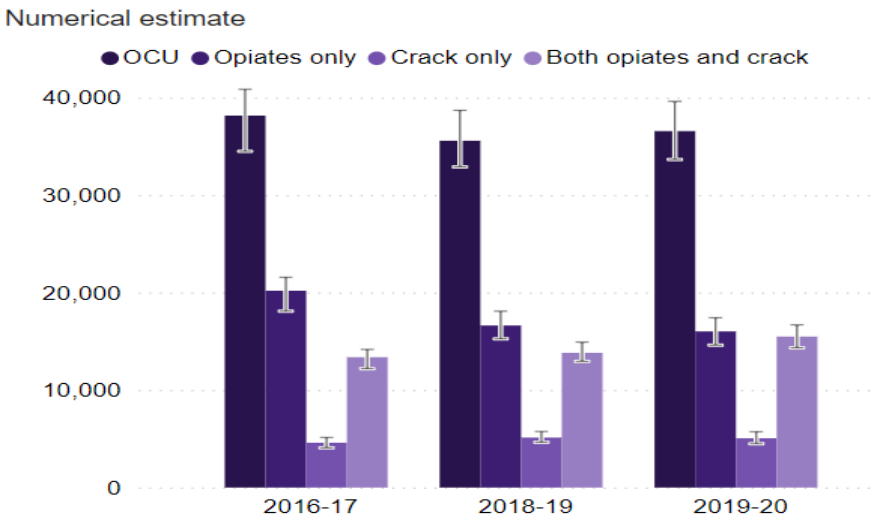
Prevalence estimates of illicit opiate and/or crack cocaine use (OCU) - South East

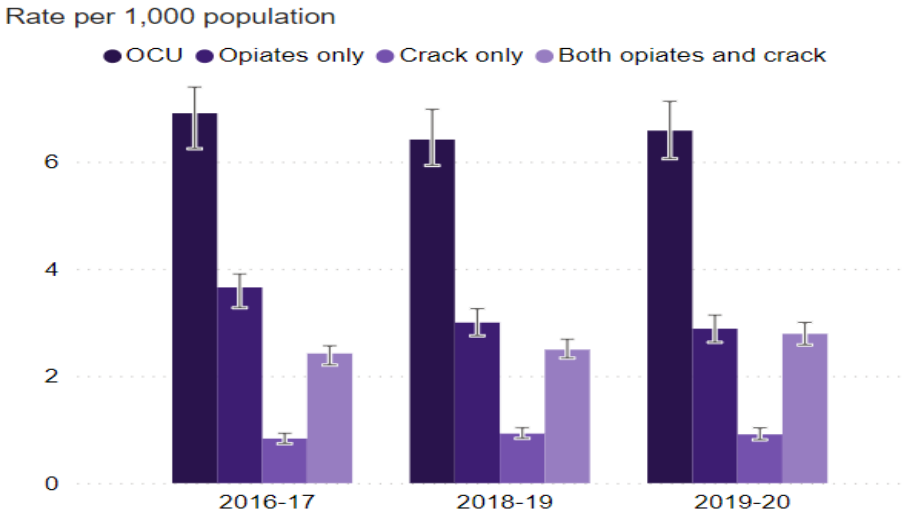
South East
2019-20

Substance group	Numerical estimate	Estimate lower bound	Estimate upper bound	Population estimate (15-64)
OCU	36,553	33,643	39,594	5,554,467
Opiates only	16,014	14,603	17,432	5,554,467
Crack only	5,055	4,492	5,740	5,554,467
Both opiates and crack	15,484	14,325	16,674	5,554,467

South East
2019-20

Substance group	Rate per 1,000 population	RPT lower bound	RPT upper bound	Population estimate (15-64)
OCU	6.6	6.1	7.1	5,554,467
Opiates only	2.9	2.6	3.1	5,554,467
Crack only	0.9	0.8	1.0	5,554,467
Both opiates and crack	2.8	2.6	3.0	5,554,467





Prevalence estimates of illicit opiate and/or crack cocaine use are shown as both numerical estimates and rates per 1,000 population for the South East. The above bar charts demonstrates the trend from 2016/17 to 2019/20.

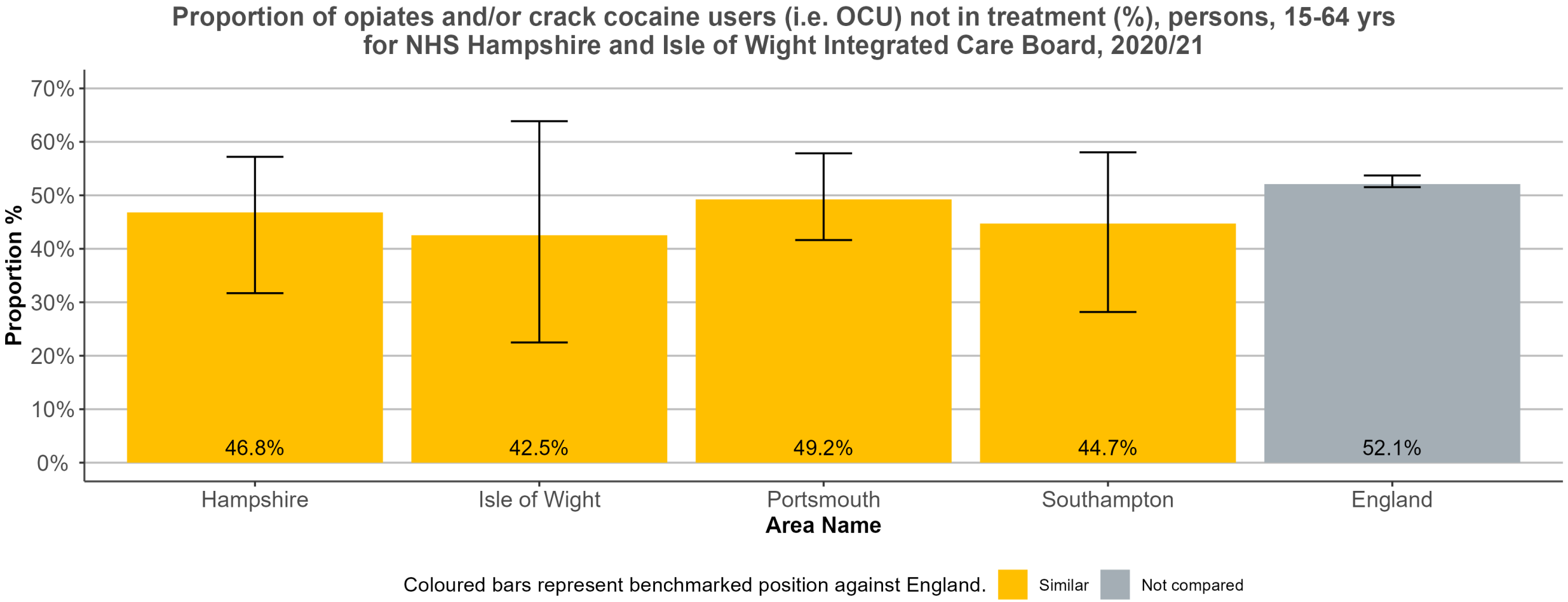
Source: Opiate and crack cocaine use: prevalence estimates - GOV.UK (www.gov.uk)

Drug dependence data

This section contains the following indicators for each ICB:

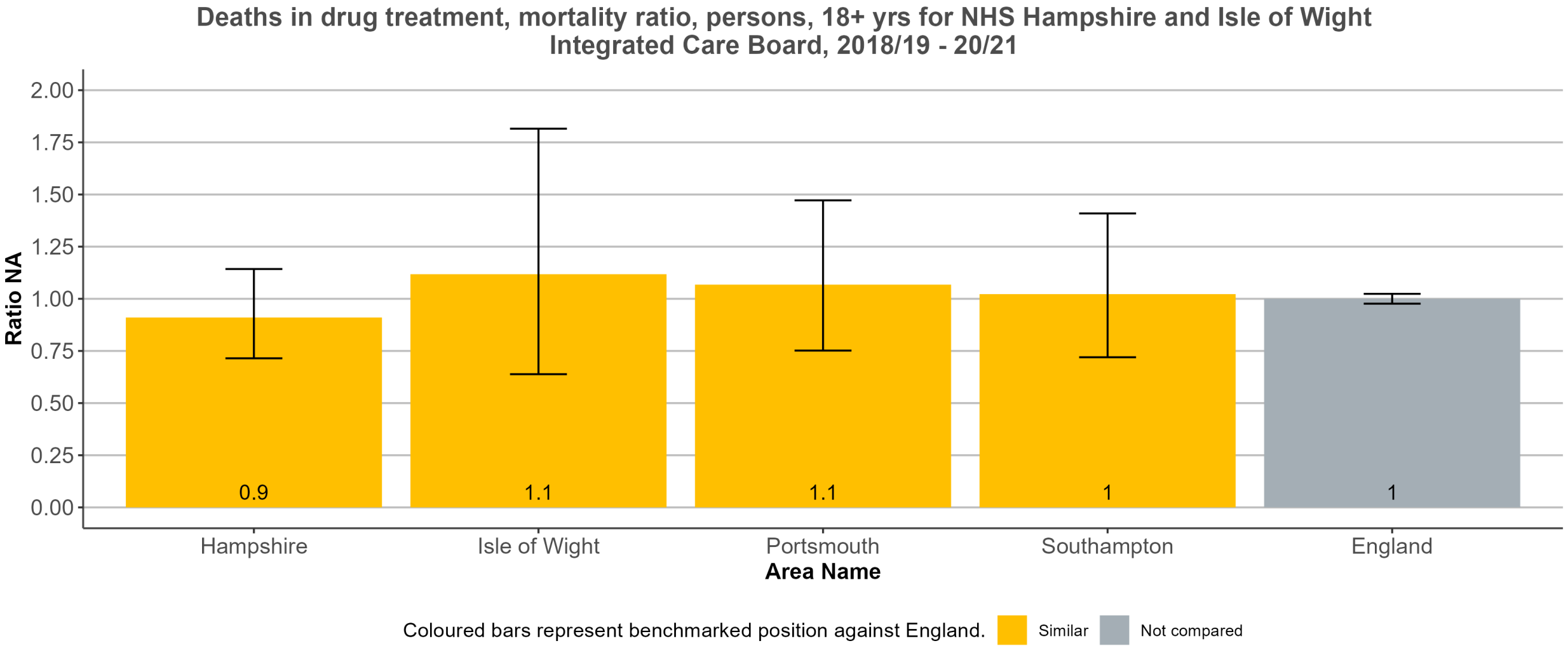
- Proportion of opiates and/or crack cocaine users (ICU) not in treatment
- Deaths in drug treatment (mortality ratio)

Proportion of opiates and/or crack cocaine users (OCU) not in treatment (%)



Source: https://fingertips.phe.org.uk/
National Drug Treatment Monitoring System and Estimates of OCU Use in England

Deaths in drug treatment, mortality ratio



Source: https://fingertips.phe.org.uk/
National Drug Treatment Monitoring System

Health outcomes: alcohol dependence (1/2)

Excessive alcohol consumption is a major cause of preventable premature death with 3 million deaths every year worldwide resulting from harmful use of alcohol (5.2% of all deaths). Overall, 5.1% of the global burden of disease and injury is attributable to alcohol (World Health Organisation).

The National Institute for Health and Care Excellence (NICE) defines harmful (higher risk) drinking as a pattern of alcohol consumption that causes health problems directly related to alcohol. Alcohol consumption is a risk factor for developing mental and behavioural conditions, along with non-communicable diseases including liver cirrhosis, cardiovascular disease and cancer (Alcohol guidelines review). Alcohol consumption in pregnancy can lead to low birth weight, preterm birth and being small for gestational age. Drinking alcohol also contributes to both unintentional and intentional injuries, including road traffic accidents, violence and suicide. The 2023 National Confidential Inquiry into Suicide and Safety in Mental Health identified high proportions of those with alcohol (48%) and drug (37%) misuse among those who died from suicide in the UK between 2010 – 2020.

The Health Survey for England (2021) found that 54% of men and 61% of women drank at levels that put them at a lower risk of alcohol-related harm. A higher proportion of men (28%) than women (15%) drank at increasing or higher risk levels (over 14 units in the last week for both men and women). The proportion of men and women who reported drinking over 14 units of alcohol per week, increased with household income and varied by age group, increasing up to the age of 55-64 (36% of men and 21% of women).

Health outcomes: alcohol dependence (2/2)

High risk drinking is associated with a range of social and economic issues and there is significant overlap of populations that experience multiple and severe disadvantage including alcohol and drug dependency, homelessness, and offending behaviours. Alcohol and drug dependency are both common among people with mental ill health with over two-thirds of people starting treatment for drug or alcohol dependence, saying they had a mental health need (70% in the alcohol only group). Over one-fifth of these were not receiving treatment to meet their mental health needs (Adult Substance misuse treatment statistics 2021-2022).

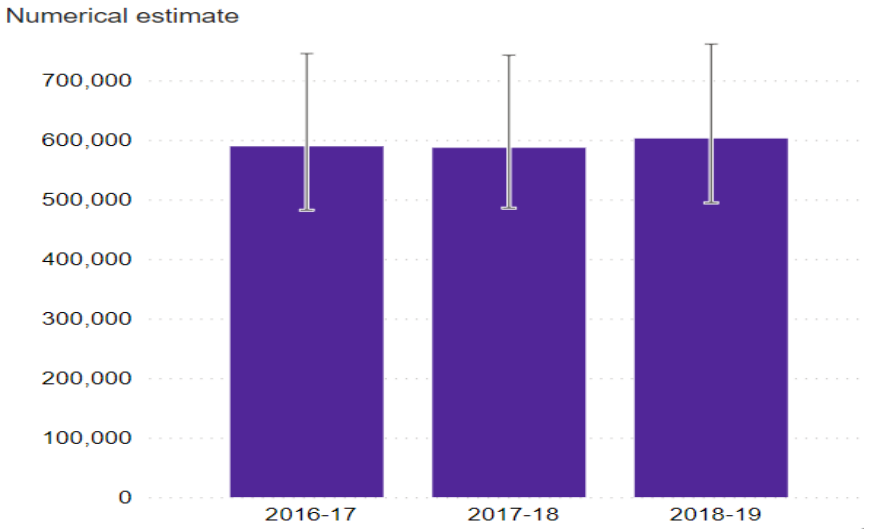
In 2019/20, there were 280,000 estimated admissions to hospital in England, where the main reason was attributed to alcohol. This represented 1.6% of all hospital admissions, which is unchanged since 2016/17, however the total number was 8% higher than that seen in 2016/17. The majority of patients (65%) were male and the number of admissions rises with age up, peaking at 55-64 with 23% of patients falling in this age range. In total, 28% of the admission were for cancer, with 14% for mental and behavioural disorders due to the use of alcohol. When the broad measure of alcohol related admissions was used (including a secondary diagnosis linked to alcohol), this represented 5.7% of admissions, 45% of which were for cardiovascular disease (Local Alcohol Profiles for England).

In 2021 in the South East, the under 75 mortality rate from alcoholic liver disease was 9.1 per 100,000 population, compared to 11.5 per 100,000 across England. In 2020, there were 974 potential years of life lost due to alcohol related conditions in males, with 431 potential years of life lost for females in the South East (Statistics on Public Health, 2021).

Prevalence estimates of alcohol dependence – England

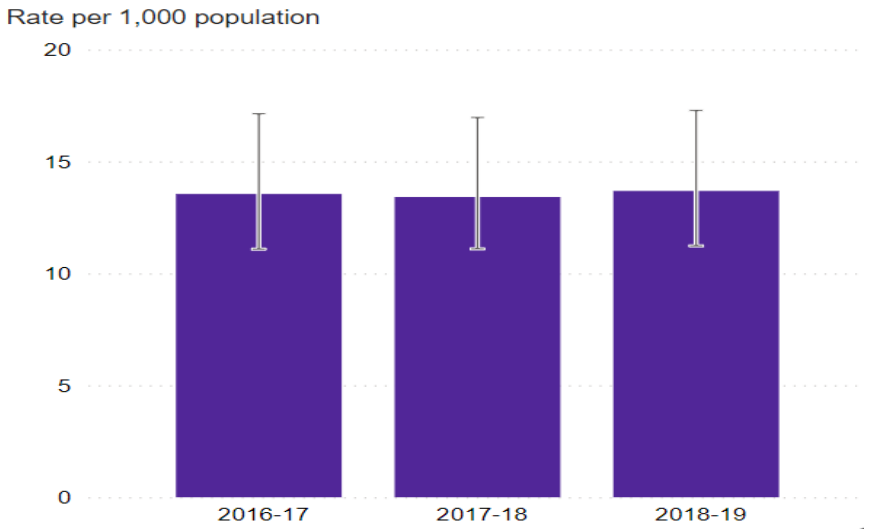
England

Time period	Numerical estimate	Estimate lower bound	Estimate upper bound	Population estimate (18+)
2018-19	602,391	494,302	760,989	44,022,560
2017-18	586,780	485,444	742,305	43,752,473
2016-17	589,101	481,965	744,996	43,482,790



England

Time period	Rate per 1,000 population	RPT lower bound	RPT upper bound	Population estimate (18+)
2018-19	13.68	11.23	17.29	44,022,560
2017-18	13.41	11.10	16.97	43,752,473
2016-17	13.55	11.08	17.13	43,482,790



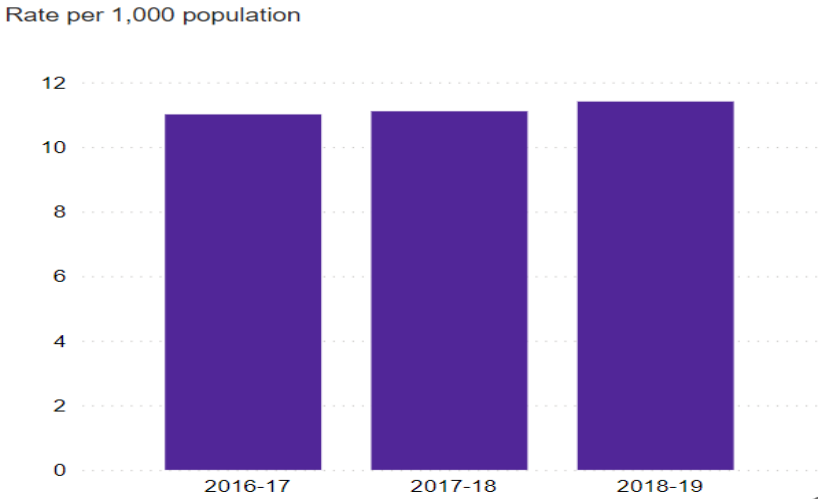
Prevalence estimates of alcohol dependence are available at an England, regional and local authority level. The above charts show the trend between 2016/17 and 2018/19 for England, during which time there has been no significant change in the overall prevalence of alcohol dependency. Figures are shown as both numerical estimates and rates per 1,000 population.

Source: Alcohol dependence prevalence in England - GOV.UK (www.gov.uk)

Prevalence estimates of alcohol dependence - South East

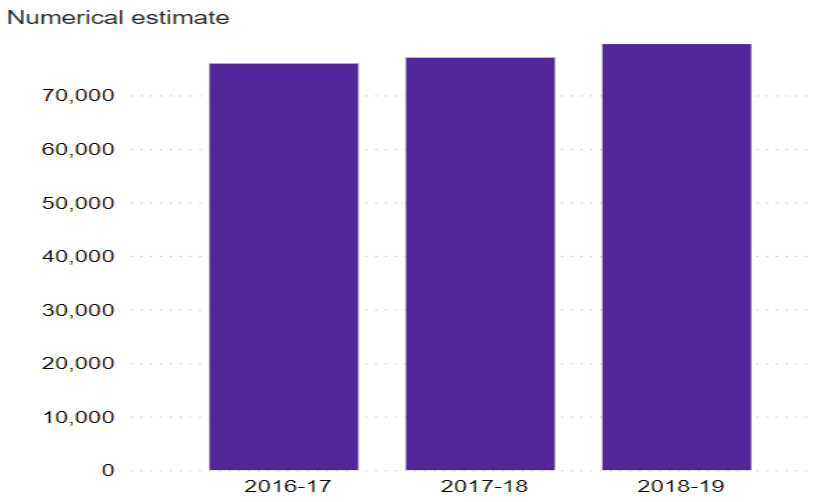
South East

Time period	Rate per 1,000 population	RPT lower bound	RPT upper bound	Population estimate (18+)
2018-19	11.41			6,975,795
2017-18	11.11			6,937,086
2016-17	11.01			6,897,114



South East

Time period	Numerical estimate	Estimate lower bound	Estimate upper bound	Population estimate (18+)
2018-19	79,579			6,975,795
2017-18	77,045			6,937,086
2016-17	75,933			6,897,114



Prevalence estimates for alcohol dependence in the South East from 2016/17 to 2018/19 show a slight increasing trend. However, confidence intervals are not available to demonstrate if this is a significant increase.

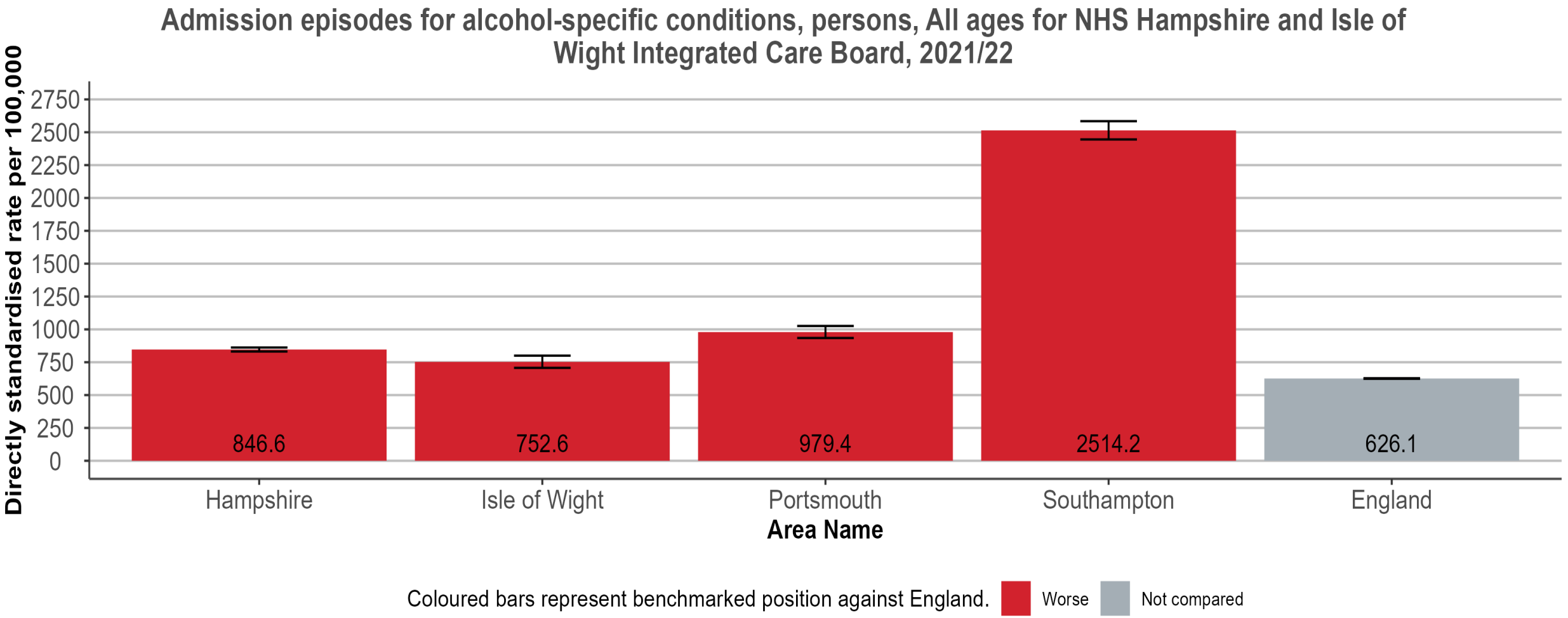
Source: Alcohol dependence prevalence in England - GOV.UK (www.gov.uk)

Alcohol dependence data

This section contains the following indicators for each ICB:

- Admission episodes for alcohol-specific conditions
- Number in treatment at specialist alcohol misuse services
- Proportion of dependent drinkers not in treatment (%)
- Deaths in alcohol treatment (mortality ratio)
- Alcohol-related mortality
- Potential years of life lost (PYLL) due to alcohol-related conditions

Admission episodes for alcohol-specific conditions



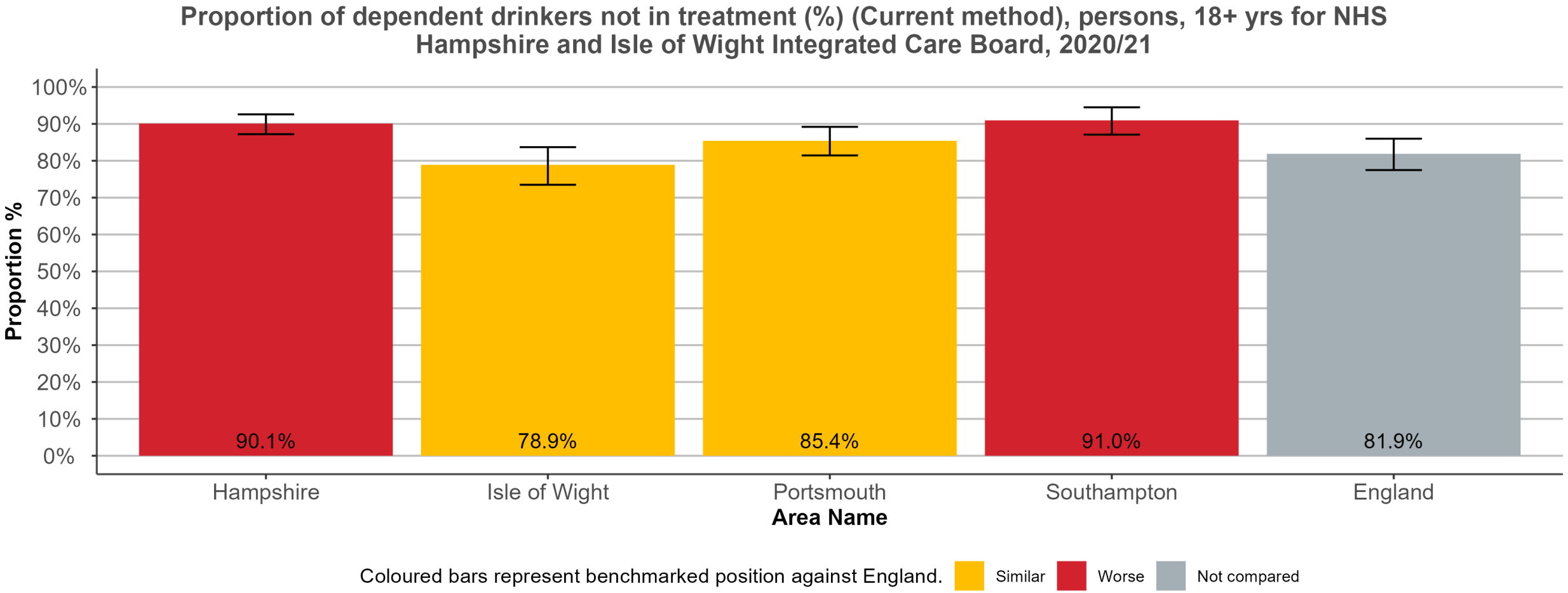
Source: https://fingertips.phe.org.uk/

Number in treatment at specialist alcohol misuse services: NHS Hampshire and the Isle of Wight ICB

Number in treatment at specialist alcohol misuse services, persons, 18+ yrs, for NHS Hampshire and the Isle of Wight Integrated Care Board, 2020/21				
Hampshire	Isle of Wight	Portsmouth	Southampton	England
797	238	336	269	76,740

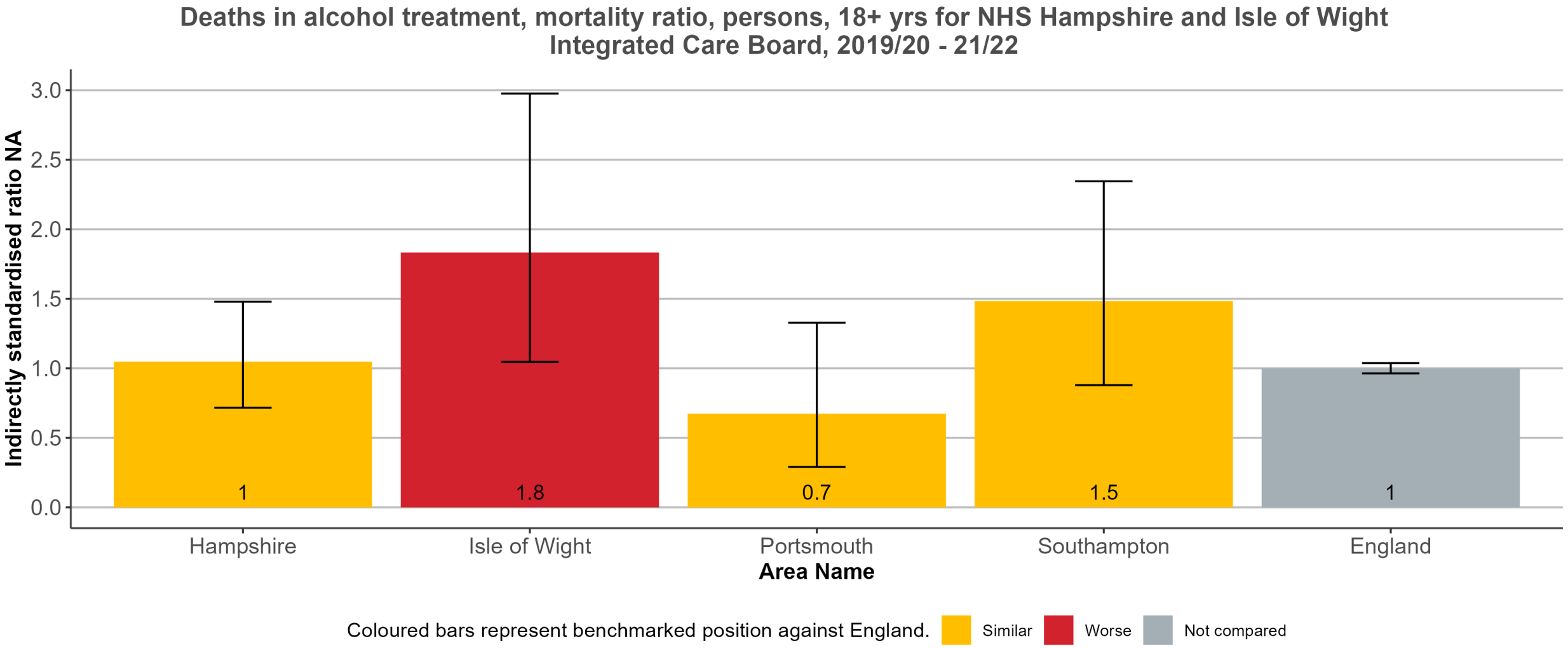
Source: https://fingertips.phe.org.uk/
National Drug Monitoring System

Proportion of dependent drinkers not in treatment (%) (Current method)



Source: https://fingertips.phe.org.uk/
National Drug Treatment Monitoring System and Estimates of Alcohol Dependence in England

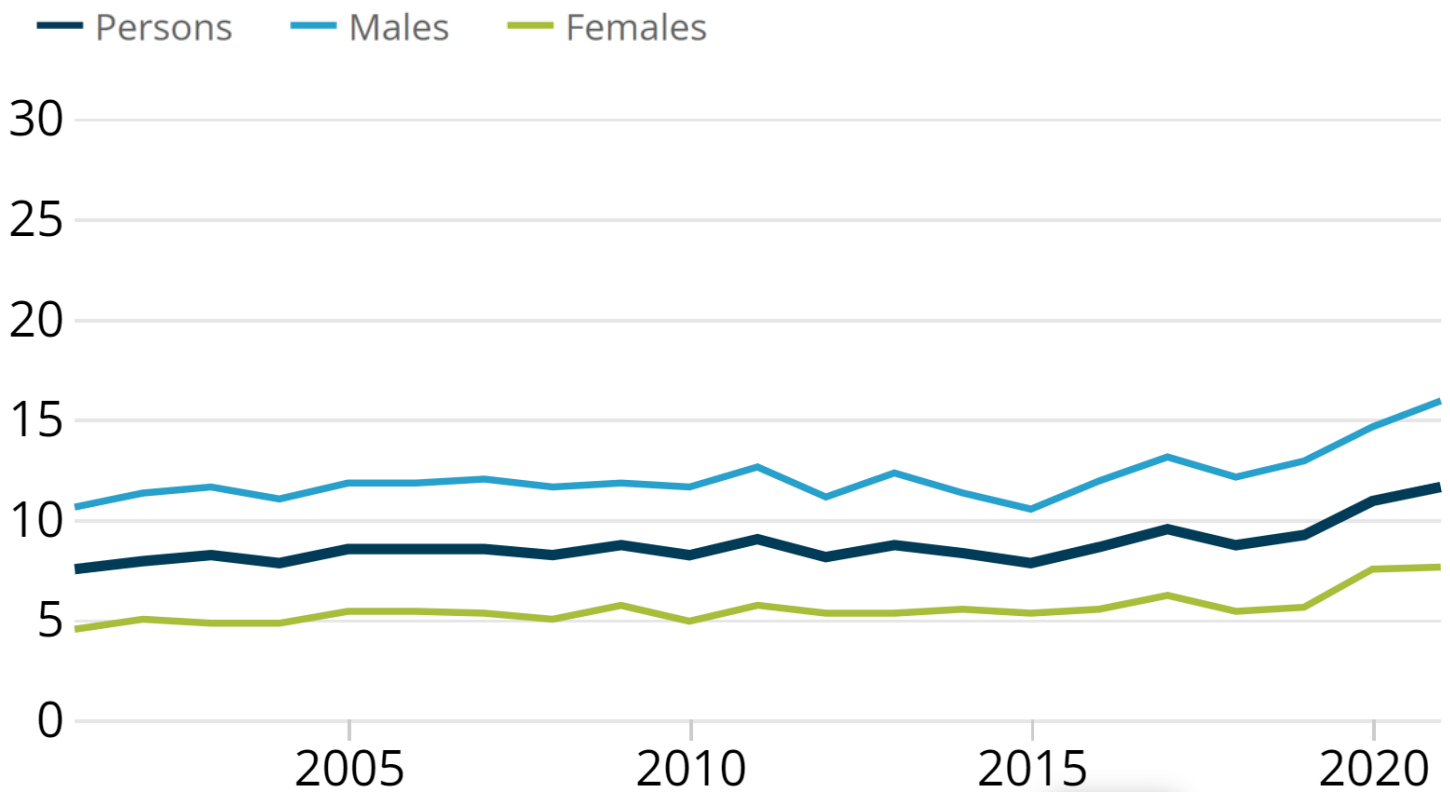
Deaths in alcohol treatment, mortality ratio



Source: https://fingertips.phe.org.uk/
NDTMS

Alcohol-specific deaths in the South East: 2021 registrations

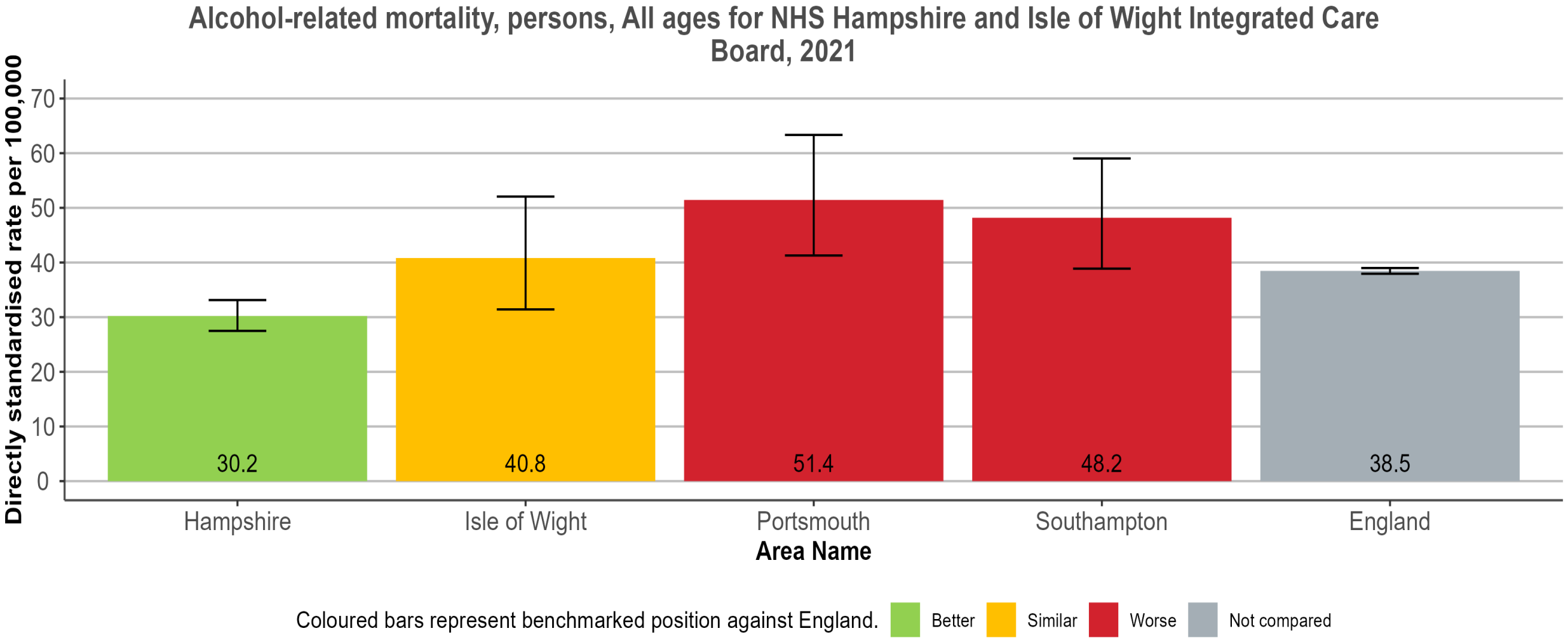
Age-standardised alcohol-specific death rates for deaths registered between 2001 and 2021



The graph shows the trend in age standardised alcohol specific death rates registered between 2001 and 2021. In the South East, the rate of alcohol-specific deaths in 2021 (11.6 deaths per 100,000 people) is a statistically significant increase of 26.1%, compared to deaths registered in 2019 (9.2 deaths per 100,000 people)

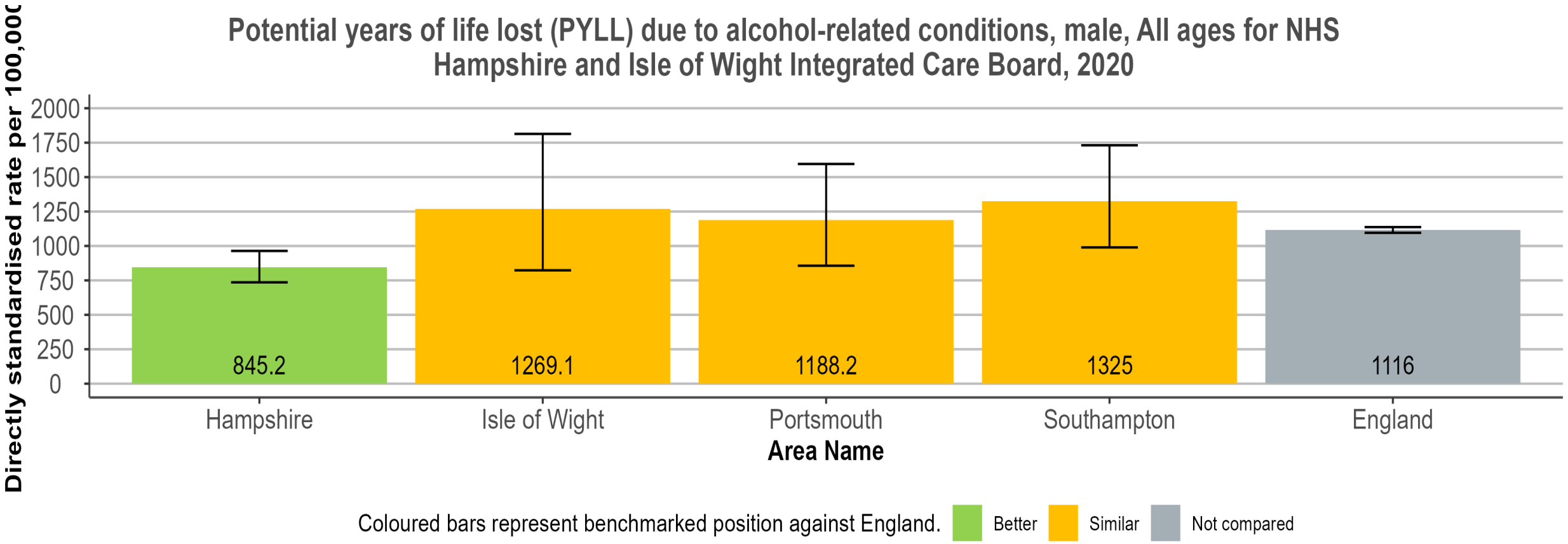
Source: OHS – alcohol specific deaths in the UK: registered in 2021

Alcohol-related mortality



Source: https://fingertips.phe.org.uk/
Calculated by OHID: Population Health Analysis (PHA) team from the Office for National Statistics (ONS) Annual Death Extract Public Health Mortality File and ONS Mid Year Population Estimates.

Potential years of life lost (PYLL) due to alcohol-related conditions



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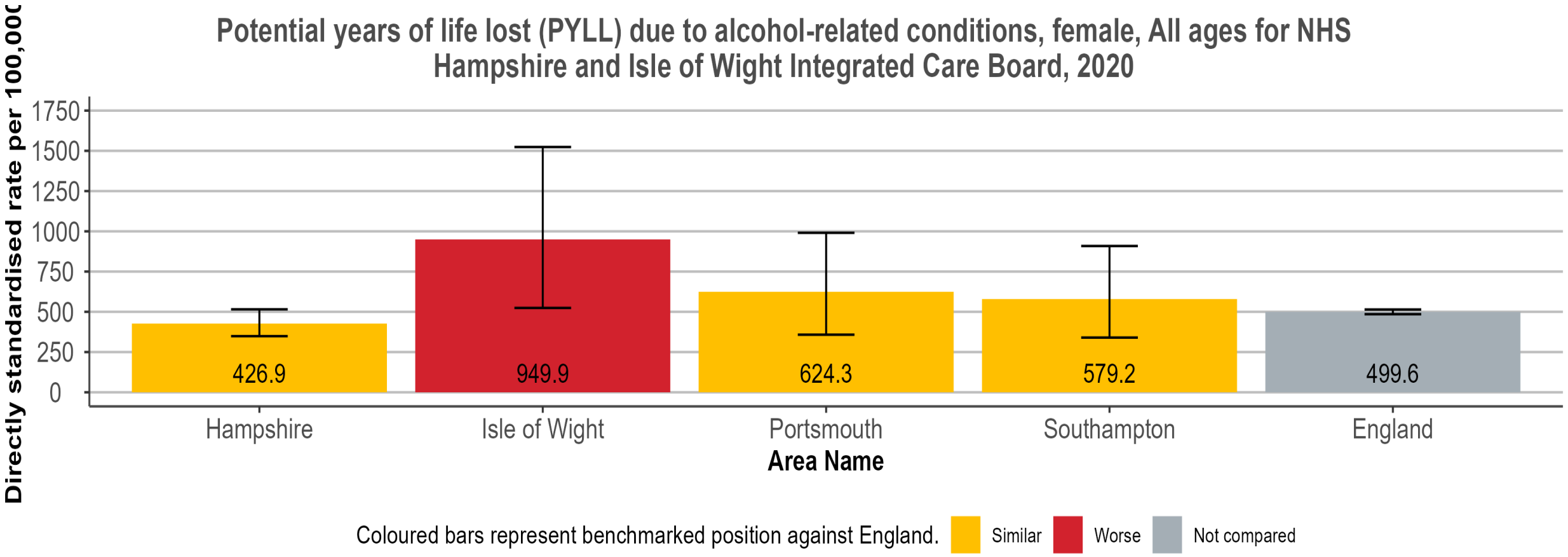

Source: https://fingertips.phe.org.uk/
Calculated by OHID: Population Health Analysis (PHA) team from the Office for National Statistics (ONS) Annual Death Extract Public Health Mortality File, ONS Single Year Life Tables, and ONS Mid-Year Population Estimates.

Drug and alcohol dependence: Guidance and Resources

- Drugs strategy guidance for local delivery partners
- Alcohol and drugs evidence reviews and inquiries
- Alcohol and drug misuse prevention and treatment guidance
- Opiate and crack cocaine use: prevalence estimates
- Local alcohol profiles for England
- National Drug Treatment Monitoring System (NDTMS)
- Local Authority data visualisation tool on Hospital admissions related to Drug misuse – England 2019/20

Metadata

ICB estimates for NHS Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (E54000044) were built using the following geographies: West Berkshire (E06000037), Reading (E06000038), Wokingham (E06000041), Buckinghamshire UA (E06000060), Oxfordshire (E10000025).

ICB estimates for NHS Frimley Integrated Care Board (E54000034) were built using the following geographies: Bracknell Forest (E06000036), Slough (E06000039), Windsor and Maidenhead (E06000040), Hampshire (E10000014), Surrey (E10000030).

ICB estimates for NHS Hampshire and Isle of Wight Integrated Care Board (E54000042) were built using the following geographies: Portsmouth (E06000044), Southampton (E06000045), Isle of Wight (E06000046), Hampshire (E10000014).

ICB estimates for NHS Kent and Medway Integrated Care Board (E54000032) were built using the following geographies: Medway (E06000035), Kent (E10000016).

ICB estimates for NHS Surrey Heartlands Integrated Care Board (E54000052) were built using the following geographies: Surrey (E10000030), West Sussex (E10000032).

ICB estimates for NHS Sussex Integrated Care Board (E54000053) were built using the following geographies: Brighton and Hove (E06000043), East Sussex (E10000011), West Sussex (E10000032).