

The Frailty, Health and Care Needs Assessment (FHCNA): development of the questionnaire and testing its feasibility in homeless hostel accommodation

Caroline Shulman, Rafi Rogans-Watson, Natasha Palipane, Dan Lewer, Michelle Yeung and Briony F. Hudson

(Information about the authors can be found at the end of this article.)

Abstract

Purpose – This study aims to co-develop a Frailty, Health and Care Needs Assessment (FHCNA) questionnaire for people experiencing homelessness and explore the feasibility of its use by non-clinical staff in homeless hostels.

Design/methodology/approach – The FHCNA, aimed at identifying frailty and other health and care priorities for people experiencing homelessness, was co-designed in workshops (online and in person) with homelessness and inclusion health staff. Its feasibility was tested by staff and their clients in two hostels, with pre- and post-study focus groups held with hostel staff to gain input and feedback.

Findings – The FHCNA was co-developed and then used to collect 74 pairs of resident and key worker inputted data (62% of eligible hostel residents). The mean age of clients was 48 years (range 22–82 years). High levels of unmet need were identified. Over half (53%) were identified as frail. Common concerns included difficulty walking (46%), frequent falls (43%), chronic pain (36%), mental health issues (57%) and dental concerns (50%). In total, 59% of clients reported difficulty in performing at least one basic activity of daily living, while only 14% had undergone a Care Act Assessment. Hostel staff found using the FHCNA to be feasible, acceptable and potentially useful in facilitating explorations of met and unmet health and social care needs of hostel clients. By identifying unmet needs, the FHCNA has the potential to support staff to advocate for access to health and social care support.

Originality/value – To the best of the authors' knowledge, this is the first study to co-develop and feasibility test a questionnaire for use by non-clinically trained staff to identify frailty and other health and care needs of people experiencing homelessness in a hostel setting.

Keywords Ageing, Homelessness, Multimorbidity, Frailty, Geriatric conditions, Inclusion health, Hostel, Homeless

Paper type Research paper

Background

People experiencing homelessness (PEH) and other excluded groups suffer extreme health inequalities. All cause standardised mortality ratios among inclusion health groups (homeless populations, individuals with substance use disorders, sex workers and imprisoned individuals) was found to be 7·9 higher in male individuals and 11·9 higher in female individuals than people living in the most deprived areas of England and Wales (Aldridge *et al.*, 2018).

Homelessness includes living without shelter of any kind (“rough sleeping”), in temporary accommodation (such as hostels) and insecure or inadequate housing (Gov.UK, 2018).

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PEH exhibit some of the poorest health outcomes in society with increased rates of many chronic diseases, such as asthma, chronic obstructive pulmonary disease, epilepsy and heart problems (Lewer *et al.*, 2019).

PEH also experience a higher rate of mental health problems (45% compared to 12% in the general population in a recent UK audit) and frequently experience problems with drug and/or alcohol (Hertzberg and Boobis, 2022). Past history of trauma, including adverse childhood experiences, are frequent and can have profound long-lasting effect and is common among PEH (Liu *et al.*, 2021).

Despite high levels of physical and mental health needs, PEH face poor access to many health and care services (James *et al.*, 2021), including palliative care (James *et al.*, 2021). Barriers include stigma (Reilly *et al.*, 2022), lack of information sharing (Armstrong *et al.*, 2021a), inflexibility in systems (Shulman *et al.*, 2018), previous negative experience of health-care setting and difficulties developing trust (Ramsay *et al.*, 2019).

Due to the burden of ill health and risk of early age of death, it is commonly accepted within specialist homelessness services that the “older” cohort relates to those aged over 50. However, the majority of health initiatives aimed at older people are not available for those under the age of 65. This exclusion is pressing as the number of “older” PEH is rising, and this population is often overlooked due to their age and trimorbidity (Stringfellow *et al.*, 2015).

This results in multiple unplanned hospital admissions, a lack of coordinated care and limited advance care planning and access to palliative care (Shulman *et al.*, 2018; Hudson *et al.*, 2017). In the UK, one mechanism for obtaining support is via a Care Act assessment. Despite having significant care needs, hostel staff often struggle to get support for clients via Care Act assessments, and the perspectives and knowledge of hostel staff, who often know their clients well, are often not taken into account (Armstrong *et al.*, 2021b).

Frailty is a clinical condition related to older age which is characterised by increased vulnerability to dramatic changes in health from the loss of inbuilt reserves in multiple body systems (BGS, 2020). It is strongly associated with disability, falls, cognitive decline, hospitalization (Hoogendijk *et al.*, 2019) and increased mortality risk in a graded severity-dependent manner (Kojima *et al.*, 2018; Kulmala *et al.*, 2014; Shamliyan *et al.*, 2013). Timely identification and management of frailty with holistic assessment and personalised care coordination can reduce hospital admissions and even reverse its progression (Pal and Manning, 2014).

A recent systematic review confirmed that frailty presents at a younger age among PEH than their housed counterparts. The review highlighted how psychosocial and structural determinants of health and well-being, including drug and alcohol use, cognitive impairment, loneliness, ethnicity and gender, were associated with frailty onset and severity among PEH (Mantell *et al.*, 2023). Improving the identification of frailty and holistic needs of PEH should improve access to appropriate health and social care, improve access to palliative and end-of-life care and improve end-of-life experiences for this population. As highlighted in NICE guidance 214, provision of care and support for this population needs to be needs-based rather than age-based (NICE, 2022).

A comprehensive geriatric and frailty assessment of clients living in a London homeless hostel found that over half (55%) met the criteria for frailty despite an average age of 56 years (Rogans-Watson *et al.*, 2020). Many conditions usually associated with older age were highly prevalent. The average number of long-term conditions per person was over seven, and many conditions associated with older age were highly prevalent. Only 9% of participants were receiving a care package from adult social care. This data was collected through interviews with residents and their key workers conducted by an experienced geriatrician.

Despite the high prevalence of frailty among PEH (Mantell *et al.*, 2023), no frailty assessment tool designed with this population in mind currently exists. Tools designed to explore health needs in the general population are likely to need adaptation to take into account the context of homelessness. Collaboration with PEH and those supporting them will be needed to develop tools that are relevant for this population (Gordon *et al.*, 2019; Grenier *et al.*, 2016).

Aims

- To co-develop a Frailty, Health and Care Needs Assessment (FHCNA) in partnership with inclusion health and non-clinical homelessness staff;
- To document the health and care needs, including frailty among clients within two hostels; and
- To explore the feasibility and acceptability of hostel staff using the FHCNA to explore and identify health and care needs with their clients.

Methods

Setting

The study was conducted within two homeless hostels in London, with different characteristics.

In the UK, most hostels are a form of “supported housing” with a remit to accommodate people who have complex support needs such as substance use disorder or mental health difficulties. Hostels are not usually designed to support people with high levels of physical health or social care needs (Hertzberg and Boobis, 2022; Mantell *et al.*, 2023). In most cases, hostels are supposed to be a short-term solution (usually up to two years), with the remit to support people to move out of homelessness (HomelessLink, 2018).

Hostel A is a 33 bedded hostel and differs from many other hostels as it is for people over the age of 55 and offers tenancies up to 12 years. Hostel B is 87 bedded and supports people over 18 years of age with a maximum two-year tenancy. In both hostels, support for clients is primarily provided by key workers who have not had training in health and social care support. Health care is provided by local General Practitioners where clients are registered. If clients require social care (such as for personal care or support with medications), an application must be made to the local authority to access this.

Part A. Co-designing the Frailty, Health and Care Needs Assessment Questionnaire

Study design. Co-production workshops with hostel staff and inclusion health practitioners to develop a questionnaire to explore markers of frailty and other health and care needs for people living in homeless hostels.

Recruitment. We recruited inclusion health practitioners (nurses, doctors, therapists and researchers) by email using the authors existing professional networks primarily via Pathway (the UK’s largest homeless health-care charity). Initial drafts of the FHCNA were developed through an iterative process online before we invited staff from participating hostels to an in-person workshop. All hostel staff were provided with an information sheet and an invitation to participate in the project (the workshops and the feasibility work).

Consultation and development of questionnaire. The starting point for the development of the FHCNA was the Edmonton Frail Scale (Rolfson *et al.*, 2006) (EFS), which is an index used to measure issues related to frailty. It has been validated for use by non-clinically trained staff to assess for frailty in patients in the general population aged over 65 years old.

The EFS assesses nine frailty domains: cognition; general health status; functional independence; social support; medication use; nutrition; mood; continence; and functional performance.

Workshops were held with inclusion of health practitioners (online) and hostel staff (in person) to discuss the EFS, potential modifications to improve its relevance to PEH and to explore what additional health issues should be explored within the questionnaire.

Within the workshops, existing tools, including the EFS and the questionnaire used in previous research assessing frailty in this population (Rogans-Watson *et al.*, 2020), were reviewed.

Once changes had been incorporated, the questionnaire was redistributed to workshop attendees by email and modified until no further changes were suggested. The frailty domains and frailty scoring system in the resulting FHCNA were aligned with the domains and scoring system in the traditional EFS.

Part B. Assessment of prevalence of frailty and health and care needs

Study design. The two-part questionnaire developed in Part A was used by key workers and their clients across two hostels. Key workers completed the first part of the questionnaire initially following which the second part of the questionnaire was completed by key workers gathering information from their clients.

Recruitment. Posters about the study were displayed in both hostels, and all hostel clients and staff were invited to participate. An information sheet and consent form were included in both the key workers and client part of the questionnaire. Key workers completed this electronically and gained verbal consent from clients, registering their consent within the questionnaire. Exclusion criteria included the inability to give informed consent or a significant communication barrier. Hostel clients were offered a £10 supermarket voucher as a token of appreciation for their time.

Data collection. Data collection took place between May and September 2021. The questionnaire was built in MS forms and completed on iPads or computers during keyworking sessions. Key workers completed the first part of the questionnaire in advance of a keyworking session with their client, during which the second part was completed together.

Data analysis. Quantitative data collected using the FHCNA was entered into Microsoft Excel and R. Participant characteristics and outcomes for each variable were described. Frailty scores were calculated by adding the total points from all the frailty domains in the questionnaire with five possible outcomes: not frail (0–5 points), vulnerable/pre-frail (6–7 points), mild frailty (8–9 points), moderate frailty (10–11 points) and severe frailty (12–17 points). Cohen's Kappa coefficient and percentage agreement were calculated to assess concordance between paired key worker and client answers to specific questions.

Part C. Feasibility of using the Frailty, Health and Care Needs Assessment in hostel settings

Study design. The acceptability and feasibility of non-clinical staff using the questionnaire were undertaken in the two hostels. This involved gathering electronic feedback from clients and hostel staff on the completion of the questionnaire by hostel staff with clients within the questionnaire and additional focus groups with hostel staff.

Recruitment. Clients were recruited as described in Part B. All staff who completed the FHCNA with clients were then invited to participate in focus groups.

Data collection. In addition to questions about health needs and well-being, questions assessing acceptability, ease of completion and potential usefulness of the FHCNA were included for both key workers and clients.

In-person focus groups took place in October and November 2022 after data collection was complete and explored client feedback on the FHCNA as well as potential benefits and challenges of using the FHCNA. Focus groups lasted approximately 60 min, were audio recorded and transcribed verbatim.

Data analysis. Qualitative data from the focus groups was analysed using thematic analysis in NVivo (Jackson *et al.*, 2019) following Braun and Clarke's six-step process (Terry *et al.*, 2017; Clarke *et al.*, 2015) by MY. This process involved line-by-line coding of the transcripts to identify key themes and issues. Once preliminary coding was complete, themes were streamlined with input from CS, RRW and BH.

Ethical approvals

The study was approved by the University College London Research Ethics Committee (ID: 6202/005). Where health concerns or unmet needs were identified, key workers sought consent to refer the client to their general practitioner (GP) or other professional where appropriate.

Results

Part A. Co-designing the Frailty, Health and Care Needs Assessment Questionnaire

Workshops to develop the Frailty, Health and Care Needs Assessment. Fifteen hostel staff including key workers and managers and ten inclusion health professionals took part in the co-design workshops to explore any modifications and additions to the proposed FHCNA. We were aiming to develop a questionnaire that key workers could complete without significant additional training.

As a result of the workshops, the following aspects of health, care and support needs were added to the FHCNA: vision or hearing issues, significant weight loss, acute or chronic pain, pressure areas on skin, leg ulcers and abscesses, concerns about feet, dental concerns, sleep difficulties and ability to budget and manage finances.

It was agreed that frailty scores within the FHCNA would be developed by modifying the EFS for this population. The main modifications included alterations of the performance-based domains. For cognition assessment, in the clockface task was replaced by a question about memory for both clients and key workers, due to the training required for implementation and interpretation of the clockface test. For functional performance, the "5 times sit up and stand test" (Csuka and McCarty, 1985) was included instead of the "timed get up and go test" to make it easier and more practical to administer in a hostel environment.

Additional modifications concerned ensuring the relevance of activities of daily living (ADL) (see Supplementary file 1 for more details of the modifications made to the original EFS questions, with explanations, and Supplementary file 2 for the final FHCNA survey).

Format of the questionnaires. Workshop attendees suggested an electronic questionnaire would be preferable to a paper one. It was agreed that the questionnaire should have two parts, one completed independently by key workers and a second completed collaboratively by key workers and their clients. This was in response to previous studies in which homeless adults underreported their functional needs (Rogans-Watson *et al.*, 2020; Rodriguez-Guzman *et al.*, 2016).

Calculation of frailty scores was derived from a combination of key worker and client responses (Supplementary files, Tables 3 and 4). Aspects of the modified EFS were

included in both parts of the questionnaire. Following the completion of the questionnaires, clients could choose to consent to a personalised summary of their results to be stored in their hostel records and shared with relevant health and/or social care professionals. The single A4 summary sheet was manually generated by the research team after each completed questionnaire and included the participant's age, gender, frailty score, summary of frailty syndromes and other key self-reported and key worker-reported health and care needs. An example summary sheet is given in Supplementary file 3.

Part B. Assessment of prevalence of frailty and health and care needs

A total of 74 clients (62% of the 120 clients in the two hostels) consented to recruitment and completed the FHCNA with their key workers between May and September 2021. Hostel A completed 21 questionnaires, and Hostel B completed 53 questionnaires by 20 different key workers.

Demographics. The overall age of clients was 48.8 years (range 22–82). Mean age was older in Hostel A (59.1 years range: 22–82) than in Hostel B (43.5 years, range 22–73). The majority of clients were male ($n = 54$, 73%), with the gender divide being similar in each hostel. The majority of clients (81% $n = 60$) consented to a personalised summary sheet to be generated and stored in their hostel files.

Utilisation of primary care services. All clients were registered with a GP, over half had seen their GP in the past six months. Over a quarter of clients had seen a dentist in the last year ($n = 20$, 27%). Regarding eye tests, 21.6% had their vision checked in the past 12 months ($n = 16$), far fewer had had their hearing checked in the past year ($n = 3$, 4%).

Health concerns. [Table 1](#) shows the prevalence of physical and mental health and substance use concerns as reported by clients. Mental health issues were reported by over half of clients. Physical health concerns affecting at least 20% of clients included dental, difficulty walking, frequent falls, chronic pain, weight loss, pressure areas and history of serious head injuries.

Concordance between reports from clients and key workers is explored using Cohen's Kappa in ([Figure 1](#)). The Cohen's Kappa takes into account agreement while accounting for the number of expected random agreements. As an approximate guide, values between 21% and 40% are sometimes considered to be "fair" concordance, between 41% and 60% as "moderate", 61% and 80% as "substantial" and 81% and over as almost perfect concordance.

Cohen's Kappa values demonstrate a substantial concordance for substance misuse and smoking, with moderate or fair concordance for the majority of responses. There was poor concordance for frequent falls, primarily because 29 clients reported frequent falls while their key workers did not. There were a number of other conditions that clients reported that key workers were not aware of, including previous head injuries, weight loss, incontinence and difficulty walking.

Activities of daily living. Key workers and clients were both asked about issues with ADL ([Tables 2](#) and [3](#)). The concordance of these results is shown in [Figure 1](#).

Variables contributing to frailty scores. Frailty scores are displayed in [Figure 2](#). Scores were calculated based on a combination of key worker and client responses.

The cognition domain score was derived from the responses from both key workers and clients to the following question: "Do you/does your client forget things more than you/they used to, or do you have more difficulty understanding information?" (no = 0 points, yes = 1 point: maximum total 2 points). The functional independence domain score was derived from key workers' responses to the number of ADLs they felt their client had difficulty with ([Figure 1](#)).

Table 1 Health concerns and substance use reported by hostel clients

	74 hostel clients N (%)
<i>Health concerns and substance misuse</i>	
<i>Geriatric conditions</i>	
Difficulty walking	34 (45.9)
Frequent falls	32 (43.2)
Visual problem	28 (37.8)
Significant weight loss	22 (29.7)
Hearing trouble	11 (15.0)
Incontinence	13 (17.6)
Cognition	27 (36.5)
<i>Other physical health problems</i>	
Dental concerns	37 (50)
Chronic pain	27 (36.5)
Pain having impact > three days a week	18 (24.3)
Pressure areas	22 (29.7)
Head injuries	20 (27.0)
Significant weight gain	16 (21.6)
Feet concerns	15 (20.3)
Ulcers/abscesses	7 (9.50)
<i>Mental health concerns</i>	
Any mental health issue	42 (56.8)
Low mood or depression	26 (35)
Schizophrenia or psychosis	15 (20.3)
<i>Substance use</i>	
Smoker	58 (78.4)
Alcohol dependence	9 (12.2)
Other substance use	38 (51.4)

Source: Table by authors

Figure 1 Cohen's Kappa for activities of daily living and reported health concerns

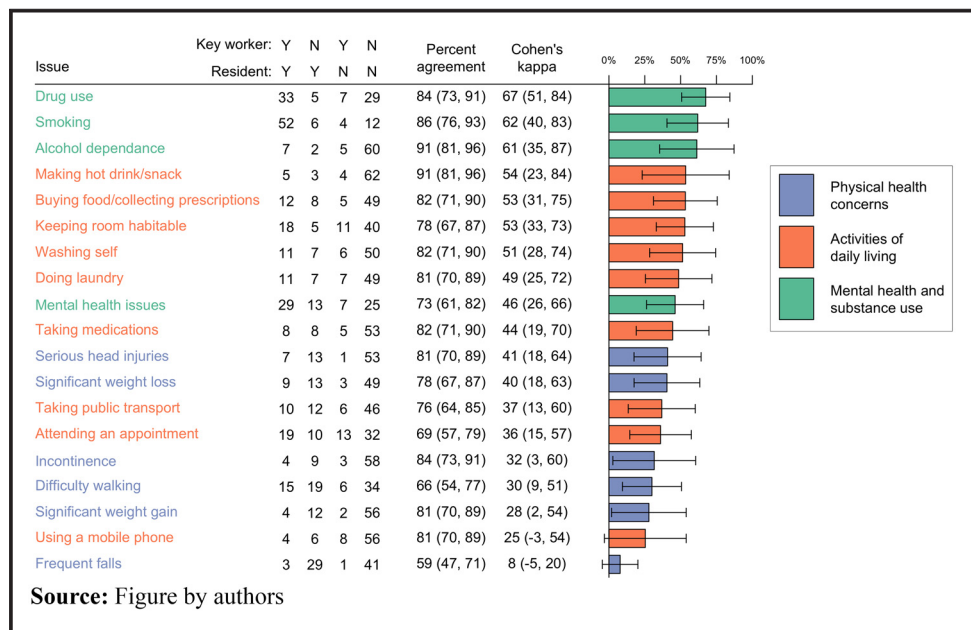


Table 2 Resident and key worker reported difficulties with activities of daily living

Activities of daily living	Resident reported difficulties (%) (n = 74)	Key worker reported difficulties (%) (n = 74)
Making a hot drink	8 (10.8)	9 (12.2)
Buying food/collecting prescriptions	20 (27.0)	17 (22.9)
Keeping room habitable	23 (31.0)	29 (39.2)
Washing self	18 (24.3)	17 (22.9)
Doing laundry	18 (24.3)	18 (24.3)
Taking medications	16 (21.6)	13 (17.6)
Taking public transport	22 (29.7)	16 (21.6)
Attending an appointment	29 (39.2)	32 (43.2)
Using a mobile phone	10 (13.5)	12 (16.2)

Source: Table by authors

Table 3 Number of ADLs per client reported by key workers

Number of ADLs that key worker felt the client had difficulty with	n (%)
0–1 (frailty score contribution = 0 points)	35 (47.3)
2–4 (frailty score contribution = 1 points)	20 (27.0)
5–9 (frailty score contribution = 2 points)	19 (25.7)

Source: Table by authors

Additional questions answered by clients that contributed to scores are in [Table 4](#). Supplementary material includes additional detail of the questions and their scoring used in the questionnaires to derive the frailty scores.

Frailty among hostel clients. In total, 53% of clients ($n = 39$) were identified as being frail. Mild, moderate and severe frailty was identified in 27%, 11% and 15%, respectively.

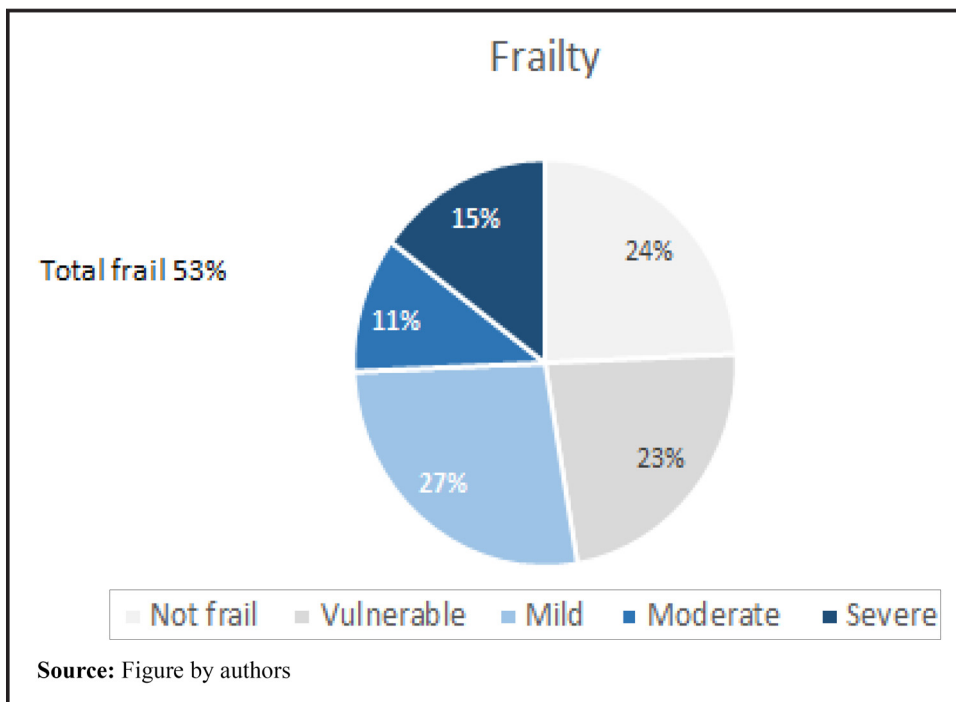
Figure 2 Percentages of clients within each category of frailty

Table 4 Questions answered by clients that contributed to frailty score adapted from Edmonton Frail Scale

Question contributing to frailty scores	Overall clients (74%)
<i>General rating of health</i>	
In general, how would you describe your overall health?	
Excellent/Good (0 points)	23 (31.1)
Fair/average (1 point)	39 (52.7)
Poor (2 points)	12 (16.2)
<i>Hospital visits</i>	
In the past year, how many times have you had to go to the hospital?	
None (0 points)	28 (37.8)
1 or 2 times (1 points)	25 (33.8)
More than two times (2 points)	21 (28.4)
Prefer not to say (0 points)	0
<i>Mood</i>	
"Do you often feel sad or depressed?"	
No (0 points)	16 (21.6)
Yes (1 point)	53 (71.6)
Prefer not to say (0 points)	5 (6.8)
<i>Medication use</i>	
"Are you prescribed more than 5 medications that you take on a regular basis?"	
No (0 points)	50 (67.6)
Yes (1 point)	23 (31.1)
Prefer not to say (0 points)	1 (1.4)
<i>Adherence to medication</i>	
"At times, do you forget to take your prescribed medication?"	
No (0 points)	47 (63.5)
Yes (1 point)	24 (32.4)
Prefer not to say (0 points)	3 (4.1)
<i>Social support</i>	
"If you need help is there someone other than your keyworker who can help you?"	
Always (0 points)	23 (31.1)
Sometimes (1 point)	32 (43.2)
Never (2 points)	17 (22.9)
Prefer not to say (0 points)	
<i>Nutrition</i>	
"How many meals do you eat a day?"	
2 or more (0 points)	40 (54.1)
1 or less (1 point)	33 (44.6)
Prefer not to say (0 points)	1 (1.4)
<i>Mobility and strength evaluation by 5x sit stand test</i>	
They managed once successfully (0 points)	46 (62.2)
Unable to stand without hands or needs help (2 points)	22 (29.7)
Did not attempt (0 points)	6 (8.1)
<i>Continence</i>	
"Do you have a problem with losing control of urine or bowels when you don't want to?"	
No (0 points)	56 (75.7)
Yes (1 point)	13 (17.6)
Prefer not to say (0 points)	5 (6.8)

Source: Table by authors

A further 23% of participants ($n = 17$) were identified as being vulnerable to developing frailty (Figure 2).

All clients deemed to be severely frail rated their health as poor. In contrast, the majority (91.4%) of clients who were either not frail or vulnerable rated their health as average to excellent.

No significant correlations were observed between the age of clients and frailty scores (Figure 3); however, this study was not designed or powered to detect such a correlation.

Part C. Feasibility of using the Frailty, Health and Care Needs Assessment in hostel settings

All hostel staff agreed to test the FHCNA with their clients. From the evaluation questions within FHCNA, 82% of clients and 86% of participating key workers agreed or strongly agreed that the FHCNA was easy to complete. Over three-quarters of key workers (78%) agreed or strongly agreed that it could be useful in supporting their clients.

Three focus groups with hostel staff were held following the completion of data collection to explore their views on the potential utility of the FHCNA (Hostel A, $N = 8$; Hostel B, $N = 12$). Focus group data highlighted how the FHCNA, and particularly the frailty score, was seen as potentially useful in advocating for support from other services via a “common language” and quantifiable measure of need, considering the young age of clients. Staff hoped this may reduce instances where their requests for support from health and social care services were “dismissed”:

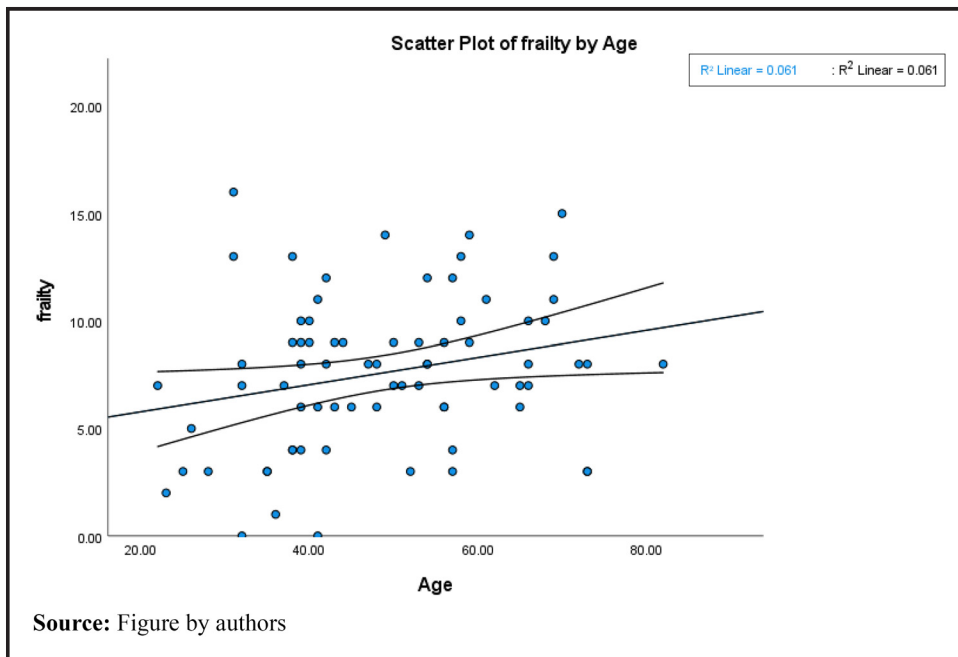
It's [...] something concrete [...] to just say, "Look, you're going to take this seriously." [...] But we get from social services "they're young. Why need a care package?" hostel keyworker.

The FHCNA was felt to be useful in considering resident's needs in a more holistic way and as a useful facilitator of conversations about underlying or undiscussed health needs. The FHCNA was felt to reveal needs that were otherwise neglected:

[...] these surveys, which are quite thorough and address all different issues, they can reveal blind spots [...] it's interesting once you've identified a blind spot to think, "Huh, I need to really think about how I'm going to approach this, actually." hostel keyworker.

One key worker recounted surprise regarding the number of clients experiencing sleep difficulties, which were initially ascribed to drug use or lifestyle behaviours. The FHCNA

Figure 3 Correlation between age and frailty score



revealed that sleep difficulties were often related to ‘aches and pains, niggles’ or toothaches instead.

Despite the positive experience generally, there remained some barriers in completing the questionnaire with clients whose engagement with their key worker was limited. Another factor that may influence engagement with the FHCNA was the wording of questions. In particular, the questions about alcohol and drug dependence were highlighted as needing consideration:

[. . .] if it had been, “do you drink”, they [. . .] would have said yes. Then you’d at least know they drink quite a bit. But because it said “dependent”, they just straight away said no [. . .] as if they didn’t drink at all [. . .] I think [. . .] a lot more would admit to drinking, than being dependent. hostel keyworker.

The overall frailty score was calculated by combining responses from the key worker form and the client form; staff reflected that this could benefit from simplification.

Discussion

In the absence of consistent in-reach support from health and social care staff, this study has demonstrated that hostel staff can undertake frailty and holistic needs assessments with their clients with the aid of the FHCNA questionnaire. Hostel staff often have established relationships with clients which can facilitate explorations of met and unmet need as well as ongoing health concerns. This is particularly relevant among younger PEH who are at risk of falling through the gaps in traditional services wherein access is determined by age.

Coproduction with experts from inclusion health and homelessness services facilitated the development of the questionnaire exploring frailty and health and care needs relevant to the population. The FHCNA provides a structure for exploring the needs of clients in a hostel setting, some of which key workers had been unaware of. It was well received and shown to be feasibly undertaken by these non health or social care trained hostel workers, alongside their clients.

Design of the Frailty, Health and Care Needs Assessment

The FHCNA comprised of two parts; one completed independently by hostel key workers, the other completed collaboratively between key workers and clients.

Paired response analysis revealed some differences in reporting patterns of physical health and functional support needs between key workers and clients. There was very low concordance with the reporting of frequent falls and only fair concordance with head injuries and incontinence, with key workers often being unaware of these problems. For other needs, such as difficulty with some ADLs including keeping room habitable or needing support in attending an appointment, some key workers felt there was a problem when their client did not. These discrepancies support the value of a combined client and key workers approach to assessing need, particularly as previous evidence suggests homeless adults often underreport their functional needs (Rogans-Watson *et al.*, 2020; Rodriguez-Guzman *et al.*, 2016). This may allow for a more accurate representation of need while also strengthening staff/client relationships by fostering greater awareness of their different viewpoints.

Frailty, frailty syndromes and health and care needs

Over half of hostel clients (53%) were frail despite an average age of 48.8 years. In addition to frailty, a number of other unmet needs were frequently identified, including dental concerns, incontinence, poor mobility, frequent falls and serious head injuries. Over half of

clients reported a need for assistance with at least one ADL. Despite high levels of functional need, only 14% of participants had undergone a Care Act Assessment and 11% were in receipt of a care package from social services.

The findings of this study are consistent with previous surveys (StMungos, 2023; Shulman *et al.*, 2023) and research exploring frailty among PEH (Mantell *et al.*, 2023; Rogans-Watson *et al.*, 2020). It also provides further evidence of limited support for hostel clients and staff in managing complex health and social care needs (Armstrong *et al.*, 2021b) and limited joint working between hostels and health and social care services (Martineau *et al.*, 2019). It is essential that hostel staff expertise is meaningfully considered in the planning and delivery of care and support for PEH.

Strengths and limitations. Working alongside people with lived experience of homelessness and experts working in inclusion health and homelessness has facilitated the development of a questionnaire which can capture information that is important to the health and well-being of PEH without the need for additional training for key workers. Testing the feasibility of this FHCNA with hostel staff and clients has provided evidence that it is acceptable in practice and has the potential to support advocacy for additional support for people residing in homeless hostels.

Previous literature has identified the need to develop specific health screening tools for this population that are informed by people with lived experience (Gordon *et al.*, 2019). The FHCNA was developed to explore the health and social care needs and priorities of PEH from their own point of view, and that of their non clinical key workers workers. Exploration of the impact of using the FHCNA on access to support and clinical outcomes such as hospitalisation rates would be beneficial.

According to key workers, there were concerns that people would not recognise themselves to be alcohol dependent. Based on these concerns, we have modified the question relating to alcohol dependency. Rather than asking about whether someone considers themselves to be alcohol dependent, we suggest asking whether the person drinks alcohol, if so, how much per day, if they are in treatment for this, and if not, whether they would like to be referred for support (see Supplementary file 2).

Conclusion

This is the first research that seeks to develop, implement, and test the feasibility of a questionnaire to be used by non-clinical staff to highlight markers of frailty and unmet functional needs among a population of people living in homelessness hostels.

This study adds to evidence of frailty in PEH and the young age at which this population may develop frailty. The findings also demonstrate the unacceptably high levels of other unmet needs among people living in hostels.

The FHCNA could help to evidence the level of need in hostels for local and national advocacy and planning to support equitable funding. It could also be used in hostels to identify clients that should be prioritised for more detailed clinical assessment and to identify important health issues to focus on.

The next steps could include a large cluster randomised controlled trial to explore the impact of the use of the FHCNA on access to care and support and the consequent impact on health and well-being.

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Author affiliations

Caroline Shulman is based at the Pathway, London, UK and Marie Curie Palliative Care Research Department, University College London Division of Psychiatry, London, UK.

Rafi Rogans-Watson is based at the Pathway, London, UK and University Hospitals Sussex NHS Foundation Trust, Worthing, UK.

Natasha Palipane is based at the Pathway, London, UK.

Dan Lewer is based at the Department of Epidemiology and Public Health, University College London, London, UK.

Michelle Yeung is based at the Nuffield Department of Primary Care Health Sciences, University of Oxford, Oxford, UK.

Briony F. Hudson is based at the Policy and Research Department, Marie Curie, London, UK; Marie Curie Palliative Care Research Department, University College London, London, UK and Pathway, London, UK.

Supplementary material

The supplementary material for this article can be found online.

Corresponding author

Briony F. Hudson can be contacted at: b.hudson@ucl.ac.uk

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