Crisis policy briefing on health amongst socially excluded groups

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Introduction

The Health and Care Bill is a new piece of legislation that reforms the delivery and organisation of the NHS, creating Integrated Care Systems (ICSs) that will aim to promote more joined-up services.[1] These new organisations will replace Clinical Commissioning Groups (CCGs) and bring together providers and commissioners of NHS services across a geographical area with local authorities and other local partners to collectively plan health and care services to meet the needs of their population. There are currently 42 ICSs covering all of England. The central aim of ICSs is to integrate care across different organisations and settings, joining up hospital and community-based services, physical and mental health, and health and social care.

The statutory Integrated Care Systems will consist of two key bodies: the Integrated Care Board (ICB) and the Integrated Care Partnership (ICP). ICBs will be responsible for day-to-day planning of healthcare services, contract providers to deliver NHS services and take on many of the responsibilities from CCGs. ICPs will operate as statutory committees made up of senior leaders from across the health, care and wider systems, and will include representatives from the ICB, local authorities, and key partners such as primary care and social care. The ICP is responsible for developing a Partnership Strategy on how to deliver and improve healthcare in their area. ICBs must have regard to this strategy when exercising their functions.

To ensure that the new healthcare reforms work for everyone, Crisis is urging the Westminster Government to amend the Health and Care Bill to require the newly created ICPs to have due regard in their strategies to improving the health outcomes for people who consistently face poor health outcomes as a result of social exclusion. This includes people who are homeless; sex workers; Gypsy, Roma and Travellers communities; vulnerable non-UK nationals; and people with substance misuse needs. These groups are often referred to as 'Inclusion Health groups' in NHS policy.[2] The amendment would also prompt ICPs to consider housing when they lay out their statement of views in their strategies on integration arrangements.

Amending the Bill will ensure people who experience the most extreme and severe health inequalities are able to access and benefit from holistic health services, and embed the integration of housing, health and social care across the delivery of NHS policy.

Why is change to the Bill needed?

ICSs are seen as key bodies through which to drive policy and provision to improve health inequalities. The Bill places duties upon ICBs to have regard to the need to reduce health inequalities. However, despite the recent policy focus on health inequalities from national Government, stakeholders have argued that the duties in the Bill do not go beyond those already placed upon CCGs and the Bill does not significantly progress approaches to reducing health inequalities.

Importantly, this also means that the Bill as it currently stands does not address the fact that approaches to reducing health inequalities for people who are most severely excluded are neither at the scale nor at the level of integration required across the health, social care and housing systems.

Health inequality is unacceptable for anyone in our society, but some people face extreme health inequalities, with levels of acute illness and death that are severe even when compared to others facing health inequality. This includes people who are homeless; sex workers; Gypsy, Roma and Travellers communities; vulnerable non-UK nationals; and people with substance misuse needs.[3]

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[1] https://bills.parliament.uk/bills/3022

[2] https://www.gov.uk/government/publications/inclusion-health-applying-all-our-health/inclusion-health-applying-all-our-health

[3] Luchenski et al. (2017). *What works in inclusion health: overview of effective interventions for marginalised and excluded populations.* Lancet 2018; 391: 266–80

There is a well-established link between disadvantage and poor health that demonstrates how social exclusion and not having a safe, secure home can acutely damages someone's physical and mental health. For example, people experiencing homelessness often have multiple and complex needs as a result of the social exclusion they face. Homeless Link's Health audit found that 73% of people experiencing homelessness suffered from a physical health problem, 80% a mental health problem, 39% said they took drugs or were recovering from a drug problem, whilst 27% had, or were recovering from, an alcohol problem.[4] There is also a much greater prevalence of lung and heart disease among the homeless population, both disease categories that significantly increase the risk from Covid-19.[5] A recent study among homeless hostel residents in London found frailty amongst them akin to people in their late 80s, with residents having on average seven health conditions, more than most people in their 90s.[6]

Yet despite these acute health needs, people who are homeless often fall through the gaps and fail to access or receive the right healthcare that meets their needs. Often, people facing homelessness will cycle round support systems with frequent interactions with A&E, long periods in inpatient secondary care, and continual interactions with wider state institutions such as prison and probation services, without a resolution to either their homelessness, social exclusion, or their health and care needs.

This is evidenced by the fact people experiencing homelessness attend A&E six times as often as people with a home, are admitted to hospital four times as often, and stay three times as long.[7] One study found that people who are homeless attend A&E sixty times more than the general population.[8] This makes integrated, multi-disciplinary and specialist healthcare for people experiencing social exclusion, working closely with wider services such as social care and housing, incredibly important.

Research has highlighted how other groups face similar levels of health needs as a result of social exclusion.[9] As it stands, people who experience the most extreme of health inequalities, such as those who are homeless; sex workers; Gypsy, Roma and Travellers communities; vulnerable non-UK nationals; and people with substance misuse issues, also encounter significant barriers to accessing and receiving the healthcare that meets their needs. These barriers can include lack of a fixed address or photo ID, stigma, fragmented services, a lack of continuity of care because of unstable accommodation, and a lack of awareness by healthcare professionals of their specific needs.[10] [11]

The severe health inequalities experienced by people facing social exclusion

- The average age of death among people experiencing homeless is **46** and **42** for men and women respectively.[12]
- Standardised mortality rates across people facing the most extreme of health inequalities are **ten times that of the general population with the most common causes of death from preventable and treatable conditions.**[13]
- Life expectancy among Gypsy, Roma, and Traveller communities is **10 to 12 years less** than the non-Traveller population.[14]

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[4] Homeless Link. (2014). *The unhealthy state of homelessness: Health audit results 2014.*
[5] Lewer D, et al (2019) *Health-related quality of life and prevalence of six chronic diseases in homeless and housed people: a cross-sectional study in London and Birmingham*, England; BMJ Open.
[6] Raphael Rogans-Watson et al. *Premature frailty, geriatric conditions and multimorbidity among people experiencing homelessness: a cross-sectional observational study in a London hostel*. July 2020.
[7] Department of Health (2010). *Inclusion health: improving primary care for socially excluded people.*
[8] Bowen M, Marwick S, Marshall T, et al. *Multimorbidity and emergency department visits by a homeless population: a database study in specialist general practice*. Br J Gen Pract. 2019;69(685):e515–e525. doi: 10.3399/bjgp19X704609.
[9] Luchenski et al. (2017). *What works in inclusion health: overview of effective interventions for marginalised and excluded populations.* Lancet 2018; 391: 266–80
[10] Armstrong M, Shulman C, Hudson B, et al. *Barriers and facilitators to accessing health and social care services for people living in homeless hostels: a qualitative study of the experiences of hostel staff and residents in UK hostels*. BMJ Open 2021;11:e053185. doi:10.1136/ bmjopen-2021-053185.
[11] https://www.bmj.com/content/360/bmj.k902/rr
[12] Office for National Statistics. (2021). *Deaths of homeless people in England and Wales: 2020 registrations.*
[13] Luchenski et al. (2017). *What works in inclusion health: overview of effective interventions for marginalised and excluded populations.* Lancet 2018; 391: 266–80
[14] Women and Equalities Committee. (2019). *Tackling inequalities faced by Gypsy, Roma and Traveller communities. Seventh Report of Session 2017–19.*

Beyond the damaging impact of these health inequalities on the individuals, these unmet health needs come with a substantial cost to the healthcare service and wider society. This amendment would help to reduce reliance on emergency care and save the taxpayer money. **Severe and multiple disadvantage (defined as experiencing homelessness, substance misuse and offending, often compounded by mental health issues) is conservatively estimated to cost society £10.1 billion per year.**[15]

What is needed to address health inequalities amongst people who are socially excluded

There are specific services designed to help meet these needs, called Inclusion Health services, that are extensions of mainstream care. The groups of people these services aim to help are therefore often referred to as Inclusion Health groups in NHS policy.

Academic research has highlighted the type of effective healthcare services that are needed to meet the health needs of Inclusion Health groups. The research shows these services need to highly prioritise these groups in order to reflect the intensity of their needs and exceptionally poor outcomes (this is called proportionate universalism).[16] Services also need to tackle the tri-morbidity of physical and mental illness and addiction; coordinate care with a wide range of services; and using active engagement methods which prioritise non-judgemental approaches.[17] Recent draft guidance from NICE (National Institute for Health and Care Excellence) on approaches to integrated health and care for people experiencing homelessness recommends multi-disciplinary teams that can meet people's holistic, and often complex, needs.[18]

Where services operate in this way, they have been shown to be highly effective at improving people's access to and engagement with healthcare services, resulting in significantly better health outcomes and facilitating a reduction in healthcare service use (and often improving wider outcomes related to areas such as housing needs).

Case Study

Pathway, the leading health charity for Inclusion Health, has helped 11 hospitals in the UK create teams of doctors, nurses, social care professionals and housing workers. These teams support over 4,000 homeless patients every year. An audit published in 2017 showed a **37**% reduction in A&E attendances, a **66**% reduction in hospital admissions, and an **11**% reduction in bed days, as well as being cost effective.[19]

The number of Inclusion Health teams has grown in recent years, often as extensions of primary care or hospital care (such as the Pathway model). However, it remains a postcode lottery – King's College London found that 56.5% of homelessness projects in England do not have specialist primary healthcare services in their area.[20]

Current initiatives to address poor health outcomes for people who are socially excluded

In recent years, and particularly in the aftermath of the first year of the pandemic, there have been various initiatives on Inclusion Health. These have included discrete, limited funding pots to tackle specific issues, such as the **NHS Long Term Plan (2019),**[21] which committed £30 million to create specialist homeless mental health support for people sleeping rough, integrated with existing outreach services; the **Changing Futures Fund (2021)**: a 3-year, £64 million programme aiming to improve outcomes for adults experiencing multiple disadvantage[22], delivered by

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[15] Lankelly Chase Foundation. (2015). *Hard Edges, Mapping Severe and Multiple Disadvantage*. England.
[16] Luchenski et al. (2017). *What works in inclusion health: overview of effective interventions for marginalised and excluded populations.* Lancet 2018; 391: 266–80.
[17] Ibid.
[18] https://www.nice.org.uk/guidance/indevelopment/gid-ng10170
[19] Wyatt L. *Positive outcomes for homeless patients in UCLH Pathway programme*; British Journal of Healthcare Management 2017 Vol 23 No 8: p367-371.
[20] Crane et al. (2018). *Mapping of specialist primary health care services in England for people who are homeless: Summary of findings and considerations for health service commissioners and providers.*
[21] https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf
[22] This refers to people who experience combinations of homelessness, substance misuse, mental health issues, domestic abuse and contact with the criminal justice system.

DLUHC;[23] **funding for Rough Sleeping Drug and Alcohol services (2021):**[24] Forty-three areas across England will receive support from a £23 million government fund designed for those with drug and alcohol support needs to get the help they need to rebuild their lives; and **DHSC Out of Hospital Care Fund (2021):** £16 million for pilot projects to support people experiencing homelessness after being discharged from hospital, with schemes intended to reduce pressure on NHS and help people who are homeless find accommodation.[25]

In addition, two significant current pieces of policy work underway include:

NHS England Core20PLUS5 approach (2021)

NHS England has also developed the Core20PLUS5 approach to support NHS Integrated Care Systems to reduce health inequalities, to enable prioritisation of energies and resources as systems address health inequalities in the period 2021-2024.[26]

The approach defines a target population cohort - the 'Core20PLUS' - and identifies five focus clinical areas requiring accelerated improvement. The approach is made up of three key parts. The first two parts together provide a population identification framework designed to be used at ICS level to offer direction & focus in improving health inequalities:

- **Core20:** The most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD).
- **PLUS:** Integrated Care System-determined population groups experiencing poorer than average health access, experience and/or outcomes, but not captured in the 'Core20' alone, based on local data, including Inclusion health groups.
- **5:** The final part sets out five clinical areas of focus. Governance for these five focus areas sits with national programmes; national & regional teams coordinate local systems to achieve national aims. The five areas are maternity, severe mental illness, chronic respiratory disease, early cancer diagnosis, and hypertension case-finding.

ICSs are expected to understand who their 'Core20PLUS' populations are and identify their specific healthcare needs, in order to make informed decisions about how to ensure equitable access, excellent experience and optimal outcomes for these populations. Nationally, the five clinical focus areas are a priority for the 'Core20PLUS' population.

NICE guidelines

NICE (National Institute for Health and Care Excellence) is producing guidelines on integrated health and care for people experiencing homelessness[27] (as recommended by the Rough Sleeping Strategy 2018).[28] This is the first time that NICE has produced guidelines on homelessness, and is very welcome. They recently held a consultation on the draft guidelines, with the aim to publish final guidelines in March 2022.

The guidelines clearly set out how we need to design services in order to meet people's holistic needs and feature many recommendations that would significantly improve approaches to homeless health across the health, care (and housing) systems.

Headline recommendations include the need for joint commissioning between health, social care, and housing, and importantly, includes the provision of integrated, multi-disciplinary health and social care teams who can contribute towards the goal to end rough sleeping and preventing homelessness.

[23] https://www.gov.uk/government/collections/changing-futures
[24] https://www.gov.uk/government/news/extra-help-for-rough-sleepers-with-drug-and-alcohol-dependency
[25] https://www.gov.uk/government/news/fund-to-help-end-cycle-of-homelessness-and-hospital-readmissions
[26] https://www.england.nhs.uk/about/equality/equality-hub/core20plus5/
[27] https://www.nice.org.uk/guidance/indevelopment/gid-ng10170
[28] https://www.gov.uk/government/publications/the-rough-sleeping-strategy

The opportunity of the Health and Care Bill

These initiatives are very welcome, and illustrate the recognition from Government of the need for specific and targeted approaches for people who face severe health inequality. However, whilst they are a promising starting point, wide-ranging plans are needed to tackle significant mortality and morbidity in Inclusion Health populations, that integrates primary care, mental health, substance misuse, and wider healthcare services, along with social care and housing. The Core20PLUS5 approach is narrowly focused on certain health conditions, rather than meeting the complex needs of people facing social exclusion and therefore it is inevitable some people will fall through the gaps. Further, NICE guidance in and of itself does not create policy change, and these guidelines will now need to be fully resourced and implemented by housing, health, and social care commissioners and providers. Integrated Care Systems are ideally placed to take the NICE guidelines forward, and therefore embedding Inclusion Health within ICSs through the Health and Care Bill is integral.

Given the importance placed on Integrated Care Systems to drive forward health improvements and reduce health inequalities, we must ensure that efforts to tackle Inclusion Health are comprehensive and organised at this strategic, regional level. Our amendment is a starting point for this activity and would embed approaches to Inclusion Health at the highest levels of strategic planning within the NHS, to ensure that the right services are commissioned to meet this need.

This amendment tabled would ensure specific and dedicated attention from Integrated Care Partnerships to people who need inclusion health services, given the extremity of the health inequalities they face. Effective provision of these services can and should serve as a benchmark for health and care; **if we get access and outcomes right for the most marginalised in our society, we will likely get it right for everyone.**

This amendment in the Health and Care Bill states the following:

- It would require an Integrated Care Partnership, when preparing its Integrated Care Strategy, to have due regard to "*the need to improve health outcomes for Inclusion Health populations".*
- It would also change the Bill's wording so that an Integrated Care Partnership, when creating its Integrated Care Strategy, can including 'housing' in its statement of views on integration arrangements (as well as health and social care services). This aspect of the amendment is light touch and would not be mandatory for an Integrated Care Partnership.

For the Westminster Government to successfully reach its target of ending rough sleeping by the end of this parliamentary term, the health and care needs of people who are homeless cannot be overlooked, and the whole health and care system must play its part. This amendment would achieve this aim by ensuring that specific strategic attention is paid to people who experience the most significant marginalisation in our society, and would pave the way for specialist services and interventions that bring people into the healthcare system, meet their healthcare needs, and through collaborative working with social care and housing support people to leave social exclusion behind for good.

More than ever, the pandemic has shown a light on the extreme health inequalities experienced by Inclusion Health groups, health inequalities that existed long before the pandemic began. By ensuring that Integrated Care Partnerships have a specific mandated focus on Inclusion Health groups, we can ensure the health and care system works for people whose homelessness and social exclusion is compounded by their health and care needs.

For more information on Crisis' work on the Health and Care Bill, please contact Chris Hicks, Senior Policy and Parliamentary Affairs Officer – chris.hicks@crisis.org.uk