# ICS Strategy Response:

## Introduction

Crisis is the national charity for people facing homelessness. We know that homelessness is not inevitable, and we know that together, we can end it. Crisis is dedicated to ending homelessness by delivering life-changing services and campaigning for change.

Crisis Skylight Brent is one of 11 Skylight centres across the UK where we offer support to secure housing and employment, opportunities to learn new skills and help improve people's health and wellbeing. In Brent, we are lucky to have strong links to other local services within the public, voluntary and community sectors. Our partnerships are some of our strongest assets and we continue to work hard to build and maintain these.

## Summary of Key Recommendations

- **Expand suggested outcome D, 'Ensure healthy standard of living' to include people experiencing all forms of homelessness and all other inclusion health groups.**
- **Emphasise the links between health and offending to ensure resources are distributed adequately to cater for people involved with the criminal justice system.**
- **Add a priority on preventative healthcare measures which directly target the homeless population to reduce the number of people requiring unscheduled healthcare and increase capacity of services.**
- **Commit to ensuring that NICE guidelines are adhered to for integrated health and social care for people experiencing homelessness.**

## Ensuring a healthy standard of living for all

Homelessness is a healthcare issue. Homeless Link's Health audit found that 78% of people experiencing homelessness reported having a physical health condition, 82% having a mental health diagnosis, 54% had used drugs within the last 12 months and 33% only ate one meal per day. Across England and Wales, the general population lives for an average of 30 years longer than the homeless population[1].[2]. NWL ICS has advised that in 2020 in Northwest London, the average age of death for homeless men was 45.9, with women at 41.6, despite men within the general population in London having a life expectancy of 80.3, and women 84.3 in 2018-2020[3]. This significant gap is often as a result of the significant prevalence of major health conditions among people experiencing homelessness, such as cancer, respiratory and heart disease. These figures also indicate that the homeless population in Northwest London have worse standards of living than people experiencing homelessness elsewhere in the country. The NWL ICS homeless health programme acknowledges that Northwest London has the largest population of people experiencing homelessness in London, therefore we know that homelessness is an issue that disproportionately affects our local health services and should be a focus of our ICS strategy.

At present, one of the objectives for the ICS strategy is to ensure a healthy standard of living for all. One of the listed outcome indicators is to monitor numbers of households residing in temporary accommodation however, given the significant health and care issues among people experiencing all forms of homelessness we suggest that this is amended to incorporate all inclusion health groups,

[1] Deaths of homeless people in England and Wales - Office for National Statistics (ons.gov.uk)
[2] Homeless_Health_Needs_Audit_Report.pdf (kxcdn.com)
[3] Life expectancy for local areas of the UK - Office for National Statistics (ons.gov.uk)

including people experiencing other forms of homelessness, as we know that these other groups experience some of the worst living standards.

Inclusion health groups refer to those who typically experience multiple disadvantages and often include people who are sleeping rough and experiencing other forms of homelessness as well as gypsies and travellers; migrants with vulnerabilities; sex workers and victims of modern slavery; people involved with the criminal justice system and those with drug and alcohol issues[4]. One of the priorities within the NWL ICS strategy draft is to use data to understand where resources could be used more effectively. However it is widely agreed that inclusion health groups are often not accounted for in data collection[5] and the recent Department of Health and Social Care guidance for ICSs on preparing their integrated care strategies recommends that the integrated care strategy should identify opportunities for research where there are gaps in evidence either of health and care need or gaps in how those needs might be effectively met and should ensure that the needs of underserved populations are identified. We also note that that life expectancy for homeless women is lower than men, and women experiencing homelessness are often more hidden and unaccounted for in statistics due to the nature of their homelessness and the barriers to verification they face.

It should be the responsibility for the ICS to address this within the strategy to ensure that resources are not withheld from these populations who are most excluded from services yet often the most in need of healthcare. To achieve this proposed outcome, the ICS cannot disregard these populations and must include people experiencing all forms of homelessness in the healthy standard of living outcome.

## Addressing inequalities: link between health and offending

As aforementioned, people involved with the criminal justice system are also an inclusion health group and often do not receive the healthcare they require. It was assessed that 90% of people in prison have a mental health issue[6] and people who have recently been released from prison are much more likely to attempt suicide than the rest of the population[7]. We also note that many women have health and wellbeing issues prior to imprisonment; 75% used substances 6 months prior, 42% excessively drank alcohol, 16% had self-harmed within 1 month prior and only 13% of them met recommended dietary intakes[8]. These statistics demonstrate that people who offend have often previously had poor health outcomes and providing people with good healthcare should reduce rates of offending. We also know that offending rates vary around Northwest London, with Brent being the home of the highest number of people known to probation within the ICS area (1641 residing in Brent, which significantly compares to the next highest of 1264 in Ealing and the lowest of 392 in Kensington and Chelsea). Due to these stark differences, we ask for the ICS to take this data into consideration, as the high rate of offending in Brent indicates that the local population will require more healthcare resources than other areas throughout Northwest London.

[4] Guidance on the preparation of integrated care strategies - GOV.UK (www.gov.uk)
[5] Ibid.
[6] Singleton N., Meltzer H., Gatward R., Coid J. and Deasy D. (1998) Psychiatric morbidity among prisoners in England and Wales. London: The Stationery Office
[7] Pratt, D., Piper, M., Appleby, L., Webb, R. and Shaw, J. (2006) Suicide in recently released prisoners: a population-based cohort study. London: Lancet.
[8] Plugge, E., Douglas, N. and Fitzpatrick, Ray. (2006) The Health of Women in Prison Study.

## Preventative healthcare measures

One of the outcomes included in the draft strategy is to strengthen the role and impact of ill health prevention, with a priority stated to increase the uptake of preventative services. We would like to emphasise the link between housing status and access to healthcare. The ICS should prioritise increasing access to healthcare for those experiencing homelessness and providing healthcare measures that directly target the homeless population. The need for homeless people to be prioritised in healthcare strategies also comes from a fiscal perspective. There is a wealth of research which has concluded that people experiencing homelessness cost public services a lot more than those in the general population. A report published by Crisis[9] estimated that a person experiencing homelessness could cost the public sector as much as £38,736 per year.

Research by Groundswell[10] found that 54% of people experiencing homelessness advised that they became homeless due to their physical and mental health issues, including substance misuse. Substance misuse is often attributed to being a cause of homelessness however it is often a result of homelessness itself,[11] as 45% of people advised that they self-medicate to cope with their mental health whilst homeless[12]. People experiencing homelessness are also disproportionately impacted by other health issues such as cancer, respiratory and cardiovascular diseases. It is therefore essential to note the linked importance of preventative healthcare measures for conditions that lead to homelessness as well as conditions that result from experiencing homelessness.

Many people experiencing homelessness struggle to access healthcare. This can be due to the experience of homelessness itself e.g., due to loss/theft of belongings when someone does not have a fixed address, or due to the effects of poor mental health and/or substance misuse on their capacity to attend appointments. People experiencing homelessness often suffer from the tri-morbidity of mental ill-health, physical ill-health and substance dependency issues, meaning another barrier they often face is that many healthcare pathways will require one of these needs being met before they are able to receive support for the other[13] - this often prevents them from receiving any help at all and losing faith in the services available.

In order to successfully address inequalities and build confidence in our communities to come forward for care and support, as is a listed priority, the strategy should have regard to the need to increase access to healthcare for people experiencing homelessness, as this will increase the number of positive outcomes people achieve and will help to restore confidence in the community to seek the health support that they need. Whilst the draft strategy mentions a proactive care target to improve equity of access, outcomes and experience for populations such as people experiencing homelessness, we believe that the ICS needs to go further and focus attention on preventative care for this population. People experiencing homelessness are much less likely than those with secure housing to be registered with a GP[14], meaning that they often only seek medical support when at crisis point. This causes homeless people to overuse acute and emergency services and have longer in-patient stays due to their unmet needs[15]. We know that people experiencing homelessness attend A&E six times more than the general population, they are admitted four times more often and their stays last three times longer[16]. The common need for acute and emergency services makes the cost of unscheduled care alone eight times higher for people experiencing homelessness than those who

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[9] Pleace, N. & Culhane, D.P. (2016) Better than Cure? Testing the case for Enhancing Prevention of Single Homelessness in England. London: Crisis. crisis_better_than_cure_2016.pdf.

[10] Benefits-for-Health-full-report.pdf (groundswell.org.uk)

[11] Centre for Homelessness Impact. What Works Evidence Notes: Drugs and Alcohol

[12] Ibid, 3.

[13] Centre for Homelessness Impact. What Works Evidence Notes: Mental Health

[14] Exploring high-intensity use of Accident and Emergency (redcross.org.uk)

[15] NICE guidance on Integrated Health and Social Care for People Experiencing Homelessness

[16] Brent ICB Homeless Health plan draft

are housed[17]. If a priority of the ICS strategy is to develop cost effective models of care, attention must be focused on preventative healthcare for people experiencing homelessness and ways of breaking down the existing barriers the cohort face. It should therefore be a priority of health services to prevent homelessness itself, as this would strengthen the capacity of wider health services.

## NICE guidelines on integrated health and care for people experiencing homelessness

Existing research demonstrates what must be done to prevent health issues leading to homelessness, including recent NICE guidelines on health and care for people who are homeless, which stipulates that integration and multi-disciplinary approaches are vital.[18] However, nationally, good practice is patchy and too often provision bears no resemblance to best practice in the NICE guidance. Key to tackling health inequalities is preventing them from arising in the first place. To increase access to healthcare for people experiencing homelessness, a flexible and person-centred approach should be taken through measures such as not penalising people experiencing homelessness if they miss appointments, but much more work is needed to understand how best practice principles can be translated into tangible preventative and effective outcomes for a population at risk of falling into homelessness or already homeless. We would encourage NWL to include a commitment in the strategy to ensuring that the NICE guidelines are implemented in full within the ICS area.

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[17] Pathway Report: Medical Respite for Homeless People
[18] Ibid, 15.