HEALTH INEQUALITIES

Core20PLUS5 – identifying “PLUS” population groups

October 2023

NHS Providers

Agenda

Welcome and introduction
Facilitated by chair – Saffron Cordery – deputy chief executive, NHS Providers

Introduction to NHSE Core20PLUS5 and inclusion health framework
Nicola Gitsham – head of healthcare inequalities, improvement and personalisation, NHS England

Providing inclusive health services
Rosie Hollinshead – health policy and project coordinator, Friends, Families and Travellers

Engaging with Gypsy, Roma and Traveller communities
Rosie Hollinshead – health policy and project coordinator, Friends, Families and Travellers

Engaging with homeless communities
Anne McBrearty – nurse consultant, homeless health service lead, Central London Community Healthcare Trust

Panel Q&A
Facilitated by chair

Summary and close
Facilitated by chair

Close of event

Housekeeping

- Please note, this event is being recorded
- Please keep your camera on wherever possible
- If you lose connection, please re-join using the link in your joining instructions or email health.inequalities@nhsproviders.org
- Please ensure your microphone is muted during presentations to minimise background noise
- We will come to questions during the panel Q&A
- Please feel free to use the chat box to ask questions
- If you would like to ask a question audibly, please use the raise hand function during the Q&A section and we will bring you in
- Any unanswered questions will be taken away and answered after the event
- You will receive a link to an evaluation form at the end of the day, please take the time to complete it, we really do appreciate your feedback.

A national framework for NHS action on inclusion health

Nicola Gitsham, Head of Policy and Sector Insights

NHS England Health Inequalities Improvement Programme

Vision: exceptional quality healthcare for all through equitable access, excellent experiences and optimal outcomes

REDUCING HEALTHCARE INEQUALITIES

The **Core20PLUS5** approach is designed to support Integrated Care Systems to drive targeted action in healthcare inequalities improvement

CORE20
The most deprived **20%** of the national population as identified by the Index of Multiple Deprivation

PLUS
ICS-chosen population groups experiencing poorer-than-average health access, experience and/or outcomes, who may not be captured within the Core20 alone and would benefit from a tailored healthcare approach e.g. inclusion health groups

Target population

CORE20 PLUS 5

Key clinical areas of health inequalities

1. **MATERNITY**
ensuring continuity of care for women from Black, Asian and minority ethnic communities and from the most deprived groups

2. **SEVERE MENTAL ILLNESS (SMI)**
ensure annual Physical Health Checks for people with SMI to at least, nationally set targets

3. **CHRONIC RESPIRATORY DISEASE**
a clear focus on Chronic Obstructive Pulmonary Disease (COPD), driving up uptake of Covid, Flu and Pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations

4. **EARLY CANCER DIAGNOSIS**
75% of cases diagnosed at stage 1 or 2 by 2028

5. **HYPERTENSION CASE-FINDING**
and optimal management and lipid optimal management

SMOKING CESSATION
positively impacts all 5 key clinical areas

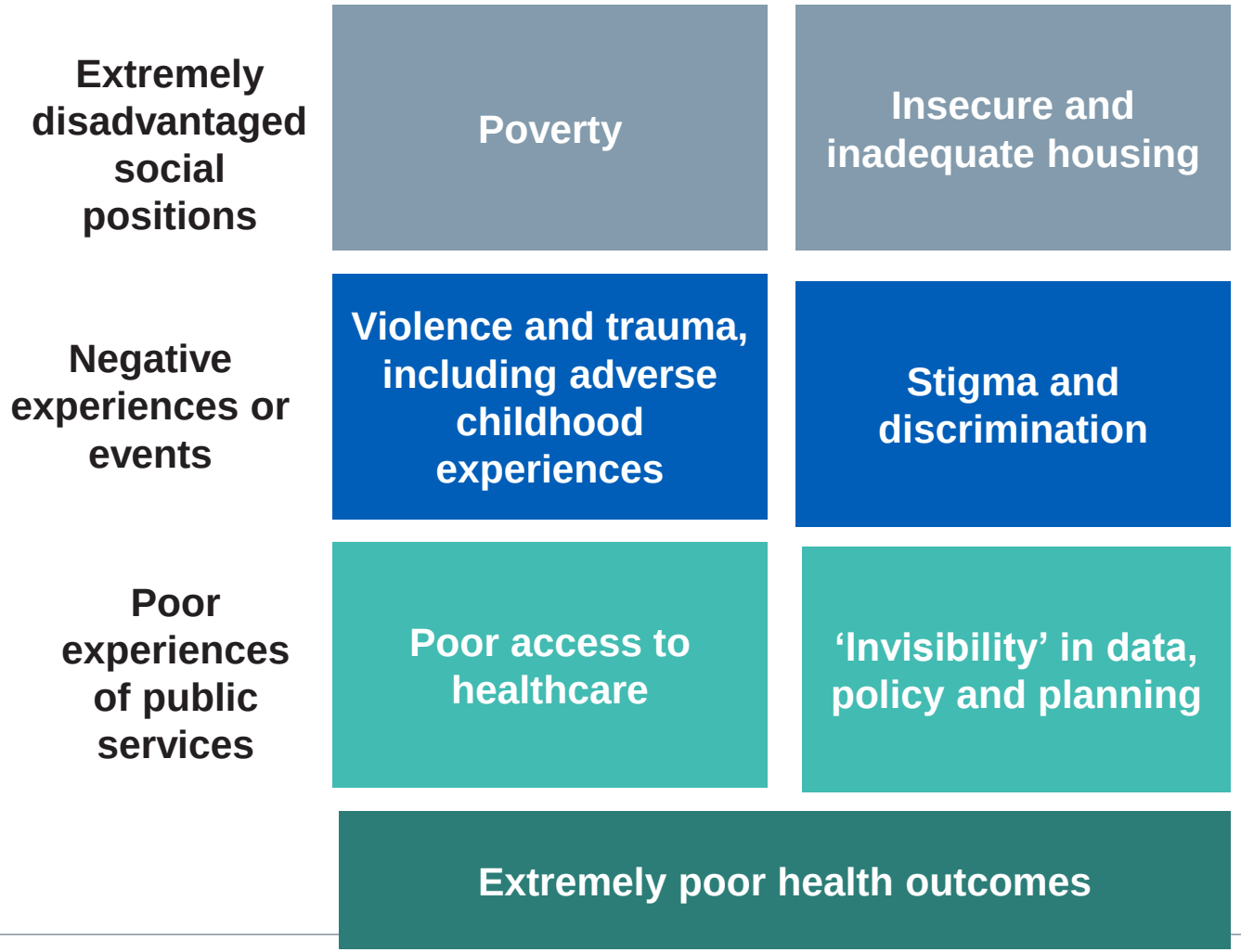
What is inclusion health?

Inclusion health is an umbrella term to describe any group that is socially excluded

Inclusion health groups include:

- **People who experience homelessness and rough sleeping**
- People in contact with the criminal justice system
- Vulnerable migrants
- People dependent on drugs or alcohol
- Gypsy, Roma, and Traveller communities
- Sex workers
- Victims of modern slavery

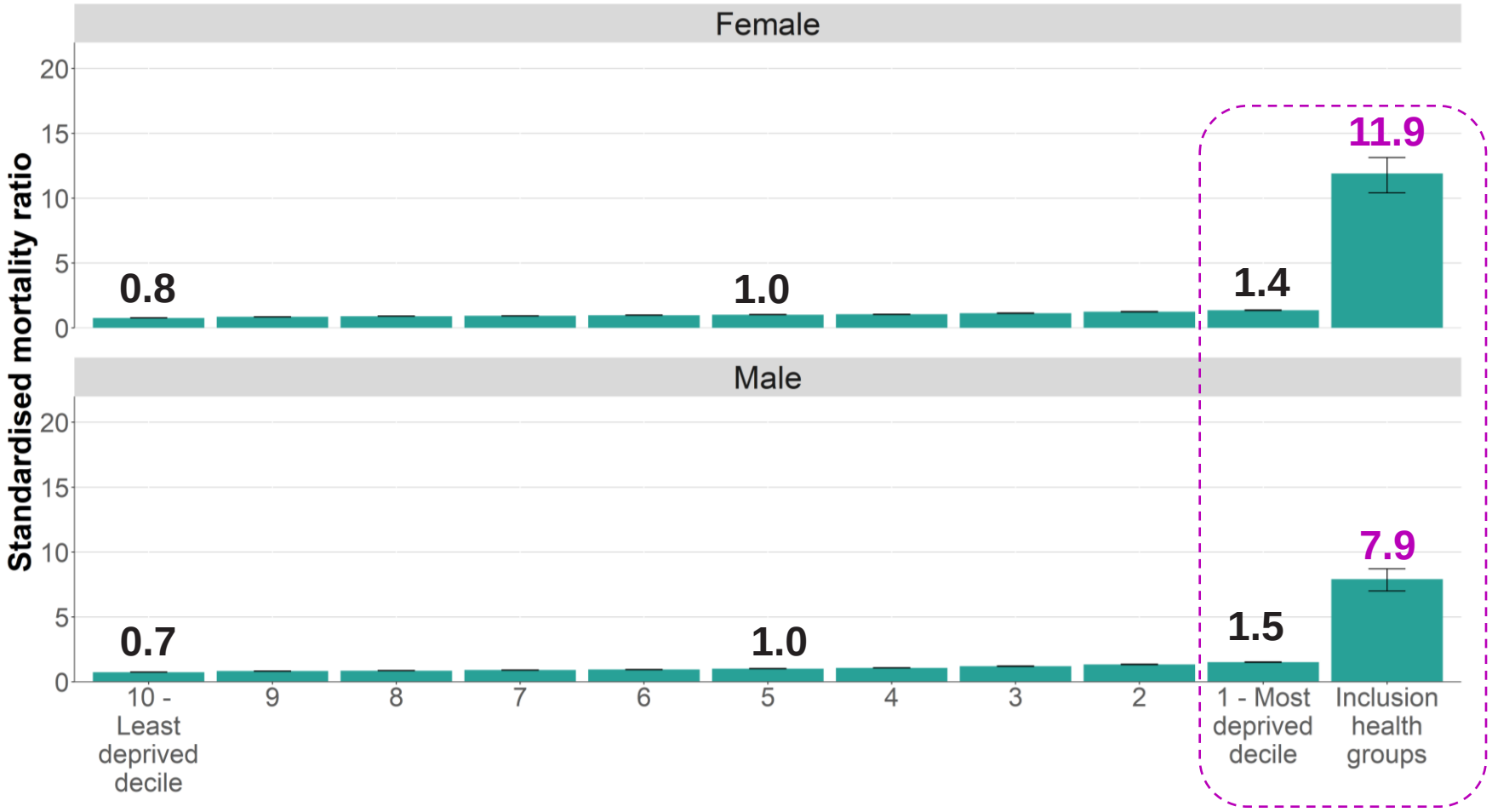
Social exclusion involves extreme inequality and multiple interacting risk factors for poor health



People inclusion health groups tend to have shorter lives than the general population

The relative mortality of people in inclusion health groups far exceeds that of people from the most deprived communities of England

The average age of death for patients experiencing homelessness and rough sleeping is 43 years for women and 45 years for men.



Source: Office for Health Improvement and Disparities (2022). Available at: https://analytics.phe.gov.uk/apps/spotlight/

Inaction comes with significant costs yet there are known effective interventions to improve access to healthcare services

Costs of inaction

Without good access to primary and community care, and early or preventative interventions, people in inclusion health groups are likely to turn to acute services.

- A&E attendance is 6-8 times higher for people experiencing homelessness and 28 times higher for people who experience both homelessness and rough sleeping and alcohol dependency.

- High intensity users are thought to equate to almost a third (29%) of all ambulance arrivals at A&E, and one in four (26%) emergency admissions.

Benefits of intervention

Improved health and social care pathways and accessible effective services, benefit patients and reduce the costs of health and social care services.

- A study undertaken in 2022 investigating the cost-effectiveness of three different ‘in patient care coordination and discharge planning’ configurations for adults experiencing homelessness, highlighted that specialist **Homeless Hospital Discharge (HHD)** care is more cost-effective than standard care.

- Cost effective analysis shows that patients accessing HHD care use fewer bed days per year (including both planned and unplanned readmissions) and presented better quality-adjusted life year (QALY) outcomes.

Action is needed across a complex system

Integrated care systems (ICSs)

Key planning and partnership bodies from July 2022

NHS England
Performance manages and supports the NHS bodies working with and through the ICS

Care Quality Commission
Independently reviews and rates the ICS

Statutory ICS

Integrated care board (ICB)

Membership: independent chair; non-executive directors; members selected from nominations made by NHS trusts/foundation trusts, local authorities, general practice; an individual with expertise and knowledge of mental illness

Role: allocates NHS budget and commissions services; produces five-year system plan for health services

Cross-body membership, influence and alignment

Integrated care partnership (ICP)

Membership: representatives from local authorities, ICB, Healthwatch and other partners

Role: planning to meet wider health, public health and social care needs; develops and leads integrated care strategy but does not commission services

Influence (ICB)

Influence (ICP)

Partnership and delivery structures

Geographical footprint	Name	Participating organisations
System Usually covers a population of 1–2 million	**Provider collaboratives**	NHS trusts (including acute, specialist and mental health) and as appropriate voluntary, community and social enterprise (VCSE) organisations and the independent sector; can also operate at place level
Place Usually covers a population of 250–500,000	**Health and wellbeing boards**	ICS, Healthwatch, local authorities, and wider membership as appropriate; can also operate at system level
	Place-based partnerships	Can include ICB members, local authorities, VCSE organisations, NHS trusts (including acute, mental health and community services), Healthwatch and primary care
Neighbourhood Usually covers a population of 30–50,000	**Primary care networks**	General practice, community pharmacy, dentistry, opticians

The Kings Fund

Developing a National Framework for NHS Action on Inclusion Health

Reviewing the Evidence

The first step was conducting a desktop research exercise to properly review the existing literature relating to inclusion health.

Working with People

We held workshops with charities and people with lived experience, and 121 sessions with other key stakeholders.

Programme Governance

We convened senior leaders from across NHS England, OHID and UKHSA National and Regional teams.

Showcasing Best Practice

We put out a call for evidence for examples of best practice in Inclusion Health, which were written up into case studies.

Content Drafting

We pulled together everything we learnt and lots of stakeholder feedback into the framework.

Final Framework

The final framework is due to be published on 10th October 2023, to coincide with World Homeless Day.

National Framework for NHS Action on Inclusion Health - five guiding principles

Next steps

Publication in October to coincide with World Homelessness Day

Integrated care systems to work on developing plans to improve inclusion health

NHS England will work with partners to continue to co-ordinate activity, share learning and best practice

FRIENDS, FAMILIES & TRAVELLERS

Core20PLUS5: Meeting the needs of Inclusion Health Groups

Rosie Hollinshead

Health Policy & Projects Coordinator

gypsy-traveller.org

Agenda

- Introduction to Friends, Families & Travellers (FFT)
- Inclusion Health Groups: an overview
- Barriers to healthcare access for Inclusion Health Groups
- Identifying your local Inclusion Health Group populations
- Improving services for Inclusion Health Groups
- Good practice examples

Friends, Families and Travellers: About Us

We work to end racism and discrimination against Gypsy, Roma and Traveller people and to protect the right to pursue a nomadic way of life.

- Active since 1994, we are a leading national charity that works to end racism and discrimination against Gypsy, Roma and Traveller people and to protect the nomadic way of life.
- We support individuals and families with the issues that matter most to them, at the same time as working to transform systems and institutions to address the root causes of inequalities faced by Gypsy, Roma and Traveller people.
- We investigate and expose unfair treatment, advocate for equal rights and empower individuals to challenge inequality.
- We educate professionals to provide fair access to services.
- We celebrate Gypsy, Roma and Traveller people's rich histories, cultures and contributions to society and share this with the wider public.
- We use all this to create a compelling case for change to a safer, more just society for Gypsies, Roma and Travellers.

At least half of our Trustees, staff, interns and volunteers are from Gypsy, Roma or Traveller background.

Friends, Families & Travellers: Vision for Change

We support individuals and families directly with the issues that matter most to them through our casework and outreach teams, at the same time as working nationally to transform systems and institutions to address the root causes of inequalities.

Our main areas of work are:

Health

We believe that everyone should receive the support, care and treatment they need, with the compassion, respect and dignity they deserve.

Hate

We believe that everyone has a responsibility to stand up against hate, prejudice and negative stereotypes and that the government has a duty to prevent and punish discrimination and hate crime.

Accommodation

We believe that everyone has the right to safe and adequate living conditions and that the government has a duty to facilitate the nomadic way of life.

Education

We believe that every child and young person has a right to learn in a safe environment that is free from bullying and that is affirming towards their culture and way of life.

VCSE Health & Wellbeing Alliance

In consortium with Roma Support Group (RSG), FFT is a member of the VCSE Health and Wellbeing Alliance (HWAlliance) which is a partnership between the voluntary sector and the health and care system to provide a voice and improve the health and wellbeing of all communities. The HWAlliance is jointly managed by the Department of Health and Social Care (DHSC), the UK Health Security Agency and NHS England and is made up of 18 VCSE Members that represent communities who share protected characteristics or that experience health inequalities and a VCSE coordinator.

The Alliance has been established to:

- Facilitate integrated working between the voluntary and statutory sectors
- Support a two-way flow of information between communities, the VCSE sector and policy leads
- Amplify the voice of the VCSE sector and people with lived experience to inform national policy
- Facilitate co-produced solutions to promote equality and reduce health inequalities

Within the HWAlliance, FFT is also the Secretariat and Co-Chair of the Inclusion Health Subgroup.

HWAlliance 2023-2024 Core Projects

Infant Feeding

Developing guidance on tackling inequalities for Gypsy, Roma and Traveller communities in maternity services: Infant feeding, peer support and early information.

Developing culturally pertinent information resources for parents on infant feeding and accessing support.

Social Prescribing

Developing guidance for social prescribing link workers on engaging with Gypsy, Roma and Traveller communities and diversifying workforces.

Led by Roma Support Group.

Digital Enablers

Investigating factors that enable use of digital tools and resources for accessing primary care among Gypsy, Roma and Traveller communities.

Developing best practice guidelines and or/standards for the development of digital tools and resources, to improve accessibility.

Inclusion Health Groups: an overview

Inclusion Health Groups

Inclusion Health is a ‘catch-all’ term used to describe people who are socially excluded, typically experience multiple overlapping risk factors for poor health (such as poverty, violence and complex trauma), experience stigma and discrimination, and are not consistently accounted for in electronic records (such as healthcare databases).

Inclusion Health Groups

These experiences frequently lead to barriers in access to healthcare and extremely poor health outcomes. People belonging to inclusion health groups frequently suffer from multiple health issues, which can include mental and physical ill health and substance dependence issues. This leads to extremely poor health outcomes, often much worse than the general population, lower average age of death, and it contributes considerably to increasing health inequalities.

Inclusion Health Groups fall under CORE20PLUS5 ‘PLUS’ groups, which should be identified at a local level.

Inclusion Health Groups

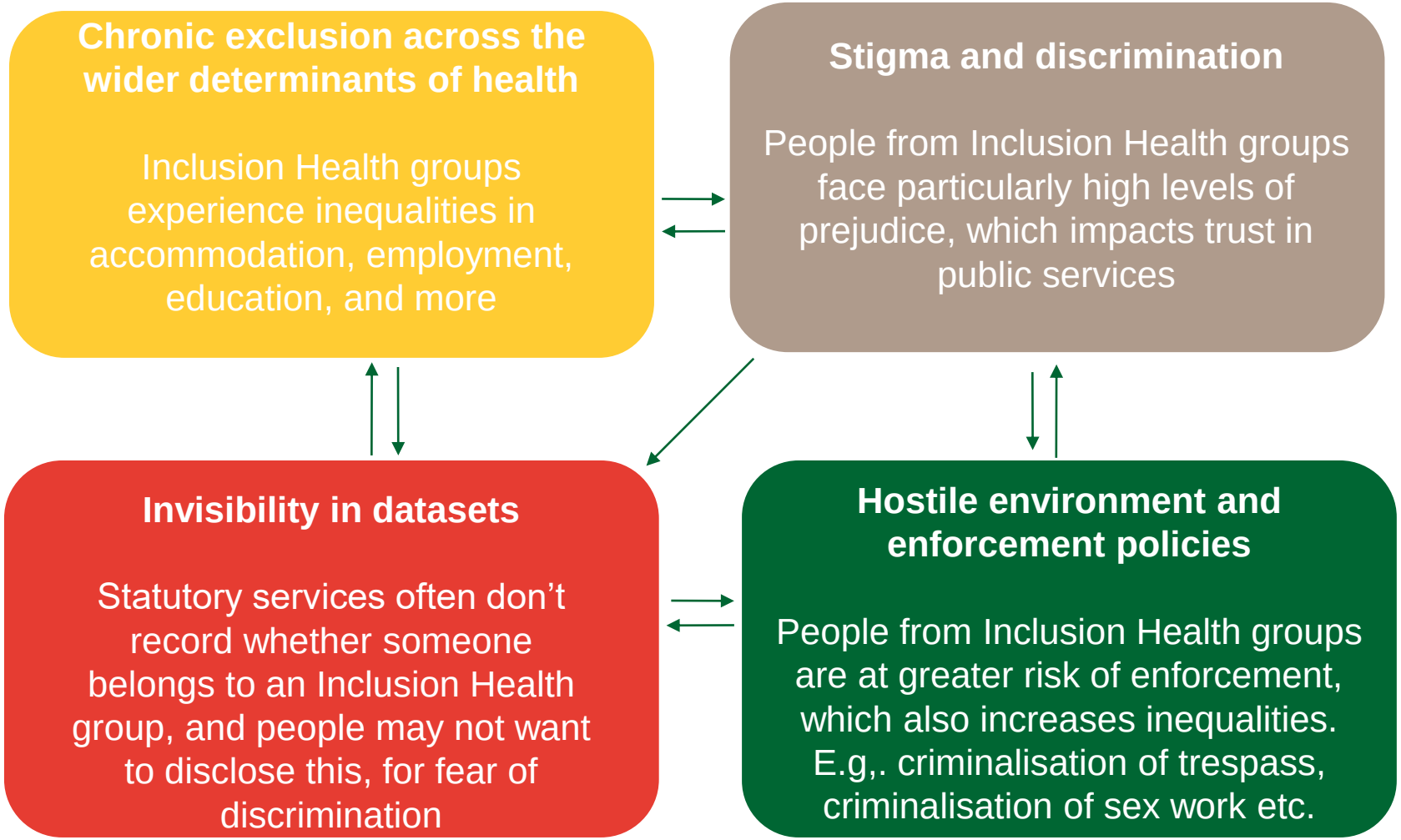
Inclusion health includes any population group that is socially excluded. This can include:

- **Gypsy, Roma and Traveller communities**
- **People who experience homelessness**
- **Vulnerable migrants**
- **Sex workers**
- **People in contact with the justice system**
- **Victims of modern slavery**
- **People who experience drug and alcohol dependence**

Inclusion Health groups are not a homogenous group and may be facing a wide variety of experiences. There will be differences in needs within socially excluded groups (for example different genders and age groups, and for people who sit within two or more Inclusion health groups); these differences must be understood and responded to appropriately.

However, many barriers to accessing health services are shared across groups.

Why do Inclusion Health groups experience poor health outcomes?



Gyspy, Roma & Traveller Communities

Gypsy, Roma & Traveller Communities: An Introduction

The term Gypsy, Roma and Traveller (GRT) encompasses various communities, including Romany Gypsies (English Gypsies, Scottish Gypsy Travellers, Welsh Gypsies, and Romany people more widely), Irish Travellers, New Travellers, Boaters, Showmen and Roma. Use of the 'GRT' grouping presents the same issues as the use of 'BAME', as it arguably fails to reflect the true diversity of the communities referenced.

Gypsy, Roma and Traveller communities have traditionally lived nomadic lives in the UK, although members of these communities have increasingly moved into bricks and mortar housing. The 2011 census for England and Wales recorded 74% of Gypsies and Travellers as living in houses, flats, maisonettes or apartments.

This video produced by Travellers' Times provides a short, animated history of Britain's nomadic communities.

Nomadism and Gypsy and Traveller Communities

There are an estimated 300,000 Gypsies and Travellers in the United Kingdom.

- Around ¾ of Gypsies and Travellers in England and Wales live in bricks and mortar accommodation and the remaining ¼ live in a caravan or other mobile structure.
- There are approximately 3,000 caravans lived in by families with no place to stop in England.
- Living nomadically is part of the Gypsy and Traveller cultural heritages and identities, and whilst many now live in bricks and mortar, they continue to maintain this tradition for part of the year.

The ‘Last Acceptable Form of Racism'

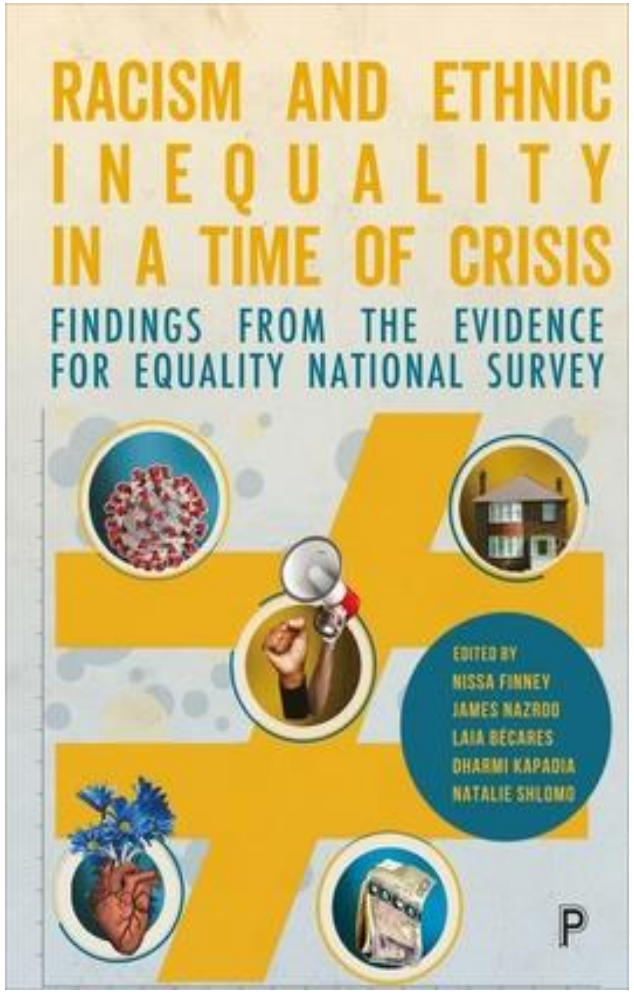
- A 2022 survey undertaken by the University of Birmingham showed that 44.6% of the British public express a 'negative view' of Gypsies, Roma and Travellers.
- This is the highest percentage of any group.
- Sensationalist newspaper reporting, television shows, and derogatory language used by politicians serve to create a level of acceptable racism towards Gypsies, Roma and Travellers.

EVENS Survey Data:
Racism and Ethnic Inequality in a Time of Crisis

FFT collaborated with the Centre on the Dynamics of Ethnicity (CoDE) on producing the first and largest survey of its kind in Britain, designed to explore the realities facing ethnic and religious minorities.

Key findings:

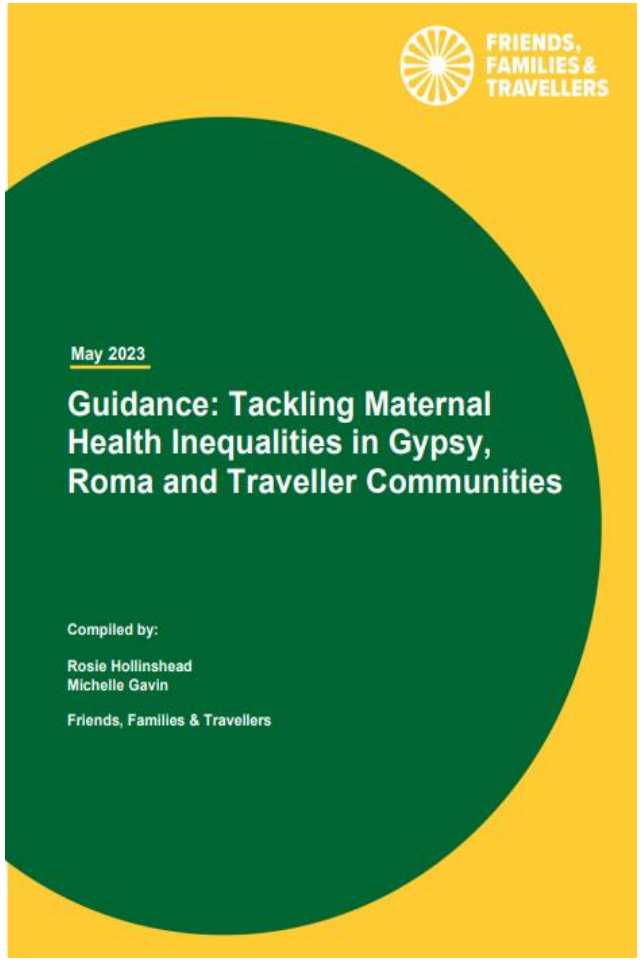
- 62% of Gypsies and Travellers had experienced **racial abuse**, which was the highest out of all minority ethnic groups surveyed;
- 47% of Roma people had been **racially assaulted**; and
- 37% of Roma people have been **physically attacked**.
- The wider effects of discrimination led to Gypsy, Roma and Traveller people experiencing the **highest levels of social and economic deprivation**, with:
    - More than half of Gypsy, Roma and Traveller people having **no educational qualifications**;
    - 85% of Gypsy or Traveller men and 65% of Roma men were in **precarious employment**, compared with 19% of white British men.
    - The survey also highlighted stark health inequalities across **health outcomes and access to services**:
        - Gypsy, Roma and Traveller men were over 12 times more likely to suffer with **more than two physical health** conditions than white British men; and
        - Roma people had the highest risk of **not being able to access health and social care services**.



Health Context for Gypsy, Roma and Traveller Communities

- Members of Gypsy, Roma and Traveller communities have the worst health outcomes of any ethnic group in the UK (House of Commons Women and Equalities Committee, 2019).
- The 2021 census for England and Wales revealed that 14% of Gypsy or Irish Traveller respondents described their health as “bad” or “very bad”, more than twice as high as the White British group.
- The Race Disparity Audit reveals that Gypsy and Traveller people are less likely to be satisfied with access to a GP than white British people (60.7% compared to 73.8%) and are also less likely to be satisfied with the service they receive (75.6% compared to 86.2% for white British).
- Life expectancy for Gypsy and Traveller men and women is 10 years lower than the national average (Equality & Human Rights Commission, 2017).
- 42% of English Gypsies are affected by a long-term condition, as opposed to 18% of the general population (Royal College of General Practitioners, 2013).
- Roma communities experience specific social exclusion factors and barriers in access to health and care services. They have multiple overlapping risk factors for poor health and a life expectancy up to 10 years less than non-Roma communities in the UK (European Public Health Alliance, 2018).

HWAlliance Research: Tackling Maternal Health Inequalities in Gypsy, Roma and Traveller Communities



Key Issues:

- Lack of effective communication and accessible information in health services. These relate primarily **to high rates of low literacy, language barriers, and digital exclusion.**
- Barriers to accessing and maintaining **continuity of care** for Gypsy, Roma and Traveller communities – particularly those who are nomadic.
- Issues relating to the **wider determinants of health**: often linked to housing and accommodation.
- **Discrimination,** both direct and structural, within public services in healthcare and beyond.
- **Fear and mistrust** of public services and state bodies.
- Lack of awareness and accommodation in services around **cultural norms.**
- **Stigma and taboo** relating to **perinatal mental health**, as well as **barriers to access** for mental health support.
- High rates of **Caesarean** birth, **miscarriage, pregnancy loss** and/or **child loss** reported by Gypsy, Roma & Traveller research participants.
- High rates of **Classical Galactosemia** among infants born to Irish Traveller parents.

Vulnerable Migrants

Vulnerable Migrants

Certain groups of migrants are particularly vulnerable to potential health needs because of their experiences either before, during or after migration.

Groups of vulnerable migrants living in the UK include (but are not limited to):

- **asylum seekers and refugees**
- **unaccompanied children**
- **people who have been trafficked**
- **undocumented migrants (those who are living in the UK with no legal status)**
- **low paid migrant workers**

Health problems of vulnerable migrants are frequently related to destitution, poor conditions during migration, and lack of access to clinical and non-clinical services, rather than long-standing illness or poor health. Barriers and charges vulnerable migrants face when accessing care significantly contribute to poor health among some vulnerable migrant populations.

Refugees and asylum seekers may have high levels of mental health need, which may be caused both by traumatic events in origin countries, and the socio-political conditions in host countries, which can lead to experiences of criminalisation and discrimination.

Depending on their country of origin and how long they have been travelling for, vulnerable migrants may not have had access to healthcare, screenings or any preventative care for a long time. It is vital that they are able to register with a GP so they can gain access to the care they are entitled to.

Vulnerable migrants face particular barriers to healthcare access due to the presence of 'Hostile Environment' migration policies in healthcare, which can involve charges for treatment and the risk of data being shared with the Home Office.

Sex Workers

Sex Workers

‘Sex work’ refers to the exchange of sexual services for some form of payment. This is a broad category, that covers a diverse group of individuals, some of whom may belong to more than one inclusion health group. In terms of health impact, it is relevant to distinguish between ‘street-based’ and ‘off-street’ sex work, because of the differing nature of the work, the risks and needs of the groups involved.

Sex workers face additional barriers to statutory service access, relating to immigration status, language barriers, fear of criminalisation and difficulty navigating systems.

‘Street’ sex workers are considered to have the most acute health needs and are more likely to be in contact with health care services than the general population. On average, they reported visiting the GP 8.5 times in the previous year compared to 4 times for the general population.(1) They also reported going to A&E 2.5 times, to an STI clinic 2.7 times, to an inpatient clinic 2 times and an outpatient clinic 4.3 times in the past 12 months.(2)

Despite this, a comparatively low percentage have had routine health checks, such as cervical screening, or attend antenatal checks when pregnant.(3) This is due partly due partly to a number of institutional and systemic barriers to accessing healthcare.

People experiencing homelessness

People experiencing homelessness

Homelessness, and the fear of becoming homeless, can result in ill health or exacerbate existing health conditions. Homelessness and housing insecurity in the UK is on the rise: the official 'street count' for England has risen 164% since 2010.(1)

Shelter estimated that 320,000 people in the UK are currently homeless.(2) This includes people sleeping rough, those residing in homeless hostels, and those in temporary and bed and breakfast accommodation. Additionally, the Big Issue has suggested that at least a further 300,000 are 'hidden' from statistics.(3)

There is widespread evidence from across the world of the negative impact of homelessness on health. One of the key reasons for these poor health outcomes is 'tri-morbidity'. This means that people are more likely to experience having a physical health, mental health and addiction problem at the same time. They are also more likely to have certain health conditions, such as Hepatitis C, Tuberculosis, Epilepsy, and heart disease. (6,7)

Subgroups & Intersections

Subgroups & Intersections: LGBT+ people experiencing homelessness

There are many examples of subgroups within Inclusion Health groups, one of which is LGBT+ people experiencing homelessness.

- Almost one in four young homeless people identifies as LGBT and 77% of LGBT youth homelessness is caused by family rejection, abuse or being asked to leave home.
- Over half (59 per cent) of LGBTQ+ young people have faced some form of discrimination or harassment while accessing services.
- Almost one quarter (24 per cent) weren't aware of any support services available to them.

Barriers to accessing healthcare

Barriers to accessing healthcare

People in inclusion health groups tend to have poor experiences of healthcare services because of barriers created by service design.

These negative experiences can lead to people in inclusion health groups avoiding future contact with NHS services and being least likely to receive healthcare despite have high needs.

This can result in significantly poorer health outcomes and earlier death among people in inclusion health groups compared with the general population.

Barriers to accessing healthcare

Barriers to accessing services vary depending on the inclusion health group in question, as well as individual circumstance. However, some common factors include:

- **Lack of fixed address or identification documents**
- **Digital exclusion**
- **Literacy & language barriers**
- **Low levels of awareness around services**
- **Lack of trust in, or willingness to engage with, health services (due to fear of discrimination, data sharing, charges for care etc.)**
- **Discrimination or a lack of cultural competency within healthcare settings**
- **Services ill-equipped to support patients with multi-morbidities**

Identifying local Inclusion Health Group populations

Getting to know local inclusion health group populations

Inclusion health groups are often not recorded in electronic health records and may be reluctant to engage with services and research, which can make understanding their health and social needs very challenging. Official data often fails to offer clear estimates of population sizes, with many official reports considered to be undercounts. The NHS Data Dictionary does not include Gypsy, Roma or Traveller ethnicity categories, for example.

It's important to draw data from a variety of sources, to give as clear a view of local populations as possible.

- The VCSE sector can be key to understanding local population need and to gain insight into Inclusion Health groups
- Local Authorities and CCGs produce Joint Strategic Needs Assessments (JSNAs), which describe the characteristics and needs of the local population and highlight inequities of health outcomes and in access to services. The needs and outcomes of inclusion health groups should be considered in these assessments.
- Public Health Outcomes Framework (PHOF) indicators, such as homelessness indicators, school readiness and drug misuse indicators, can be used to build this understanding of local needs.
- Speaking with frontline staff and local people with lived experience of social exclusion should complement the data obtained via other sources.
- Use Patient Participation Groups effectively, and recruit from diverse communities

Getting to know local inclusion health group populations: relevant datasets

Gypsy, Roma & Traveller communities	Vulnerable migrants	Sex workers	People experiencing homelessness
• The NHS does not routinely collect data for Gypsy, Roma and Traveller populations. • Fear of disclosure due to discrimination. • Census records, Gypsy and Traveller Accommodation Assessments and the Caravan Count can be used to assess some data on local population sizes.	• Fear of disclosure due to fear information will be shared with the Home Office. • Refer to information provided by VCSE organisations such as Doctors of the World.	• Self-identification may vary depending on the individual and the nature of their work • Sexual Health Needs Assessments and Public Health Rapid Needs Assessments are published by some local authorities • National Ugly Mugs provides further information on the needs and experiences of sex workers.	• Carrying out homeless health needs audits can identify health needs of people experiencing homelessness in your local area. Partnering with VCSE organisations in this is key. • Guidance on conducting audits can be found from: Homeless Link QNI Pathway & Kings

Improving services for Inclusion Health Groups

Tackling the wider determinants of health: data collection

Collecting data on wider determinants of health such as education, deprivation, housing, access to public funds, and more, can help to ensure patients are provided with the support they need. As part of registration procedures, services could ask patients the question:

"Are there any things that it may be helpful for us to know about which may affect your health, wellbeing or experience of care? This may include that you lead a nomadic way of life; you don't have entitlement to specialist care; you are currently in receipt of benefits, you may not be able to commit to appointments far in advance because of shift patterns and so on."

It should be made clear to patients that this information will not affect the care they receive in any way within the service but will instead provide the opportunity to best support the patient based on wider circumstances and needs.

Ensuring access to all services: Registration

Barriers when attempting to register for primary care services are a major issue for many members of Inclusion Health Groups. Some measures which can improve this include:

- **Ensuring staff are trained in Inclusive Services and registration requirements.**

NOTE: patients are not required to provide a fixed address when registering with an NHS GP, however there is significant evidence of this being used as a basis for refusing registration.

- **Ensuring drop-in services are offered, as well as same day appointments**
- **Offering flexible timing for appointments**
- Ensuring people experiencing **digital exclusion, low levels of literacy or low levels of fluency in English can easily book appointments**, and that **communication preferences** are recorded and adhered to.
- **Providing a range of options** is often the best way to meet multiple complex needs within Inclusion Health groups and the wider community.
- Practices can **declare themselves a ‘Safe Surgery’ for everyone**, ensuring that lack of ID or proof of address, immigration status or language are not barriers to patient registration.

Adapting services for patients with multi-morbidity

Members of Inclusion Health groups are more likely to experience multi-morbidity. Often, services are ill-equipped to support this. Some measures to adapt services include:

- **Routinely offering double or longer appointments for patients with multiple conditions, including mental health diagnoses**.
- Ensure that reception and support staff **record communication needs/preferences at first point of contact** with the service
- **Consider wider non-clinical health needs** such as housing, financial issues and debt etc.

Longer appointment times can allow the time to provide relevant advice, information and signposting. Extra time can also help when supporting patients who experience barriers relating to literacy and language, or who are unfamiliar with NHS systems.

Providing accessible information

Low literacy

- For patients with low literacy, completing lengthy registration forms is an automatic barrier. This can be a sensitive issue: instead of saying "*Can you read and write?"*, staff should say, *"Can I offer you help with filling out the form?"*
- Include verbal communication options when creating content and information for websites and social media.

Low or no fluency in English

- Ensure easy access to interpretation services, and at first point of contact
- Based on understanding of local population need, practices can ensure that hard copy information is available in relevant languages

Digital exclusion

- Ensure that alternatives are always offered, such as providing details for registration over the phone
- People experiencing digital exclusion should have access to the same number of appointments as people who are able to book appointments online
- Ask patients for their contact preferences

Developing targeted services

Different models of targeted service provision:

- **In-reach, and drop-in services in places that people are already attending:**
  Engaging with people in their own communities offers services within your PCN and opportunity to build trust with people rather than expecting initial engagement at a surgery level, especially for patients from communities who often fall through the gaps in traditional appointment systems
- **Outreach services**:
  Many people from inclusion health groups report having poor past treatment. Targeted outreach services can enable services to move beyond a “door open” approach to service delivery. Trust building often takes time and it’s important that outreach services take time to understand the areas in which individuals would like to receive support
- **Multi–disciplinary hubs:** collaborations within PCNs between clinical services and advice or advocacy organisations can enable patients to address clinical health needs at the same time as addressing issues across the wider determinants of health which ultimately affect their health
- **Peer support:** having peers as patient advocates is a proven way to increase engagement with patients from underrepresented groups and can also ensure that patients are offered the right information and support, from someone with lived experience
- **Specialist practices** such as those for homeless communities can support in improving access and outcomes for some inclusion health groups. It is important that these services supplement existing services, and do not replace them.

Developing targeted services with organisations

Homelessness:

Groundswell, Care Navigation

Co-Lab Exeter

Migrants in Vulnerable Circumstances:

Bevan Healthcare CIC

Doctors of the World Clinics

Sex workers:

56 Dean Street, Soho

All Welcome, All East

Spires Streetlink

Gypsy, Roma and Traveller communities:

Friends Families and Travellers

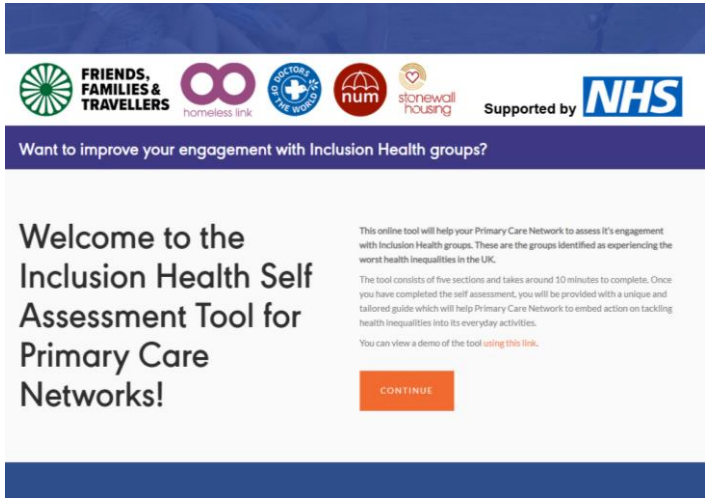
Roma Support Group

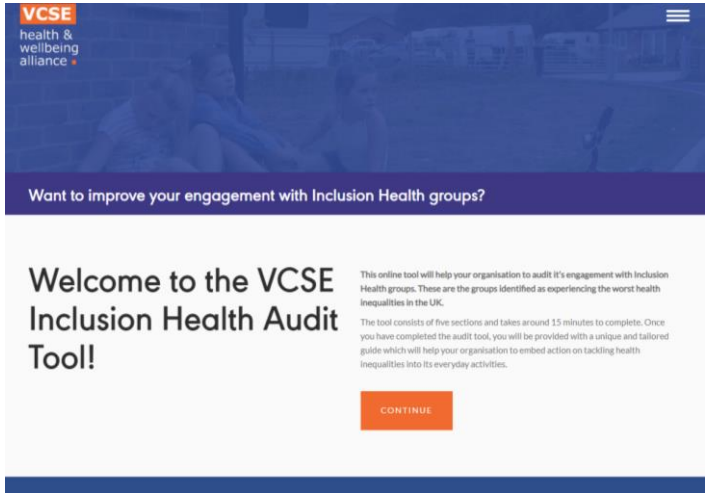
Leeds GATE

Inclusion Health Self-Audit Tool

Inclusion Health Self-Audit Tool

In collaboration with several partner organisations (each representing the perspective of an Inclusion Health Group) FFT produced two self-audit tools for Primary Care Networks (PCNs) and VCSE organisations to assess their engagement with Inclusion Health Groups. Based on PCN responses to the Self-Assessment, we then delivered tailored Inclusion Health Training sessions. The trainings offered an introduction to inclusion health groups, as well as recommendations and principles for developing more accessible services.





Inclusion Health Self-Audit Tool: Outcomes

- 100% of respondents to our evaluative survey of the Tool said **the guidance provided helped their practice with improving healthcare for Inclusion Health groups.**

- Actions taken by PCNs as a direct result of the Tool include actioning **further training**, **updating resource databases**, signed up to **Safe Surgeries training by Doctors of the World**, talks with teams about **further support**, updating **new patient registration forms**.

- Examples of changes as a result of the Tool include offering **double length appointments for Inclusion Health patients** and writing **reminders on patient files if they need interpreters** etc.

Good practice examples

Dedicated Inclusion Health Roles

One recommendation from FFT's Inclusion Health Training advises PCNs to **appoint a named lead to drive forward Inclusion Health** in local Trusts. This person can be an important champion for Inclusion Health in their area.

A named lead can set objectives for local service leaders and practice managers, share good practice across the network, and can highlight key priorities.

One example of this is Lincolnshire Partnership NHS Foundation Trust's creation of a **new specialist Traveller community wellbeing link worker role** – the first role of its kind in the region. This role was funded by the Lincolnshire NHS Charity and **involves working collaboratively with the Lincolnshire Traveller Initiative (LTI).**

This is also a great example of how partnering with local voluntary sector organisations can help to connect with local communities and improve service provision.

Working with VCSE Sector Organisations

NHS Sussex: Digital Inclusion Engagement Project 2021

NHS Sussex funded FFT to gather insight around digital exclusion, via a range of research methods including: questionnaires, 1:1 interviews and focus groups.

FFT produced the following recommendations:

1. To continue the digital access work in West Sussex focusing on supporting communities to access digital services – via CCG funding
2. To co-design tutorials which can be watched on Facebook and WhatsApp platforms instructing how to download apps (including NHS Digital app)
3. To train some digital ambassadors on key sites in West Sussex to become the go-to community members with technical issues

FFT produced a report which was shared with commissioners alongside insight and reports from other contributors about access issues for marginalised communities. **The commissioners took the recommendations on board and launched a digital inclusion project in response.**

Community perspectives:

“I use my smart phone for social media ... I would like the NHS App and tried to verify but gave up in the end - I would like a bit more support to use it”

“I have been asked to do online GP appointment but told them I couldn’t - I wouldn’t know how to do a picture an upload anything - I can do online shopping now I have been shown”

“…I would like the NHS app and to know a bit more about what I can do on the internet - I do feel as if I am being left behind - I am all for learning about it”

What happened next?

Digital Inclusion Project launched to support digitally excluded people in Sussex to become digitally confident and to be able to use the digital healthcare (**NHS App, Online Consultation and NHS 111 Online**).

Activities included:

- one-to-one and group support tailored to the individual and training to develop digital champions within the communities
    - *FFT encouraged community members to become Digital Champions and empowered individuals to become **change agents** for the whole of the community through appropriate culturally focused activities, resources and support that strengthened their skills, abilities and confidence.*
- co-designed film tutorials that can be cascaded throughout communities
  FFT co-produced an NHS App tutorial with Gypsy and Traveller community members viewed in full over 400 times

"This project had a huge positive impact on Gypsy and Traveller community members in Brighton. Through our 'making every contact digitally count' methodology we have empowered and encouraged 115 community members to use digital tools and devices to improve their holistic health and well-being."

Friends, Families and Travellers

FRIENDS, FAMILIES & TRAVELLERS

Thank you

gypsy-traveller.org

FRIENDS, FAMILIES & TRAVELLERS

Ways to contact us

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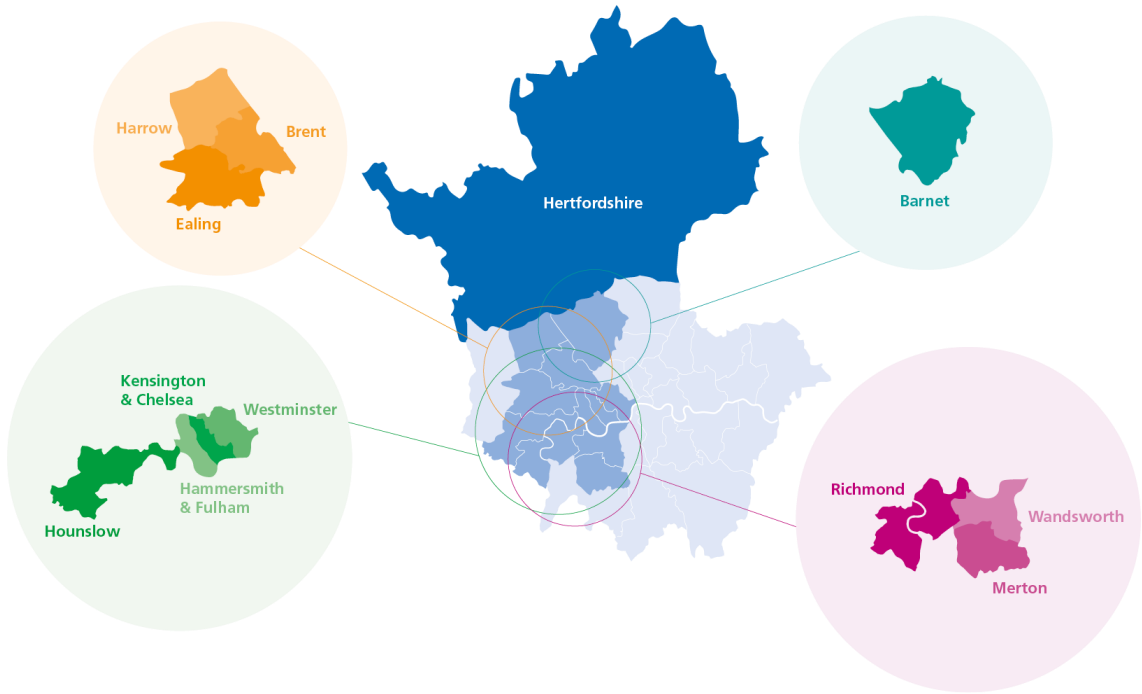
Facebook @FriendsFamiliesandTravellers
Instagram @FriendsFamiliesandTravellers

gypsy-traveller.org

NHS
Central London
Community Healthcare
NHS Trust

Homeless Health Service

Anne McBrearty
Nurse Consultant
CLCH



Why does homelessness matter?

Significant:

- **320,000 people experiencing homelessness** in the UK
- Nearly 5000 rough sleepers on a single night
- **7 'hidden homeless' for every rough sleeper** officially 'counted'

Rising:

- After a dip in numbers during 'Everyone In' - now rising again
- 5000 'new' rough sleepers in London alone (2021)
- Rough sleeping has risen 169% since 2010

Serious:

- Experience **poor health outcomes with high mortality rate**
- Average age of death: **45 years (male), 43 years (female) 2021)**

Homeless Health

Multimorbid - complex physical, mental & social care needs

- 73% physical health problem
- 80% mental health problem
- 66% drug or alcohol problem

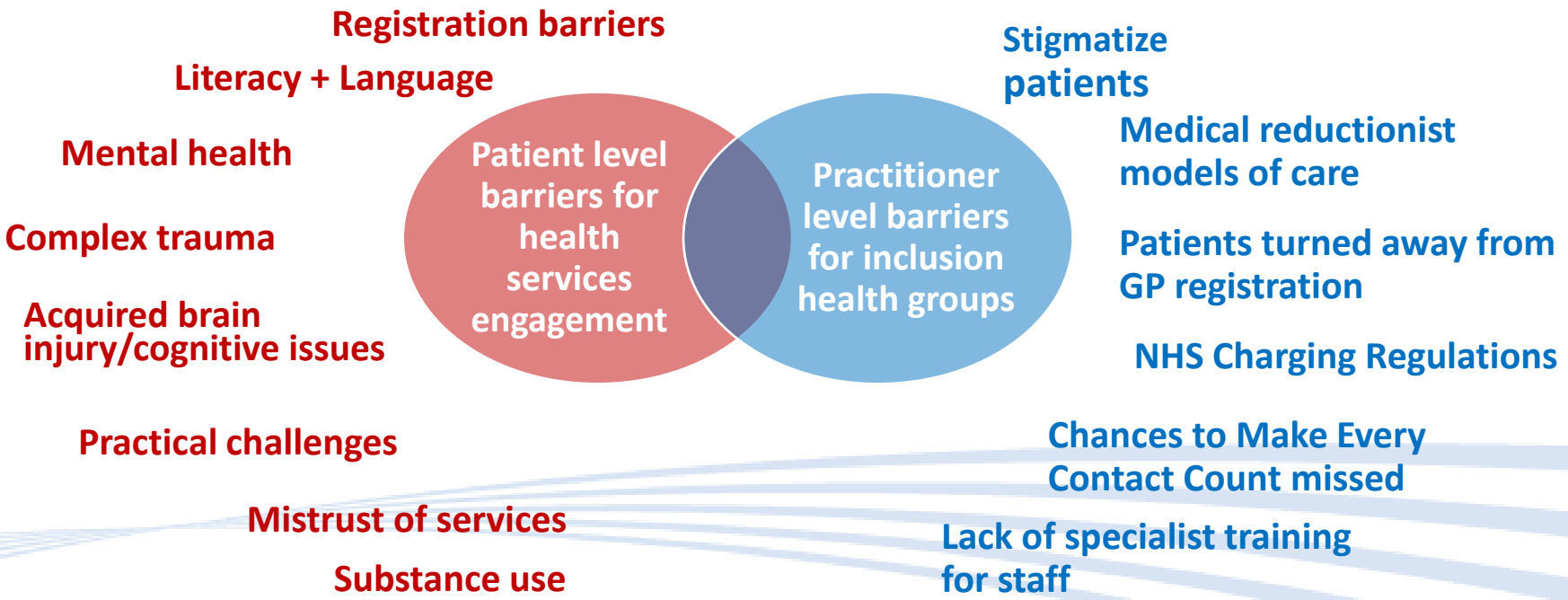
Homeless Health: Social determinants of health

- ACEs
- Poverty and deprivation
- Low resilience
- Low levels of support
- High levels of barriers and rejection

Premature Frailty+ Death

- Rogans-Watson et al
- **Frailty** was identified in **55%** and **pre-frailty** in **39%** hostel population
- Comparable to **89-year-olds** in the general population
- The average of **7.2 LTCs** (range 2–14) per study participant far exceeds the average for even the oldest people in the general population.
- ‘Physiological age’ **30 years older** than chronological age
- Significant for both health and adult social care
- Average age of death: men 45, women 43

Homeless Health: Barriers affecting outcomes



CLCH Homeless Health Service

Clinical Team

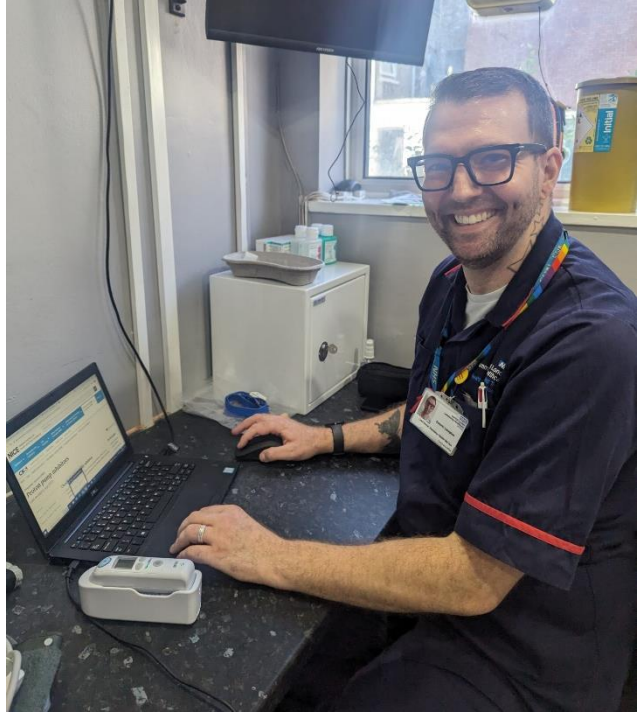
- Nurse led service
- 2 Lead Nurse Practitioners
- 11 nurses working in advanced practice
- 3 counsellors
- 1 health advocate

Boroughs

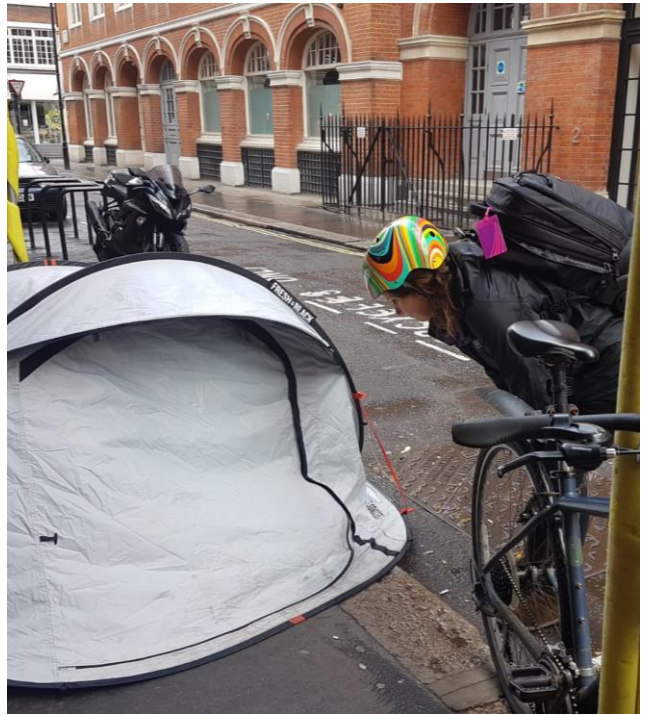
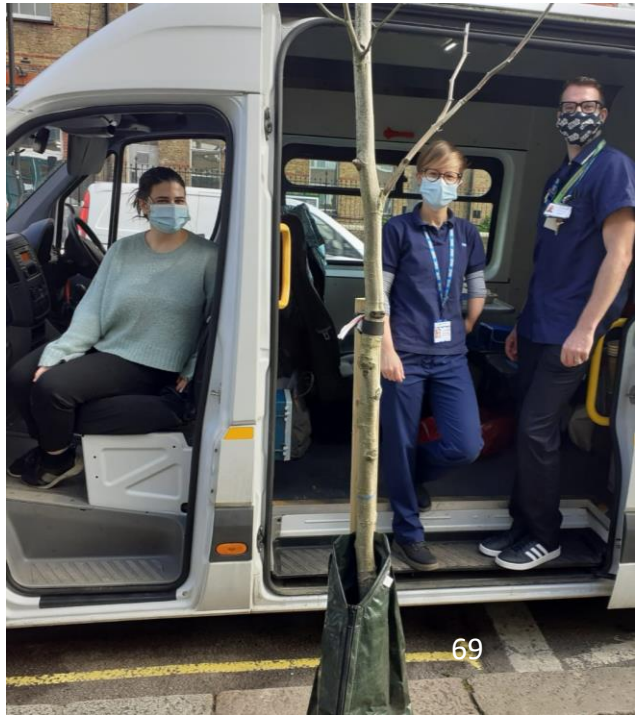
Westminster
- Street Outreach
- Day Centre Clinics
- Hostels
- Specialist GP Practices

H&F
- Hostels
- Temp Accommodation
- Street Outreach

Wandsworth
- Church Drop in Clinics
- Hostels
- South London Refugee Association





Homeless Health Service-a history

- 2002: Westminster, working with people sleeping rough, in day centres only. Joining up of a collection of different services into one
- 2015: H&F, supporting people living in hostels following high number of ambulance call outs
- 2020: Wandsworth, community services came across to CLCH from St Georges.

What we do

- See and treat minor injuries and illness
- BBV screening, wound care, vaccinations
- Case manage people with complex needs
- Pre engagement, building trust, linking people back into the NHS
- Advanced physical assessment, non medical prescribers
- Harm reduction – substance use, Pabrinex, Naloxone
- In reach into hostels / day centres
- Outreach onto the streets
- Teaching / training

Partnership working:
a team around the person

- Outreach teams (St Mungos, SPEAR, Thames Reach)
- Day Centre teams
- Hostel key workers
- Substance use teams (drug + alcohol)
- Peer Advocates / EbE (Groundswell)
- Local authority RS + Housing commissioners
- Drug + Alcohol commissioners
- NWL ICB Homeless Health Programme
- Hospital Inclusion Health Teams

Service development: responding to patient need

- Always adapting our service to meet the needs of people experiencing homelessness, including SWEP, winter accommodation hotels, Crisis at Christmas.
- 2018: street outreach developed to reach those still on the street, not able to access day centres
- 2018: Outreach Prescribing Clinic, joint service with specialist GP, Connections at St Martins, Turning Point and CLCH
- 2018: Rough Sleepers Drug and Alcohol Treatment Grant (RSDATG) funding for additional nurse in Westminster to support complex needs hostels
- 2020: Pandemic / Everyone in Campaign – supporting, triaging people moving from the streets and into hotels. Moving our service to where the patients were, providing clinics within hotels, increased street outreach
- 2021: Covid (+flu) vaccination clinics, primary dose + boosters
- 2021: Out of Hospital Care Team (DHSC pilot) – Tri borough, 3 additional nurses, working alongside St Marys + Charing X Inclusion Health Team, supporting people coming out of hospital and back into the community
- 2022: Westminster reconfiguration of services
- 2022: Development of Clinical Guidelines- Pabrinex for Change Resistant Drinkers, + Freestyle Libre 2 initiation Guidelines
- 2023: Rough sleepers Initiative (RSI) funding 2 additional nurses working with people with Severe Multiple Disadvantage
- 2023: H&F Inequalities Fund, additional nurse to support hostel population + street outreach
- 2023: Wandsworth + Richmond RSDATG, additional nurse to support hostel population + street outreach
- 2023: Out of Hospital Care Team (3 year funding, NWL ICB) Tri borough + Ealing and Brent, working alongside Imperial + LNW NHS Trust Inclusion Health teams, supporting people coming out of hospital and into the community

Patient story

- 38 year old man, poly substance use, deteriorating mental and physical health. Increasing criminal activity- to pay for substances, more time spent sleeping rough vs staying in hostel
- Medical history of liver disease, bilateral leg ulcers, DVT
- MDTs arranged – services struggled to engage meaningfully as patient sleeping rough
- A&E attendance- self discharged due to limited support with substance use, patient felt he was “gotten rid of” rather than helped
- MDT- hospital + community services: more holistic plan in place
- Hospital stay: support with substance use, seen by psych liaison, community drug team, infected leg ulcers treated. “Treated with dignity and respect, all needs met”
- Discharge: Community methadone script arranged with regular collection, fibroscan arranged, regular dressings, supported to see his GP, mental health improved (self- reports), engages with MH team, has plans for detox/rehab.
- Feels that he has been given a “second chance at life

References

- https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsofhomelesspeopleinenglandandwales/2013to2017

Homeless Link Health Audit

- https://www.homeless.org.uk/facts/homelessness-in-numbers/health-needs-audit-explore-data
- Prof Marmot –Marmot Review - Fair Society, Health Lives http://www.parliament.uk/documents/fair-society-healthy-lives-full-report.pdf

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