The Homeless and Inclusion Health Barometer

2024

About Pathway

- Established in 2009, by Professor Aidan Halligan, inspired by the death of a patient facing homelessness who had been discharged to the street from University College Hospital
- Instrumental in establishing the field of inclusion health, and pressing for major improvements such as the recent National Institute of Clinical Excellence guideline
- Our goal is to improve the health and end the homelessness of the most excluded and vulnerable people
- 16 employees and around 1800 people in our wider networks (the Faculty for Homeless and Inclusion Health)
- Entered into a strategic partnership with Crisis, the UK homelessness charity, in 2021

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Crisis
Together we will end homelessness

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How we work

We operate in different ways across the system to drive change

Supporting the delivery of our network of Pathway teams, multi-disciplinary teams based in NHS hospitals

Influencing national policy to drive progress on homeless and inclusion health at system level

Working with places and local systems. Our work with Integrated Care Systems aims to boost the priority of homeless and inclusion health locally and provide them with support to provide better services

Co-production with colleagues with lived experience

Running the Faculty for Homeless and Inclusion Health, providing peer support, networking, professional development and a way to share good practice.

Developing research and best practice, building on our solid track record in driving clinical practice and evidence of need and effective approaches

Methodology

Literature

A rapid scoping review of recent literature on inclusion health, identifying 85 UK-based research reports from the previous two years.

Spotlight

Analysis of key public health data presented in this analytical tool developed by the Office for Health Improvement and Disparities (OHID).

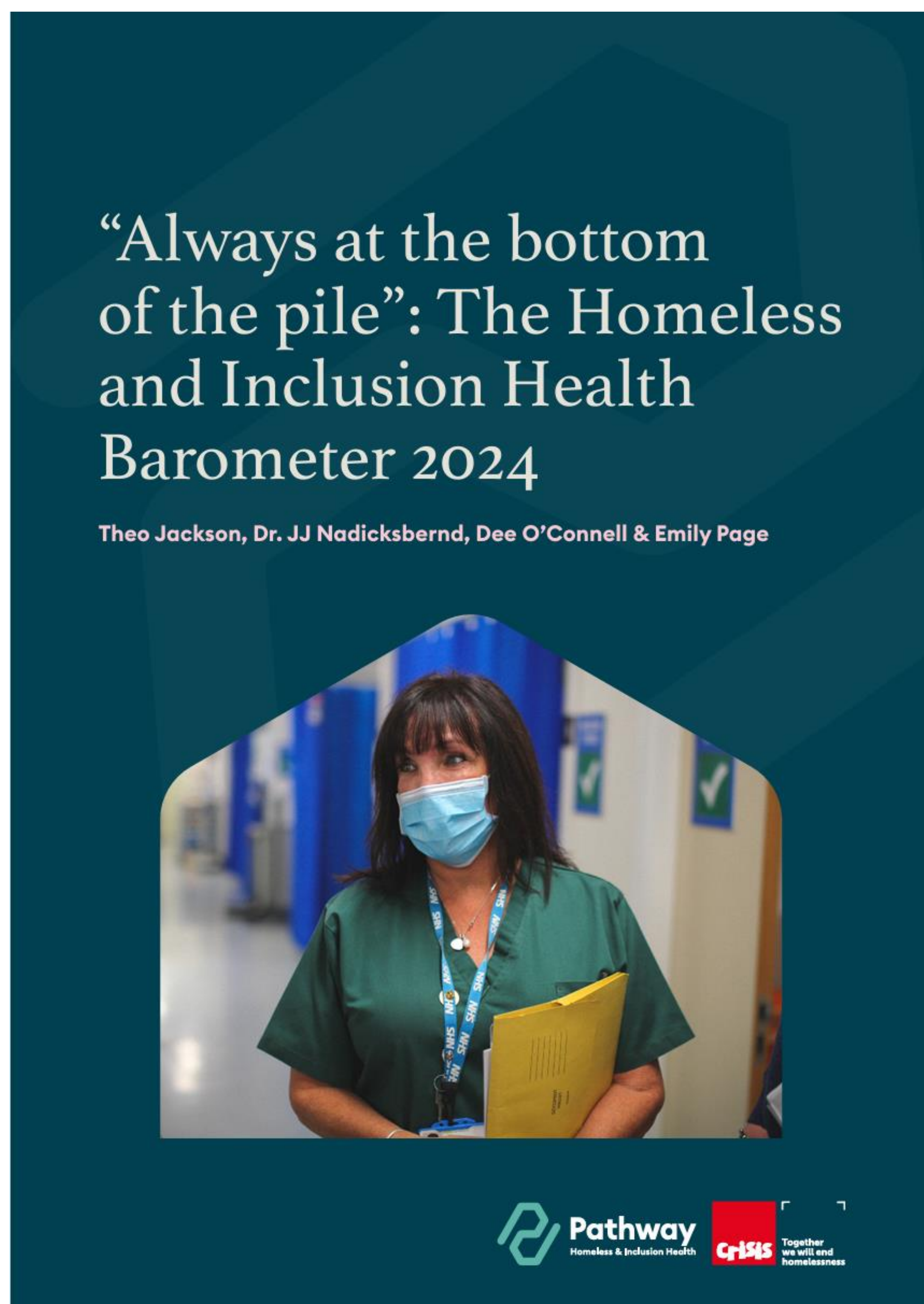
Pathway Needs Assessments

Analysis of 16 Pathway health needs assessment reports, covering 23 NHS Trusts. These studies employed mixed methods approaches to examine how hospital systems provide care, manage, and discharge people experiencing homelessness.

Faculty of Homeless and Inclusion Health Survey

A cross-sectional, mixed methods online survey to capture the perspectives of the Faculty of Homeless and Inclusion Health. 156 people in England completed the survey, representing people working in mainstream and specialist health services, and those in commissioning and managerial roles.

The Homeless and Inclusion Health Barometer



Objective – a robust annual review of the state of inclusion health services and populations in England

- **Started life as a synthesis and analysis of recent publications and research on inclusion health – no other publication had done this in the UK.**
- The findings drove us to take a more strident approach in the document and surrounding communications – we couldn't ignore the overwhelmingly bleak picture.
- Produced by Pathway staff, with oversight from a steering group with Crisis, academia and other specialist charities.
- Launched at our international conference in March 2024.

A word about the UK health system

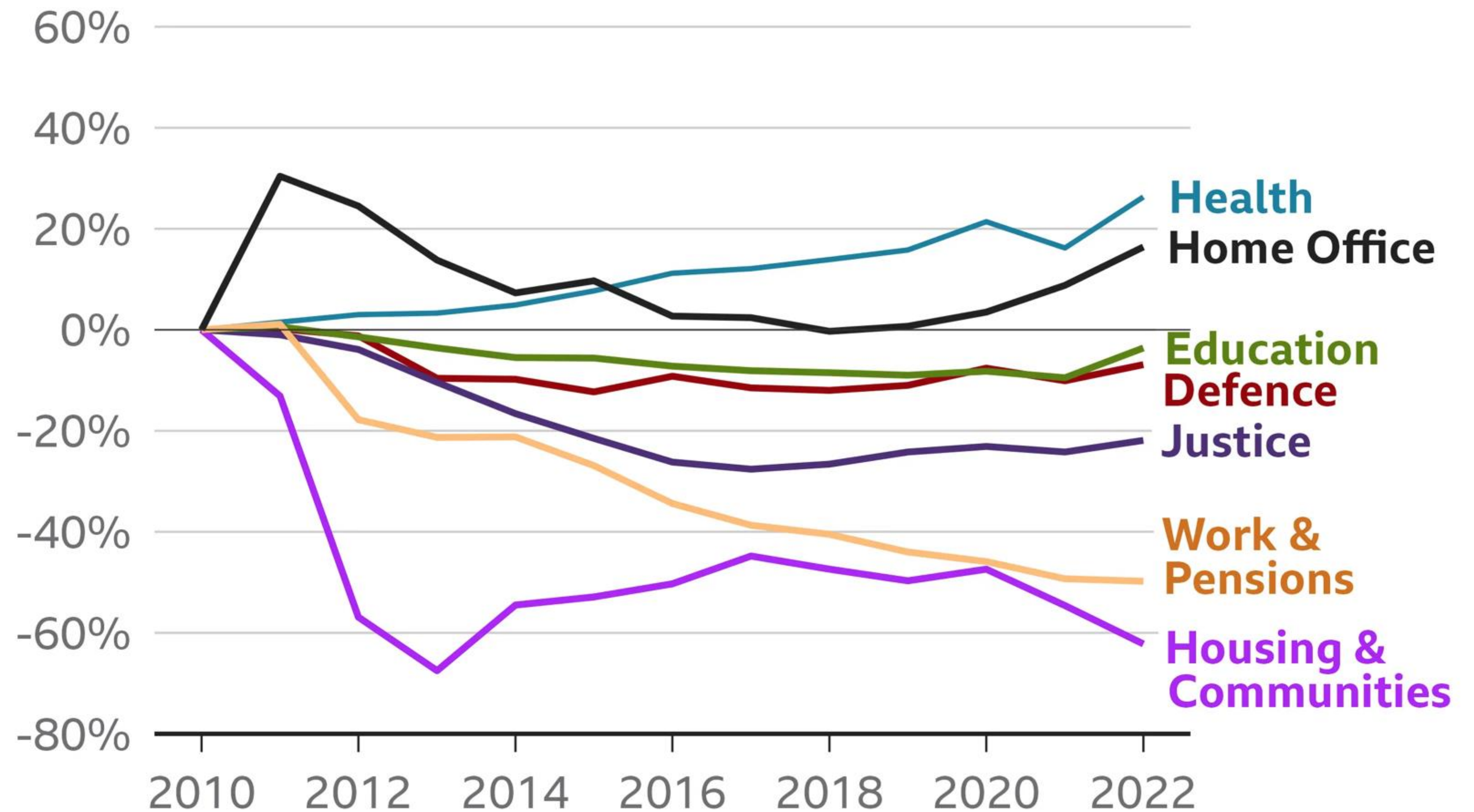
- Healthcare in the UK is delivered through the National Health Service (NHS).
- a complex system of organisations working together, rather than a single entity.
- Management is devolved, but central Government funds it directly and has some directive powers.
- Still based – in theory - on the founding principle of healthcare provided on the basis of needs, free at the point of delivery.
- Policy developments and funding choices since 2010 have undermined these principles, f for example making access harder for some migrants.

Primary Care
Secondary Care
Community and Mental Services

Crisis in the NHS and housing is the backdrop to our findings

- Around 6.39 million people are currently waiting for treatment because of the backlog in hospital care.
- Public satisfaction with the NHS has reached record lows in recent years, with many in the general population struggling to access care.
- The UK faces a deep housing crisis. Rising rents, LHA freezes, changes to housing benefits, and the benefit cap have all drastically reduced the affordability of renting. There is also a basic lack of sufficient social-rented and affordable housing.
- 'Core homelessness' reached 242,000 in 2022 (Crisis). Between July and September 2023, 109,000 households were living in temporary accommodation, which has almost doubled in the last ten years. (DLUHC)

A decade of austerity



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The UK policy context has exacerbated this situation

Government policy choices adversely affected the social determinants of health and access to healthcare:

- The 'hostile environment', especially no recourse to public funds
- We are losing more social homes than we are building
- Lack of serious action to tackle the root causes homelessness
- Welfare policy that does not address the cost of living crisis

This makes it almost impossible for dedicated policy interventions on health inequalities to make a meaningful difference:

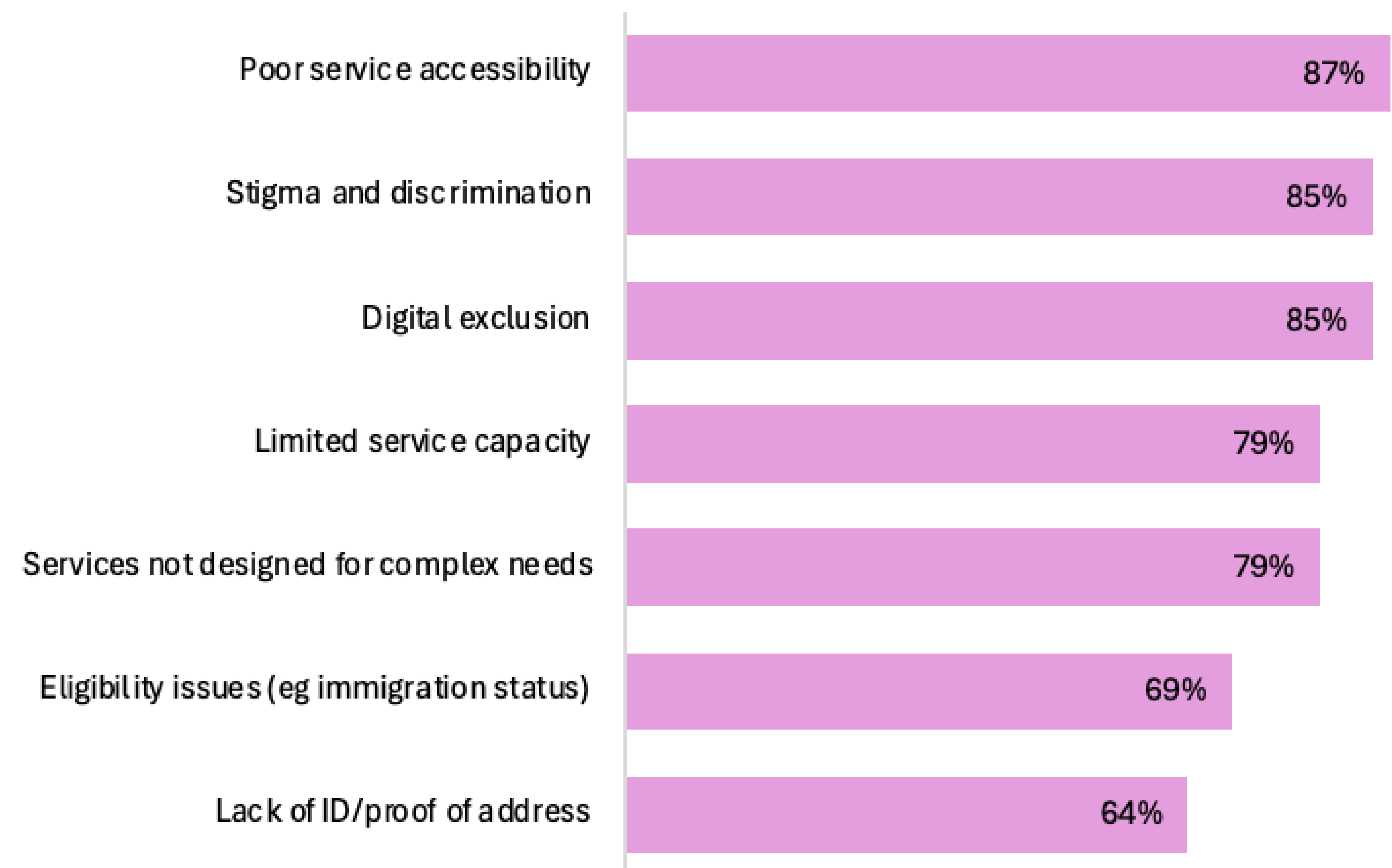
- NHS England's Core20Plus5 framework
- NHS England Inclusion Health Framework
- The Health and Care Act 2022, and the establishment of Integrated Care Systems – with legal duties on health inequalities

“Pressures on the NHS means services are even less flexible when people don’t attend, arrive late, or exhibit difficult behaviour.”

GP, Specialist Practice

This context creates barriers to care for people in inclusion health groups

- Despite pockets of good practice, these pressures are driving inflexibility in services, the opposite of what the evidence says is needed.
- They are also driving service higher thresholds, meaning people don't get care until they reach crisis point – when their needs are more complex and opportunities for prevention have been missed.
- A shift to digital services exacerbates this, further locking out people who are digitally excluded.



Stigma and discrimination are major barriers to both access and quality

- People with lived experience described stigmatising and discriminatory experiences (Pathway needs assessments). This included being treated differently to others, left until last to be seen and receiving rude communication from healthcare staff.
- Much of the research shows these attitudes and behaviour are underpinned by lack of understanding.
- The research and survey found this had an impact on the quality of health and social care people received, across adult social care, mental health services, A&E, in-patient care and discharge among others.
- Importantly, people's own awareness of this stigma affects their engagement with care.

The widespread nature of these issues point to system failure

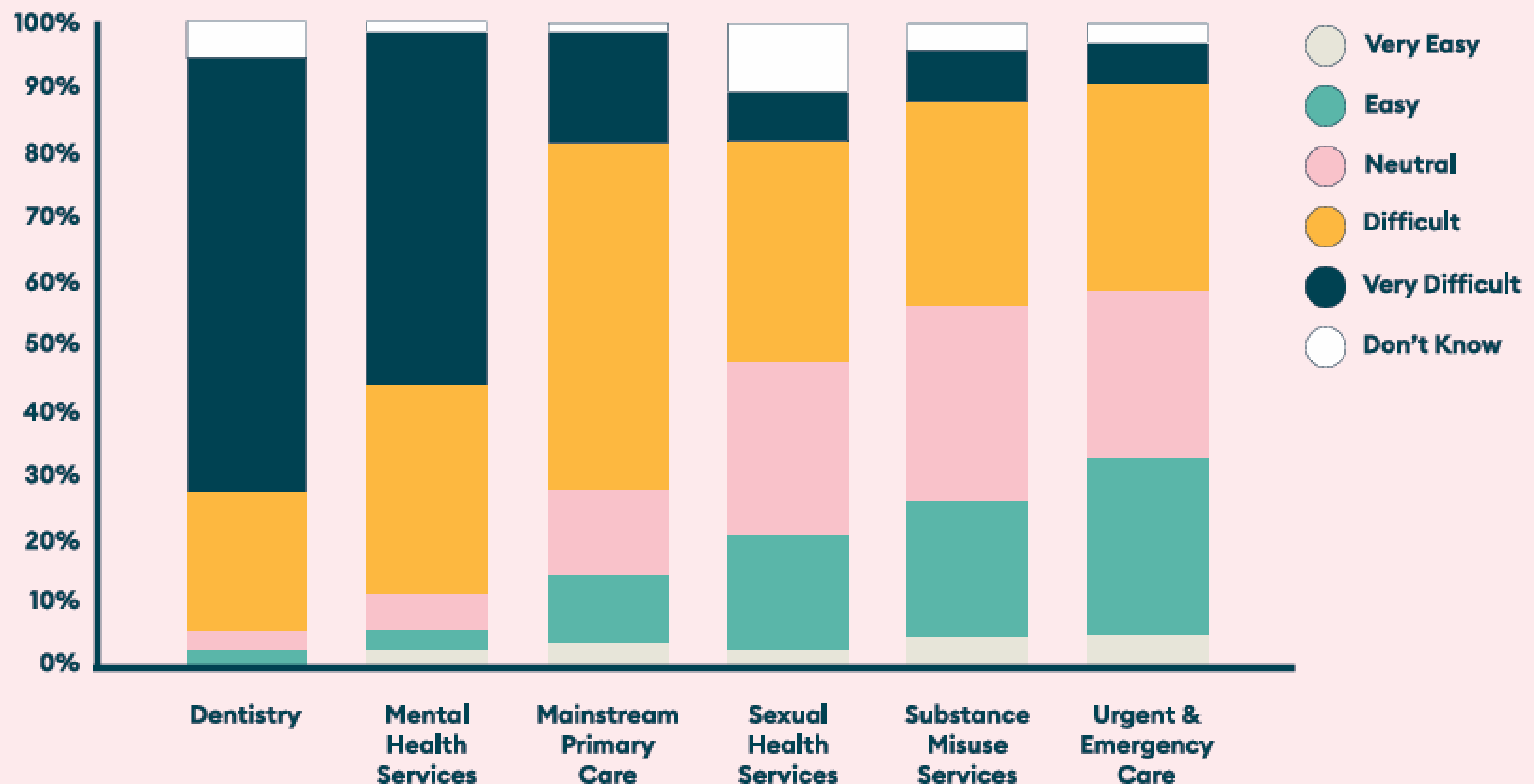


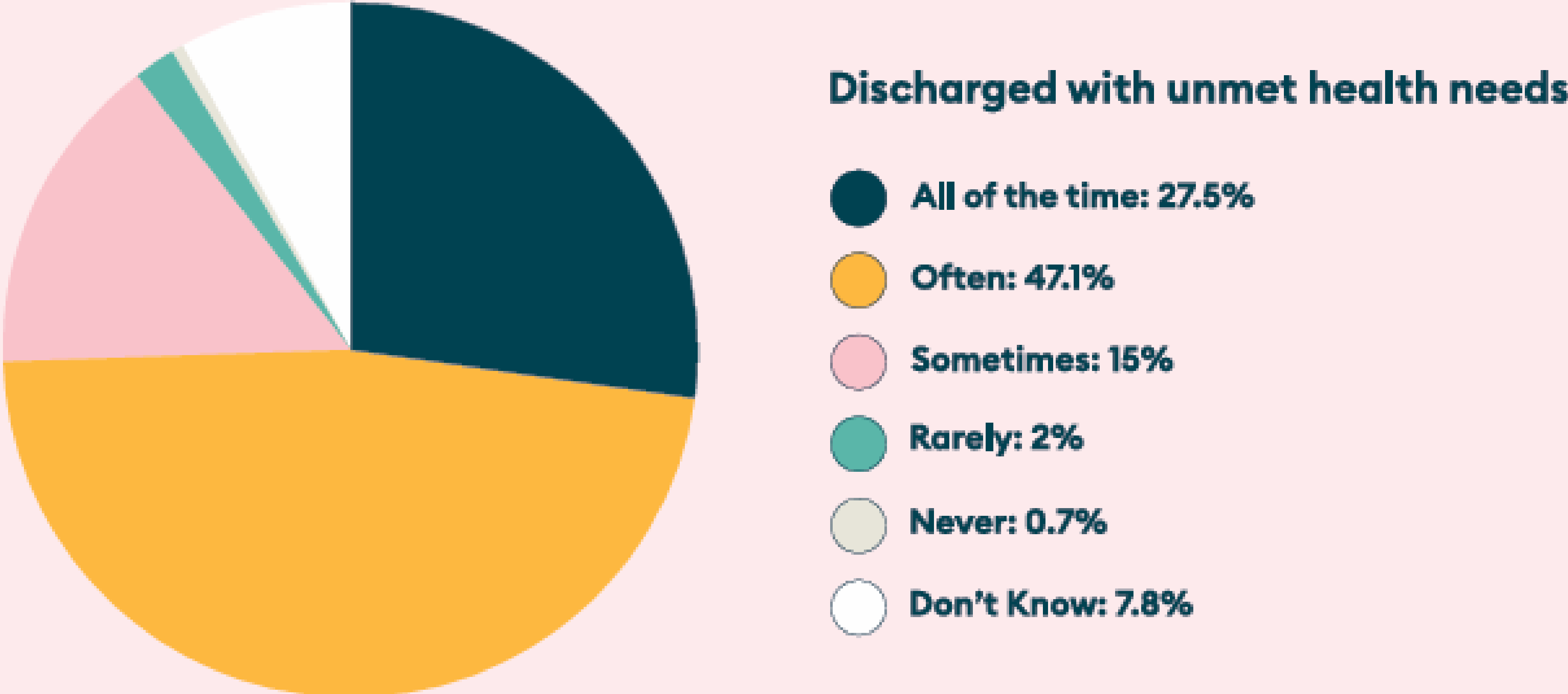
Figure 2.2: Ease of service access to mainstream healthcare services for people in inclusion health groups.
Source: Faculty Survey n=156

on Health

“Safeguarding concerns are only dealt with in a timely manner if there is professional shouting from the rooftops.”

Mental Health Practitioner,
Specialist Substance Misuse Service

Hospital discharge outcomes for people in inclusion health groups



Discharged to the street

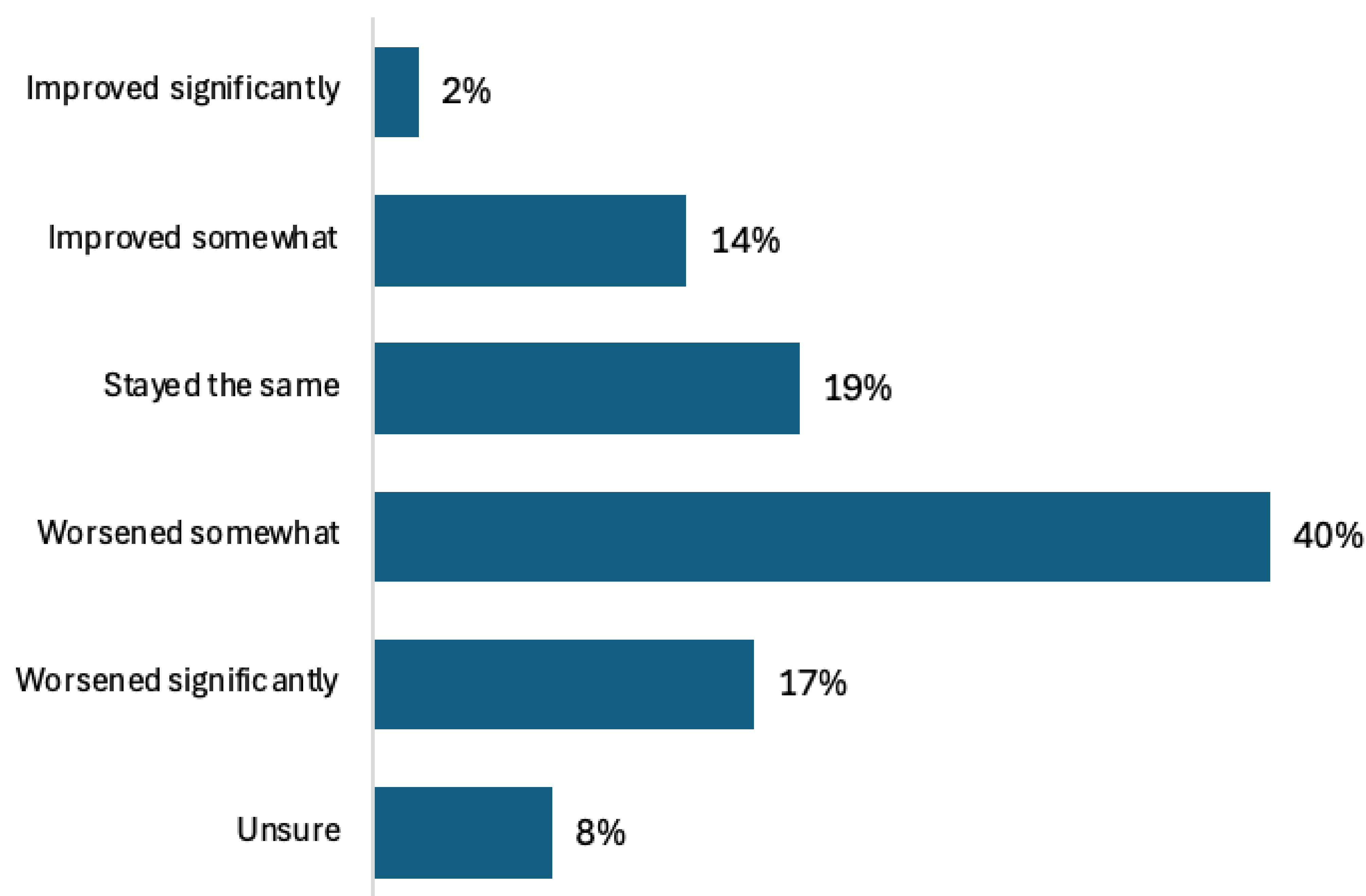
- All of the time: 13.7%
- Often 35.3%
- Sometimes: 26.8%
- Rarely: 9.2%
- Never: 0.7%
- Don't Know: 14.4%

Figure 2.4: Hospital discharge outcomes for people in inclusion health groups
Source: Faculty Survey n=153

These problems lead to unsafe practice and ultimately cost lives

- Just 5% of Faculty respondents said there was enough intermediate care for patients in inclusion health groups
- Safeguarding research shows practitioners do not complete full assessments on risk and capacity, as well as care and support needs and do not make use of the full extent of the law
- Lack of awareness among social workers about self-neglect and homelessness, according to one study.
- The ONS reported 741 deaths of people facing homelessness and is considering the cessation of these statistics.

Outcomes are poor and getting worse



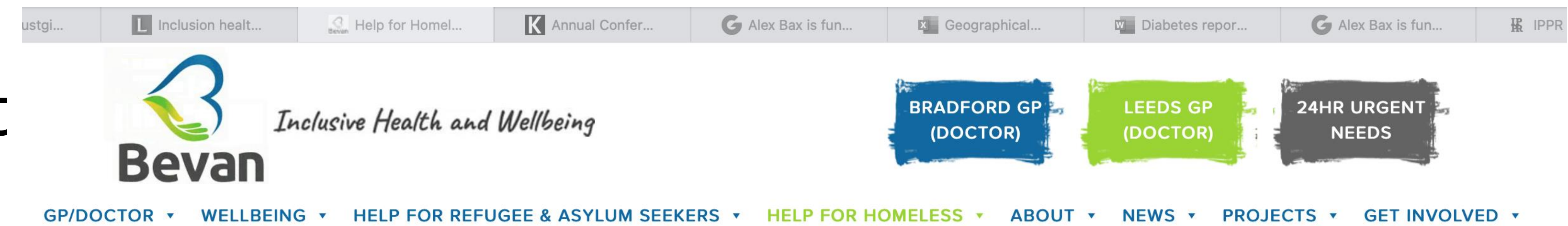
- The research shows significant multi-morbidity. For example, 20.5% of White Gypsy/ Irish Travellers having at least two long-term conditions, compared to 13% of the general population (Spotlight)
- 29% of people facing homelessness have between five and ten health conditions (HHNA)
- Trauma and poor and isolating living environments are driving poor mental health among asylum seekers.

“We do our best and have things to celebrate but we are simply tinkering with the shop window. There is very little in the shop itself.”

GP, Specialist Practice

Relationship between specialist and mainstream services demands system-wide reform

- There is growing evidence about the relatively greater efficacy of specialist inclusion health services.
- Half of Faculty members said provision had improved in past three years but pointed to major gaps between services and needs.
- Specialist services are vulnerable, often operating on short term funding.
- Research shows that the extent to which these services achieve positive outcomes for patients is constrained by the challenges that people in inclusion health groups face when accessing support from mainstream health, housing and social care services.



HELP FOR HOMELESS

REGISTER WITH A BEVAN GP

HOSPITAL TEAM

STREET HEALTH TEAM

WHAT IS HOMELESSNESS

WELLBEING HEALTH & RESOURCES

ACCESSING NHS CARE

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Poor and precarious housing drives poor health and disrupts access to care

- 80% of respondents said people in inclusion health groups were not getting their housing needs met in a timely manner
- They highlighted extreme difficulties in securing housing for people in inclusion health groups: delayed responses, a lack of housing options, the rejection of referrals.
- Living in temporary accommodation can limit access to essential health services, literature shows. People may be placed in areas far away from the services they were previously using.
- The provision of Housing First remains far below the level of need and there are also gaps in the provision of other kinds of specialist accommodation, such as long-term care placements

Recommendations

1. Government, working with NHSE and ICSs, should increase the availability of specialist primary care, acute hospital, and community services to better meet the needs of inclusion health populations.

2. NHS England should set out clear expectations in its next Operational Planning and Contracting guidance to address the extremely poor experiences and outcomes of inclusion health groups.

3. Integrated Care Systems should assess themselves against the NICE Homelessness Guideline (NG214) and the NHSE Inclusion Health Framework, and to act accordingly.

4. The Care Quality Commission should assess ICSs for action on inclusion health groups.

5. All NHS hospital trusts and General Practices should assess how far their frontline services deliver trauma-informed care and put improvement plans in place.

6. Over the long term, Government should put in place a plan to increase the supply of social rent homes to meet current and future need – 90,000 new social rented homes in England per year for the next 15 years.

Homelessness and Inclusion Health Data in the United Kingdom

Challenges and Opportunities

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Why is good quality healthcare data important?

- Understanding the size of the homeless/inclusion health population, nationally and locally
- Understanding the healthcare needs of inclusion health groups
- Understanding how inclusion health groups use/interact with healthcare services
- Effective service commissioning
- Effective policy development/planning

1) Poor data sharing between services

What are the issues?

- Issues with GP access (eg being refused for lack of ID) results in incomplete and fragmented care records
- Systems lack interoperability meaning that healthcare information is not shared effectively across different services
- Information sharing agreements and information governance can be challenging
- Data sharing between health and non-health is difficult due to lack of shared identifiers

What is the impact?

- Complex health needs and transient lifestyles mean that people in inclusion health groups need to access mutliple services
- Poor quality of care, lack of care coordination
- Missed opportunities for preventative healthcare
- Re-telling stories can be re-traumatising
- Inefficient and poor quality delivery of healthcare

2) Invisible in the data, invisible to decision makers

What are the issues?

- Identifying patients from inclusion health groups within healthcare data is very challenging. For example;
- Gypsy, Roma, Traveller ethnicity code, refugee/asylum seekers codes are not used, despite being available
- No indicators for vulnerable migrants, people who are sex working – issues around stigma and identification
- No standardised indicators for homelessness across the health system
- Accommodation status/housing fields are not standardised across different healthcare settings

What is the impact?

- Limits ability to understand and evidence population size, characteristics, health needs, use of healthcare services – challenging for national and local commissioning, policy development
- Limits ability to evidence the problems – challenging for wider policy and influencing work
- Limits ability to understand mortality rates within the population in real-time – current modelling likely underestimates

What work has been done?

- Standardised list of housing fields – applied to Emergency Care Dataset and working to get into the Mental Health Dataset – however, completion rates are low
- 'Homeless Health' templates in EMIS/SystmOne (primary care and hospitals) - collecting the same data
- Coordinate My Care (Bristol) - linked care records across hospital, primary care, mental health, substance missue, hostels within the region
- Homelessness Data England Project – linking data across housing, health, education and criminal justice datasets

Further considerations

- Training is needed for healthcare staff to 'ask the right questions', understand why it is important to record (eg) homelessness
- Stigma – due to poor experiences, people may be hesitant to disclose information on housing status, immigration status, sex working, due to fears of being labelled and stigmatised
- A lack of top-down ownership and responsibility?

Whose responsibility???

Conclusions

Data issues limit effective healthcare delivery, service commissioning and policy development

Stigma and training are key facilitators to improvements

Improvement is limited by a lack of ownership, despite some solutions being available

Thank you

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Our 14th International Homeless and Inclusion Health symposium takes place in London on March 12 and 13 2025

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