Royal College of General Practitioners

inclusion health

Improving access to health care for Gypsies and Travellers, homeless people and sex workers

An evidence-based commissioning guide for Clinical Commissioning Groups and Health & Wellbeing Boards

RCGP Clinical Innovation and Research Centre (CIRC)

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HYMS
THE HULL YORK
MEDICAL SCHOOL

UNIVERSITY OF BIRMINGHAM

Improving access to health care

In memory of Helen Lester (1961 – 2013)

'In areas with most sickness and death, general practitioners have more work, larger lists, less hospital support, and inherit more clinically ineffective traditions of consultation, than in the healthiest areas [...]. These trends can be summed up as the inverse care law: that the availability of good medical care tends to vary inversely with the need of the population served'.

(Julian Tudor-Hart, 'The Inverse Care Law')

'In a better society, [...] many of the medical problems now present would not exist. I like to think that there might even be fewer doctors, fewer social workers and do-gooders because good would be done by itself'.

(David Widgery, Preserving disorder: selected essays 1968-88)

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Improving access to health care

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Foreword by Dr. Clare Gerada

Forty years after GP Julian Tudor-Hart developed his concept of the 'inverse care law' to describe the unfair distribution of access to good medical care, it is disappointing and disheartening that some patients are still falling victim to a 'postcode lottery'.

Whilst life expectancy and a range of other health indicators are improving for the wider population, recent research has shown large disparities across particular social groups, with travellers, homeless people and sex workers among those with the worst outcomes.

As well as being ethically wrong, this also comes at an enormous social and economic cost.

Under the Health and Social Care Act 2012, commissioners of healthcare services now have a duty to reduce health inequalities in access to services and outcomes. This provides us with an opportunity to distil what we already know about the health needs of forgotten and disenfranchised groups, to share best practice and support new commissioners in complying with their health inequalities duties.

There are many different models across a variety of care settings for achieving this, with no one size to fit all. There are also many good examples of how this issue has already been addressed successfully in different settings, including the London Pathway for homeless people at University College Hospital in London, Brighter Futures in Stoke-on-Trent or the Luther Street Surgery in Oxford.

It would be unrealistic to expect every commissioner to make all services available in one area, so we are proposing a three tier framework, based on the model of caring for patients with substance abuse issues.

This recommends that the direct provision of services should be proportional to the number of users in a certain area and provides support ranging from generalist to highly specialist services like dedicated hospital pathways.

Whilst this guide is primarily intended for Clinical Commissioners in England, we hope it will also prove useful to other providers, policy makers, third sector organisations, as well as the devolved nations.

Perhaps most importantly, we hope it will be an important step towards redressing the balance and delivering fair access to safe care for all our patients, regardless of their circumstances or where they live.

Dr Clare Gerada MBE MOM FRCPsych FRCGP FRCP
Chair of Council
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Foreword by Prof. Steve Field

With the implementation of the 2012 Health and Social Care Act, we have a unique opportunity to try to get things right, and break the circle of exclusion for some of the most vulnerable in society.

Specifically, the data shows that, in a context of general improvement, health outcomes for some groups are still significantly worse than for the rest of the population, and the gap is growing. This is not only morally wrong, but it also comes at an enormous human and social cost.

In this changing landscape, with GPs becoming commissioners as well as providers of care, we need to make sure that some of the most vulnerable in society remain high on the agenda.

The RCGP's Commissioning Guide for Gypsies and Travellers, homeless people and sex workers provides a very useful introduction to the needs of these patients, as well as a vast range of good practice case studies and sources of further information. In particular, sourcing the right information for the Joint Strategic Needs Assessment will be crucial to make sure those 'invisible' patients will finally be seen.

Together with the other publications of the National Inclusion Health Board, this report is part of the evidence and knowledge base we are setting up to help commissioners and providers to address the unmet needs of these patients.

I would encourage every commissioner and member of frontline staff working with vulnerable patients to read this guide, consider following the suggested steps and making some of the services reviewed available to their local populations. This would not only help to narrow the gap, but it would also greatly improve the functioning of our system as a whole.

Steve Field

Prof. Steve Field CBE FRCGP FFPH FRCP
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DEFINITIONS

• **Social exclusion**: Silver (2007) has defined it as a process, 'detaching groups and individuals from social relations and institutions and preventing them from full participation in the [...] activities of the society in which they live'. More recently, it has been looked at as a dynamic concept, consisting of social processes that create inequalities in power, resources, and ultimately, opportunities (Popay, 2012)

• **Social determinants:** the World Health Organization (WHO) describes them as 'the conditions in which people are born, grow, live, work and age'

• **Health inequalities:** the 2008 WHO Report defines them as 'the differences in health status or in the distribution of health determinants between different population groups'. Across social groups, they reflect an unfair distribution of the underlying social determinants of health (Kawachi et al., 2002)

• **Gypsies and Travellers:** persons with a cultural tradition of nomadism or of living in a caravan, and all other persons of a nomadic habit of life, whatever their race or origin (Housing Act, 2004)

• **Homeless people:** the concept of homelessness is often referred to as a continuum. This ranges from statutory homelessness, where temporary accommodation, often in the form of unsuitable B&B lodging, is provided whilst waiting for housing by local authorities, through to rough sleeping and overcrowded or unfit for purpose accommodation, and people towards whom local authorities do not have a statutory duty (Homelessness Order 2002, EIRE Homeless Agency, 2009). Particularly in the case of migrants, the phenomenon of homelessness is often exacerbated by the inability to recur to public funds in the form of housing benefit. More broadly, it defines someone who is roofless, houseless or in insecure or unsuitable accommodation (Homeless Agency, 2009)

• **Sex workers:** refers to male or female workers offering sexual services in exchange for some form of payment, usually money or drugs (Home Office, 2004)

ABBREVIATIONS AND ACRONYMS

- **CCG:** Clinical Commissioning Group
- **CQC:** Care Quality Commission
- **DH:** Department of Health
- **EDS:** Equality Delivery System
- **GP:** General Practitioner
- **GPwSI**: General Practitioner with Special Interest
- **HWB:** Health and Wellbeing Board
- **HWBS:** Health and Wellbeing Strategy
- **JSNA:** Joint Strategic Needs Assessment
- **LA:** Local Authority
- **LAT:** Local Area Team (of the NHS Commissioning Board), now NHS England
- **LES**: Locally Enhanced Service
- **NHSCB:** NHS Commissioning Board, now NHS England
- **PCT:** Primary Care Trust
- **PH:** Public Health
- **PHE:** Public Health England
- **RCGP:** Royal College of General Practitioners

Acknowledgements

Executive summary and key messages

Executive summary

The Royal College of General Practitioners' (RCGP) Clinical Innovation and Research Centre (CIRC) has undertaken the production of this Social Inclusion Commissioning Toolkit for the commissioners from Clinical Commissioning Groups (CCGs), Public Health England, Local Authorities (LAs) and NHS England (formerly NHSCB). It is aimed at widening access to health services and contributing to improving the health outcomes of marginalised groups, by looking specifically at homeless people, Gypsies and Travellers, and sex workers, given their particularly poor health outcomes. This decision reflects the priority groups identified by the national Inclusion Health Board, and is in line with the government priority of proportional universalism and 'improving the health of the poorest fastest', as recommended in the Marmot Report *Fair Society, Healthy Lives* (2010).

This guidance is part of the Department of Health's Inclusion Health programme of work, and it links with the Inclusion Health working groups on Data and Research; Leadership and Workforce; Provision, Prevention, Promotion, and Assurance and Accountability. It has been written primarily for the English context, but many of the issues and recommendations will be equally relevant to systems in the devolved nations.

With local CCGs and Health and Wellbeing Boards (HWBs) taking on their statutory responsibilities from April 2013, this provides a unique opportunity to embed the reduction of health inequalities amongst these groups in local commissioning strategies.

This practical guide is designed to support CCGs, LAs and HWBs to commission health services in ways that improve health outcomes for the most vulnerable groups. Whilst local authorities will lead commissioning on the public health side, CCGs will take responsibility for leading the commissioning of specialist and enhanced general health services for these patients.

This guide aims to provide professionals with the following:
- an overview of the health needs of these three vulnerable groups in society
- practical support to help commissioners to build the understanding of local needs into the Joint Strategic Needs Assessment (JSNA) and Health and Wellbeing Strategies (HWBS)
- sample models of how services can meet needs to inform commissioning and local service provision, looking at both health-only and more holistic initiatives

Key messages

1. Patients need a holistic approach, as they are not experiencing their needs in isolation. Mental health, substance misuse and general health issues occur simultaneously with social and environmental needs
2. HWBs will need a designated Director-level lead to direct the work on social exclusion, ideally with clinical, commissioning or public health experience
3. There is no 'one size fits all' approach, but as commissioning should be evidence and needs-based, services provided in an area should reflect the epidemiological profile and the level of need in the local population
4. Access remains a crucial issue for socially excluded groups, especially for primary care as the system gatekeeper
5. The role of the 'trusted individual' is invaluable to enable the 'bridge-building' and navigating work carried out by health and voluntary sector organisations working with excluded, high-need clients
6. The variable standards of local provision and the fragmented working of the different agencies involved

further complicates access for patients and makes tracking difficult

7. Multi-disciplinary working should be encouraged from the beginning of clinical training, by stressing social inclusion aspects in formal education, as well as through secondments or volunteering
8. There is a need to systematically capture and share examples of good practice and success stories, as there are strong examples of creative and effective provision of services
9. Building capacity in the community is a valuable element of working with excluded groups, as it simultaneously engages these communities, and creates social and human capital as well as skills
10. Radical changes are needed to ensure that the personalisation and patient choice agenda cover excluded groups
11. Outreach work is often the first, most important step in re-connecting the system with the user
12. Provision of intermediate care is variable, but it is crucial to ensure sustained recovery after hospital discharge

KEY FINDINGS

Overarching

Under the old commissioning arrangements, there was a wide range of services providing for the health, social and wider wellbeing needs of socially excluded groups. These were commissioned by a network of organisations including legacy PCTs, LAs and other grant-awarding bodies, through a variety of funding sources, including primary care, public health, voluntary sector and other grants.

With NHS England being unlikely to use its powers to commission Locally Enhanced Services (LES), in line with the localism agenda, it is clear that the intention is to retain discretion at local level in order to allow the set up of additional services to meet specific local needs (NHSCB, 2012).

Primary care

As outlined in the Health and Social Care Act 2012, primary care will be commissioned by NHS England, rather than CCGs. Nevertheless, the latter will commission secondary care and a range of specialist services on behalf of their population, and support quality improvement developments, as well as retain some level of discretion around local initiatives. CCGs will also be an integral part of local Health and Wellbeing Board (HWB), with their colleagues from LAs and NHS England. Also, whilst many specialist services will be commissioned jointly with LAs, ideally at a HWB-level, CCGs will remain responsible for the health element of funding for the service. As a result, CCGs will play a crucial role in agreeing the priorities for the local area, and are most likely to have a degree of autonomy in determining the services made available to reflect the needs of the local population.

Some LES agreements linked to Public Health funding will follow the move of Public Health departments and become the responsibility of LAs. These include Sexual Health, Health Promotion, Smoking Cessation, Alcohol and Substance Misuse Services.

The role of primary care is now even more pivotal, as in addition to determining local priorities, it also acts as gatekeeper to the system and it is the main point of contact with the patient. As a result, it is particularly important for patients to have timely access to primary care, and action should be taken to resolve recent confusion around GP registration and eligibility.

Key findings

Secondary care

This area will be directly commissioned by local CCGs, and it is important that any decisions are informed by an adequate and encompassing understanding of the needs of the local population, including seldom heard and excluded groups.

Whilst access to secondary care is often seen as an area of less concern than primary care, and the main issues identified mainly relate to cultural sensitivity, the admission and length of stay patterns for members of socially excluded groups are showing an underlying problem. These patients are admitted more often, stay longer and are re-admitted more frequently. This highlights a number of issues further upstream: that these patients struggle to access other services, and therefore they turn to secondary care, and that they are sicker and do not receive the same quality of care as other patients, particularly when looking at discharge arrangements.

This situation needs to change: no one should have to go to hospital to seek care they could receive in other settings. This is much more expensive than other arrangements, takes up resources from more needy patients, and it also increases the risk of hospital-acquired infections.

One of the key areas of concern across the different groups is the lack of suitable intermediate care solutions following discharge from hospital. In fact, the absence of appropriate step-down solutions has a negative impact on patient outcomes and there is a need to ensure that patients are linked up with the appropriate supporting services. In addition to this, early small scale pilots have proven to be cost-neutral, offsetting the costs with vast reductions in costly hospital readmissions and ambulance call-outs (Hendry and Dorney-Smith, 2009).

Community and voluntary sector

After most of the funding for community interventions was previously held by PCT Public Health Departments, in line with the requirements of the 2012 Health and Social Care Act, from April 2013 these have become an integral part of LA responsibilities. Services affected by this include Community Development Interventions, Alcohol and Substance Misuse Services, Smoking Cessation and Health Checks. Whilst the first year is seeing a carry-over of current arrangements, services will have to compete for funding in the future.

The role of the voluntary sector is a crucial and pivotal one in implementing both the social inclusion agenda, and the government's Big Society vision. Voluntary sector organisations act as conduits, building bridges between mainstream services and disengaged users, who are unable or do not want to use the services available. Their input to commissioners helps to make those services more accessible, as well as supporting communities and individuals to build capacity and grow, acquiring new skills and taking on new responsibilities.

In addition, voluntary sector organisations frequently do not just provide advocacy and hand-holding into generalist services, but also deliver specialist services of their own, including outreach, community advocacy and representation, cultural awareness training for public sector staff among others. It is particularly in this role, where voluntary sector organisations have strong links with local communities and their knowledge to provide those services can not be matched by other organisations. For this reason, they are critical in implementing the Big Society Agenda.

The main problems encountered in this sector are excessive service fragmentation and duplication, missing economies of scale, sometimes lack of skills and capacity, short funding cycles and the need for better mechanisms to share good practice.

A simplified, schematic representation of how the different sectors come together, working on providing the necessary services for these patients at a whole health economy level, can be seen below:

Figure 1. A gradual, stepped approach for health services to tackle social exclusion

Specialist Services	Specialist health needs	Specialist services	Gateway services
TIER 3	Non-specialist health needs	Mainstream health	Core services
TIER 2	Structured social and generic needs	One-stop shop	Gateway services, Case management
TIER 1	Generic needs	Signposting, navigation, handholding	Ancillary services, Self management
TIER 0	Assessment	Initial contact	Outreach

CONTEXT - WHY IS THIS IMPORTANT?

Legal obligations

- Under the 2012 Act, the Secretary of State 'must have regard to the need to reduce inequalities between the people of England with respect to the benefits that they can obtain from the health service', which includes both the NHS and Public Health England.
- NHS England and CCGs must 'have regard to the need to reduce inequalities between patients with respect to their ability to access health services […and] to the outcomes achieved […] by the provision of services.
- CCGs will have duties around integrating health services with other health, social care or health-related services in order to improve quality, reduce inequalities in access and outcomes.
- The Act also includes duties around planning, reporting and assessing services. Specifically, CCGs and NHS England will be required to explain how they will fulfill their inequality obligations in business and commissioning plans. The Secretary of State, NHS England and CCGs will have to report on their performance in the area in their annual reports. The Secretary of State will also assess NHS England on its performance in the annual report, and the latter will evaluate CCGs based on their reports.
- In addition, the NHS Constitution is being reviewed at present to incorporate health inequalities aspects, as is the NHS Outcomes Framework.

The 2012 NHS and Public Health Outcomes Frameworks also contain provisions to reduce health inequalities, specifically:
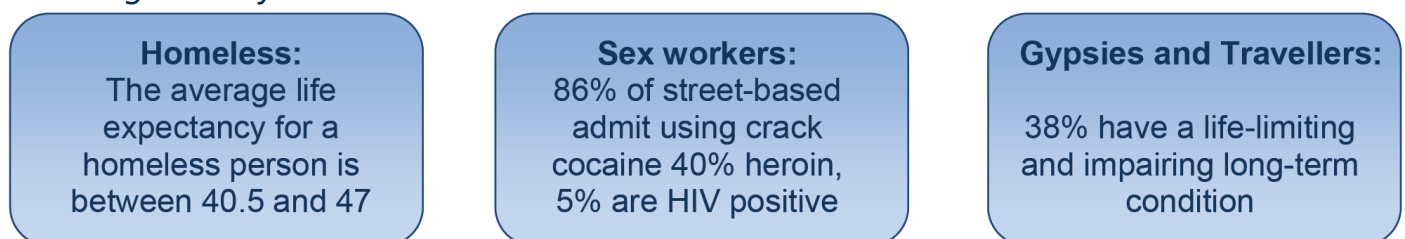
- The second high-level outcome of the PH Framework is 'reduced differences in life expectancy and healthy life expectancy between communities', and there are two relevant domains, 'improving the wider determinants of health' and 'preventing premature mortality'
- The NHS Outcomes Framework will play a crucial role in helping NHS England 'in fulfilling the health inequalities duties proposed in the […] bill', with a number of relevant target domains, including 'preventing people from dying prematurely', 'ensuring people have a positive experience of care' and 'preventing avoidable harm'

A matter of social justice

People from socially excluded groups also experience much poorer health outcomes than the general population across a range of indicators including self-reported health, life expectancy and morbidity. For many of these patients, previous negative experiences with health professionals, complex needs and chaotic lifestyles can make it difficult to access services and navigate the health system. This, coupled with a lack of awareness and sensibility from staff, can further discourage users from accessing services.

In addition, the Department of Health has taken on board the recommendations from the Marmot Report on health inequalities, and has recognised the need to 'improve the health of the poorest fastest' (DH, 'Healthy Lives, Healthy People', 2010) in order to fulfil its duties to provide for the public health of its population and prevent premature mortality.

Figure 2: Key statistics on social exclusion and health

| Homeless: The average life expectancy for a homeless person is between 40.5 and 47 | Sex workers: 86% of street-based admit using crack cocaine 40% heroin, 5% are HIV positive | Gypsies and Travellers: 38% have a life-limiting and impairing long-term condition |

Quality, Innovation, Prevention, Productivity (QIPP)

The point that the system is currently failing the most vulnerable patients in society has been made repeatedly (see e.g. Hewett, 2012, Crisis, 2010), and this is not only unacceptable for a society based on the values of fairness and equal opportunity, but also because the 'cost of doing nothing is enormous' (Marmot, cit.) in both human and financial terms.

This is the reason why this work also has a strong link with the QIPP agenda, as the correct management of these patients will not only make sure that their patient experience improves, but it will also help the NHS to deliver care more cost-effectively. For example, homeless patients are five times more likely to attend A&E, three times more likely to be admitted as inpatients, and stay three times as long (Hewett, cit.). This extends beyond hospital-based care, as intermediate care pilots, particularly around homelessness, have also been proven to be cost-effective, or at least cost-neutral, thanks to a reduced hospital admission and emergency service usage, whilst having a significantly positive impact on patient outcomes and quality of care.

In addition, by broadening the horizon beyond an exclusive health focus, and including the welfare, education and criminal justice systems, it would become clear that the systemic cost of a society not adequately providing for its most vulnerable patients is vast. There are several initiatives currently underway, of which Resolving Chaos, part of the Big Lottery 'Fulfilling lives' programme, is an interesting example of modelling these costs and impacts at a systemic level (Resolving Chaos, 2012).

The NHS Equality Delivery System (EDS)

The NHS EDS is a new system launched in 2011 to help NHS commissioners and providers to meet the public sector Equality Duty (2010) and improve services for patients, communities and staff. It is currently an optional tool, but the evidence collected for it will also support organisations to deliver on Care Quality Commission (CQC) and Human Rights Act requirements, as well as with the localism and personalisation agendas.

In particular, commissioners should consider that the Equality Duty cannot be delegated, and by concerting and planning together with their providers, they should be 'promoting equality throughout the local health system' (NHS Midlands and East, 2011). Through service specifications and contract and performance monitoring, commissioners can ensure that providers are improving health outcomes and patient experience as well as meeting their workforce equality obligations.

Figure 3: Steps for a successful implementation of the Equality Delivery System

Step 1 Governance	• Organisations set up governance arrangements to comply with Equality Act and duty, then confirm arrangements for EDS
Step 2 Identify Local Interests	• In this stage, organisations need to identify the local interests in the implementation of the EDS, which as a minimum should include: patient and staff organisations, providers, voluntary sector and community organisations
Step 3 Assemble evidence	• As part of this stage, commissioners should start to assemble evidence on their performance addressing equality, including JSNAs, NHS Outcomes data, CQC registration submissions, patient and workforce data, PALS
Step 4 Agree roles	• This stage consists in agreeing objectives and roles and responsibilities in joint working with Local authority, NHS Commissioning Board colleagues in delivery the NHS EDS at a Health and Wellbeing Board Level
Step 5 Review performance	• Having collected the information and agreed roles and responsibilties at a local level with their partner organisations, commissioners now share the information with colleagues to review their performance
Step 6 Agree grades	• At this stage, organisations should agree an assessment of their performance against the outcomes that have been set, ranging from: excelling, achieving, developing and undeveloped
Step 7 Prepare Equality Objectives	• Starting from the set 18 of outcomes, organisations and their partners should agree no more than 4-5 priority objectives. The planning needs to occur as part of the yearly business planning period so that objectives can be incorporated into mainstream plans
Step 8 Integrate Objectives in mainstream	• In this stage, the actions to deliver the equality objectives agreed by the various organisations are embedded into the annual business planning documents, including how health inequalities will be addressed in their specific objectives
Step 9 Publish grades and quality objectives	• Once objectives and delivery plans have been agreed with partner organisations, they should be shared with the HWBs, published in the various annual plans and performance be reported on in scorecards

Suggested outcomes are clustered around four main goals consisting of:

- Better health outcomes for all
- Improved patient access and experience
- Empowered, engaged and well supported staff
- Inclusive leadership at all levels

Further details can be found at: **www.eastmidlands.nhs.uk/about-us/inclusion/eds/**

The Commissioning Cycle

Whilst the commissioning cycle is a well-known representation of the process to assess need and establish services that meet the needs of users, it is also a useful and recognisable way to represent the different steps required to successfully meet agreed objectives.
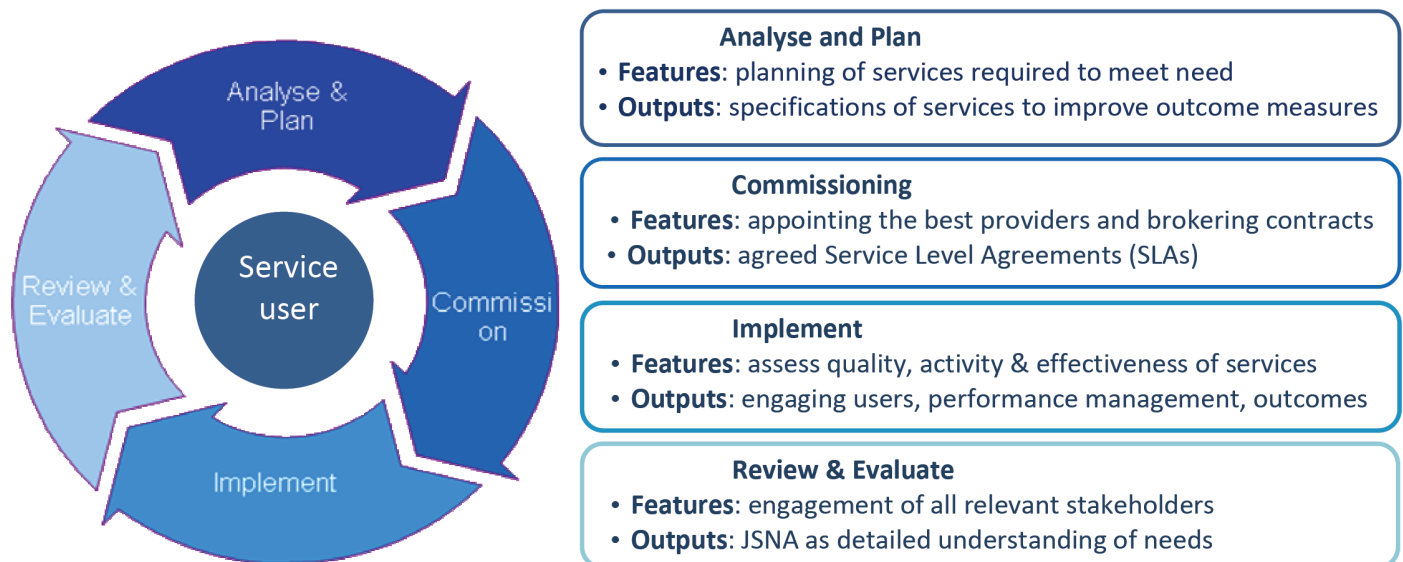
Specifically, it is important for commissioners to have a robust underlying Joint Strategic Needs Assessment (JSNA), which represents an accurate and encompassing representation of the profile and the needs of the local population, including minority and marginalised groups.

In turn, the JSNA should inform the set of priorities collectively agreed by the HWB and set out in the Health and Wellbeing Strategy (HWBS). The strategy should address the needs of the whole population, and should extend beyond a narrow health and social care services perspective, also by looking at potential for integration.

On the basis of the overarching priorities identified, commissioners should define the outcomes they would like to achieve for individuals and for the population as a whole, as well as which providers are best placed to deliver them, and how to engage them. Once the providers have been appointed, commissioners should also outline how to measure their efficiency and effectiveness in providing the desired outcomes, and how satisfied their patients are.

This final stage, during which user feedback and outcome data are collected and monitored for the services, serves the purpose of agreeing whether they are appropriate and best placed to meet the identified needs of individuals, and closes the commissioning cycle.

Figure 4: The commissioning cycle

Analyse and Plan
- **Features**: planning of services required to meet need
- **Outputs**: specifications of services to improve outcome measures

Commissioning
- **Features**: appointing the best providers and brokering contracts
- **Outputs**: agreed Service Level Agreements (SLAs)

Implement
- **Features**: assess quality, activity & effectiveness of services
- **Outputs**: engaging users, performance management, outcomes

Review & Evaluate
- **Features**: engagement of all relevant stakeholders
- **Outputs**: JSNA as detailed understanding of needs

Stage 1 – Analyse and Plan:

The first stage of any commissioning process consists of a robust assessment of the needs of the local population through the JSNA. This document was previously owned by the PCT Public Health Department, and with the Public Health reforms, it will be produced by LAs with input from CCGs, under arrangements made by the HWB.

In order to meet the health inequalities duties described in the 2012 Act, and to make sure that the JSNA is a comprehensive reflection of the needs of the local population, commissioners have to ensure that the

groups suffering most acute inequalities are included.

Current practice is heterogeneous, with some JSNAs reflecting these groups, but to varying extents. Some PCTs, for example, have not mentioned these groups in their JSNAs, whilst others have even carried out group-specific assessments. NHS Westminster, for example, produced a dedicated Homelessness JSNA in 2010. In addition to conventional sources of information, like hospital data, organisations working in the field often have a wealth of information to offer.

- This stage will be primarily informed by the JSNA, produced by the local HWB. It should assess the 'current and future health and social care needs that could be met by the local authority, CCGs, or NHS England. It should include a range of both qualitative and quantitative information, and also be looking at ward or district levels, or at specific ethnic or social groups' (DH, 2012).
- If data for hard-to-reach groups is not captured in the JSNA, it is unlikely that their needs will be highlighted in the HWBS, and they will possibly remain unaddressed. While many of these indicators may not be reflected in routinely collected national datasets, like HES or primary care data systems, there can be a range of different information being collected by other agencies, especially from the voluntary sector. In addition, specialist localised surveys, also featuring qualitative user surveys, can be useful to address the health inequalities duty in the absence of other data to meet the HWB's obligations on health inequalities.
- One of the key changes arising from the 2012 Act is that the JSNA should inform commissioning plans by all actors, including HWBs, LAs, CCGs, and by NHS England.
- When outlining the HWB's commissioning priorities, the HWBS should also provide an overview of the Board's plans to tackle key health inequalities in the area.
- HWBS should also draw on the expertise and experiences of local partners and voluntary sector agencies who are working on the ground providing services, and contributing to the achievement of the planned health outcomes.

At present JSNAs across the country are variable in their quality, length and extensiveness, so it is possible that some localities are not currently aware of the issues relating to any of these groups. This could be either because extensive analysis has shown no presence of any of these groups in the boundaries, or more likely because no questions have been asked, and no provision has been previously made. Hence it is important for any attempts to provide an insight into the condition of socially excluded groups to be robust and evidence-based, to avert the risk of perpetuating current situations of prejudice and stigma.

Specifically, as a minimum a good JSNA should do the following:

- **Provide an accurate picture of the demographics of vulnerable groups within the HWB's and CCG's boundaries, considering variations across sex and age**
- **Provide an extensive representation of their health and social needs**
- **Describe how existing services and assets held by the community are currently meeting those needs, and where there are any gaps in provision**
- **Use a range of qualitative and quantitative data**

The commissioning cycle

Good practice example: CHAIN database

In London, the homeless charity and service provider Broadway has set up the Combined Homeless and Information Network (CHAIN). It is a system used to help workers engaging with homeless clients from over 80 organisations to share information to ensure that they act as quickly and effectively as possible to help those they encounter. Reports based on information held in CHAIN help decision-makers monitor the needs of rough sleepers in London.

Who do people record information about on CHAIN?

Workers record information on CHAIN about people who have been seen 'bedded down' on the streets by outreach workers, as well as users who have entered the hostel and day-centre system.

What information is recorded on CHAIN?

- Basic identifying and demographic information
- Contacts made with outreach workers, both when a person is 'bedded down' and when they are not
- Arrivals and departures from short term accommodation such as hostels and rolling shelters, including the reasons for departures
- Basic indications of people's support needs, for example drug misuse or physical health problems

Where does the information come from?

Information is added to the system by people who work directly with rough sleepers and the street population in London, such as:

- Outreach Teams and Building Based Services
- No Second Night Out
- Day Centres
- Accommodation projects: night shelters, rolling shelters, hostels, second-stage accommodation projects
- Resettlement teams

For further information on CHAIN, please contact Broadway, **www.broadwaylondon.org/CHAIN.html**

Good practice example: NHS Westminster/Inner North West London Homeless Needs Assessment

Westminster has a track-record of commitment to tackle the health inequalities around homeless and rough sleeping. In 2010, it produced an extensive Health Needs Assessment for homeless people and rough sleepers, which has informed the local Rough Sleeping Strategy. This has been a specific focus of the needs assessment, given the disproportionate burden of inequalities and illness faced by this group. As a result, a range of specialist services have been commissioned.

As a follow-up, in February 2013, the Inner North West London Cluster (INWL), comprising NHS Westminster, Kensington and Chelsea and Hammersmith and Fulham has partnered up with Broadway to produce a new 'Rough sleepers health needs and healthcare costs' review. Specifically, the report argues that adequately providing for the health needs of homeless people is not only important for a fair society, but should also be a prime goal for commissioners looking to get the best outcomes and value for money from services.
It also features a section with insights and feedback from rough sleepers, as well as from frontline healthcare and other professionals, which reveals the need to lead cultural and systemic shifts to remove the barriers to good health for rough sleepers, posed by the individuals as well as by the system.

For further information, please contact Inner North West London Public Health: Tri-Borough Public Health Service, **www.westminster.gov.uk** or Broadway **www.broadwaylondon.org**.

Stage 2 – Commissioning services

Once the needs of the local population have been assessed and described in the JSNA, the next stage is laying out a strategy describing how they will be met. This will be agreed in the HWBS by the various member organisations, and should identify a set of agreed priorities for joint action.

As described by DH Guidance (JSNA and HWBS Consultation, 2011), the HWBS should also set out opportunities for more effective and efficient service provision, particularly looking at joint working across health and social care, as well as in partnership with the community and the voluntary sector. Examples include joint appointments, pooled budgets, integrated services and lead commissioning arrangements. Specifically, a good HWBS should:

- Set shared priorities based on evidence of greatest need with a clear rationale for how these are agreed
- Not try to solve everything but provide a strategic overview on how to address the key issues identified in JSNAs, including tackling the worst inequalities
- Concentrate on an achievable amount of objectives
- Address issues through joint working and describe what individual services will do to address priorities
- Support increased choice and control by people who use services by putting independence, prevention and integration at the centre
- Consider how needs can be met through pooled budgets and other joint commissioning arrangements
- Consider how the priorities reflect the National Outcome Frameworks – which should 'inform' rather than 'overshadow' these local priorities
- Consider how the priorities align to other assessments and plans to encourage more joined up commissioning
- Use a range of qualitative and quantitative data

Good practice example: Fulfilling Lives – Resolving Chaos

Resolving Chaos is partnering up with the Big Lottery Fund to deliver Fulfilling Lives: 'Supporting people with multiple and complex needs' in Lambeth, Southwark and Lewisham.

Through the project, they are coordinating work in the south London tri-borough to help individuals with entrenched needs, and who use a range of high-cost services across health social care and other domains on a regular basis. For the pilot, they have targeted the top 270 high cost, low outcome clients across the health and social care system, and will create enhanced access to support by designing personalised care packages and giving clients an individual budget of up to Ł12,000 to meet their needs. The ultimate goal of the project is showing that – for high need users – high intensity investment in services is more cost-effective than the current status-quo.

They are working with service users, the voluntary sector, the NHS and other key stakeholders to develop and deliver a model that will be successful in positively changing people's lives and in creating opportunities across the sector.

This is an exciting programme and stakeholders can get involved through the Reference Groups which are informing the Business Case, Vision and Strategic Planning for this work. There are three groups: service users, statutory bodies and commissioners, and voluntary sector and community organisations.

For additional information, please contact Resolving Chaos at: **www.resolving-chaos.org**

Stage 3 – Implement

This stage is the result of the reconciliation between the JSNA, which outlines the needs of the local population, and the service coverage by the providers of the local health economy. Any gaps highlighted by this process should be filled through the commissioning of new services that will support the achievement of the agreed local outcomes.

Implementation plans should highlight what a good service and a good pathway will look like, starting from a specification which describes the desired outcomes and performance metrics for the service, together with expectations around activity, costs, key interfaces with other services, quality standards and a range of other procedures.

As recent guidance has highlighted, NHS England is unlikely to use its powers to commission LES agreements, so the responsibility for socially excluded groups will predominantly be delegated to CCGs. As a result, CCGs and LAs have to involve the HWB and its member organisations in the preparation of their commissioning plans, in order to both ensure that the potential for integration is maximised, and that they adequately align with the JHWS. If this is not the case, NHS England can take action (ibid.).

Once commissioning intentions are clarified and plans have been agreed, commissioners will embark on the procurement of the solution by identifying the best route and mechanism to source the desired service, be it through a full competitive tender, a competitive dialogue between selected organisations, a grant award to an established organisation, or other forms of financing the organisation providing the service. For each of these routes, there is a clear contracting process to be followed, but this should always be proportional and commensurate with the size of the undertaking.

Particular aspects to consider at this stage are a provider's ability to deliver the services in question to the agreed standards and prices, appropriate staff skills and training, robust modelling underpinning the expected demand service volumes, together with appropriate performance and activity monitoring systems.

As a reflection of this process and of the next stage of 'Delivering and Improving', commissioners should also de-commission those services that are not adequately contributing to improving the health of the population in question, or are not doing so in an effective and efficient way. A major distinction to raise is the difference between de-commissioning and disinvestment, which is explained very clearly, together with the detailed process in the London Health Observatory guide 'Embedding Health Inequalities Considerations in the Decommissioning Process: Resource Document' (2012). Whilst the former is defined as 'a reconfiguration of a service or a significant part in order to bring about an improvement to existing service provision [...the latter refers to] the withdrawal of funding from a provider' (LHO 2012).

Good practice example: Meadowell Surgery

Meadowell opened in 2003 to offer enhanced access to primary health care for homeless and disadvantaged people living in the Watford and Three Rivers area. 'Homeless' in this context includes people in temporary accommodation, staying with friends or at risk of being made homeless, as well as those who find themselves sleeping on the street.

Having started as a direct PCT-provided service, following the publication of 'Transforming Community Services', NHS Hertfordshire had to divest its provider arm, and after a short period as part of the community services trust, Meadowell became a social enterprise. Subsequently, Meadowell submitted a successful bid for a block contract under the Alternative Provider Medical Services (APMS) framework, for a term of 5 years.

As a social enterprise, Meadowell is able to act in relative freedom, providing for the needs of more than 600 patients with a range of services.

Meadowell provides a holistic, 'one stop shop' service, and is able to address health problems together with housing departments, and are used to supporting patients with mental health or drug and alcohol issues.

As homeless people often find it hard to engage with health services, aside from a schedule of planned appointments, Meadowell offers daily drop-in sessions.

Besides full range of primary care services, Meadowell also provides:

- Specialist services for the treatment of drug and alcohol misuse in primary care
- Maintenance opiate replacement therapy
- Alcohol home detox support
- Housing and welfare advice and support

For additional information, please contact Meadowell at **www.meadowell.co.uk**

The commissioning cycle
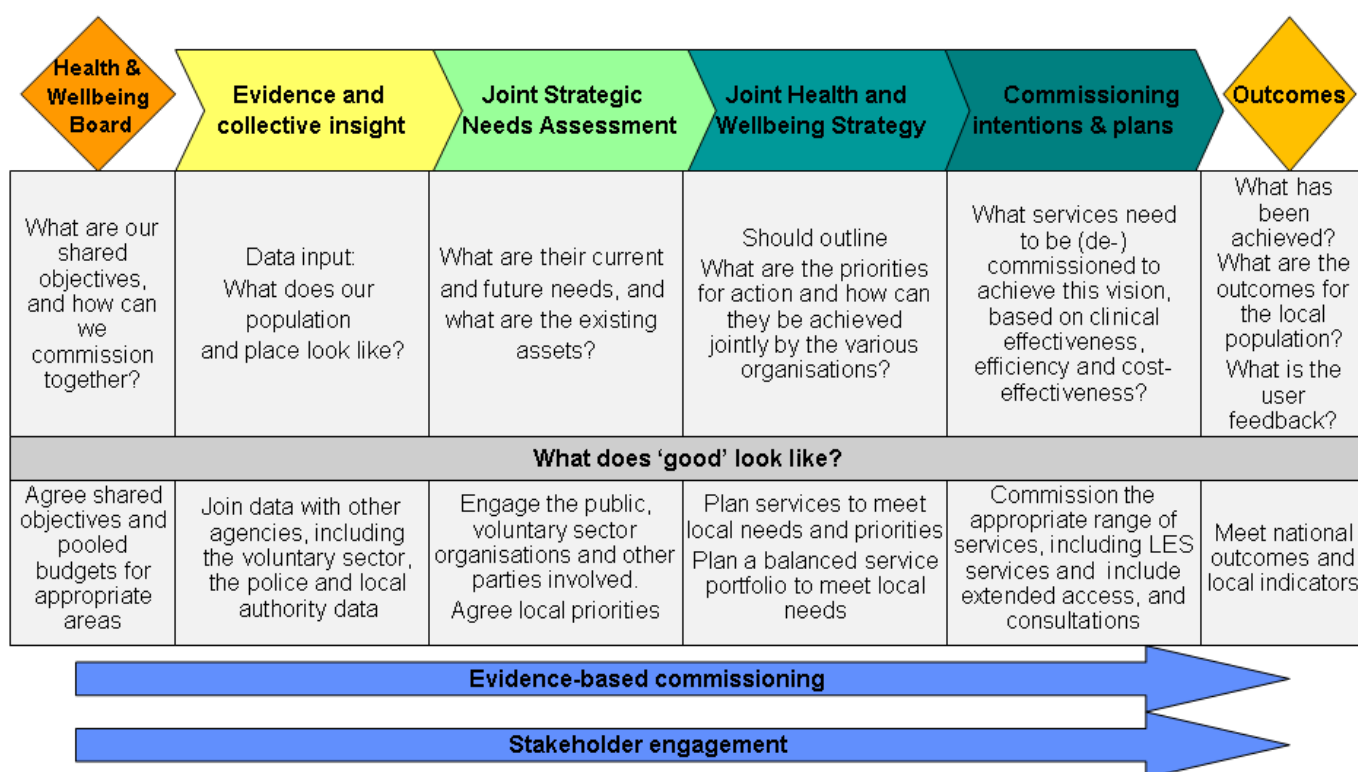
Stage 4 – Review & Evaluate

At this stage, local CCGs and HWBs should be managing the demand for local services by being able to provide a reasonable estimate of the needs and the size of the target population through the JSNA.

This stage consists primarily of reviewing the services currently provided. By looking at the performance against the national and local indicators agreed in the specification, this stage considers how the services can be further improved to ensure that they are appropriate to meet the objectives they have been set up to achieve. Specifically, the performance is reviewed to ensure the services are safe, of the highest quality, clinically effective, ensuring a positive patient experience and offering value for money. Based on the outcomes of this phase, commissioners should be able to assess which services are working effectively, and which ones are not meeting their objectives as expected.

Whilst patient involvement and feedback should be continuous throughout the whole process, at this stage it is particularly important, as user feedback should have a substantial impact on the evaluation of any service. This can be done through structured user consultations, patient fora, and other consultative arrangements.

On top of the aforementioned local and national indicators, commissioners should pay particular attention to the following aspects: meeting their statutory duty to reduce health inequalities; applying the principle of proportionate universalism, according to which, to reduce inequalities, the most resources should be targeted at those with the highest need; coordinating care with other providers and agencies, particularly through joint commissioning with LAs for public health interventions, as well as with NHS England and Public Health England; engaging the public to both provide feedback on the services providedand promoting the use and uptake of services, which will often be articularly based on word of mouth.

Figure 5: Translating objectives into outcomes (Adaptation from DH JSNA and HWB Strategy, 2012)

Health & Wellbeing Board	Evidence and collective insight	Joint Strategic Needs Assessment	Joint Health and Wellbeing Strategy	Commissioning intentions & plans	Outcomes
What are our shared objectives, and how can we commission together?	Data input: What does our population and place look like?	What are their current and future needs, and what are the existing assets?	Should outline What are the priorities for action and how can they be achieved jointly by the various organisations?	What services need to be (de-) commissioned to achieve this vision, based on clinical effectiveness, efficiency and cost-effectiveness?	What has been achieved? What are the outcomes for the local population? What is the user feedback?
What does 'good' look like?					
Agree shared objectives and pooled budgets for appropriate areas	Join data with other agencies, including the voluntary sector, the police and local authority data	Engage the public, voluntary sector organisations and other parties involved. Agree local priorities	Plan services to meet local needs and priorities Plan a balanced service portfolio to meet local needs	Commission the appropriate range of services, including LES services and include extended access, and consultations	Meet national outcomes and local indicators

Evidence-based commissioning

Stakeholder engagement

Good practice example: 'How to engage with Gypsies and Travellers as part of your work' guide

The contact between Gypsies and Travellers and service providers is still too often characterised by suspicion, indifference and occasionally, hostility. Leeds GATE believe that there are characteristic features of interaction between Gypsy and Traveller people and professionals which lead to lack of interventions, or failure to achieve improvements. 'Fear', 'mistrust', 'lack of contact' and 'ignorance on both sides' are some of the words that professionals have found themselves using.

Professional workers charged with the task of improving life chances should be familiar with the idea that positive, effective, and sustainable change begins with communities and families. Commissioners should ask themselves if the services provided being accessed by Gypsy and Traveller people and if so is that access leading to successful outcomes?

There is a need to ensure inclusion and recognition of all groups in society, including Gypsies and Travellers. This guide aims to help practitioners overcome these communication difficulties by supporting practitioners to develop open and nurturing relationships with Gypsy and Traveller people, and assisting commissioners and managers to understand the practical barriers that are faced.

As part of their work, Leeds GATE have highlighted the statistics on poor life expectancy, high maternal and infant mortality rates, vastly poor educational outcomes, widespread homelessness, depression and mental illness, amongst Gypsy and Irish Traveller families.

For further information, please contact Leeds GATE: **www.leedsgate.co.uk/information/leeds-gate-toolkit**

Good practice example: Groundswell

Groundswell's Homeless Health Peer Advocacy (HHPA) service works to improve the health of homeless people by facilitating access to services and giving the ability to successfully navigate and utilise community health services.

A homeless client is matched to a trained volunteer Peer Advocate – someone who has a personal experience of homelessness and who will support the client to address a self-identified health issue. The advocate helps the client identify the steps needed and supports them to attend appointments with a GP, a specialist, or any tests, and complete their healthcare intervention. Peer advocates offer practical support such as paying travel expenses, accompanying people to appointments, and work to build the client's confidence and independence, enabling them to continue looking after their health following the brief intervention.

Groundswell Advocates proactively reach out to homeless people, running health promotion events in hostels and day centres and accompanying rough sleeping street outreach teams on night shifts, or step in through referrals via A&E.

The key objectives of the project are:
- To improve homeless people's access to appropriate health services, thus supporting people to improve their health outcomes
- Make services more accessible: to support health services to work more effectively with homeless people
- Support advocates: to recruit, train and support peer advocates to engage in volunteering and increase knowledge, skills and employability, to create a robust, independent evidence base which demonstrates both the effectiveness and cost-effectiveness of the service to ensure ongoing sustainability

The project was developed in 2010 with an NHS Regional Innovation grant, and has now expanded into Hammersmith & Fulham, Camden, Lambeth and Tower Hamlets.
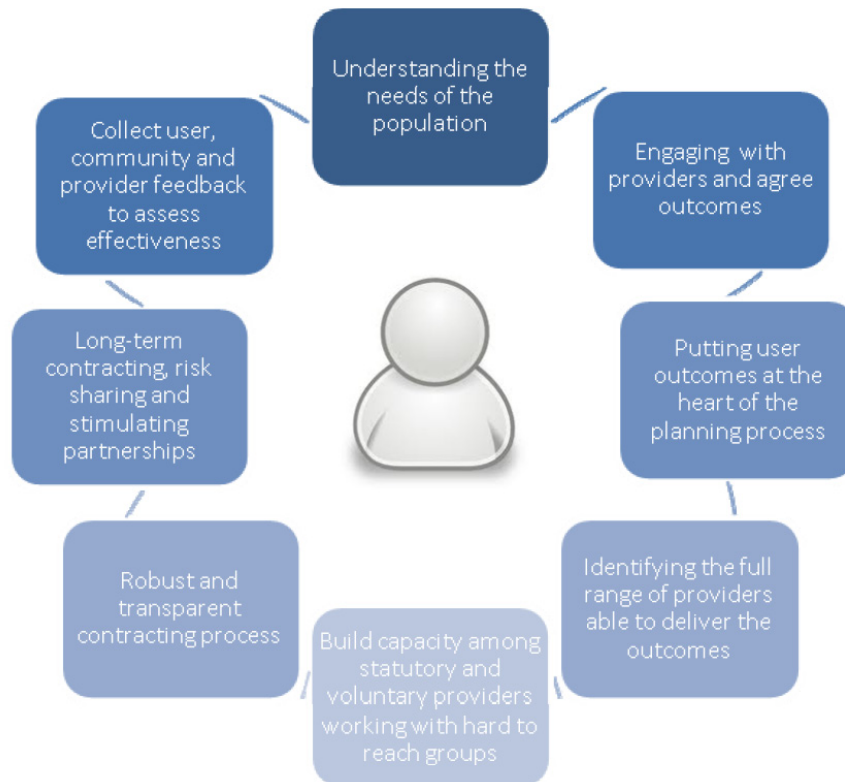
For further information, please contact Groundswell: **www.groundswell.org.uk**

As the health and social needs of Gypsies and Travellers, homeless people and sex workers are extending beyond organisational boundaries, it is essential that the different actors on the scene work together and commission jointly and holistically, involving and seeking regular feedback from users, staff and other interested parties.

Building on the different stages of the commissioning cycle, and on the guidance provided by the National Audit Office on Commissioning (2010), good practice in commissioning can be based on the following eight key principles:

Figure 6: Principles for good commissioning for social exclusion (adapted from NAO, Successful commissioning guide, 2010)

A framework for provision

In a similar fashion to the national service framework for Substance Misuse treatment outlined by the National Treatment Agency (2002), services for socially excluded groups could be grouped into a series of tiers based on level of specialisation and modalities of treatment. By building on the findings from the JSNA, as well as on intelligence collected by organisations working on the ground, commissioners will be able to determine the size and the level of need of the different vulnerable groups. As a result, in most areas with only small numbers across these groups, commissioners will only look at the more generalist, lower-end of provision, while partnering up with other nearby commissioners for more specialist services to achieve the necessary critical mass of users.

The 'models of care' framework was not originally intended as a rigid, binding set of standards for service provision to substance users, but rather as a conceptual framework to apply with flexibility in a given locality. Whilst all tiers should be available to the population, where this is practical, commissioners can
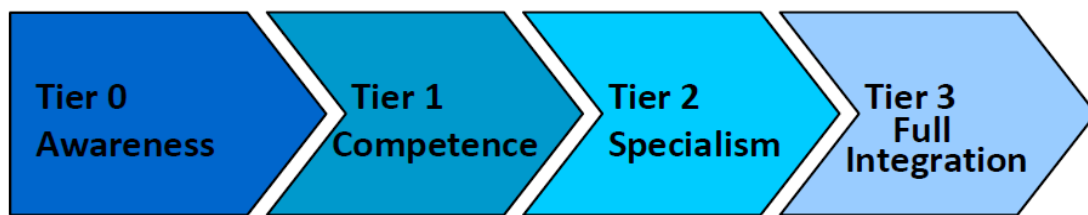
join forces to make provision more effective by providing services to a larger amount of users and more cost effectively.

Likewise, the methodology outlined below is intended as a 'best practice proposition' to guide the harmonisation of provision across the country with discretion, based on local needs.

The four tiers proposed, ranging from generalist, community based services to highly specialised inpatient services, are detailed below:

Figure 7: the tiers of provision

Tier 0 Awareness → Tier 1 Competence → Tier 2 Specialism → Tier 3 Full Integration

- **Tier 0 – Awareness:** This should represent a general standard of provision available across mainstream, generalist services, and particularly in primary care. It is based primarily around the ability of providers to spot patients who are potentially victims or at risk of social exclusion and being able to relate appropriately and referring to more appropriate providers. This should be the minimum standard expected from all providers.

- **Tier 1 – Competence**: Provision of a full range of primary care services in a generalist practice, with the appropriate elements of cultural sensitivity and the ability to provide some specialist resource, like a GP with a special interest (GPwSI) or a specialist practice nurse, or dedicated specialist sessions. Depending on levels of need, all localities with small populations at risk of social exclusion should have at least one practice with some specially trained staff who are able to provide a basic range of services.

- **Tier 2 – Specialism:** Services provided under this category should be specifically targeted for members of these socially excluded groups. Providers should be able to provide a full range of primary care services for moderately chaotic and distressed users, together with close links and the ability to signpost to other relevant services. This should also include inreach sessions from other more specialist services, including mental health counselling, specialist substance misuse, housing advice and similar services. Whilst specialist services of this kind should be available across the country, localities with a very low prevalence should cluster together and provide jointly with neighbouring commissioners.

- **Tier 3 – Full Integration**: This category defines highly specialised and integrated services, ranging from outreach and dedicated general practice to specialist intermediate care after discharge. Services of this kind are delivered by an integrated team of primary and secondary care clinicians working across boundaries. Given the high level of specialism, realistically those services can only be provided in densely populated urban areas, or in parts of the country with a very high numbers of any of the above groups. In other cases, commissioners should make appropriate arrangements with providers to guarantee access to referrals to the appropriate services based upon need on a case by case basis.

Good practice example: Brighter Futures, Stoke-on-Trent

Brighter Futures originally started as a housing provider in 1974, under the name of Potteries Housing Association. Then, in 2007, a dramatic incident which saw two homeless persons being killed in a fire, prompted the establishment of a task force to review the underlying causes of the incident. This concluded that the various organisations active in the sector had to work together to tackle the underlying causes of homelessness and exclusion.

The result of this process was the creation of a dedicated homelessness partnership between the council and local service providers, including the Potteries. Subsequently, to reflect the growing range of services provided and responsibilities beyond mere housing, the name was changed into Brighter Futures.

As a result of this move, Brighter Futures has had the opportunity to address the whole spectrum of social exclusion, from providing accommodation to training and skills-building, providing alcohol-interventions after A&E admissions, community engagement, employment services and health interventions.

For further information, please contact Brighter Futures: **www.brighter-futures.org.uk**
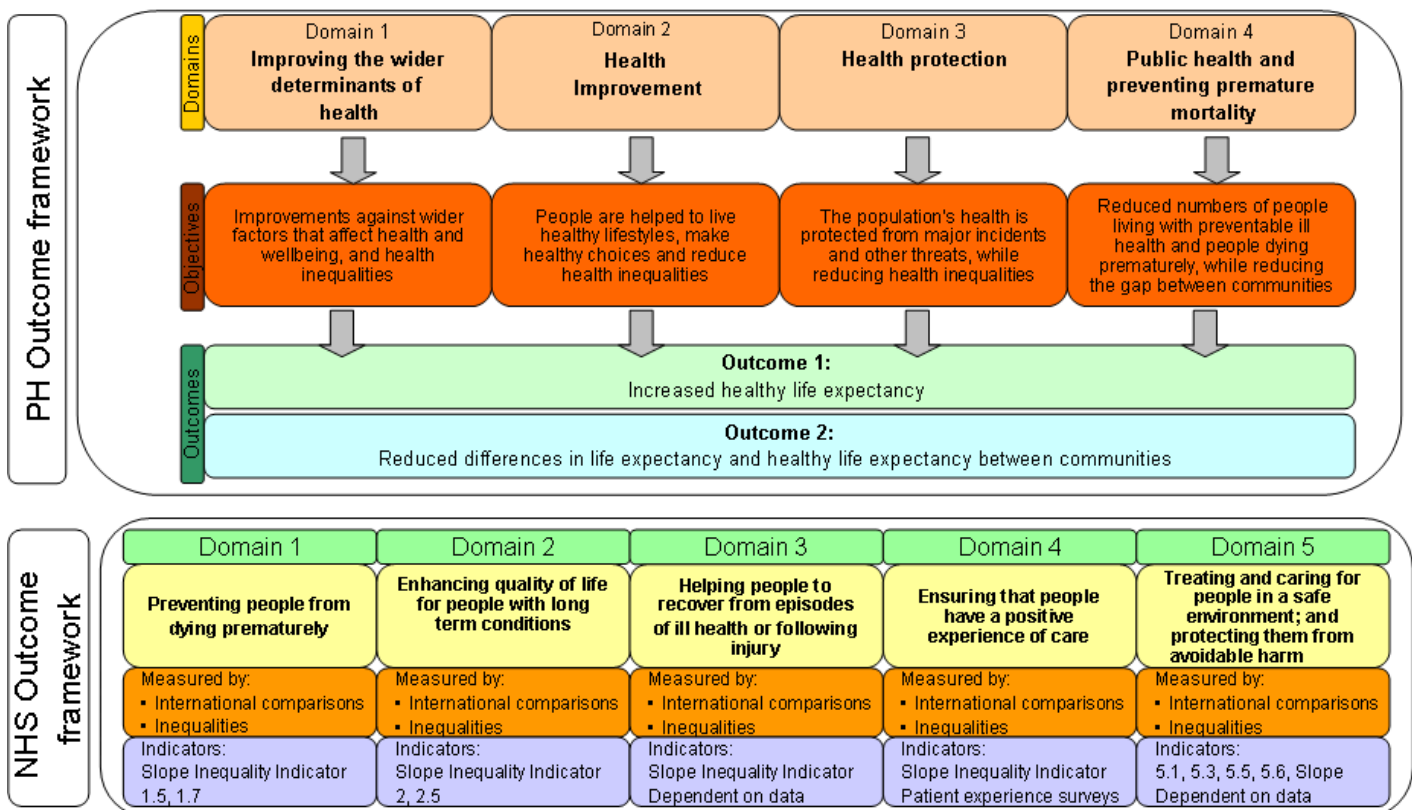
Evaluating the outcomes of health-related and social interventions is crucial. This process allows to separate those interventions which are effective and those which are not providing the desired outcomes. It ensures that services are of the highest quality, effective and offering value for money, as well as meeting the specifications that have been agreed in contracts and delivering in accordance with national and local quality standards. It is also essential that locally negotiated targets between commissioners and providers reflect the objectives agreed for services both in the annual planning cycle, and in strategic, long-term plans.

A range of measures are available to evaluate the impact of public health interventions on individual wellbeing, levels of mental disorder and other social and economic outcomes. These include outcomes outlined in the Public Health, NHS, Social Care and Commissioning Outcomes Frameworks.

First of all, good targets should reflect the domains and high-level outcomes identified in the relevant Public Health and NHS Outcome Frameworks (available **here** and **here**) which are summarised below:

Figure 8: The various domains of the NHS and Public Health Outcome frameworks, and the relevant outcomes for commissioners to keep in minds when planning services for socially included groups

As a general guideline, it is also worth mentioning that any targets and objectives set out to assess the efficiency and effectiveness of services in meeting the patient needs should be SMART (Specific, Measurable, Achievable, Realistic and Time-limited). Examples include:

Examples of SMART Non-SMART objectives		
	Non-SMART	**SMART**
Specific	'Improve the wider condition of...'	'Reduce number of re-admissions by x'
Measurable	Does not feature any indicators	Can be measured numerically
Achievable	'Tackle the underlying causes of the determinants of health'	'Ensure hospital discharges are coordinated with community providers'
Realistic	'End health inequalities'	'Reduce the inequalities in health outcomes for group x by 10 per cent'
Time limited	Open-ended statements	Has a specific time-frame

Given the specific needs of the socially excluded groups targeted as part of this work, which revolve particularly around unmet health needs, social needs, housing, social networks and employment, a set of potential objectives for relevant services is outlined below by domains with possible sources:

(*overleaf*)

Outcomes

Potential outcomes by domains and sources *(Adaptation from Think Research, 2008)*

Activity related:

Indicators: volume, unit cost, throughput, re-admissions, number of admissions, crises or relapses

Sources: activity data, patient/user records and case notes, financial data

Joint working:

Indicators: hand-overs to other agencies, multi-disciplinary managed cases

Sources: activity data, patient/user records and case notes

Physical health and wellbeing:

Indicators: number of users supported into exercise, healthy living advice sessions attended, stress reduction, weight and BMI reduction, smoking reduction, substance misuse

Sources: activity data, patient/user records and case notes, user and staff interviews, smoking status, substance maintenance status and doses

Mental health:

Indicators: mental health-related hospital admissions, improved confidence and self-esteem, ability to manage stress

Sources: activity data, patient/user records and case notes, user and staff interviews, hospital admissions

Social factors:

Indicators: number of users who improved existing relationships or created new ones, users accessing support networks, users supporting others

Sources: activity data, patient/user records and case notes, user and staff interviews

Accommodation and independent living:

Indicators: number of rough sleepers supported into temporary accommodation, number of users supported into permanent housing, users moved to 'step-down' accommodation after hospital discharge

Sources: activity data, patient/user records and case notes, user and staff interviews, hospital data

Employment:

Indicators: number of users supported into training, users gone into paid employment or interviews

Sources: activity data, patient/user records and case notes, user and staff interviews, courses completed

Patient choice:

Indicators: number of users using personal budgets or direct payments, users able to choose service providers or community activities

Sources: activity data, patient/user records and case notes, user and staff interviews, community provider and third sector data

Gypsies and Travellers snapshot

Overview

It is estimated that there are between 200- and 300,000 Gypsies and Travellers in the UK, two-thirds of which are settled in brick and mortar (REF, 2006; FFT, 2010).

The Traveller identity is often used as an umbrella definition for all populations coming from a nomadic cultural background, including Romany, Welsh, Irish, English and Scottish Gypsies, Roma, as well as fairground and boating communities.

The availability of culturally appropriate accommodation in the form of authorised, appropriately equipped site plots is extremely limited, hence many recur to illegal or non-fit for purpose arrangements, or reluctantly move into stable housing.

Health & social exclusion issues

There are a range of contributing factors to the poor health outcomes and the difficulties in accessing services for members of this community. Low levels of literacy, together with stigma, poor access to health information and some widespread health-beliefs increase the likeliness that they will not seek treatment, or will underestimate the seriousness of the condition (Van Cleemphut, 2009).

42 per cent of English Gypsies are affected by a long-term condition, as opposed to 18 per cent of the general population (Parry et al., 2007).

Gypsies and Travellers are reporting the highest levels of perinatal infant mortality of all ethnic minorities in Britain (FFT, 2010).

Health outcomes among Travellers living in brick and mortar are considerably worse than those of nomads (Parry et al, 2004).

Poor mental health, excessive alcohol consumption and substance misuse, including commercial drugs, are additional reported factors that reflect the underlying problem of social exclusion.

The poor quality of some sites, including pollution and poor sanitation has a direct impact on health outcomes.

Access issues

The main reported health-related difficulties for this group are lack of suitable accommodation and GP registration, as many are turned down as problematic users (Cemlyn et al., 2009).

Lack of cultural awareness, including racism, perceived judgemental behaviours, or inability to 'explain things properly' often contributes to the poor patient experience (FFT, 2010).

The nomadic lifestyle complicates access to appropriate care: registration can be difficult, information is not being shared, and patients can often not articulate their needs. Hence, they often travel long distances to see a professional they trust (Cemlyn, 2002).

Gypsies and Travellers snapshot

Overview of services

Outreach: helps to establish a connection to local communities, in order to build the initial relationship and raise awareness among travellers on the range of services available.

Mobile units and clinics: whilst bringing services directly to sites might be a way to establish some rapport, it does not ultimately help fostering integration in mainstream services. Community building and health education are positive alternatives.

Patient access: due to the high mobility of these patients, accessible records and interoperability of care records software will be of great benefit to the continuity of care.

Peer-education: is a valuable means to get access to strong communities, gaining the trust of community leaders and role models can be very beneficial to reach out to the wider group, and gradually challenge some health beliefs and behaviours.

Cultural awareness training: as Gypsies and Travellers are often targeted by traditional forms of racism, the cultural competence of all frontline staff, including receptionists, is crucial to accomodate their specific needs.

Commissioning considerations

- **Information sharing** between different agencies is a key factor in improving access for Gypsies and Travellers, especially given their high mobility and complex needs.

- **Community engagement** is important for professionals to establish a relationship with the wider network of people, and makes sure that a trusted relationship is gradually set up. This will also contribute to the design of a service that meets the community's perceived need and develop a sense of ownership.

- **Mainstream services:** Even though one of the most widely implemented strategies has been the 'dedicated health visitor', this should not necessarily be seen as an example of best practice. In fact, Travellers do not want dedicated services, but would much rather be able to access the same high quality services as everyone else, which will also reduce 'singling out' (PCC Framework, 2009).

- Poor **living conditions** and environmental factors are the single most influential contributing factor to the poor health status of Gypsies and Travellers, including stress. This makes partnership working between the different agencies, including the NHS, Local Authorities Social Services, Housing and Environmental Health, and voluntary sector organisations, even more important to provide a coordinated response to these inter-related issues.

Sex workers snapshot

Overview

It is estimated that there are about 80,000 sex workers in the UK, up to 20,000 of which could be migrants (TAMPEP, 2009).

Whilst the common representation of the phenomenon involves street-based sex-work, this only accounts for about a third of the total volume, whilst the other two-thirds consist of 'parlour-based' activity and takes place indoors (Hough & Rice, 2008).

The motivations drawing these two very different groups into the sex industry tend to vary, as substance addiction and chaotic lifestyles are influential drivers among street-based workers, whilst financial difficulties are often the key motivation for indoor-based prostitution (Home Office, 2004).

Key health & social exclusion issues

There is a widespread substance misuse problem among this group, which is frequently the main reason they are recurring to prostitution in the first instance. 86 per cent of street-based sex workers admit using crack cocaine, 40 per cent using heroin, and 5 per cent are HIV positive (Hough & Rice, 2008).

Due to the fact that prostitution remains a punishable offence under the Sexual Offences Act (2003), a vast proportion of sex workers have been through the criminal justice system. Estimates assess the scale of this phenomenon between 30 per cent (THT, 2007) and 50 per cent (Hough & Rice, 2008).

Migrant workers are much more likely to work in indoor parlours in comparison to the wider group (TAMPEP, 2007). This could is often related to an illegal or irregular immigration status, so that the workers themselves might wish to 'stay put', but given the legal circumstances, there could also be an element of exploitation by who manages the brothels.

The lack of stable accommodation is recognised as both a risk factor for entry and a barrier to exit from sex work (Cabinet Office, 2004), and about a quarter of sex workers are reporting no fixed abode', with another quarter living in hostels.

Key access issues

The gradual move of prostitution off the streets is making sex workers harder to contact with outreach.

Real and perceived barriers, such as low levels of self-esteem and fear of being stigmatised or treated judgmentally by staff when attempting to access a service make contact more difficult and sensitive.

Substance misuse problems often represent a barrier to accessing health care, as health professionals sometimes use this as a reason to push-back , particularly in mental health.

Sex workers snapshot

Overview of services
Outreach: is the main means to establish an initial relationship with service users who might not otherwise access services by visiting them on their grounds. It also offers the chance to learn about the circumstances and needs of the group with first-hand experience.
Mobile units and clinics: as many sex workers are leading chaotic lifestyles, bringing services directly to them will often be an effective strategy to ensure that they undertake the first step to address their health needs, for example through on site testing.
One-stop shop: especially in urban areas, where access to clinics is comparatively easy, services can be provided through a hub system concentrating a range of different services on one site, and signposting to others. For these services, word-of-mouth of positive experiences is a powerful means of promotion.
Peer-education: is a means to get to hard-to-reach patients by using the networks and the credibility of members of that community to reach others. It can help to convey key messages and direct users to access new services.
Cultural awareness training: is crucial for professionals to establish positive relationships, together with presenting patients with gradual empowerment and choice around their options and rights.
Hostels: a recurring issue for sex workers upon discharge from hospitals or in crises is the lack of safe and targeted single-sex accommodation. Its absence can be a determining factor to relapses and revolving doors.

Commissioning considerations

- **Early intervention** is crucial to prevent the circle between addiction and prostitution
- **Inter-agency work** between health services, the police and others can facilitate access and navigation of the system for sex workers, and can help to construct an encompassing picture of the extent of the phenomenon with data
- The choice between commissioning **mainstream and dedicated services** should depend primarily on the type of service to be made available to the local population. Primary care and substance misuse services are predominantly mainstream, whilst sexual health and gynaecology services are normally dedicated (Gaffney et al., 2008)
- Gaffney et al. (2008) suggest that the prime aim for **outreach** is the first step to bridge the gap between sex workers and health and social services
- **Dedicated hostel beds**, particularly during crises, are an important factor for the safety and the wellbeing of sex workers embarking on the journey to recovery

Homeless snapshot

Overview

Homelessness is a broad concept that includes a number of different categories, ranging from rough sleepers to those temporarily sheltered in homeless hostels, to hidden groups like 'sofa surfers', who are seeking temporary accommodation from friends and families following the loss of their own lodging, to those in overcrowded and unsuitable accommodation.

Given the breadth of these categories, it is difficult to assess the full scale of the problem, but according to Homeless Link, in 2012 there were 43,000 people housed in homeless hostels. In addition, in 2004 Crisis assessed the other groups between 310- and 380,000, a number that has most likely risen substantially since then, particularly as a result of the financial crisis, and now more frequently involves people who are in employment but cannot afford accommodation.

Health & social exclusion issues

The impact of rough sleeping on the wider health and life expectancy of individuals is well recognised. A recent evaluation by Crisis (2011) assessed the average life expectancy at 47, as opposed to 77 for the general population. With an average of 43, this is even lower for women.

Most homeless people suffer from a combination of poor physical and mental health, often together with some form of substance misuse (Wright, 2012). They are 5 times more likely to go to A&E, and 3 times more likely to be admitted and stay longer (Hewett et al., 2012).

About a third of deaths among homeless people are directly connected to substance problems. In addition, homeless people are also much more likely to die due to 'external factors', such as various infections and traffic accidents (Crisis, 2011).

Access issues

Due to a combination of factors, including more immediate needs such as food and shelter, poor staff attitudes, fear of being judged and others, homeless people find it generally quite difficult to access health services, particularly when trying to use mainstream general practice (Crisis, 2003).

As a result of the above factors, in relation to their uptake of services, homeless people can fall into two distinct groups: those that do not engage with services at all, and those with a much higher than average A&E and emergency service usage.

Patients with dual diagnosis have historically been facing increased difficulty in accessing health services, as substance misuse problems have often been a reason for passing the responsibility for these patients on to other parties.

Homeless snapshot

Overview of services
Outreach: is a very important element, as it not only provides an opportunity for initial engagement on the streets, but also supports new rough sleepers before they become 'entrenched' in the lifestyle.
'In-reach work': provided by health professionals in the setting of hostels to preserve continuity of care and deliver care in a trusted environment. It should be a temporary measure to stabilise clients to help them subsequently to move on to lower intensity services.
Dedicated hospital pathway: it has been proven that a 'transversal' pathway, cutting across medical specialties has both a positive impact on the user experience and on the cost effectiveness of the care provided.
One-stop shop: is one of the key modes of provision for homeless people, combining basic facilities such as washing, with access to health services, housing, as well as Drug and Alcohol Services and various recreational and skill-building activities.
Peer-education: is a strong strategy to promote recovery and gradually empower disempowered individuals, while building up skills and capabilities to take up a place in society.
Cultural awareness training: is important for professionals, as it supports patients to build up confidence and self-respect, and be able to build a gradual road of recovery back into mainstream services.
Intermediate care: is one of the often overlooked grey areas between intensive in-hospital care and the community. The rationale is to provide appropriate step-down care in order to maximise recovery.

Commissioning considerations

- Whilst the needs of **statutory homeless** people (those entitled to a recourse to public funds), and non-statutory homeless people are very similar, the practical picture is very different. The former are entitled to Supporting People funding and to increasingly scarce statutory accommodation, whilst the latter have to rely on charities, and often the only possible outcome is a reconnection to their place of origin.

- Following the removal of the ringfence around **Supporting People** funding and a renewed local focus, the system has become more flexible in accommodating the different needs of clients. Conversely, commissioners have sought to consolidate their number of providers, frequently hitting smaller provider organisations.

- This focus on local decision making has also had an impact on achievable **economies of scale**, as most commissioners are still working in isolation. The establishment of commissioning networks, in a similar way to specialised clinical networks, could provide an opportunity for similar localities to cluster together, share experiences and agree shared strategies.

- At present, most health services for homeless patients are being commissioned under the **Local Enhanced Services** (LES) scheme, which has given local commissioners the autonomy to establish services targeting specific local needs. It is uncertain how this modality will be upheld after April 2013.

- There are a number of **intermediate care** models, including the London Pathway model of sanctuaries inspired by the US, and St Mungo's Cedars Road. There is evidence that appropriately tailored intermediate care has a positive impact both in terms of readmission and quality of care.

Conclusion

This report highlights the need to improve health care and access to services for socially excluded groups, which is dictated not only by moral motives, but also by common sense. In Sir Michael Marmot's words, 'doing nothing is not an economic option […and] the human costs are enormous' (cit.).

The revised normative framework, which is now more prescriptive around health inequalities, as well as recent guidance on JSNAs and HWBSs is a good starting point. The next part depends on the choices of the new commissioners from April 2013.

The various examples of good practice and useful resources highlighted throughout this report provide a wealth of tools currently available to support commissioners engaged in the commissioning of services for socially excluded groups. The principles to implement the changes are simple and they can be summarised as follows:

• Removing material and psychological barriers to services
• Improving joint working between professionals and voluntary sector organisations and other potential providers
• Asking the right questions and building up the data and evidence base
• Establishing proportionate and appropriate services where there is unmet need
• If users are not coming to the service, take the service to them

The evidence available suggests that, for a variety of different reasons, patients from some of the most vulnerable groups, including homeless people, sex workers and Gypsies and Travellers, are being failed by the system. By focusing on their health, social care and other needs in a holistic way, and implementing some of the effective interventions outlined in this report on an appropriate scale, commissioners can make a real difference that will help to enable people from socially excluded groups to live longer and more fulfilling lives in line with the rest of the population.

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Appendix: useful resources

(All links as accessed on 20 March 2013)

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