

NHS WHITE PAPER EQUITY AND EXCELLENCE: LIBERATING THE NHS

HOMELESS LINK'S RESPONSE OCTOBER 2010

Homeless Link is the national umbrella organisation for frontline homelessness charities in England. Currently we have more than 470 member organisations. Our members include hostels, day centres, outreach and resettlement agencies, housing advice centres, youth projects, health projects, welfare rights groups, regional homelessness networks, refuges, drug and alcohol services and faith run voluntary services. As the collaborative hub for information and debate on homelessness, we seek to improve services for homeless people and to advocate for policy change. Through this work, we aim to end homelessness in England.

Homeless Link welcomes the opportunity to respond to this important consultation. We support the governments continued commitment to the NHS and to the principles of a comprehensive service free to all at the point of use and based on clinical need and not the ability to pay.

The experience of our member agencies working with homeless people across England informs us about the persistence of poor health and inequalities in access to health care. A recent audit homeless people found 8 in 10 have one or more physical health need, and 7 in 10 have a mental health problem¹. Their poor health is caused and exacerbated by high levels of housing need, poor diets and high rates of substance use.

Because of their higher levels of need, homeless people use acute health services disproportionately to the general population. The audit found that in a 6 month period, 4 in 10 homeless people have been to A&E at least once, and 1 in 3 were admitted to hospital.

Research by the Department of Health supports this finding and adds to it the high cost to the tax paying public of treating homeless people in acute services.²

- Average length of stay is approximately double for the NFA population
- Use of the health service by homeless people costs roughly £3,000 per homeless individual per year. This compares to an equivalent per capita cost of almost £400 a year for non-homeless individuals.
- 89% of all NFA episodes were admitted as emergencies compared to only 41% for the comparison group.

¹ Homeless Link, Interim Findings from the Health Needs Audit, 2010 www.homeless.org.uk/health-needs-audit

² Healthcare for Single Homeless people, (DH, 2010) http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_114250

These issues taken together are the reason that we urge the government to recognise the need to build equality of access and specific services that respond to the needs of socially excluded groups into the implementation of their proposals. As is recognised in *Inclusion Health*, 'it makes economic sense to invest in improved services...these savings will be felt not only in health care, but across a wide range of services and require a long-term investment for long-term benefits.'³ Unless poor health is tackled, it is difficult for homeless people to move towards employment and more settled accommodation. Research by the homelessness agency Thames Reach found for 67% of their homeless clients, it was their poor health preventing them getting a job.⁴

We welcome many of the principles outlined in the strategy set out in the White Paper which we see as positive for improving health for homeless people. However, there are some proposals where we feel additional measures need to be taken to enable the government to achieve its vision of an NHS which truly has Equity and Excellence at its core.

We have responded to each of the four consultations which accompany the NHS White Paper in turn in this document.

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³Inclusion Health, 2010 <http://www.cabinetoffice.gov.uk/media/346571/inclusion-health.pdf>

⁴ Source: Thames Reach Service User Survey, 2008

KEY MESSAGES

Our particular interest is the way that the proposals will impact on homeless people and the agencies which work with them. There are a number of key themes which we have identified across the four areas of consultation. We hope this provides a useful summary for consideration.

1. Better protection for the most vulnerable and disadvantaged

We welcome the aim for a 'better NHS that eliminates discrimination and reduces inequality in care'. However we feel there are insufficient safeguards to protect those patients who suffer from the most complex and costly health problems, such as homeless people. We call for greater responsibilities for health inequalities to be built into the each level of the new NHS structure and a specific target to reduce health inequalities built into each of the outcome domains. We also urge that the standards and principles outlined in the *Inclusion Health* programme⁵ are adopted.

2: Creating a framework to achieve more holistic health outcomes

As it stands the new commissioning framework will create a clinically driven model of outcomes. We wish to highlight that improving people's health is rarely done by medical interventions alone, but is dependent on the wider determinants of health, such as housing. As such we urge the new outcomes framework to reflect a more holistic model of health. We understand there will be a new outcomes framework for public health and social care services, but we would prefer to see a unified health and well being framework spanning all services. Formal joint expenditure accounts for a relatively small amount of total health and social care spend.⁶ Joint outcomes would help health and social care commissioners release resources to flexibly meet local needs in partnership.

3: Improved joint working with the voluntary sector

We support the focus on joint working at the local level, and the health and well being boards presents a useful vehicle for this process. However the concept of joint working in the paper does not fully take advantage of opportunities for joint working with the voluntary sector and user groups, with whom engagement is presented more as an optional requirement. We believe membership of the Health and Wellbeing Board should be opened up to local voluntary sector providers of care who are well placed to identify need and deliver services to the more disadvantaged members of our local community.

4. Ensuring JSNAs capture the needs of the whole community

We welcome the enhanced role for Local Authorities to co-ordinate the JSNA process. However to ensure the needs of the whole community are considered and evidenced in the JSNA process we agree greater guidance is needed to help them undertake this role. This should include a review of any inequalities and disadvantaged groups in their local population and requirements for these to be addressed in a clear set of commissioning recommendations within the JSNA document.

5. Supporting consortia to respond to the most vulnerable patients

We believe more safeguards are needed to ensure consortia act on the health needs of disadvantaged patients in their local area. Chronically excluded groups such as homeless people rarely feature in routine needs assessments and may not be

⁵ Inclusion Health, 2010 <http://www.cabinetoffice.gov.uk/media/346571/inclusion-health.pdf>

⁶ The Audit Commission's review of joint financing across health and care found that this amounted to only 3.4% in 2007/8, *Means to an end, Joint financing across health and social care*, October 2009 www.audit-commission.gov.uk/localgov/nationalstudies/pages/91029meanstoanend_copy.asp.

registered with GPs and mainstream services. Each consortia must identify, include and act on information about these needs to fulfil its 'duties to promote equality and to assess progress in reducing health inequalities'. Conducting an audit of need among homeless people and naming a lead for inequalities within consortia are steps to address this. The voluntary sector is well placed to provide additional expertise and we would welcome the opportunity to advise how consortia could work with people who are homeless.

6: Creating a strong voice and choice for homeless people

We welcome the paper's vision making patient choice central to the NHS. However we feel greater provision is needed at every level to understand the barriers to choice and address these. We feel there is a risk that the degree to which choice will drive services will disadvantage those who find it difficult to make informed choices or get their voices heard. Homeless people have a wealth of expertise and input to offer: we need measures to support their participation in HealthWatch, their ownership over decisions and more rigorous access to redress the lack of choice and involvement if they feel this is not been achieved.

7: Placing preventative health at the heart of the NHS

We welcome the additional responsibilities for local authorities around public health and the commitment that health improvement grants will include a premium to reduce health inequalities. This allocation should take into account the local homeless population to recognise their higher health costs. However, while some prevention activity will be in the domain of public health, the ethos of prevention needs to cut across the NHS and built into all health care interventions. Prevention does not feature in the outcomes framework as it is currently described. We would like to see a domain based on an evidence-based programme of preventative interventions that are effective for all groups including the most socially excluded.

8: Ensuring competition does not compromise innovation and quality

Greater competition can improve service quality and choice. However, competition can also lead to unnecessary duplication of services and a less efficient commissioning process. There is also a danger that larger providers will capture the market which could stifle innovation and prevent the necessary transfer of resources into primary and community care. We hope the new regulatory regime recognises the imbalance of power and gives opportunities to community based providers who are well placed meet the needs of disadvantaged patient groups.

9. Protecting expertise amid the pace of change

We support the need to create a more efficient NHS. However, we are concerned about the pace and scale of some of the proposed changes. Consortia will have to develop new capacity and expertise to take on their additional commissioning responsibilities and their associated risks with significantly reduced management resource when compared to that in PCTs. It will be important to retain in some form the organisational knowledge and competencies that has built up in PCTs and make these available to new consortia throughout and beyond the transitional period.

10: Measuring the impact of austerity on health

The austerity measures around cutting of welfare benefits (including housing benefit), as well as the uncertain economic climate place more people at risk of homelessness and the associated impacts on health services we describe in the introduction. We call on the government to take a broad appreciation at an inter-departmental level so these impacts can be mitigated, and to consider how the new arrangements will be able to respond to this likely increase in demand for preventative and emergency healthcare.

1. TRANSPARENCY IN OUTCOMES- A FRAMEWORK FOR THE NHS

The paper is about determining how the success of the NHS should be judged. From our perspective addressing inequalities in health need to be at heart of outcomes as homeless people experience some of the worst inequalities in health of any group in society.

As stated in the Marmot review on a fairer society, 'inequalities in health arise because of inequalities in society – in the conditions in which people are born, grow, live, work, and age. So close is the link between particular social and economic features of society and the distribution of health among the population, that the magnitude of health inequalities is a good marker of progress towards creating a fairer society'.⁷ We believe this marker should also lie at the heart of the new outcomes framework.

1. Do you agree with the key principles which will underpin the development of the NHS Outcome Framework?

We agree that each of the principles will be important in developing the new Outcomes framework. However, our major concern is that they give the green light to a very clinically driven NHS. We understand that there will be an outcomes framework for the new public health service and for social care services but we would prefer to see a unified health and well being framework spanning the services.

A clinically driven framework is coherent with the whole strategy which places commissioning responsibilities with GPs and promotes the autonomy of health care professionals. Our concern with this is that an NHS (and its constituent parts) held to account for outcomes that it alone can influence will deliver a very predominantly medical model of care. We know from our members that a holistic approach to homeless people with health needs is the most effective. This has been recognised more generally as important in working with socially excluded groups in the *Inclusion Health*⁸ guidance which suggests 'tailoring care across pathways to allow more holistic and person-centred identification of need and service provision'. Research by the University of York supports this approach: 'health services should work jointly with social housing and social care services, as part of a holistic multi-service response to homelessness.'⁹

For homeless people, as for most disadvantaged groups, this evidence strongly supports that a social model of care that takes into account their holistic needs for support, housing, a decent income and a feeling of control over their own lives, is more likely to be effective.

⁷Marmot Review Fair Society Healthy Lives Executive Summary
<http://www.marmotreview.org/AssetLibrary/pdfs/Reports/FairSocietyHealthyLivesExecSummary.pdf>

⁸ Inclusion health Social Exclusion Task Force 2010
<http://www.cabinetoffice.gov.uk/media/346571/inclusion-health.pdf>

⁹ Delivering Health Care to Homeless People: An Effectiveness Review
<http://www.york.ac.uk/inst/chp/publications/hebs.html>

Case study from nurse member in QNI homeless health Initiative ¹⁰

“(the client) was aged approximately 65 years old, had been rough sleeping for approximately 2 years, and misusing alcohol for approximately 25 years. He had diabetes, difficulty with weight bearing, awaiting surgery, moderation, several medications and was vulnerable to exploitation....we met with the housing team, GP services and outreach from the local hostel. (the client) was offered outreach care in a bed and breakfast – health was fully reviewed, medication was arranged with support from outreach team. Now the individual is living in independent accommodation, alcohol use is less, he regularly attends GP appointments.”

We are pleased that promoting equality is in the framework but we would like to see this backed up with a specific commitment to a reduction in health inequalities. The Marmot review shows very clearly that the mortality rate and life expectancy are determined by levels of social advantage¹¹. The DH report ‘Healthcare for single homeless people’ amply demonstrates the level of health inequalities experienced in the single homeless population ‘*The average length of stay (in hospital) is 6.2 days for NFA patients, compared to 2.1 days in the population aged 16-64. Although this average for NFA patients is almost triple that of the comparison population, it is almost fully explained by the severity of their health conditions (their ‘case mix’) rather than differences in delays for discharge.*’¹²

Action on health inequalities requires action across all the social determinants of health. An NHS based on clinical outcomes will not turn around the social gradient on health. The Marmot review states ‘*This link between social conditions and health is not a footnote to the ‘real’ concerns with health – health care and unhealthy behaviours – it should become the main focus.*’ We agree with this and have concerns about how this might be achieved in the context of this framework. There is an economic as well as a moral incentive to reduce inequalities in health. As stated in the Marmot review it is estimated that inequality in illness accounts for productivity losses of £31-33 billion per year, lost taxes and higher welfare payments in the range of £20-32 billion per year, and additional NHS healthcare costs associated with inequality are well in excess of £5.5 billion per year. It is estimated that homeless people consume around 4 times more acute hospital services than the general population, costing at least £85m in total per year.¹³

We strongly welcome the key principle of ‘what matters to patients and health care professionals’. However we would also emphasise that patients are not a homogenous group, and different things will matter to different people.

We understand that tools will be used to capture patient reported outcome measures. However if the focus of these is solely on ‘what the NHS can focus on’ it may not capture the wider factors which also matter to patients in achieving good health outcomes– for example that a patient’s physical health care is co-ordinated with their social care; or that they are not excluded from mental health treatment because they continue to drink. Good health care outcomes are as dependent on having somewhere to live, education, a decent income, control over one’s life, living in a

¹⁰ Homeless Health Initiative Partnership working in Homeless Health <http://www.qni.org.uk/homeless-health-initiative/hhi-resources.html>

¹¹ The Marmot Review, Fairer Society, Healthy Lives, (February 2010)

<http://www.marmotreview.org/AssetLibrary/pdfs/Reports/FairSocietyHealthyLivesExecSummary.pdf>

¹² Healthcare for Single Homeless People, (DH, March 2010)

¹³ *ibid.*

healthy and sustainable community but this will not be evident by collecting outcomes that the NHS alone can influence.

2. Are there any other principles which should be considered?

The paper states that a crucial element in designing the NHS outcomes framework will be considering how to incentivise integrated care. We agree that this should be one of the key principles and supports the need as outlined above for a more unified framework. Integrated care is particularly important to groups that experience multiple disadvantage. Treating their physical health care without taking account of their misuse of substances, their mental health symptoms or finding out that the instability of their housing situation makes it impossible to follow a treatment regime can undermine the effectiveness of the health intervention.

We urge the incorporation of *Inclusion Health* guidance¹⁴ into the new framework as this addresses how to improve the way we meet the primary health care needs of the socially excluded. The *Inclusion Health* commissioning guidance highlights the need for partnership: ‘the health needs of socially excluded groups are often complex and require a sophisticated, coordinated and flexible response from services. The costs of failure are great not only to the individual life chances of socially excluded clients, but also to the taxpayer, services and the communities who pick up the pieces.’

In order to address these there are a set of recommendations in the *Inclusion Health* guidance around leadership, the workforce, how to set priorities around an accurate picture of need, joined-up, cost-effective and equitable care, raising health aspirations, and promoting prevention and early intervention. It suggests this will need a focused and coordinated effort, both nationally and locally. We understand that this government is planning to take forward the recommendations from the *Inclusion Health* programme. In order to do so the building of effective partnerships will need to be incorporated into the way that the success of the health services is measured.

3. How can we ensure that the NHS Outcomes Framework will deliver more equitable outcomes and contribute to a reduction in health inequalities?

Homeless people as a population group experience some of the worst health inequalities. Research demonstrates consistently the particularly poor morbidity and mortality rates in the homeless population. In order to ensure that the NHS outcomes framework delivers more equitable outcomes there will need to be an explicit commitment to addressing the health inequalities experienced by the most socially excluded groups. Reducing health inequalities should be an improvement area within each of the five proposed domains informed by baseline data about the current outcomes/experience of the most socially excluded.

The Marmot review suggests ‘to reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. We call this proportionate universalism.’ The *Inclusion Health* commissioning guidance¹⁵ and the DH report ‘The Health Care of Single Homeless People’¹⁶ suggests the development of specific services targeted at groups which experience social exclusion. We believe that GP consortia will need to

¹⁴ Inclusion Health, 2010 <http://www.cabinetoffice.gov.uk/media/346571/inclusion-health.pdf>

¹⁵ Inclusion Health, 2010 <http://www.cabinetoffice.gov.uk/media/346571/inclusion-health.pdf>

¹⁶ Healthcare for Single Homeless People, (DH, March 2010)

appoint a lead on inequalities and social exclusion in order to inform themselves sufficiently about the type of services which will deliver equitable outcomes and contribute to a reduction in health inequalities.

4. How can we ensure that where outcomes require integrated care across the NHS, public health and/or social care services, this happens?

Integrated care is crucially important and efficient. There has been improvement in the provision of integrated care and single assessment in mental health but it needs to happen across health and adult social care.

There are many examples of GP practices and other health professionals which work very closely with social care and other partners, and who are closely aligned to the public health agenda. However one of our concerns about GP commissioning is that some GPs are less well engaged with these areas and therefore it will be vital that local authorities and voluntary and community sector partners sit on commissioning boards in order to represent both public health and social care.

An appreciation of a social model of health will support this integrated working. For example it can be of benefit to understand how providers of housing related support, a befriending services or a needle exchange could add value to health interventions, particularly for socially disadvantaged groups. The case study below, from the Homeless Health Initiative, highlights the importance of developing effective partnerships.

Case Study No Fixed Abode (NFA) Primary Health Care Team, Leeds¹⁷

“Historically the NFA primary health care team has formulated and forged both formal and informal partnership working with a range of agencies within the city. NFA have also moved towards formalising many of their previous informal partnerships, both to improve the way they demonstrate partnership working and to improve pathways for their service users.

One example of an informal partnership is their close working with a non-statutory sector agency that provides outreach to homeless people with complex needs and who are poor engagers of services. In this partnership, both agencies work together to formulate and implement social and health care packages. The non-statutory agency can promote the NFA service to the people they engage with, and work intensively with them to help them access it for their health care needs. In return NFA can utilise the skills of the non-statutory agency when they are concerned about clients who have disengaged and thought to be rough sleeping.

We would like to see integration go further than across the NHS, public health and/or social care services and there to be more understanding of integration of the planning, transport, housing, environmental and health systems to address the social determinants of health in each locality. This would require national and regional leadership to promote awareness of the underlying social causes of health inequalities and build understanding across the NHS, local government, third sector and private sector services of the need to scale up interventions and sustain intensity using mainstream funding”.

¹⁷Partnership working in homeless health, (QNI, March 2010)
www.qni.org.uk/userfiles/file/Case%20studies%20of%20partnership%20working_final.pdf

Five domains

5. Do you agree with the five domains that are proposed in Figure 1 as making up the NHS Outcomes Framework?

The five domains are all important issues to tackle and we would not challenge the importance of any of them. We would like to add another domain around prevention and health promotion. Prevention does not feature in the outcomes framework as it is currently described. We recognise that some prevention activity will be in the domain of public health and under the remit of local authorities but it also the remit of the NHS and needs to be built into all health care interventions.

Homeless people suffer completely disproportionately to the general population across a whole series of health care issues that are amenable to health promotion and or/preventative interventions. These examples are drawn from the Homeless Link Homeless Health Needs Audit¹⁸ and compared with health statistics in the general population.

	Percentage who smoke	Percentage who eat 5 or more fruit a day	Percentage with mental distress	Drug use
General population	21%	29%	30 %	10% (one or more illicit drug in last year)
Homeless population	77%	7%	72%	52%

We would like to see a domain added to implement an evidence-based programme of ill health preventive interventions that are effective across the social gradient. This is one of the recommendations of the Marmot review which states: 'At present only 4% of NHS funding is spent on prevention. Yet, the evidence shows that partnership working between primary care, local authorities and the third sector to deliver effective universal and targeted preventive interventions can bring important benefits'.

Inclusion Health guidance echoes the specific importance of preventative initiatives for excluded groups. 'Investment in prevention and early intervention is important because of the benefits over the medium and longer-term. It will rely on partnerships between organisations and the skills of those who are 'at the front door' of prevention, such as health visitors, and will require maximising the services and professionals who are 'touch points' for the vulnerable (such as pharmacists, housing officers and A&E)¹⁹ ...

The guidance goes on to highlight the need for pathways which could include intermediate care and appropriate medicine management. 'For commissioners and providers, this means providing multiple and compelling pathways to better lifestyle choices that help socially excluded groups achieve the same health status as others. This could include the provision of intermediate care services which prevent hospital admissions or the expansion of smoking cessation services to include 'hard to reach' groups. In primary care, this also includes the equitable and appropriate use of medicines that are likely to help people live longer healthier lives'.²⁰

¹⁸ Homeless Link Health Needs Audit <http://www.homeless.org.uk/health-needs-audit>

¹⁹ <http://www.cabinetoffice.gov.uk/media/346571/inclusion-health.pdf>, p.34

²⁰ <http://www.cabinetoffice.gov.uk/media/346571/inclusion-health.pdf>, p.36

There is evidence that medicine management is needed for many chronically ill clients who have been long term in homeless hostels.²¹ The following example of an intermediate care project for homeless people is showing promising results in relation to prevention of admission to more acute services.

Economic Evaluation of the Homeless Intermediate Care Pilot Project - Three Boroughs Primary Health Care Team²²

'During the year of the pilot project the number of hospital admissions was 77% lower than in 2008, the number of A&E attendances was 52% lower, and the number brought to A&E by ambulance was 67% lower. There have also been significant gains in terms of client mortality and morbidity. The project has been demonstrated to be essentially cost neutral with better client outcomes.'

We recognise this will be part of the role of public health and that there will be a new ring fenced public health budget including a health premium designed to improve population wide health and reduce health inequalities. However in order to improve joint working and joint commissioning health prevention and health promotion must also be seen as core functions in the NHS.

6. Do they appropriately cover the range of healthcare outcomes that the NHS is responsible for delivering to patients?

In line with our response to the above question we don't feel that the domains address the issue of health promotion and prevention of ill health which is part of the range of health care outcomes that the NHS is responsible for delivering to patients.

7. Does the proposed structure of the NHS Outcomes Framework under each domain seem sensible?

We agree that the NHS has focused too much on narrow process measures, however some process measures are still required because of the absence of a well-defined outcome, or because the outcome is too distant. Process measures can be used to measure progress along the way and provided the process measures are valid and have professional support they should not be discarded wholesale.

We have some concerns about providers being always held to account for producing improved outcomes in relation to specific indicators. We know that within the homeless population there are people with extremely complex morbidities and with behaviours that are not conducive to their health. For example in one of the pilots of Homeless Link's Homeless Health Needs Audit, self harm was the single most common reason for clients to be admitted to hospital.²³

The following extract is from guidance issued by the National Mental Health Development Unit and the CLG in 2010.²⁴ It illustrates why mainstream GP surgeries may have difficulty in engaging some homeless people in compliant health

²¹ 'Demand Management at Graham House', Lambeth Primary Care Trust, Samantha Dorney Smith 2007

²² Chiara Hendry, 2009, available at www.threeboroughs.nhs.uk

²³ Homeless Link Health Needs Audit <http://www.homeless.org.uk/health-needs-audit>

²⁴ Meeting the Psychological and emotional needs of people who are homeless CLG and NMH DU 2010 www.nmhd.org.uk/.../meeting-the-psychological-and-emotional-needs-of-people-who-are-homeless.pdf

behaviours and why some homeless people behave in a way towards their own health which others find irrational.

'People with complex trauma who have experienced homelessness may behave in a range of ways that suggest underlying difficulties with relationships, or with managing their own emotions. Some people may for example:

- self-harm or have an uncontrolled drug and/or alcohol problem
- appear impulsive and not consider the consequences of their actions
- appear withdrawn or socially isolated and reluctant to engage with help which is offered
- exhibit anti-social or aggressive behaviour
- lack any structure or regular daily routine
- not have been in work or education for significant periods of time
- have come to the attention of the criminal justice system due to offending.

Some people may have had unsatisfactory experiences of housing, health or care and support services in the past; and some may now be wary of all forms of authority or bureaucratic systems, despite the good intentions of the service provider. Some may be reluctant to reveal the full extent of their problems until they are reassured that their trust will not be betrayed, others may need to challenge services to test the response, until they are sure that trust is well placed. It is estimated that 55-60 per cent of adults in supported accommodation have a diagnosable personality disorder, in many cases resulting from neglectful and abusive early experiences. This can result in anti-social and violent or disruptive behaviour which is hard for frontline staff to manage and which, in some cases, can lead to exclusion or eviction.'

An emphasis on outcomes and payment reflecting outcomes could potentially have a distorting effect. In relation to our client group, GP's or other health providers could become more reluctant to register homeless people. Results from the Homeless Link health audit showed that 9% clients said they had been refused access to a GP or dentist. Patients who are less compliant either because they have low self worth and don't care about their health outcomes, or because their living circumstances make it impossible to follow medication or healthy lifestyle regimes, and those who continue to use drink or drugs are likely to have poorer health outcomes.

The white paper states that 'GP consortia will align clinical decisions in general practice with the financial consequences of those decisions.' If finance drives all decisions there will be unintended consequences of a payment by outcomes approach. The NHS commissioning board needs to put other incentives in place to ensure that more expensive patients who are likely to have poorer health outcomes are not excluded. If reducing health inequalities is an improvement area under every domain this should help to address this issue.

**Domain 1 - Preventing people from dying prematurely
Is mortality amenable to healthcare an appropriate overarching outcome indicator to use for this domain? Are there any others that should be considered?**

Premature death is an issue in the homeless population. Several sources show that of deaths that occur in hostels or while registered with homelessness services, the average age at death is low, about 40-44 years. This is an average age at death of a sample of homeless people who die whilst they are homeless and it does not take into account those people who become settled in a home, however it has stayed

stable for at least the last fourteen years and needs to be addressed at a national level.²⁵

One of the largest homelessness providers in London, St Mungo's, has appointed a specialist palliative care co-ordinator, which is an indicator that death in the hostel population is much higher than one might expect in a client group of this age. The DH End of Life care programme also recognised this was an issue and are developing specialist guidance on end of life care in hostels. One of the most common reasons is liver failure, and some specialist work needs to be done around this to enable providers to be more aware of the signs and symptoms.

The paper suggests that while the NHS will aim to narrow inequalities in all the outcome indicators it may be desirable to select some improvement areas where there are significant inequalities in outcomes. A specific target around reducing the age of death of people living in hostels would generate a focus on their health care needs and would be likely to generate an improvement in access to services and understanding of their specific needs.

We would prefer the domain to be described as mortality amenable to public service intervention as this widens the scope from purely medical intervention.

Domain 2 - Enhancing the quality of life for people with long-term conditions

We welcome the inclusion of this domain and specifically the inclusion of people with long term mental health problems as often the interaction between chronic mental ill health and poor physical health is missed.

We are pleased that a view of needs and desired outcomes crossing physical and mental health is being taken as too often physical and mental health are approached in silos. The paper states that 29 % of people with long term conditions now live with more than one condition. Research suggests that 41% of clients in an average homelessness project have multiple needs.²⁶ The pilot of Homeless Link's Homeless Health Needs Audit found that 56% homeless participants had a long term physical condition, and 45% a long term mental health problem.²⁷ Multiple needs and exclusion often go hand in hand as services can perceive these clients to be too expensive or challenging to help²⁸.

We also welcome a holistic approach in recognising the debilitating effects long term conditions can have on people's lives. As the paper states interaction with other services and effective partnership will be particularly important in this domain. From the perspective of the homeless sector we would like to stress the importance of statutory services working closely with voluntary sector services such as homelessness providers and providers of housing related support. The NMH DU guidance referred to earlier²⁹ emphasises the importance of a Psychologically Informed Environment:

²⁵ At the Dawn Centre in Leicester, where all patients are homeless at registration but not necessarily rough sleeping, the average age at death for clients who died between 1989 and 2007 was 40.2 years. At the Cambridge Access Surgery, the equivalent figure for 2003-2008 was 44 years. Crisis reported a similar figure. <http://www.homelesspages.org.uk/node/24178>

²⁶ Homeless Link Survey of Needs and Provision SNAP 2010 <http://www.homeless.org.uk/snap-2010>

²⁷ Homeless Link, Interim Findings of the Health Needs Audit, 2010

²⁸ Please see www.meam.org.uk for more, including the publication, 'Hardest to Reach? – The politics of multiple needs and exclusions', (MEAM and Fabian Society, 2010)

²⁹ Meeting the Psychological and emotional needs of people who are homeless CLG and NMH DU 2010 www.nmhd.org.uk/.../meeting-the-psychological-and-emotional-needs-of-people-who-are-homeless.pdf

'The psychologically informed environment (PIE) can be created in a service such as a hostel or day centre where the social environment makes people feel emotionally safe. A PIE is an approach rather than a place, and an example of what the Royal College of Psychiatrists terms an 'enabling environment'. PIEs can be developed within existing commissioned services, wherever appropriate training and development enables staff to respond effectively to people with psychological needs and longstanding emotional problems. This includes trying to understand people's behaviour, helping them to be involved with others in a genuine way, and to take as much responsibility for themselves as possible.'

Homeless Link believe that developing this idea in hostels would be a really progressive way of enabling an improved response to the range of mental health problems and behavioural difficulties expressed in the hostel and day centre environment. The homeless sector needs the help of statutory mental health services to offer staff appropriate training and support. We see this as one aspect in which effective partnerships would help to address long term conditions in a positive way.

For people who have been resettled from homelessness and are living with long term conditions indicators such as being able to keep their own home and live independently would ensure that health services became more aware of the nature of housing related support and how health services and floating support can work together to improve someone's quality of life. Below is an illustration of health services and floating support working together to enable someone with several long term conditions to stay in their own home.

Mrs. S had been a local authority tenant for some years. She suffers from various health issues including mental health and physical health problems, the latter affecting her mobility. She had found it increasingly difficult to cope with all aspects of her daily life as her medical circumstances had deteriorated. Her benefits had lapsed due to her poor mental health, leaving her with no income. She was struggling with her personal hygiene and was not eating properly. She was also unable to take adequate care of her property, which had become so unkempt it was both a risk to her welfare and was causing problems for her neighbours. A suspended warrant for possession was about to be enforced which would have left Mrs. S homeless.

Floating support began working with Mrs. S in March 2005. The initial action taken was to support Mrs. S to claim all the appropriate benefits available to her, including disability benefits. As part of this process direct payments for her rent and the arrears were set up. Arrangements were also made to pay off her other debts at manageable amounts. Funding from various sources allowed for both the inside and outside of her property to be cleared and cleaned. In addition new furniture was arranged. Referrals to other appropriate support services were made resulting in assistance from both the Social Care Team and the Community Mental Health Team. An emergency alarm and a phone were also installed at the property.

Following this initial period of intensive support Mrs. S's impending homelessness was prevented. She remains living at home and now needs a much lower level of support to monitor her progress and continue to increase her confidence.

Domain 3 – Helping people to recover from episodes of illness or following injury

The issue of particular relevance to homeless people in this domain is that of emergency bed days associated with repeat acute admissions to hospital indicating that original treatment was not as effective as it could have been.

From the homelessness perspective, the particular issue is not so much about effective treatment as not taking into account the impact of social factors. Admission to hospital should be used as a window of opportunity to discharge a homeless person to improved housing conditions and never to discharge them back to the street. Figures collected by the Rt Hon Grant Shapps MP in 2007 showed that 5,453 people were discharged from a hospital bed to no fixed abode and that 67% of hospital trusts are unable to identify an existing policy addressing the discharge of homeless patients.³⁰ Re-admission to hospital of homeless people is high because if they are discharged to the street or to poor housing conditions where their health cannot be taken care of it is likely that their condition will re-occur.

Homeless Link, alongside the CLG, DH and other partners, helped to develop a template protocol for the admission and discharge of homeless people from hospital.³¹ This encourages the working together of housing, hospital staff, and adult social care and voluntary sector. However to encourage more effective use of protocols we would like to see specific monitoring of re-admission to hospital of patients with a homeless status as this is one indication that their after care has not been properly managed.

An effective housing pathway is vital in enabling recovery from ill health as highlighted in points 1-5 above. In addition to effective aftercare from hospital, this principle should also underpin outcomes for patients recovering from alcohol or drug treatment programmes.

Domain 4- Ensuring people have a positive experience of care

We welcome the fact that patient experience of care is prominently featured. Being listened to, experiencing respect and being treated with dignity feature highly in homeless people's priorities and needs to be given equal importance with the actual clinical care received.³²

Homeless people often report a very negative experience of contact with statutory services so sometimes particular care is needed to redress the discrimination that they have experienced³³. It is important to understand that they may approach health care providers with an expectation of not being treated well and that this can result in a defensive approach. Specific feedback mechanisms will be needed to collect the views of patients who are disadvantaged and marginalised, these will need to take into account diversity, feelings of alienation, and expectation of discrimination. Surveys will need to be supplemented with focus groups, and perhaps peer research. Homeless Link is happy to advise on effective ways of consulting with homeless people.

³⁰ Discharged to No Fixed Abode 2007 Grant Shapps <http://www.shapps.com/reports/>

³¹ Hospital Admission and Discharge: People who are homeless or living in temporary or insecure accommodation <http://www.communities.gov.uk/publications/housing/hospitaladmission>

³² Listening to homeless people – Health Link 2007 http://www.health-link.org.uk/publications/Listening_to_Homeless_People.pdf

³³ See for example 'Service User Consultation Report', The Queen's Nursing Institute Homeless Health Initiative and Groundswell (February 2008) found GP attitude as a key barrier to effective care. Homeless Link's health needs audit found 9% homeless people were refused access to GP or dentist care.

We welcome the fact that a positive experience of mental health care is recognised as particularly important. People experiencing mental distress are in a particularly vulnerable position. They are also quite likely to make repeated use of services, and less able to be assertive while in a mental health crisis. For the homeless client group with multiple needs they are likely to be using a range of services, wider than those provided directly by the health service, including alcohol and drug services so it will be important to ensure that these services are covered as part of the service improvement in different settings.

23. Would there be benefit in developing dedicated patient experience quality standards for certain services or client groups?

Homeless Link would like to see the development of specific quality standards for different excluded or minority groups. Without specific standards the views of minorities, who are the most likely to have difficult experiences, will get hidden. The domain of ensuring people have a positive experience of care will not be meaningful unless feedback can be given on the experience of care for specific ethnic groups, for homeless people, for travellers, etc. This is the only way in which this domain can be used to ensure equality of service, and otherwise it cannot be used to rout out discrimination.

Homeless Link welcome the fact that services where little work has been conducted to date such as services for people with co-morbidities is mentioned. In terms of capturing the experience of particular groups we would like to urge that the range of groups that experience social exclusion are included.

Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm

Homeless Link agrees with this as an overarching indicator. An active patient safety culture and one where staff and patients feel empowered to expose failings in care is very important. It is particularly important for more vulnerable people, older people, people using mental health services, and learning disabilities services. There has been a move away from big closed institutions where we know harm was done to vulnerable people, but those practices have not entirely gone. It is vitally important to protect staff that expose bad practice and that patients have access to advocacy and independent advice to complain if they want to.

Specific vulnerable groups are referred to, including women about to give birth, older people, people with mental health difficulties and learning disabilities. We would like to see this extended to all groups that experience social exclusion. There also needs to be recognition that everyone is vulnerable when they are ill and feel less able to fend for themselves and assert themselves.

Safe discharge is identified as one of the improvement areas– we would like to see a standard built in that that no-one is ever discharged to the street.

27. What action needs to be taken to ensure that no-one is disadvantaged by the proposals, and how do you think they can promote equality of opportunity and outcomes for all patients and, where appropriate, NHS staff?

Specific actions have been referred to earlier in the paper:

- We would prefer to see a unified health and well being framework spanning the NHS, public health and social care services to ensure a more integrated approach.
- Reducing health inequalities should be an improvement area within each of the five proposed domains informed by baseline data about the current outcomes/experience of the most socially excluded. We would also like to see the particular focus on vulnerable groups referred to in domain 5 extended to all domains
- We would like to see a mandatory requirement for each GP consortia to have a lead on inequalities.

31. Is there any other issue you feel has been missed on which you would like to express a view?

We would like to offer the help of Homeless Link as the membership body for the homeless sector to act as an adviser on how to make these reforms work for disadvantaged and vulnerable people. We have experience of what sort of services work for people who experience multiple disadvantages, how to consult with homeless people to ensure that their views are fed into the new consortia. We would be happy to discuss how to incorporate inequalities leads into the NHS commissioning board and into GP consortia.

2. LIBERATING THE NHS: COMMISSIONING FOR PATIENTS

The focus of Homeless Link's response to this consultation paper is how the new commissioning arrangements will impact on people who are homeless. In many areas, people who are homeless struggle to get the services they need, creating long term exclusion from appropriate treatment, and high knock on costs to acute care and wider society. Commissioning health care which specifically meets the needs of homeless people will help reduce costs to the NHS in the future.

The proposed restructure of the NHS creates a new opportunity to deliver this and make a system which is truly equitable. However, we believe greater safeguards need to be built into the planning and allocation structures both within consortia and the NHS Commissioning Board which will identify and address the full spectrum of health needs of homeless people.

We have responded to the questions most relevant to our interests and areas of expertise, and referenced our responses to the other sections of the White Paper as appropriate.

Responsibilities of GP consortia

Devolving greater responsibilities to GPs presents considerable change to the way services are currently commissioned. While we agree GPs are based close to communities, we believe further safeguards are needed to ensure they identify and include the needs of unregistered and less visible patients, and those who are excluded from routine needs assessments.

How can the NHS Commissioning Board and consortia work best together to ensure effective commissioning of low volume services?

The paper states that consortia will have the 'freedom and responsibility to decide for themselves at what level low volume services are best commissioned'. We agree that some low volume services should be provided at either a regional or unitary level. Indeed, there is a danger that if this is not done then such services could be lost under the new arrangements if deemed too low volume and hence not cost effective to provide otherwise.

Therefore a clearer mechanism is required to identify exactly what constitutes a 'low volume' service and some guidance to support consortia to consider how these could be provided at a different level. For example, it may make sense to pool budgets to fund such services between groups of consortia, or in other cases for responsibility for these to pass to the NHS Commissioning board. These decisions should consider some of the small yet high need populations – such as homeless people, or those with complex dual diagnosis issues. Although 'low volume', if they not addressed they will incur high costs to acute services in the long term.

Our experience has shown that it is more efficient to provide these types of services across different authority areas. The JSNA should be used as one mechanism to inform these decisions as it will identify need across a wider area than that covered by consortia.

Example: The Three Boroughs Primary Health Care Team³⁴ is made up of five sub-teams working across the London boroughs of Lambeth, Southwark, Lewisham. The 3BPHCT provides health care to marginalised people who may not have equitable access to health services and who, compounded by deprivation, suffer disproportionate amounts of ill health such as addictions, poor physical/mental health, high rates of airborne disease (TB), and high rates of blood borne viruses (hepatitis/HIV).

Services are provided in a variety of appropriate settings in the community that are easily accessible. The team also facilitates access for clients to mainstream services, ensuring a more equitable and responsive service is provided.

What safeguards are likely to be most effective to ensure transparency and fairness in commissioning services from primary care and in promoting patient choice?

We think there need to be mandatory safeguards built into the commissioning cycle to ensure any proposals for services are fair and equitable to the whole local population. This could take the shape of an equalities assessment of a local area which takes into account the needs of seldom-heard or more excluded population groups including homeless people. Consortia should be expected to outline how their commissioning plans address any inequalities identified in this assessment to ensure no patient groups are inadvertently overlooked. Homeless Link's Homeless Health Needs Audit Tool³⁵ was developed to assist commissioners identify the health needs of homeless people which can otherwise be missed out from routine data collection.

This safeguard could be integrated into the JSNA which should identify the needs of all those in a local population. Consortia should have clear responsibilities to engage with the JSNA and use it as the basis for their commissioning decisions. This would promote both fairness and transparency as will clearly demonstrate upon what information commissioning decisions have been based.

We would also like clarity from the government about how commissioning in the new NHS may relate with former attempts to develop comprehensive area commissioning such as Total Place. Is this, or a similar scheme, something that GP consortia are expected to feed into? There would be merit in linking to these as the new structures are developed.

The role of the NHS Commissioning Board

How can the NHS Commissioning Board develop effective relationships with GP consortia?

We believe the NHS Commissioning Board will have a vital role to play under the new proposals. While locally devolved commissioning has the potential to better respond to local need, we believe there are still a number of responsibilities which are better delivered at a regional and national level and the Board will be the main vehicle for these in the new NHS.

³⁴ www.threeboroughs.nhs.uk

³⁵ The audit tool was developed in partnership with DH, CLG and a range of local partners. It has been piloted in 9 regions across England with over 700 homeless people. Please see www.homeless.org.uk/health-needs-audit

In the NHS paper, details about the shape and structure of the NHS commissioning board remain deliberately undefined, and we hope that given the hugely important and ambitious roles set out for the Board, further and careful consideration is given to its role and membership. To fulfil its duties around commissioning, patient choice and quality we hope the NHS Commissioning Board does not lose the expertise which currently sits within many PCTs and regional structures, particularly around health inequalities. In our experience, many Strategic Health Authorities (SHAs) and PCTs have developed a valuable strategic understanding about the needs of certain population groups, and of their complex problems which go beyond purely clinically-led need. We hope the NHS board will continue to draw on this expertise as fulfils its own commissioning activities, as well in setting quality standards and allocating resources.

As there is little detail about the structure or membership of the NHS Board it is as yet unclear how relationships should be best established with the consortia and at what level – for example will all consortia across England be accountable to one single Board, or will the Board be split to a regional level where this makes sense (for example within London)? There will potentially be a large number of consortia and we would question how manageable it will be for one NHS Commissioning Board to oversee the function and accountability of every consortia in England. As present there is little information about how these relationships will be formalised.

There is also insufficient detail about how the NHS Board will be expected to engage with the Health and Wellbeing Board and other structures in order to commission those services referenced in 3.30 such as prison health and regional specialised services. The *'Local Democratic Legitimacy in Health'* paper suggests the NHS board can have representation on health and well being boards 'where appropriate'. We call for greater clarity on this, and how the capacity of NHS board will accommodate this important role.

In addition to relationships with consortia, the Board will need to establish effective relationships with other sectors. We would like to see specific avenues opened up for communication with the homeless sector and with homeless people so that the board has an understanding of why health inequalities persist for homeless people and what sort of client involvement has a track record of working with homeless people.

Are there other activities that could be undertaken by the NHS Commissioning Board to support efficient and effective local commissioning?

The main White Paper document, *'Equity and Excellence: Liberating the NHS'* states that the NHS Commissioning Board will have 'an explicit duty to promote equality and tackle inequalities in access to healthcare' (p.5). However we feel further steps are needed to ensure it can achieve these aims.

The *'Commissioning for Patients'* paper makes limited reference to how this responsibility will be fulfilled. It refers to an expectation from the Secretary of State in the Board's 'multi year planning cycle' for measures it will take in tackling inequalities in outcomes of healthcare (pp.17-18) and gives one reference to the way the new outcomes framework will be used to measure how consortia reduce inequalities in health (p.27). However this detail is limited and we believe the Commissioning Board needs to play a far greater role in mainstreaming the health inequalities agenda at every level of the new NHS. Addressing health inequalities is critical to the government's overall vision of equity and excellence and we believe this lack of detail could seriously undermine the credibility of this commitment.

The *Inclusion Health* guidance³⁶ provides measures which go a significant way to addressing the health inequalities which run throughout the healthcare system. We urge the NHS Board to implement a set of standards based on these recommendations to underpin activity at each level of the new NHS structure to address health inequalities.

Should there be a minimum/maximum population size for GP consortia?

There is the risk that a greater number of consortia will lead to fragmentation of services in some areas, and diseconomies of scale. This in turn could place the commissioning of valuable low volume services at even greater risk. We equally see risk of provider capture from consortia which cover a large population size.

As such there would be value in setting guidance about minimum and maximum size. However it is also important to consider the demography of a local population as well its size, taking into account levels of economic activity, poverty and social inclusion. This information is already provided by local health profiles and should be considered when setting allocation formulas for consortia.

Freedoms, controls and accountabilities

How can GP consortia best be supported in developing their own capacity and capability in commissioning?

While the transfer of new responsibilities to GPs opens up opportunities for commissioning based on a better understanding of local need, we have concerns that some GPs may not have a full understanding about the needs of homeless and other vulnerable groups who are less visible and who are likely to have more complex needs than the general population.³⁷

Research suggests 71% of non homeless health specialists are not confident in their ability to care for homeless people³⁸. Homeless people have historically experienced difficult relationships with some GP practices. Research suggests a lack of awareness of homeless people's needs and attitudinal barrier persist in many surgeries, with some staff being unwilling to register patients, offer flexible appointments or engage in certain treatment pathways³⁹. It is this context that concerns us if GPs will now have responsibility for commissioning the wider health services for this group.

It can be difficult for the health sector to assess and understand their health needs as many homeless people do not access mainstream services and are not routinely included in health assessments. In the new NHS, GPs will need to access an evidence base about the needs of these individuals and ensure they have a strategic

³⁶ <http://www.cabinetoffice.gov.uk/media/346571/inclusion-health.pdf>

³⁷ These findings have been identified in a range of sources, including research from the Social Exclusion, the Audit Commissioning and Homeless Health Initiative, please see www.cabinetoffice.gov.uk/media/346574/inclusion-health-evidencepack.pdf, p.18.

³⁸ Quoted in Inclusion Health Evidence Pack, (DH 2010). A survey by QNI of its members reported this figure.

³⁹ 'Service User Consultation Report', (QNI Homeless Health Initiative and Groundswell, February 2008). GP attitude was identified as a key barrier to effective care. Homeless Link's health needs audit found 9% homeless people were refused access to GP or dentist care.

understanding about the full range of services required to meet these. Some of these services may be more specialist interventions, particularly in the field of mental health.

We believe there is great potential for the voluntary sector to provide this expertise and support GPs to develop their commissioning capability for socially excluded groups. The *Inclusion Health* guidance encouraged commissioners to use more varied evidence based on local need, which draws on the experience both of patients and voluntary sector groups working with them. We would welcome a similar expectation for GP consortia to ensure they do not rely solely on data about more visible patient groups which are easier to quantify in more routine needs assessments.

One way to ensure this happens will be through the local health and well being board which we believe needs to play a key role in informing the commissioning decisions of consortia. However, this needs to be brokered in a systematic way to enable this to happen. At present we feel the proposed structure of the HWB does not adequately facilitate the involvement of voluntary and community sector groups who are well positioned to provide these sources of data and expertise.

The Homeless Link Homeless Health Needs Audit⁴⁰ is a means to measure the needs of a local homeless population and would offer GP consortia a rich source of data about a patient group who may otherwise be excluded. This tool works on a principle of partnership and shared expertise between providers, patients and commissioners would greatly enhance the capability of consortia in their new role.

What support will GP consortia need to access and evaluate external providers of commissioning support?

We regret that commissioning expertise may be lost as PCTs are disbanded. We hope measures are put in place to ensure the competence and skills which many have employed, particular relating to vulnerable groups, is not overlooked. The voluntary sector is also well placed to contribute their skills and expertise and we hope this is taken advantage of, in addition to the other mechanisms, such as the scrutiny functions of the health and well being board.

We also ask the reform to consider how guidance from World Class Commissioning and *Inclusion Health* will be continued to assess quality of commission support. This was detailed guidance with some very valuable aspects which we believe should be taken forwards.

Should some part of GP practice income be linked to the outcomes that the practice achieves as part of its wider commissioning consortium?

We urge some caution in making income dependent on outcomes. While it can help to drive up quality, it should consider carefully what outcomes are deemed to be a success and hence linked to income. Any system which draws on the principle of payment by results needs to consider the variation in patient group, local health inequalities and levels of need which will all impact on the outcomes a practice can achieve.

⁴⁰ www.homeless.org.uk/health-needs-audit

If too heavily linked to outcomes, practices will not be incentivised to register patients who have higher levels of need, who may be less likely to comply with treatment, and for whom a successful outcome may be different when compared to the general population. In our response to the TRANSPARENCY IN OUTCOMESmes paper we expand on these ideas further and call for greater dis-aggregation of outcomes for more vulnerable patient groups.

For GP practices that are not achieving their outcomes, we also seek clarity about what remedial action the government envisages would be taken to ensure that they did so in future? While the threat of cutting income might be an incentive to the GP practices themselves, what happens to the people who GPs are failing to support well? The eventual result could be that practice has its funding cut, so no service is provided. In addition, if outcome framework does not take into account the level of patient need, poverty and exclusion which will impact on their 'success', this also increases the danger of 'good' services being concentrated in more affluent areas. Those who are less able to travel to another service, or navigate alternative provision, may be left with no provision in place creating a two tier system, greatly undermining the governments' vision for an equitable and excellent health service.

What arrangements will best ensure that GP consortia operate in ways that are consistent with promoting equality and reducing avoidable inequalities in health?

As described above, putting in place safeguards to ensure consortia take into account an equalities assessment of their local population would help minimise the risk of perpetuating inequalities in health. We also believe gathering and drawing data about health needs will help identify areas where inequalities can be addressed.

We also urge GP consortia to incorporate a social model of health, to ensure services take into account the wider determinant of health which are not purely clinically driven. There are examples of GP practices which use this model and recognise that wider services than just medical interventions can be provided at a GP level and greatly reduce the inequalities of their local area. For example GP can be used as a gateway for welfare advice, mental health support groups, or specialist advice on substance misuse⁴¹. As we outline in the TRANSPARENCY IN OUTCOMESmes section of the reform, GPs have a role to play beyond a purely clinical one. Acting on input from community and statutory partners, and being accountable both to inequalities identified in the JSNA and joint working with the HWB will be important arrangements to ensure their services do not deepen inequalities in both access and health outcomes.

Partnership

We welcome the emphasis on patient insight and involvement, and the principle of shared decision making. However we have concerns that it will not work for clients that feel disempowered and disadvantaged unless specialist provision is made for them.

⁴¹ The Open Door surgery in Grimsby is an example of how health services can be part of a wider 'one stop shop' for health and social care. www.thebiglifegroup.com/open-door/94/the_surgery. There are numerous GP practices with specialist awareness and expertise around homelessness – for example Great Chapel Street in Westminster (<http://www.greatchapelst.org.uk/>), and the Homeless Healthcare service in Southampton (<http://www.homelesshhealthcare-southampton.nhs.uk/>)

- **How can GP consortia and the NHS Commissioning Board best involve patients in making commissioning decisions that are built on patient insight?**
- **How can GP consortia best work alongside community partners (including seldom heard groups) to ensure that commissioning decisions are equitable, and reflect public voice and local priorities?**

There is a danger that any involvement activity will favour patients who are more articulate, engaged with services and capable of advocating for their own needs. Patient insight must reflect the views of those who are harder to engage.

The paper states that ‘a range of third parties will be encouraged to provide information to support patient choice. Assistance will be provided for people who do not access online health advice or who would particularly benefit from more meaningful support.’ We fully support the need for greater advocacy to support disadvantaged groups to use their voice and exercise choice. Assistance is likely to include intensive support from trusted sources, and a range of tools to gather patient insight. It is our experience that standard patient experience surveys will be unlikely to capture meaningful feedback from vulnerable groups. Efforts need to be taken to run other engagement activities which could include activities done in partnership with agencies with which an individual is already engaging. The homelessness sector could be resourced to provide this more intensive brokerage and support.

Example: Advocating choice through peer-led support

There are many examples of this type of support being successfully provided by ‘peers’, or people with experience of accessing health services and homelessness. These include the Peer2Peer TB project which recruited and trained peer educators to support clients to access TB screening; and a Homeless Health Peer Service pilot in Westminster where peers will support others to navigate services and exercise more informed choices about their healthcare.⁴²

There also needs to be recognition that for socially excluded groups increased choice and control does not always lead to choices that will enhance their health. Recent guidance from the CLG and NMHDU alerts services to these issues: ‘People with complex trauma who have experienced homelessness may behave in a range of ways that suggest underlying difficulties with relationships, or with managing their own emotions.’ It cites issues relating to self harm, substance use, or unsatisfactory experiences of past health services, as contributing to this behaviour.⁴³

The NHS reform states that it wants to ensure commissioning decisions are equitable. However commissioning decisions may too easily favour those who can exercise choice, who are able to take responsibility for the health consequences of their lifestyle, and who can comply with treatment programmes. Many homeless patients will not neatly fit into this model and are likely to need a psychologically informed approach and multi-agency case management. Experience in the homeless sector is that homeless people with the most complex health issues need

⁴² The Peer2Peer project was delivered by Groundswell www.groundswell.org.uk. The *Homeless Health Peer Service* is funded by NHS London’s Innovation Fund, the operational partners are: Groundswell, NHS Westminster, St Mary’s Imperial A&E, Great Chapel Street Medical Centre, Dr Hickey Surgery, Homeless Health Team

⁴³ <http://www.nmhd.org.uk/complextrauma>

specialist services where the practitioners get to know them and understand their background and circumstances.

We ask the NHS reform to recognise some patients require the level of support outlined above to truly exercise this meaningfully, otherwise it will only be the stronger more vocal ones which carry through in the new NHS.

How can we build on and strengthen existing systems of engagement such as Local HealthWatch and GP Patient Participation Groups?

One way to achieve this to ensure patient groups are truly representative of the whole population. While existing systems of engagement have worked to some degree in better involving local patients, more can be done to strengthen these and we welcome the opportunities for doing this in the new reform. Our members report that LINKs can be patchy in terms of how representative they are, and they can be biased toward more vocal patient groups. For HealthWatch to be more representative, they should make particular provision to reach out to more marginalised groups. These groups may have been identified in the JSNA process, but the HealthWatch can also consult local VCS forums or agencies with specialist local knowledge to ensure they are capturing these.

What action needs to be taken to ensure that no-one is disadvantaged by the proposals and how do you think they can promote equality of opportunity and outcomes for all patients and where appropriate, staff?

Please see our comments which run throughout our response which address equality in access and outcomes.

We would welcome further opportunities to advise about how to ensure the new proposals do not disadvantage homeless people. Homeless Link is engaging with the inter-ministerial group on homelessness and we look forward to building on this relationship as the proposals are developed.

3. LOCAL DEMOCRATIC LEGITIMACY IN HEALTH

We support the paper's focus on making local health services more accountable and responsive to local need. We believe that the role of all local partners, from across the voluntary and statutory sector and patient groups, will be vital in achieving this vision.

Homelessness agencies and service users have a great deal of experience to contribute to the new structures proposed in the consultation paper. Below we outline some additional measures we believe are needed to ensure this can be captured in the new local landscape.

Strengthening public and patient involvement

We welcome the increased focus on patient and public involvement, and HealthWatch could potentially be an important catalyst for driving this forward.

However, overall we believe firmer measures are needed to ensure HealthWatch is fully representative of a local population. Local involvement structures tend to favour those patients more able to participate – those who understand and can navigate the health system, and who have the skills and capacity to voice their views. It will be vital that HealthWatch have sufficient resources to engage with some of the 'seldom heard' groups.

We also feel HealthWatch needs to have independence to fulfil its functions, and current proposals for its commissioning and regulation by Local Authorities could compromise this.

1. Should local HealthWatch have a formal role in seeking patients' views on whether local providers and commissioners of NHS services are taking account of the NHS Constitution?

It has been our experience that the NHS Constitution is not widely known among some patient groups, including homeless people. Homeless Link has been a member of the DH led NHS third sector forum which has consulted on how to improve the dissemination and understanding of the NHS Constitution among socially excluded and vulnerable patient groups. This followed recognition that due to its limited distribution to some patients and services, the Constitution has not had a significant impact in challenging poor practice or those services which fail to honour patient rights.

While we welcome the DH previous work to address this, if HealthWatch were to take on this role, we feel further work would first be needed to make the NHS Constitution more widely available and understood. If this is not done there will be limited opportunity for making this a document which patients can meaningfully use to hold services to account. We feel HealthWatch resources would be better spent in seeking and representing patient views and holding consortia and Health and Well Being boards to account to these.

2. Should local Health Watch take on the wider role of complaints advocacy and supporting individuals to exercise choice and control?

We feel HealthWatch would struggle to take on these additional responsibilities without significant additional investment in training, skills development and a properly resourced personnel structure to support this function.

While the paper in paragraph 17 states it would provide additional funding to help transform HealthWatch into 'a citizens advice bureau for health and social care' it is vital to recognise the unique skills they will require to support more vulnerable patients navigate the health system and exercise their choice.

Some members of the community require intensive support to understand the choices available to them and realise how these will impact on their own health and treatment options. In addition to chronic health and housing needs, many homeless people have ongoing but undiagnosed problems relating to learning disabilities or mental health issues.⁴⁴ This highlights how important it is to have appropriately trained staff who can assist these individuals in a meaningful way.

This is a role already undertaken by many staff, volunteers and peers from the voluntary sector who have the specialist expertise to engage with potentially very vulnerable people. The expectation that a local HealthWatch could provide this role needs very careful consideration. We feel it may be more prudent to draw on and resource existing specialist advocacy work within the health and voluntary sector to undertake this role⁴⁵.

3. What needs to be done to enable local authorities to be the most effective commissioners of HealthWatch?

Local Authorities need to have a thorough understanding of their local population in order to commission a HealthWatch which is representative and responsive to not just their clinical needs but the wider needs such as housing and employment, which will impact on their health.

This intelligence should be linked to the JSNA whose key purpose is to identify local needs. However we also suggest this is underpinned by additional joint working with local voluntary sector groups (for example LVCS forums, homelessness agencies) to ensure that groups which are less visible and vocal within the local community are given the opportunity to engage and input into the formation and running of a HealthWatch.

Each local population and its health needs will change over time. Therefore we suggest a review of HealthWatch membership is undertaken on a regular basis to ensure it remains representative and responsive. Again, this could be linked to the annual refresh of the JSNA, and the review of the health and wellbeing board's membership.

In addition we raise a potential conflict of interest in Local Authorities commissioning and holding HealthWatch to account over 'effectiveness and value for money', if one of the key functions of HealthWatch is in fact to hold Local authorities to account. One alternative could be to establish HealthWatch as Community Interest Companies to ensure they can maintain an independent role, or for the performance

⁴⁴ In a recent Homeless Link survey 80% of homelessness services reported working with clients with borderline learning difficulties. Homeless Link Survey of Needs and Provision 2010
<http://www.homeless.org.uk/snap-2010>

management of HealthWatch to be undertaken more explicitly by the CQC rather than the Local Authority.

Improving Integrated Working

We welcome the paper's vision for a 'personalised health and social care system that reflects people's health and care needs'. We believe that an individual's health cannot be tackled in isolation from their housing and social care needs.

A more unified health and wellbeing outcomes framework which takes into account wider housing and social care needs would be a strong incentive for more integrated working.

4, 5. What more, if anything, could and should the Department do to free up the use of flexibilities to support integrated working? What further freedoms and flexibilities would support and incentivise integrated working?

We welcome the specific reference in the paper for joint working to include that around hospital admission and discharge (para. 21) as this is a valuable opportunity for 'full engagement of the wider health and social care economy.' Research suggests 67% hospitals do not have discharge policies in place despite the greater risk this will place them of needing a re-admission.⁴⁶ This is an example of how integrated working between housing and health should work to achieve joint outcomes of preventing homelessness and improving somebody's health.

However an ethos of joint working needs to run throughout the healthcare pathway – from initial consultation and identification of need right through to treatment and recovery – as achieving health outcomes will be dependent on wider determinants such as housing and social care. Any attempts to improve integrated working will fail unless these recognise the wider determinants which will impact on somebody's health at every stage of their journey.

As such we would urge the reform to include specific consideration to housing related support and social care needs of an individual.

We agree there is far greater potential for pooled budgets, joint commissioning and joint service delivery. To date, there have been several moves to improve integrated working. Place-based commissioning, through Total Place, and joint working at a local level, through the LAA, have sought to strengthen the ethos and practical implementation of integrated working, and we would seek further clarity about how these will feature in the new NHS landscape.

However, a lack of innovation, trust and appreciation of shared outcomes continues to stifle joint working at a local level. Pooled budgets and jointly commissioning services need to be far more mainstreamed activities. The *Inclusion Health* programme offers practical guidance for this we should be continued. A more equal playing field into local decision making structures such as the health and well being boards, and clearer responsibilities for consortia around how they should work with the voluntary sector and health and well boards, particularly around public health, will also incentivise integrated working.

⁴⁶ Discharged to No Fixed Abode 2007 Grant Shapps <http://www.shapps.com/reports/>

6. Should responsibility for local authorities to support joint working on health and well being be underlined by statutory powers?

Working together effectively in partnership is crucial to meeting people's health needs. We believe responsibility for joint working should be underlined by statutory powers. This will reaffirm to local authorities the importance the government gives to joint working.

We believe, however, that joint working should be broadened to include joint working between the full range of stakeholders at a local level including voluntary sector partners and community groups. This should be integrated with the functions of the Health and Wellbeing board and the JSNA process. Joint working on health should also be underwritten and adhered to within the new Compact.

7. Do you agree with the proposal to create a statutory health and well being board or should it be left to local authorities to decide how to take forward joint working arrangements?

The functions set out for health and wellbeing boards are considerable, and represent the main way in the new reform for cross sector working. As such we agree that local authorities should be required to create a statutory health and well being board.

Flexibility will be useful to determine how these boards can best facilitate joint working but as above we believe some formal structure is required to underpin the local commitment to joint working and provide a legitimate opportunity for stakeholders to meaningfully engage at a local level.

8&9. Do you agree that the proposed health and well being board should have the main functions described in paragraph 30? Is there a need for further support to the proposed health and welling boards in carrying out aspects on the these functions – for example undertaking JSNAs?

We agree the health and well being board will be well placed to promote integrated working and joint commissioning, and in particular welcome the inclusion of social care and public health as key partners in achieving health outcomes. The health and well being board could also be well placed to undertake the scrutiny role.

In particular we welcome the health and well being board's role in leading the JSNA process and feel this could give renewed focus to the JSNA being used to underpin local commissioning decisions.

To date the JSNA programme has had mixed success in some areas. Evaluation has suggested improvements are needed to improve representation of seldom heard groups in the process⁴⁷, strengthen engagement with voluntary and community sector, and improve the impact that the JSNA document has had on commissioning decisions⁴⁸. One reason for this is a lack of accountability for taking the results forwards, so we welcome the renewed opportunity there will be for health and well being boards to undertake this process and ensure it has a direct impact on which services are commissioned.

⁴⁷ 'Patient and Public engagement: the early impact of World Class commissioning' (Picker Institute 2009)

⁴⁸ 'Joint Strategic Needs Assessments: Progress so far' (Improvement and Development Agency, 2009)

In order to fulfil these functions however we would suggest the following points:

- For health and well being boards to have the expertise to fulfil these duties, they need to have wider membership than currently proposed (see point 12 below). For the board to be a transparent and accountable body there need to be clear routes of engagement for stakeholders not formally part of its membership. One way to safeguard this is to have a named member to lead on effective engagement with agencies working with 'seldom heard' groups
- There is an opportunity for health and well being boards to take stronger local leadership for addressing health inequalities. Responsibility should be clearly delegated to a specific role within health and well being board to ensure equality is addressed across each of the proposed functions.
- We agree additional support would benefit the health and well being board to undertake their JSNA function. The experience of our members shows great variation to how JSNAs are conducted. We understand revised guidance for the JSNA is being developed. This should include advice about the full range of data sources which can be used in the JSNA as currently an over-reliance on the core dataset persists. It should also include clear expectations for involving homelessness sector agencies and user groups to ensure their needs are included⁴⁹. The homeless health audit is a means to gather and incorporate this type of information and will offer JSNAs an important source of data.⁵⁰ We would welcome the opportunity to further discuss how Homeless Link and our members can further assist with the collection of data through this tool.

11. How should health and well being boards operate where there are arrangements in place to work across local authority areas?

Health and well being board should have flexibility to determine where it makes sense to operate across authority areas.

We agree that some of the progress achieved in health has come about because of the wider strategic approach this level of operation has afforded, for example work to tackle alcohol related harm and offender health at a regional level. It would be wasteful to restrict the continuation of these working arrangements, and the structure of health and wellbeing boards should accommodate these, for example provision for boards to operate as unitary authority areas.

12. Do you agree with our proposals for membership requirements set out in paragraphs 38-41?

We feel that the current membership proposals do not make the most of the expertise and added value that voluntary sector providers could bring to the health and well being board. We believe the health and well being board will be able to achieve its responsibilities around the JSNA and joint working far more effectively if a greater role is given to VCS agencies.

As outlined above, often these agencies are those who best understand the needs of local people and are providing the services to them, particularly more vulnerable

⁴⁹ The process used by Cambridge offers a replicable model to systematically include homeless people's needs in the JSNA. A review of homeless health was undertaken as a discrete phase in their wider JSNA process. See <http://www.cambridgeshire.gov.uk/business/research/health/>

⁵⁰ www.homeless.org.uk/health-needs-audit

groups who often have the highest health needs. Without their input a valuable source of expertise will be lost, and integrated working will not be put into practice.

We appreciate it is impossible to invite every agency around the table, but there should be a mechanism for routinely inviting VCS agencies to participate on areas relevant to their areas of expertise. There should also be clear routes for engagement so that the board can operate in the 'equal and transparent manner' set out in the paper. For example, papers should be available in the public domain for comment and input; and annual reviews could be held where wider stakeholders can hold the health and well being board to account on its functions.

16. What arrangements should the local authority put in place to ensure that there is effective scrutiny of the health and well being board functions?

In addition to the points above, the health and well being board could be a standing item at structures such as the local authority Scrutiny Panel. The health and well being board should be required to produce regular reports on progress against achieved outcomes.

We voice some concerns about how the board can exercise independent scrutiny given its membership would potentially include those providing the services being scrutinised (eg GP consortia, public health and social care). Clear guidance is needed to avoid this conflict of interest.

17. What action is needed to ensure nobody is disadvantaged by the proposals and how do you think they can promote equality of opportunity and outcome for all patients, the public and where appropriate, staff?

Throughout our response we have referred to measures needed to prevent the measures disadvantaging homeless people. In summary, we suggest the following action and would welcome the opportunity to offer further advice in implementing these changes:

- Strengthening local measures through HealthWatch to ensure choice and involvement is meaningful for homeless people
- Unified outcomes which take into account a patients wider health and social care needs
- JSNA to have an enhanced role for identifying needs of socially excluded people, and becoming a tool which acts on evidence where health inequalities exist

4. REGULATING HEALTHCARE PROVIDERS

Homeless Link has a number of concerns about the general direction of this aspect of the reforms and the impact this will have on socially excluded and disadvantaged population groups. We have taken the final issues raised in this consultation paper and reported those we are concerned about under these more general questions.

Q20. Do you have any further comments or proposals on freeing foundation trusts and introducing a system of economic regulation?

Foundation trusts as universal model

We have fundamental concerns about the proposal that it will not be an option for organisations to decide to remain as an NHS trust rather than become or be part of a foundation trust, and that in due course the NHS trust legislative model will be repealed. We are not convinced by the evidence that foundation trusts provide better overall patient care; indeed there is recent evidence of a trust given elite foundation trust status which had been driven by cost-cutting and despite regulation delivered appalling patient outcomes and patient experience.⁵¹

We agree with the BMA position that NHS hospitals should be part of a collaborative publicly owned system of the provision of care for clinical need and that poorly performing hospitals will not improve their standards by moving to a more autonomous system of financial regulation.⁵² We are concerned that greater freedom over income generation, investment, borrowing and governance are likely to mean in some areas that financial management takes precedence over the core business of patient care. Providers will be subject to commercial insolvency with all the adjunct financial pressures.

Q21. What action needs to be taken to ensure that no-one is disadvantaged by the proposals, and how do you think they can promote equality of opportunity and outcome for all patients, the public, and where appropriate, staff?

The role of Monitor

The paper states that Monitor will license providers of NHS services in England and exercise functions in three areas: regulating prices, promoting competition and supporting service continuity.

We do not agree with the fundamental principle that competition uniformly drives up quality. We also have concerns about whether a competitive market is compatible with other key aims of the reforms, such as the joining up and integration of local NHS services, social care and health improvement. Competition law will start to override principles applied on the basis of benefits to the patient and to the taxpayer. In the field of housing related support, there is evidence that competitive tendering brings with it massive administration and process costs for both local authority and providers. The CLG Select Committee highlighted major problems with this process and stated that, "*constant cycles of competitive tendering are burdensome and expensive and this has a disproportionate impact on Third Sector and smaller providers.*" The Committee recommended that "*unambiguous guidance is needed to assist local authorities in developing approaches to commissioning and procurement*

⁵¹ <http://news.bbc.co.uk/1/hi/health/8531441.stm>

⁵² Executive summary of BMA response to White paper 1st October 2010
http://www.bma.org.uk/healthcare_policy/nhs_white_paper/index.jsp

*which are legal, proportionate to the size of contracts being let and focused on both cost and quality outcomes.*⁵³

Competition between hospitals and other health providers can be similarly wasteful and inefficient and can only be justified where it is clear it will benefit patient care. In challenging economic circumstances the overriding focus of competitive tendering is likely to be on the cheapest offer and not the best quality of care. For patients that experience social exclusion and present with complex needs we cannot see any circumstance in the proposed arrangements when promoting competition is likely to drive up the quality of their care.

The rationale for competition is that choice will spur providers to become more responsive to patients' needs, stimulating innovation, improvements in the quality of care and increases in productivity. Patients who experience multiple need and disadvantage and are at the bottom of the health gradient will not experience having services structure themselves around their needs. A theoretical choice of provider is unlikely to mean much to people who rely on health care being delivered to the hostel or day centre they use or wait until their health needs are so acute that they access emergency services. Exclusion is experienced in many ways, not accessing the same information services due to digital exclusion, poverty resulting in having no money for fares to access alternative providers, and the exclusion of few providers offering the type of services where homeless people and others experiencing multiple disadvantage feel welcome.

It is stated in the paper that Monitor should have regard to providing equitable access to essential health and adult social care services, however this does not appear in the description of their core functions and it is hard to see how promoting equitable access fits into the role described. If Monitor are to have this role we would like to see it embedded in their core functions and some clarity about how they are expected to fulfil it

Any willing provider policy

The NHS attracts high quality staff partly because there are national pay agreements, pension rights and stability of employment. This may be undermined by individual employers determining pay and term and conditions.

We recognise there are opportunities in this reform for voluntary sector organisations that work with socially excluded groups and have a detailed understanding of their needs to establish themselves as providers of services. However we are very unsure whether the system of financial regulation and the fact that Monitor will raise costs to fund its regulatory activities for licensed providers by charging fees will not exclude small voluntary sector providers from entering the market. The question is asked:

***Do you agree that Monitor should fund its regulatory activities through fees?
What if any constraints should be imposed on Monitor's ability to charge fees?***

In relation to small voluntary sector providers or social enterprises, they will not be in the market at all if they are subject to the same financial structures as big businesses, if there is to be a level playing field there will need to be a structure of staggered fees according to the size of the organisation bidding for it tapering to no fees for very small organisations.

⁵³ House of Commons, Communities and Local Government Committee, The Supporting People Programme, Thirteenth Report of Session 2008-2009, Vol. 1, 3 November 2009, The Stationary Office.

The new structure needs to recognise that meeting complex and multi-dimensional needs can be more costly and more specialist than the general population. There is a risk that a payment by results structure and a lack of grant funding to innovate will mean that providers established up to work with patients with complex needs continue to not be a viable proposition. There is suggested scope to modify tariffs where providers have higher costs than other organisations, the example given is providers in a rural location providing services to a small isolated population. We support an extension of this consideration and scope for those providers working with homeless people

We do not believe that increased commercialisation of the NHS is of benefit to patients, the BMA quote research that has found that Independent Sector Treatment Centres (ISTCs) could damage the local health economy, profiting from NHS funding by explicitly choosing to treat only less risky patients while being paid the same rate as publicly funded hospitals⁵⁴. The client group we are concerned with are exactly those more risky patients with complex needs which the private sector will not be offering services too because they are aware they are expensive and complex to treat and need a more holistic response. There is unlikely to be significant benefits for them from increased competition or commercialisation.

Our overriding concern is that the policy on ‘any willing provider’ may lead to large private health companies obtaining the majority of local contracts. While providers who can credibly support the health needs of the whole population, including seldom-heard groups should be considered as partners if these reforms are implemented, private sector providers ultimately have a duty to protect their shareholders’ interests. This is rarely compatible with putting the interests of patients first.

Homeless Link, as the membership agency of the homeless sector is happy to play a role in advising Monitor around the issue of equitable access to essential health and adult social care services. We are also happy to share our experience of the kind of structures that may work to allow smaller providers and those with expertise of working with socially disadvantaged groups to participate in the new opportunities to provide health care.

CLOSE

We thank the DH for considering our submission. We would like to offer the help of Homeless Link as the membership body for the homeless sector to act as an adviser on how any forthcoming reforms could best work for people homeless people and to offer our support throughout the implementation of any change.

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⁵⁴ Street A, Sivey P, Mason A, Miraldo M, Siciliani L. ‘Are English treatment centres treating less complex patients?’ *Health Policy* 2010; 94(2): 150-157.