



## LIBERATING THE NHS: AN INFORMATION REVOLUTION

### HOMELESS LINK'S RESPONSE JANUARY 2011

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, health projects, 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 government's commitment to improve access to the right information for patients, and the priority for improving data to underpin the new outcomes framework.

Homeless people persistently experience poor health and inequalities in access to health care.<sup>1</sup> Due to the complexity of the health needs with which many present, homeless people can be marginalised from mainstream services which leads to poorer health outcomes and also higher costs to acute services in the long term. A recent study by the Chief Analyst<sup>2</sup> identified the disproportionate cost to the Health Service of the high use of emergency and crisis services, caused by the failure of mainstream services to offer appropriate access. It found that inpatient costs were 8 times higher for homeless clients than in the general population

Obtaining and using good quality information is vital to help facilitate better access to appropriate health services and to measure where services are failing these individuals. For homeless people, access to the right information can be a barrier to choice and control as many of the information channels used can be inaccessible to those with particular support needs.

Our response focuses on how the Information Revolution can work for homeless people and our member agencies which support them. We have focussed our response to the questions most relevant to our client group and area of expertise.

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<sup>1</sup> Research from a national pilot, working with 9 PCTs and over 700 homeless people in 2010, found that 7 in 10 homeless people report one or more mental health need, and 8 in 10 a physical health need. Results can be found here [www.homeless.org.uk/health-needs-audit](http://www.homeless.org.uk/health-needs-audit)

<sup>2</sup> Healthcare for Single Homeless People, Office of the Chief Analyst Department of Health March 2010

## **Q1: What currently works well in terms of information for health and adult social care and what needs to change?**

We have divided this into the three spheres of Information we believe should be prioritised:

**(a) Information about levels of need:** many of the routine needs assessments do not include information about the health needs of excluded groups, or more hidden populations who are not registered with mainstream services. To ensure services can be responsive to the needs of all patients in a community, new commissioning structures must identify, include and act upon information about needs of homeless people who can be less visible but often have the most severe and costly health needs in our communities.

To do this, we ask for a specific requirement in Joint Strategic Needs Assessments to include data about excluded groups' health needs and determinants of health, which could be identified by an inequalities assessment of the local population. It is important that JSNA guidance for Local Authorities is revised to show how to include this data. Homeless Link has developed a Health Needs Audit tool to enable local authorities to gather this information in partnership with the voluntary sector<sup>3</sup>, and use of such tools could prove a valuable means to achieve this aim.

The DH Inclusion Health guidance urged commissioners to proactively include a range of data sources on more excluded patients in order to capture their needs: *"[commissioners need] to go beyond the routinely available local data and work creatively with partners to identify the pattern of needs and experiences of socially excluded people in the local community."*<sup>4</sup> The principles of Inclusion Health have much to benefit the Information Revolution and we would like to see this commitment to more innovative ways of gathering data taken across health and social care.

**(b) Information to support improved outcomes for all:** Homeless people as a group experience some of the worst health inequalities. Research demonstrates consistently the particularly poor morbidity and mortality rates in the homeless population.

We welcome the drive in the consultation to have better information so that more integrated outcomes can be effectively measured across health and social care. However current data collection can make it difficult to determine if certain patient groups achieve the same outcomes, resulting in the persistence of health inequalities.

We would suggest information about patient outcomes is disaggregated by population groups who we know experience the worst health outcomes – such as those with No Fixed Abode or who are living in temporary accommodation. The DH report, Healthcare for single homeless people<sup>5</sup>, used this source of data to provide

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<sup>3</sup> See [www.homeless.org.uk/health-needs-audit](http://www.homeless.org.uk/health-needs-audit) . The tool will be available in March 2011 following a national pilot process.

<sup>4</sup> Inclusion health: improving primary care for socially excluded people, DH March 2010

<sup>5</sup> The report analysed hospital data using a 'No Fixed Abode' indicator as a proxy to identify hospital admission data for part of the homelessness population. This indicator highlighted differences in the emergency/elective split of admissions, with 89% of all NFA admissions are emergency admissions compared to around 41% of admissions for the comparison population, and a longer length of stay of 6.2 days compared to 2.1 days. This coding could be used to analyse other health outcomes data to help measure health inequalities.

an informed picture of the costs of homeless health on the NHS. Using this or similar coding more effectively throughout primary and secondary care services will contribute to a more informed picture of where outcomes are not being achieved. In turn, this approach will identify where action must be taken in order to drive up quality across all patient groups and target resources more efficiently.

**(c) Information for users of health and social care services:** we feel there needs to be more accessible information for users of health and social care.

There is a risk that an Information Revolution will favour patients who are more articulate, engaged with services and capable of navigating the sometimes complex information channels which exist. The strategy needs to recognise the barriers some groups, like homeless people, face in accessing and understanding information:

- homelessness can erode skills and destroy confidence. It is estimated that 60% of homeless people have low or no qualifications<sup>6</sup>.
- 80% of homelessness services report working with clients with borderline learning difficulties.<sup>7</sup>
- Research backed by the Department for Communities and Local Government (DCLG) found that almost 60% of the hostel population meet the threshold of personality disorder<sup>8</sup>

These needs and others associated with homelessness can make it much harder to access and engage with traditional sources of information.

To address this, we suggest that:

- More effective support is needed for people who do not access online health advice. We would like to see greater advocacy to support disadvantaged groups to use their voice and exercise choice. This is likely to include intensive support from trusted sources – like homelessness agencies - who can help broker more informed choices into health services.
- The policy of ‘no wrong door’ should underpin the Information Revolution – a principle which recognises that an individual may enter a range of community settings to seek health services or treatment, and that ‘proactive efforts’ are needed so the individual – wherever they seek help – is provided with the information or effective signposting they need. In particular GP and community services must be able to act as this information hub for the broad range of patient needs.
- Care should be taken with digitising information. The value of face to face exchange must not be lost and there should be an option for this type of contact with GPs and other health professionals. Non digitised channels are also important to facilitate feedback mechanisms so excluded patients can share their feedback on service quality.

**Q7: As a patient or service user in what ways would it be useful for you to be able to communicate with your GP and other health professional online, or would you prefer face to face contact?**

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<sup>6</sup> See Crisis, <http://www.crisis.org.uk/pages/causes-consequences.html>

<sup>7</sup> Homeless Link Survey of Needs and Provision 2010 <http://www.homeless.org.uk/snap-2010>

<sup>8</sup> Meeting the psychological and emotional needs of homeless people, CLG and NMHDU 2010

For this question we convey the views of some Peer advocates involved in the Homeless Health Peer Advocacy Service<sup>9</sup> who assist homeless people to navigate health services and support them to access the services they need.

They felt it important to retain a range of communication options to reflect the needs and preferences of people with a diverse range of needs. They stressed that not all patients have the skills and confidence to use IT and felt face-to-face contact must be offered to make appointments, discuss treatment and referral options, and access health records/plans.

**Q10: As a patient or service user, what types of information do you consider important to help you make informed choices? Is it easy to find? Where do you look?**

The clients we spoke to said that information can be difficult to access or locate. They stressed the importance of making information available via organisations with which people may already be engaged, whom they trust and from which they are comfortable seeking advice. Findings from one of Homeless Link's Health Needs pilots in the West Midlands found that 65% clients went to housing staff for help around their health which demonstrates the need to equip such staff with the right information.<sup>10</sup> NHS services should proactively target information at these organisations, as this can be passed onto and discussed with clients.

Feedback from clients also raised the importance of sourcing support and information from peer groups or advocates who often bridge the gap between the patient and health professionals. In Homeless Link's national health needs audit, 23% homeless people said they turned to their peer group for help around health. Many clients require this support: *"I get anxious going out on my own so accessing services or groups can be difficult and sometimes impossible."* It is important to support the growth of these organisations as valuable hubs of information alongside their advocacy functions.

**Q15: What additional information about outcomes would be helpful to you?**

As above, being able to identify how outcomes are achieved for groups who are known to experience health inequalities will help target interventions to address these gaps in quality and access.

**Q16: How can the benefits of seamless and joined up information be realised across the many different organisations a service user may encounter?**

It is important health services proactively engage with other services which are involved in supporting a service user – for example treatment agencies, homeless hostels, or those providing employment support.

Joint working, supported by better Information Sharing protocols at a local level would assist this effort. Services should be encouraged to develop these protocols with service users to clarify what information is shared and how this will happen. It is

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<sup>9</sup> This project is being delivered by Groundswell and is funded by NHS Westminster. The Homeless Health Peer Advocacy Service trains people with an experience of homelessness to provide advocacy support to people currently experiencing homelessness in Westminster to address a health issue

<sup>10</sup> This audit surveyed homeless people in hostels, day centres and supported accommodation

particularly important care records can be accessed across geographical and service boundaries for homeless people and others who lead transitory lives.

One example which typifies the value of information sharing is hospital discharge. Frequently homeless people are not assisted with discharge, often returning to the streets, which greatly lowers patient outcomes as well as increasing the risks of avoidable readmission. Several hospitals have protocols which enable hospital staff to access and share information with local outreach, mental health and other services, allowing them to take joint action to provide a more suitable option for a homeless person leaving hospital<sup>11</sup>. This can help reduce the costs of readmission as well as better outcomes for the individual.

Ensuring clients understand how their data is recorded and used is vital. Homeless Link is running a project<sup>12</sup> which has looked at the ethics of data sharing for homeless people and would be happy to advise on this issue.

**Q31: How can a health and social care information revolution benefit everyone, including those who need care most but may not have direct access to or know how to use information technology?**

As above, we want to stress the need for a range of means for accessing information which take into account needs of more excluded patients. Support for advocacy services and intermediary agencies already supporting these groups are two important ways to achieve this goal. In addition we highlight the need for training for health professionals to improve their awareness of vulnerable patients and the reasons which impact on their level of engagement with services. This is particularly important for new GP structures to help them respond to the interests of all their patients.

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<sup>11</sup> For example one hospital has shared access of CHAIN, a London wide database managed by the charity Broadway, which records details of rough sleepers. Accessing CHAIN allowed NHS staff to share client data with local homelessness services and make appropriate referrals to improve their discharge.

<sup>12</sup> Critical Mass project, see <http://www.homeless.org.uk/critical-mass> for details.