homeless link

HEALTH AND SOCIAL CARE BILL
Submission to the Future Forum: Health reforms risk failing the most vulnerable

Homeless people are a group with some of the most severe and costly health needs in our communities. The experience of our 500 member agencies working with homeless people across England informs us about the persistence of poor health and inequalities in access to health care. This is supported by a substantial body of evidence on the acute health needs of homeless people:

- Eight in ten have one or more physical health need, and seven in ten have at least one mental health problem[i].
- Rough sleepers experience TB at 200 times that of the known rate among the general population.[ii]
- Research by DH in 2010 estimated the average age of death of a rough sleeper to be 40-44 years of age[iii]
- 50-75% rough sleepers have Axis 1 mental health disorders (anxiety disorders, depression, dementia and psychosis).[iv]

Because of their higher levels of need, homeless people use acute health services disproportionately to the general population. The Department of Health conservatively estimate that this group uses hospital services at a rate 4 times greater than the general population, rising to a rate 8 times higher for inpatient services.[v]

There is a clear case for improving access and health outcomes for homeless people. However, amid the widescale change proposed in the Health and Social Care Bill, we are concerned that the needs of the most vulnerable are being overlooked.

Despite the clear evidence about the acute health inequalities experienced by homeless people, their needs are often excluded from the assessments which drive commissioning decisions. As a marginalised group, they face barriers to mainstream services and their voices are rarely captured in local planning processes and patient forums. The services which homeless people require are often the specialist, 'low volume' services which are most at risk in a new system which will be driven by greater competition, the need for efficiencies, and a concept of patient 'choice' likely to be dominated by the most able and vocal members of our communities.

We welcome aspects of the NHS reforms: we believe they represent an opportunity to more effectively integrate health services with social care and housing- services upon which achieving better health are dependent. The new commissioning responsibilities for GP Consortia and Health and Wellbeing boards have the potential to better identify and respond to local needs.

However, within these changes we believe the most vulnerable groups are being overlooked. The Bill lacks clarity as to how Consortia and the other new commissioning structures will be held accountable for addressing the most acute health inequalities experienced by people who are homeless, and where redress lies if these are not achieved. Without swift changes to the current proposals, we believe there is a real risk that vulnerable groups who often require more targeted and specialist services will be side-lined and their already poor health left to deteriorate.

At a critical time in the re-structure of our health service, we urge the NHS Future Forum to consider our concerns and take them forward in the review of the proposed reforms. Below we outline some of the changes we would like to see in the new NHS: this will help the government achieve its aim of providing a 'fair and equitable' NHS; equip local areas to better and more efficiently meet the needs of this client group; and ensure homeless people experience better health in the future.

ACCOUNTABILITY AND PATIENTS		
ASPECT OF THE CURRENT BILL	**OUR CONCERNS**	**OUR RECOMMENDATIONS**
The Bill outlines that the NHS Commissioning Board [section 19 13F] and Consortia [section 22, 14N]] have duties to: *(a) reduce inequalities between patients with respect to their ability to access health services;* *(b) reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services;* The Bill also outlines [as amended in Public Bill committee] the Secretary of State's duty as to reduce inequalities: *"In exercising functions in relation to the health service, the Secretary of State must have regard to the need to reduce inequalities between the people of England with respect to the benefits that they can obtain from the health service."* [section 3, 1B]	**There is not enough accountability for addressing the health inequalities of the most excluded.** Although we welcome the inclusion of specific duties to reduce inequalities, there is a lack of detail in the Bill about how Consortia and the NHS Commissioning Board will be held to account for meeting these duties. Amid immense other pressures for NHS Board and Consortia, we are concerned that without stronger accountability, this responsibility will not be achieved. This group has been consistently overlooked in the past: we need a stronger commitment that the Bill will grasp the opportunity to change this.	**There must be stronger mechanisms built in at every level in the new NHS to hold services to account for tackling health inequalities.** Local accountability • The Joint Strategic Needs Assessment (JSNA) should identify health inequalities within a locality. There should be a requirement for every JSNA to assess groups in the community with the poorest health to ensure this picks up the needs of the most excluded. • To ensure this translates to action, Consortia should report on how their commissioning priorities have responded to the needs of people with complex, multiple problems in order to reduce their inequalities in access and health outcomes. National accountability • The government needs to provide more detail about how the NHS Commissioning board will be held accountable for reducing inequalities. • In turn, we need clarity on how the NHS Commissioning board will hold Consortia to account for reducing inequalities. The government should consider appointing an Inclusion Board to oversee this responsibility. They must ensure the outcomes framework incentivises targeted action to improve the health of the most vulnerable, and report annually on progress made by Consortia to improve services

		for those with the poorest health.
The bill states that Consortia have responsibility for providing services for those people who: *(a) were provided with primary medical services by a person who is or was a member of the consortium, or* *(b) have a prescribed connection with the consortium's area. [section 9]*	**Patients who are unregistered risk being overlooked in the new structures.** The Consortia have been given responsibility for people in contact with services in their area or a 'prescribed' connection which is not defined. Evidence shows that homeless people are refused registration by some GP practices due to their perceived 'chaotic' and transient lifestyles (latest research shows nearly 1 in 10 are refused GP access for this reason[vi]). We are concerned that Consortia will not see this client group as their responsibility, leaving them invisible in commissioning considerations and without the services they need.	• In their commissioning plans Consortia must identify groups in their area who are not registered and take steps to ensure their needs are met by service plans. • Consortia must provide clear channels whereby agencies working with homeless and other vulnerable patient groups can feed in their concerns if they feel they are being excluded from Commissioning plans.
The bill states that the Health and Wellbeing Board *'may encourage persons who arrange for the provision of any health-related services in its area to work closely with the Health and Wellbeing Board.' [section 179]* The bill states that local commissioning structures (Consortia and HWB) should have regard to: *a)the most recent assessment of relevant needs prepared by the responsible local authority and each of its partners commissioning Consortia under section 116 and;* *b)the most recent joint health and wellbeing strategy prepared by them*	**The Bill does not put enough in place to fully integrate health commissioning with wider local factors and services which will impact on achieving health outcomes.** Although the bill makes reference to working with 'health related services', there should be stronger requirement for joint working, at both Consortia and Health and Wellbeing boards, to ensure local commissioning is integrated. Despite the impact housing has on people's health, there is no provision for Health and wellbeing boards to incorporate housing needs assessments into developing strategies or discharging other duties, despite housing being a key factor on achieving health outcomes	• The health and wellbeing board must promote stronger integration with housing and other related services which impact on health. The language in the bill should be strengthened to reflect this. • The strategic housing lead for each local authority should form part of minimum membership requirement for Health and Wellbeing Boards. • Housing needs assessment is retained as part of the local requirements to develop a public health strategy.

under section 116a [section 166b]		
The Bill makes provision for a Local Healthwatch organisation for each local authority. The bill states that each HealthWatch will appoint one person to represent it on the Health and Wellbeing Board. The Bill also outlines duties for Consortia to: *c) promote the involvement of patients and their carers in decisions about the provision of health services to them;* *(d) enable patients to make choices with respect to aspects of services provided to them as part of the health service.[section 22, 14N]*	**There are not enough mechanisms to support a meaningful 'patient voice', particularly for the most vulnerable.** Despite the role described for Healthwatch in the Bill, and the duties for it lacks the authority and resources to enable them to fulfil this. We also believe that despite the emphasis on patient choice there are in insufficient mechanisms for public and community groups to be represented in decision making. It is unclear how they can hold decisions to account should they feel services are not paying due regard to the JSNA or meeting the needs of certain population groups.	• GP Consortia should have a duty to involve patient and specialist groups in gathering 'appropriate advice' • Consortia should publish plans about how they have discharged their 'public involvement duty' with regard to excluded patient groups and how they have included and responded to input from public and community groups • HealthWatch must be given sufficient authority to hold Consortia and Health and Wellbeing boards to account should they feel they have not responded to recommendations or concerns of the local Healthwatch. • HealthWatch must be adequately resourced to proactively engage with more marginalised patient groups and ensure they are included in Healthwatch
CHOICE AND COMPETITION		
The Bill extends provision to 'Any qualified provider' (AQP) and promotes an NHS driven by choice and competition.	**The focus on competition will provide a disincentive to treat groups, such as homeless people, perceived as complex and 'costly'.** Health outcomes can be harder to achieve for those with the highest inequalities in access and outcomes, and any proposals for 'any willing provider' must take this into account so that 'cherry picking' of patients does not marginalise homeless people even further.	• Incentivise providers to deliver healthcare to people who have multiple needs or who are socially excluded • There needs to be greater commitment that the re-design of NHS prices will reflect the complexity – and length of time- of treatment for some patient groups, and ensure that all providers are paid fair prices for their services • 'AQP' must demonstrate and be assessed on

	We are also concerned that increased competition will disincentivise collaborative and integrated working between providers, leading to more siloed and fragmented services.	how they collaborate with other services as part of meeting their quality standard.
The Bill as it stands (and indeed the white papers preceding it) does not stipulate clearly how GPs will commission for low volume services.	**Low volume services will not be prioritised or viable in locally-set commissioning plans** Homeless people require targeted, specialist services as mainstream services can be inaccessible and are not set up to adequately address multiple problems. These specialist services are likely to constitute 'low volume' services in some areas and hence a non-priory. To commission such services may require a regional or pan-authority approach which the current proposals do not encourage.	• There needs to be guidance which identifies what constitutes a 'low volume' service and how these could best be provided. • Consortia's commissioning plans must propose how commissioning for low volume services will be done. • There needs to be further consideration for the criteria NHS Commissioning Board will use to determine which services they will commission. These decisions should consider some of the small yet high need populations – such as homeless people, or those with complex dual diagnosis issues.

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[i] Homeless Link, Interim Findings from the Health Needs Audit, 2010 www.homeless.org.uk/health-needs-audit
[ii] See Inclusion Health: Evidence Pack (March 2010) www.cabinetoffice.gov.uk/media/346574/inclusion-health-evidencepack.pdf
[iii] This should not be confused with life expectancy figures. This estimate is based on figures from two homeless health services and research conducted by Crisis. See p. 10 Healthcare for Single Homeless People (March 2010) Office of the Chief Analyst, DH www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_114369.pdf
[iv] See Inclusion Health: Evidence Pack (March 2010) www.cabinetoffice.gov.uk/media/346574/inclusion-health-evidencepack.pdf
[v] DH Office of the Chief Analyst 2010, Health care for Single Homeless People
[vi] Findings from the national pilot of a health audit which surveyed over 700 homeless people, www.homeless.org.uk/health-needs-audit