



HEALTHY LIVES, HEALTHY PEOPLE: Transparency in Outcomes

HOMELESS LINK'S RESPONSE MARCH 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, welfare rights groups and drug and alcohol 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.

We welcome the opportunity to respond to this consultation. Our particular interest is how public health can be improved for people who are homeless:

- The Consultation rightly states that good public health is strongly linked to appropriate housing and other wider determinants of health. We support an Outcomes framework which recognises the role housing plays in giving people healthier lives. We urge the new framework to integrate public health outcomes with other services such as social care and housing, in order to achieve better public health and reduce health inequalities
- Homeless people experience many of the health and well being needs covered by the new Public Health Framework at a rate far higher than the general population. The new commissioning responsibilities for Public Health Directors and their local partners presents an excellent opportunity to improve preventative services and ensure those who have the poorest health benefit from health improvements. It is vital voluntary sector providers are included in identifying need and can fully participate in the new local structures.

People who are homeless have higher mortality and morbidity rates. 7 in 10 have a mental health need, 56% a chronic physical health problem¹. Because of their higher levels of need, homeless people use acute health services disproportionately to the general population, at 4 times the amount for health services, rising to 8 times as much for inpatient care.² We believe improving preventative and public health services can go a long way to reducing both the ill health of homeless people and the wider costs their poor health currently has on the NHS and wider community.

¹ Results from a national audit of Homeless People, Homeless Link 2010

² Healthcare for Single Homeless people, (DH, 2010)

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_114250

1. How can we ensure that the Outcomes Framework enables local partnerships to work together on health and wellbeing priorities, and does not act as a barrier?

The new public health Outcomes Framework as it currently stands goes some way to achieving a more holistic model of health. Our concern is how this new framework will sit alongside the NHS Outcomes Framework and the proposed social care outcomes measures.

In this way, the different Frameworks – despite underpinning many shared aims- may inhibit local partnership and joint working, as agencies with responsibility to improving health will be working to potentially different indicators. Where indicators and outcomes do overlap, this needs to be clearly understood and outlined in local planning processes so that partnership working can be encouraged.

It is essential a joint vision and priorities are therefore underpinned in the JSNA and Health and Wellbeing strategy. To ensure this is a truly ‘shared endeavour’, this needs to be more meaningfully co-produced with the full range of local stakeholders who have a role to play in improving public health: the voluntary and community sector, housing providers, and agencies delivering services to individuals who often fall beneath the radar of mainstream services as well as those individuals themselves, must be included in this process.

To achieve this aim, there need to be clearer mechanism for these stakeholders to input into the Health and Wellbeing boards, via sub-groups or other channels. Representation of appropriate voluntary sector and housing providers should also be a requirement for achieving more integrated approaches to achieving health and wellbeing priorities.

2. Do you feel these are the right criteria to use in determining indicators for public health?

We agree that this criteria offers a useful framework for determining indicators for public health. In particular selecting indicators which can highlight reductions in health inequalities (criteria 3) offers an important way to measure outcomes and we urge this is used to determine indicators in the final set.

Our concern is that the paper calls for there to be ‘existing systems’ with which to collect the data required to monitor this indicator. While we appreciate the need to minimise developing additional data measurement systems, this potentially will exclude a number of issues being measured purely because it can prove difficult to capture. This could have grave consequences for measuring less visible population groups, or complex needs which often fall outside existing datasets.

We would urge that this must not be allowed to prove a barrier in determining indicators; if a gap in data collection is identified proactive efforts should be made as a priority to fill this. The Homeless Health Needs Audit³, records from local voluntary services (such as client record information, or drug treatment statistics) and shared assessment tools such as the New Directions Team assessment⁴ may all be sources of relevant data for population groups often overlooked in top down data sources.

³ www.homeless.org.uk/toolkits-and-handbooks/health-needs-audit

⁴ <http://www.meam.org.uk/wp-content/uploads/2010/05/NDT-Assessment-process-summary-April-2008.pdf>

3. How can we ensure that the Outcomes Framework and the health premium are designed to ensure they contribute fully to health inequality reduction and advancing equality?

We welcome the strong recognition throughout the Framework of the wider determinants of health which makes public health ‘the responsibility of everybody’. However to ensure that the Outcomes Framework reflects the contributions of all partners it must take into account the full range of determinants which impact on reducing health inequalities.

To contribute fully to advancing equality, we support the inclusion of Domain 2 in the Outcomes Framework. The relationship between housing and health has been well documented; a lack of suitable and safe accommodation can have a negative impact on health. The design of the framework and premium must incorporate and measure these determinants to ensure reducing health inequality is a fully integrated and shared responsibility.

4. Is this the right approach to alignment across the NHS, Adult Social Care and Public Health framework?

We welcome the focus the new Public Health Framework will place on preventative services and shared responsibility with other services for reducing health inequalities. Many of the complex health needs experienced by homeless people can be improved through more targeted and earlier interventions which we believe the new public health framework could drive forward.

It is essential, however, that the existence of a separate framework for public health does not prevent other key players in the health system for taking responsibility for preventative approaches to health. The proposed framework for the NHS is a far more clinically driven framework. However we know from our members that a holistic approach to homeless people with health needs is the most effective.

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. These partnerships demonstrate how providers of housing related support, a befriending services or a needle exchange could add value to health interventions, particularly for socially disadvantaged groups.

However one of our concerns about the NHS framework is that it places greater responsibility on clinically driven, GP led commissioning, which may lack engagement with the areas of social care and public health.

The three Outcomes Frameworks must be understood and shared across each function. Each must take responsibility for preventative services and have an appreciation of the wider determinants of health, rather than this be the sole domain of Public Health.

5. Do you agree with the overall framework and domains?

We welcome the five proposed domains. Homeless people suffer disproportionately to the general population across a whole series of health care issues that are amenable to health promotion and/or preventative interventions.

The examples below are drawn from the Homeless Link Homeless Health Needs Audit⁵ and compared with health statistics in the general population. As such, the domains offer ambitious and commendable goals to tackle both the causes of ill health, but improve early intervention to prevent it.

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

This is an approach we would like to see across the NHS, and believe it is the right one to underpin the Public Health Outcomes Framework. It is important however that the selected indicators within these domains focus specifically on the most excluded groups in the population so that they can effectively measure the improvement of ‘the poorest, fastest’.

6. Have we missed out any indicators that we should include?

We have suggested some additional indicators to include in the following domains:

Domain 1: Health Protection and Resilience

We welcome the inclusion of indicators for vaccination coverage. This should be measured in particular relation to ‘at risk’ population groups who are more susceptible to certain conditions and diseases and for whom the health impact can be more severe (for example homeless people are more at risk from seasonal flu due to poor living conditions and lower immune systems).

We also welcome Treatment completion rates for TB. This could be amended to measure screening rates for at-risk populations. Research has suggested homeless people suffer from TB at a rate 200 times the known rate among the general population. Detection is crucial for these and other ‘at risk’ groups, and access to screening would be a more useful indicator to target interventions and measure improvements, alongside the treatment completion rate.

Domain 2: tackling the determinants of ill health

We endorse the approach to this domain which require ‘combined efforts of all public services to focus on the factors that drive health problems amongst the poorest and most vulnerable.’ Domain 2 should measure issues which contribute to poor health and as such can be used to capture the characteristics of a local population.

Poor housing and homelessness can be a direct cause and impact of poor health. Improving health cannot be tackled in isolation from improving an individual’s housing status.

While rates of statutory homeless households can offer a measurement of levels of homelessness, this will not capture those who are non –statutory and these individuals are often those who experience the poorest health:

⁵ Homeless Link Health Needs Audit <http://www.homeless.org.uk/health-needs-audit>

- Areas can use their Rough Sleeping Counts as indicator of housing need. Tackling rough sleeping is crucial to reduce the high levels of morbidity and mortality among homeless people and should be the benchmark for a healthy locality.
- Numbers of non statutory homeless people – taken from Supporting People data and other existing data sources (eg Homeless UK which records number of bedspaces) should also be used as an indicator.

Housing overcrowding rates could be amended or added to include the number of homes attaining decent homes standard. Insanitary accommodation is a major cause of ill health particularly among younger and older populations.

‘Proportion of people with mental illness and/or disability in settled accommodation’ could be amended to include other vulnerable groups (e.g. substance misuse). Clarity over what constitutes settled accommodation would also be helpful.

Domain 3: Health improvement

We would welcome an indicator relating to nutrition. While the 5 a day indicator is limited, it does provide a useful indicator of access to healthy foods.

Reduction in drug use and harm minimisation are also indicators which should be considered. ‘Numbers leaving drug treatment free of drug dependence’ will overlook significant improvements in reducing drug use among more entrenched drug use.

Domain 4: Prevention of ill-health

We welcome the inclusion of ‘Emergency re-admission to hospital within 28 days of discharge’. Evidence shows that homeless people are among patient groups often discharged to inappropriate or no accommodation, which makes it harder to achieve recovery.

Domain 5: Health life expectancy and preventable mortality

Mortality rate indicators are important and we support their inclusion. To assess if these improvements are helping to reduce health inequalities however, there must be provision to disaggregate this information by certain population or at-risk groups who are known to experience poorer health. To meet the health of the ‘poorest fastest’, the outcomes framework must be able to identify if more excluded groups are also experiencing improvements to their health. A flag in the data systems to record homelessness would help provide this analysis.

7. Which indicators are the most important?

As above, indicators which record housing need are crucial to this domain. We would be happy to advice on which indicators beyond statutory homelessness could be used.

We have summarised the additional indicators – described above - which as a minimum should be considered for inclusion:

	Indicator	Rationale/Description
Domain 1	TB screening rate and vaccination coverage for at	TB can go undetected in many excluded groups including homeless people. Access to screening alongside treatment completion rates will be a more effective improvement indicator.

	risk groups	The proposed indicator on vaccination coverage should also be disaggregated by groups known to disproportionately experience and be at risk from preventable health conditions (eg Hepatitis A&B).
Domain 2	Rough Sleeping count/estimate	Rough sleeping leads to significant health inequalities and is often the result of physical or mental ill health. Data on rough sleeping counts or estimates for every local authority area is published by DCLG.
	Numbers of non statutory homeless people	As above. Can be taken from Supporting People and existing data on hostel bedspaces.
Domain 4	Emergency readmission to hospital	This should be disaggregated by NFA or other marker of homelessness. Poor discharge results in high rates of hospital re-admission for homeless people
Domain 5	Mortality rates of homeless people against general population	To assess if these improvements are helping to reduce health inequalities there must be provision to disaggregate this information by certain population or at-risk groups who are known to experience poorer health

10. Which indicators do you think we should incentivise?

Incentivising indicators should depend on the priorities jointly identified by a local JSNA. Any incentives needs to be integrated into the health premium and how this allocation formula is developed: if incentives are to drive up health improvement and reduce inequalities, they should be matched to the particular areas of inequality or client group which have been identified. Local stakeholders from housing and the voluntary sector – including those who may not be represented in the Health and Wellbeing Board - should have recourse to this process and means to redress should this not be the case. The NHS commissioning board in its remit for health inequalities should also have greater scrutiny to ensure Health and Wellbeing boards are responding to inequalities identified in the JSNA.

11. What do you think of then proposal to share a specific domain on preventable mortality between the NHS and Public Health Outcomes Frameworks?

We support this proposal. A shared domain will help a more integrated approach between NHS and the local authority. As in section 6 above, to assess if preventable mortality is experienced across more vulnerable and ‘hard to reach’ population groups, there must be provision to disaggregate this information by at-risk groups who are known to experience poorer health. A flag in the data systems to record homelessness would help provide this analysis and we would be happy to offer further advice about how this could be designed implemented.

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