

Standards for commissioners and service providers

The Faculty for Homeless and Inclusion Health

Version 2.0
Revised September 2013





Standards of the Faculty for Homeless and Inclusion Health

With the support of the National Inclusion Health Board the Faculty offers these revised standards to include vulnerable migrants, Gypsies and Travellers and sex workers as well as homeless people

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With warm thanks to all those members of this Faculty, service users and professionals, who contributed so generously of their time and expertise to develop this revised edition.



The Faculty for Homeless and Inclusion Health of the College of Medicine

The College of Medicine is an alliance of doctors, nurses and health professionals with patients and scientists. Modern medicine depends on teams, not on a single profession, and patients are part of those teams. Yet the new College of Medicine is the only organisation to bring patients, scientists, doctors and all healthcare professionals together on an equal footing. That unique and powerful alliance allows it to develop a different perspective on how the health services operate and what they can and should deliver in the years ahead.



Pathway is a charity formed to transform the quality of healthcare for homeless people and other socially excluded groups. Pathway is delighted to publish this revised set of standards for homeless and Inclusion Health in partnership with the Faculty for Homeless and Inclusion Health and the National Inclusion Health Board.

For more information about Pathway visit our web site at www.pathway.org.uk

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A call to action

Vulnerable migrants, Gypsies and Travellers, sex workers and homeless people constitute a red flag symptom, marking a significantly increased risk of ill health and premature death. For too long, the NHS has dismissed these vulnerable minority groups as simply an issue of housing and social care, but there is a growing body of evidence that long-term 'dispossession' is fundamentally an issue of health. These disadvantaged groups lack work, home and health.

"In the end, we will remember not the words of our enemies, but the silence of our friends." Martin Luther King, as ever, encapsulates the well of guilt that so many of us share in relation to these groups of hitherto almost invisible vulnerable individuals in our society.

This Faculty did not begin with think tanks, committees and research documents. It began with people, passion, experience and story, not policy, statistics and theory. It has become credible not because of whom it claimed to represent but because of what it actually does. Too much time has been spent in well organised conferences looking at large graphs and hearing about policies for change and endless statistics. Too much time has been spent in eloquent criticism of each successive administration, very little of which has translated into a benefit for those who most need it. The messy details of people's real lives and experience are often startlingly absent – no one actually mentions anyone with a name and no address. Martin Luther King said, "Our lives begin to end the day we become silent about things that matter". We who have the ability, have the responsibility. The health of disadvantaged groups is a community problem, needing a community solution built on local ownership. This is a problem that cries out for compassion at the heart of the solution. The unacceptable has become the norm. We avert our gaze and have lost hope that anything can be done. As a first step on the road to embracing our dispossessed and vulnerable, we have published a charter of healthcare standards that should be enshrined in the expectations of all healthcare professionals when they come into contact with these individuals.

Levels of social disadvantage in the UK are an extreme symptom of wider levels of inequality in British society. The way we treat the most vulnerable and damaged is a basic test of our civilisation. We intend that this second version of a set of clear standards for health services for the disadvantaged and vulnerable should begin to help us live up to our collective responsibilities.



A handwritten signature in black ink, consisting of a stylized 'A' followed by a horizontal line and a small flourish.

Professor Aidan Halligan
Chair, Faculty for Homeless and Inclusion Health
College of Medicine

Summary

Our first set of Standards were published in 2011 and focussed on health care for homeless people. In 2013 we became the Faculty for Homeless and Inclusion Health, extending our remit to include explicitly Gypsies and Travellers, vulnerable migrants and sex workers, as well as homeless people.

This revised set of standards for health services for homeless and Inclusion Health has been written by a collaborative of professionals from a variety of disciplines in consultation with people with a personal experience of health inequalities. We do not consider the standards presented here to be either completely definitive or comprehensive, but they are a start. Future versions of this document will enhance, improve and extend them. We therefore welcome comments, criticisms and suggestions for additions or amendments.

The purpose of this document is to set clear minimum standards for planning, commissioning and providing health care for homeless people and other multiply excluded groups. This Faculty challenges all parties to work to these standards while undertaking to revise and improve them. The Pathway Charity will offer active support for those trying to deliver them.

Our primary purpose is to re-affirm the fundamental rights of all people to be treated with dignity, compassion and respect. But an increasing body of evidence provides an additional driver for change. At the sharp end of health inequalities, homelessness and other expressions of social exclusion are associated with extremely high health care costs coupled with appalling outcomes – we have to be able to do better than this.

Part A outlines our strategy for improving health care for homeless people, Gypsies and Travellers, vulnerable migrants and sex workers, to be overseen by the Chief Executive of NHS England and the Chief Executive of Public Health England.

Part B provides commissioning guidance to ensure high quality health services for homeless people, Gypsies and Travellers, vulnerable migrants and sex workers. This guidance responds to DH commitments on health inequalities and is mapped onto the Public Health and NHS Outcomes Frameworks.

Part C presents generic standards for all services, followed by specific standard sets addressing a wide range of clinical settings and considering specific excluded groups. The Faculty for Homeless and Inclusion Health will offer clinical governance oversight for any member organisation that requests it, and evaluate services against these standards.

Introduction

This revised paper of the Faculty for Homeless and Inclusion Health sets out to define the essential qualities required for services that aim to reduce health inequalities. The importance of the subject in sheer human misery and financial costs is emphasised.

The fundamental principles guiding this paper are Articles 1 and 25 of the Universal Declaration of Human Rights. All human beings are born free and equal in dignity and rights and everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control. Motherhood and childhood are entitled to special care and assistance.

Guidelines for policy makers and commissioners are set out in the context of an overarching strategy. Clinical standards for service delivery in different settings are defined. At the heart of any service will be the encounter or consultation between a service user and a care giver. We recognise the central importance of nurturing and sustaining this relationship in order to provide effective care. For many disadvantaged groups, clinical encounters and contact with service providers is still too often characterised by suspicion, indifference and occasionally, hostility, rather than dignity and respect.

In this approach, generosity, kindness, and compassion combine with a passionate commitment to professional quality to become the defining characteristics of health services for homeless and multiply disadvantaged people. These standards will be regularly reviewed and updated.

Background

National Context

- While significant progress has been made to improve health outcomes of the population as a whole over the last decade, a gap persists, with health inequalities between different population groups, particularly burdening certain socially excluded groups. Health needs of these groups are wide-ranging, generally high and related to the complexity and nature of exclusion¹.
- Socially excluded groups are often invisible in national data sets. This may be in part because of the impact of transient lifestyles or the complexity of their problems. There are also few questions to help identify them in the national health surveys. There are limited definitive statistics on access to health care for socially excluded people, but the literature indicates that points of access and service usage vary according to group, and the level and complexity of need¹.
- Many socially excluded people have low health aspirations, poor expectations of services and get little opportunity to shape their care¹.
- There is a growing awareness of hidden costs to the NHS - the annual cost of the failure to address health inequalities to the NHS is estimated by the Institute of Health Equity to be £5.5 billion.

- The 2010 Marmot Review '**Fair Society-Healthy Lives**' states - "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."² Closing the gap in health inequalities requires outcomes for the most disadvantaged to improve faster than the most advantaged.
- The vision of Public Health England expressed through the Public Health Outcomes Framework is "to improve the health of the poorest fastest"
- The Health and Social Care Act 2012 introduces – for the first time - statutory duties on NHS commissioning organisations to have regard to the need to reduce health inequalities in access to and outcomes achieved by services, and to integrate services where this will reduce inequalities.
- The National Inclusion Health Board has specified vulnerable migrants, sex workers, Gypsies and Travellers and homeless people as particularly subject to health inequalities. This second set of Standards for Homeless and Inclusion Health reflects this wider agenda.

Homelessness

- The annual cost of unscheduled care for homeless patients is 8x that of the housed population³ and homeless patients are overrepresented amongst frequent attenders in A&E.
- Despite this expenditure the average age of death for homeless patients is just 47 years⁴ and associated with the reduced quality of life caused by multi-morbidity.
- Prevalence of multi-morbidity increases with deprivation and has an onset 10-15 years earlier in deprived groups than in the most affluent⁵.
- Homelessness is an independent risk factor for premature mortality⁶ and is associated with extremes of deprivation and multi-morbidity.
- There is a growing understanding, supported by international research⁷, that chronic homelessness is an associated marker for tri-morbidity, complex health needs and premature death. Tri-morbidity is the combination of physical ill health with mental ill health and drug or alcohol misuse. This complexity is often associated with advanced illness at presentation, in the context of a person lacking social support who often feels ambivalent both about accessing care and their own self worth. Tri-morbidity often has its roots in histories of complex trauma, including high levels of child neglect and abuse, that impact on developmental trajectories and mental health.
- The current mental health strategy is called '**No Health without Mental Health**' and recognises the links between mental ill health and homelessness. Inaccessible and inadequate prevention and treatment for poor mental health generates and sustains long term homelessness and multi-morbidity.
- **Costs to the NHS:** Research by Professor Barry McCormick³, DH Chief Analyst has shown that homeless people attend A&E five times as often as the housed population, are admitted 3.2 times as

often and stay 3 times as long – because they are 3 times as sick. This results in secondary care costs that are 8 times higher than average, largely consisting of unscheduled emergency admissions. The Nuffield Trust recently reported an overall increase of 11.8% in emergency admissions in England over the past 5 years at a cost of £330 million per year⁸. Professor McCormick's analysis produces a conservative estimate of £85 million spent each year on secondary care for No Fixed Abode (NFA) patients, most resulting from emergency admissions. In fact this is likely to be a considerable underestimate, as many homeless people will give a hostel or "care of" address and not be revealed by this type of analysis.

- Simply housing long-term homeless people (although an essential first step) does not, of itself, resolve the underlying problems. When homeless people die they do not commonly die as a result of exposure or other direct effects of homelessness, they die of treatable medical problems, HIV, liver and other gastro-intestinal disease, respiratory disease, acute and chronic consequences of drug and alcohol dependence⁹.

Gypsies and Travellers

- A 2012 report by the Ministerial Working Group on tackling inequalities experienced by Gypsies and Travellers¹⁰ confirmed that they have the lowest life expectancy of any group in the UK and continue to experience high infant mortality rates (18% of Gypsy and Traveller women have experienced the death of a child¹¹), high maternal mortality rates, low child immunisation levels (particularly where specialist Traveller Health Visitors are not available^{11,12}), mental health issues (including suicide), substance misuse issues and diabetes; as well as high rates of heart disease, premature morbidity and mortality^{11,12,13}.
- In 2004, life expectancy (LE) was estimated at around 12 years less for Gypsy and Traveller women and 10 years less for men than in other populations¹¹. The 2005 Leeds Racial Equality Council (LREC) Baseline Census¹⁴ found a greater disparity in life expectancy, with Gypsies and Travellers average LE of 50 years of age compared to 78 years among the general population of Leeds; only 2.3% of Gypsies and Travellers were aged over 60 years. More recent Health Needs Assessments (e.g. Bedfordshire NHS Trust¹⁵, NHS West Sussex in 2010¹⁶) suggest little improvement.
- As well as lower life expectancy, Irish Travellers have consistently lower healthy life expectancy (HLE) and disability-free life expectancy (DFLE) than the general population¹³.
- Even after controlling for socio-economic status, Gypsies and Travellers, including those in housing, have poorer health outcomes and more self-reported symptoms of ill-health than both other UK resident English-speaking ethnic minority groups and economically disadvantaged white UK residents^{11,18}.
- Travellers experience worse health and have significant health needs, yet are less likely to receive effective, continuous healthcare¹³. Identified barriers to healthcare access^{11,12,13,20}, include inequalities in registration with GPs (discrimination, mismatch in expectations, 'expensive patients', reluctance of GPs to visit sites), poor literacy, and lack of 'cultural awareness/competence' amongst service providers.

- There is significant evidence of missed opportunities for preventive healthcare (particularly among Gypsy and Traveller men) and for effective treatment for pre-existing conditions^{11,19}, contributing to high rates of premature mortality.
- Travellers have low expectations about health, accepting long-term illness and ill-health as a normal part of life, an inevitable consequence of adverse social experiences and perceptions of hostility and racism^{21,22}. Just under half (46%) of Gypsies/Travellers in the East of England²³ perceive their own health to be good or very good compared to 77% of the general population.
- For Gypsies and Travellers, living in a house has been associated with poorer health, long-term illness and high rates of anxiety and depression¹¹.
- Despite being a recognised ethnic group, official statistical data are not collected on the health needs of Gypsies and Travellers, with a dearth of reliable national and local data, alongside the general lack of awareness of Gypsy and Traveller health issues in local health services²⁴. Most data are based on health studies.
- **Costs to the NHS:** A recent simple cost-benefit analysis²⁵ based on a real current experience of Gypsy and Traveller families, shows that an improved health and social care pathway not only offers clear benefits to Gypsy and Traveller people themselves, but delivers greatly reduced costs to health and social care services. Up-front investment, for example in appropriate social work engagement, or in GP outreach work, can pay for itself many times over in the longer term.

Vulnerable migrants

- Vulnerable migrants are not simply refugees or asylum seekers. This group includes undocumented migrants and especially victims of trafficking and slavery. Migrants are at higher risk of homelessness and destitution than the general population and the need to prove rights of access to NHS care may challenge the human right to health care.
- Health problems of vulnerable migrants are frequently related to destitution and lack of access to services, rather than to complex or long standing ill health²⁶.
- One in six UK refugees has a physical health problem severe enough to affect their life and two thirds have experienced anxiety or depression²⁷. A meta-analysis has shown that Post Traumatic Stress Disorder is prevalent in 8-10% of refugees in Europe²⁸. Links to detailed guidance on mental health services for vulnerable migrants are included in section 3.

Sex workers^{1,29}

- Commercial sex workers are likely to experience poor health because of the risks associated with their work.
- Female sex workers in London suffer from a mortality rate that is 12 times the national average.
- Up to 95% of female sex workers are problematic drug users.

- 68% of female sex workers meet the criteria for Post-Traumatic Stress Disorder, in the same range as victims of torture and combat veterans undergoing treatment.
- Street sex workers have significantly higher rates of health service use compared to the general population, reporting visiting the GP 8.5 times (compared to 4 times for the general population), A&E 2.5 times, an STI clinic 2.7 times, an inpatient clinic 2 times and an outpatient clinic 4.3 times in the previous year.
- Despite frequent use of health services, a comparatively low percentage have had routine health checks such as cervical screening, or attend antenatal checks when pregnant.
- Psychological and institutional barriers to accessing healthcare include: fear of criminalisation, institutional factors (e.g. opening hours, location), stigmatisation and discrimination.

Addressing health inequalities is a form of secondary prevention – reducing the harm resulting from long-standing and increasing inequality in Society. We recognise that in the long term primary prevention is the only rational response – reducing poverty and inequality to tackle the root causes of homelessness and multiple disadvantage. By highlighting the direct costs to the health care system resulting from multiple disadvantages we hope to inform and support the drive to address inequality in our Society.

New Standards for Integrated Care to Address Health Inequalities

Shared standards will improve care

Integrated care is central to overcoming the problem of fragmented and uncoordinated services³⁰. This is of particular importance for excluded groups who have difficulty in advocating for their own needs. A shared integrated care plan/formulation with individualised goals and strengths will be a key tool. Attention to the needs of excluded communities along with understanding of their culture, integration of services at the point of delivery, and care providers working towards shared outcomes, can result in better health outcomes for individuals, their families and communities, and reduced costs.

For example, Professor McCormick's paper highlights the potential for developing a new model of health care delivery for homeless patients, based on the highly successful service provided in Boston USA³. This model is of a fully integrated primary and secondary health care service including specialist primary care, out-reach services, intermediate care beds and in-reach services to acute beds.

Standards for mental health services for vulnerable migrants have recently been published and endorsed by the Faculty.

Other examples of promising practice/models of care for various excluded groups can be found in the 2010 DH and Cabinet Office Inclusion Health Evidence Pack¹.

New Health Inequalities Duties

The Health and Social Care Act 2012 imposed a number of health inequalities duties that are of particular relevance to service provision for marginalised groups. These duties apply to the Secretary of State for Health, NHS England and Clinical Commissioning Groups.

Secretary of State (SofS)

“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 1C of the NHS Act 2006, as amended by the 2012 Act*)

The phrase “health service” incorporates both the NHS and public health. This duty will also impact on Department of Health in terms of its role to establish NHS and public health systems.

NHS England (NHSE)

The Board must have regard to the need to reduce inequalities in access to health services and outcomes achieved by health services (*Section 13G*).

Clinical Commissioning Groups (CCG's)

CCGs must also have regard to the need to reduce health inequalities in access to and the outcomes achieved by services, (*Section 14T*) and to provide services in an integrated way where this will reduce health inequalities in access and outcomes (*Section 14Z1*). This service integration is not confined to primary and secondary health care, but includes social care and health related services.

“Health related services” are broadly defined and can include services related to the wider determinants of health such as housing, fuel poverty, debt, education, employment etc. The practical effect should be that services are integrated around the needs of the individual.

There are equivalent integration-related duties for NHSE (*Section 13N*) and for Monitor (*Section 62*).

Planning

The Act requires NHSE (*Section 13T*) and CCGs (*Section 14Z11*) to include, in their business plan and commissioning plans respectively, an explanation of how each proposes to discharge their duties as to reducing inequalities.

Reporting

The SofS (*Section 247D*), NHSE (*Section 13U*) and CCGs (*Section 14Z15*) are required to include, in their respective annual reports, an assessment of how effectively they have discharged their duties as to reducing inequalities.

Assessment

The SofS, having considered NHSE's annual report, is required to make an assessment of how well the Board has discharged its duty as to reducing inequalities (*Section 13U*). NHSE is required to undertake a similar annual assessment of how well CCGs have discharged their duty as to reducing inequalities (*Section 14Z16*).

Part A

A Strategy to address Health Inequalities

1. **NHSE, Public Health England (PHE) and CCG's** should be supported to discharge their statutory duties around health inequalities by **Health Inequality Networks** led by Directors of Public Health (DsPH) of Local Authorities, who will be well positioned in the council architecture to ensure that health inequalities remain at the top of the agenda, using the important vehicles of the **Joint Strategic Needs Assessment (JSNA)** and the **Health and Wellbeing Board Strategy (HWBS)**. **The Health and Wellbeing Boards** include representation from the Local Authority, CCG and the Area Team of NHSE, and have a crucial role to play in ensuring services meet the needs of all the local community.
2. Health inequality networks will draw together health and social care professionals with voluntary sector and service user organisations. It is important that within these fora there is explicit recognition of health inequalities in communicable and non-communicable diseases, as well as other health and wellbeing issues.
3. **Joint Strategic Needs Assessments (JSNAs)** will include the impact of homelessness across health, housing, social care and the criminal justice system and include hostel dwellers and the insecurely housed as well as rough sleepers. Sex workers', vulnerable migrants' and Gypsies and Travellers' health care needs will be specifically considered. **Health Inequality Networks** will be particularly important in ensuring that excluded groups are not further marginalised because they are not included in official statistics, GP lists etc³¹.
4. Service user involvement must be integral to commissioning and delivery.
5. Enhanced access to health care services for excluded groups is essential and will have to be demonstrated for each area. This may include specialist services, or workers, move on and enhanced mainstream services, according to local need³².
6. Expenditure on health care services for excluded groups across primary and secondary care should be reported to NHS England and related to estimates of need.
7. **Public Health England** should play a central role in the reduction of health inequalities, and 'should be tasked with marshalling evidence and guidance around reducing health inequalities, supporting local action, and evaluating the effectiveness of local health-inequality reduction plans'³³.
8. NHS commissioning organisations (NHS Commissioning Board and Clinical Commissioning Groups), as well as Acute Trusts, should be required to develop health-inequality reduction plans and should be evaluated against their delivery³³.
9. There is a need to inform the evidence base around what works to reduce health inequalities for excluded groups. New research calls addressing health and healthcare interventions should include the requirement for researchers to assess or demonstrate reductions in health inequalities.

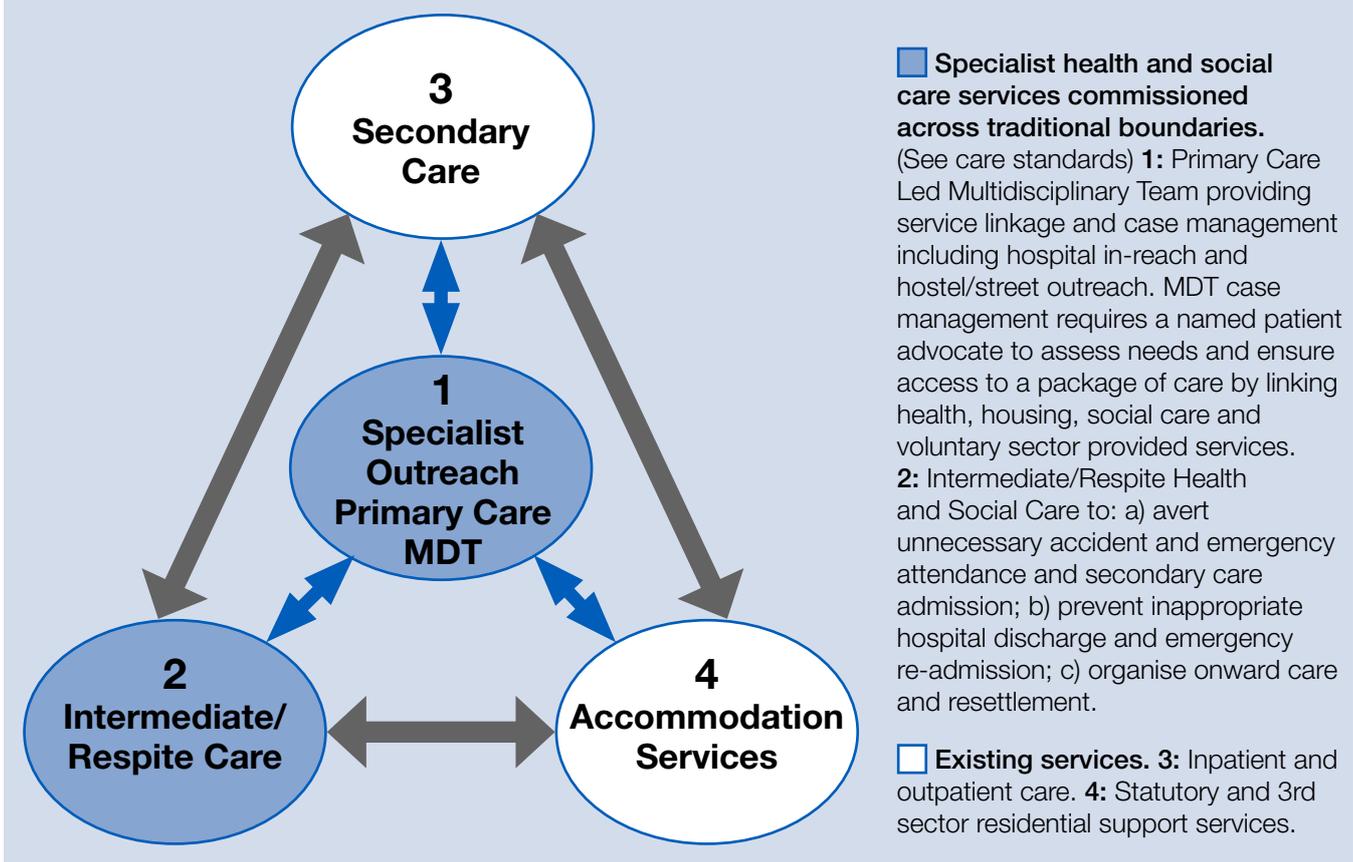
Part B

Commissioning Standards for Inclusion Health

The clinical, moral and financial arguments for addressing Health Equity are now established and do not need to be repeated here. The duty to have regard to health inequalities is embedded in law. This revision of the Faculty Standards can focus on how to commission for Inclusion Health.

Healthcare commissioning has huge potential to tackle inequalities in access, experiences, and outcomes between various population groups, and particularly to impact on the lives and experiences of those most excluded.

Figure 1 - Integrated approach to commissioning of homeless health services.



Measurement of outcomes

Outcomes for excluded populations need to be an integral part of the NHS, Public Health Outcomes Framework (PHOF) and Adult Social Care Outcomes Framework (ASCOF) allowing measurement of the proposed indicators within homeless, vulnerable migrant, sex worker, and Gypsy and Traveller populations. Appendix 1 maps these standards onto Public Health and NHS Outcomes Frameworks. This should start with ensuring that these groups can be identified locally e.g. Gypsies and Travellers.

1. Standards for Commissioners.

- 1.1 In line with their statutory duties, commissioning organisations must understand and address health inequalities as part of their core responsibilities (rather than as a marginal agenda); consider synergies with other key policy agendas, e.g. NHS Improving Quality (<http://www.nhsiq.nhs.uk/>).
- 1.2 The accountable officer for Inclusion Health (whether in a CCG or NHS England local area team) should be at Director level or above.
- 1.3 The Faculty recommends that responding to the health inequalities duty should require collaboration with a Public Health led Inclusion Health Network, which must include partnership working with statutory and voluntary sectors and service users.
- 1.4 Standard data sets concerning numbers of homeless people, vulnerable migrants, sex workers and Gypsies and Travellers, their health and associated expenditure in primary and community care and secondary care, as well as offender health care should be collated, and inform commissioning to address health inequalities. Data should be collated in such a way that targets do not distort outcomes. The Public Health England Data and Knowledge Gateway (<http://datagateway.phe.org.uk/>) provides a single point of access to data and analysis tools, and via a health inequalities category, has links to a health inequalities gap measurement tool, health inequalities intervention toolkit, health inequality indicators, and life expectancy calculator (at local authority and ward level).
- 1.5 Means of enhanced/easy access to health care for homeless people, vulnerable migrants (including those without documentation), sex workers and Gypsies and Travellers (including those living on unauthorised encampments) should be described, publicised and promoted in an accessible format, and made available to the respective excluded communities for each area – specialist services are not the only solution, enhanced access and outreach services from mainstream providers are also important. All primary care providers should be routinely tested for their willingness to register patients from these groups and refusal of access should be robustly contested.
- 1.6 Appropriate service responses to Inclusion Health patients - to these standards - must be commissioned, publicised in an accessible format and performance managed for community health care, specialist primary care, mainstream primary care, dental care, mental health care and secondary care.
- 1.7 It can not be assumed that the health needs of Gypsies and Travellers are met by existing policy in relation to other ethnic minorities and socially disadvantaged groups; cultural beliefs strongly influence health and health-seeking behaviour – targeted culturally-appropriate services or specialist liaison workers may be needed.
- 1.8 Collaborative commissioning will be required since primary care is commissioned by NHS England while community care and locally enhanced services are commissioned by CCGs, and public health services are commissioned by Public Health England and local authorities, but service delivery needs to be seamless.

- 1.9 Commissioners should require proactive care planning, so encouraging a move away from gate keeping (spending time assessing and rationing entitlement) towards proactively planning to meet people's needs.
- 1.10 Commissioners should require horizontal, patient-centred integration. By this we mean care planning and continuity across community settings and service provider boundaries, so that people can continue to receive continuity of care even if they lose the address that originally gave access to that care.
- 1.11 Commissioners should require vertical integration. By this we mean care planning, multiagency working and continuity of care into secondary care and back into the community. A clear expectation of compassion, communication and continuity of care between secondary, primary and community care.
- 1.12 Measures of success should be shared across multiple agencies, such as reductions in rough sleeping, antisocial behaviour, un-scheduled re-admission within 30 days, and unplanned A&E re-attendance within 7 days. Innovative approaches to managing total costs over a 12 month period used for long term conditions might also be applied for some excluded groups.
- 1.13 There should be specific commissioning plans for children and young people of excluded groups, as their care pathways and service requirements may differ; this particularly applies to commissioning of immunisation, where special attention needs to be given to the needs of excluded groups.
- 1.14 **Immunisation:** vaccination programmes have been shown to reduce health inequality worldwide³⁴. However, differences in vaccine uptake persist in England and are associated with a range of social, demographic, maternal- and infant-related factors³⁵. The 2009 NICE guidance³⁶ on reducing the differences in immunisation uptake identified a number of groups at increased risk of not completing routine immunisations in England and Wales, including: those not registered with a GP, looked-after children, younger children from large families, those from some minority ethnic groups, those from non-English speaking families, and vulnerable children, such as those whose families are asylum seekers or are homeless.
- 1.15 Low vaccination coverage and frequent movement of Traveller communities presents a particular challenge for measles elimination in Europe, and underserved minorities have repeatedly been involved in vaccine-preventable disease outbreaks within the UK and across Europe^{37, 38, 39}. Indiscriminate population-based interventions that aim to improve overall uptake of vaccination are unlikely to reduce social inequalities in uptake⁴⁰. Evidence suggests that social inequalities in immunisation only start to narrow when uptake of the most affluent groups is very high⁴⁰. While coverage for primary vaccination is now approaching or above 95% in most English regions outside of London⁴¹, concerted efforts need to be made to reach excluded groups - with specific approaches to improve coverage - in routine vaccination programmes, e.g. Specialist Health Visitor for Travellers.

- 1.16 A number of cross-European resources are available which may be useful for those planning and delivering immunisation programmes, including: a review of the evidence for effective national immunisation schedule promotional communications⁴²; a communication action guide for health care providers in relation to childhood immunisation (see 'Section 4: A so-called 'hard-to-reach' population perspective')⁴³; a guide on building trust in communication re: immunisation programmes⁴⁴, and a communication guide in relation to MMR specifically⁴⁵. Additional examples of promising practice for improving immunisation uptake among underserved groups across the EU (with specific examples for the Roma population) can be found on the website of an ECDC meeting on Immunisation in Underserved Populations⁴⁶. (http://ecdc.europa.eu/en/press/events/Lists/Events/ECDC_DispForm.aspx?List=43564830-6b8a-442f-84e7-2495fa49489b&ID=224&RootFolder=/en/press/events/Lists/Events)
- 1.17 Commissioning of more innovative partnership working with third sector agencies, which already demonstrate good practice in delivering health initiatives, e.g. the Traveller Movement in Britain and Royal Free NHS Trust Maternity Services project, under the DH-funded Pacesetters programme⁴⁷.
- 1.18 Offender healthcare: Prison Health Performance and Quality Indicators (PHPQIs)⁴⁸ are available to guide Strategic Health Authorities (SHAs), Clinical Commissioning Groups (CCGs) and prisons in judging their own performance in commissioning, and where relevant, delivering healthcare services to prisoners. There is a need to include the monitoring of excluded groups in PHPQIs.
- The Health Protection Agency (now Public Health England) has previously outlined the standards⁴⁹ that it should meet in supporting the delivery of specific health protection PHPQIs in prisons that are part of the prison estate under control of HM Prison Service. Private prisons (contracted out prison estate) have separate performance arrangements but are expected to meet similar levels of healthcare service provision.

Part C

Detailed clinical standards for Inclusion Health care in different specialities and situations

In this section we set out clinical standards for Inclusion Health services in general, and specific standards for a range of specialist services that should be accessible to excluded groups.

These standards will be regularly reviewed and we encourage suggestions for improvement. Coordinated service provision across primary and secondary care including mental health treatment is a requirement of these commissioning standards. Provision of good quality primary care, in the absence of integrated good quality secondary and mental health care would not meet these standards.

We start by setting out general clinical standards relevant to all settings. We then present specific additional standards for primary care and for a range of other services important or relevant to improving Inclusion Healthcare. The Faculty will offer, on request, evaluations against these standards for service providers who are members of the Faculty.

Core values shared by Faculty members centre around valuing each individual, building a respectful and trusting relationship and working with their priorities to a position of hope.

“It is more important to know what sort of person has a disease than to know what sort of disease a person has”. Hippocrates.

“Those who have a ‘why’ to live, can bear with almost any ‘how’.”
Viktor E. Frankl.

- 2.0 Continuity – a trusting and respectful relationship formed with a familiar clinician and team.
- 2.1 Ease of access also requires walk in provision, in reach to hostels and street outreach to rough sleepers – commonly described as “Street Medicine” and promoted by the Street Medicine Institute⁵⁰. (<http://streetmedicine.org/wordpress/>)
- 2.2 Multi-disciplinary collaborative care is central to effective care because many homeless people present with multiple healthcare needs.
- 2.3 Person centred care with service user involvement in planning and delivery.
- 2.4 Cultural competence and sensitivity.

2. Clinical Standards in any setting

Principles for Clinical Standards in Inclusion Health Care

- 2.5 The Recovery approach developed by users of psychiatric services should be incorporated into the design of all services. Summarised by the phrase – Hope, Agency and Opportunity for all⁵¹, this seeks to make shared decision making the norm. “No decision about me without me”⁵².
- 2.6 Where specialist services are provided they should act as a catalyst to improve care throughout the local health service.
- 2.7 Inclusion Health services should provide a bridge linking hospitals and community care through hospital in-reach services.
- 2.8 Inclusion Health services should work closely with public health departments particularly with important communicable diseases (e.g. TB or blood borne virus transmission).
- 2.9 Services should actively seek to offer treatment to vulnerable migrants and those with no recourse to public funds..
- 2.10 Homeless services should include the provision of “respite care” (now in over 50 Cities in North America and Europe) – community based residential medical facilities for homeless people with significant and complex health care problems. This could be achieved cost-effectively through joint working with local hostel providers and the voluntary sector. These services improve outcomes and reduce subsequent unscheduled hospital admissions^{53,54}. Pathway has recently published standards for Medical Respite in England⁵⁵.
- 2.11 Regular involvement in, and where necessary leadership of, multi-agency planning for rough sleepers.
- 2.12 Visible service user involvement in planning and evaluation of services.
- 2.13 Coordination of the health care of excluded people as they move between different organisations and settings (hostels/drop-ins, shelters for homeless families, Gypsy and Traveller sites etc.). This may be best achieved via a named liaison worker and supported by a shared integrated care plan/formulation emphasising individual goals and strengths.
- 2.14 Child and family services to be linked to homeless family hostels with children treated and recorded as individuals, not nameless adjuncts to the parent. Useful guidance for non-specialists on safeguarding vulnerable families is available at http://www.qni.org.uk/for_nurses/opening_doors/guidance_notes.
- 2.15 Coordinated health care in hospital settings – for homeless population – by collaboration with homeless ward rounds and attending multi-agency care planning meetings. For all excluded groups, informative and timely discharge summaries to primary care should be standard even when the patient self discharges.

All services meeting these standards should include the following

- 2.16 Plans for assertive outreach for non-engaged clients in each area; e.g. specialist clinicians with flexible hours, able to provide street outreach; specialist Health Worker/ Health Visitor for Travellers.
- 2.17 Using guidance on the Mental Capacity Act, Mental Health Act and Safeguarding Alerts for adults at risk of abuse, in assessing rough sleepers who refuse care. This guidance may also help in situations in which vulnerable people are not being offered care⁷⁵. (<http://www.pathway.org.uk/news/mental-health-service-interventions-for-rough-sleepers/>)
- 2.18 Recording of housing status with regular review.
- 2.19 Recognition and support of the need to build an evidence base for what works for socially excluded groups. Participation in documenting, researching and publishing on the health hazards of exclusion, evaluations of service delivery models (including models of preventative healthcare), continuous monitoring of longer term outcomes, action research approach to service development.
- 2.20 Education and involvement in undergraduate and postgraduate training of medical, nursing, dental, psychological therapy and social work students. Develop links with relevant professional bodies.
- 2.21 Promotion and encouragement of accessible provision of mental health, dental and podiatry care.
- 2.22 Promotion of Inclusion Health care as a viable and attractive career choice for staff.

3. Specific Standards for particular settings

Standards for primary care services:

Services will need to be planned according to local and regional need. In some areas specialist services will be necessary. Where there are fewer excluded people enhanced access to mainstream services may suffice, but the standards of care outlined should apply in every setting.

- 3.1 Information is the key – a unified electronic record accessible wherever the patient is seen (e.g. EMIS web or System One). All patients must be registered at first consultation. Ideally and usually this should be full registration, unless already registered with another homeless service, when temporary registration is acceptable. For those only entitled to emergency treatment from the NHS, an immediate and necessary registration is to be completed. In this way every patient is logged and costed and becomes visible to the NHS. Services which cannot register patients – such as nurse led community services - should have achieving GP registration for all their patients as a primary goal.
- 3.2 **QOF (Quality and Outcomes Framework) standards.** Locally designed Key Performance Indicators (KPI's) may be better suited to specialist Inclusion Health practices. KPI's should cover the following areas:

- Managing long term conditions to QOF standards
 - Pro-active management of selected patients with high needs by – weekly multi-agency meetings including local street outreach, statutory and non-statutory services
 - hospital in reach ward rounds/visits for homeless patients where necessary in the local Acute and Mental Health Trusts
 - regular outreach clinics in local hostels and drop-in centres
 - collaboration with multi-agency review and care plans for all registered patients admitted to hospital twice or more in any 6 months period and when necessary those with Combined Homeless Information Network (CHAIN) or other rough sleeping record in the same period
 - all patients offered drop-in clinics with presenting problem addressed first, but offered health screening and access to treatment to include, physical health assessment, screening for dental/oral problems, BBV (Blood Borne Viruses), smoking, drug and alcohol problems, TB (Tuberculosis) screening, screening for mental health problems, diet and exercise
 - regular review of locally negotiated approach to ensure easy access, including drop-in clinics and outreach clinics at hostels and drop-in centres to include primary care based mental health treatment
 - QOF or KPI funding thresholds should reflect the challenges of working with excluded groups.
- 3.3 An annual report should be produced including QOF data.
- 3.4 Individual service level measures should be defined by the service and defined by the question “What do we expect to change for our clients as a result of what we do?”
- 3.5 There should be routine liaison with and provision of medical support to street outreach teams and provision of continuing care for recently housed and socially excluded patients, with a focus on enabling access to mainstream services.
- 3.6 Services should collaborate with case tracking, contact tracing, community treatment and public health measures e.g. TB, HIV, Hepatitis C.
- 3.7 Prescription review: case studies in the Gypsy and Traveller communities reveal examples of repeat prescriptions being renewed without review for long periods, particularly when families are highly mobile, and also inappropriate usage (wrong dosage, frequency or sharing prescriptions) due to literacy problems¹.
- 3.8 Concerted efforts need to be made to reach excluded groups - with specific approaches to improve coverage - in routine vaccination programmes.
- 3.9 Ensure professionals within the primary care team are switched onto the specificity of socially excluded clients’ needs and appropriately supported, e.g. turn receptionists into ‘gate openers’ for excluded groups rather than ‘gatekeepers’ (Bromley-by-Bow Centre project¹).

Standards for Children and Family Services for Excluded Groups

- 3.10 There should be a local health strategy jointly with social services and housing departments, under the new public health remit of local authorities.
- 3.11 Operationally, child and family services should include: physical health, child mental health and social services, including child protection.
- 3.12 There should be clear care pathways between these services. Subsequent care requires evidence of follow up and not being lost when returning to the community (when they are most vulnerable and in need of services).
- 3.13 Measurement of outcomes across physical, developmental and psychosocial child domains.

Standards for Migrant Health Services

These Standards should apply to all vulnerable migrants, including undocumented migrants and especially victims of trafficking and slavery. Migrants are at higher risk of homelessness and destitution than the general population and the need to prove rights of access to NHS care may challenge the human right to health care.

- 3.14 Full registration for migrants, including those without documentation. GP's should be aware that they can register anyone at their own discretion. If someone is 'no fixed abode' (NFA) or effectively homeless then the GP can register the patient c/o the practice address. However sensitivity is required, as some patients will fear that registration will draw attention from the UK Border Agency or other official bodies.
- 3.15 Non-UK born communities should have access to culturally competent and language supported services.
- 3.16 Collection of country of birth information in primary care should be improved; this information can help when considering what health conditions someone may be at risk from.
- 3.17 Primary care practitioners play a vital role in early identification of infectious diseases; early identification of risk and diagnosis of infection can improve health outcome⁵⁶. Services for homeless migrants should promote and facilitate screening and treatment, e.g. HIV, Hepatitis B, C and HIV, and where appropriate haemoglobin electrophoresis and full antenatal screening. The PHE online Migrant Health Guide (launched Jan 2011) provides both a checklist to extend the standard new patient check for migrant patients and country specific advice on infectious disease risks⁵⁷. (<http://www.hpa.org.uk/migranthealthguide>)
- 3.18 Healthcare practitioners should ensure that migrants are offered full immunisation according to the UK schedule. PHE provides regularly updated guidance on Vaccination of individuals with uncertain or incomplete immunisation status⁵⁸.

Standards for Health Services for Sex Workers

- 3.19 Services should offer access to the full range of primary health care interventions, with referral to secondary care where appropriate. It is not the responsibility of the GP to ascertain eligibility for secondary care. Hospitals and primary care should be aware that antenatal care should always be considered immediate and necessary although the hospital may issue a bill.
- 3.20 Mental Health Services for vulnerable migrants should be provided according to the detailed specification published by Mind⁵⁹.
- 3.21 Liaison with voluntary sector organisations such as the Refugee Council can enhance support for vulnerable migrants⁶⁰. (http://www.refugeecouncil.org.uk/how_can_we_help_you/i_am_an_adviser_working_with_adult_asylum_seekers)

Sex workers are likely to intersect many of the groups identified within the Inclusion Health agenda and great care should be taken by health professionals to understand and address the multiple and complex health and social care issues that they are likely to present. Good health care services have greater potential for reducing the number of people in prostitution than criminal justice approaches⁶¹.

- 3.22 As with other excluded groups the attitude of staff can frequently discourage engagement with health services. Awareness training for A&E, primary care and clinical staff working within criminal justice settings should be widely available. This training can be accessed through numerous sex worker support services throughout the UK. Contact www.uknswp.org for more information.
- 3.23 Specialist outreach services for sex workers are vital to improving access⁶¹ and should include enhanced access to primary care and not be confined to sexual health and contraception. Depending upon local epidemiology, services should also create pathways into long-term condition treatments such as TB and respiratory health, mental health and specialist addiction services.
- 3.24 Criminal justice services can provide an excellent opportunity for engagement with health care if there is an appropriate non-judgemental attitude. Sex workers who are homeless and live chaotic lifestyles often have untreated conditions. When criminal justice services offer health care this can be a positive starting point at which to assess general health status, stabilise conditions and begin medication.

Standards for Health Services for Gypsies and Travellers

Who are Gypsies and Travellers?

- 'Gypsies and Travellers' is a commonly used catch all term that includes people from a variety of groups, all of whom were – or are – nomadic. These include: Romany (English/Welsh) Gypsies (the majority group in England and Wales (E and W)), Scottish Gypsies/Travellers, Travellers of Irish heritage (Irish Travellers), Roma, Fairground and Show people, Circus people, New Travellers, and Bargee and water craft/canal boat Travellers.
- Today, although nomadism/'travelling' is an important part of Gypsy and Traveller people's culture and history, the words 'Gypsy' or 'Traveller' is more accurately a description of ethnic identity and distinct culture(s) (e.g. social organisation; value system; shared history, language, traditions etc.), rather than a description of actual daily activities or an identifier of nationality. Many Gypsies and Travellers in the UK today live among the 'settled community' in permanent housing (estimated two-thirds), with a further significant portion living on permanent sites, either privately or publicly provided, and others – due to national shortages of sites - on unauthorised sites (as of 2011, approx. 20% of Gypsy/Traveller caravans are stationed 'unlawfully' rendering the occupants technically homeless⁴⁷); the nomadic aspect of their culture is expressed in periods of 'travelling' from their home base to attend family events, annual fairs etc., rather than being a constant feature. Settlement in housing is often due to an inadequate supply of Traveller sites rather than preference¹³ (Sources: LeedsGATE, GRTHM, The (Irish) Traveller Movement (ITMB/TM)).
- Gypsies and Irish Travellers are recognised ethnic groups under UK law, and were included as such – for the first time – in the 2011 National Census ('Gypsy or Irish Traveller').

The following points provide important context for this section

- Gypsies and Travellers have significantly poorer health outcomes, compared with the general population of England, and with other English-speaking ethnic minorities and are frequently subject to racial abuse and discrimination¹³.
- Under the Race Relations Act, Romany Gypsies and Irish Travellers are recognised as minority ethnic groups, and should be afforded protection in law against discrimination.
- Gypsies and Travellers cannot be defined or identified solely by their current travelling status; rather, it must also be recognised that Gypsies and Travellers have strong and distinct cultural identities, practices and sets of beliefs. Gypsies and Travellers who are now living in settled housing do not cease to be Gypsies or Travellers.
- All Gypsies and Travellers have a legal right to access NHS and social care services whether they are nomadic or living in permanent settlements.
- There is a serious under provision of official trailer sites for Gypsies and Travellers across the country and as a consequence, many community members find themselves living in irregular locations, (for instance, under motorways or next to sewage works), consequently

they face many health hazards that are not commonly faced by the general population for example, lack of sewage disposal and limited access to water¹³.

- Health professionals should be aware that many Gypsies and Travellers are not literate and therefore information concerning treatment and appointments may need to be explained.
 - Ethnic monitoring based on self-categorisation or self-disclosure may well result in under-reporting, with many Gypsies and Travellers reluctant to disclose their identity due to fears of prejudice, and a deeply engrained mistrust of authority.
- 3.25 The DH should issue a national 'data change notice' to include Gypsies, Roma and Travellers alongside the 16+1 other ethnic categories which are monitored by the NHS. This would bring the NHS in line with Gypsy and Traveller inclusion in the 2011 census.
- 3.26 'Gypsy or Traveller' should be included as an ethnic category in the national health surveys, e.g. the ONS General Lifestyle Survey⁶² (a household survey); the Health and Social Care Information Centre's Health Survey for England (HSE) and Smoking, Drinking and Drug Use among Young People in England survey⁶³; and the DH GP Patient Survey⁶⁴.
- 3.27 Services should be designed and commissioned in collaboration with communities, through inclusion in Health and Wellbeing Boards and consultation for Joint Strategic needs Assessments. In a 2012 study by the Irish Traveller Movement⁶⁵, only 16% (20/125) of responding Primary Care Trusts had monitoring procedures in place to assess Gypsies and Travellers' service use and health and wellbeing outcomes, and only 29% made reference to Gypsies and Travellers being included in local HNAs or JSNAs. Almost a quarter of respondents (23%) cited non-inclusion of 'Gypsy and Traveller' ethnic code in the NHS Data Dictionary as either justification for not monitoring or as an obstacle to greater inclusion and more rigorous data collection. A survey and mapping exercise of PCTs in England by the Health Protection Agency⁶⁶ also showed that there are a considerable number of areas where knowledge of Gypsy Traveller population numbers is poor, service provision is not based on need and the uptake of immunisation services is low or not known. Guidance on including Gypsies and Travellers in the Joint Strategic Needs Assessments and joint Health and Wellbeing Strategies has been developed by a number of GT community organisations in collaboration with DH.
- 3.28 Examples of guidance for organisations working with Gypsy and Traveller communities include: LeedsGATE Toolkit⁶⁷, the Republic of Ireland Pavee Point Primary Health Care for Travellers Project⁶⁸, the Save the Children Early Years Outreach Practice⁶⁹, FFT guidance for health practitioners⁷⁰, and the DH guidance on developing cultural competence of health professionals working with GT communities⁷¹. Examples of practice for improving immunisation uptake among underserved groups across the EU (with specific examples for the Roma population) can be found on the website of an ECDC meeting on Immunisation in Underserved Populations⁴⁶. Additional good practice examples can be found in the 2008 Race Equality Foundation briefing paper¹².

- 3.29 Commissioning dedicated or specialist health workers.
- 3.30 Hand Held Records (HHR) (developed initially under the DH Pacesetters programme; used by Traveller education services very successfully for years). Many Travellers have poor education and literacy levels; HHR can also be used for keeping full records of appointment schedules and are useful for other family members who have good literacy levels in helping patients' manage their care.
- 3.31 There is often a poor take-up of preventative healthcare by Gypsies and Travellers, particularly among males, with conditions usually well advanced before any type of healthcare is sought. Targeted services are needed to increase male engagement in preventative health care. Consider: fast tracking of Gypsies and Travellers to preventative services in recognition of high level of unmet need and health inequalities, peer/community health promotion workers.
- 3.32 Research suggests that community members would welcome advice and care provided by trained/qualified community members. Culturally appropriate educational materials and use of trusted community members as health advocates (in line with work carried out with other BME communities) are anticipated to reduce negative health impacts of membership of Gypsy, Roma and Traveller (GRT) communities. Support for initiatives that help Gypsies and Travellers to become health advocates, service providers and trainers within their own communities e.g. ITMB's Level 2 NOCN Health and Community Engagement Course⁴⁷, LeedsGATE training.
- 3.33 Improve the cultural competence of health service staff, e.g. by providing Gypsy and Traveller (GT) community led training, including understanding the importance of kin-group responsibilities (e.g. family demands made by even quite distant relatives may be regarded as higher priority than professional expectations) and the impact this may have on care, attending appointments etc.
- 3.34 Good practice projects developed by Gypsy and Traveller community organisations such as the Irish Traveller Movement/ The Traveller Movement (ITMB/TTM), LeedsGATE and Friends Families and Travellers (FFT), and by NHS organisations working with the Gypsy and Traveller community should be promoted and encouraged, e.g. ITMB: Maternity Services project, Mental Health project.

Standards for Community Mental Health Services

Many Inclusion Health patients have mental health problems and experience difficulty in accessing and maintaining therapeutic relationships with mental health services. Where there are significant numbers of homeless or other excluded people specialist services may be necessary; in other areas enhanced access to mainstream services may suffice. In both situations, services should be provided to the standards outlined. A willingness to work around relatively high rates of non-attendance at appointments will help to ensure that patients are not

further excluded. It is crucial that mental health services are integrated with other health services and that there is good communication between them.

- 3.35 Services for homeless people should accept self or non-health agency referral and respond to mental distress and dysfunctional behaviours. Diagnostic criteria should not be a means of gate keeping services.
- 3.36 Complex trauma and psychosis are significant drivers behind the poor mental health of homeless people, and the responses of mental health services and clinicians to this group should be designed with this in mind.
- 3.37 In areas with high concentrations of Inclusion Health patients, specialist services should be provided to ensure the necessary expertise is available and that there is flexible service provision.
- 3.38 All mental health services should be ready to work with people with drug and or alcohol problems in addition to mental health issues, and Mental Health (MH) services should foster good partnerships with drug and alcohol services to ensure effective joint working. Mental health treatment should still be offered even when the patient does not wish to engage with substance use treatment.
- 3.39 Access to care enhanced by outreach, for example to hostels and drop-ins, on the streets and to Gypsy and Traveller sites. See section 3.49 for guidance on assessment of rough sleepers with possible mental health problems.
- 3.40 A flexible approach centred on patient choice to overcome geographical barriers to accessing care. Nationally agreed and universally applicable standards of access for Inclusion Health patients will ensure treatment according to the needs and best interests of the person and prevent exclusion due to short term address changes or street homelessness, lack of an officially recognised address (e.g. living on an unauthorised encampment) or lack of access to within-area culturally appropriate services. This will include willingness to maintain therapeutic relationships with homeless patients and other excluded groups who have temporarily moved out of the geographic boundaries of a service, including short stays in prison.
- 3.41 There should be enhanced and easy access to psychological ('talking') therapies for individual and tailored group work.
 - There should be access to treatment at Level 4 of the Stepped Care model⁷², recognising the high incidence of complex trauma among homeless patients.
 - For Gypsies and Travellers, there should be access to culturally-appropriate talking therapies.
- 3.42 Support and training should be available for other health workers and for non-health key workers in understanding and working with people with mental health problems and histories of complex trauma, and in cultural awareness and community engagement training regarding the Gypsy and Traveller community.

- 3.43 Projects working with people with histories of complex trauma should be aware of and have regard to the Psychologically Informed Environments guidance⁷⁶.
http://www.southampton.ac.uk/assets/imported/transforms/peripheral-block/UsefulDownloads_Download/A6FD3BB1EB2A449987C12DFF91EF3F73/Good%20practice%20guide%20-%20%20Psychologically%20informed%20services%20for%20homeless%20people%20.pdf
- 3.44 For homeless patients, there should be regular and structured meetings with hostel and outreach staff to discuss potential referrals and on-going cases, improve conditions in chaotic hostels and encourage preventative work such as anti-bullying strategies, noise abatement and therapeutic groups.
- 3.45 Reflective practice is an essential part of effective working with people with complex trauma, and group and individual reflective practice should be developed by clinical, social care, and multidisciplinary teams.
- 3.46 The emerging issue of adults with Attention Deficit Hyperactivity Disorder (ADHD) may disproportionately affect homeless people and needs enhanced access to specialist care.
- 3.47 A history of acquired brain injury due to physical trauma and the effects of alcohol is increasingly recognised amongst homeless people and requires referral routes for further assessment.
- 3.48 Antenatal and post-natal mental health: see NICE guidance⁷³. Understanding that – with certain excluded groups (e.g. vulnerable migrants, Gypsies and Travellers)– presentation of mental ill-health may be culturally bound/specific.

Many people from excluded groups will only come into contact with mental health services when they are acutely psychotic and, perhaps, need admission to hospital. Such episodes can be: Part of a continuing disorder such as schizophrenia or bipolar disorder, a brief episode in someone with a personality disorder, drug-induced, or a consequence of long-term excessive alcohol intake. These different presentations will naturally require different services and treatment responses.

- 3.49 Some long term rough-sleepers have significant mental health problems and may benefit considerably from treatment⁷⁴. New tools and guidance have recently been published to support consideration of Mental Capacity, as well as Mental Health and Safeguarding procedures as means of obtaining appropriate treatment⁷⁵.
- 3.50 Some homeless people have long histories with mental health services and have been on medication for many years, with periods of 'non-compliance', psychotic episodes, with returns to the streets and returns to hospital via section. For people with an established psychosis who have been on medication, regardless of brief periods of non-compliance, it is dangerous to stop medication. However, medication should always be reviewed after transition between accommodations, including hospital

Standards for Inpatient Psychiatric Services

discharge, and a recovery-oriented plan worked out with the client. Medication should be reviewed regularly and frequently.

- 3.51 Discharge planning should begin on admission and involve as wide a network of health and social care as required. As with physical health services, there should be intermediate care discharge accommodation available, so that those who no longer need psychiatric support can continue to recover within a therapeutic setting. These projects should take into account the Psychologically Informed Environments guidance⁷⁶. A CMHT should be involved as soon as possible so that there is care and support, clinical and social that bridges the transition from hospital to community.
- 3.52 Psychiatrists have a key role to play in outreach services to socially excluded communities who do not use mainstream services, for example on Travellers' sites or on the streets. This should not just be attendance at Mental Health Act assessments. Assessments should be longitudinal and built up over a period of time.
- 3.53 Psychiatrists have a role in creating a picture of mental health within excluded groups and individuals over a period of time, offering leadership to local mental health service staff, expert opinion to commissioners and Health and Wellbeing Boards, and data to JSNA's.

Standards for Personality Disorder Services

Primary care, psychiatric, psychological and counselling services all need to take account of the particularly high incidence of personality disorder (PD) in the homeless population. NIMHE guidance⁷⁷ offers specific standards for PD services. PD services for homeless patients should include:

- 3.54 Local specialist multidisciplinary team offering specific interventions and consultation and supervision to other teams. Treatment at level 4 of Stepped Care (NICE guidance)⁷², recovery oriented, integrated with social care.
- 3.55 Specialist day services in areas of high concentrations of morbidity. Local services at all levels should be able to recognise people who present with significant personality difficulties, and offer them equitable, accessible and appropriate services.
- 3.56 Local services should be accessible and responsive to people with personality disorder, offering a range of levels of support and intervention.

Standards for Psychological Services

Many of the problems experienced by Inclusion Health patients are amenable to psychological treatment. But for services to be accessible they need to be specifically designed and delivered.

- 3.57 Services should be flexible and open access by self-referral.
- 3.58 Provision should be made for specialist psychologists and psychotherapists to directly deliver psychological therapies and support all staff involved with those individuals through consultation and the provision of facilitated reflective practice.

- 3.59 Psychological therapies should include explicit phases of engagement and/or engage outreach workers to use psychological skills in engaging service users in the process of change, via the provision of training.
- 3.60 In order to increase use of such services, direct therapeutic input should be enabled in the environments in which homeless people are found, e.g. homeless healthcare teams, day services, hostels rather than solely on an outpatient basis in psychiatric services – however provision of therapy away from accommodation should also be available.
- 3.61 Psychological services should be carefully evaluated in terms of outcome. In order to address the paucity of evidence in the field, psychological services should adopt an ‘evidence-generating practice’ approach to interventions. All staff should be taught to monitor outcomes individually formulated with each service user, and to enable them to perceive meaningful change as a result of their input.
- 3.62 The critical importance of the therapeutic relationship in psychological therapies, which is common to all psychotherapeutic models should be explicitly recognised and supported in service design and delivery.
- 3.63 The forms of psychological intervention used should make use of existing and developing research on the processes underlying the causes and maintenance of homelessness in order to target interventions effectively.
- 3.64 A flexible approach to the implementation of psychological therapies should be developed in order not to exclude on the basis of current alcohol and substance abuse, emotional lability or varying forms of self-harm.
- 3.65 Other services with which the service user is involved (e.g. social care, secondary care and third sector staff) should continue to support the person who engages in psychological therapy. In this way the therapy targets of the psychological intervention may be communicated to and reinforced and supported by a wider team of enabling staff.
- 3.66 Staff in primary and secondary care and third sector organisations should be enabled to understand the interaction between mental health issues and the behaviours leading to homelessness using specific therapeutic frameworks, thereby increasing their understanding of the issues and increasing the range of responses available to them when dealing with challenging behaviours, in line with Psychologically Informed Environments guidance⁷⁶.

Counselling may be particularly beneficial for Inclusion Health patients, but a different approach is needed to encourage patients to move towards engagement with the process.

Services should:

- 3.67 Be flexible and open access by self-referral.

Standards for Counselling Services

Standards for Police and Criminal Justice Medical Services

- 3.68 Offer flexibility of location of service provision.
- 3.69 Be culturally appropriate.
- 3.70 Recognize the need to create a culture of trust and for 'opportunistic' outreach and 'pre-engagement' work in the form of non-clinical, but transitional activities (chatting, art groups, etc).
- 3.71 Recognize the need for flexibility in the face of lowered frustration tolerance thresholds and emotional outbursts, challenging/disengaging behaviour.
- 3.72 Incorporate a flexible counselling approach capable of offering an assessment of immediate, medium and longer term needs; a mix of crisis management, supportive counselling skills, problem clarification and solving skills, taking into account the dynamics of the therapeutic relationship, in order to support through the referral process to a more structured treatment.
- 3.73 Recognize people with Personality Disorder, engaging and supporting them through the referral process to more structured treatment.

Responsibility for offender healthcare rests with NHS England (as the commissioner of offender healthcare services nationally), with providers of healthcare, and with prison governors. Ensuring the delivery of high quality healthcare in prisons is a contribution to reducing health inequalities specifically and also to improving the health of the whole community in general.

The Bradley Report (2009)⁷⁸ highlights the extent to which people with mental health or learning disability disorders are channelled into the Criminal Justice System. Homeless people are often dealt with inappropriately and at considerable expense by the law with the additional problem that a number of low level offences (vagrancy, public order, antisocial behaviour, begging) are available for officers to target this group. In some situations desperate people commit minor offences to obtain shelter and food. A complete narrative of any homeless person should take into account their relationship with police and courts and consider ways in which their various needs can be addressed constructively. Police stations in many boroughs now have input from drug workers and mental health liaison nurses, but general medical input is often lacking.

Irish Travellers (mostly male) make up between 0.6% and 1% of the entire prison population in E and W, and are regularly subjected to racism and discrimination in the prison system⁷⁹. Almost two-thirds (64.7%) of female Traveller prisoners suffer from mental illness, and 26.1% of all Irish Traveller prisoners have one or more mental illnesses (compared to 10% of the prison population), with high rates of self-harm and depression⁷⁹. Key factors which exacerbate the poor mental health of Travellers in prison include: (i) (lack of) access to services - major contributory factor in the high levels of detected mental illness amongst this group, (ii) disruption of family and community support, and (iii) prejudice and loss of self-respect⁷⁹.

Irish Travellers generally enter prison at a higher risk of ill-health than other prisoner groups, are accepting of ill-health, and access healthcare only infrequently outside prison, thus any expression of ill-health by this prisoner group may indicate an urgent need. Many of the most serious difficulties facing this prisoner group are attributed (by prisoners themselves and prison staff) to the widespread inability to read and write, limiting access to health and other services in prison⁷⁹.

3.74 Medical input to police stations should include mental health liaison, substance misuse workers and general medical care to treat wounds, treat medical conditions and screen for infectious diseases.

3.75 It is estimated that 15 percent of people are homeless when sentenced to a time in prison and 30 percent are homeless on release⁸⁰. It is important that health services for prisoners at risk of becoming homeless, and for formerly homeless prisoners, are connected to other health services involved in the patient/prisoners care.

There is a range of guidance already available in relation to prison health care and prison dentistry^{81,82,83}. Many of the standards set out elsewhere in this document will apply to prison medical services.

In addition they should include:

3.76 Full registration of patients treated, including documentation of ethnicity. See 3.25 - ensure DH-issued national 'data change notice' to include Gypsies, Roma and Travellers alongside the 16+1 other ethnic categories which are monitored by the NHS is also applied to the prison medical care system.

3.77 Use of a standard primary care record system incorporating past medical records and passing on full record to the NHS primary care record system on release.

3.78 Active liaison with medical service outside prison on release and pro-active commitment to ensuring smooth transition of care.

3.79 Ensure the needs of Gypsy Roma Traveller prisoners are addressed:

- Awareness among healthcare teams that Travellers experience high levels of mental illness and suicide
- Ensure literacy problems don't impact negatively on negotiating bureaucracy involved in accessing health and other services
- Ensure literacy and nomadism don't impact on maintaining links with families (e.g. writing applications for Visiting Orders (VO), ensuring families can receive VOs if they live on an unauthorised site/possess no officially recognised address).

Standards for Dentistry Services

Access to dental care for homeless people is worse than access to general medical services. Homeless people have similar levels of dental disease to the housed population; however they have higher levels of untreated dental disease, which has considerable impact on their quality of life⁸⁴. Most homeless people wish to have their dental needs addressed but face many barriers to accessing dental care which

include: dental anxiety and fear, confusion about where and how to register with a dentist, confusion about entitlement to free or subsidised dental care, the requirement to meet other more pressing survival and welfare needs and fear of rejection or refusal of care from a dental practice⁸⁵. Most dental treatment needs of homeless people are not complex and may be readily treated in a primary dental care setting, however current arrangements within NHS Dentistry do not facilitate the flexibility required in managing the provision of dental care for homeless people⁸⁶.

- Travellers have a high level of unmet need, low dental registration and very little use of preventive dental services, with more disadvantage being experienced by Travellers on unauthorised and transit sites⁸⁷. There is strong anecdotal evidence⁸⁸ that Gypsies and Travellers suffer significant oral and dental health problems resulting in hospital intervention. There is some suggestion – from local Gypsy and Traveller Accommodation Assessments (GTAAs) and casework – that access to dental care and oral health for Gypsies and Travellers has worsened¹.
- In a Friends, Families and Travellers (FFT)-delivered ‘Collaborative Programme to Improve the Oral Health of the Gypsy and Travelling Communities in Sussex’⁸⁸, determinants of poor oral health were identified as: lack of accessible, culturally appropriate information; distrust and negative attitudes – both among the population and among professionals; a historical neglect of dental health services in reaching out to the Travelling community; raised levels of fear and anxiety about visiting the dentist; and challenges associated with being a transient population.

Commissioning of dental care for excluded groups

- 3.80 The commissioners for health care for excluded groups in each area must identify an individual (Head of the Salaried Dental Services or Head of Special Care Dental Services or Consultant in Dental Public Health) who will champion access to dental care and advise how access could be facilitated within local arrangements for NHS dentistry (appropriate local NHS primary dental care and/or salaried dental/special care dental services).
- 3.81 Dental care for excluded groups should be included in an area’s oral health strategy. Services for excluded groups should be specified in contractual arrangements with appropriate local NHS primary dental care and/or salaried dental/special care dental services. The strategy should include raising awareness of the dental needs of excluded groups to those outside the dental profession, including local public health teams, health professionals, community workers, education service, and the service users themselves.
- 3.82 Support for initiatives that help Gypsies and Travellers to become oral health advocates within their own communities.
- 3.83 Registration of patients treated, including documentation of ethnicity.
- See 3.25 - ensure DH-issued national ‘data change notice’ to include Gypsies, Roma and Travellers alongside the 16+1 other ethnic categories which are monitored by the NHS is also applied to records for dental patients, to enable access to care by Gypsies and Travellers to be reported on.

Integration of dental care with primary medical and social care

- 3.84 All homeless people attending for a health needs assessment with a member of the primary health and social care team should be asked about their dental health and be referred for a dental needs assessment as part of a single assessment process. The latter is particularly important for children in homeless families.
- 3.85 All members of a primary health and social care team including key liaison workers (e.g. peer workers, Specialist Health Visitor for Travellers) in contact with excluded groups should receive training on assessing dental health and prevention of oral disease.
- 3.86 Health promotion with excluded groups should have an integrated oral health element and use a common risk factor approach addressing nutrition and diet, smoking, alcohol and substance use and basic hygiene.
- 3.87 Dental services providing care for excluded groups must be integrated with and complementary to other health and social services and agencies providing services to those groups.
- 3.88 Local NHS primary dental care and/or salaried dental/special care dental services within an area must work as an integrated team to share experience, network, and facilitate referrals. This may be particularly important for primary dental care services that have limited knowledge of the specific needs of excluded groups. For services working with specific groups e.g. Gypsies and Travellers, cultural awareness sessions for all members of the dental team may be necessary.
- 3.89 Dental services for homeless people and other excluded groups should be delivered flexibly to enable and facilitate access. Different modes of delivery will be required to address different categories of need in different localities and should include a mix of 'safety-net' services delivered at fixed site (e.g. based at facilities for homeless people) and outreach clinics (to include mobile dental clinics) and mainstreaming to local NHS primary dental care. Peer support workers can be helpful in supporting people to make and keep dental appointments. A mix of 'drop-in' and appointment clinics should be offered.
- 3.90 Services should be non-judgemental and non-threatening providing reassurance particularly for the dentally anxious.
- 3.91 Mainstream services must not prevent access by excluded groups; this should be regularly tested and refusal of access robustly contested.
- 3.92 A dental clinical governance framework has been developed by the Department of Health to help set out criteria for the standard and quality of primary dental care to be commissioned and evaluated by Primary Care Trusts⁸⁹. Dental care for excluded groups would be expected to comply with these standards and

Local NHS arrangements for dental care for excluded groups

Standards for Physiotherapy Services

quality guidelines. Standards and quality in relation to dental care provided in mobiles and in outreach clinics must comply with the themes in relation to: Infection control, child protection, staff, patient, public and environmental safety, clinical records, patient privacy and confidentiality.

- 3.93 All members of excluded groups attending for dental care should receive an oral health assessment and timely provision of treatment. Evidence suggests that treatment plans based over short time frames are more likely to be completed. The dental health education/ oral health promotion provided should be sensitive and appropriate to the person's oral risk factors, housing situation, and literacy level (using visual aids where necessary, e.g. story sacks, puppets and games for the children, or models, pictures, and flipcharts for adults⁸⁸) as well as culturally appropriate.

A national audit of people who are homeless revealed that 70% reported health problems involving chest pain/ breathing problems or joint/ muscle problems⁹⁰.

Commissioners of health care for homeless people should recognise when homeless and vulnerable people struggle or fail to access mainstream physiotherapy services. Consideration should then be given on how to improve access to physiotherapy by this population. Physiotherapy may be important in the management of the physical health component of tri-morbidity, including musculoskeletal injury management, amputee care, cardiac and pulmonary rehabilitation and neurological rehabilitation.

- 3.94 Where need is identified, recruitment of a 'Specialist Physiotherapist for Homeless and Vulnerable People' should be considered.
- 3.95 In multi-disciplinary teams where a specialist physiotherapist for homeless and vulnerable people does not exist, a member of the physiotherapy team should be identified as a homeless and vulnerable people "champion" for liaison and advocacy.
- 3.96 The training needs of specialist physiotherapists for homeless and vulnerable people should be considered. For example: conflict resolution, working with interpreters, the long and short term effects of illegal drugs and alcohol, mental health, domestic and sexual violence, child protection, the criminal justice system, immigration, torture, self defence.
- 3.97 To raise awareness of the potential for specialist physiotherapy services for homeless and vulnerable people within the profession of physiotherapy, various strategies should be considered, including: rotation of mainstream junior physiotherapists through the service, practice placements for physiotherapy students, liaison with university colleagues regarding inclusion of issues surrounding homelessness and vulnerability in undergraduate curricular, publications and conference presentations.

Footcare is particularly vital for homeless people. Where numbers of homeless people justify drop-in centres and other specific provision a specialist podiatry service is very likely to be necessary. In other areas enhanced access should be planned.

Standards for Podiatry Services

- 3.98 'Drop in' access by self referral with continuity of provision to build trust – including cover for leave. Appropriate and accessible advertising of service including EasyRead and translation and clinical access to translators and language line.
- 3.99 Provision at all main homeless drop ins and homeless GP surgeries in area. New patients to be referred to GP/nurse for full health assessment.
- 3.100 Security should be considered, including set up and location of clinical room, access to notes and alerts, chaperones when necessary.
- 3.101 To apply standards of infection control, waste disposal, equipment, lighting and note taking equal to mainstream and delivery of equipment and stores in same way as mainstream although working in non NHS premises. Also provision of sample taking and collection (e.g. wound swabs and nail clippings).
- 3.102 Links with mainstream podiatry service. Lead clinician to work in both to maintain links and equitable standards. Equal access to other specialities to which podiatrist will frequently refer via GP, e.g. physiotherapy and surgical footwear. Arranging support to attend where necessary. To promote annual diabetic neurovascular foot checks and diabetic foot care advice on an opportunistic basis by all health team members. Screening for alcohol related neuropathy.
- 3.103 Signposting to other services as in a position to build up trust rapidly due to instant relief of pain by non painful treatment, repeat consultations and opportunity for talking during treatment. Foot health and podiatry awareness training for day centre volunteers. Frequent care plan review according to patient's changing situation. Assertive outreach for non engaged clients Advise of drop-in podiatry clinics in local area if sleeping outside area. Encourage provision of free shoes and socks in day centres. Provide supporting letters for grants/loans for shoes from DHSS if necessary. Service user involvement and patient satisfaction surveys.
- 3.104 For recently housed patients services should ensure continuing care or refer on.
- 3.105 Modify treatment if necessary. e.g. the use of strong acids to treat verrucae needs care as the patient cannot rest, need to liaise with day centre staff with regard to possible temporary accommodation provision when patient is particularly vulnerable due to a foot problem.
- 3.106 Training and education: Consider training need for homeless podiatrists in conflict resolution, working with interpreters, drugs and alcohol effects on lower limb, mental health, torture, self defence. Build links with other local agencies and services. Offer training to profession through mandatory rotation of mainstream podiatrists, placements for podiatry students, university guest lecturing and workshops on homeless healthcare with podiatry

students, publications and conference presentations, audit and research.

- 3.107 Equal grading of post to other specialist podiatrists in the team. All podiatry teams to have a 'Specialist Podiatrist for Homeless and Vulnerable People'. Podiatrists should have independent prescribing rights where appropriate.

Standards for Substance Misuse Services

Not all homeless people have problems with alcohol and drugs, but for many people substance misuse becomes a significant barrier to moving out of homelessness. This Faculty broadly supports the 2010 Drug Strategy⁹¹, particularly acknowledging that recovery is an individual person-centred journey and recognising that many homeless people lack the social, physical, human and cultural capital listed as central to starting and sustaining recovery.

- 3.108 Integrated drug and alcohol services should be easily accessible in places where homeless people go, such as drop-in centres and primary care centres.
- 3.109 People with drug and alcohol problems must be able to access active help with both problems from one key worker.
- 3.110 People dependent on drugs and alcohol should not be excluded from hostel accommodation because of their dependence.
- 3.111 Where there are high levels of intravenous drug use, hostel accommodation staff should be trained in the administration of Naloxone, and the project should have procedures covering the safe disposal of needles etc.
- 3.112 Drug and alcohol workers should recognise the high levels of poor mental health among homeless substance users, and ask if people want referral to mental health treatment/someone to help with emotional and/or psychological distress. Most homeless people say they use drugs and alcohol to lessen their mental distress: this should be respected.
- 3.113 Primary care delivered services may improve coordinated delivery of health care and preventative services. Where there are separate services communication with the GP service about current medication doses, vaccinations and screening is vital.
- 3.114 Early appointments should be arranged for chronically alcohol dependent people who may then be able to attend with less alcohol in their blood than later in the day; this is also important for other healthcare providers working with alcohol dependent clients.
- 3.115 Opportunistic provision of health promotion should be an integral part of substance misuse services. This should include screening for blood borne viruses and vaccination against hepatitis A and B, particularly for injecting drug users and those with hepatitis C. An accelerated schedule should be used without delay for pre-testing⁹². Thiamine should be prescribed for alcohol dependent patients.
- 3.116 Close links (ideally on the same site) with services providing benefits advice, housing support, and support into education,

training and work are particularly important for homeless people in substance misuse treatment.

- 3.117 Medically assisted recovery with harm reduction and maintenance substitute opioid prescribing remains the safest option with the best evidence base for most homeless drug users with complex needs.
- 3.118 Acute services should be actively supported to ensure timely provision of substitute prescribing for opiate dependent patients admitted to hospital.
- 3.119 The role of pharmacists in supporting people who are substance dependent, and particularly those on substitute prescribing, should not be underestimated, and pharmacists should be involved in local multidisciplinary teams.
- 3.120 Ensure substance misuse services for Gypsies and Travellers are culturally appropriate.

End of life care for excluded groups needs particular sensitivity to ensure that patients are supported to make their own choices. Guidance for homeless patients is provided by St Mungos and Marie Curie⁹³.

For Gypsies and Travellers, lack of facilities for terminal care on Gypsy/ Traveller sites means that death may occur in hospital rather than (as may be preferred) amongst family at home⁹⁴. Need for services to understand the importance of family support and kin-group responsibilities to manage expectations, and avoid conflict over numbers of visitors or caravans/vehicles parked at a specific location e.g. gathering to support a person having medical treatment or following bereavement¹⁹.

Homeless services may include the provision of “respite care” (now in 50 Cities in USA and Canada) – community based residential medical facilities for homeless people with significant and complex health care problems. This could be achieved cost-effectively through joint working with local hostels and the voluntary sector. These services improve outcomes and reduce subsequent unscheduled hospital admissions^{53,54}. Pathway has recently published standards for Medical Respite in England⁵⁵.

- 3.121 Person centred case management to include physical health, mental health and drug or alcohol misuse when relevant.
- 3.122 A Psychologically Informed Environment, with regular reflective practice integral to daily practice⁷⁶.
- 3.123 On-site access to a full range of primary care services.
- 3.124 Integrated team working across medical treatment, social care and housing support, ideally from one provider organisation.
- 3.125 Access to education, training, sports, arts activities.
- 3.126 Traditionally, Gypsies and Travellers look after their elderly within the community. More needs to be done to support the extended family as carers, including access to culturally appropriate respite

Standards for Palliative Care

Standards for Medical Respite Care

where necessary. Home adaptations for caravans need to be considered and promoted.

It is not for the Faculty of Inclusion and Homeless Health to propose standards for non-medical services for homeless people and other excluded groups, but certain other services provided by local government, the voluntary sector and national government are vital to the wellbeing and long term life chances of these excluded groups. These services include hostel providers, skills and training agencies, benefit offices, housing staff for homeless people, and provision of adequate settlements for Gypsies and Travellers.

Inter-departmental partnership work to address social determinants of health, and inclusion of service users in service planning and delivery will be central to delivering improved health outcomes for all excluded groups.

Homelessness is a health problem as well as a social one. Our ambition is that health and social care should be integrated in recovery pathways for homeless people, and to achieve this it is crucial that health professionals work closely alongside other services in the interests of their patients, integrating care packages and advocating for the best possible outcomes for our patients.

Standards for Secondary Care Services

All admitted patients should be asked “do you have somewhere safe to stay when you leave hospital” and staff should be trained and supported to help people who say “no”. For hospitals with significant number of inclusion health patients, the Pathway care coordination approach has demonstrated improved patient care and cost efficiency⁹⁵. GP and nurse led ward rounds, multi-agency care planning meetings and involvement of Care Navigators are the key elements. Pathway teams have been commended by the RCP Future Hospitals Commission Report⁹⁶.

All hospitals should have protocols for discharge planning for excluded groups, based on the guidance developed by St Mungos and Homeless Link⁹⁷.

Demonstrating that a service meets these Standards

The Faculty aspires to develop a methodology that will help services to demonstrate that they meet these Standards. This approach will need to build upon the essential requirements of statutory inspection, continuous professional development, appraisal and revalidation to demonstrate the added value offered by inclusion health services. We will, of course, have service users at the heart of the process.

We aim to support services to demonstrate:

- A service which is welcoming, holistic and inclusive.
- Easy access to care, including outreach.
- Multi-agency working, joined up care across health, social care and voluntary sector with updated directories of partner agencies.
- Service user involvement in service design and evaluation.

- A systematic approach to highlighting the plight of vulnerable people in contact with the service.
- Promotion of permanent GP registration.
- A considered response to Public Health challenges involving its service users.
- A mechanism for monitoring and responding to frequent attendance at A&E.
- Monitoring of outcomes for service users.
- A process aimed at recovery and movement towards mainstream services.

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Appendix

The NHS, Public Health and Adult Social Care Outcomes Frameworks 2013/14 ^{98,99,100}

The Public Health Outcomes Framework (PHOF) has two high level outcomes; (i) increased healthy life expectancy, and (ii) reduced difference in life expectancy and healthy life expectancy between communities.

The Adult Social Care Outcomes Framework (ASCOF) has four domains; (i) Enhancing quality of life for people with care and support needs, (ii) Delaying and reducing the need for care and support, (iii) Ensuring that people have a positive experience of care and support, and (iv) Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm.

These outcome frameworks are increasingly aligned.

It is in the area of safeguarding that there is the most potential for improvement for excluded groups. It is a common experience that vulnerable adults from excluded groups have difficulty in getting safeguarding concerns addressed because of problems with habitual residence or ordinary residence blocking access to a safeguarding assessment.

The NHS Outcomes Framework has 5 domains summarised below, with relevant sections of the PHOF and ASCOF shown in brackets. There is an emphasis on inequalities – but measured at a geographical level. This means that many homeless people, Gypsies and Travellers, and vulnerable migrants may be excluded from consideration because their outcomes are not recorded.

| Domain | Overarching Indicators | Improvement areas |
|--|---|--|
| <p>1. Preventing people from dying prematurely</p> <p><i>Homeless people have an average age of death in their 40's and are twice as likely to die before the age of 75 compared to housed people</i></p> <p><i>Gypsies and Travellers experience a life expectancy of around 50, with infant mortality 3 times higher than the national average.</i></p> | <p>1a. Potential years of life lost (PYLL) from causes considered amenable to healthcare</p> <p><i>– a specifically targeted and coordinated primary healthcare and public health response is necessary to make health care more accessible to those in excluded groups.</i></p> | <p>Reducing premature mortality from the major causes of death. (PHOF 4.4 to 4.7)</p> <p><i>Homeless people have increased mortality resulting from cardiovascular respiratory and liver disease (1.1 to 1.3) and tend to present late with Cancer with resulting increased mortality (1.4) 1.5 premature death in serious mental illness also likely to be over-represented amongst homeless people.</i></p> <p>1.6 Reducing deaths in babies and young children (PHOF 4.1)</p> <p><i>These indices will be raised by the extremes of poverty and deprivation experienced by homeless families, Gypsies and Travellers and vulnerable migrants.</i></p> |

| | | |
|---|--|--|
| <p>2. Enhancing quality of life for people with long term conditions</p> | <p>2. Health related quality of life for people with long term conditions</p> <p><i>Drug and alcohol related conditions can be particularly problematic for homeless people and are identified by NICE standards as meriting particular attention.</i></p> | <p>2.3i Unplanned admissions for chronic ambulatory care sensitive conditions and 2.3ii unplanned hospitalisation for diabetes, asthma and epilepsy in under 19s</p> <p><i>Lack of family support and chaotic lifestyles for homeless adults and young people make hospital admission more likely.</i></p> <p>2.6 (PHOF 4.16 and ASCOF 2F). Enhancing the quality of life for people with dementia to improve diagnosis and care</p> <p><i>Long term homelessness is associated with high levels of dementia related to traumatic brain injury and alcohol related brain damage, which is often poorly recognised.</i></p> |
| <p>3. Helping people to recover from episodes of ill health or following injury</p> | <p>3.a Emergency admissions for conditions that should not usually require hospital admission</p> <p><i>suggest a particular role for close support from primary care teams for homeless people - more expensive than standard care, but cheaper than admission.</i></p> <p>3.b Emergency re-admissions within 30 days of discharge from hospital (PHOF 4.11)</p> <p><i>Rates are particularly high amongst homeless people and suggest a role for enhanced community support and treatment for homeless people (respite model) combined with Pathway care coordination during admissions.</i></p> | <p>3.1v Improving outcomes from planned treatments – psychological therapies</p> <p><i>Psychological therapies need to be specifically tailored for excluded groups and made particularly accessible – see details in this Standards document.</i></p> <p>3.2 Emergency admissions for children with LRTI's</p> <p><i>Particularly likely amongst homeless children in temporary and/or overcrowded accommodation- suggests a role for enhanced support and health surveillance for this group.</i></p> |
| <p>4. Ensuring that people have a positive experience of care</p> | <p>4.a Patient experience of primary care</p> <p><i>Access to GP services and dental services can be particularly difficult for excluded groups and often requires services to offer enhanced access – see standards.</i></p> <p>4.b Patient experience of hospital care. Evidence suggests that this can be improved by Pathway care coordination</p> | <p>4.2 Responsiveness to inpatient's personal needs</p> <p><i>This may be enhanced by Pathway care coordination. This is particularly important for 4.9 improving people's experience of integrated care. Homeless people commonly report poor experiences from health care providers, specific surveys of their experiences in primary and secondary care should improve services approach to homeless people.</i></p> |
| <p>5. Treating and caring for people in a safe environment and protecting them from avoidable harm</p> | | |

Glossary

| | | | | | | | |
|----------|--|--|---|---|--|--|-----------------------------|
| A | ADHD | <i>Attention Deficit Hyperactivity Disorder</i> | K | KPI | <i>Key Performance Indicator</i> | | |
| | A&E | <i>Accident and Emergency Department</i> | | L | LE | <i>Life expectancy</i> | |
| | ASCOF | <i>Adult Social Care Outcomes Framework</i> | | | LRTI | <i>Lower Respiratory Tract Infection</i> | |
| B | BBV | <i>Blood Borne Viruses</i> | LREC | | <i>Leeds Racial Equality Council</i> | | |
| | BME | <i>Black and Minority Ethnic</i> | M | MDT | <i>Multidisciplinary Team</i> | | |
| | C | CCG | | <i>Clinical Commissioning Group</i> | MH | <i>Mental Health</i> | |
| CHAIN | | <i>Combined Homeless Information Network</i> | | MMR | <i>Measles, Mumps and Rubella</i> | | |
| CMHT | | <i>Community Mental Health Team</i> | N | NFA | <i>No fixed abode</i> | | |
| D | DFLE | <i>Disability-free life expectancy</i> | | NHSE | <i>NHS England</i> | | |
| | DH | <i>Department of Health</i> | | NICE | <i>National Institute for Health and Care Excellence</i> | | |
| | DHSS | <i>Department of Health and Social Security</i> | NIMHE | <i>National Institute for Mental Health in England</i> | | | |
| E | DsPH | <i>Directors of Public Health</i> | NOCN | <i>National Open College Network</i> | | | |
| | F | ECDC | <i>European Centre for Disease Prevention and Control</i> | O | ONS | <i>Office for National Statistics</i> | |
| | | G | FFT | | <i>Friends Families and Travellers</i> | P | PCT |
| GRT | | | <i>Gypsies, Roma and Travellers</i> | | PD | | <i>Personality disorder</i> |
| GRTHM | <i>Gypsy Roma Traveller History Month</i> | | PHE | <i>Public Health England</i> | | | |
| H | GT | <i>Gypsy and Traveller</i> | PHOF | <i>Public Health Outcomes Framework</i> | | | |
| | GTAA | <i>Gypsy and Traveller Accommodation Assessments</i> | PHPQI | <i>Prison Health Performance and Quality Indicators</i> | | | |
| | I | HHR | <i>Hand Held Records</i> | PYLL | <i>Potential years of life lost</i> | | |
| HLE | | <i>Healthy life expectancy</i> | Q | QOF | <i>Quality and Outcomes Framework</i> | | |
| HNA | | <i>Health Needs Assessment</i> | | S | SHA | <i>Strategic Health Authorities</i> | |
| HSE | <i>Health and Social Care Information Centre's Health Survey for England</i> | SofS | | | <i>Secretary of State</i> | | |
| J | HWBS | <i>Health and Wellbeing Board Strategy</i> | T | | TB | <i>Tuberculosis</i> | |
| | K | ITMB | | <i>Irish Traveller Movement in Britain (see TM)</i> | TM | <i>Traveller Movement (formerly the Irish Traveller Movement in Britain)</i> | |
| | | L | | JSNA | <i>Joint Strategic Needs Assessments</i> | V | VO |

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