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Beyond Pockets of Excellence: Integrated Care Systems for Inclusion Health

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The Inclusion Health Network was a partnership between The King's Fund, Pathway and Groundswell

The King's Fund
Groundswell
Out of homelessness

Beyond Pockets of Excellence: Integrated Care Systems for Inclusion Health

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Introduction

> This report is intended for local and national policy makers and commissioners with an interest in improved outcomes for Inclusion Health populations. It presents lessons from a collaborative ICS learning network co-curated by Pathway, Groundswell and The King's Fund over six months in late 2022 and early 2023.

Senior NHS and ICS system leaders may be most interested in the report (pages 6 – 17). It sets out the case for Inclusion Health and describes a strategic road map towards a better service response for these populations.

ICS managers and commissioners with responsibility for health inequalities and Inclusion Health will also be interested in the material presented in the annex (pages 18 – 45). This delves into the detail of what programme participants considered good services should look like, and considers some of the levers and enablers that participants thought from their experience can help systems to create the conditions for success.

This report is not intended to be used as a guide to best practice. We aim to present our shared learning about Inclusion Health, to raise questions about what enables and what inhibits action, and tentatively to describe a way forward that systems may wish to adopt.

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Finally, our sincere thanks to Gill Leng, a key figure in Inclusion Health, who played a significant role in shaping this programme.

1 Route Map to Inclusion Health

1.1 Introduction: what our collaboration was all about

Integrated Care Systems have been on a statutory footing since Summer 2022. Amid the creation of new structures and in anticipation of longer-term strategic plans, there is a yearning for action, for results, and for real change. In that spirit, seven Integrated Care Systems (ICSs) were chosen in Autumn 2022 to form part of a ground-breaking new network focused on meeting the health and wellbeing needs of many of the most marginalised communities in the country: Inclusion Health groups or populations.

This network was jointly supported by Pathway, the national homeless and Inclusion Health charity; Groundswell, whose focus is the voice and power of individuals and communities experiencing homelessness; and The King's Fund, which works with health and care systems to support improvements in care.

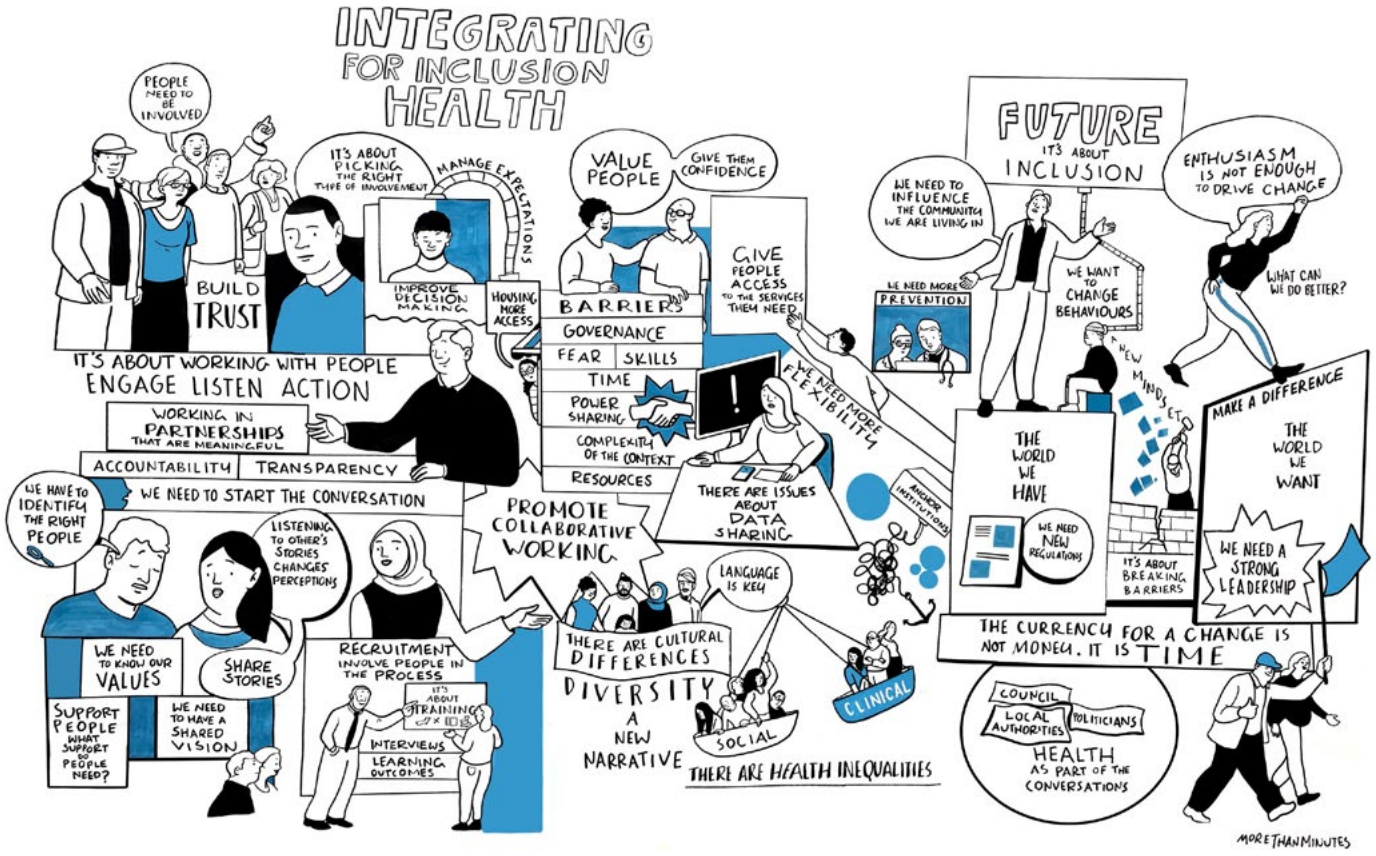
Inclusion Health is not a new construct. But nor is it one that is widely used by all involved in health and care. For some the terminology is confused with wider concepts of inclusion and diversity. It is sometimes obscured within a broader focus on inequalities, a focus that is growing in vigour amidst a twin-demic of COVID-19 and poverty with the cost-of-living crisis. Elsewhere, the needs and interests of the most excluded are framed in different ways – severe and multiple disadvantage (SMD) being perhaps the most common alternate labelling.

The evidence of common needs among populations at the extreme margins of communities is compelling and widely accepted. The consequences and costs of exclusion are evident and striking. The challenge to public services, and to community partners, is how to give priority to what is seen as both an intractable set of very poor outcomes and relatively small groups within the population as a whole.

Our network sought to flip that script. Integrated Care Partnerships are often looking to tackle structural inequalities, while their membership bodies aim to address huge imbalances of supply and latent demand in the system. Inclusion Health populations represent an initial opportunity to introduce approaches to participation, care delivery, and health creation at modest scale – while broader whole system thinking and work to lessen life expectancy gaps takes root and, inevitably, takes time. If the challenge of sharing power with excluded groups can be met, we argue, then momentum should grow for a wider set of changes consistent with what Professor Sir Michael Marmot labelled as 'building back fairer', designed to address the levelling-up and health equity ambition to narrow disparities in healthy life expectancy across England.

1 Luchenski, Sarah et al. "What works in Inclusion Health: overview of effective interventions for marginalised and excluded populations". https://www.researchgate.net/publication/325142265_What_works_in_inclusion_health_overview_of_effective_interventions_for_marginalised_and_excluded_populations

2 Marmot, Prof. Sir Michael. "Build Back Fairer: The COVID-19 Marmot Review". https://www.health.org.uk/publications/build-back-fairer-the-covid-19-marmot-review?gclid=EAIaIQobChMIqLbV8omf_wIVT-vtCh0YGALaEAAYASAAEgIJNfD_BwE



The network's work is rooted in two phenomena:

- The excellence of particular places in providing good quality care to a particular Inclusion Health population, sitting alongside poorly developed services for other populations within the Inclusion Health cohort.
- The excellence of places in providing access and care to a high standard in one neighbourhood, without that leading to better quality on a bigger footprint.

This pattern, widespread though not universal, was christened 'pockets of excellence' by those involved in the network. Such pockets are not confined to Inclusion Health. But perhaps because much of the excellence here reflects exceptional effort and specific collaborations on the part of a single service or even individual, there is a real concern that spread will not occur without explicit intention and clear leadership. ICS leaders are well placed to provide the drive that is needed.

We wanted to create a space in which emergent Integrated Care Systems could together think about what good looks like and develop their own rapid trajectory to deliver that hoped for real change in 2023 and 2024. As one of our leaders suggested at the outset of our work, "if integrated care cannot tackle Inclusion Health, we should all be worried".

> *"if integrated care cannot tackle Inclusion Health, we should all be worried".*

We set out below why ICSs should want to focus on Inclusion Health populations and present the ambitions of the ICS leaders who took part in this network.

3 Lewis, Toby. "If integrated care cannot tackle Inclusion Health, we should all be worried". https://www.kingsfund.org.uk/blog/2022/09/if-integrated-care-cannot-tackle-inclusion-health-we-should-all-be-worried

1.2 Why Inclusion Health?

People and populations within the Inclusion Health definition experience health outcomes far worse than the general population. Their health status and health outcomes are many times worse even than people in the poorest decile of the general population. Inclusion Health groups have remained extreme outliers in health equity terms even as austerity has intensified health inequalities since 2010.

What defines and unites Inclusion Health groups are common experiences of sustained social and economic marginalisation. The impact of this extreme structural exclusion leads to people's needs, and the ways in which they try to access care, exceeding the capacity and capability of standard service models to respond. When they do access services, people can experience being further labelled (as difficult or complex) and then again excluded for being too hard to help. And this in turn sets up further cycles of stigma, alienation and shame in the individual: again common shared experiences of Inclusion Health groups. This combination of profound marginalisation and service failure underpins the shocking mortality rates and life expectancy deficits which also define Inclusion Health groups.

What is Inclusion Health?

"Inclusion Health is a research, service and policy agenda that aims to redress the extreme health and social inequities among the most vulnerable and marginalised in a community.

To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity to the level of disadvantage. We call this proportionate universalism.

Those who are living on the margins of society are too often poorly served. We believe that care must be tailored to reflect the particular needs of each patient, with clinicians addressing the patient's total health, care and social needs. Whilst many people experiencing deprivation will face the health impact of inequality, this impact is particularly acute for the most marginalised. People in this situation may include people experiencing homelessness, vulnerable migrants, sex workers, Gypsies and Travellers and those in contact with the criminal justice service."

Joint Statement, The Academy of Medical Royal Colleges and the Faculty for Homeless and Inclusion Health, 2017

Faced with these challenges services can default only to respond to the immediate, presenting problem, failing to take time to understand what has really happened to someone or at least to build some initial trust or offer some compassion. Episodic models of care will struggle appropriately to respond consistently to these factors, all too often requiring a re-iteration of the layers of problems, and not uncommonly retraumatising the person seeking help. Services under pressure will also often retreat to work more and more tightly within their own defined parameters and not want to get involved in the wider issues in a person's life: for example, their lack of anywhere to sleep, or any source of income. As a result, services regularly fail these groups despite the readily apparent, treatable and very significant burdens of unmet health needs.

One response to this challenge could be to approach each Inclusion Health population discretely, recognising there are differences between, for example, sex workers and prisoners. However, the case for Integrated Care Systems to approach Inclusion Health groups in common rests not only on the similarities of truly awful outcomes and of the groups' shared experiences of exclusion, but on the similarities of the disease burdens they face, the common psychological consequences of exclusion (trauma) and the growing evidence base that the most successful service responses to these needs themselves share a wide range of characteristics. The general principles of the NICE homelessness guidelines, while geared towards one segment of the Inclusion Health population, sets out some general principles that could be applied to all.

Integrated Care Systems have an opportunity to approach this systematically and consistently and to drive substantial and relatively rapid health gains for these groups. Whilst recognising the differences between Inclusion Health groups there is real benefit in seeing the similarities in terms of service provision, and to use the new structures to drive more consistent improvements right across systems for those within Inclusion Health groups. Inclusion Health groups need more integrated services across health, housing and social care: Integrated Care Systems have been set up to do this.

4 Overview | Integrated health and social care for people experiencing homelessness | Guidance | NICE

1.3 Who has been involved in this work and what did we do?

Seven ICSs were selected, from 14 who applied to be part of the programme. We spent 35 hours with them, over the course of five months. The six sessions focused on what good Inclusion Health services look like, and what system change is necessary to support this. We drew in experts from the world of Inclusion Health and beyond to provide evidence-based learning to our participants and supported them to think about how what they learned applied to the challenges in their areas. Section 2 goes into more detail on this content.

We asked our seven ICSs what motivated them to be part of the programme, and what reflections they have on participating:

> *"By participating in this learning programme, the Lincolnshire Integrated Care System hoped to understand how to apply an evidence-based, effective health inclusion approach into a rural, coastal county with specific challenges around deprivation and a lack of a single urban centre and service hub. Being about a system-wide approach, our response will be across health, social care, housing, and other social determinants of health."*

-**Sean Johnson**,
Lincolnshire Integrated Care System

"I jumped at the chance to be involved with the Inclusion Health learning set, as it was an opportunity to work with The King's Fund, whom I greatly admire, to discover what other ICSs were doing that we could learn from and to explore ways of collaborating with 'like minds' in Devon. This work has coincided with Pathway carrying out a Health Needs Assessment. It is always nourishing to spend time with 'like-minded' people, it provides a reassurance that change can happen and your thinking is in sync."

-**Dr Nicola Glassbrook**,
Devon Integrated Care System

"On reflection, what I sought from the programme was an opportunity to connect with like-minded people from across a range of ICBs who are also grappling with how to provide leadership to the health inclusion agenda and deliver in what is an increasingly challenging environment. This programme was perfectly timed to take forward some of that learning from COVID and share it more widely. This has been both enlightening and energising and has helped to start to reframe what is possible in North East London and how we might do things differently."

-**Ellie Hobart**,
North East London Integrated Care System

"South Yorkshire ICS were keen to have access to the knowledge and experience of national experts from The King's Fund, Pathway and Groundswell around Inclusion Health. We also wanted to hear the brutal truth from people with lived experience and to understand how we can work together and better support them to live happier and healthier lives. We valued the opportunity to be able to link with other ICSs and to learn from the good work they were doing, as well as having the opportunity to consider some solutions to the common challenges we are all facing."

-**Mandy Espey,**
South Yorkshire Integrated Care System

"In Norfolk and Waveney our contribution was seeking to gain a shared evidence base, and understanding of Inclusion Heath priorities both nationally and across our region (East Of England) so that our ICS can put in place the system changes needed to decrease inequalities found within Inclusion Health groups. Further, to identify the ICS dependencies with Inclusion Health workstream approaches (e.g., linked to primary care, strategic commissioning, urgent emergency care, mental health, our Health Roadshow Bus, Project Adder, our Strategic Housing Partnership) and work with partners to support the alignment of ICS resources and to influence our ICS understanding at all levels of Inclusion Health."

-**Alice Vickers**,
Norfolk and Waveney Integrated Care System

"Through The King's Fund Programme, we wanted to look through new ways of working together to better meet the needs of people within our population experiencing multiple disadvantages. Our involvement in The King's Fund/Pathway/ Groundswell Inclusion Health programme was an opportunity to learn new ways of identifying and working to meet the needs of our communities, harness best practice, network and collaborate with other people within the programme. We have initiated needs assessment, collaborative and partnership working, established communities of practice and employed the expertise of local groups. This has enabled us to identify and address the gaps in inadequate access to healthcare."

-**Sayanti Banerjee**,
Sussex Integrated Care System

"Our ambition is to place Inclusion Health as part of mainstream service design and production and not as an exception. Focusing on reducing barriers and giving our collective focus and resources, we have come from a range of partner organisations with the intention to improve services to communities that are underserved. Being part of The King's Fund/ Pathway/Groundswell Learning Set is helping us solidify our approach – one of 'collaboration in action' in taking the work forward. We saw the Learning Set as a place to seek assurance that we are on the right path to sustainably work differently across organisations and with communities. The effortless insight that colleagues with lived experience have shared provides a lens and real circumstances which we may often miss, and makes real our ambitions."

-**Jackie Stevens**,
Hampshire and Isle of Wight
Integrated Care System

1.4 Where next? Towards an Inclusion Health route-map – getting started

The work of our network over the last six months has provided an opportunity to explore how Integrated Care Systems, both partnerships and boards, could make a start in addressing Inclusion Health issues. Based on this exploration we set out below seven steps we propose ICS leaders need to take to move towards success.

It is apparent to us from the material shared within the network that good work is taking place in many locations and services. Whilst much of our focus has been on health, we have listened to examples of outstanding integration between service providers well beyond the confines of the NHS alone – and the hope remains that Integrated Care Partnerships, Boards, and Systems can build on that at scale. Through the network's discussions and exploration, it became ever clearer the fundamental role of a stable home environment in life. The absence of a decent, safe and secure home is a common thread across Inclusion Health groups.

At the same time, we have recognised the primacy of research and evidence sharing drawn from the homelessness field in the work that we have done – or rather the risk of generalising from that work into other Inclusion Health populations. The commonality of trauma as a thread among these populations has to be acknowledged.

There remains a separation between those with knowledge and insight into service provision, those with lived experience of the need to do better, and those with decision-making and priority setting roles in local leadership. The steps below aim to close that gap.

Seven steps to change	Includes
1 Brutal truth and honesty from the outset	**Why?** There is a real risk that Inclusion Health groups, whose outcomes are many times worse than the lowest decile local population, are overlooked or subsumed within other, larger agendas. Or even considered 'hard to reach' – an institutional othering. **What: local leaders need to immerse themselves in the reality of the lived experience of Inclusion Health groups**, in order to truly listen and consider the urgency of change in their communities. The pace and insistence established by senior leaders can create a momentum to allow their teams to focus on addressing the harms experienced by marginalised communities.

2 Shifting the balance of power

Why? Openness to hear and to see the realities of marginalisation is a start. But this needs to be used to open the door for influence from those experiencing such marginalisation. Top team sponsorship is needed to avoid this influence being wasted in the middle of complex systems.

What: by overtly opening up decision making to Inclusion Health populations, leaders can signal a change in how services are judged and by whom. **The important step is to make Inclusion Health an early litmus test for coordinated care and preventive upstream health transformation.**

3 Harnessing levers for radical change

Why? Business as usual incremental changes are unlikely to create the climate of sizeable and rapid adaptation that is needed to address extreme exclusion. Senior leadership momentum is needed to address vested interests that struggle to adjust to the changes that are necessary.

What: intentionally create a financial model which enables service leaders to respond to the data and intelligence they hold on Inclusion Health populations. The approach may vary locally but personalised budgeting approaches will be important to hand control to the client group to secure service needs. The first step is to establish clarity of existing intra-agency spend and the opportunity cost of a locally excluded population: Inclusion Health excellence requires repurposing of funds currently spent ineffectively.

4 Beyond health, considering housing as a foundational step

Why? The norm for many in Inclusion Health populations is not one of safety or stability. The absence of such crucial mediators impacts the effectiveness of service provision even where it can be accessed.

What: this means that **housing, benefits, health, education, and others have to cooperate to respond to trusted professionals working with Inclusion Health clients.** Otherwise, efforts become a futile signposting exercise.

We know that peer support workers play a critical role in supporting trust but ultimately this work requires a joined-up and yet flexible approach to how services co-create a multi-disciplinary plan with an individual.
A no-wrong-doors approach requires different responses from agencies to their current norms. There is a strong case for focusing first on housing stability as a foundational factor that is the basis for accessing other provision in public services.

5 Establishing specialist services that reflect best practice

Why? The evidence base for what is needed is validated and known. Service provision remains patchy and often reflects legacy arrangements developed over some years.

What: Dedicated or hypothecated teams and sites are needed for some elements of good care for Inclusion Health groups. Templates for such provision have been validated by NICE. What is missing is a comprehensive deployment of such resource in forty-two ICSs. **ICP strategies and ICB operating plans need to demonstrate a timetable for creating dedicated services** that will permit better outcomes for the most marginalised.

6 Holding the mirror up to generalist services

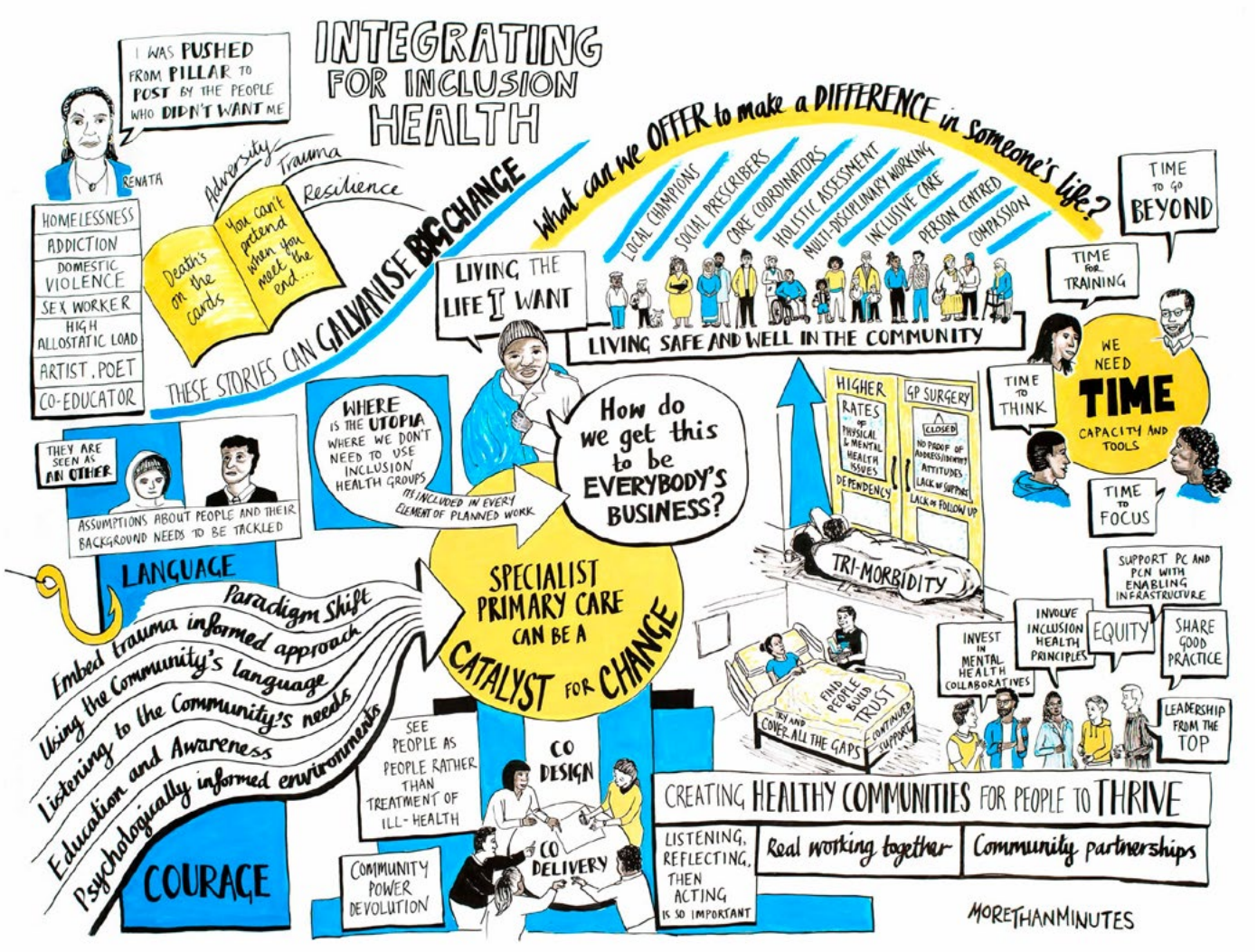
Why? Exclusionary practices remain normalised in many parts of health provision, whether it is address-proving in primary care, or an absence of dual-diagnosis services in mental health and addiction teams. Some practices are a deviation from local policy, others reflect a pattern of service design.

What: the step needed is to assess the accessibility and unconscious bias of services through the experiences of Inclusion Health populations. What is important is to establish an expectation of **accessibility, moving towards a position of commissioning only from providers who can actively demonstrate their approach.** It is important that this reaches into issues of administrative practices, digital exclusion, skills and training of key staff, and data collection compliance. Values and intent are insufficient.

7 Keeping truth to the fore: evaluation and revision

Why? The work involved in establishing high-quality services creates a risk of undue allegiance to those solutions, and a lack of curiosity about their effectiveness in practice.

What: in the absence of national metrics or regulatory involvement, **local systems will need to create a clear framework of evaluation that tests the results achieved from the changes made.** Access to services can be measured for those in contact with service providers. What is more difficult is to measure excluded individuals. Outcome measures require some longitudinal assessment and comparators.



Implied by these steps is the capacity and capability to both execute change and harness expertise – both professional and peer. Senior leaders in ICSs will wish to consider how to tap into those skills within their systems and beyond. It is important that Inclusion Health expertise informs local approaches but without question successful deployment will require the active leadership of those drawn from outside the field. Inclusion Health practitioners need to consider how best to enable other influences to shape local planning.

In particular, delivery skills are needed for this work, which has often not moved beyond theory or strategy. Equally, working with complex populations, including Inclusion Health, is difficult and affecting work – and it will be important for systems to create support models, including supervision, within their services. Such approaches will help to address inhibitions and burnout affecting staff working in this field.

An approach to workforce development that promotes multi-disciplinary working, space for curiosity, trauma-informed approaches and reflective practice will pay dividends in supporting the seven steps on our route map. In the absence of an Inclusion Health 'curriculum', leaders can draw on educational resources from expert organisations, outlined below.

Drawn from the experiences of the network, and from those advising it, we suggest that these steps represent important contributions to local effort. They are most likely, taken as a whole, to secure significant gains for Inclusion Health populations. But their impact goes beyond that – securing gains for the most excluded will create patterns of service provision and habits of service change which are highly likely to ebb into other gains for those experiencing inequalities.

Seven Steps summary: a route map to Inclusion Health for ICSs

1	Brutal truth and honesty from the outset	Local leaders need to immerse themselves in the reality of the lived experience of Inclusion Health groups.
2	Shifting the balance of power	Make Inclusion Health an early litmus test for coordinated care and preventive upstream health transformation.
3	Harnessing levers for radical change	Intentionally creating a financial model which enables service leaders to respond to the data and intelligence they hold on Inclusion Health.
4	Beyond health, considering housing as a foundational step	Housing, benefits, health, education, and others have to cooperate to respond to trusted professionals working with Inclusion Health clients.
5	Establishing specialist services that reflect best practice	ICP strategies and ICB operating plans need to demonstrate a timetable for creating dedicated services that will permit better outcomes.
6	Holding the mirror up to generalist services	Establish an expectation of accessibility, moving towards a position of commissioning only from providers who can actively demonstrate their approach.
7	Keeping truth to the fore: evaluation and revision	Local systems will need to create a clear framework of evaluation that tests the results achieved from the changes made.

Resources

Pathway's health education map, a review of current free and low-cost Inclusion Health online education - https://www.pathway.org.uk/publication/inclusion-health-education-mapping-and-review-professional-group-report/

Figure A: A summary of the seven steps that Integrated Care Systems need to consider.

The Annex in pages 18-45 describes in more detail how services that broadly follow each element of the roadmap might look.

2 Annex of resources - for commissioners and managers across ICSs

What we have shared – key insights from this work

These resources draw on the important insights and principles that leading practitioners, clinicians and commissioners from Inclusion Health and beyond shared with our network's programme participants. They are shared here, so that other ICSs may use them for the benefit of their Inclusion Health populations.

The structure of the annex follows the seven-step route map recommended in the report and provides more detail about what the programme's expert contributors believe good services look like, and the enablers that ICSs will want to put in place to support them based on their experience. This section will be of most interest to those responsible for planning and commissioning services for Inclusion Health groups, and their partners.

This is not intended to be a formal best practice guide, rather a substantial collection of advice and insight intended to help guide those involved in planning and commissioning services for Inclusion Health groups.

2.1 Brutal truth and honesty from the outset

There is a real risk that Inclusion Health groups, whose outcomes are many times worse than the people living in the bottom ten percent most deprived areas, are overlooked or subsumed within other, larger agendas. Or even considered 'hard to reach' – an institutional othering.

Putting the voices and experiences of people in Inclusion Health groups at the heart of local strategic planning is the key way to counterbalance this and get to the truth of their experiences. Groundswell have been working in partnership with people experiencing homelessness for over 20 years, promoting opportunities for people with lived experience to contribute to society and create solutions to homelessness. Drawing on their extensive experience of participation, and championing the NHSE statutory guidance on working with people and communities, Rachel Brennan, Participation and Progression Director, shared practical advice and examples of why and how ICSs can involve people from Inclusion Health groups.

Reasons to involve people with lived experience

- Promotes collaborative working: To effectively address health inequalities for Inclusion Health groups health and care cannot work alone. The act of seeking to include people, listening to them and reinforcing that the system does care and is trying to improve can provide a strong foundation for building trust.
- Tackles health inequalities through better use of resources: Working with people can provide a greater understanding of why some health inequalities exist. Working in partnership to develop solutions to tackle them can lead to a better use of resources and interventions that will work.
- Improves quality and effectiveness of services: Services designed and delivered in partnership are more likely to work as they will be personalised to the needs of the people who will access them.
- Improved decision making: Business cases and decision making are improved when insight from people is used alongside financial and clinical information to inform the case for change.
- Positive impact for participants: Having the opportunity to participate in meaningful processes can support people with lived experience to develop new skills, build confidence and self-esteem, build positive social connections, all of which can improve health and wellbeing.
- Positive impact on the workforce: Working with people and communities can build engagement around a shared purpose and reinforce the importance of their own roles and job satisfaction.
- Recommended practice and legal duty: NICE guidelines on integrated health and social care for people experiencing homelessness recommends co-designing and co-delivering services with people with lived experience of homelessness to improve quality of health and social care. This principle should be applied to all Inclusion Health groups. The NHS also has legal duties on public involvement.

Different ways of involving people

There are many different yet effective ways to involve people with lived experience and it is important that it is remembered that there is not a 'one size fits all' approach to participation. Certain forms of participation may be appropriate at different stages of a project and it may be useful to incorporate multiple methods of involving people over the lifespan of a project. The best approaches are often developed by involving people with lived experience as early as possible in any activity and using their skills and expertise to inform the process and level of participation needed.

Principles of participation

The NHSE guidance provides excellent advice and guidance on all the things that should be considered to effectively work in partnership with people and communities. Rachel highlighted some key considerations based on Groundswell's experience:

- **What do you already know?** Research, data and evidence that already exists can be a good way of engaging people around a cause. It prevents people from becoming disillusioned if they are being asked the same thing that they feel they have been asked about previously. Who is doing this work well already and can support you?
- **Diversity:** Don't start from scratch when recruiting people for participation, link in with the organisations and networks who are already connected with the people you want to engage with. Keep perspectives fresh and promote broad engagement with people to avoid the risk of only hearing a few voices.
- **Power sharing:** Recognise different power dynamics and how to promote power sharing. One of the most effective ways is to support people to understand the different types of power and strengths that they all have and talk about ways to address any imbalances.
- **"Give a lot to get a lot":** People are contributing their time, energy and expertise and they should be rewarded for doing so. This can be formally through financial incentives or informally through options such as training, progression support, access to volunteering and employment opportunities.

- **Make it meaningful:** Recognise, acknowledge and celebrate people's contributions. Feedback to them on what's changed and the impact of their involvement. Consider different ways to engage people such as the location, offering food, utilising a range of different facilitation techniques to keep people energised and engaged.
- **Don't be afraid to get it wrong:** It is better to work with people and learn from getting it wrong, than not to work with them at all. Learn from the experience and continue to work with people to refine and develop your approach to getting it right.

2.1.2 Shifting the balance of power

People in Inclusion Health groups are among the most powerless in society. This is bad for their health and bad for services' ability to meet their needs. Openness to hear and to see the realities of marginalisation is a start. But this needs to be used to open the door for influence from those experiencing such marginalisation. Top-team sponsorship is needed to avoid this influence being wasted in the middle of complex systems.

Starting with the experiences of a very marginalised group like members of Gypsy, Roma and Traveller communities is a good starting point for designing inclusive services for everyone. "They are experts in Inclusion Health", argued Ellie Rogers, CEO of the Leeds Gypsy and Traveller Exchange (Leeds GATE), "because they know what it means to be excluded".

Rogers urged ICSs to look at and listen to the experience of Gypsy, Roma and Traveller communities in a respectful way, bearing in mind that Gypsies and Travellers have protected status under the Equality Act.

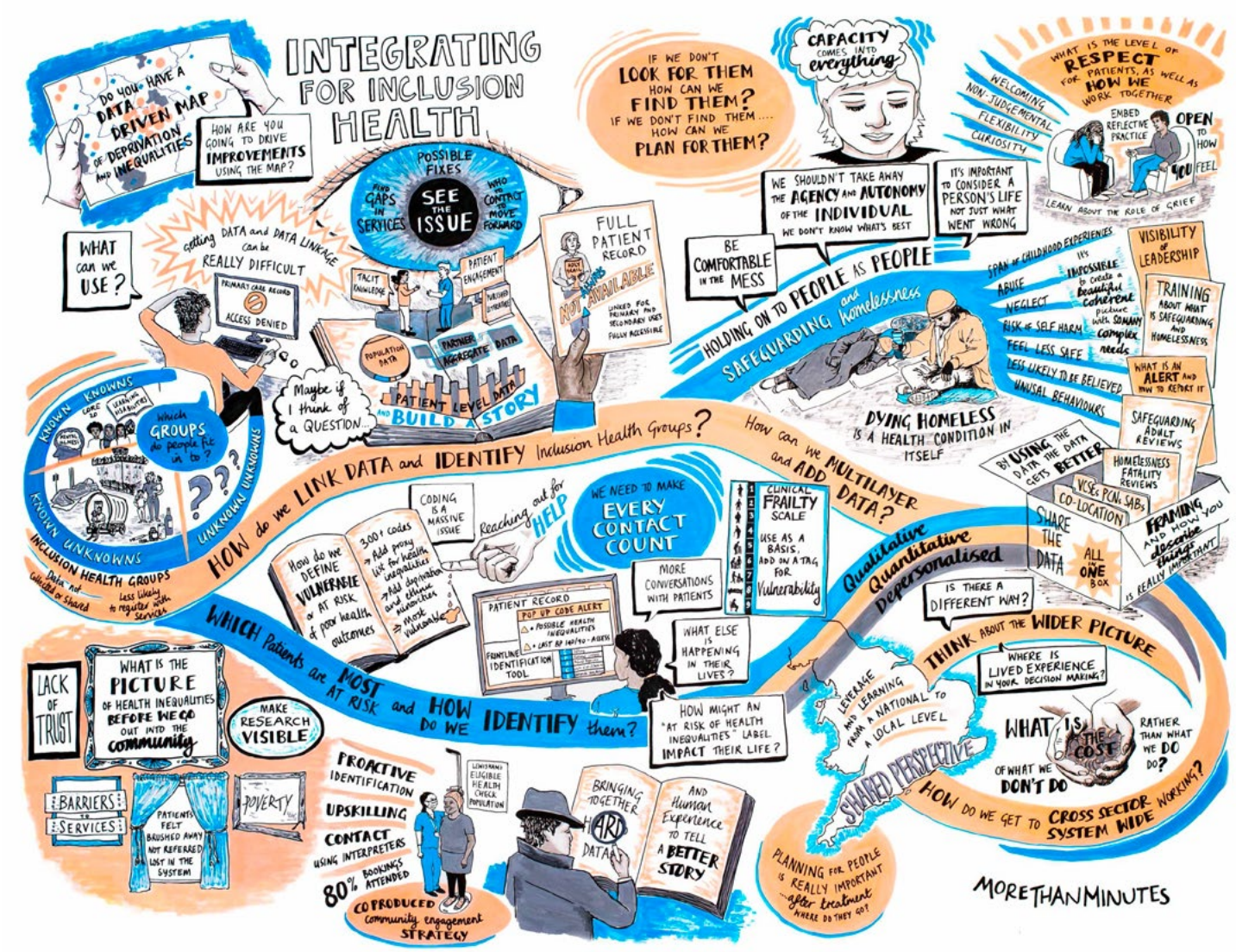
Leeds GATE work with Gypsies and Travellers, so Rogers explored the specific inequalities faced by these groups. People in Gypsy and Traveller communities carry a significant burden of morbidity and mortality, particularly through long-term conditions, such as asthma and arthritis, infant mortality and suicide. Members of this community report that the biggest contributors to their poor health are discrimination and hate crime, followed by their accommodation situation. In common with other Inclusion Health groups, their experiences are often rooted in trauma and discrimination, which needs to be the starting point in thinking about services that meet their needs.

The accommodation picture for Gypsy and Traveller communities is very mixed. Contrary perhaps to popular belief, two thirds of Gypsies and Travellers live in houses, so are faced with the same issues around homelessness and insecurity as the settled population. Traveller sites are often in unhealthy locations, rundown, far from proper facilities, with too few of them to meet the community's needs. There are 3000 families living in caravans who have nowhere to lawfully stop and are therefore statutory homeless.

At the same time ICSs need to consider the significant strengths of Gypsy and Traveller communities. They are resourceful and adaptable and provide significant informal care to one another.

Rogers set out some key principles for ICSs in thinking about how to provide better health services that build on these strengths and address the major inequalities and discrimination the community faces:

- Engage your local Gypsy, Roma and Travellers civil society groups, but go at the pace of the organisations. They may be small organisations due to years of underinvestment and may find new money and interest overwhelming.
- Map your local places – where are your sites and encampments?
- Zoom out and look at your ICSs policies and strategies. Where do Gypsy, Roma and Traveller communities show up in Health and Wellbeing Board strategies, suicide prevention plans, Joint Strategic Needs Assessments, and so on?
- Plan and design services in a way that actively addresses the barriers that Gypsy, Roma and Traveller communities face. The Roads, Bridges and Tunnels animation in Resources, below, goes into more detail.
- Engage with the development of Local Plans,and Accommodation Needs Assessments. Ask Local Authority planning departments how accommodation for Gypsy, Roma and Traveller communities will benefit their health.
- Take responsibility for your own learning and education and show leadership in this to your workforce.
- Involve people and communities meaningfully and with respect, bear in mind that promises have been made and not kept.
- Show leadership and be brave in challenging stereotypes, and think about how this plays out in the allocation of resources.



Resources

- Leeds Gypsy and Traveller Exchange (GATE) - Roads, Bridges and Tunnels - a short film on service design for Gypsy, Roma and Traveller communities. https://www.leedsgate.co.uk/roads-bridges-and-tunnels
- Friends, Families and Travellers – a charity working to end racism and discrimination against Gypsy, Roma and Traveller people and to protect the right to pursue a nomadic way of life. https://www.gypsy-traveller.org/
- Travellers' Times YouTube channel – online resource linked to Britain's only magazine for Gypsies, Roma and Travellers. https://www.youtube.com/TravellersTimesFilms
- Local plans: guidance and information from the Planning Inspectorate - GOV.UK (www.gov.uk)

2.2 Harnessing levers for radical change

Business as usual incremental changes are unlikely to create the climate of sizeable and rapid adaptation that is needed to address extreme exclusion. Senior leadership momentum is needed to address vested interests that struggle to adjust to the changes that are necessary.

Our programme considered two important areas of focus that systems are using to help to bring about these changes: data and money. These are described below – other levers will matter too, and safeguarding was explored as a third tool some systems have used to good effect as part of 'mainstreaming' work on Inclusion Health into safety-critical ways of working.

2.2.1 Data – making the invisible visible

Understanding the population and their needs in an ICS is the critical first step towards providing services for them. Inclusion Health populations are often 'invisible' in key data sets, because of poor recording, data fields that do not allow for accurate recording of their situations, or people not accessing services in the first place.

This is a challenge for ICSs but it should not be an absolute barrier. ICSs need to redouble their efforts to create a rich data picture about their local Inclusion Health populations. The ICSs in our programme heard how this is possible.

Layering the data in Lancashire and South Cumbria

Scott Johnson of Lancashire and South Cumbria Commissioning Support Unit described the creation of a fully integrated data repository.

A willingness to look beyond core data sets and to layer different sorts of data to create a richer picture of Inclusion Health In each ICS's data is critical. Johnson used this typology of data in his work:

- **Known knowns:** Every area has data, though imperfect, on the Core 20 groups, learning disabilities, severe mental illness and ethnicity.
- **Known unknowns:** Drawing on NHS data (albeit incomplete) about enhanced health risks such as homelessness, contact with the criminal justice system, poverty and being a member of a Gypsy, Roma, Traveller community.
- **Unknown unknowns:** Keep in mind that there will be things you will not know, but may be important. Rely on operational and district leads for this sort of tacit knowledge.

Together, these different kinds of data can create a better starting point for action than statutory data alone.

> *"If we don't look for them, how can we find them? And if we can't find them, how can we plan for them?" Dr Patience Okorie, Sussex.*

A data driven approach to Inclusion Health through wider health inequalities in South London

A Primary Care Network in Lewisham, South London, kickstarted a data-driven approach to health inequalities, including Inclusion Health. Led by GP Dr Aaminah Verity, they set out to identify which patients are at the highest risk of health inequalities, using proxy codes which relate to patterns of social exclusion.

Engaging with the community identified three key themes local people wanted to focus on when tackling health inequalities; poverty; barriers to care; and lack of trust.

> *Dr Verity and colleagues coded the population of the PCN using Snomed codes across three domains – those associated with Inclusion Health (often poorly coded and small numbers), broader proxies for risk of health inequalities, and well-documented vulnerabilities (such as learning difficulties). With population health, they added deprivation and ethnicity filters using the Cerner system, resulting in the identification of a group of patients who were the most vulnerable to health inequalities (as shown below). This links to the Core20Plus population.*

This resulted in two valuable changes to practice.

- A frontline identification tool to prompt the GP to be alert to the risks of health inequalities to encourage better care. This also asks GPs to ask for more information from the patient, which was generally welcomed by patients who appreciated the opportunity to discuss aspects of their health such as substance misuse. This tool is still in pilot stages.
- Proactive identification of the 'at risk' population for prioritised NHS Health Checks. GPs are already incentivised to do this work as the practice is paid per health check. This new data tool was used to target checks at people who were assumed to be at greater risk of poor health as a result of health inequalities. The PCN increased engagement by upskilling care coordinators to proactively invite people. This provided capacity to focus on this population without adding burden to existing clinical teams. 80% of those contacted made an appointment, and 80% of those attended on the day. The approach identified significantly higher disease detection in the 'Plus' categories that otherwise would have been missed.

Dr Verity identified three key success factors, all things that ICSs can create the conditions for:

- **Dedicated staff time:** Reversing the inverse care law is not something that can be done in someone's spare time. The PCN employed GP SPIN Fellows (see Resources below) to take forward the coding and analysis. Dr Verity was paid for two sessions a week as a health inequalities lead, and South East London ICS now funds similar roles in all six PCNs in Lewisham.
- **Community:** Engaging the community and rooting this work in their concerns was vital to the success of this work.
- **Culture:** ICSs and PCNs need to create a culture where the coding of vulnerabilities is important to you as an organisation.

Dr Verity highlighted the value of this approach in prompting a debate around appropriate resourcing for health inequalities – how to meet the need once it has been identified. This might involve stopping or altering some work with other parts of the population in order to free up the resource needed to address the sharp end of health inequalities.

Resources

- Salaried Portfolio Innovation (SPIN) Fellowship (London only) - SPIN is a HEE funded programme for GPs in their first year of joining general practice in London to work on a project of interest one day a week. spin-overview.pdf (hee.nhs.uk)
- Fingertips - a governmental public health data collection, with data organised into themed profiles, e.g. Learning Disability Profiles. Public health profiles - OHID (https://fingertips.phe.org.uk/)
- Spotlight – a data dissemination platform that collates and presents key statistics related to the public health outcomes of Inclusion Health groups. https://analytics.phe.gov.uk/apps/spotlight/
- Pathway introduction to the Homeless Digital Template - https://www.pathway.org.uk/about-us/what-we-do/knowledge-share/homeless-digital-template/
- Oracle Cerner population health management tools – intends to provide a community-wide information network linking health history, social and environmental factors, mental health aspects, and more to yield critical insights. https://www.cerner.com/solutions/population-health-management

2.3 Money - Paying for Inclusion Health

For many stakeholders involved in work on Inclusion Health, it can feel as if funding is a significant barrier to getting things done. Toby Lewis, then at The King's Fund, led a session which sought to challenge the approach typically taken to exploring finance in this space, and looked instead at how it should be a lever for radical change.

He began by reflecting on the huge scale of spending on exclusion and inequality:

- Spending £39.3m on inequalities in health.
- About £4bn per annum in the NHS on substance misuse.
- Or £48,162 per prison place per annum in 2021.

These estimates exclude the opportunity cost lost to the economy from those at the margins of society, unable to contribute to growth or tax revenues. This suggested our problem is not lack of funds to invest – it is how we spend it presently, as opposed to better ways to do so.

In fact, the real challenge, once funding is identified, is finding a way to cash release it.

Parts of spend tied up in other service models, need to be repurposed to support Inclusion Health. Ingenuity is needed to do this – and a focus on the time of the workforce, whose wages are the cost involved. To that end, a focus on two things matters:

- Hospital expenditure dominates NHS spending. Their funding follows an average price model in which they are paid for the notional cost of a typical patient with a defined diagnosis. Too much deviation from that average eats into the margins of a hospital. Hospital leaders want to tackle that deviation, which is expensive, and means that Inclusion Health ought to be of interest to Trust leaders, perhaps especially in the present financial climate faced by acute services.
- Meanwhile, Integrated Care Systems are seeking to align health investment models with the real wider local economy. This creates a new opportunity to make sense of money spent on reablement and rehabilitation as a route to gains in that wider economy.

Part of the historic difficulty, Lewis argued, is that too much of the investment case for Inclusion Health is based on the idea that upstream investment for a specific individual is better value than downstream cost.

The real challenge that has be to met is to find the net population cost – and this makes the case for the wider Inclusion Health approach - because only by taking that broader group approach can innovators hope to produce net gains of material value for funders.

They face a further problem, however: releasing spend from where it happens now, the cash-release issue. To this issue Toby proposed a focus on time. Because costing models are typically and dominantly a way of accounting for the time of a clinical workforce, time is also a barrier to clinicians being able to work with complex patients, who may require more time than is typically allocated. Inclusion Health advocates have to engage with this nuance if they are to match resource funding to the workforce resource which drives the care system. If proposals shift workforce with cost they do not create redundancy or deficits.

None of this suggests avoiding the bidding opportunities that arise in Inclusion Health. Not simply in health, but through departments including DLUHC, with Changing Futures representing the most high-profile in the last two years. However, the principal focus of effort should be on the annual investment pots in health organisations, which each Trust runs, however opaquely on occasion, with investment through Inclusion Health being used to "tackle otherwise continued growth in acute sector spending.

The equation to tackle deferred demand and to address costs in other agencies' budgets' is one that can be built, with *the first action being to undertake a local cost estimate in each ICS of current spend.*

2.4 Safeguarding, and learning from deaths

Narrative and practice around safeguarding often excludes or creates barriers for Inclusion Health groups. Enlightened practitioners and decision makers are increasingly realising the value of applying a safeguarding lens to inform practice improvement and strategic service design to meet the needs of these populations.

By any measure, many people in Inclusion Health groups face concerns that would be squarely in the ambit of safeguarding if experienced by a member of the mainstream population. However, often for reasons to do with stigma, discrimination and the structure of the health and care system itself, they rarely meet the thresholds that would elicit a meaningful safeguarding intervention.

This should not deter professionals in ICSs from using the mindset and principles of safeguarding to think and act creatively to meet the health and care needs of people in Inclusion Health groups. This work was developed with and for people facing homelessness, but the principles apply to any Inclusion Health group where there are often overlapping needs, experiences and identities.

Gill Taylor, then Assistant Director of Communities and Housing Support, Haringey Council, has been in the vanguard of this work. She described how processes to review the deaths of people experiencing homelessness – including Homelessness Fatality Reviews and Safeguarding Adult Reviews – can help areas learn from these deaths, and sets out some strategic principles that arise from this. The Safeguarding Adult Review (SAR) is described in the Care Act, and is a multi-disciplinary review aimed at learning from adult safeguarding failures. People experiencing homelessness, who have a mean age of death of 45 for men and 43 for women, along with other Inclusion Health groups often do not meet the threshold for a SAR.

This meant for a long time that little was done to identify why and how someone had died at a young age and what could have been done to prevent it from happening.

> *As a response to this, Haringey Council developed the Homelessness Fatality Review to identify systemic issues and practice improvement opportunities to improve the housing and health care of people affected by homelessness.*

Establishing Homelessness Fatality Reviews in Haringey has led to significant learning and improvement. The key insight is that although solutions and improvements may happen in a diverse range of areas, safeguarding vulnerable people is always a whole system issue, to do with the individual themselves, the practice that surrounds them, the factors affecting the organisations supporting them, and the local and national policies and laws that govern all of this.

Homelessness Fatality Reviews point to the need to build capacity in the system for relationships with, between and beyond practitioners or clinicians. Informal conversations and opportunities to get to know each other build trust, which is the basis for improved engagement and outcomes in healthcare. Integrated Care Systems need to build time for relationships, informed consent, privacy and curiosity into their services for Inclusion Health groups.

While many people's deaths' do not meet thresholds for Safeguarding Adult Reviews (SARs), in recent years a number of SARs have taken place exploring the deaths of people who have experienced homelessness. These are a rich source of learning that ICSs can use to develop and strengthen services that meet the needs of Inclusion Health groups.

Working with adult social care

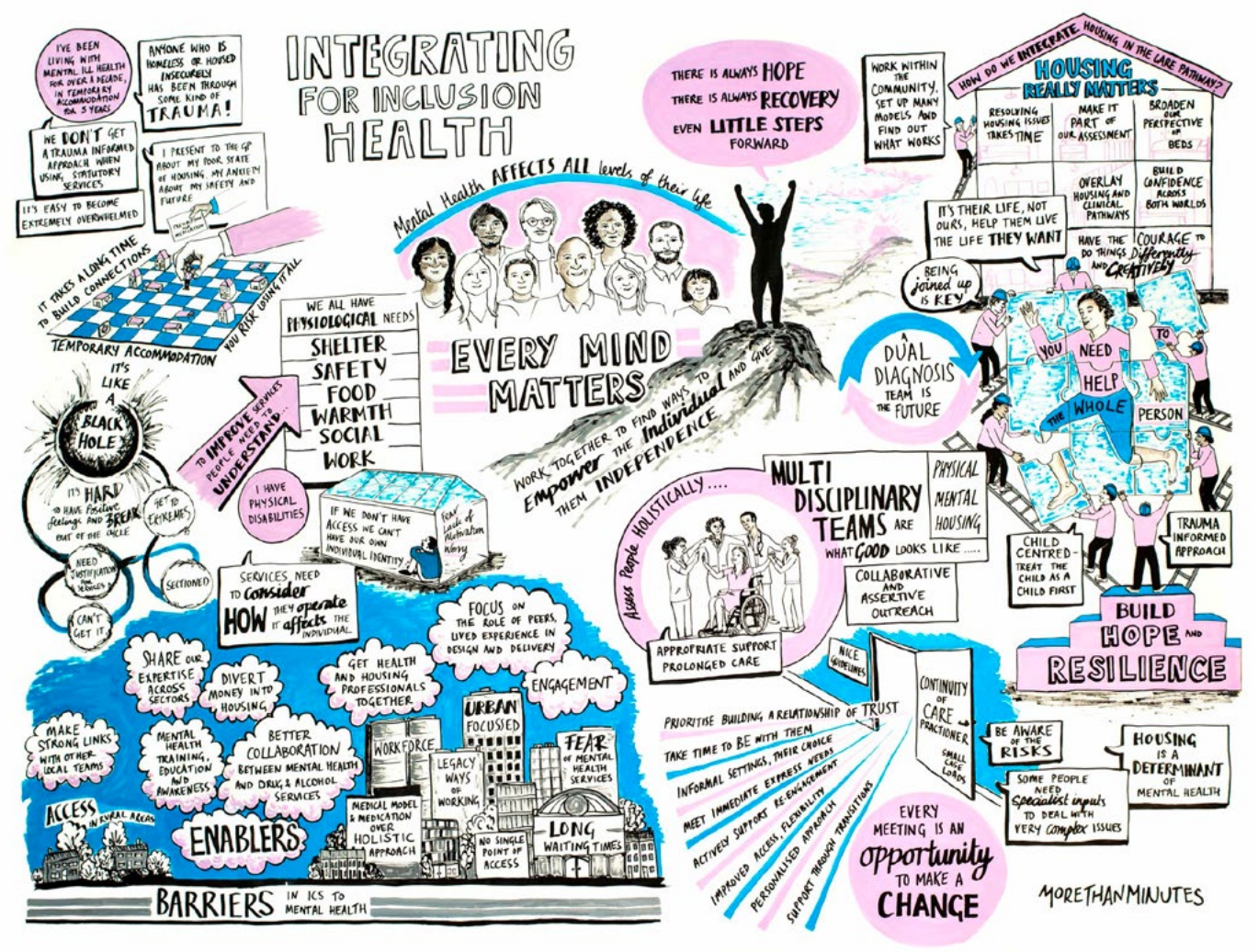
Melanie Williams produced landmark guidance on safeguarding and rough sleeping for the Association of Directors of Adult Social Services.

She echoed similar themes around safeguarding and showed the vital role that Adult Social Care can play: the challenge — and the opportunity – Integrated Care Services face is that no single agency has the answer to providing wrap around care for people in the right place at the right time.

When partnership working is at its best, we place the person at the centre of our decision-making, we listen to needs whether that is individually when working directly with someone or strategically when planning and commissioning services, and we find practical solutions that make a difference.

Resources

- Adult Social Services (ADASS) guidance – guidance given to Councils in their role as the supervisory body for the Mental Capacity Act Deprivation of Liberty Safeguards. https://www.adass.org.uk/deprivation-of-liberty-safeguards-guidance/
- Thematic Safeguarding Adult Review: Homelessness - Professor Michael Preston-Shoot's 2021 paper for Haringey Council reviewing the effectiveness of safeguarding measures for those experiencing homelessness within Haringey. https://www.haringey.gov.uk/sites/haringeygovuk/files/thematic_sar_homelessness_report_2021.pdf
- Homeless Link safeguarding advice – Homeless Link are a charity specialising in meeting the diverse needs of those experiencing homelessness and rough sleeping. https://homeless.org.uk/knowledge-hub/guidance-on-safeguarding/
- "Supporting people experiencing homelessness in an accident and emergency setting" – eLearning module, jointly managed and funded by Department of Health and Social Care, NHS England and UK Health Security Agency. https://www.fairhealth.org.uk/course/homelessness-ed
- Museum of Homelessness. Dying Homeless - A memorial to remember with love the people who have died whilst homeless since October 2017, when the count began. https://dying-homeless.museumofhomelessness.org/
- Care and Support and Homelessness: Top tips on the role of adult social care – developed by the LGA and ADASS to support directors of adult social services and their teams, focusing on the role of social care in supporting people experiencing and recovering from homelessness. https://www.local.gov.uk/publications/care-and-support-and-homelessness-top-tips-role-adult-social-care



2.5 Beyond Health – considering housing as a foundation

The norm for many in Inclusion Health populations is not one of safety or stability. The absence of such crucial mediators impacts the effectiveness of service provision even where people can access it. Nowhere is this more evident than in housing - grasping the opportunity of integration to improve housing, helping to keep people well, is one of the immense potential wins for ICSs.

Andrew Van Doorn of the Housing Associations' Charitable Trust (HACT) pointed to the growing body of evidence showing that housing matters, including the NICE guidelines, CQC and Getting It Right First Time. He argued ICSs should ask themselves 'how do we make housing an integral part of the care we offer people?' rather than thinking of it as something that happens 'over there'.

ICSs may not have all the housing levers at their disposal, but they still need to make it their issue not only for Inclusion Health, but mental health and population health more generally.

Four housing questions ICSs should be able to answer:

1. How do you own the issue of housing within your work?
2. How are you and your team thinking about housing as part of someone's assessment? It is not something to refer to later. It can take a long time to work through housing circumstances. Make sure your services can think housing pathways throughout, alongside clinical pathways.
3. How do you work with housing to prevent admission? When people end up in inpatient admission, that person stays there for a while and sometimes does not need to be there. Someone just needs a space to recover.
4. How can you work with partners to ensure enough of the right kind of supported housing?

HACT has supported collaboration across health, housing and social care to develop a more strategic approach to housing. They have found some enablers and blockers to integration for housing and mental health that seem similar everywhere.

Enablers

- NHS senior leadership at provider and system levels is critical – we cannot default to local government for the answers.
- Time is needed to understand and appreciate how different sectors operate – most supported housing is not provided by local authorities. It is housing associations and charities, so get to know and work across those sectors.
- Seeing is believing – commissioners and clinicians need to see excellent supported housing to believe it.
- Early engagement on issues and solutions is critical, unrealistic expectations around timescales are frustrating.
- Increase your capacity within your system to interface with housing – some ICBs have appointed Directors of Housing (such as Jon Pritchard of Southern Health, a participant in this programme).

Blockers

- Tussles at the boundaries of funding between housing, public health and social care can destroy the best of strategies – a common purpose that is followed through into investment decisions is important. Systems have got to stop and behave better at those boundaries than current practice.
- Leaving housing in 'the wider determinants of health bucket' – as if it is what someone else does, rather than a shared responsibility.
- Organisations commission their own services and hope their services will join with each other. Mental Health Trusts must involve themselves in the co-design and commissioning of housing at all stages. Provider collaboratives are an exciting development – integrated at their core.
- Procurement rules should not be a barrier to creative conversations - early market engagement and discussions about what could work makes for better solutions. It is about culture and leadership and people being willing to do things.

Supported housing – in a variety of forms – should be a core plank of ICSs' efforts on housing and mental health for Inclusion Health groups.

Van Doorn pointed to the volume of commissioning happening without an evidence base and called on the sector to invest in the evidence base.

He cautioned that "it's not a tap that can be turned on and off. Getting the right mix of supported housing requires a long-term investment strategy".

Resources

- Housing Associations' Charitable Trust (HACT) - charity of the social housing sector driving value for residents and communities. https://hact.org.uk/tools-and-services/housing-services/
- Getting It Right First Time (GIRFT) Webinars - national programme designed to improve medical care within the NHS by reducing unwarranted variations; the webinars focus on the integration of housing within mental health pathways. https://gettingitrightfirsttime.co.uk/webinar-series-to-focus-on-the-integration-of-housing-within-mental-health-pathways/
- NHS Confederation/HACT Report – report which explores the steps needed to integrate housing as part of the mental health pathway. https://www.nhsconfed.org/publications/healthy-foundations-integrating-housing-part-mental-health-pathway
- Centre for Homelessness Impact – article providing context for new NICE advice on practical ways to improve health and social care for people experiencing homelessness. https://www.homelessnessimpact.org/post/nice-guideline-advice

2.6 Establishing specialist services that reflect best practice

The evidence base for what is needed to meet the needs of people in Inclusion Health groups is validated and known. Service provision remains patchy, however, and often reflects legacy arrangements developed over some years. Our network's participants heard about two excellent specialist services that show what might be possible for marginalised people: one in mental health, and one led from primary care.

2.6.1 Specialist mental health services

Poor mental health is too often a feature of life among Inclusion Health groups, whose situations make it hard for them to access the support they need and can even cause their problems in the first place.

Specialist mental health services in South London

For people with severe and enduring mental health problems in Inclusion Health groups, specialist services are often necessary because of the barriers presented by mainstream care. START, a specialist psychiatric service for people who are sleeping rough in South London that started in 1990, highlights these barriers for people who are sleeping rough. Mainstream Community Mental Health services might require clients to have GP registration, mobile phone, and be able to read and understand appointment letters – all potential barriers for Inclusion Health groups. Clients might have more urgent priorities to stay alive, and distrust or fear authority.

Dr Jenny Drife described how people may present differently with serious mental health difficulty, leading to them being overlooked by mainstream services. "Mental illness can present in different forms - some people with schizophrenia don't have delusions, and don't come to the attention of the police or the ambulance service – they're 'quietly unwell' and may be seriously self-neglecting".

START is a multi-disciplinary team that works flexibly to meet people's needs. The team is made of up of social workers, nurses, doctors, psychologists, occupational therapists and a peer support trainee. They build relationships with patients, do outreach work and make several attempts to meet someone and get an idea of what they need.

Getting a service like this commissioned has relied on two key things – data and persistence. The START team started with pilot funding and Fran Busby, senior social worker, described how they immediately began to gather data to show the impact on high level objectives of importance to commissioners. "A good business case is key", she said. "Make the case for how the service will reduce A&E attendance, reduce bed days, reduce Criminal Justice System contact. It matters that you're going to see a reduction in pressure on emergency services".

Trimorbidity – the more that you can do in one place the better.

Two of the boroughs where START operates have smaller sub-teams for those with co-existing mental health and substance misuse needs. Many people have clear and obvious psychotic illness for which they have not received treatment because of their drug use. "This is the future – having everything in one place", said Dr Drife. "The principle for ICSs should be not to divide people into their disparate needs – you need to think about treating the person when you're commissioning, so you need to join up with others". In these dual diagnosis teams, clients can access physical health care, psychiatric treatment, therapy and drug treatment all under one roof thus minimising the number of services they have to 'engage' with and maximising outcomes.

2.6.2 Primary Care

Primary care is the service we all rely on most when we need healthcare. People in Inclusion Health groups are no different but the evidence shows that they struggle to access it, to the detriment of their health, and with consequent effects for other services. Our programme participants and contributors recognised that services are doing their best to meet unprecedented demand, and at the same time, that something needs to change to address the unmet need among Inclusion Health groups.

Dr Chris Sargeant is Medical Director of Pathway and GP/Director at ARCH Community Interest Company - Brighton and Hove, a specialist integrated primary care service for people who are homeless. Dr Sargeant set out his view that the complexity of issues facing people experiencing homelessness need specialist, integrated services, working across current service boundaries. This must include specialist primary care services, accessible drug and alcohol services, and mental health services. These services should be able to collaborate and reach into other services, such as hospitals, and reach out to places where patients can be found such as the street, day centres and homelessness accommodation.

Dr Sargeant highlighted key themes for ICSs to consider when assessing and developing services:

- Access to primary care is vital (which should be specialist primary care where demand is sufficient).
- Fund according to need. Double appointments are standard in ARCH, and the contract allows for 1.5 times the standard per patient general practice funding. A Pathway team in-reach to hospital has massive benefits.
- In-reach and outreach are needed to find people as they will not come to regular services.
- People experiencing homelessness need personal support and help to make use of the health system.
- Existing services often do not meet the needs of people experiencing homelessness, and need to work beyond their usual boundaries and with enhanced collaboration to achieve this.

2.7 Holding the mirror up to mainstream services

When places do not consider that they have enough Inclusion Health patients to warrant a specialist service, it is vital that they ensure that mainstream primary care is accessible. Dr Caroline Shulman is a specialist Inclusion Health GP and researcher. She recommended that once ICSs have a picture of the needs of their Inclusion Health population, they can look to rebalance primary care services to meet these needs. GPs cannot be given more to do without other aspects of their work reducing. Digital access to services and population management opens the opportunity to target how they use their resources.

Dr Shulman pointed in particular to the evidence of multi-morbidity and frailty among people experiencing homelessness (reflecting the data study illustrated earlier in this annex). One study of a London hostel found that residents with an average age of 55 had similar levels of frailty to that found in people in their late 80s. All had multimorbidity with the average number of long-term conditions per person being seven. These numbers sound more like what would be expected in a care home, but only 9% of residents had a package of care. In addition, hostel staff struggle to get adequate primary care support for their residents as, unlike care homes, there is no Direct Enhanced Service (DES) around health care in-reach in hostels.

> *ICSs should look at the existing levers within Primary Care Networks (PCNs) and DES and consider how they can be used to meet the needs of this population. Examples of the roles that should be considered are social prescribers and care coordinators.*

Dr Shulman highlighted the Anticipatory Care DES (now called Proactive Care) as another example. ICSs have responsibility for planning anticipatory care for their system. Due to their relatively younger age, despite high levels of need, people experiencing homelessness are often not considered for this sort of care, but evidence of their needs suggests that they should be.

The DES has **three key aims**:

1. Enabling patients with complex needs to stay healthier for longer, with personalised, proactive and self-supported care.
2. Reducing need for reactive health care for and support actions to address wider determinants of health.
3. Delivering better interconnectedness between all parts of the health system, social care and VCSE.

These should be achieved through a combination of:

1. identifying people who would benefit most, by population segmentation, followed by risk stratification and clinical judgement; and
2. multi-disciplinary primary and community teams, including social care and the voluntary sector working together.

To achieve this for homeless and Inclusion Health populations, the ICSs should go further to identify the people who would benefit as they may not appear in GP lists. Using this data, ICSs should lead conversations, involving PCNs and other providers, about the local development and implementation of proactive care for this population.

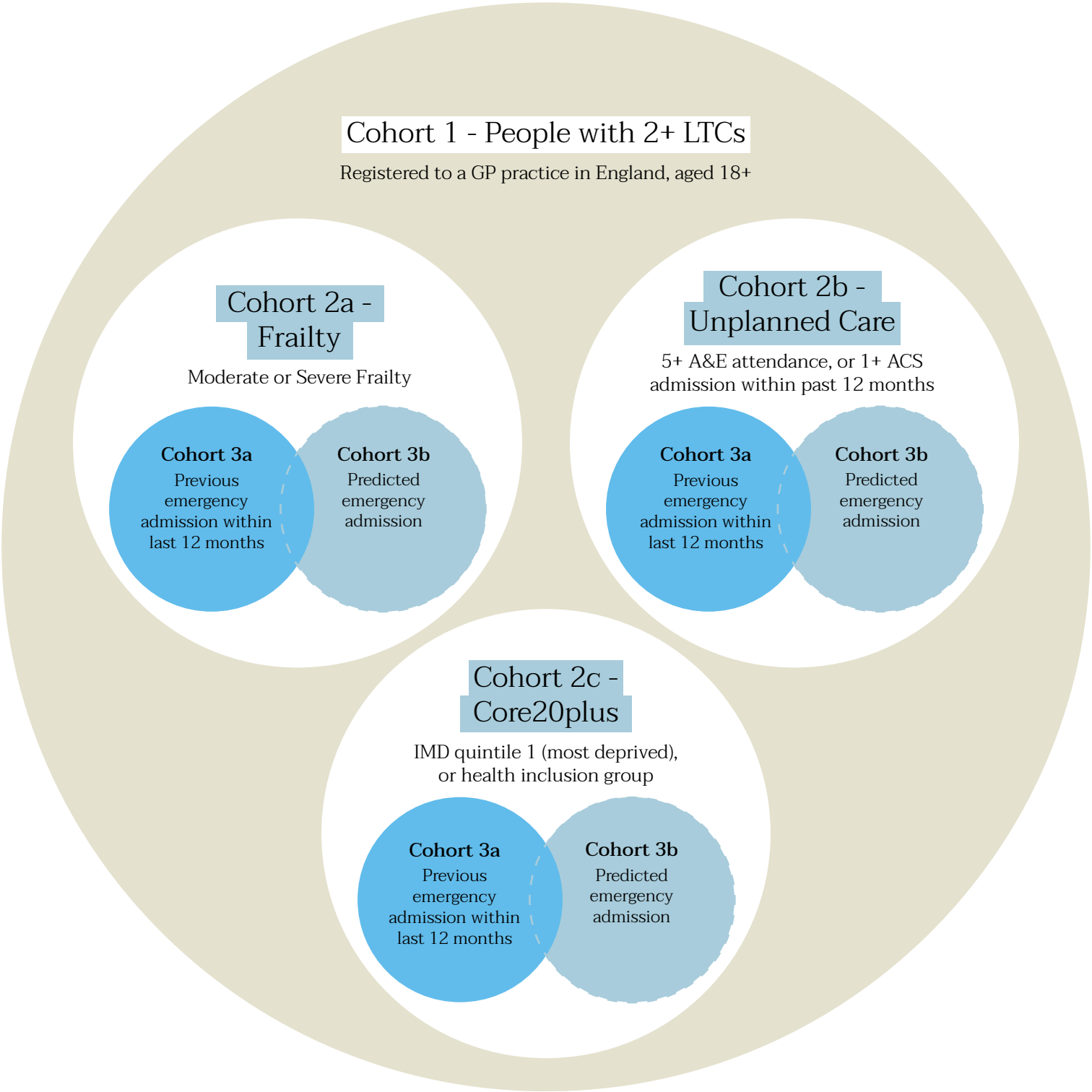


Figure B: Proactive Care DES cohorts – a better understanding of an ICS's Inclusion Health population can help map their needs to the cohorts in this DES.

Dr Shulman highlighted other tools and models that can help ICSs improve their mainstream primary care offer for Inclusion Health populations:

- PCN Inclusion Health audit tool – inclusion-health.org/pcn. This encourages PCNs to reflect on how well they are meeting the needs of their Inclusion Health populations.
- Resource PCNs to appoint an inequalities or Inclusion Health lead, working with practices to identify people who need services to be rebalanced in their favour.
- Encourage the adoption of the Safe Surgeries model – any GP practice can commit to tackling the barriers that migrants face to GP access.
- Consider adopting a hub and spoke model, where mainstream practices can gain support from specialist services.

Dr Lucy Chiddick is an Inclusion Health GP currently based in Hull with a long history of working in commissioning and strategic planning for Inclusion Health. She shared some of her top tips for ensuring that ICSs can meet the needs of the people who need healthcare the most.

- Horizon scan: Look at where the gaps are and make the case for change.
- Create an enabling infrastructure through becoming a trauma-informed system and reviewing financial priorities: A paradigm shift is required to enable the needs of someone to be heard (and a plan developed for them to be met) at their point of engagement with any service in the system.
- Establish a leadership culture that promotes compassion, care and psychological safety for both the workforce and individuals who need healthcare.
- Mainstream trauma-informed approaches: If your ICS is focusing on tobacco and cardiovascular disease, ensure these interventions are trauma-informed which enables safety, equity and inclusion.
- Create time and space for people to reflect: Invest in time to free staff (e.g. GPs) up for space to think about what is happening in their area and how best to respond to need.
- Put Inclusion Health at the centre of key mechanisms: Such as Place based Health and Wellbeing Board strategic documents and Joint Strategic Needs Assessments, and formal ICS structures eg Population Health boards.
- Consider disinvestment as well as investment: Some things may need to stop or be done differently to meet the needs of this group.

Resources

- Drs Caroline Shulman & Rafi Rogans-Watson – Pathway study in collaboration with Marie Curie and UCL exploring premature ageing and frailty amongst people in a homeless hostel. https://www.homelessnessandhealth.co.uk/events/wp-downloads/2020/presentations/Pathways_from_Homelessness_2020_Seminar_Stream_A5_Rogans-Watson_Shulman.pdf
- Dr Bruce Perry & Oprah Winfrey - What Happened to You?: Conversations on Trauma, Resilience, and Healing.
- Homeless Link Homeless Health Needs Audit (HHNA) – a tool developed by Homeless Link for gathering local data about the physical and mental health needs of people experiencing homelessness and how they access services. https://homeless.org.uk/what-we-do/research/health-needs-audit/
- Inclusion Health Self-Assessment tool for Primary Care Networks – Friends, Families & Travellers developed this tool to help Primary Care services improve their engagement with Inclusion Health groups. https://www.inclusion-health.org/pcn/
- Power, Threat, Meaning Framework (PTMF) – The British Psychological Society provides this conceptual alternative to more traditional models of Clinical Care based on psychiatric diagnosis. https://www.bps.org.uk/member-networks/division-clinical-psychology/power-threat-meaning-framework
- Safe Surgeries initiative – run by Doctors of the World, the initiative allows any GP practice which commits to taking steps to tackle the barriers faced by many migrants in accessing healthcare to be designated a “Safe Surgery”. https://www.doctorsoftheworld.org.uk/safesurgeries/

2.8 Keeping truth to the fore: Time for national evaluation standards?

The scale of exclusion outlined in the introduction underscores the urgency of something better. An unrelenting focus from Integrated Care Systems on Inclusion Health offers a prospect of that change.

The 2022 national rough-sleeping strategy, published by the Department for Levelling Up, Housing and Communities, offers some such compulsion and focus for one small part of the Inclusion Health population. The data-driven emphasis of that work, with downward pressure to support local leaders in making change, could support collaboration. The proposed duty to collaborate in the strategy may assist. The risk remains of self-assessment by those asked to lead – ‘marking their own homework’. There is little that requires agencies to hand such judgment over to the population themselves affected. A whole host of agencies and actors need to align to improve care. What then is needed to help Integrated Care Systems to play their part?

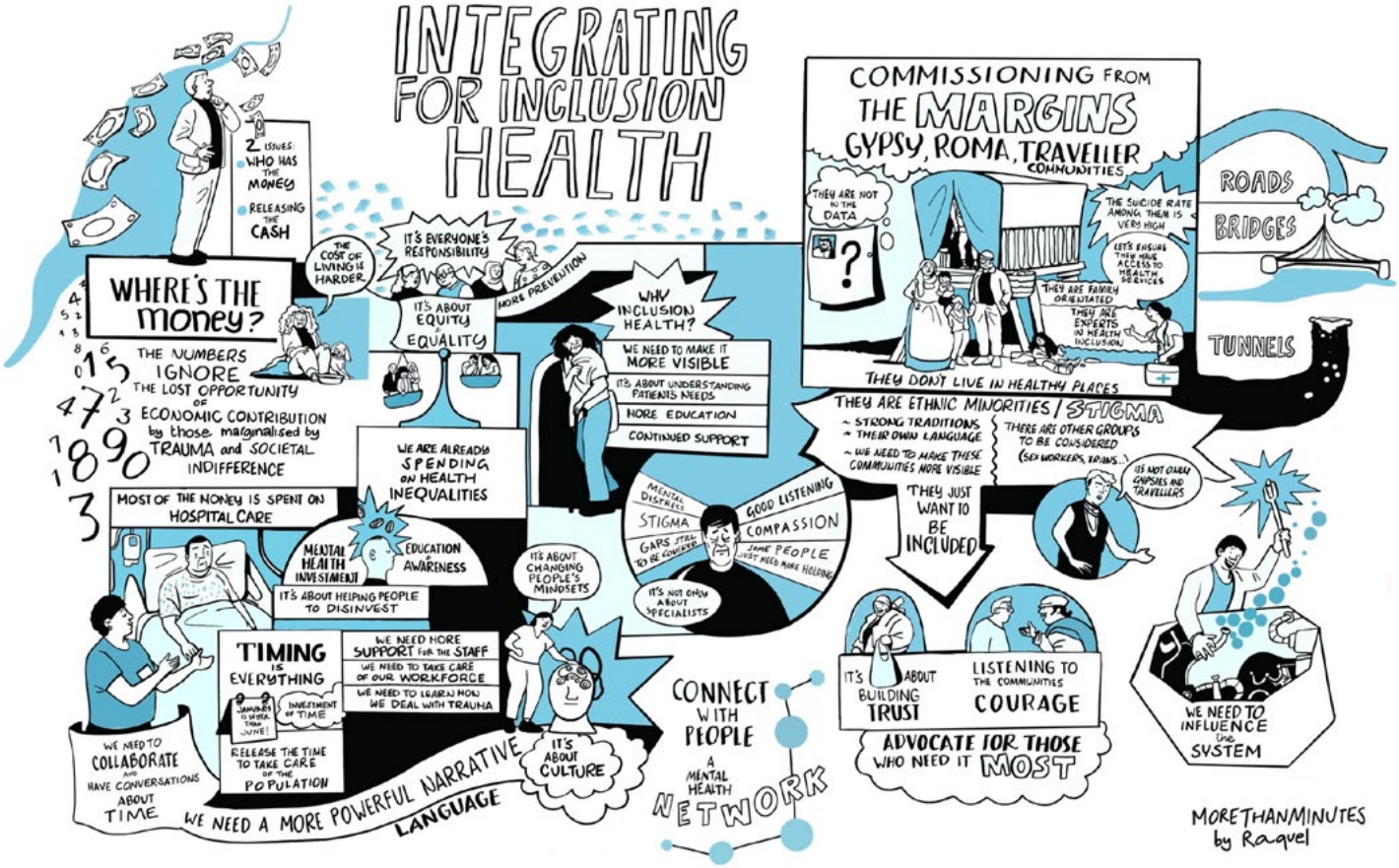
The network discussed and explored what is truly needed at the high level and large scale ICB. We concluded that support with initiation will help, but an equally pressing need for evaluation tools. This might be in the form of a guide for boards by which to assess, or evaluate, the calibre of what is being provided locally. The existence of such an approach would challenge the prevailing idea of exclusion as an area without established best practice or known best fit approaches, and require local areas to step forward to match this best practice.

Given the scale of evidence about what to do for many aspects of Inclusion Health there is a strong case for providing assistance to this work at once, perhaps from nationally commissioned experts. This would incorporate offering tools in assessing service provision

and advice on the measures of success that systems might consider. Such measures of success ought properly to be rooted in the views and hopes of local communities and service users.

Such an evaluative guide should immediately provide the transparency that Inclusion Health demands. It allows a network to share a sense of which systems are delivering most and best for this population. It moves the dialogue beyond intention or novelty and into a conversation about effectiveness. That then permits economic evaluation and closes the evidence gap on how to achieve an all-systems return on investment, as excluded individuals not only are supported to better health but enabled to make an economic and societal contribution.

At the outset of our work, we were inspired in part by NICE having issued long-awaited national evidence guidance. This publication challenged any notion that what to do was not understood. ICBs and ICPs should be invited to ask a question about the comprehensiveness and effectiveness of their Inclusion Health offer. Tools to help with asking that question, and answering it, would undoubtedly accelerate its impact within communities.



2.9 Case studies in excellence – six areas of promise and potential

The participants in the programme were invited to share a project, programme, or approach that was being used within their system. It is important to reflect in network discussions that other systems may have better examples and that learning very often comes from persistent effort and initial failure. Nonetheless, the breadth of approaches outlined shows something of the scale and ambition of those who have contributed to this ongoing work.

Welcoming refugees into Norfolk health and care

In May 2022, the first contingency hotel was opened in the Norwich locality, a 70-person hotel for families seeking asylum provided by SERCO/Cromwood Housing under a Home Office Directive. During August and September 2022, a further three contingency hotels for asylum seekers, all single males, were set up at pace.

The People from Abroad Team located in Norfolk County Council, which has a co-located integrated health care team, supported GP registrations across 8 Norwich practices, undertook the initial health triage and holistic health assessments and ongoing complex cases with safeguarding concerns of varying severity. The ICB set up multiagency operational groups - which include police, district councils and health partners - to support the response in the two locality areas and secured funding to enhance the health care offer, plus support for GP practices through the Inclusion Health Locally Commissioned Service. Mental health VCSE wellbeing support and activities including football and English as a Second Language classes were set up. The current number of asylum seekers staying within Norfolk and Waveney at the contingency hotels is 400. This number can fluctuate each week depending on those that move on. To ensure that practices and other local organisations are aware of the remit the People from Abroad team have a video and leaflet explaining their work:

https://m.youtube.com/watch?v=mmIy6mtEs6U&feature=shares

To support practices with caring for the needs of asylum seekers as well as other Inclusion Health groups, a Local Commissioned Service specification has been developed. This LCS has been in place since 1st April 2022 and has allowed practices to sign up to varying levels depending on their demand. These levels are:

- **Inclusion Friendly** – offering training to reception staff, encouraging practices to sign up to be a safer practice and providing training about Inclusion Health practices.
- **Inclusion Health Assessments** – providing health assessments which are more detailed than the standard GMS new patient health check.
- **Outreach support** – providing outreach appointments to undertake health assessments/appointments for Inclusion Health with specific locations e.g., hostels.

Norfolk & Waveney Asylum and Migration Strategic Board has been set up for oversight and collaborative working – aiming to create a strategic and joined-up approach for our asylum seeker and refugee community (including our guests from Ukraine). The ICB have worked with public health teams on an asylum seeker needs assessment. This will inform a future proposal for a more integrated people from abroad team: a proposal that will be co-produced with those with lived experience and with the support of specialist VCSE partners.

North East London: getting transitions right

> *Hospitals are dealing with an increased demand from those who are homeless and facing homelessness, in particular those who are street homeless with complex needs. As a result of the social challenge of helping them procure or be provided with accommodation, there are significant delays with discharging patients and ensuring that they are getting the care they need in the community.*

The particular focus of work is to support those who are rough sleeping upon discharge, however the challenge comes from the complex needs of this client group. For example, accommodation from the local authority may not always be well suited for a person with drug and alcohol misuse issues, mental health issues, and those with physical health conditions. On the other hand, if not provided with accommodation, someone's needs could increase, they could become unwell and need medical assistance, resulting in a cycle of street homelessness, short term care and then street homelessness again. We now have a pathway in place where a homeless checklist is carried out with the patient, it is reviewed by the homeless coordinator and then if it meets criteria a referral under the duty to refer mechanism is sent to housing for assistance.

The homeless coordinator in place at Barking, Havering and Romford hospitals helps to oversee the needs of the patient for housing and to train and help health professionals. The coordinator works with local authorities, charities, health organisations and rough sleeping teams to help facilitate safe discharges and to ensure support in the community is put in place. Multi-disciplinary team meetings are taking place weekly to discuss homeless patients currently within the Trust. This work is supported by five step-down beds specifically for those who are eligible for housing assistance and on no recourse to public funds placement. These beds have an estimated length of stay of six weeks and allows the person to get more holistic assistance in a supported environment. Importantly, they also help to give local authorities time to help source a long-term suitable property.

There is much more to do.
In particular we are seeking to reach out to other organisations to establish a broader coalition of support with accommodation/health/benefits/drug and alcohol misuse and mental health. Our current step-down work, as a pilot, is only targeting those with lower-end needs, excluding the larger group with more complex needs.

Working with Roma Women in Doncaster to improve access to Reproductive Health services and Family Planning

In late 2022, the Solutions4Health service contacted Doncaster Council's Public Health team for advice.
They had started seeing a rise in groups of Roma Romanian ladies presenting for the contraceptive implant. The ladies would arrive in small groups and try to explain their request in very broken English with some even saying that they had travelled from Romania for the service. Staff would then explain that an appointment for an implant would last around 90 minutes and provide them with a card with a return appointment date and time. More often than not, these ladies would not return for their allocated appointment.

Alina, a Health Protection Engagement Officer with Gypsy Roma Traveller focus, discussed the issue with Solutions4health and gave them suggestions to address the language barrier- translating flyers in order to make their services more accessible, using behavioural change principles.

> *The Public Health engagement team supported distribution of the translated information to Roma Ladies in Hexthorpe, which is one of the most deprived communities in the country, The Junction (a community and advice drop-in centre in Hexthorpe) and The Flying Scotsman (a GP practice).*

Alina held a focus group in February 2023 with Roma and non-Roma women to assess their health needs. In order to make sure that Roma women will have better access and experiences when coming forward to the Solutions4Health service, Alina is going to be providing training to all the frontline staff in the Solutions4Health team about the Roma community, outlining common barriers to healthcare access and the different cultural nuances which should be considered. Alina is a Roma woman, who is fluent in the Romanian language, understands the cultural nuances and has taken a lot of time to develop safe, trusted relationships with the community. Alina highlights that Roma patients in general could have a positive experience connecting with health services through a combination of factors:

- Cultural sensitivity.
- Knowledge of common barriers to care and taboos.
- Understanding the effective methods for delivering health-related information to Roma patients.
- Welcoming, friendly and approachable services.
- Clarity that services are free of charge.
- Recognition that language barriers and low levels of literacy and computer literacy make services very difficult to navigate without individual help and targeted support.

Next steps

It was agreed that a 'sense check' should take place in three months' time to assess the situation again. The hope is that the measures taken will make the service more accessible for the Roma Romanian community.

Access to Primary Care in Sussex

Local Community Networks (LCNs) have been developed across West Sussex to provide the forums to enable partners to work together differently. The approach was endorsed by the Health and Wellbeing Board in Spring 2020. LCNs are fundamentally different to past efforts locally in that, using both data and local intelligence, they identify how they, working together as a collaborative system, can support integrated working and improve population health outcomes. The diversity across West Sussex - population size roughly 860,000, 7 District and Borough Councils, urban, rural, and coastal communities - means that we need to be flexible to local need, rather than always take a 'West Sussex wide' approach.

> *Through the COVID 19 pandemic and subsequent vaccine rollout it was evident that there were a significant number of residents who were not registered with a GP practice. While it is easy to understand why GP registration is often a requirement, for example, follow up treatment, access to secondary care, payments, data collection, etc, it also widens the health inequalities for some of our most vulnerable residents.*

In May 2021 a Crawley LCN 'Access to Primary Care' subgroup was established with an aim to raise awareness of the issue with residents and frontline GP surgery staff, who were included in the subgroup. Their work has given rise to changes in approach:

Better informed:

- An information card was created that could be used by residents to contact the national phone line from NHSE and the local CCG email address.
- A flyer for asylum seeker residents giving contacts and information on their rights to healthcare, using Doctors of the World as the main source.
- Worked with CCG colleagues to develop and support the NHS App Toolkit which gave residents access to their 'COVID passport'.
- Developed an instructional leaflet for the NHS App in several languages.
- Distributed information card and flyers to several support services and voluntary sector organisations.

Changed practice:

- Challenged referral pathways to see if it was essential to insist on inclusion of GP registration.
- Removed referral criteria for the Wellbeing service across the county (in Crawley, access to some services may be limited if not registered with a GP).
- Challenged and supported pilot projects to address this issue offering solutions that could be implemented e.g., mobile lung screening pilot.

Non-registered patients are now a key priority for our Core20PLUS5 inequalities programme. The LCN Access to Primary Care Working group was paused in October 2022, although the LCN will continue to get regular feedback in order to maintain an overview. This is because work is now being led by ABC GP Federation, who are also working on same day urgent treatment access and registrations to GPs for refugees and asylum seekers housed in the hotels in Crawley.

Trauma-informed in Hampshire and the Isle of Wight

Adverse Childhood Experiences or ACEs are things that happen directly to, or around children under the age of 18 (for example neglect or growing up around domestic abuse). ACEs in the absence of consistent loving adult care giving (including poor attachment), can increase the risk of trauma which can stay with a person their whole life. Trauma can result in harmful coping mechanisms (including self-harm, eating disorders, risky behaviour, multiple sexual partners and drug and alcohol abuse) which increases demand across public services. For example, risky behaviour and substance misuse can result in people being trapped in the revolving door of the Criminal Justice System, being sent to Prison, becoming homeless, or having on-going mental health challenges i.e. outcomes which may be associated with harmful coping mechanisms as a result of trauma.

> *Over the last 2-3 years we have nurtured and built a collaborative style of working with system partners using home as a common lens to wellbeing. Hampshire's Minding Every Gap project (MEG) focuses on prison leavers who are vulnerable to homelessness and who suffer from poor mental health.*

This case-study focuses on the steps we are taking to embed Trauma-informed Practice across public services. In 2021 Hampshire successfully bid for Home Office funding to develop Trauma Informed Practice.

This enabled us to deliver the following:

- Element 1: ACE/Trauma Training for over 2000 professionals.
- Element 2: Short video showcasing the value of Trauma-informed Policing.

To view, please email Karen.dawes@hampshire.police.uk

- Element 3: Life Journey of Trauma-informed Conference.
- Element 4: Trauma-informed Practitioners (TIPs) supporting police.

This fourth element is the first of its kind in the UK. TIPs patrol with police in a live environment, observe communication, and provide feedback through reflective practice. Police are introduced to basic grounding techniques that can help bring someone stuck in 'fight or flight' back to the present time. This may help them be more receptive to support, increase feelings of safety and trust, and increase reachable moments.

What Next?

The Trauma-informed Executive Board produced a Concordat with a mission to embed Trauma-informed Practice across public services. This has been signed by 18 senior leaders. A Trauma-informed Knowledge and Skills Framework was also produced. The Violence Reduction Unit have now commissioned WAVE Trust to support the 18 organisations to produce a Trauma-informed Strategy by March 2023.

STaR Project (System Treatment and Recovery) - Rough Sleeping Drug and Alcohol Treatment – Devon ICS

The STaR project in Exeter brings together a One Team partnership approach to providing wrap around support and engagement to people rough sleeping or in temporary accommodation, who are experiencing substance misuse challenges but are not yet engaged with relevant services, using a MEAM, trauma informed approach.

> *As well as providing a new operating model and a service to work with people who are not yet engaged, we aim to create the conditions for learning by adopting learning cycles using a Human Learning Systems Approach. This is to inform commissioning approaches and service development both within the project and more widely through the Devon System Change Action Alliance.*

We aim to increase engagement by testing different ways of working with this population with the aim of attracting more people into treatment and to learn how our treatment services and wider system can better meet people's needs, as well as to increase the numbers of people completing treatment. The problem is lack of flexibility to respond to what matters to the individual and treatment targets not reflecting actual client progress towards their desired goal. A further problem is an increased entropy in the local system identified by a recent Cultural Values Survey and an historical lack of investment in treatment services and in staff development and training.

We plan to focus on outputs determined by the client, as well as the team, and to enable staff to act autonomously, intensively and holistically when an individual has a treatable moment. Using learning from an external consultancy, we intend to develop appreciative enquiry approaches and test and learn cycles to develop our learning to inform local commissioning approaches and service development activity.

We have co-produced a Charter and started to design a logic model. We are scoping how we can best support people with lived experience to be at the heart of the development of this as a system and how to ensure they are adequately supported to meet their goals. And how we can use the Exeter STaR model to test approaches which then can inform wider system development and vice versa.

Integrated hospital and primary care in Brighton and Hove

The specialist, multidisciplinary in-reach Pathway team has operated in Brighton for 11 years, and has established excellent practice in multi-agency working. A homeless multi-disciplinary team meeting discussion PEH in hospital has developed to a community and hospital complex case management meeting, helping patients to maintain recovery and stability in the community.

A new health engagement service, run by voluntary agency Justlife, originally put in place for hospital discharge follow up, has grown to cover people in all the emergency accommodation units.

Specialist Primary Care service, in-reach and outreach services have all been combined into one co-ordinated ARCH contract with the recent addition of step-down beds for people experiencing homelessness leaving hospital, and an enhanced outreach team. The aim is to cover all the places people experiencing homelessness may be so there are no uncovered gaps in services.

The Pathway team now see 450 people per year and very few leave hospital to the street. The team works with a range of services in the area and beyond to ensure best outcomes for people experiencing homelessness.

#HealthNow

#HealthNow is a four year project funded by The National Lottery Community Fund. It is led by Groundswell and delivered in partnership with Crisis and Shelter in Greater Manchester, Birmingham and Newcastle. The aim of the project is to work toward an inclusive health system where everyone has access to the health care they need, ultimately moving people out of homelessness. Participation of people with experience of homelessness is central to the #HealthNow project and there are many different ways that people are involved:

- **Peer Research:** each year #HealthNow recruits and trains Peer Researchers, people with lived experience of homelessness, to support the delivery of a participatory research project. Peer Researchers codesign and pilot research tools; conduct all fieldwork interviews and focus groups; support to analyse the data; review and feedback on the reports; codesign recommendations; and present the findings.
- **Homeless Health Peer Advocacy (HHPA):** Based on Groundswell's award winning model. Pilots of HHPA have been established in the three #HealthNow areas. Volunteers and staff with lived experience of homelessness are provided with training and personalised support to provide advocacy services that enable people currently experiencing homelessness to access and engage with health care. Volunteers are provided with progression support to move them towards goals including employment and education.
- **Local #HealthNow Alliances:** Stakeholders from homelessness, housing, health and VCSE meet regularly with lived experience volunteers to tackle health inequality in the local areas. Peers set the agenda, work with stakeholders to create solutions to key issues and hold key decision-makers to account for any actions.
- **National #HealthNow Peer Network:** Volunteers and staff with lived experience from across the country have formed a network to promote opportunities to share insight, participate in consultancy and codesign solutions and recommendations to health inequality at a national level.

Pathway is the UK's leading homeless health charity.

We work with NHS partners to created improve models of care for people experiencing homelessness; to shine a light on un-met needs and lobby for wider system changes to improve health and care outcomes for the most excluded. Pathway founded and hosts the UK Faculty for Homeless and Inclusion Health.

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