Towards Equity in Healthcare

Cardiff and Vale Health Inclusion Service

Dr Ayla Cosh

Clinical Director

CARDIFF CAERDYDD

CAVHIS

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro

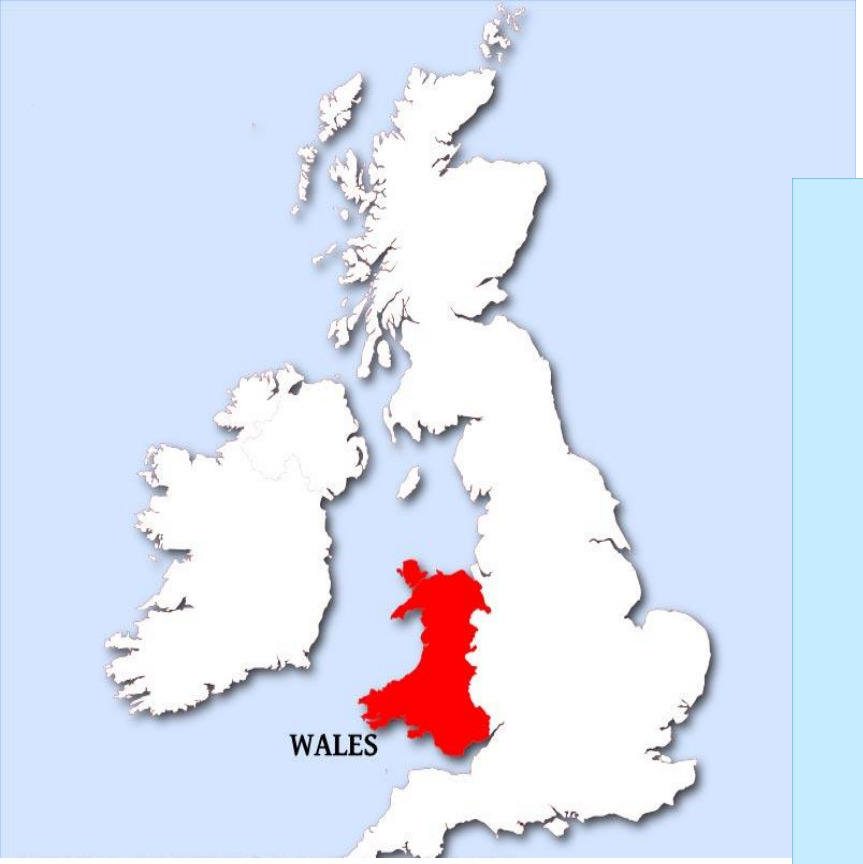
Cardiff and Vale University Health Board

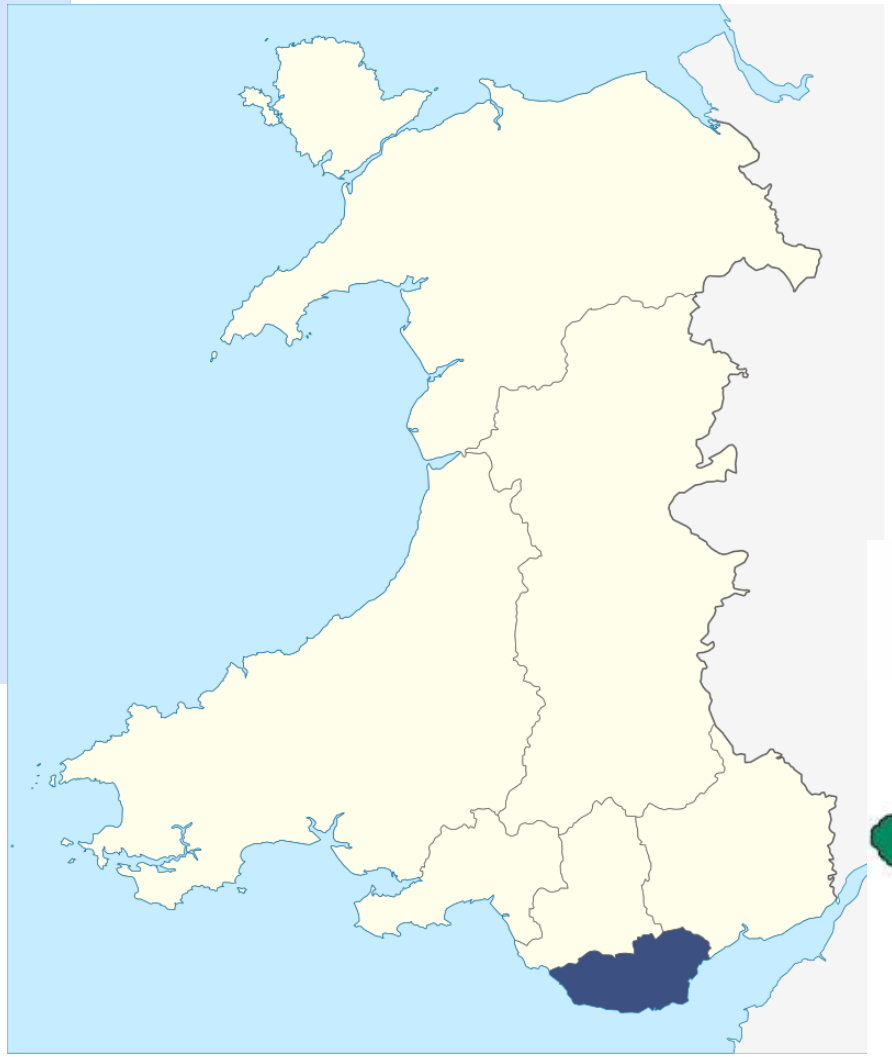
British RedCross

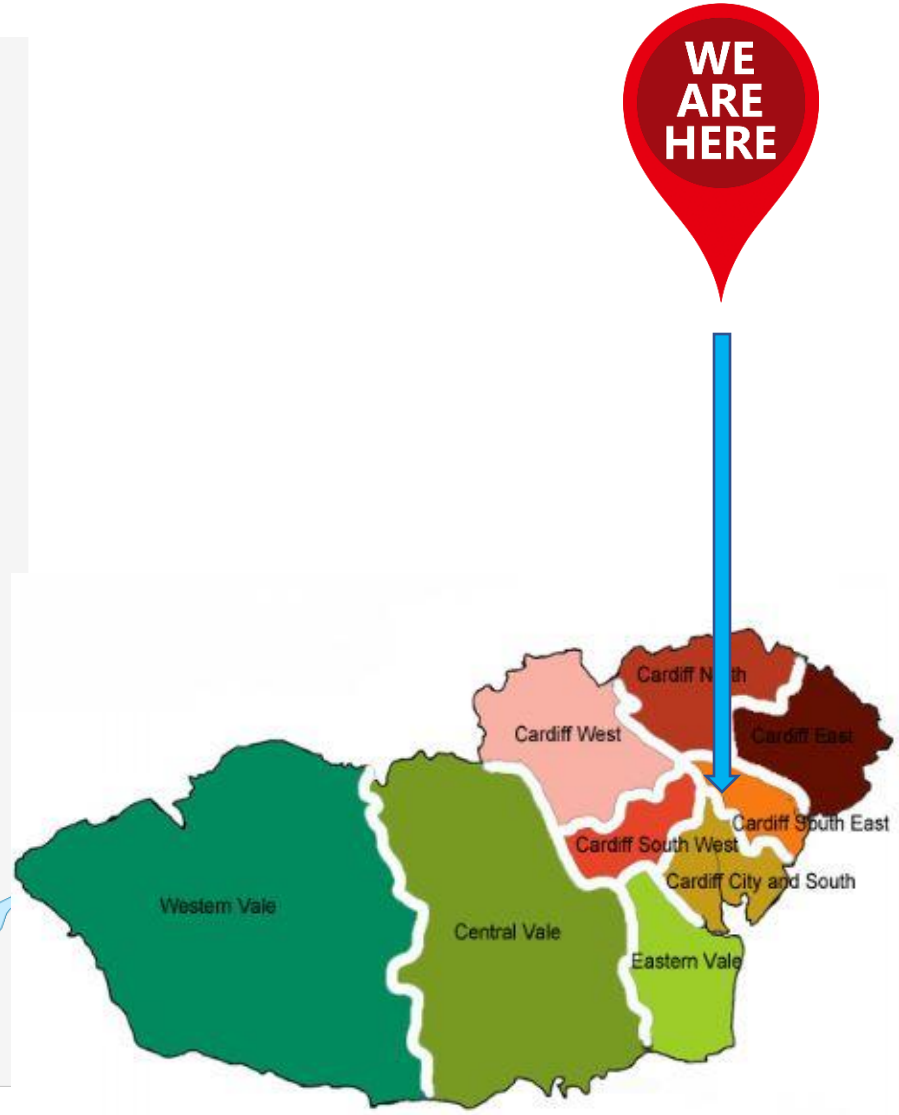
C3SC

Cardiff Third Sector Council

Cyngor Trydydd Sector Caerdydd


WALES




WE ARE HERE
Cardiff North
Cardiff West
Cardiff East
Cardiff South East
Cardiff South West
Cardiff City and South
Western Vale
Central Vale
Eastern Vale

- What CAVHIS Provides
- How did we get there?
- Current activity/projects/pilots
- Patient pathway – People arriving via irregular routes
- Data
- British Red Cross Partnership – Kaveh Karimi
- Vision for CAVHIS
- A potential model for tiered primary care
- Barriers
- Facilitators

CARDIFF CAERDYDD

CAVHIS

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

British RedCross

C3SC
Cardiff Third Sector Council
Cyngor Trydydd Sector Caerdydd

Current Services:
Cardiff and Vale Health Inclusion Service

Cardiff Health Access Practice (CHAP)

*Public Health Screening for newly arrived people seeking asylum placed in Cardiff for initial assessment.

CAVHIS

Tier 3 Service – Sept 2021

Core Service:

*Public Health Screening for Asylum Seekers and Refugees, including GP registration and access to medical care for up to 3-4 months, whilst individuals are supported in transitioning into traditional primary care (including Midwifery and Health Visiting services).

*Alternative Treatment Service.

*Level of specialist nursing supporting the homeless.

*GP outreach clinics in high need hostels.

*Health inclusion nursing presence in EU.

Probation Outreach planned – Dec 24

What did we do?

- Set up an Informal Health Inclusion Network
- Executive sponsor
- Health Needs Assessment led by Local Public Health Team - recommendations

Suggested recommendations

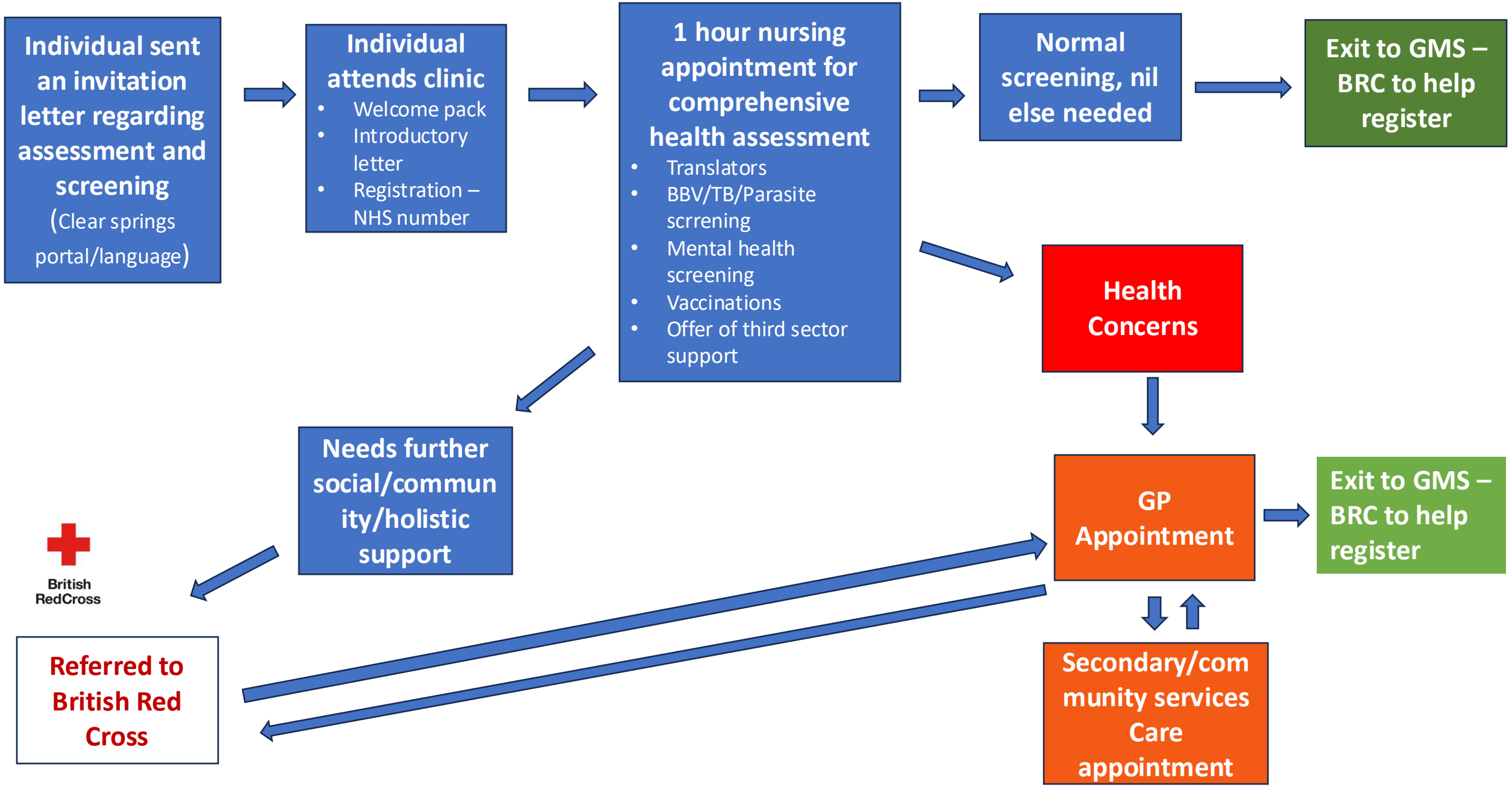
- ✓ Address leadership structures for Inclusion Health
- ✓ Incorporate Inclusion Health in future reviews and assessments
- ✓ Incorporate Inclusion Health in future plans
- ✓ Improve care and prevention around trauma and adverse childhood events
- ✓ Improve primary care and dental access for health excluded groups
- ✓ Improve access and engagement around mental health services for health excluded groups
- ✓ Increase Complex Case Management for Inclusion Health
- ✓ Public health inputs into Inclusion Health

Cardiff Council Homeless MDT already running with seconded nursing input – isolated and not joined up

This led on to:

- **Health Inclusion Program Board** - representation from Exec level in Health, Local authority and C3SC to develop and implement an appropriate integrated model for a tier 3 service
- Developing a **tiered model across primary care** (still in development/discussion)
- Commissioned **3rd sector support** from BRC in the department
- **Pilot outreach** with grants/temporary funding – High needs homeless hostels
- **Data collection** – EU attendance by group, Length of stay, deaths, DNA outpatient appointments
- Evidence based **screening** for new arrivals with **Co located Infectious disease** clinic
- **Business case** for expansion into the full model as per recommendations
- Partnership with Faculty of Homeless and Inclusion Health **Pathway program**
- **Education resource directory** https://primarycareone.nhs.wales/topics1/reducing-health-inequalities-through-primary-care/reducing-health-inequalities/directory-of-education-and-training-in-inclusion-health-for-health-professionals/

Process for newly arrived people seeking asylum and refugee resettlement schemes



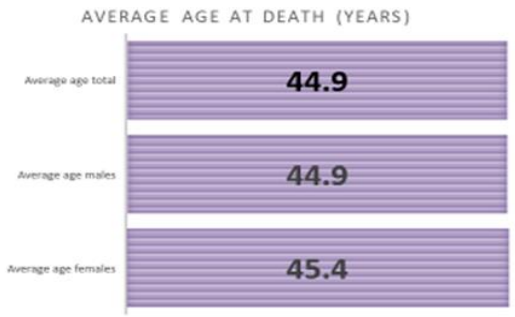
Homeless

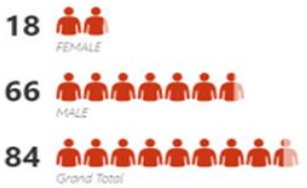
- UHB Business Intelligence System (BIS) reviewed **349** homeless patients' NHS activity between **2018-2023**.
- Data showed over 85% had attended the Emergency Unit (EU) and were, at least, **8 times more likely to attend EU than general comparator group.**
- 22/23 costs: EU £200,178, admitted patient care £1,366,146, outpatient £66,633.

	EU	Outpatient			Admissions			Community		
	EU Visits	Attended	DNA	DNA Rate	Inpatient	Daycase	Bed Days	Attended	DNA	DNA rate
2018/2019	487	278	242	47%	128	7	748	738	156	17%
2019/2020	567	309	204	40%	123	13	935	612	169	22%
2020/2021	622	414	259	38%	140	9	1437	592	200	25%
2021/2022	627	511	311	38%	139	8	2799	748	199	21%
2022/2023	741	406	294	42%	140	12	1965	924	194	17%

The Local Picture: Cardiff homelessness deaths

- Between January 2020-March 2024 there was a total of 84 individuals closed to the SPG and YPG with the end reason 'deceased'.
- Not an accurate reflection of all homeless deaths across Cardiff- likely to be higher.





Refugees and People seeking asylum

- UHB BIS reviewed 2,221 asylum seekers and 1,234 refugees (Ukrainian and Afghanistan) NHS activity between 2022-2023.
- Transient nature makes it difficult to paint an accurate picture. However, asylum seekers were, at least, 2 times more likely than a general comparator group to attend EU. Refugee EU attendance mirrored the general population.
- 10% of asylum seekers did not wait in EU (higher than general population).
- Community activity was exclusively mental health, with virtually all this activity linked to asylum seekers.
- 22/23 costs: EU £96,669 and admitted patient care £561,154.

Cost across services – this cannot be addressed by health alone

- Small cohort of 25 people experiencing homelessness have been examined using the Council's SPG and the UHB BIS, with the aim to understand any public services costs associated.
- 92% had one or more reported mental health condition, 100% were engaging in substance use, 72% had physical/chronic illness and 84% had been arrested at least once.
- The review found the estimated cost per person, per year (for the identified services) totaled £48,923.

Important to note that this is a rough indication of various costs to public services. The review recognises that there are significant challenges in identifying the true costs (e.g., establishing the 'counterfactual', which is needed to move from estimating gross costs, to estimating the additional, or net costs).

Department	Item costed	Source	Estimated Costs
Homelessness	Homeless Accommodation	Single Person Gateway	£782,056
Health	Emergency and secondary care activity	UHB Business Intelligence System	£593,648
Substance Misuse	Contact with service	Crisis (2016) Study	£44,880
DWP	Universal Credit with limited capability for work- and work-related activity	DWP annual figures	£417,021
CJS	Contact with CJS	Crisis (2016) study	£503,622
Mental Health	Contact with mental health	Crisis (2016) study	£104,950
		Total Estimated Cost between 22-24	**£2,446,177**
		Annual Average Cost	**£1,223,088**
		Estimated Cost Per Person, Per Year	**£48,923**

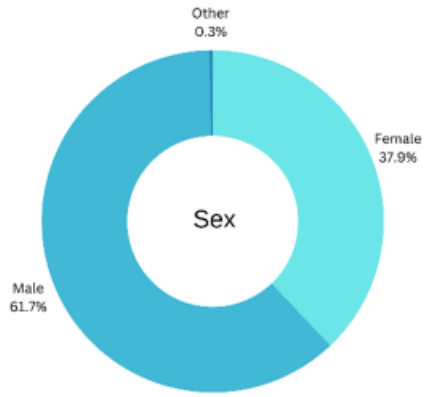
Homeless outreach drop in clinic pilot – 3 months data

- Scheme started 8th January 2023
- CAVHIS GP and 3 specialist homeless nurses
- Drop-in clinic runs 5 days a week 9-12am
- Rotating around high needs hostels in Cardiff:

—Ty Ephraim
—Adam's Court
—Ty Tresillian
—Huggard centre
—Street

Length of consultation	Percentage
>10 mins	11
10 minutes	23
20 minutes	46
30 minutes	17
40 minutes	2
>40 minutes	1

Demographics



Age	Total: 311
18-29	45
30-39	114
40-49	87
50-59	47
60 and over	15
Unknown/ not recorded	3

Outcome

What would have happened if not been seen?	total	percentage
Worsening of condition	128	41
Would have gone to ED	78	25
Would have done nothing	68	22
Would have tried to contact GP	18	6

Avoided use of unscheduled care/ED?	total	percentage
Yes	114	37
Possibly/probably	69	22
No –didn't need to go	105	34
No – needed to go to ED anyway	4	1
Not recorded	19	6

Kaveh Karimi

British
RedCross

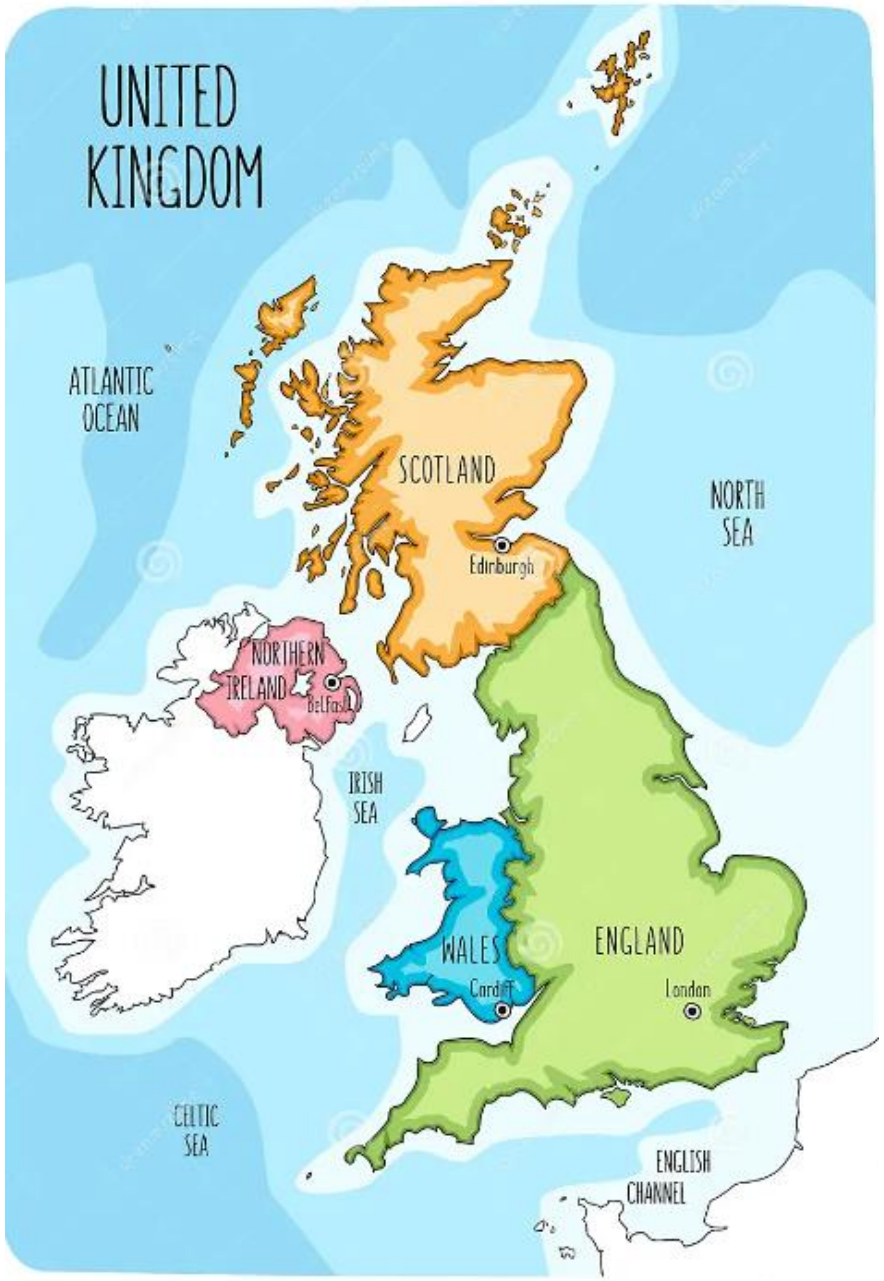
BRC Health Inclusion Service

NHS Wales

Health inequality

Improve wellbeing

Advocacy



British Red Cross | Y Groes Goch Brydeinig

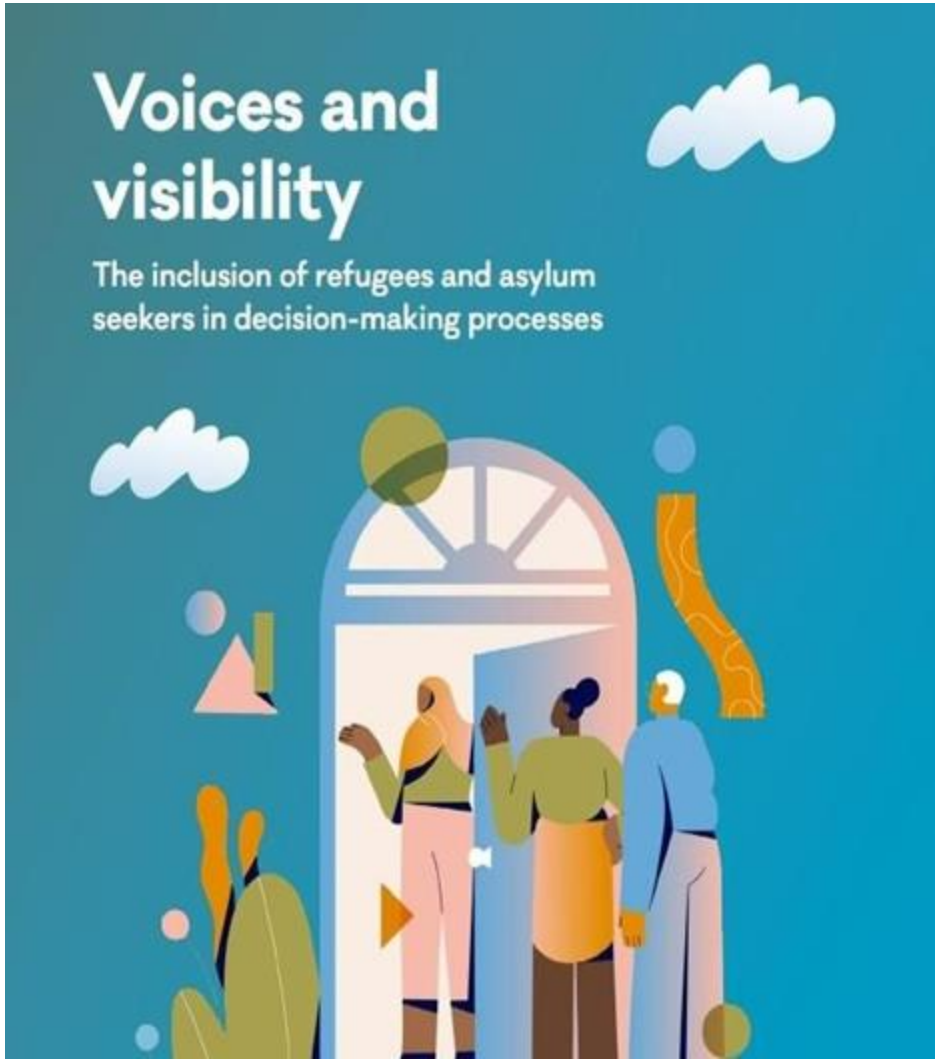
Health Access Project

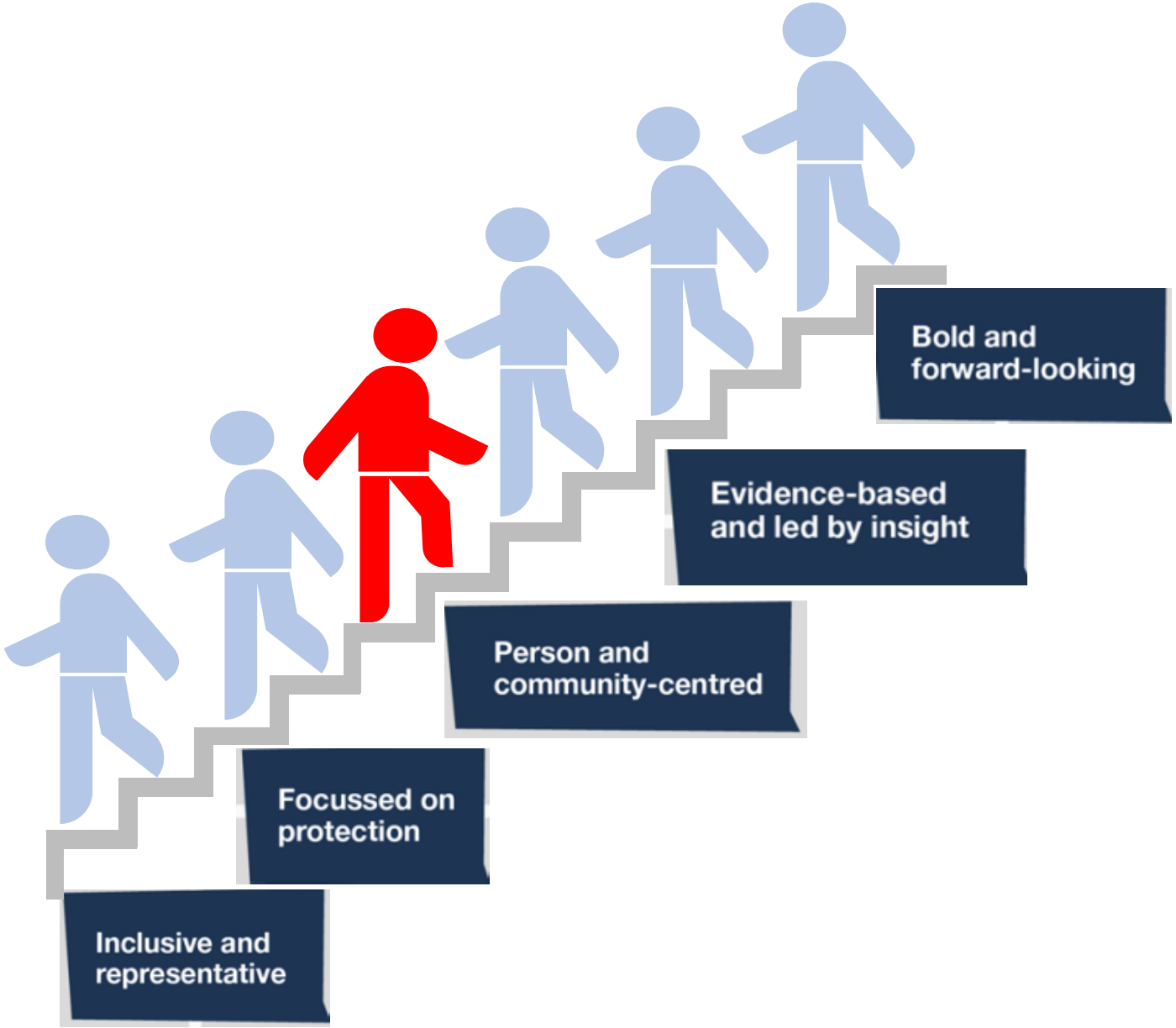
British RedCross

Context

- The British Red Cross was commissioned by the Cardiff and Vale University Health Board to deliver support to asylum-seeking patients within Cardiff for an initial two year period from September 2021
- The service supports two groups as part of the asylum dispersal scheme into Cardiff and surrounding areas: it firstly supports asylum seekers in initial accommodation who access an initial health assessment, health screening, and health care at the Cardiff and Vale Health Inclusion Service (CAVHIS); secondly, it supports asylum seekers, refugees and other vulnerable migrants who have been accommodated in Home Office dispersal accommodation in Cardiff and need to register or are registered at a GP practice within the GP cluster in Southeast Cardiff and beyond.

Strategic plan





British Red Cross | Y Groes Goch Brydeinig

BRC team provide an orientation and complex casework service

BRC coordinators conduct a holistic needs assessment with each service user.

As part of their initial assessment, the team assess for wider vulnerability issues such as safeguarding, trafficking indicators, pregnancy, care needs and social service requirements, hate crime and other policing issues, destitution, and support issues.

The team also pick up on practical issues for engaging with services, examples of this is linking in with different accommodation providers to check whether services have adequate catering for their needs and transport to initial health screenings etc.

The BRC team have established referral protocols based on need, examples of these are improved access to **Dental services, Mental health services, Pharmacy, Opticians**.

The Red Cross **acts as an intermediary** within the referral pathway which ensures that language barriers and administrative issues do not prevent attendance and we are able to advocate for access to transport support to appointments where required.

*they are **absolutely invaluable**. I could not do my job without them*

“ We appreciate the staff of red cross for supporting us.

“ Thank you very much from the heart.

“ Everything was so good, thank you.

British RedCross

What we do?

Holistic and outcome center need assessment

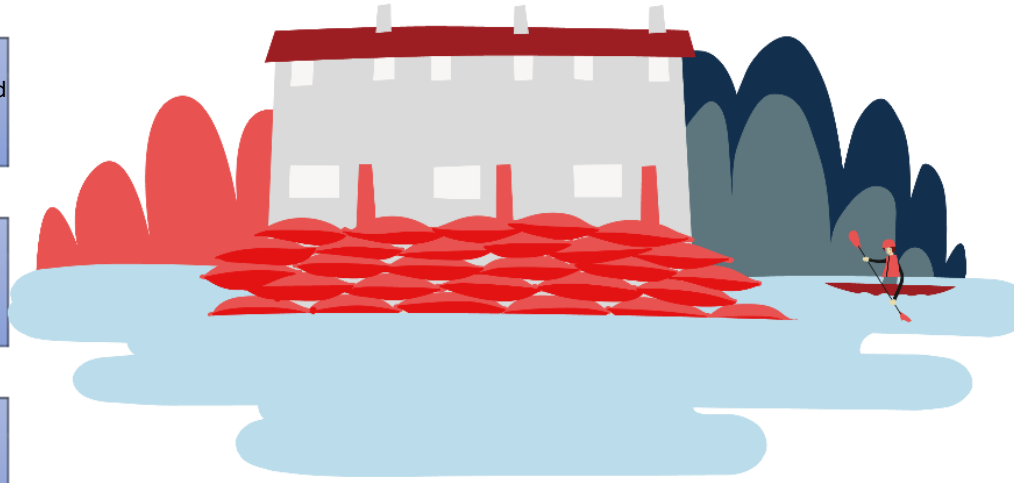
- information on Accessing legal representative
- Support accessing other health services

- Help to access asylum support and adequate accommodation
- Optician

- Food and clothing provision referral (DASPS)
- accessing emergency and ongoing dental care
- Community orientation
- Mental help referrals

- Support accessing transport
- Registering with GP and CAVHIS

- Provide information on Asylum journey
- Health Inequalities Escalations
- Providing access to specialized services
- Advocacy on Health matters



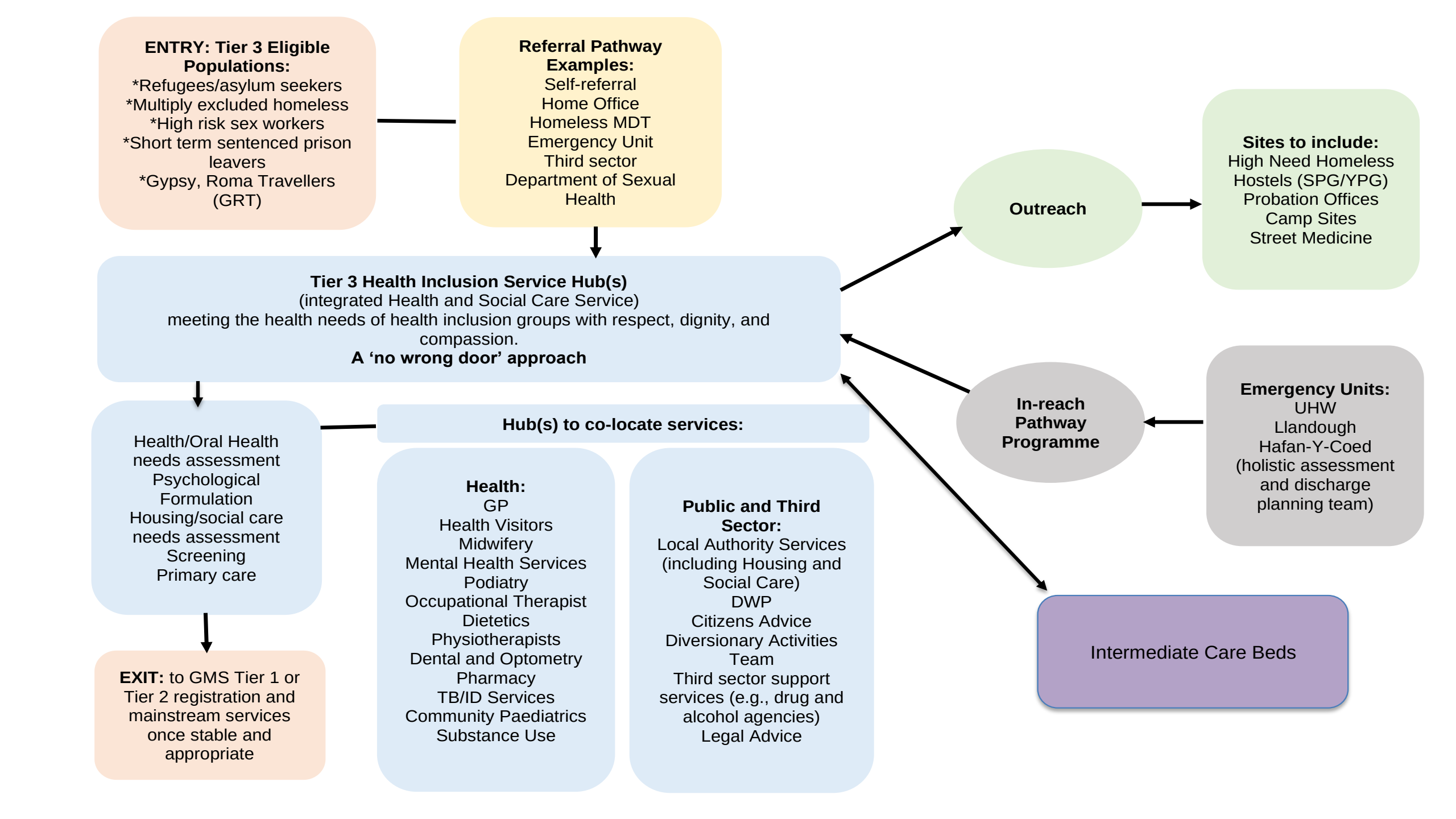
Survey Outcomes

British RedCross

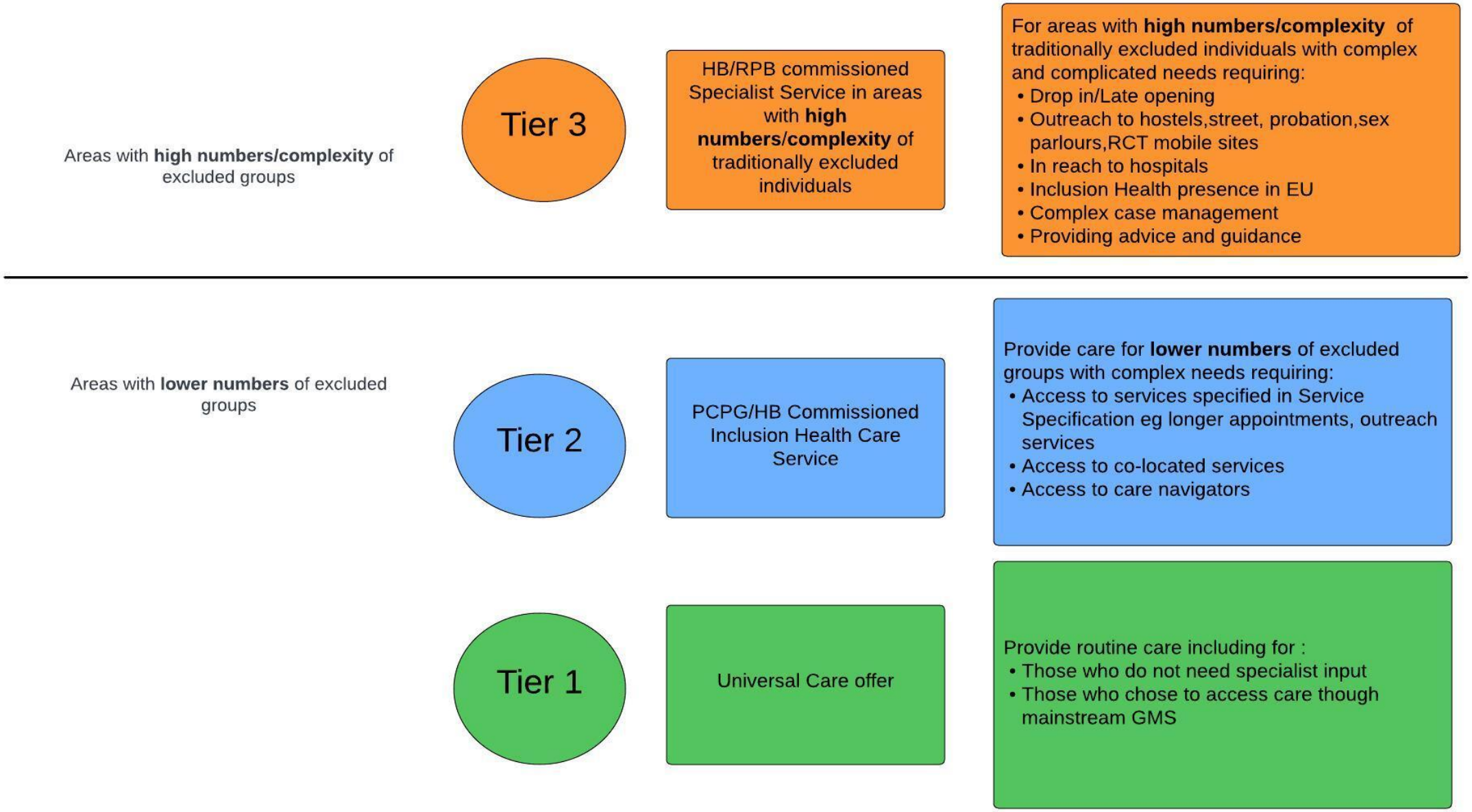
- 66 service users responded to our most recent service user outcome survey.
- 80% say the health access project helped them a lot or a little to access the health system confidently and 79% say the project helped with their knowledge of available support in the health system (*n=66*).
- 75% had increased confidence to access government services independently and 61% had increased knowledge of available government support (*n=66*).
- 71% have increased confidence to access charity and community-based services independently and 72% have an increased knowledge of available charity and community-based support (*n=66*).


TREATED WITH DIGNITY
CARE I RECEIVED
START AGAIN
NEW LIFE
LOOKED AFTER BY DOCTORS
FEELING SAFE
BEING HERE IN HOSPITAL
NEW FRIENDSHIPS
TREATED WITH KINDNESS
BEING SAVED
GETTING STATUS
BEING HAPPY
HAVING FAMILY BACK
PEACEFUL
HOPEFUL
HOPE
RESPECT
KINDNESS
THRIVING
LOVING
SAFETY
GROWING
FEELING NEW
FAMILY
BECOMING HEALTHY
FIXED AND SORTED
NO STRESS
ACCEPTANCE
LOOKING FORWARD TO THE FUTURE
DIGNITY


Welcome/Croeso


ENTRY: Tier 3 Eligible Populations:
*Refugees/asylum seekers
*Multiply excluded homeless
*High risk sex workers
*Short term sentenced prison leavers
*Gypsy, Roma Travellers (GRT)
Referral Pathway Examples:
Self-referral
Home Office
Homeless MDT
Emergency Unit
Third sector
Department of Sexual Health
Tier 3 Health Inclusion Service Hub(s)
(integrated Health and Social Care Service)
meeting the health needs of health inclusion groups with respect, dignity, and compassion.
A 'no wrong door' approach
Outreach
Sites to include:
High Need Homeless Hostels (SPG/YPG)
Probation Offices
Camp Sites
Street Medicine
In-reach Pathway Programme
Emergency Units:
UHW
Llandough
Hafan-Y-Coed
(holistic assessment and discharge planning team)
Intermediate Care Beds
Health/Oral Health needs assessment
Psychological Formulation
Housing/social care needs assessment
Screening
Primary care
EXIT: to GMS Tier 1 or Tier 2 registration and mainstream services once stable and appropriate
Hub(s) to co-locate services:
Health:
GP
Health Visitors
Midwifery
Mental Health Services
Podiatry
Occupational Therapist
Dietetics
Physiotherapists
Dental and Optometry
Pharmacy
TB/ID Services
Community Paediatrics
Substance Use
Public and Third Sector:
Local Authority Services (including Housing and Social Care)
DWP
Citizens Advice
Diversionary Activities Team
Third sector support services (e.g., drug and alcohol agencies)
Legal Advice

The Vision: Proposed Three-Tiered Approach across primary care



Phased Approach

Phase 1 (24/25):
Embed and expand the existing outreach and in-reach element of the model.

Phase 2 (25/26):
Focus on co-locating appropriate services within a hub to provide the provision of full specialist primary care for tier 3 individuals.

Phase 3 (26/27):
Commissioning of intermediate care beds- which potentially could be included as part 2 if suitable accommodation identified.

Phase 1: December 2024 onwards…

Outreach

- Secured current outreach services into high needs hostels (now core funded).
- Expanding outreach services into probation.

In-reach

- Increases nursing presence in EU and on wards to identify health inclusion patients presenting to EU, linking with appropriate services to plan and facilitate timely discharge.
- Duty to refer
- In-reach health inclusion team (includes x3 GP sessions) to provide preventative primary care to inpatients.

Whole Model

- Dedicated 3 day a week dental service.
- Adult Social Worker.
- Increased health visiting and midwifery care.
- Additional administrative support.
- High Intensity Therapist.

What hinders moving towards Equity? - Barriers

- Lack of appropriate models/locations – maintaining a one size fits all for primary care
- Carr Hill Formula in primary care – strategic funding decision
- No recourse to public funds condition – lack of consistency
- Criminalisation of sex work – driving fear of presentation
- Lack of knowledge and understanding among health and social care front line staff and strategic decision makers
- Siloed funding/siloed services
- Too hard

What Helps move towards equity? Facilitators

- Integrated Holistic model with local authority and third sector
- Tiered model appropriate to need – bespoke services/models
- Outreach to hostels/probation/parlours
- Outreach of secondary care colleagues to community – ID/Resp
- Duty to refer – extended to primary care services
- In reach to EU/Secondary care
- Molecular diagnostics and POCT – end TB/Hep C/HIV
- Service changes outside of Health Inclusion services completing EQIA
- Education and Training

Key Learning!

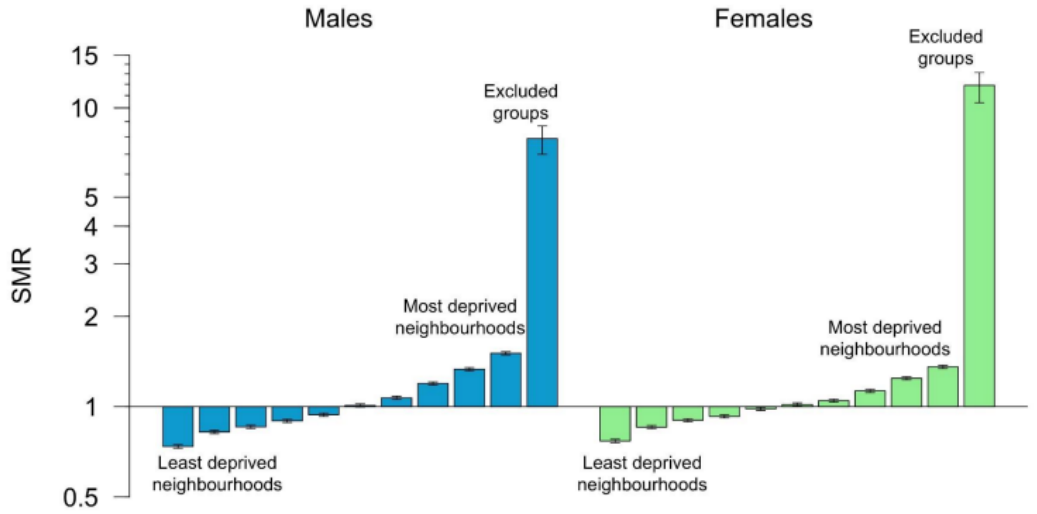
- Single system and service response is not an efficient or cost-effective response. **Joint commitment to action** and investment into health inclusion is required to tackle the serve and multiple disadvantages.
- Need to take a **strategic systems approach** to health inclusion to understand how best to utilise resources and work together to develop approaches that reduce pressures on systems, provide cost savings, improve health life expectancy, and importantly save lives.

Focus on prevention, co-location and integrated health, housing, and social care services.

Current situation:

Standardised mortality ratios by deprivation and exclusion

Standardised mortality ratio (SMR) for the general population in England, 2015, by neighbourhood deprivation, compared to SMR for excluded groups, with 95% confidence intervals.



Notes

1. SMRs for the general population are calculated using ONS mid-year population estimates by IMD decile for 2015 and ONS number of deaths in 2015 by IMD decile. Standardisation is conducted using 5-year age groups. The reference population is the whole population of England in 2015.
2. SMRs for excluded groups are taken from *Aldridge RW, Story A, Hwang SW, et al. Morbidity and mortality in homeless individuals, prisoners, sex workers, and individuals with substance use disorders in high-income countries: a systematic review and meta-analysis. Lancet 2017; 6736: 1–10.* Note that these estimates are made from studies from a number of high-income countries, while the SMRs for the general population are for England only. Also note that the studies that contribute to the SMR estimate for excluded groups use a range of comparison groups.

Average age of death for homeless **men is 45 and 43 for women** (ONS, 2021).

Annual number of people dying whilst under probation services in Wales **increased exponentially by 194%** between 2018/19 and 2020/21 (PHW 2023). Accidental drug deaths were the leading cause of death.

Gypsy, Roma and Traveller people face life expectancies **between 10 and 25 years shorter** than the general population (Friends, Families, Travellers 2021).

An international systematic review found that among adult asylum seekers and refugees, the prevalence of **PTSD was 31.46%** and **depression was 31.5%,** compared to the general population which is 3.9% for PTSD and 12% for depression (Blackmore et al., 2020).

Study revealed that **68% of street-based sex workers** interviewed meet the criteria for post-traumatic stress disorder – this is in the same range as victims of torture and combat veterans undergoing treatment (Litchfield et al., 2010).

In 2021, across England and Wales, there were an estimated **741 deaths** of people experiencing homelessness. The estimated number of deaths among homeless people has **increased by 54%** since records began in 2013 (ONS, 2021).

Current Situation:

- Traditional models of primary care do not address the needs of people with multiple disadvantage
- Defining vulnerability/those with the most need – no universally agreed definition

Vulnerable populations are groups and communities at a **higher risk for poor health** as a result of the **barriers** they experience to social, economic, political and environmental resources, as well as **limitations** due to illness or disability.' Home | National Collaborating Centre for Determinants of Health (nccdh.ca)

Services need to be flexible to meet need – difficult in high demand core services, **access for 'vulnerable' people is often facilitated by families, friends and carers.**

The most excluded/marginalised groups do not have such advocates