01
Health Inequalities

Introduction

Restricted access to healthcare is a strong and consistent theme in our casework. Client case studies evidence a stark and disturbing picture of the very real health inequalities experienced by people with multiple and complex needs.

Client data shows that 84% (43 of a total 51) of current clients have a physical health problem or problems. Many have a combination of long-term chronic conditions such as liver cirrhosis, hepatitis C, diabetes and circulatory diseases. The female clients we work with have more complex and chronic conditions compared to men. A number of factors contribute to this, including the impact of domestic abuse and violence, as well as the stress on the body from rough sleeping.

The average life expectancy of homeless people is low – for men this is 47 years of age, for women this is 43 years of age. Fulfilling Lives (FL) has worked with 94 clients to date. Ten clients have died, eight of whom were female clients (their average age was 41 years at the time of their death).

What we know from the project's work

There are high levels of repeat attendance at A&E. The table below shows the four highest users of A&E on our caseload to date. Client A attended A&E 19 times between Oct 2017 and Oct 2018. This client has a learning disability alongside other complex physical and mental health problems. These attendances were for pregnancy related complications including a miscarriage, mental health crises and an overdose.

Client	M/F	Area	Number of A&E attendances
1	F	Eastbourne	26
2	F	Eastbourne	25
3	M	Brighton	23
4	F	Hastings	21
		Total	95

- 78% of FL clients describe themselves as having a disability. This is compared to 16% of working age adults in the UK[1]
- FL clients have a higher prevalence of almost all health conditions than the general homeless population in the UK[2]
- Hastings has the lowest number of clients registered with a GP, but the highest prevalence of long-term conditions, as well as the highest average number of conditions per client

The East Sussex Homeless Health Needs Audit (2016) identified that access to health services was restricted, with 47% reporting a time in the previous 12 months when they could not be seen by a practitioner for a physical /mental health problem. This is compounded by the difficulty of making appointments by telephone and the lack of drop-in clinics available. Our recent client work suggests this is still the case and we have many examples of restricted access and barriers in provision for clients with complex needs.

1 This figure is from DWP data 2014

2 Figures are from Homeless Link's 2014 report on health inequalities for homeless people

Our casework demonstrates that healthcare services are often unable to meet the needs of clients with multiple and complex needs without significant intervention from support workers.

Healthcare services can be:

- Inflexible
- Punitive for non-attendance of appointments
- Unaware of trauma presentation and needs
- Unaware of substance misuse issues
- Lacking the processes to communicate with agencies who are supporting the client
- Stigmatising in their language and attitude

Access to GP and outpatient appointments

It is unsurprising that this client group, due to the level of their complex needs, frequently miss appointments and lose medication. This commonly results in a punitive response from GPs and hospitals, including removing the 'privilege' of being able to book appointments in advance.

People with multiple co-occurring long-term health conditions usually access a number of designated clinics to manage their health, and are able to do so. The FL client group rarely prioritise their health needs and rely on scarce GP appointments or on A&E to address urgent or emergency care.

Hospital discharge

Case example

S is a female homeless client who had been in hospital for five weeks. She was diagnosed as suffering from endocarditis, with damage to the mitral valve,

two thalamic infarcts and two cysts on the brain. At the beginning of week six, despite her being homeless, it was recommended that she be discharged and that she "go home and gain further weight and return after a month to review her health ahead of a referral for heart surgery".

Stigma

Examples of stigmatising practice witnessed by FL Specialist Workers include:

After he had read she had alcohol related liver disease the consultant said "I will see her at some point, but I have other people to see who are very poorly".

Regarding stronger medication I heard a consultant say, "give her whatever, give her anything". [A client dying from liver disease]

Special Patients Scheme (SPS)

Following a violent or aggressive episode in a health care environment, clients can be put on the Special Patients Scheme (also known as the Violent Patients Scheme) and a number of FL clients have been put on this scheme. We have identified that, due to reviews not taking place, clients can remain on the scheme and have this label despite the event(s) being historic.

J, a client in Hastings, has been on the SPS for over three years without being offered a review. Being on the scheme means that:

- He is unable to access the GP building without a prior appointment
- He can only access the GP building on a Tuesday when security is present
- The surgery will only see him with a keyworker present, not a family member or friend
- Because only one surgery in Hastings accepts people on the SPS he is unable to attend a surgery closer to his accommodation, despite being disabled with a serious leg injury

Our work to date

Health Watch are currently reviewing the Special Patients Scheme following FL highlighting barriers. We have provided anonymised case studies to help evidence the negative impact of the scheme on this client group.

In their casework, FL workers consistently challenge health care services and advocate for greater flexibility and understanding of clients' needs. They have negotiated flexible appointments, have flexed the rigid approach of the Special Patients Scheme to allow appointments to be made on any day of the week, and have represented clients' best interests when they are discharged from hospital. They have challenged stigma and have appealed for dignity for patients who are receiving end of life care.

The FL casework evidences the complexities of clients' needs and the complicated coordination required to ensure services and professionals are in place when needed. What appears to be a straightforward task of accompanying someone to a GP or a hospital appointment requires significant planning, and often many hours of time, factoring in outreaching and preparing someone emotionally to enter a clinical environment.

Our Commitments for Change

We acknowledge that the organisational anthropology of the NHS and its complex governance and management systems brings additional challenges to achieving systems change.

Our commitments relate to key pressure points for clients with MCN within the healthcare system:

1. People with MCN will have improved access to, and coordination of, primary care to better address their needs

2. All clients with MCN who are placed on the SPS will have an annual review in line with current guidelines

3. The triage system in A&E will be able to identify people with MCN and to assess potential risks and the need for follow-up care and support when they are discharged

4. Workers who support clients with MCN will be informed and empowered to use official systems to challenge and escalate unsatisfactory responses and care

5. Hospital discharge protocols for MCN clients will be fit for purpose and consistently implemented