North Central London Integrated Care System

NCL Inclusion Health Needs Assessment – Final Report

Finalised March 2023

Camden and Islington Public Health on behalf of NCL ICB

Final report – last updated 30/03/2023

Report structure

North Central London Integrated Care System

Executive summary - Background

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- Socially excluded groups often face **compounded risks** as a result of poverty, trauma and marginalisation, and disproportionately experience overlapping physical health, mental health, and substance use conditions.
- The North Central London Integrated Care Board (NCL ICB), commissioned Camden and Islington Public Health and Groundswell to conduct an Inclusion Health Needs Assessment (IHNA) to **understand how to improve health outcomes and access to care for** people experiencing: **Multiple disadvantage**, **Homelessness, Individuals with a history of imprisonment, Sex workers, Vulnerable migrants and Gypsy, Roma and Traveller (GRT) communities**. Findings will help **to inform the ICS commissioning plan for homeless and inclusion health**.
- This Needs Assessment has been split into two phases. Phase 1 involved a rapid review which aimed to synthesise existing local and national data and insight on Inclusion Health Groups (IHGs) across the 5 NCL boroughs, identifying the size and demographic profile, health needs and gaps in evidence. A summary of key findings can be found on page 4.
- Phase 2 was an engagement piece to deepen our understanding of the needs and challenges facing IHGs in NCL. **This report primarily presents findings from Phase 2 of the IHNA,** presenting evidence and insights from: face to face interviews with 24 residents from different IHGs, frontline staff survey (n=142), 24 key stakeholder interviews and analysis aiming to estimate overlaps between different facets of multiple disadvantage.
- Phase 2 fieldwork took place between July and December 2022. During this period a number of developments have taken place within NCL such as the implementation of the out of hospital care model and additional funding for substance use. Therefore there is work underway to address some of the issues mentioned in the report.
- Stakeholders and frontline staff consistently reported three overarching structural issues. 1) A lack of housing stock and affordable accommodation for the level of need. 2) Persistent cuts in funding and financial pressures over many years impacting the provision of local services. 3) Difficulties meeting the needs of individuals with No Resource to Public Funds (NRPF) due to constraints of national immigration policy.
- The findings are split into three sections:
    - **Section 1: Synthesis of key findings –** theme, Inclusion Health Group and borough.
    - **Section 2: Lived experience interviews and profiles –** Cross-cutting themes are presented first (mental health, substance dependency, physical health, barriers to healthcare access, wider support needs, homelessness, engaging with services & gendered experiences), followed by example inclusion health profiles / user journeys.
    - **Section 3: Stakeholder and staff engagement are presented under three umbrella themes –** understanding inclusion health groups (IHG), accessing services and partnership working/models of service delivery**.**

Executive summary - rapid review overview

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- For the rapid review, we reviewed local reports, websites and documents sent to us by key stakeholders, 14 local and publicly available datasets and published literature.
- Across the five groups, **data and local insights on people experiencing homelessness is the most recent, local and comprehensive**.
- The accuracy of even the most basic data - estimates of the size of each group - is complicated by legal, stigma, mobility and access barriers. There is no readily available local data on the size and profile of undocumented migrants, and limited data on people with a history of imprisonment, sex workers and Roma communities in NCL.
- The demographic **profiles of subgroups varies**; for example, the majority of sex workers are female, whereas people with a history of imprisonment, experience of sleeping rough and asylum seekers residing in hotels are overwhelmingly male.
- Our phase 2 engagement found many similarities with our review of the grey and published literature including:
    - IHGs often have many similar **health needs**, particularly related to mental health, substance use, TB and STIs and untreated long-term conditions, leading to higher morbidity and premature mortality.
    - Overlaps among IHGs, with many individuals facing severe **multiple disadvantage.**
    - **Substantial diversity within IHGs**: those engaged in direct (on and off-street), survival and indirect sex work; Romany Gypsies, Irish travellers, Roma people, travelling show people, new travellers and liveaboard boaters; asylum seekers, refugees and undocumented migrants; people with an experience of sleeping rough , statutory, single and hidden homelessness.
    - Common **barriers in accessing healthcare** across groups include: fear of stigma and discrimination, lack of identification or proof of permanent address, lack of awareness of the healthcare system and entitlements, trauma triggers, language and digital exclusion. Sex workers and undocumented migrants face additional fears of prosecution.
- **Our Phase 2 engagement explores these findings in greater depth.**
- For the full report please contact hannah.jones@islington.gov.uk

Executive summary – Overarching themes

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Health needs & priorities	In the rapid evidence review and lived experience interviews we found that there is **substantial physical and mental health need across all IHGs**. **Mental health needs, ranging from severe mental illness to poor wellbeing, was prominent across all groups**. **Substance dependency and its co-occurrence with mental health disorders** was prevalent, especially amongst those with experiences of sleeping rough or leaving the criminal justice system. Residents also experienced a **wide range of physical and wider determinants of health needs including chronic conditions, dental issues, housing instability, financial difficulties, inability to afford transport to reach appointments, digital exclusion, food insecurity and limited social integration**.
Understanding IHGs	A **lack of understanding of IHGs needs was viewed by staff as directly impacting care and support,** yet understanding was not consistent across boroughs, IHGs, or service areas. **GRT communities and sex workers** were specifically pointed out as groups where our **understanding and knowledge was lacking**. In lived experience interviews, residents commented that they would like greater compassion and personalisation in their care.
Accessing Healthcare services	We found **common barriers to access** such as fear and discrimination, including poor treatment by professionals, lack of proof of a permanent address, services not being holistic or trauma informed, limited integration between services, fixed appointment times, language barriers and digital exclusion. **There are examples of effective specialist primary care provision for people experiencing in most NCL boroughs** but this is not the case for all IHGs. **Access to mainstream primary care, hospital discharge and intermediary care were specifically mentioned by senior stakeholders and frontline staff as needing improvement**. Access to mental health services (ranging from inpatient to community services) was problematic. **The lived experience interviews highlighted a particular gap in access to therapeutic interventions vs. pharmaceutical and community support for low-to moderate mental health and wellbeing needs**. There is a clear gap in the provision of **dental care** and residents report negative experiences of hospital stays.
Partnership working	There are **examples of effective partnership working, but it is not universal**. According to frontline staff, collaboration across sectors and services is working better than collaboration across geographies. Enabling factors for good partnership working included operational and strategic multi-disciplinary team (MDT) meetings and staff valuing other professions. Barriers included short term contracts and poor information sharing. Outreach and specialist hubs for different IHGs were viewed as important. In particular, stakeholders suggested that services need to be tailored for GRT communities and sex workers. There was a general consensus that the ICS should provide strategic oversight and provide sponsorship for activities happening at borough level.

Executive summary – Findings by group

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Multiple disadvantage	**We estimate that 2,810 individuals in NCL experience 3 domains of disadvantage (substance use, homelessness and offending) at the same time**. Common challenges highlighted by residents interviewed included: instability from dealing with co-occurring substance dependency and mental health conditions, housing instability, personal safety whilst sleeping rough, difficulties associated with transitioning out of prison, lack of social capital and the desire to prioritise physical health needs but not being able to due to mental health issues or competing life priorities for basic survival.
Homelessness	Amongst key stakeholders and staff, there was **greater awareness of and support to address the needs of people experiencing homelessness, especially those sleeping rough**. The 'Everyone in' initiative had fostered closer partnership working especially around rough sleeping. The majority of key stakeholders provided examples of specialist primary care provision in NCL. Experiences within hospital were commonly cited as problematic for people experiencing homelessness by stakeholders and residents. Hospital discharge processes were viewed as inadequate by stakeholders.
History of imprisonment	In the lived experience interviews, residents who had contact with the criminal justice system highlighted that the **transition from prison was challenging due to housing insecurity, unemployment, substance dependency and few support networks.** This cohort was infrequently mentioned by stakeholders and staff but those who did, cited issues around the delay in transfer of health records after release from prison.
Sex workers	Frontline staff felt that there was **limited understanding of the sex work industry** and their unique experiences including sexual violence, experiences of trafficking, precarious living situations, fear of stigmatisation and prosecution, and gender specific health issues. Therefore, they advocated for specialist provision such as wraparound hubs and outreach. This mirrors the experience of a female sex worker interviewee, particularly the need for female-only spaces and services**.** The UCL Right to Care project will explore sex worker experiences and effective interventions in more depth in the coming year.
Vulnerable Migrants	**Individuals who have no access to public funds (NRPF) often have very limited access to services and staff are unclear what support they can offer**. We interviewed asylum seekers / NRPF individuals who were generally well educated and spoke English; therefore, their experience might not reflect the most vulnerable. Common issues included: financial insecurity, frustration and poor wellbeing caused by the asylum seeker process, family separation, lack of community integration, housing precarity or poor quality accommodation offered by the Home Office, disrupted healthcare access due to continued relocation by statutory services, language and digital exclusion.
Gypsy, Roma & Traveller	Stakeholders and frontline staff reported that there is **limited knowledge of the GRT community within NCL**. They called for more culturally sensitive pathways and better understanding of the breadth and difference of need between different GRT groups (e.g. Roma vs Irish Traveller). Despite stakeholder engagement, we were not able to interview anyone from a GRT background.

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Methodology

IHNA Overall approach

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Phase 1 (April-May June 2022)

Rapid evidence review

- Reviewed over 100 local and national data sources
- Meetings and correspondence with ~20 stakeholders

Phase 2 (July–December 2022)

Frontline staff survey (n=142)

Key stakeholder interviews (n=24)

Estimates of overlaps of severe multiple disadvantage using existing data

Conducted by Groundswell Sept-Dec 2022

Lived experience interviews / Service user journeys (n=24)

Phase 3 (December 2022-March 2023)

Final report to synthesise all evidence sources

Develop recommendations

ICS plan for homeless and inclusion health

Interviewing key stakeholders

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24 key stakeholders took part in a virtual 40-minute semi-structured interview with researchers from the Camden and Islington Public Health team between July and October 2022. Detailed notes were taken, and thematic analysis was carried out.

Who did we speak to?

- NCL ICB provided C&I Public Health with a list of key senior stakeholders. They represented a range of different service and geographic areas.
- Job roles included: Directors of Public Health, Chief Executives, Senior ASC and Housing representatives and senior clinicians.
- Most stakeholders were most knowledgeable talking about people experiencing homelessness and were less knowledgeable about other IHGs especially GRT communities. We did speak to stakeholders who worked directly with the other IHGs (2 sex workers, 1 offenders, 3 GRT, 2 vulnerable migrants).

	N
Islington	10
Camden	7
Enfield	5
Barnet	4
Haringey	2
Other	2
NCL ICB	1

	N
Mental Health	5
Housing	5
ASC	3
Public Health	3
Primary Care	2
Sexual Health	2
Substance use	2
VCS	2
Secondary Care	1

Participants were asked about:

- Areas that are working well and the main challenges in supporting inclusion health groups.
- Factors which negatively impact people in inclusion health groups when transitioning between different services.
- Key opportunities to improve the provision of care and support for people in inclusion groups, related to strategy, service and delivery, collaboration between organisations and use of data and evidence).
- The role of the ICS in improving care and support for inclusion health groups.
- How they engage with people with lived experience.

Surveying frontline staff

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The online frontline staff survey ran from 22nd August to the 21st September. The survey was a convenience sample and relied upon NCL ICB and key stakeholders distributing the survey via email distribution and newsletters. **There were 142 valid responses from across the 5 NCL boroughs**.

What did we do?

- All frontline staff working across NCL in housing, health and Adult Social Care were invited to take part in the survey.
- The survey was piloted with 4 frontline staff members before going live on an online survey platform.
- The survey contained 13 multiple choice and 7 open-ended questions.

Borough	Number
Haringey	32
Islington	30
Camden	24
Enfield	16
Barnet	15
Multiple London boroughs / pan London	13
Unknown	11
Other	1
Total	142

Survey respondents were asked about:

- Their views on which IHGs were most underserved and why.
- Areas that were working well and main challenges.
- Their views on how to work better with other organisations and more generally how to improve care and support.
- Types of data their service collects about service users and how it is used.

Characteristics of survey respondents

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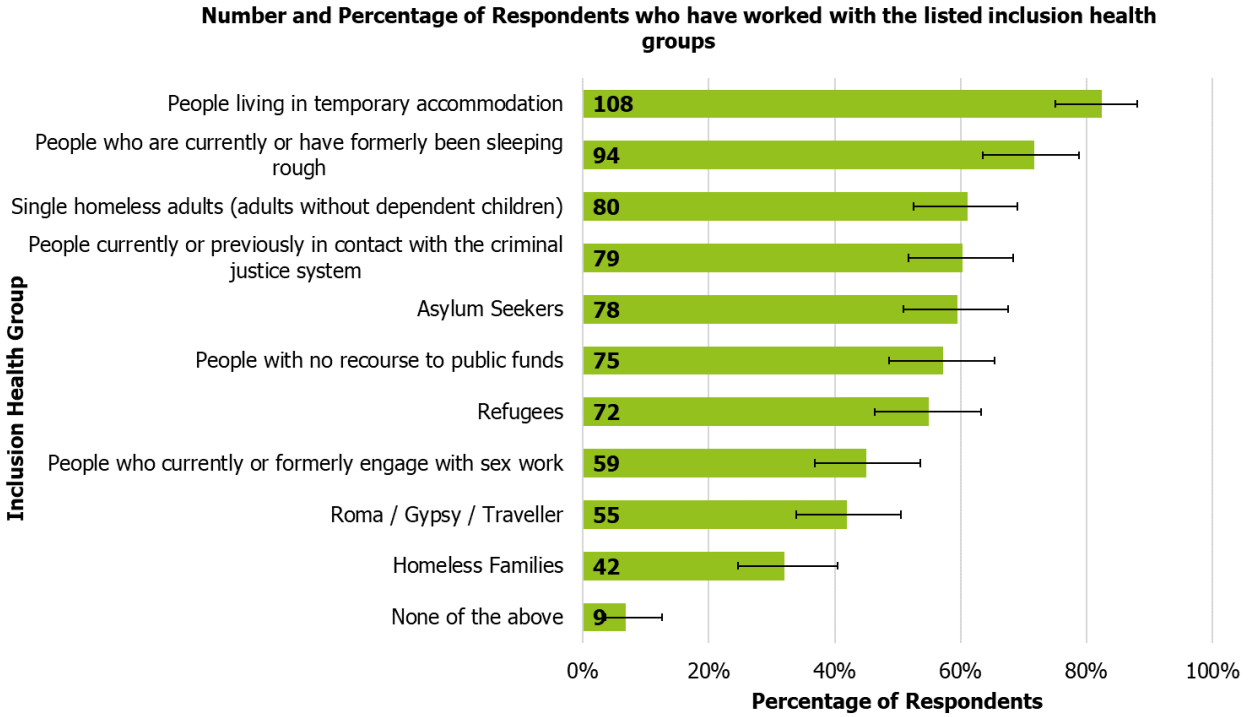
Only 7% of respondents had not worked with one of the inclusion health groups listed. The majority had worked with people sleeping rough and people living in temporary accommodation. Respondents were least likely to have worked with homeless families (32%), GRT communities (42%) and sex workers (45%).



Note: Respondents who did not answer this question have been excluded.
Source: Frontline Staff Survey, 2022

Respondents worked across a range of service areas:

- Community health services (25%)
- Housing services (16%)
- Adult social care (16%)
- Other (11%)
- Community outreach (10%)
- Primary Care services (8%)
- Dedicated/specialist inclusion health service (8%)
- VCS (6%)

The majority had been working in their area for more than 6 years (54%), and 10% for less than a year.

Calculating multiple disadvantage

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Severe multiple disadvantage is the term used to describe individuals who are dealing with a combination of problems, including homelessness, substance use, and offending. In this report, we use the 2015 Lankelly and Chase “Hard Edges” report to calculate region-adjusted borough-level estimates of multiple disadvantage in NCL. More details about the methodology can be found in Appendix A.

What did we do?

- We took the national prevalence estimates for each domain of disadvantage and applied this to local boroughs using 2022 projected population estimates. This produced **borough estimates** of multiple disadvantage.
- Lankelly and Chase argued that there are elevated levels of homelessness, substance use and offending in London and this should be adjusted for. Their report provided adjustment factors of 1.88 and 1.85 for Camden and Islington respectively.
- The report did not provide figures for the other 3 NCL boroughs so a modest adjustment of 1.5x was selected to avoid overestimating the numbers in the outer London boroughs.
- We then applied this to the borough-level estimates to produce **region-adjusted borough estimates**.
- **Limitations**: Although borough population estimates use 2022 projections, the Lankelly and Chase data is from 2011. Furthermore, the adjustment factor used in Barnet, Haringey and Enfield was informed by but not specified in the report and should be interpreted with caution.

Lived experience interviews (1)

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Residents who belonged to 1 or more inclusion health group were invited to be interviewed by Groundswell peer researchers. Interviews were between 15 and 60 minutes and took place July-December 2022. The interviews were recorded, transcribed and thematically analysed by Camden and Islington Public Health. In total 24 residents were interviewed.

Approach and recruitment

- Groundswell use peer researcher methodology, which is a participatory research method in which people with lived experience lead the research.
- Participants were recruited through refugee support services, hostels and supported accommodation, and approached by peer researchers on the street.
- Many stakeholders signposted us to organisations and supported with recruitment. The table opposite lists the organisations where interviews took place.

Participants were asked about:

- Their personal journeys and experiences that led them to needing additional support.
- Their needs and priorities, including but not limited to healthcare.
- The services they've interacted with, barriers to service use, and the kind of support they still need.

Organisation	Borough	Type of organisation
SHP 88 Arlington Rd.	Camden	Hostel
SHP Ashleigh Road	Islington	Hostel
NRPF, Migrant & Refugee Team	Islington	Islington Council
Kings Cross Road Hostel	Islington	Hostel/Hotel
Edmonton Green, Methodist Church	Enfield	Drop-in Centre
Mulberry Junction	Haringey	Drop in Centre
Street Interviews	Wood Green, Haringey	Indiviudals currently rough sleeping
New Citizens Gateway	Barnet	NRPF, Refugee drop-in centre

Lived experience interviews (2)

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Who did we speak to?

- More than half of the participants belonged to at least 2 inclusion health groups, while 3 participants belonged to at least 3 groups.

	TOTAL	Homeless	History of Imprisonment	Vulnerable Migrants	Sex Work	GRT
Barnet	**5**	5		5		
Camden	**6**	6	4	2		1
Enfield	**2**	2	1			
Haringey	**6**	6	4	2	1	
Islington	**5**	4	1	1		

Limitations and lessons to take forward

- As Groundswell is a homeless charity, their peer researchers' lived experience centres around homelessness. So for some of the inclusion health groups, the peer element might not be translatable.
- Our approach was initially to ask different stakeholders for lists of individuals who fell into 2 or more inclusion health groups. This approach did not work, as it required pre-set appointment times, which did not suit most participants. We ended up widening the approach and Groundswell instead did opportunistic interviews at various locations, which proved more successful.
- Engaging with sex workers and GRT communities was particularly difficult, requiring more time and resource which was not available. For example, to properly engage with the Roma community, researchers who speak Bulgarian are needed.
- Our budget did not enable us to cover translation costs so we were only able to speak to people who could speak English which constrained who we were able to speak as part of the lived experience interviews. For instance, the cohort of migrants we spoke to were in general well-educated and could speak English. Therefore, it is possible that their experiences are not reflective of many in this group.

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Section 1: Synthesis of key findings

Final report – last updated 30/03/2023

Overarching structural barriers

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Several issues were mentioned by stakeholders & frontline staff that hindered their ability to meet the needs to inclusion health groups. These are: housing stock and affordability, lack of funding and resources and National immigration policy.

Housing stock & affordable housing

- Staff noted that there are more people in need of accommodation than what is available.
- People without access to public resources (NRPF) were specifically highlighted as they are not entitled to council housing.

Example: *A stakeholder in Enfield mentioned housing as a particular structural concern. There are many single homeless people who are on universal credit but do not have complex needs, so are not a priority for council housing, and there is not enough affordable private rent stock.*

Lack of funding and resources

- Cuts in funding and financial pressures over many years were viewed as impacting local services.
- There are not enough resources to keep up with service user demand.

"The lack of resources meant our service staff are always overwhelmed and stressed with current workload, resulting in always firefighting and unable to see the wood for the trees. The pandemic has exacerbated the situation." (Psychologist, Community Health Service in Islington - Frontline staff survey)

Immigration policy & NRPF

- Meeting the needs of NRPF individuals is tricky as they are not entitled to most local authority services and some health care.
- It is costly to support NRPF individuals.

Example: *A senior ASC stakeholder explained that individuals with NRPF are prohibited from accessing local services so they end up sleeping rough and then go to A&E. They might then become so unwell that they become eligible for section 117 support or social care, or are forced to commit crimes, but by this point they have reached a crisis point. This also puts additional costs on prisons and the police.*

Areas that are working well vs main challenges

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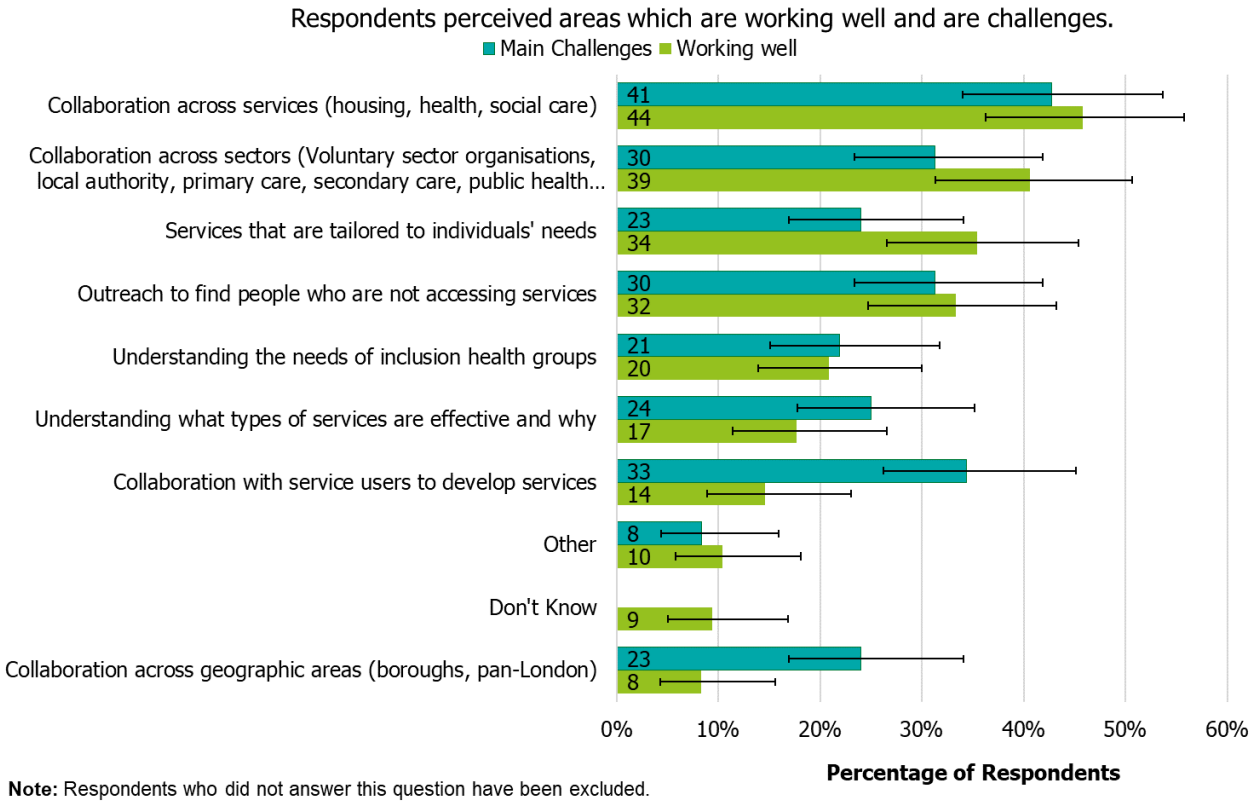

Note: Respondents who did not answer this question have been excluded.
Source: Frontline Staff Survey, 2022

- Collaboration across services such as housing, health and social care' was most frequently cited as a challenge and as an area that was working well.
- Whilst this might seem contradictory, the suggestion was that there are pockets of excellence in relation to collaborative and partnership working between services, but it is not consistent.
- Collaboration across geographic boundaries was seen to be working well amongst 8% of those surveyed, compared to collaboration across services (46%) and across sectors (41%).

Key Theme - Health needs & priorities

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- In the rapid evidence review, we found that there is substantial health need across all inclusion health groups relative to general population.
- In the lived experience interviews with residents, mental health needs were commonly raised. This ranged from people experiencing severe mental health conditions (e.g. schizophrenia) to low self-esteem and poor wellbeing. This showcases the range and different levels of support needed for these groups.
- Residents also experienced a wide range of physical health needs ranging from chronic conditions like diabetes to broken bones and tooth ache. Engagement with physical health needs was highly dependent on the mental health state of the individual. Those with poor mental health often withdrew, felt overwhelmed by the system making it difficult to address other health needs.
- Non-health-related issues included: housing instability, financial difficulties, not being able to afford transport to reach appointments, digital exclusion, food insecurity and lack of social integration.
- A majority of participants experienced some form of homelessness or housing insecurity. These experiences, however, varied between sleeping rough, being insecurely accommodated by the Home Office, sofa surfing, and moving in and out of hostels or temporary accommodation. **Those sleeping rough experienced the highest degree of vulnerability**, though housing concerns impacted everyone.
- Substance dependency consistently contributed to compounding the vulnerabilities of participants, especially among those with experiences of sleeping rough or leaving the criminal justice system. Addiction takes over the recognition of other basic humans needs (housing, food security, physical health, employment), with the individual often being in a state of chaos. This in turn often led to either sporadic, unstructured, and repetitive engagement with services, or to complete disengagement.

"I think my mental health is one of the main things for me, I think I've got anxiety all the time, so I think that's why I struggle" (Enfield resident, multiple disadvantage)

"But the reason why is because I was using substances, and when I say I lost myself, I literally mean it. I mean I was using substances in a way that was to me disrespectful to myself. I was disrespecting myself in way that I unable to set up limits, for example, this is something I learnt here, I have learnt here" (Camden resident, rough sleeping and substance dependency)

Key Theme – Understanding IHGs

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- Key stakeholders and staff commented that a lack of understanding of the needs of inclusion health groups negatively impacts care and support.
- Stakeholders/frontline staff explained that there were pockets of excellence, but understanding was not consistent across boroughs, inclusion health groups or service areas.
- There was some consensus that there was greater awareness of and support to address the needs of people experiencing homelessness, especially those sleeping rough. **GRT communities and to a slightly lesser extent Sex workers were both** identified as communities that we know little about in NCL.
- In the lived experience interviews, residents mentioned that professionals needed more understanding and compassion towards them where their needs were listened to more attentively.
- The use of data and evidence was valued by many stakeholders but was it is not being used to its full potential. Stakeholders argued that data should be collected at local borough level, collated, and fed back up to NCL level.
- Less than half of frontline staff respondents collect **feedback on services** and only 34% of respondents said that they use information about service users to **adapt how services** are delivered.

Key Theme – Accessing Healthcare services

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- Accessing Mental Health services was identified as problematic including services such as community mental health support, crisis intervention and inpatient services. In lived experience interviews, residents reported that they were often offered medication as the only treatment option. There is a gap in access to counselling services and support for low-to-moderate level needs.
- Staff & stakeholders raised mental healthcare access as problematic, particularly the high demand for services population wide, separate mental and physical health commissioning, limited pathways between mental health services and other, non-MH services, friction between substance use and mental health services and a lack of dedicated resource for Section 117 support.
- There were examples of **effective specialist primary care provision for people experiencing homelessness** in most NCL boroughs. However, stakeholders reported that access to specialist primary care for other inclusion health groups was patchy as was access to mainstream GP practices which was mirrored in the lived experience interviews.
- A gap in dental services was noted by, staff and key stakeholders.
- Residents reported negative experiences in hospital stays, and stakeholders commented that **staff working in hospitals** need to be better equipped to support inclusion health groups and take a more holistic approach due to stigmatising attitudes and behaviours towards IHGs, especially those who are 'visibly' homeless.
- A minority of stakeholders reported that the out-of-hospital provision had plugged gaps but there were still issues with individuals being discharged into unsuitable accommodation or back onto the streets. Moreover, current intermediate care facilities were not appropriate for all patients with mobility issues. Discharge to assess pathways were also viewed as inappropriate.
- A clear priority amongst those with substance dependency is being able to access methadone scripts easily. Common issues reported included inconvenient opening times, and issues around negotiating dosage.

Common access barriers

- Lack of appointment availability / fixed appointment times
- Fear and discrimination including poor treatment by professionals
- Lack of proof of permanent address
- Services not being holistic, or trauma informed
- Limited integration between services
- Language barriers and digital exclusion
- Need for personal advocacy
- Relocation / Transience

Key Theme – Partnership working & models of service delivery

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- Partnership working was viewed as essential for inclusion health groups who are often transient with multiple/complex needs. There are **examples of effective partnership working but it is not universal.** Most stakeholders called for further work to strengthen partnership working between organisations, service areas and across NCL. Frontline staff reported that collaboration was working better across sectors and services than across geographies.
- Residents commented that services were not co-ordinated across geographies for example having to re-register, not being able to access services in other boroughs and not being known to the council when sleeping rough all contributed to this perception.
- **Operational and strategic multi-disciplinary meetings** were viewed as an enabling factor for good partnership working **and valuing each other's roles**. Stakeholders reported that this is not always the case and there is sometimes tension between healthcare and non-healthcare services who work in different ways. Barriers to partnership working included short term funded services and a lack of information sharing and communication.
- **Outreach and specialist hubs** were viewed as important particularly a need to tailor to **GRT communities** and **sex workers**.
- There was a consensus that the **ICS should provide strategic oversight and sponsorship** for borough level activities. Stakeholders also felt that services should be delivered at borough-level because that is where people are most in touch with local communities. Each borough is different in terms of their inclusion health populations, service landscape, philosophy, level of resource and stage of IHG provision. The ICB could play an important role in continuing to **raise the needs of less resourced boroughs**.

Key findings by Inclusion Health Group

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Multiple Disadvantage

- We estimated that 2,810 individuals in NCL experience 3 domains of disadvantage (substance use, homelessness and offending) at the same time. There is a lack of consistent understanding across the system around **how to support people experiencing multiple disadvantage**.
- Common challenges highlighted by residents included:
  - instability from with dealing co-occurring substance dependency and mental health conditions
  - housing instability
  - personal safety whilst sleeping rough
  - difficulties associated with transitioning out of prison
  - lack of support networks
  - access to methadone scripts
  - Wanting to prioritise physical health needs but not being able to due to mental health issues or addiction taking over the recognition of other basic human needs, with the individual often being in a state of chaos.

"Okay, so I've been struggling with homelessness and my drug addiction on and off for 10 years. I've been in and out of jail for things like shoplifting and theft. I've just come out of prison, on tag and had to use the tag agencies in prison because I didn't have an address to go to. So they put me in BASS accommodation in Edmonton and that's how I've ended up around here." (Enfield resident, multiple disadvantage)

Key findings by Inclusion Health Group (1)

North Central London Integrated Care System

Homelessness

- Amongst stakeholders and staff, there was consensus that there was greater awareness in recent years of support to address the needs of people experiencing homelessness, especially those sleeping rough. The 'Everyone in' initiative had fostered closer partnership working especially around rough sleeping.
- Frontline staff perceived single homeless adults to be more underserved than people sleeping rough and those in temporary accommodation, all of whom were perceived to be more underserved than homeless families.
- Examples of effective specialist primary care provision for people experiencing homelessness were: GP service in Homeless Action Barnet, Camden Health Improvement Practice (CHIP), Camden Adult Pathway Partnership (CAPP), Somewhere Safe to Stay Hub, Homeless Health Inclusion Team (HHIT), and the specialist GP service based at homeless hostels in Islington.
- Individuals who are 'visibly' homeless or displaying 'difficult behaviour' are often not treated well in hospitals and there are still issues of individuals being discharged back into inappropriate settings and without adequate support.

People with a history of imprisonment

- People with a history of imprisonment were rarely mentioned by stakeholders or frontline staff. It may be that we did not speak to enough stakeholders who work with this group, little is known about them or they are conflated with other groups (e.g. people experiencing homelessness).
- One key issue was the delay in transfer of health records between prison and non-prison services. Which was unclear across NCL.
- In the lived experience interviews, residents who had contact with the criminal justice system highlighted that the transition from prison was challenging due to housing insecurity, unemployment, substance dependency and few support networks.
- Relationships with probation officers were generally described as positive but were not viewed as helping achieve longer term stability.

Key findings by Inclusion Health Group (2)

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Sex workers

- Staff spoke about a lack of knowledge around the different types of sex work (i.e. commercial sex work vs. survival sex work), which impacts an individual's needs and how they access services.
- Staff said their service users would prefer to be seen in a specialist clinic due to judgemental attitudes. A minority of stakeholders reported on having to rely on services for people experiencing homelessness.
- Sex workers are often hidden and have high level of distrust of authorities, especially the police and social care staff. The sex worker population is also very transient. This means there is a need for outreach.
- Stakeholders argued that they feel that sex workers are often forgotten about as a commissioning priority.
- Stakeholders working directly with sex workers said that having specialist wraparound hubs dedicated to their health and support needs was important. They argued that sex workers had unique experiences because of their work, often experience sexual violence or are victims of trafficking, and are often living in precarious housing situations, or not born in the UK and do not speak English fluently and often fear stigmatisation.
- In reference to sexual health services specifically, they said that compared to men who have sex with men (MSM), sex workers were more underserved and there was less provision. For example, for female sex workers gender-specific issues such as menopause support is a service gap.
- We were only able to speak to one female who engaged with on street sex work. Their experience mirrors findings from stakeholder interviews as they spoke about the trauma of sex work and the importance of have supportive female-only spaces and services.
- UCL are starting a research project called 'Right to Care' which will look at how to improve care for sex workers.

I'd rather stand on the corner and sell my body then I'm in control of what I'm smoking […] but this is the thing, where is the support for a sex worker that wants to stop sex working? There's support when you're sex working, where's the support for when you don't want to do it? ***(Haringey resident, sleeping rough, with criminal justice history & history of sex work] resident)***

Key findings by Inclusion Health Group (3)

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Vulnerable migrants

- Vulnerable migrants often come from different health systems and have different health seeking behaviours. For example, registering for a GP when you are not sick might seem unnecessary for certain groups if this is not the norm in their birth country.
- Groundswell primarily spoke to non-European migrants with NRPF who had been in the UK a long time and were waiting for their application for asylum to be accepted or had recently arrived in the UK. They were also only able to speak with those who could speak English.
- Key issues flagged included:
  - struggling with daily expenses due to low allowances provided by the Home Office, which led to a reliance on foodbanks and other charity
  - migration status uncertainty and interactions with the Home Office often caused mental strain and frustration
  - housing precarity and quality lack of community integration and family separation and support, which caused reduced wellbeing
  - disrupted healthcare access due to continuous housing relocation
  - frustration at the inability to work whilst waiting for refugee status
- Language and digital exclusion were frequently mentioned as barriers to accessing care. Often there is a need for an interpreter but this is hard to access.
- Individuals who are NRPF often have very limited access to services and staff are unclear of what support they can offer. Staff are also often unclear what NRPF individuals are entitled to.

"I've lived here almost 20 something years, studied here, worked here, went through a process where the Home Office made a mistake, went to court, the judge ruled in my favour […] Sat with them for a year, then [the Home Office] came back and said, "I'm missing something". You know like after 20 years they say, "You're missing a document in 2007" […] unless you kept all that paperwork, you're not going to be able to produce it." (Barnet Resident, housed in home office accommodation)

"I told her [the social worker] we were moving but she didn't quite get me, so they had to take her [my daughter] from me for three days, and that was the worst experience of my life because that girl she's my life; that girl is the only hope I've got in my life which I've left. They [social services] said it's either I seek asylum to get my status to be settled or they take her away from me forever." (Barnet Resident, housed in hostel waiting status)

Key findings by Inclusion Health Group (4)

North Central London Integrated Care System

Gypsy, Roma, Traveller Communities

- Stakeholders and frontline staff said that they **knew very little about GRT communities and their needs** and felt there was **little contact** with these groups. There is a lack of understanding of the breadth of these groups – Irish travellers would have different needs from the Bulgarian Roma community.
- Stakeholders argued that there is a lack of awareness of the trauma faced by the Bulgarian Roma community, for example that that many young girls are involved in sex work or are victims of modern slavery and they have no support.
- Culturally sensitive pathways, including wraparound care were suggested; for example, mental health is often stigmatised amongst Irish Traveller groups, which stops people coming forward for help. Staff also called for more **tailored public health campaigns** (i.e. stop smoking).
- Digital literacy and language barriers were discussed, with alternatives (e.g. WhatsApp, video calls and F2F) suggested as alternative to traditional methods of contact (e.g. letters).
- Unfortunately, we were unable to interview anyone from a GRT community. Whilst we reached out to stakeholders who work with these groups, we only had the capacity to interview in English.

Key findings by borough

North Central London Integrated Care System

- Stakeholders across boroughs have similar views on what does/does not work for IHGs (e.g. importance of outreach and taking services to service users)
- **Borough profiles can be very different** (demography, services, philosophy, VCS landscape, level/stage of resource) and so whilst it is important to have strategic oversight at ICS level for inclusion health, work should operationalised at borough level.
- For example, in some boroughs raising the profile/understanding of IHG might be the key priority, whereas in other boroughs the development of pathways/services would be required.
- Unfortunately, frontline response rates were too small to do sub-analysis or reporting by borough for frontline experiences.
- As the profile of resident interviews varied, it is not possible to make borough comparisons.

"Inclusion health has to be embedded in the clinical strategy and reviewed in the context of the system and its governance. That brings in financial conversations and resource conversations; for example, the Health Inequalities Fund which can support key programs of work. The ICB in the context of the ICS has the responsibility to make those decisions about money and leadership and strategy to make sure every organization embeds that in their working. At the ICS level: creating an enabling architecture to allow services to happen at a local level; figuring out what is the envisioned offer – is it a core offer or is it bespoke – and how is it standardised across localities. At a local level: implementation, local relationships, place-based partnerships, etc. Councils will need to deliver services in their borough. It's key to help people understand the overarching population need and the strategy, including how money is going to flow at the ICS level. Then some resources need to be allocated at borough level depending on need with greater resources going to where there is greater need." (Key stakeholder interview – ICB perspective)

North Central London Integrated Care System

Section 2: lived experience interviews and Inclusion health profiles

Final report – last updated 30/03/2023

Key Theme – Mental Health (1)

North Central London Integrated Care System

Interviews revealed **overwhelming mental health needs across all participants**, irrespective of what inclusion health group they belonged to. Levels of support were varied, and there is a **gap in access to counselling services** and support for low-to-moderate level needs. The prevalence of **unaddressed low-self-esteem and reduced wellbeing** is noteworthy. **Mental health, alongside substance dependency, was the most frequently cited priority among interviewees.**

Severe Mental Health Need

- Multiple interviewees mentioned **experiencing severe mental health needs**, such as schizophrenia. Others talked about **deeply unstable mental and emotional lives**, including clear mental health problems but without having a formal diagnosis.
- Severe mental illness was most **prevalent among individuals experiencing homelessness and rough sleeping.** It was often **co-existent with substance dependency.**
- Levels of **accessing support are mixed.** While some interviewees mentioned receiving treatment, others seemed to have no support.
- **Over-medication,** unsupported by counselling or therapy, was a common theme. Interviewees sometimes felt they were **given medication instead of addressing more complex underlying issues.**
- A minority of residents mentioned frustration that the system treats people with mental illness as criminals.

After revealing a history of self-harm: "Mental health, I feel I have no mental problem, but I don't know, maybe. The mental health problem I say no problem, but I don't know, maybe the doctor check me.
[Camden resident sleeping rough, with criminal justice history]

"It's like, "Here's some pills, go and take them." Then they weren't strong enough, so they upped the dosage, but then you're drugged out your eyeballs […] Which isn't much different to being on a cocaine high is it, it's all chemicals you're putting into your system to make yourself feel better."
[Haringey resident, sleeping rough, on antidepressants]

Example: *A Haringey resident led a stable, successful life until he suffered a mental health crisis, during which he became violent. This led to a sentence, time spent in prison, as well as hospitalization for their mental health needs. Upon release, the individual received no additional support and found themselves homeless, unemployed, and still struggling with underlying poor mental health. They express frustration that the system treats them as both a patient and criminal, while also not supporting full recovery.*

Key Theme – Mental Health (2)

North Central London Integrated Care System

Mild to Moderate Mental Health Needs

- Common mental health illnesses such as **anxiety, depression, panic attacks, and low self esteem** were mentioned by all interviewees.
- Some individuals sought out explicit support for these mental health needs, but for **the majority these conditions remained untreated.**
- **PTSD** and experiencing trauma were commonly mentioned in passing, though they were not being addressed as an explicit mental health need.
- **Poor mental health was seen as a given**, especially among individuals who've experienced sleeping rough, substance dependency, and imprisonment.

Low Self-Esteem and Reduced Wellbeing

- Even when not explicitly addressing mental health needs, it was clear that the **general mental wellbeing of all interviewees was low.**
- Low self-esteem sometimes led to **self-neglect, social isolation, and dissengagment from services.**
- The **ability to find meaningful activity, such as volunteering or gardening was a strong protective factor**, however many individuals sleeping rough and struggling with substance dependency **did not have the capacity to engage in these activities**. Volunteering was most common among asylum seekers still waiting for their refugee status.

"You get anxious, you have anxiety; actually I started having, one thing I started having was panic attacks, but I know why I get panic attacks. Panic attacks means I know when I've done everything and done everything right and I don't have control and I just feel like I'm being messed around and I've done everything, so I'm just so frustrated with life, I get a panic attack."
[Barnet resident, hosted in hostel, long standing NRPF awaiting status]

"My mental health is already, if I was normal I don't know where I'd be… […] Sometimes my face tells more, the smile level is going on up here because I'm higgledy-piggledy and one minute I might be up here and the [next] minute I'm down there. But my mental health, I've got PTSD, I've got trauma from the past working as a prostitute. I've got PTSD from a lot of things previous to domestic violence. I've got a trailer load behind me. I am what you call a walking book of anything that can happen to a female on a roadside."
[Haringey resident, sleeping rough, with criminal justice history & history of sex work]

"Yeah, so you can imagine how really good it is, so volunteering gives you an opportunity honestly and when you, like I said, when you also help other people, it's just fantastic."
[Barnet resident, housed in hostel, long standing NRPF awaiting status]

Key Theme – Substance Dependency

North Central London Integrated Care System

Substance dependency contributed to **compounding the vulnerabilities** of participants, especially among those with experiences of sleeping rough or leaving the criminal justice system. Interviewees describe dependency as making their lives **chaotic with little capacity for addressing other needs** (housing, food security, physical health, employment). This in turn often led to **either sporadic, unstructured, and repetitive engagement with services**, **or to complete dissengagment.**

- Interviewees described substance dependency **making their lives unmanageable**. Many felt they could only focus on obtaining alcohol or other drugs and had **no capacity to focus on other needs.**
- A variety of substances were mentioned, including **alcohol, heroin, and cocaine.** The impacts of these, however, were similar.
- For some, untreated substance dependency was the **cause of job loss, homelessness, and family estrangement.** For others, substance dependency was a **consequence of time in prison, interactions with the criminal justice system, or sleeping rough.**
- **Self-medicating mental health issues** with alcohol or other drugs was common. Some felt that such substances were the only way to cope with the strain of sleeping rough.

Accessing Support

- A few interviewees mentioned **long waiting times for accessing detox services** as a barrier to taking the first steps in treating alcohol dependency.

Methadone Replacement Scripts

- Access to methadone replacement is felt to be **critical to those struggling with substance dependency**, many of whom are also sleeping rough.
- While many describe **neutral experiences of accessing methadone scripts**, some stories included **frustration at opening times**, not being able to pick up prescriptions, or **negative stories about negotiating dosage.**

"I became homeless from using drugs too much and drink. I fell out with the parents, spent all my money that I sold my house and sort of fucked myself up. I put myself in this position really. […] I pissed it up the wall. I ended up out on the street."
[Haringey resident, sleeping rough]

"I've never been able to find the right support to stop it [substance dependency]. I want to stop it but I can't find the right support."
[Islington resident, with a history of sleeping rough]

"The doctor actually went out of her way to shred my script, and write up a new script for 10ml less. For stability, any doctor knows for a dose review you're only going to go in to see if your dose is good enough or if you need to go up. […] My point is I could have died that weekend, and I was intravenous using at that time as well."
[Camden resident, now housed in hostel, with criminal justice history]

Key Theme – Physical Health

North Central London Integrated Care System

A **wide range of physical health needs** were mentioned, including chronic conditions. For those struggling with poor mental health, **physical health was often neglected**. Experiences with service access were mixed, with **difficulty accessing dental care** especially prevalent and **hospital care generally experienced negatively**. Contact with **GPs was mostly positive**, though **individuals who were rough sleeping were reliant on specialist walk-in surgeries.**

- Interviewees experienced a **wide range of physical health needs,** including **a range of chronic conditions** such as diabetes or epilepsy. Those aware of their chronic condition generally reported adequate self-management, including taking medication. However, for those struggling with substance dependency, sleeping rough, or poor mental health, **physical health needs were often neglected,** leading to **possible underdiagnosis** of chronic conditions, and **interventions only happening during acute crisis.** Multiple interviewees reported **non-specific chronic pain** for which they were struggling to find support.
- The **ability to manage healthcare access for physical needs was highly dependant on the mental health state of an individual.** Those with poor mental health often withdrew, felt overwhelmed by the system, or led lives to address other health needs.
- There is a **gap in provision of dental care,** with most reporting either not having a dentist, or struggling to see one.
- **A&E use was not commonly reported.**

Experiences with GPs

- Some interviewees regularly accessed GP surgeries, while others struggled with access or disengagement.
- Individuals experiencing rough sleeping, and especially those with substance dependencies, were **reliant on specialist walk-in surgeries.** Those living in hostels often accessed medical care through **in-hostel provision.**
- Those that did interact with GPs report **generally positive and supportive experiences,** with GPs being accessible and responsive.
- In addition to supporting health needs, GPs played an **important role in writing letters to secure housing.**

Experiences in Hospitals

- Hospital stays were experienced much more **negatively,** often marked by **confusion, fear, and trauma.**
- **Lack of clarity and communication** about the situation was the main factor making the experience negative.
- **Hospitalization for mental health needs was often described as a prison-like experience,** with strict rules and loss of personal freedom.

““No, I don’t want to go to hospital,” thinking, “That’s all the sick people,” and I said to them, “I’m not sick, I’m not ill, I’m just tired. I’ve been sleeping – I’m homeless.” And then she put the handcuffs on me and then the next thing I wake up in the hospital […] and this Martian dressed up in this like white plastic suit holding like some plastic gun on my head, trying to measure my pandemic situation.”
[Camden resident, now housed in hostel, with criminal justice history]

Key Theme – Barriers to Healthcare Access

North Central London Integrated Care System

A range of **common barriers** to accessing healthcare were mentioned. Barriers commonly included **lack of appointment availability, cost, and struggles with GP registration**. Other barriers, such as **relocation, need for personal advocacy, discrimination, or inability to engage** impacted both use of healthcare services and seeking other support.

Lack of appointment availability	Many struggled with **wait times and appointment availability**. This was **more pronounced in accessing specialist services** (e.g., dental or hospital appointments) than in GP appointments, though reaching GPs on the phone was sometimes difficult.
Cost	The **need to seek private** dental care, or other services such as physiotherapy, was often seen as the **only option to service access**, however at a **prohibitive cost.**
GP registration	Some interviewees were not registered with a GP at the time of the interview. Some struggled with GP registration due to **relocation to a new area, lack of an address, and not having any form of identification.** Others were too disengaged with services or **concerned with other needs** to actively seek out GP registration.
Relocation / Transience	Housing relocation consistently led to **service discontinuity,** including the need to re-register with a GP. Relocation often forced interviewees to **incur travel costs** in order to consistently engage with services. Relocation was most significant in the context of Home Office relocations, not in the context of individuals moving themselves.
Need for personal advocacy	The need for support with personal advocacy was common, with individuals **unable to engage with services or articulate their needs.**
Discrimination	Though uncommon, some felt the **care they received was of lower quality** due to stigma and discrimination. **Delays in appointments or cancellations were sometimes understood as discriminatory** and attributed to their background
Inability to engage	The inability to engage in services was evident, especially among those with mental health needs. Many mentioned **wanting to prioritize health but being unable to do so due to their mental state.**

"Fucking hell, trying to get a GP appointment, phoning them up is ridiculous, the line is always busy."
[Haringey resident, sleeping rough, with criminal justice history & history of sex work]

"At the moment, no, because I have GP, I can go for GP. I didn't tell yet my GP I am homeless because they must do something. Just my GP, they don't know I'm in this situation. If I go to hospital or GP, they cannot take me.
[Enfield resident, sleeping rough]

"Why are you doing this? Is it because I'm a woman of colour? Is it because I'm not English?" For five times, five good times they were changing the appointments and just pushing me back, pushing me."
[Barnet resident, housed in hostel, long term NRPF awaiting status]

Key Theme – Wider Support Needs

North Central London Integrated Care System

A **range of support needs** beyond homelessness and health were identified. These included **financial support, transportation, social integration, digital access, food security, and legal support. Vocational support needs** were also common especially among recent refugees.

"I go to the Northumberland Resource Centre. They do a coffee club every Tuesday, which is quite good if you get things off your chest, gives you a social circle. So trying to address my mental health needs and not being stuck on my own in the flat and that does that.
[Haringey resident, now housed in hostel, with criminal justice history]

"It's basically if you're homeless you go there and you have access for internet, so you can apply for what you need. And plus people inside, they help you."
[Enfield resident, sleeping rough]

"Although a couple of times I got access to food banks and later I just sort of felt a bit [ashamed] standing behind the food bank. […]To be honest most of the food they provide is of the type that makes you fat and heavy, like a lot of rice."
[Barnet resident, housed in hostel, recent asylum applicant]

Financial Support	Almost all interviewees struggled with financial security, **irrespective of their benefit status** or access to Universal Credit. Those with substance dependency struggled with not spending their income on drugs or alcohol, often resorting to **begging.** Others felt they could not support a family on their current income, while others still had limited access to financial support (e.g. those who were NRPF).
Transportation	Many interviewees mentioned struggling **with transport costs,** especially when traveling to access services across London. These services included GP surgeries where they were registered prior to a move, schools, hospital appointments, substance dependency services, and befriending charities.
Social Integration	Struggles with social interaction and isolation were prominent among all groups**. Language and cultural barrier**s, as well as the inability to work, contributed to the isolation of asylum seekers and refugees, while those with experience of rough sleeping or other trauma often faced **trust issues and social avoidance** in **fear of "mixing with the wrong people".**
Digital Access	Digital access commonly posed challenges, especially in the context of **the cost of phone credits** to contact and access services, including GP services. **Libraries were often points of internet access.**
Food security	Many of those interviewed were **reliant on food banks** and/or **begging for food. Inadequate kitchen facilities** in hostels and **substance dependency** could also contribute to poor nutrition.
Legal Support	Many of the interviewees needed some form of legal support to **regularize their immigration status**, **move through the criminal justice and probation systems**, or **recover personal identification**.
Vocational needs	Most interviewees were **not in employment** at the time of interviews, though some were **working with job centres and vocational support.** Despite this, for many their engagement with employment services were **not culminating in paid work.**

Key Theme – Homelessness (1)

North Central London Integrated Care System

A majority of interviewed participants experienced some form of homelessness or housing insecurity, making **experiences of homelessness cut across all other inclusion health groups**. These experiences, however, varied between sleeping rough, being insecurely accommodated by the Home Office, sofa surfing, and moving in and out of hostels or temporary accommodation. **Those sleeping rough experienced the highest degree of vulnerability**, though housing concerns impacted everyone.

- Interviewees could broadly be categorized **in two groups: those going through the asylum process who were accommodated by the Home Office** or were leaving Home Office accommodation, or **those with experiences of sleeping rough.**
- **Constant mobility** across geographies was **especially high among asylum seekers and refugees**, often forced by Home Office relocations. Those with experiences sleeping rough were mobile across addresses, rest places, or hostels, but tended to stay in a smaller geographic area (though not always defined by borough lines).
- **Sofa-surfing was used as stop-gap by both groups,** including staying with friends occupying hostel rooms and using friends' spaces to store belongings or use facilities.

Home Office Accommodation

- Type of Home Office accommodation varied, from self-contained flats to hostel rooms.
- Many reported the **provided accommodation didn't meet their needs**, e.g. shared cooking facilities not accounting for severe food allergies, need for orthopaedic mattresses, or harassment in hostel settings.
- **Constant relocations across geographies made this housing insecure, complicated service access** such as GP registration or schooling, and led to **increased stress.**
- Upon gaining refugee status, interviewees found themselves with **limited time to secure other housing and needing housing support.** Some report sofa surfing with friends during this time, or moving in search for affordable private rents.

"Very awkward because even before [the Home Office tried to move us to] Cardiff they said we should move to, there's another far place, Plymouth […] [Then] they said the only accommodation they've got is in Haringey and they kept on giving me Haringey. I explained to them the postcode from my child's school to Haringey is quite far, it's opposite, but they say it's not [possible to be housed in] Wembley.
[Barnet resident, housed in hostel, long term NRPF awaiting status]

Key Theme – Homelessness (2)

North Central London Integrated Care System

Sleeping Rough

- Sleeping rough was by far the **highest vulnerability** experienced by interviewed participants.
- The main causes of street homelessness were **job loss, substance dependency, inability to find housing after leaving the criminal justice system, and family breakdown or estrangement.**
- Most of those interviewed experienced **long term street homelessness**, **moving between the streets and hostels** for multiple years.
- Sleeping rough led to **constant threats to personal safety** with theft and assault being common. This in turn lead to **trauma and social mistrust.**

Support Moving off the Streets

- For those sleeping rough, **moving into permanent or even temporary accommodation often feels unachievable**.
- **Outreach work by organisations approaching those on the street was crucial** in encouraging engagement with housing services or hostels. **StreetLink** was often mentioned.
- **Complex trauma, poor mental health, and substance dependency** mean that individuals often **need support in staying in accommodation.**
- Those actively seeking help face **barriers such as needing to be known to the council** as homeless, not wanting to part with pets, or fearing being housed alongside individuals with whom they have a history of conflict.

"On the street, I fall asleep anywhere, in a building or a street, wherever I've slept, in Finsbury Park, in the bushes, that is a risk in itself. Because when I'm sleeping I don't know what's going on, especially if I've been up for days blazing and I've gone on a bender, and you go into that comatose sleep, sometimes you don't know what's going on around you."
[Haringey resident, sleeping rough, with criminal justice history & history of sex work]

"Because they feel, I suppose being, a rude way of putting it I know, but I suppose they feel as if they're caged in for some reason. I felt that myself. When I first moved into [a hostel] I felt I couldn't relax. I knew it was safe, psychologically I knew I had to go, and I'd stay out, because I was so used to it. It's like coming off drink. You can get addicted to the street way of life, you can, believe me. Then when I went into the hostel […] psychologically I knew I had somewhere to go back to, but then I would spend maybe one night or two nights, not too long, outside and not go home."
[Camden resident, now in supported accommodation]

"So I got made intentionally homeless. From there, there's nowhere for me to reach, absolutely nowhere. After maybe a couple of years Streetlink [made contact] …
[Haringey resident, sleeping rough]

Key Theme – Engaging with Services (1)

North Central London Integrated Care System

How individuals engaged with services **varied significantly**, ranging from consistent contact to complete disengagement. **VSC organisations play an important role in providing various forms of support**, while **relationships with council services and social services can be more tenuous. Key workers,** when present, often played an important coordination and advocacy role for individuals. Unfortunately, **lack of individualised approaches** and **discrimination** were also present, as were signs of a **lack of coordination across services and geographies.**

- Though certain patterns of engagement were visible, it was **often unclear what services individuals were referring to**, due to their own lack of knowledge about the nature of the service (e.g., is it a council service or VSC organisation).
- **Asylum seekers and recent refugees were often best at navigating services and maintaining constant engagement**, however the individuals we spoke to were all proficient in English and came from higher educational backgrounds, and thus may not reflect the most common experience.
- Individuals struggling with rough sleeping or substance dependency had **mixed interactions with services**, marked by moments of **disengagement and inability to keep appointments**. Those with **no formal identification found it especially difficult to engage.**

Social Services

- **Experiences with social services were mixed.** Some reported social services **successfully linking them to other support** on a path to stability and recovery, while others reported **feeling pushed away or being excessively questioned about eligibility** for services.
- Women often experienced **traumatic separation from children** by social services.

Council Services

- Most were at least **somewhat engaged with council services,** mainly through **housing support.**
- **Experiences with council services were mixed.** Positive experiences included migrant and refugee support, access to temporary accommodation, and general compassion. Others mentioned **difficulty gaining access to council support when sleeping rough, feeling ignored, or the council lacking sufficient services such as mental health support.**

Voluntary & Community Sector

- **Charities and VSC organisations play a key role** as support services and were used extensively. Legal support, financial help, food security, advocacy, support groups, and digital access were all provided by the VCS.

"So I think a lot of times the [council] services are there, but they have huge constrictions of what they can truly offer you. So in that sense I definitely had a problem with housing to begin with."
[Haringey resident, now housed in hostel, with criminal justice history]

Key Theme – Engaging with Services (2)

North Central London Integrated Care System

Key Workers

- Key workers played an important role in **enabling access to services by signposting, advocating, and coordinating care.** Examples include arranging for a computer for a client, or making personal introductions across services.
- It was not always clear from interviews if key workers were assigned through social services, housing services, or the VCS.
- Key workers were also mentioned successfully working with and **collaborating with probation officers.**
- **A few negative experiences with key workers were mentioned**.

"[…] she's a housing support intense worker for Haringey Council outreach. She does a lot of work for homeless whoever, she's a superwoman. She's got everything, she knows how to, even if you're having a shit day, [she] will see and say, "Look it's okay." So you don't feel like you're upsetting someone or if you miss an appointment with her or you stand her up, she's not upset or judgemental, she understands. She says, "Look, I understand."
[Haringey resident, sleeping rough, with criminal justice history & history of sex work]

"Now that I remember the reason why the process didn't work out is because, wait a second, you are from Camden, so what are you doing here? But they showed me it, like this is the place, this address, and I was like, hah, it's going to happen, right…?"
[Camden resident, sleeping rough accessing Islington-based food bank]

Need for Personalization

- It was common for interviewees to mention feeling they **needed a more personalised approach**, with **professionals more attentively listening to their needs** instead of following a set course of actions.
- Many mentioned professionals needed **more understanding and compassion** in how they approached their situations.
- Some also felt **discriminated** against due to their background, especially if they were non-citizens.

Coordination Across Services

- Interviewees consistently felt that **services were not coordinating across geographies**. The need to **re-register with medical services**, **inability to access services** across borough lines, and **not being known to councils** when sleeping rough all contributed to this perception.
- Coordination across services was seen as slightly more successful, **with GPs, VCS and council services liaising to meet individual needs**. **Probation officers** were also consistently mentioned as signposting to and working with other services. Working across services, however, was sometimes **limited to signposting** to other organisations and still **required an individual to re-tell their story.**

They're trying to move you down a very restrictive way without understanding what you're understanding, your comprehension, your participation is restricted by, it feels like you're being dragged if that makes sense. So if the system took a bit more time to have that much more flexibility to tailor it to your ability, as much as it is trying to deliver a service as well that is subscribed by people."
[Haringey resident, now housed in hostel, with criminal justice history]

Key Theme - Gendered Experiences

North Central London Integrated Care System

The experiences and profiles of interviewed men and women were often similar, however a few **distinct female experiences** emerged: **negative interactions with social services leading to child separation, domestic violence, and sex work.** These were more prominent among women who had been sleeping rough and among those with substance dependency, though mentions of them exist among other profiles. These experience underline the need for **female-focused support services.**

Negative interactions with social services and child separation

- Multiple women reported experiencing **traumatic child separation** by social services, often unresolved by the time of the interview.
- One woman recounted being forced to apply for asylum and migration status regularization under **threat of never seeing her child**.
- Another women related feeling that **her child was turned against her** while not in her care.

Yeah, but then the bailiffs came […]. My grandson was screaming in the back of the police car because he saw me and they wouldn't let me near him because I was with him every day in those days. I was sleeping on the floor next to his bed. Because we had a dog and a cat as well and I cleaned up the whole back garden, made it all look nice and stuff because it was a complete mess and I was doing well considering that. And then the bailiffs came, two bailiffs and then four police officers. They packed my grandson in the baby-seat. He was screaming, he burst his vein in his eyes, that's how hard he was screaming.
[Camden resident, housed in hostel, with criminal justice history]

At that stage I had four kids with the same guy. He was constantly battering me and everything. Social services took the kids off us and that was it, no kids anymore. Two years later, I don't know, I had enough and I just left him and I didn't go back near him. So that was hard.
[Islington resident, sleeping rough]

Domestic Violence

- Women also commonly mentioned **domestic violence.**
- The inability to leave violent relationships was often tied to the **threat of homelessness** and not having a place to go.

I'd rather stand on the corner and sell my body, then I'm in control of what I'm smoking […] but this is the thing, where is the support for a sex worker that wants to stop sex working? There's support when you're sex working, where's the support for when you don't want to do it?
[Haringey resident, sleeping rough, with criminal justice history & history of sex work]

Sex Work

- One women engaged in on-street sex work as an **income strategy** tied to needing money due to substance dependency.
- Despite using sex work for personal financial gain, this was **described as traumatic.**
- The interviewee felt there was **inadequate support for women who want to leave sex work**.
- The importance of **supportive female-only spaces and services** was emphasized.

North Central London Integrated Care System

Section 2: Example Inclusion Health Profiles

Example inclusion health profiles

North Central London Integrated Care System

Two distinct profiles emerged based on interviews conducted with residents and service users belonging to one or more inclusion health group: **migrants moving through the asylum system** and **individuals experiencing multiple disadvantage.** Typical journeys and challenges, as well as case studies for these two profiles are provided in this section. An additional **case study based on a single interview with a sex worker is also included**. Unfortunately, **no GRT focused interviews were conducted.**

How were the profiles created?

Distinct profiles were created by grouping qualitative interviews based on similarities of experience, such as migration status, access to public funds, and the circumstances that led to a person being classified as someone belonging to an inclusion health group.

Please note that profiles are aggregates of experiences, and there will always be differences in each person's individual story.

Migrants moving through the asylum system

Includes individuals with **complex migration and legal histories, often including trauma.** May be recent arrivals or long-time UK residents with NRPF due to unregulated immigration status. Group may show varying degrees of English proficiency and familiarity with the UK. Receiving refugee status provides ability for legal employment and access to benefits, however this also presents additional vulnerability as individuals **lose Home Office support and right to temporary housing.**

All interviewed individuals were in contact with the Home Office. Those with NRPF but not aiming to regularize their immigration status may have other challenges and needs.

Individuals experiencing multiple disadvantage

Includes individuals with experiences of **long-term street homelessness and rough sleeping.** Commonly **co-occurring with a history of criminal justice involvement and substance dependency**. Individuals in this group often had competing life priorities and often struggled to address long-term needs, instead **focusing on basic survival.** When asked about priorities, **mental heath, life stability, and managing their substance dependency** were the key struggles individuals hoped to address. Service engagement varied from **consistent, to fragmented support, to complete dissengagment.**

Journey: Migrants Moving Through the Asylum System

North Central London Integrated Care System

Arrival to the UK after often traumatic journeys. Some apply for asylum soon after arrival. Others will live in the UK long-term without any status, but may be supported by family and work in the informal economy. Will experience **difficulty accessing services due to NRPF.**

Application to Home Office for Refugee Status or Naturalization

- Many applications made soon after arrival to the UK.
- Applications can also be **caused by a moment of crisis**, (e.g., job loss) among long-term residents with NRPF.
- Immigration history often complex and **requiring legal support.**

Home Office provides Housing and £40/week for food and other needs.

Constant relocation by the Home Office leads to challenges with:

- Maintaining GP registration
- Educational continuity for children
- Ability to engage in local services / service use across geographies

Receiving Refugee Status seen as a life changing moment and opens up **benefit access.**

Creates **vulnerability during transition** out of asylum seeker system.

Knowledge gap on the needs of long-term residents with NRPF who have not yet applied to the Home Office for status.

The process of receiving status can **last multiple years**.

- Low weekly allowance leads to **financial strain**, making individuals reliant on **food banks and charity.**
- Many express frustration at their **inability to work** due to legal status.
- Many experiencing **high mental health needs** (PTSD, depression)
- **Language and Cultural Barriers** contribute to difficulty in accessing services and sense of social isolation.
- **Family Separation** creates emotional strain.
- High level of **legal support needs** to make asylum claim.

High housing and employment needs once refugee status received:

- Sofa surfing and **housing insecurity common.**
- High level of **vocational support needs,** especially around language.
- Legal challenges around **family reunification** remain.

"When it came to COVID I just said, "No, I'm not going to …" I just called the Home Office and I remember they were shocked and I said, "You know what, I'm going to be your problem so what do I apply for?" **[Barnet resident, housed in hostel, long term NRPF awaiting status]**

"Yeah, because right now I can't work, which is not my kind of personality, I'm not a lazy being, I want to work, I want to make an impact in people's lives." **[Barnet resident, hosed in hostel, long term NRPF awaiting status]**

Strong service engagement with council migrant support, housing and vocational teams, but also VCS organizations providing legal aid, migrant help, and general support around food security, digital access. GP registration and NHS engagement around needs, though with some challenges around relocation and mobility.

And so right away after you get a refugee status, you have to leave within 28 days. So, you know not being able to get a job before you get status and it puts you in a very difficult situation. **[Barnet resident, sofa-surfing with friends, recent refugee]**

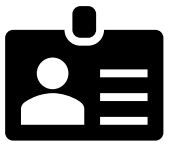
Challenges for: Migrants Moving Through the Asylum System (1)

North Central London Integrated Care System

Longstanding Trauma and Vulnerability

- Many individuals will be arriving in the UK with **traumatic experiences and long journeys.**
- Those who have been in the UK long-term with no status would have experienced **NRPF and limits to the forms of support available for extended periods of time.**
- In two cases, the decision to seek status after long-term UK residency was sparked by a **personal crisis** in which they felt they had no other option. **Job loss** caused by the Covid pandemic, and **insecure housing or sofa surfing** were commonly mentioned.

"So I just want the Home Office to understand me, that's what I want, I want them to work on my case."
[Barnet Resident, housed in hostel, long term NRPF awaiting status]



Migration Status Uncertainty

- **Interactions with the Home Office** were consistently marked by long waiting periods, unclear processes, lack of communication, and a sense of being forgotten. The **need for legal support** was common.
- The **prohibition on legal employment** left individuals feeling a lack of personal worth, and the **desire to work** was common among all interviewees.

Struggle with Daily Expenses

- £40/week allowance from the Home Office is insufficient to cover daily expenses leading to **reliance of food banks and charity.**

Healthcare Needs & Disrupted Healthcare Access

- Health needs in this group include both **mental health needs** (e.g. depression, panic attacks, PTSD) as well as **complex physical needs** (e.g. chronic pain or fibroids).
- **Need for GP re-registration** was common due to high levels of mobility and **Home Office relocation.** However respondents were usually **engaged with their GPs** and taking an active role in their health.
- Many expressed frustration at **poor access and long wait times to specialist or dental care.**

"I haven't yet registered with the GP because still I am getting my prescriptions from the GP in Barnet, my last prescription. […] I have to [re-register] because now it is so far, like I'm not their responsibility now because I'm in a different area and I didn't have time to go to the GP because I was so busy I have several appointments to attend.
[Barnet resident, housed in hostel, long term NRPF awaiting status]

Family Separation and Support

- Family separation creates a constant **mental health strain** and need for **legal support,** even after receiving refugee status.
- Worries about financially supporting family were also evident.

Challenges for:
Migrants Moving Through the Asylum System (2)

North Central London Integrated Care System

Housing Relocation and Adequacy

- Home Office **relocation leads to instability in service use** or school participation. One participant reported being unwilling to re-register with their GP due to fear of loosing their spot on a hospital waitlist.
- Individuals sometimes feel **the housing provided by the Home Office is inappropriate to their needs**, e.g., shared kitchens despite severe food allergies or mattresses contributing to chronic pain).
- Individuals often incur **high transport costs** in an attempt to stay engaged with services.

"I was due for another operation and my GP hadn't come to Barnet yet and there was no way I was going to change my GP to Barnet because I'd already been in the queue for a very long time because I have fibroids, so I reached the top of the list and there was no way if I changed then I start the process all over again. And I couldn't take the chance with that."
[Barnet resident, housed in hostel, long term NRPF awaiting status]

Housing Vulnerability

- Housing during asylum process is of **various degrees of quality**, from self-contained flats to hostels with limited amenities.
- Moment of **receiving refugee status often leads to huge housing vulnerability** as individuals move out of Home Office provided accommodation. Some end up **sofa-surfing** as they struggle to secure other accommodation. Found housing may also be **far from support services** that were being accessed.
- Frequent relocation can lead to fragmented service engagement and lack of stability.

"Your family need food, your family need your support and also every day Job Centre tell me, "You have to work" for example, how can I do that? When I have finished everything [migration paperwork and some vocational training at a security company] and I am still waiting for one year. ."
[Islington resident, recently granted refugee status]

Employment & Vocational Support

- All interviewees expressed **frustration and lack of self-esteem at their inability to work** while waiting for refugee status.
- Once refugee status is received, **vocational support** is often needed to help secure employment, despite often **leaving successful careers** in the countries they fled (e.g., doctor, researcher)

Community Integration

- Limited **language proficiency, cultural barriers, and lack of pre-existing support networks** can lead to social isolation.
- **Meaningfully engagement with the community through volunteering** opportunities was described as incredibly beneficial in supporting mental health and community engagement.

Migrants Moving Through the Asylum System
CASE STUDIES

North Central London Integrated Care System

Suzan, long-time UK resident going through asylum process

BARNET

Suzan came to the UK from Kenya as a student 20 years ago and had a successful career. Her legal status, however, was questioned by the Home Office and she **lost recourse to public funds**. She hired an solicitor to look into her legal situation, but found that she could not provide all the appropriate documentation. This legal process left her **financially insecure.** The Covid-19 pandemic additionally led her to **lose her job,** and ultimately **become homeless**. She has since **applied to the Home Office for her legal status** to be regularized through the asylum process, and is now awaiting a decision.

She currently lives in **a studio with shared kitchen facilities provided by the Home Office**, and **receives £40** per week for other expenses. She is frustrated that she **cannot legally work** and **struggles with daily costs**, and **digital access**. Shared kitchen facilities worry her as she has serious food allergies alongside other **health needs** for which she is waiting for specialist care. Not wanting to lose her place in the queue for certain procedures, she is **still registered with her old GP practice outside of Barnet,** which leads to confusion over medical entitlements (such as a carer after surgery) and the need to incur travel costs to seek medical care. Though she uses NHS services regularly, she has **missed appointments due to relocation** and **struggled to access dental care** despite loosing a tooth. She has also begun experiencing **panic attacks**, though she has not received any support for these.

Suzan is **reliant on the support she gets from various charities**, including **legal aid**, access to food through **food banks,** and a **key worker** who helps signpost her to digital support and other services. Suzan also **tries to volunteer** when her health allows for it to feel useful, often supporting other asylum seekers who are less familiar with the UK. She **hopes she can receive legal status to be able to return to work,** which she hopes would also help with medical access as it would give her the funds to access care privately.

Mohammad, recent refugee from Afghanistan

ISLINGTON

Mohammad had a successful high-status career in Afghanistan, however he **was forced to flee overnight** with his whole family, including infant son, when the Taliban came to power. He is grateful that his immediate family of 5 could come with him, but is still **worried about the family and friends left behind,** including his mother and brother. He applied for asylum upon arrival to the UK and has recently **received refugee status in the UK, giving him the right to work, reside, and claim benefits.**

When he first arrived he was housed alongside other asylum seekers in a hostel, **but had to move out once refugee status was granted.** He has since **found a home in the private rental sector** with the help of the Islington Council Housing team.

He is incredibly grateful to the Islington Council **refugee support team, and their caseworker,** who have helped his family along the way with **school registration, universal credit applications, and navigating the NHS**. However, he still feels he struggles with stability. Despite working with a job coach, he is **struggling to secure employment.** He has accessed some courses through a collaboration between Islington and a employment charity, but despite completing these he has not been offered work. He is **worried he will not be able to support his family as the breadwinner,** especially given rising costs.

Mohammad also **struggles to access the healthcare he needs**. Though he has **registered with a GP**, he feels that care is insufficient. He has **not managed to register with a dentist** despite tooth pain, and feels wait lists for other services are unreasonably long. He also needs to regularly measure his blood pressure, but does not have a pressure cuff, so has **resorted to regularly going to A&E or urgent care to have his blood pressure monitored.**

Journey: Individuals Experiencing Multiple Disadvantage

North Central London Integrated Care System

Possible traumatic pasts including **abuse, adverse childhood experiences, and mental illness**. Interviewees often refer to their circumstances as ongoing for many years with no singular moment of becoming vulnerable. Sometimes a **destabilizing event,** such as a mental health crisis, can be the cause of **job loss, homelessness, and loss of support networks.**

"It started from my teenage days really. […] I was [pause], before me was my brother who died of cot death. I came along, my parents wrapped me up in cotton wool when I was growing up. I rebelled, ended up rebelling, in and out of care."
[Haringey resident, sleeping rough, with criminal justice history & history of sex work]

Homelessness & Sleeping Rough

- Most **fluctuate in-and-out of street homelessness**, with occasional sofa-surfing or stays in temporary accommodation.
- **Begging** as the primary form of income, though **petty theft** is also mentioned. Some, especially women, may **turn to sex work**.

Most will struggle with destabilizing substance dependency. Many use alcohol or drugs to self-medicate. **Addressing substance misuse seen as priority.**

- **Unstable life sleeping rough** leads to an inability to focus on long-term support, including maintaining medical, probation, and other appointments. The **sole focus is on meeting basic needs**, including sometimes sustaining substance dependency.
- **Personal safety on the street is a huge concern** with instances of theft, assault, stabbings, and even murder common.

Criminal justice interactions common, usually occurring over **drug possession or theft**. In many instances individuals are not sure what their arrests are for.

"No, they kept on telling us we needed to sort out housing, but I was struggling to sort it out, I was struggling with addiction and things like that, I missed one appointment, and they only gave me one chance."
[Enfield resident in temp. housing, with criminal justice history]

"No I never tried [to access additional support]. I say every time I try to survive all by myself, but I never have help."
[Haringey resident, sleeping rough, with criminal justice history]

Upon release many lack support and revert back to homelessness and substance dependency.

Creates vulnerability during transition out of criminal justice system. Many maintain interaction with probation officers but this is often insufficient. One interview mentions loosing a housing contract while in prison, leading to rent dept.

For some, l**ack of formal documentation** becomes a real barrier to work, rentals, **and ability to confirm recourse to public funds**. It also leaves individuals **without access to a bank account.**

Fragmented Service Engagement

- Engaged with services on inconsistent basis, including probation services, VCS, housing support, healthcare services or substance dependency services. Some will remain entirely unengaged.
- Lack of recognition from services poses a real barrier.
- Often stay within a smaller geographic area, though will move across borough lines.

Challenges for: Individuals Experiencing Multiple Disadvantage (1)

North Central London Integrated Care System

Substance Dependency & Mental Health

- In addition to often **severe substance dependency,** many interviews mentioned **severe mental health needs**. While some interviewees were receiving support for these needs, contact with services was sporadic. Additionally, a few reported they **received medication but no holistic support or therapy.**
- The combination of poor mental health and substance dependency leads to **deeply unstable lives**, in which individuals **focus only on their basic needs,** including maintaining dependency.
- **Stabilizing mental health and substance dependency was the main priority for individuals in this group.**

Personal Safety

- Individuals who experienced sleeping rough commonly speak of **threats to personal safety on the street.** This includes **theft, assault, stabbings, and murder.** Many develop **trust issues, PTSD, and heightened anxiety** which lingers even after they are no longer rough sleeping.

"Yeah, well you can't. Here on the streets you can't trust people. What they say everybody is just looking to kill us."
[Haringey resident, sleeping rough, with criminal justice history]

Social Distrust

- Many interviewees developed **fear and distrust in social groups** and social situations based on past experiences This leads to a need for support in **reintegrating into social settings.**

Housing and Sleeping Rough

- All individuals in this group experienced not only housing insecurity, but **rough sleeping.**
- Many **struggle to move into supported accommodation** or accept other housing support due to feelings of being trapped, continuous struggles with dependency, or difficulty adhering to rules in hostels.

"Because they feel, I suppose being, a rude way of putting it I know, but I suppose they feel as if they're caged in for some reason. I felt that myself. When I first moved into [supported accommodation] I felt I couldn't relax. I knew it was safe, psychologically I knew I had to go, and I'd stay out, because I was so used to it. It's like coming off drink. You can get addicted to the street way of life, you can, believe me. Then when I went into the hostel […] psychologically I knew I had somewhere to go back to, but then I would spend maybe one night or two nights, not too long, outside and not go home. But I thought, "Hang on, if I do this too often I'm going to lose my room."
[Camden Resident, now in supported accommodation]

"Then I got into a situation that wasn't my fault. I was witness to a murder, and I went to court and the two boys got released, they didn't get charged with the murder. Then two years after that, one of them found me in Charing Cross sleeping rough and kicked lumps out of me and put me in hospital for two weeks."
[Islington resident, sleeping rough]

Challenges for:
Individuals Experiencing Multiple Disadvantage (2)

North Central London Integrated Care System

Well for my substance misuse I told you they had me on a script of methadone, so they were quite good. I was having weekly appointments when I was on tag, so that was quite good. For my housing I wasn't really getting a lot of support with my housing, you kind of have to do it off your own back. But you've got no time because you've got drug issues, having a whole day, you don't have a whole day to yourself when you've got a drug addiction problem, so it's hard to address these things.
[Enfield resident, sleeping rough, with criminal justice history]

Transition out of Criminal Justice

- The moment of transition out of the criminal justice system upon release left many in a place of **extreme vulnerability,** struggling with **housing insecurity, joblessness, continued substance dependency**, and **few support networks.**
- Relationships with **probation officers** were generally described in **positive and supportive** terms, and, when present, could lend themselves to finding accommodation or triangulating with key workers.
- Probation officer support, however, was **often insufficient** in securing long-term stability.

"[After experiencing a conflict with a housing support service:] But I was still on probation, my probation officer backed me, [the worker] from Dual Diagnosis backed me, he works with mental health and Dual Diagnosis […] he's an absolute superstar. They were aware of fucking everything, Probation, […] I had everyone backing me…"
[Haringey resident, sleeping rough, with criminal justice history]

Methadone Access

- **Receiving methadone scripts** was a common intervention for managing substance dependency, and many interviewers recounted where and how they got scripts.
- Many recounted getting a methadone script in **matter-of-fact** terms, though some recounted **struggling with picking up scripts** around opening hours or **disagreeing with GPs on the correct dosage.**

"[Outreach worker] agreed to fax my prescription over to Boots, but what she didn't tell me is she was going to reduce my prescription. That was the thing. I was due to go in for a dose review to see if I'd go up, or if I'm comfortable on what I'm on. Now, the only way you'd go down or stay where you are, is if you're looking to opt to go onto Subutex or something. But basically, I told her I wasn't able to make it in, I would want to keep at the same dose, and she actually shredded that script and written me out a new one for 10ml less. So in actual fact, it put me back for stabilisation if you like."
[Camden resident, sleeping rough, with criminal justice history]

Other Healthcare Needs

- Other, more **complex healthcare needs** were mentioned in passing in some interviews, including diabetes and epilepsy, however the all-consuming nature of substance dependency left **many of these needs unaddressed and likely poorly managed.**
- Multiple interviewees mentioned **wanting to prioritize health, but not having the mental capacity to do so.**

Challenges for: Individuals Experiencing Multiple Disadvantage (4)

North Central London Integrated Care System

Lack of Support Networks & Estrangement

- **Estrangement from family** and a complete **lack of support networks** was common among this group. Some also reported high levels of **social mistrust** as well as **not having any friends.**

> *"Yeah, I feel like everybody try and abuse me you know. Like everybody, all my friends, my ex-lady, my family, I feel like everybody like they give/take it. If they need something they fuck you up. I don't care about people. I don't care about me. Maybe because of that. I don't want to ask people for help because I know people don't give a shit about you."*
> **[Haringey resident, sleeping rough]**

Lack of Formal Identification

- Lack of ID, passport, or other forms of identification was **prohibitive to taking steps to stabilize daily life**. This included:
  - An inability to rent or secure employment
  - An inability to prove access to public funds or immigration status for migrants.
  - An inability to travel to home country
  - An inability to register with GP (due to lack of address)
- The lack of ID also left individuals feeling isolated from potential services.

> *If I access benefit, OK, I know after that he's going to give me free, so it's OK. But just I need to access the benefit things and that's it. That's what is so difficult for me now, because again I need address, passport, ID. This is how, money, time. Time I have it, but I don't have money, address and all this. I have to take from, even I don't know where to try stuff first.*
> **[Enfield resident, sleeping rough, with criminal justice history]**

Lack of Recognition by Services

- The **need to be "known to a council"** before aid is provided has meant that even those who have tried to engage with services have been met with rejections or have been directed back to a council that does not have the housing facilities to meet a person's need.
- Individuals have also been **rejected by NHS services** due to lack of address or inability to prove recourse to public funds.

> *No, and also you've got to be referred to by the council, but you can't just ring the council and say, "I'm homeless," because straightaway they'll say, "Go back to the council that you're most known to." […] Yeah, or you have to find like people local that will ring up and go, "There's a man here living on a bench," and if you get enough people to ring up then the council will come down and see you. But if you don't know no one, you know, you can't just say to people, "Oh can you ring Haringey council for me and tell them I'm living on the street."*
> **[Haringey resident, sleeping rough]**

Individuals Experiencing Multiple Disadvantage
CASE STUDIES

North Central London Integrated Care System

Mike, sleeping rough after exit from criminal justice system

CAMDEN

Mike came to London from Manchester and has a history of both serious **mental health needs** (schizophrenia) and **epilepsy**. He has also struggled with **substance dependency,** and has been in-and-out of prison for multiple years. **Upon release from prison he often finds himself street homeless** and **lacking any support for his physical and mental health.**

Most recently he was **approached while rough sleeping** by a support organisation and moved into **supported accommodation** in Camden, where he feels much better due to helpful staff and provision of food. It is also through this supported accommodation that he has been **directed to a psychologist, psychiatrist, and some medical support**. However, he struggles to stay in supported accommodation and has **moved hostels frequently.**

Mike **continues to struggle with substance dependency** and is **waiting for detox** and rehab services; he expresses some **frustration at the amount of time he's needed to wait.** His **physical health is also deteriorating** due to alcohol and other drugs, but he finds it difficult to take care of his physical health while still dependant on substances. Due to his experiences sleeping rough, he has **PTSD and a lot of social anxiety**, making group therapy such as AA meetings incredibly difficult. He finds **that people treat him differently or judge him due to his circumstances**, making in **especially difficult to engage.**

"Sometimes, yeah, sometimes people look at you different and you can just tell they're judging. Some people shouldn't be in a job what they're in because their attitude and things like that. Not everybody – most of them are all right. It's just there's a bad few […] they look down on you and stuff like that."

"I feel everywhere is closed. They tell me, "Hi, you need ID". I don't have address, "OK, you need address", bye-bye. You need […]to make it, I don't have it, so how I …? Even they told me, "How I can help you?"

Andrei, Romanian man disengaged from all services

ENFIELD

Andrei **arrived to the UK from Romania** some time ago, and has since **lost his job and house**. His relationship has also deteriorated and he is **currently alone rough sleeping** on the streets of London. He suffers from **severe depression and has engaged in self-harm** but is not receiving any support for this. In the past he received some medication but **could no longer afford the £12 fee he was charged per box.**

Given Romania's EU status, it is likely Andrei entered the UK on a EU passport and he could **apply for pre-settled or settled status** and access benefits such as universal credit. However, Andrei has **no passport, ID, or formal documentation** and has thus struggled with accessing any support. He had a GP in the past, but has since struggled with access because of lack of address and ID. The lack of ID has also left him without a bank account and he is worried he will not be able to rent a flat. He uses the words **"handcuffed" and "gridlocked" to describe his situation.**

Andrei has attempted to apply for support using the **internet connection at his local library.** He has also **tried to contact his council's housing services, however after making an application he has never heard back.** He currently is not in touch with any services and expresses bitterness that UK citizens and those with drug dependencies seem to get more support.

Individuals Experiencing Multiple Disadvantage
CASE STUDY which includes sex work

North Central London Integrated Care System

Sarah, experiencing multiple disadvantage with a history of sex work

HARINGEY

Sarah rebelled against her parents in her teenage years and has since been **dependant on alcohol and other drugs,** as well as experiencing **domestic violence from male partners**, including her daughter's father. She has been **separated from her daughter** who now lives with extended family. She has **experience with the criminal justice system** and has spent time in prison for multiple drug abuses. She has also spent time in prison abroad for fraud. Time in prison led Sarah to lose her property, making her **street homeless** for multiple years. Sarah feels that **coming out of jail put her in a very vulnerable place** with no support to address housing insecurity, substance dependency, or mental health needs.

Sarah now **lives in supported accommodation** after being **approached by StreetLink** and helped into accessing homelessness services. Before that she sometimes slept in a church charity on the floor, but she disliked this as there were too many men sharing the space. She is now also being supported by her **probation officer and key worker** who coordinate around her care. She **uses a methadone replacement service** and **walk-in GP surgery;** however, she also feels that in the past she has experienced poor medical care, for example when she was prescribed morphine despite her substance dependency.

Sarah has also **engaged in on-street sex work** to make money in order to buy alcohol and drugs. While she describes this as **a choice she made to be in control of her own finances**, she also mentions this generating **trauma and leading to PTSD**. **Violent experiences while rough sleeping**, including witnessing a murder, have also contributed to poor mental health. Because of these experiences she **values women-only spaces and services**, including ones that help with social integration by providing a casual social environment.

Sarah feels that de-stigmatization of experiences like hers are incredibly important, and hopes that in the future, the system will become more compassionate and focused on individual needs.

"Because you know in jail there's no security, nowhere to live, nowhere to find yourself because remember you're coming out of jail, you're being forced to come off methadone, you're being forced to come off ... You've got emotions that you forgot you even had in jail, they all start coming back again because you're not supressed anymore. So when you come out you're just like, "Hey wow, what's going on, let's go and have a smoke quick," because you don't know no better."

"The [professionals] need to be all put in a room or you know, like a virtual reality, put them in one of them on a day I live in my life for the last 30 years, a GP or a certain key professional, put them in a virtual reality room of whatever I've done with my life, then they will have understanding of what I'm trying to say to you. They think, "You chose that." We might have chose that, we don't know where we're coming from, we don't know why we chose that life. You know like Star Trek where you could press the button and it goes into any scenario you want to go into, virtual reality, make them see what it is. Because technology that is easy. […] Yeah, put them in my world, make a day of a female who's a prostitute and a drug addict and what they go through, sleeping rough at night time in the bushes, you know, plant that scene as a dramatic drama scene, put that down. […] I really should hope so because if it doesn't [change perceptions] then there's no hope for us. There is no hope for the system. If that doesn't change your perception of trying to do something like that with someone, it doesn't make sense because there's no hope."

North Central London Integrated Care System

Section 3: Stakeholder and Staff Findings - Understanding inclusion health groups

Understanding & Awareness of IHGs

North Central London Integrated Care System

In the frontline survey, there were no significant differences between whether 'understanding the needs of IHGs' was working well (21%) vs. being a main challenge (25%). However, free text comments and stakeholder interviews suggest that there have been improvements in understanding, especially around homelessness, but this is not consistent across inclusion health groups, service areas or boroughs. For example, stakeholders working in Enfield argued that raising awareness of IHGs was a key priority for them, with different boroughs being at different stages. A lack of understanding was viewed as directly impacting care and support. Staff identified specific needs and barriers faced by each group, which is presented in the accessing services section.

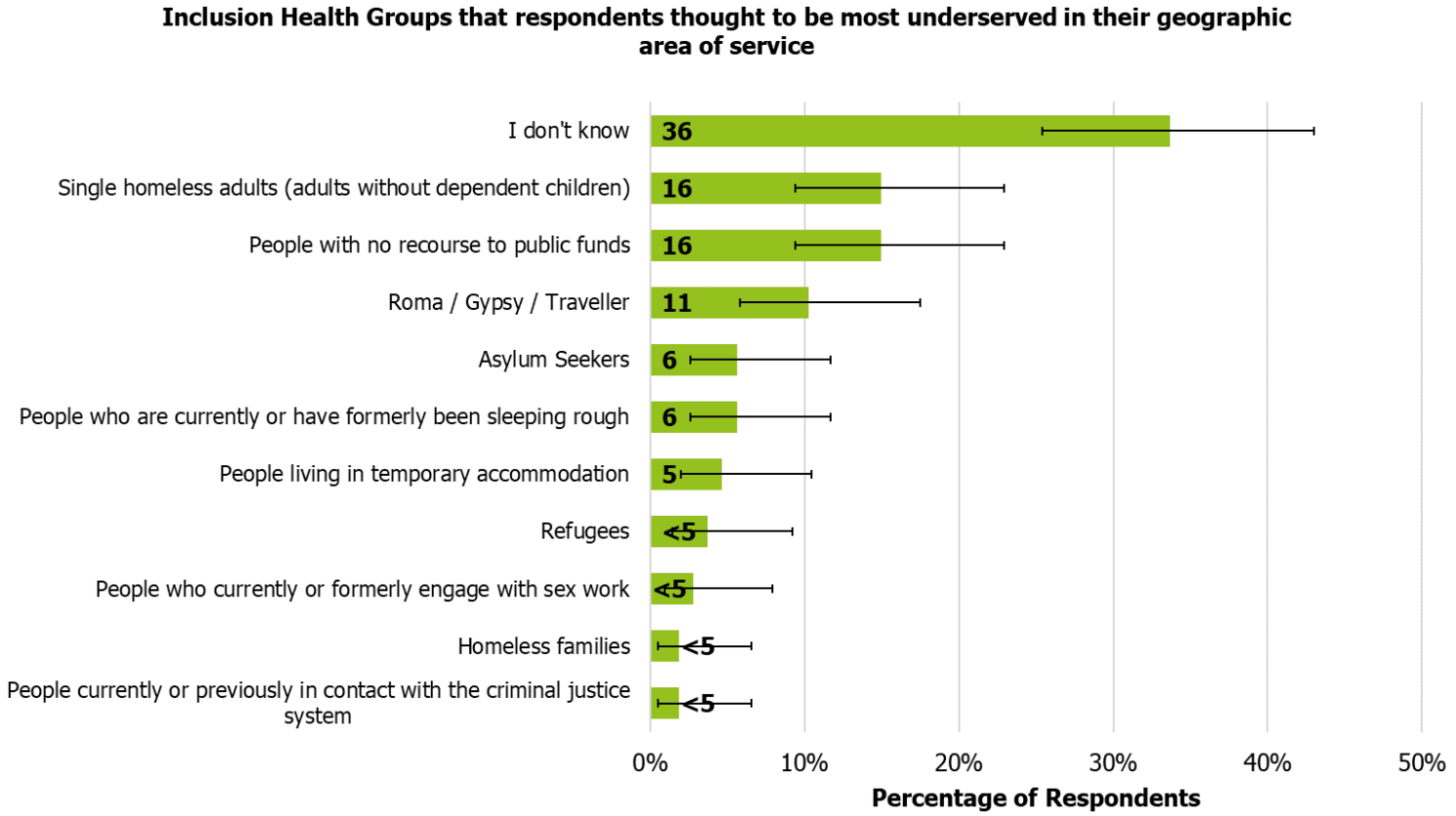
*"I think the needs of inclusion health groups are **well understood** and that a lot of work has been done with service users to seek their views. I think a shift to an outreach model is beginning, and services like Routes off the Street are great, but should be encouraged much much more - maybe services with a lot of inclusion health groups should be contractually obliged to offer outreach to those with highest need."* (Service manager in a specialist inclusion health service in Camden - Frontline staff survey)

*"We do struggle with cross sector communication, I think **not everyone understands the needs** of our client group. They can be seen as 'difficult' or challenging because people in other services don't have adequate training or exposure to them."* (Homeless housing service in Islington - Frontline staff survey)

*"I think there are **still a lot of services that aren't tailored to individuals' needs**, e.g. mental health services rejecting people with high need due to substance use. Also, I think mandatory training should be introduced similar to the Psychologically Informed Environment training whereby healthcare staff (GPs, hospitals, etc.) are trained on how to interact with vulnerable groups. I have heard lots of stories of health staff actively making things worse (commenting on homeless people's clothing or lateness, ending up in arguments, etc.) The whole system needs to be mindful of inclusion health groups and how to ensure they are well-supported and engaged in care."* (Service manager in a specialist inclusion health service in Camden - Frontline staff survey)

Views on underserved groups

North Central London Integrated Care System



Note: Respondents who did not answer this question have been excluded.
Source: Frontline Staff Survey, 2022

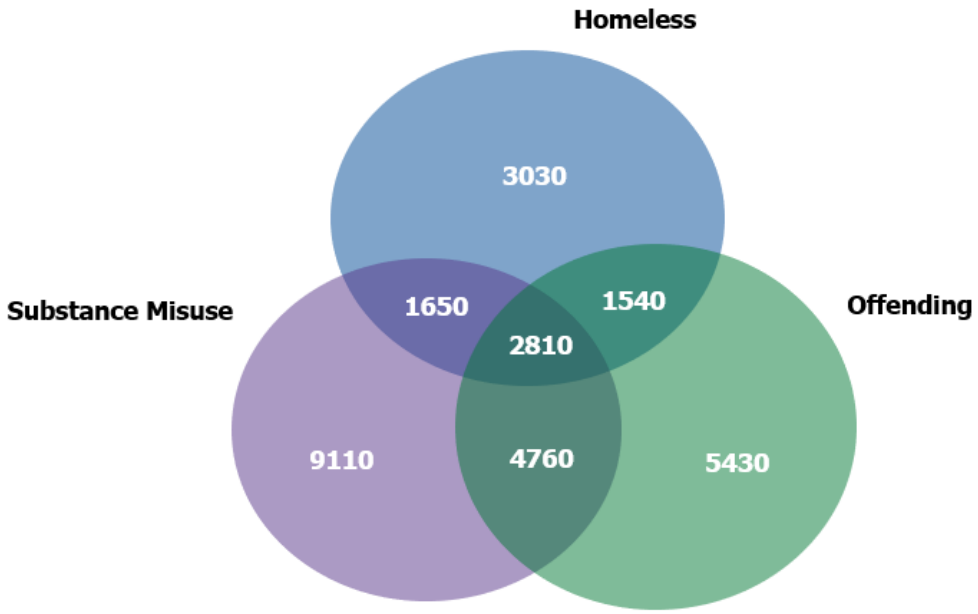
- **34% of respondents indicated they did not know** which inclusion health groups were the most underserved in their area.
- Single homeless adults and NRPF individuals were most frequently viewed (15%) as underserved, followed by GRT communities (10%).
- In free text comments, respondents commented that many of the groups overlap and that additional individual characteristics often mean residents are underserved. For example, women, single adults, ethnic minorities, people with disabilities, individuals with mental health issues and those with substance use issues.

"Street homeless women, especially pregnant women seem to slip through the net a lot" (Specialist Health Visitor in Camden -Frontline staff survey)

Understanding multiple disadvantage

North Central London Integrated Care System

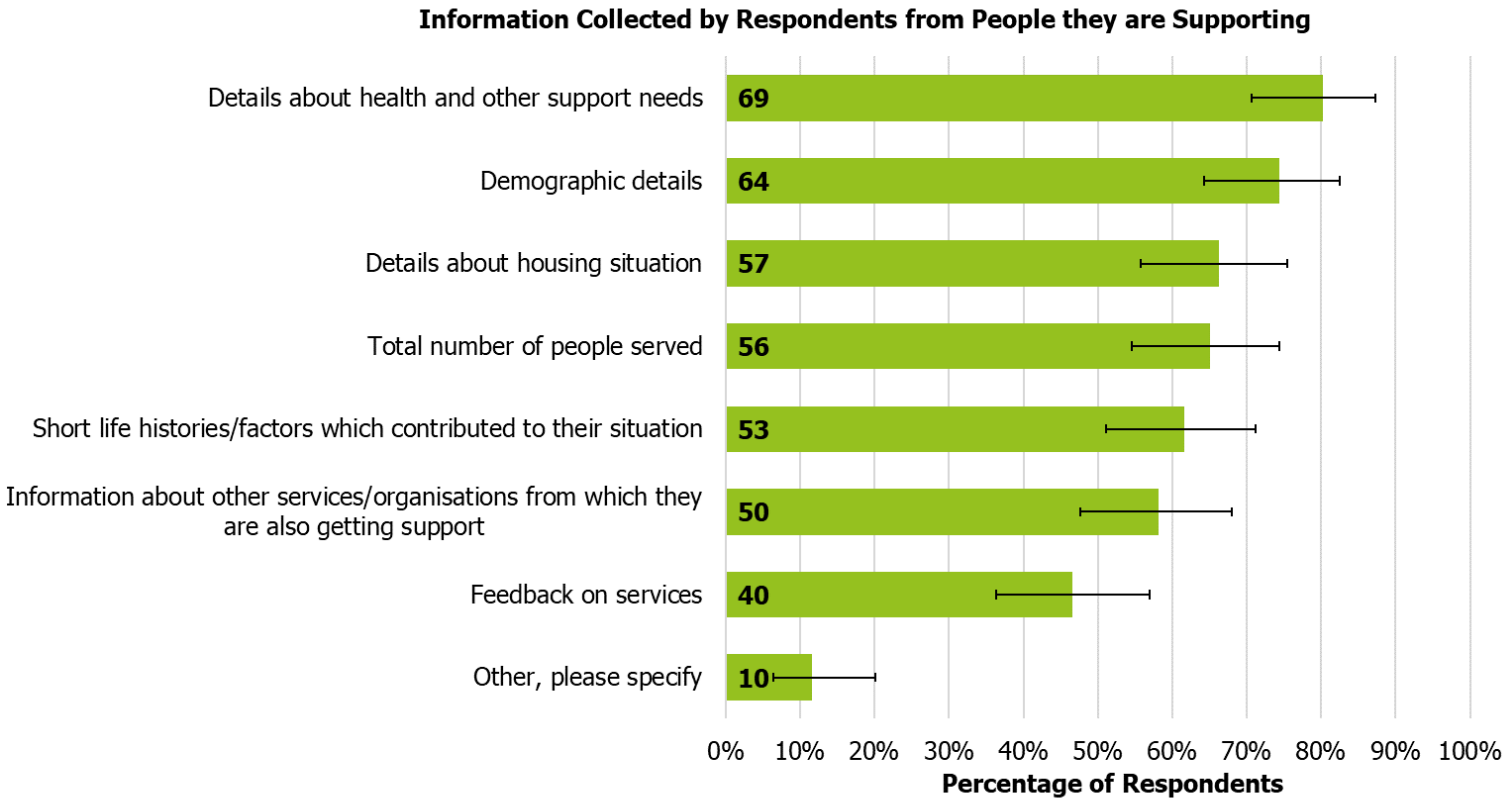
Overlaps between facets of multiple disadvantage in NCL



Note: This venn diagram is based off region-adjusted borough estimates derived from methodology used in the Lankelly and Chase 2015 report (Appendix A).

- People who experience multiple disadvantage are often characterised as experiencing a combination of problems including homelessness, substance misuse, contact with the criminal justice system and mental ill health.
- In 2015, Lankelly and Chase estimated that nationally approximately 58,000 people face problems of homelessness, substance misuse and offending in any one year, showcasing that there is huge overlap amongst populations.
- Based on this methodology, we estimated that 2,810 individuals in NCL experience homelessness, substance use and have had contact with the criminal justice system, demonstrating that there is also a large overlap in the region.
- The rapid evidence review showed that these individuals tend to fall through the gaps between services and systems.
- Interviews with stakeholders and frontline staff suggest that this is also the case in NCL, and there is a lack of consistent understanding across the system of how to support people who experience multiple disadvantage.
- To our knowledge, there is a not a standard estimation method to quantify overlaps that include the additional 3 inclusion health groups covered in this report (GRT, sex workers, vulnerable migrants).
- See Appendix A for Borough estimates of SMD.

Information collected by services

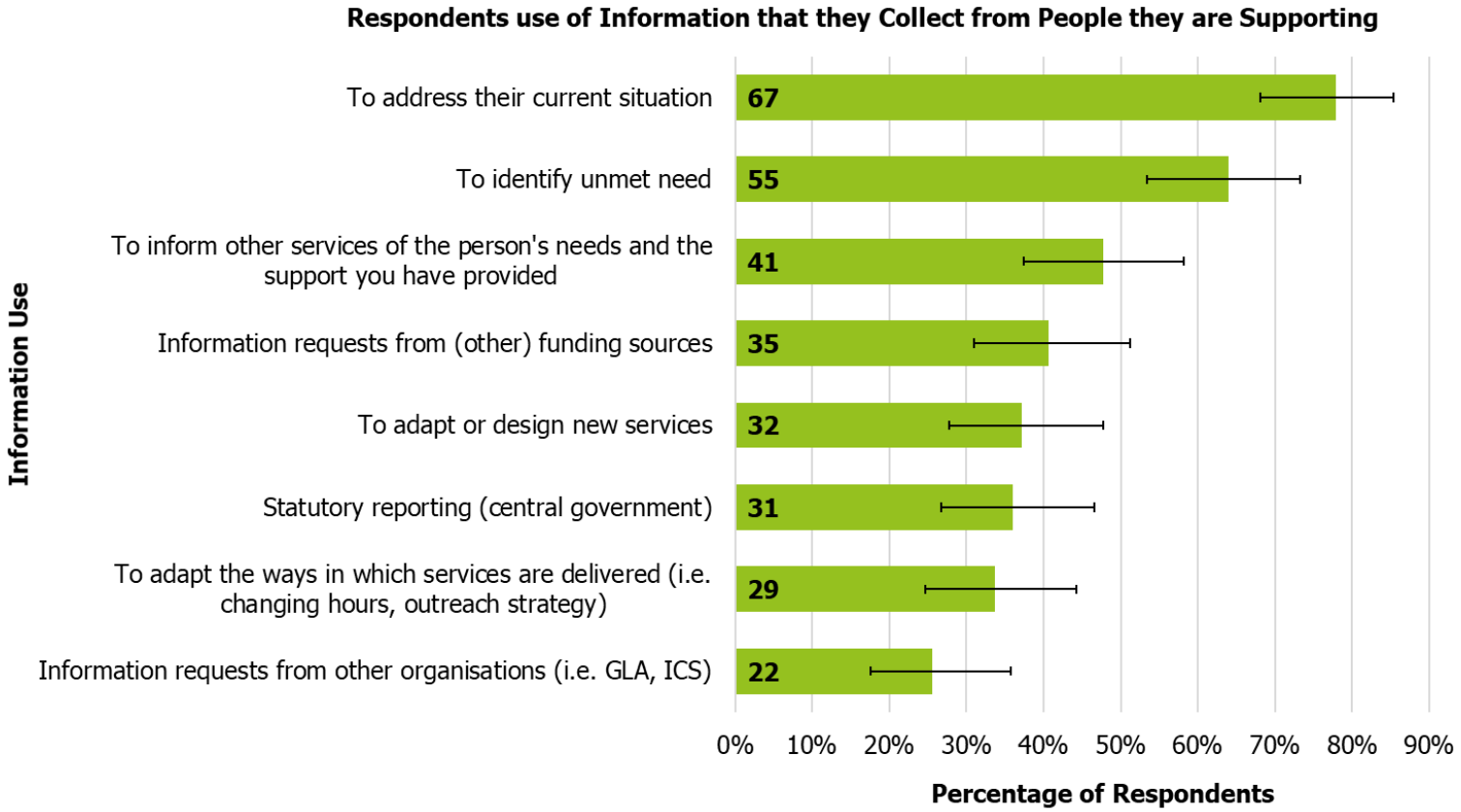


- Services consistently collect a range of different types of information about their clients.
- The most common forms of information collected are:
  - Details about health and other support needs (80%)
  - Demographic details (74%)
  - Details about their housing situation (66%)
- Less than half of respondents (47%) collect feedback on services.

Notes: Respondents who did not answer this question have been excluded.
Source: Frontline Staff Survey, 2022

Ways data is used by services

North Central London Integrated Care System



- Information collected by services is primarily used to address an individual's current situation (78%) or to identify unmet need (54%).
- Only 34% of respondents said that they use information about service users to adapt how services are delivered.

Notes: Respondents who didn't answer this question have been excluded
Source: Frontline Staff Survey, 2022

Views on using data and evidence

North Central London Integrated Care System

The use of data and evidence was valued by many stakeholders but it was felt by some that we should be using data better and become more ‘data positive’. There was general consensus that data should be collected at local borough level, collated and fed back up to NCL level.

1) Gathering data

- Stakeholders recognised that data and evidence is very important for funding, but argued that for socially excluded groups, who tend not to show up in routine statistics, or where something is not easy to evidence, there needs to be a bit of a ‘leap of faith’. They felt those working on the ground have a deep understanding of their clients and communities and should be trusted more.
- There needs to be a better understanding of how data is collected across different boroughs.
- The Fracture Risk Assessment Tool (FRAX) was viewed by one stakeholder as a tool which should be utilised more.
- The HIPA form produced in UCH is a good example of the range of specific health outcomes data that can be collected. A shorter form is being developed, which can be used by primary care. Initiatives like this will help develop the evidence base.

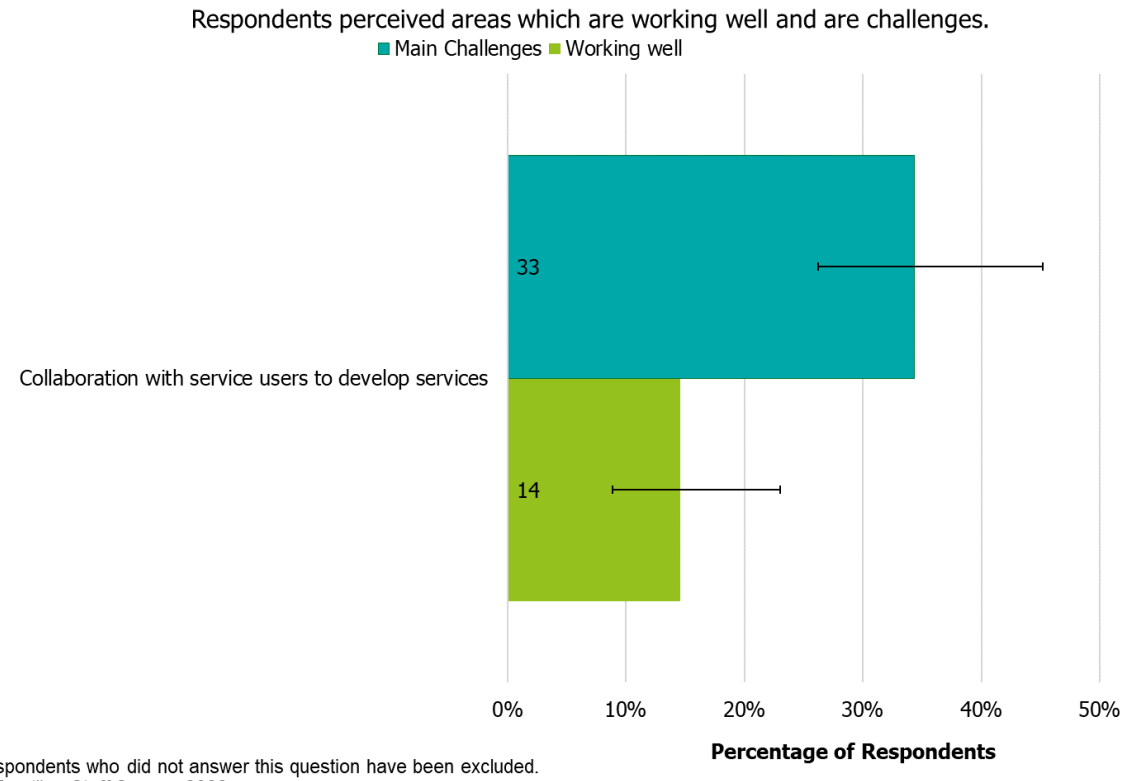
2) Sharing data

- There is currently poor understanding of what data can be shared, in particular with VCS who are commissioned to do assertive outreach, for example. One stakeholder argued that they are a commissioned service so should have parity.

3) Interpreting and using data

- Stakeholders argued that we need to make better use of technology and think about how to use data in a more automated way to support clinicians in their daily work. One stakeholder talked about how useful dashboards are; it was not clear whether this was in reference to NCL HealtheIntent platform.

Involving people with lived experience



Note: Respondents who did not answer this question have been excluded.
Source: Frontline Staff Survey, 2022

- Significantly more respondents thought collaboration with service users to develop services was a main challenge rather than area that was working well (34% vs 15%).
- All stakeholders agreed that it is important to involve people with lived experience in service design and development. However, it was noted that this can be difficult as most frontline staff are already stretched to capacity. To be able to involve people with lived experience in a non-tokenistic way, they argued that it is important that this engagement is someone's main programme of work.
- Staff also discussed the need to ensure, where possible, that people with lived experience are representative, and that there is support for individuals where involvement in service delivery might be re-traumatising.

North Central London Integrated Care System

Section 3: Stakeholder and Staff Findings - Accessing services

Final report – last updated 30/03/2023

Access and experience of services

North Central London Integrated Care System

In general, stakeholders and frontline staff reported that access to services and IHG experiences of services **needs improvement**. They spoke about **access to individual services as well navigating multiple different services**. Most stakeholders argued that it was important to have a **combination of specialist services whilst also improving access to mainstream services**. Stakeholders reported that access to dentistry services was non-existent. Other services which needed improvement include mental health, primary care, hospital discharge and intermediary care.

Example from frontline staff who explains the access difficulties as IHGs navigate the system:
"[IHGs] struggle to book or attend phone appointments, which are usually offered by GPs, due to lack of phone or credit or patience to sit and wait. Often they need support from one of us to attend and rely on our advocacy - but we struggle to get in-person appointments to facilitate this and are often told only one health issue can be discussed at a time. Letters might never reach them due to rough sleeping or hostel staff not giving out post. [There is a] lack of walk in services. Although I'm aware a new outreach GP service is starting up, this is only 1 half day a week, I believe. When our clients are in hospital we have very spotty experiences - they are forced to access A&E more often than general population and yet struggle to sit and wait quietly for their turn. No adjustments are made for them (I understand how busy A&E staff are and how hard they work) but clients have been told if they leave the waiting room they won't be seen – [waiting is] not possible for them to do as they may have substance/alcohol needs, learning disabilities or personality disorders that make being in a crowded, stressful place very traumatic. Staff often can't find them if they are admitted when we aren't present - either we aren't allowed to see them or we don't get replies from wards until they have left. The client often discharges themselves against medical advice because they need support around their substance use (sometimes a prescriber is available for ORT such as methadone, but no support is available for clients who are alcohol dependent and if they admitted over the weekend, there may not be someone there who can prescribe methadone etc). Having said that, sometimes we have wonderful medical staff who do everything they can!" (Specialist Homeless Service in Islington - Frontline staff survey)

Barriers & facilitators to access

North Central London Integrated Care System

In the rapid evidence review, we identified barriers and facilitators to accessing healthcare for multiple or all inclusion health groups. All of those factors were mentioned or expanded upon in our engagement with key stakeholders and frontline staff.

1. Fear of and experience of stigma and discrimination

- Stakeholders and frontline staff reported that many IHGs will not engage with services, as they are worried about experiencing discrimination. They also reported that stigmatising attitudes and negative assumptions about IHGs are prevalent amongst professionals (i.e. difficult behaviour, 'smelling' , too difficult to deal with, dangerous etc.).
- In the rapid evidence review and our data collection, we found that it was vital that staff across specialist and non-specialist inclusion health services were trained to support inclusion health groups; for example, around trauma informed care principles.

2. Lack of identification or proof of permanent address

- Staff reported that a lack of permanent address still prevents individuals from accessing care, especially mainstream primary care.

3. Need for holistic and trauma informed service provision

- Staff noted the need for holistic services which allow staff to spend time asking the 'right' questions and building trust with individuals who may have little trust for statutory services. Continuity of support, where possible, to build trust with the service user would also be helpful.
- They recommended an opportunistic approach; if an individual comes into a GP practice, take the opportunity to perform a range of health checks.

4. Limited integration of health and social care services, particularly for those facing multiple disadvantage

5. Fixed appointment times

6. Language barriers, literacy levels and digital first services

Accessing services – specific groups (1)

North Central London Integrated Care System

Stakeholders and frontline staff made comments around access issues which were particularly acute for specific inclusion health groups and unique needs that require tailored services.

NRPF/vulnerable migrants

- Often have different health systems in their country of birth, as well as different health seeking behaviours, which impacts how individuals access services. For example, registering for a GP when you are not sick might seem unnecessary for certain groups if this is not the norm in their birth country.
- Language barriers & digital exclusion; often a need for interpretation but hard to access.
- Lack of trust of authorities.
- Very limited access to services for NRPF, lack of clarity among staff about what support they can offer, what people are entitled to.
- Uncertain immigration status and waiting for family reunification impacting wellbeing.
- Increased risk of rough sleeping and individuals who have not applied for settled status after Brexit.

"[There is a] tendency to not trust authorities and statutory bodies including NHS, hence [migrants] may be unlikely to seek health when needed. Also, the language and cultural differences may act as barriers in seeking help. I used to volunteer in Chinese community charity organisations and service users told me about their experiences and how (1) they were not aware of the right to interpreters (2) even if [they] aware, [they] worried about confidentiality, and (3) felt discriminated and not understood by healthcare professionals at times." (Psychologist in a community health service in Camden - Frontline staff survey)

People in contact with criminal justice system

- Difficult to arrange social care support or specialist housing for people who are labelled as having high risk behaviours, such as arson.
- Newly released prisoners falling through cracks when waiting for health records to be transferred from prison to non-prison healthcare services.

Accessing services – specific groups (2)

North Central London Integrated Care System

Sex workers

- Lack of knowledge around the different types of sex work (i.e. commercial sex work vs. survival sex work), which impacts an individual's needs and how they access services.
- Very transient population; example of a sexual health clinic whereby most people attending lived outside of London but were coming into London for work.
- Often hidden, high level of distrust of authorities especially the police or social care involvement; therefore, a need for outreach.
- Lots of judgement of people who engage in sex work; clients preferring specialist clinics for this reason.
- Lack of access to support around gender specific issues, such as menopause and cervical screening.
- Income affected because of Covid-19, which has had a knock on effect on health including mental health.
- Stakeholders argued that they feel that sex workers are often forgotten about as a commissioning priority.

"I have had a number of sex workers comment that they prefer dedicated sex worker clinics as they are more likely to understand their needs and are less judgemental. Outreach is vital in helping to screen high risk groups in the community and building trust so they feel more comfortable coming to clinics." (Nurse in a specialist sex worker health clinic - Frontline staff survey)

GRT communities

- Consistent acknowledgement of the lack of knowledge about GRT communities and their breadth (needs of Irish travellers vs. the Bulgarian Roma community), little contact with these communities.
- Lack of awareness of trauma faced by Bulgarian Roma community; many young girls are involved with sex work or victims of modern slavery and have no support.
- Discrimination and stigmatisation.
- Immigration concerns impacting engagement with services..
- Digital literacy and language barriers; WhatsApp, videos, voice recordings and face-to-face engagement more successful forms of engagement then letters for example.
- Need for culturally sensitive pathways; mental health often stigmatised in Irish traveller communities, which stops people coming forward for help.
- Opportunity for more tailored public health campaigns (i.e. stop smoking campaign)

"[There is a] huge gap in engagement with GRT communities – during Covid almost a failure of engagement. There is very little understanding. For example, how many of them live in brick-and-mortar houses and there needs to be more effort to fill the gaps. (Haringey Key Stakeholder interview)

Mental Health services (1)

North Central London Integrated Care System

Mental Health issues were viewed as extremely prevalent amongst all inclusion health groups and access to support was viewed as difficult. This included a range of support: community mental health support, crisis intervention and inpatient services. Stakeholders also suggested that there needed to be more community provision for those who might not have serious mental health condition but might be experiencing low level anxiety and or depression due to their situation (i.e. precarious housing, unemployment, financial difficulties).

Common issues

- Staff recognised that high mental health prevalence and access issues were systematic problems affecting the general population too. Mental health services have been chronically underfunded, and are still commissioned separately from physical health services, which is viewed as problematic.
- Housing, VSC & ASC can find it difficult to find a service to support an individual exhibiting mental health symptoms if they do not already have a formal diagnosis and are not yet known to mental health services.
- There is friction between substance use and mental health services, with many stakeholders disagreeing with the view that mental health services will often not treat individuals if they have addressed their substance use.
- Stakeholders across the system argued that individuals were often having to reach crisis point before receiving help and emphasised the importance of improving access to mental health support at earlier stages, not relying so heavily on secondary mental health services.
- They noted ongoing issues around Mental Health Capacity Assessments and Section 117 support – the need for dedicated resources for the assessments and embedded approaches to manage the process. There was a suggestion to use a trusted assessor approach.

Stakeholder suggestions for improvement

- Having a **dedicated team who do mental health outreach**; for example, having a doctor/psychiatrist who can go out in the community and diagnose. Conducting mental health assessments would help prevent mental health issues from deteriorating or people exhibiting anti-social behaviours, which land them in the criminal justice system. Physicians would also be able to recognise physical health problems, which often go in tandem.
- Recognition that not every person needs to be seen by the mental health team. Stakeholders noted that the average **GP** should be able to support with low mood, low level anxiety and depression and that there is also **provision in the community for low level mental health issues**.
- Any staff who is funded to work in a mental health outreach capacity or in the community **should be well linked into other services**. For example, in Islington there is a funded psychologist, but stakeholders reported that they are not well linked into the C&I Mental Health Trust, when they should be acting as the conduit.
- Need to recognise that different inclusion health groups may have **different cultural norms around mental health**.

Mental Health services (2)

North Central London Integrated Care System

"Three weeks ago we had a client come to see our drug and alcohol worker and threatening suicide and to harm members of public, and it was obvious they had mental health issues and needed help. We ring the mental health crisis team and their response is 'if they are not already known to us then we won't come and assess the person.' Their suggestion is to phone an ambulance and take them to A&E, but when we called A&E they say its not an emergency so they couldn't come and get him. In then end a police person came and took him to hospital."
(Housing/VCS perspective - Barnet stakeholder)

One stakeholder said, "it feels like a stuck record". A man who was very unwell with diagnosed schizophrenia was causing issues in a temporary property and there were reports of anti-social behaviour, but he was receiving no support or compassion. The stakeholder argued that he shouldn't be evicted because he was clearly unwell, but mental health services were not providing support as they were saying it was a drug problem. The stakeholder argued that dual diagnosis often prevented people getting the help that they needed, using the example that if you have diabetes and endometritis, you don't refuse to treat one until the other is sorted. In their view, substance misuse clouds everything, when often it's just a coping mechanism.
(Housing perspective -Islington stakeholder interview)

"From a practice point view, there needs to be multiagency working around capacity assessments to keep individuals safe, especially in terms of sex work, alcohol and exploitation. These are really challenging assessments to undertake and require the person being assessed to trust you and certain skills to do the assessment. I think there are opportunities to look at trusted assessor approach, which we are not harnessing particularly well. We need a dedicated resource for the assessment. And build into systems how this going to be managed. They need training and parity. It is not easy for someone to say to a consultant that a person is not fit to go out yet when they are trying to discharge them. Often lots of people already know the individual and how their capacity fluctuates, as they are well known in the system. It's getting the opportunity to pull these things together outside of a safeguarding review when its too late. Better to try and build operation into system." (ASC perspective - Barnet and Islington stakeholder)

Primary Care (1)

North Central London Integrated Care System

Across stakeholder groups it was recognised that there were examples of effective specialist primary care provision for people experiencing homelessness in most NCL boroughs (GP service in Homeless Action Barnet, CHIP, CAPP, Somewhere Safe to Stay Hub, HHIT, specialist GP service based at homeless hostels in Islington). However, stakeholders also report that access for all inclusion health groups was patchy, as was access to mainstream GP practices.

Entrenched issues

- Although improving, many stakeholders had examples of mainstream GP practices refusing to see patients who were homeless and other IHGs.
- There is a lack of appreciation for cultural differences in health seeking behaviour.
- Digital literacy, language barriers, the transient nature of these populations and stigma still causes problems.
- There is limited capacity within mainstream services to support IHGs with complex needs which means that staff often lack patience and have limited time to support service users.
- There is a lack of specialist provision for IHGs who don't primarily identify as homeless.
- EMIS is not set up to be used flexibly; for example, a GP reported that using it in a specialist service was difficult due to complexities around coding and having to manually add patients to their list.

Areas that are working well / ideas for improvement

- Specialist inclusion health primary care provision was consistently praised by stakeholders and frontline staff.
- GPs working in specialist inclusion health services said that from a professional point of view, the work was very interesting compared to day-to-day general practice – perhaps this benefit could be better promoted.
- A minority of stakeholders floated the idea of having champions for inclusion health within mainstream practices; this could be clinical staff and also receptionists.

Primary Care (2)

North Central London Integrated Care System

GRT community
In Enfield, GRT communities struggle to register with GPs as they find filling in forms difficult and digital literacy is an issue. One stakeholder said they think there are only 560 GRT individuals registered compared to a possible 8,000 people. The Doctors of the World (DOTW) clinics have been really helpful in supporting GRT communities to register with the GP, but the clinics alone are not enough to support the large Bulgarian Roma community. Stakeholders from Enfield argued that many GPs put up barriers if the GRT community can't show proof of address, even if they present the yellow cards saying they don't need proof of address. (VSC perspective – Enfield stakeholder interview)

People with a history of offending
According to stakeholders who referenced offenders, they reported that it is not currently possible for an individual to register with a GP until they have left prison, meaning there is a delay in the transfer of health information and people often fall through the cracks. In Enfield council, they created a specialist team whose remit includes supporting people who come out of institutions, such as prison or hospital with housing and other issues. They work closely with probation to start working with people before they leave prison rather than after release.
(Housing perspective – Enfield stakeholder interview)

NRPF and vulnerable migrants
NRPF and other migrants may come from countries whose health system is completely different. One stakeholder explained that many NRPF residents don't understand why they need to register with a GP if they are not sick. (Housing perspective – Barnet stakeholder interview)

"They often have difficulty accessing GP appointments or even knowing who to speak to about health issues because of lack of language skills and also, since they have often very recently come to the country, a lack of knowledge of how the health system works" (Specialist migrant housing service in Islington - Frontline staff survey)

Hospitals, discharge & intermediate care

North Central London Integrated Care System

Stakeholders commented that hospital staff need to be better equipped to support inclusion health groups and take a more holistic approach; there are still stigmatising attitudes and behaviours towards IHGs, especially those who are 'visibly' homeless. A minority of stakeholders reported that out-of-hospital provision had plugged gaps, but there were still issues with individuals being discharged into unsuitable accommodation or back onto the streets. Moreover, current intermediate care facilities are not appropriate for all patients with mobility issues. Discharge to assess pathways were also viewed as inappropriate.

Common issues & examples

- Not all hospital staff are trained to support IHGs. For example, a common issue is that people experiencing homelessness with substance use issues such as opioid addictions will often become agitated and behave 'poorly'; this behaviour is typically because they have not received their methadone prescription and as result, end up self-discharging, leaving them very vulnerable on the streets.
- Individuals are still being discharged into unsuitable accommodation or back onto the streets. In Barnet, stakeholders described patients turning up to Homeless Action in Barnet (HAB) or Barnet Homes by ambulance still in their hospital gowns or hospitals discharging patients on Friday afternoon and expecting these organisations to sort out accommodation.
- Discharge to assess pathways were also viewed as inappropriate. A stakeholder argued that individuals from IHGs should never be put onto pathway 0 (no need for social care assessment). This was happening during Covid but is still continuing, whereby IHGs are being discharged into unsafe situations, usually unsafe hostels or back onto the streets. Stakeholders explained that this happens due to a combination of a lack of staff skills and resources and organisations not wanting to be the last entity who was responsible for the individual.

North Central London Integrated Care System

Section 3: Stakeholder and Staff Findings - Partnership working & models of service delivery

Final report – last updated 30/03/2023

Summary of partnership working

North Central London Integrated Care System

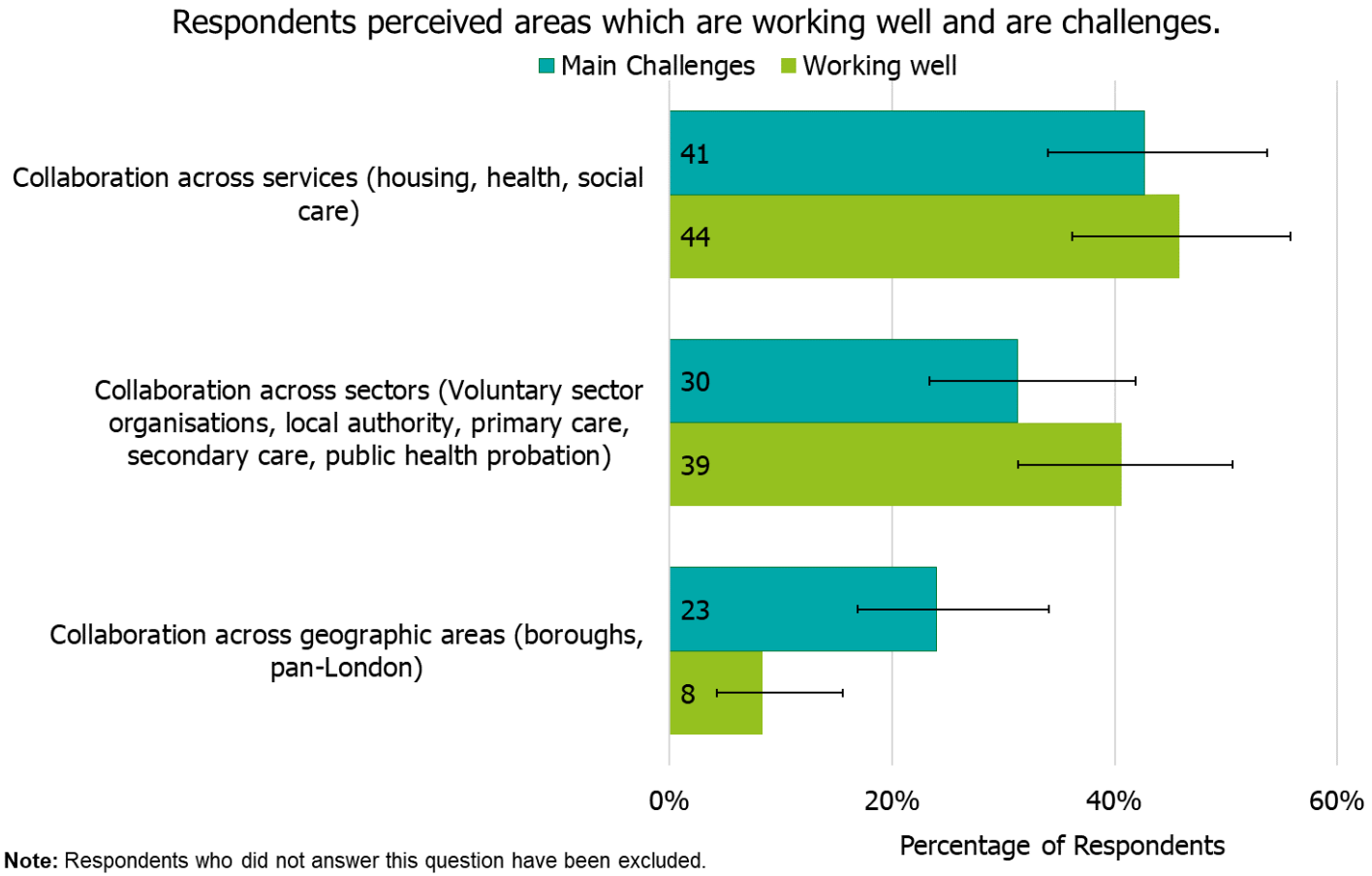
Partnership working was viewed as essential, as individuals in inclusion health groups are transient and often have multiple and complex needs, and so require support from a range of different services. Better integration between services helps provide a wraparound approach to care and support, prevents people from falling through the cracks and stops them from having to repeat their stories to multiple services. It also provides opportunities for learning through regular MDTs. There are examples of effective partnership working, but it is not universal. Most stakeholders called for further work to strengthen partnership working between organisations, service areas and across NCL.

Key points

- According to frontline staff, collaboration across sectors and services is working better than across geographies.
- Over half of frontline staff survey respondents (59%) said that improved communication across multiple services would help to provide better care and support. Collaborating with peer workers was viewed as the least important factor for improving how care and support is provided (11%).
- Operational and strategic multi-disciplinary team (MDT) meetings were viewed as a key enabler for good partnership working. Professions treating other professions with respect and valuing each others roles was also viewed as important. Stakeholders reported that this is not always the case and in particular Consultants and GPs do not treat everyone with respect.
- Barriers to partnership working included short-term funding and a lack of information sharing and communication.
- Outreach and specialist hubs for specific inclusion health groups were viewed as important.

Collaboration across services, sectors and geography

North Central London Integrated Care System



Note: Respondents who did not answer this question have been excluded.
Source: Frontline Staff Survey, 2022

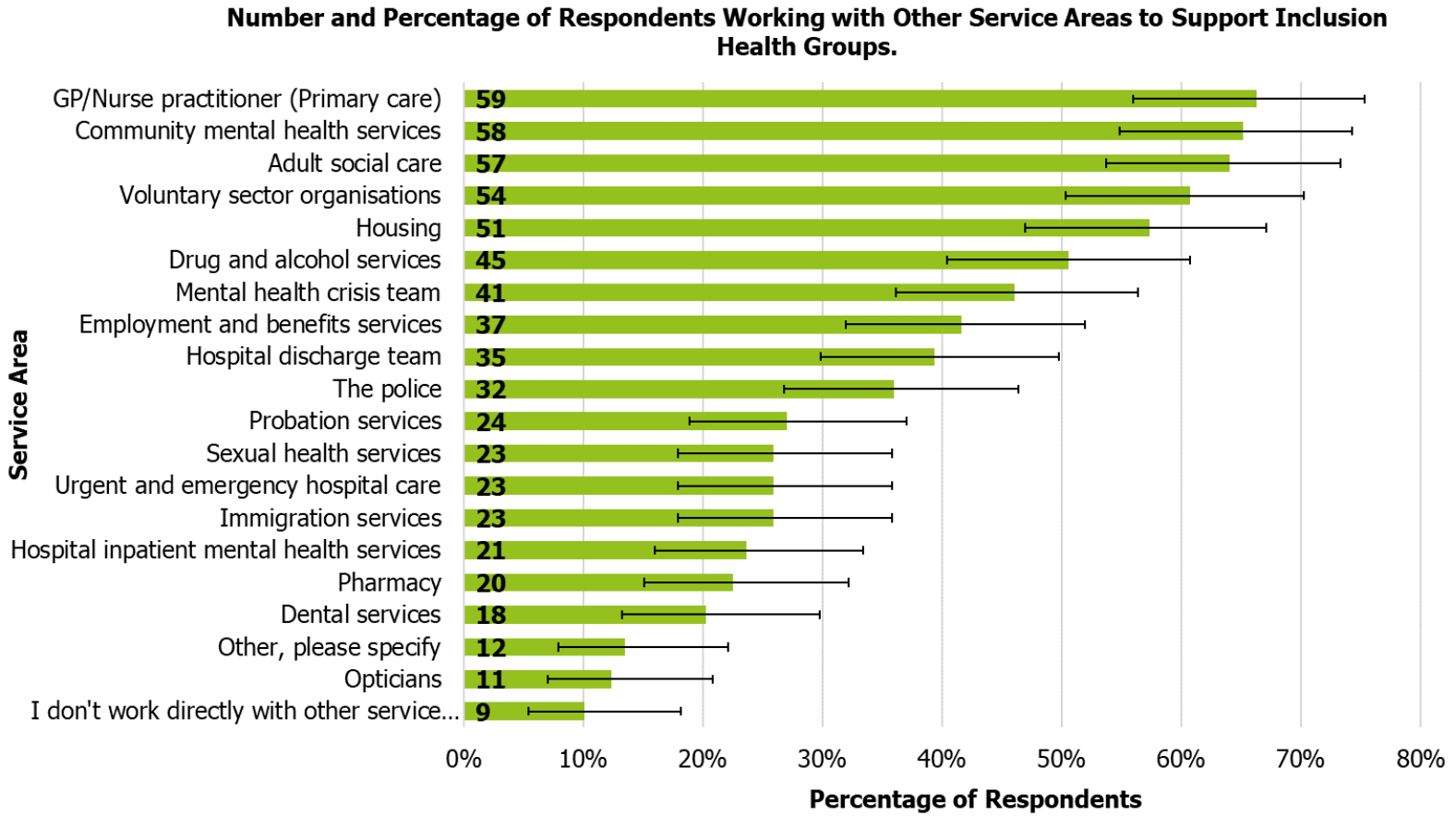
- Compared to collaboration across geographies (8%), significantly more respondents felt that collaboration across services (46%) and across sectors (39%) was working well.
- Significantly more respondents thought that collaboration across geographic areas was challenging rather than working well (23% vs 8%).
- There were no areas where significantly more respondents felt things were working well.

"Working collaboratively resolves problems faster and quicker" (Service manager in Housing service in Barnet - Frontline staff survey)

"There are also pockets of good practice: Camden historically has done a lot of work, but [there are] also other examples. Mostly coming from frontline services. Not so much on the strategic level."
(Senior NCL ICB Key stakeholder)

Collaborating with different service areas

North Central London Integrated Care System



Survey respondents worked with a range of different service areas spanning health, housing and adult social care.

The majority of respondents had worked with:

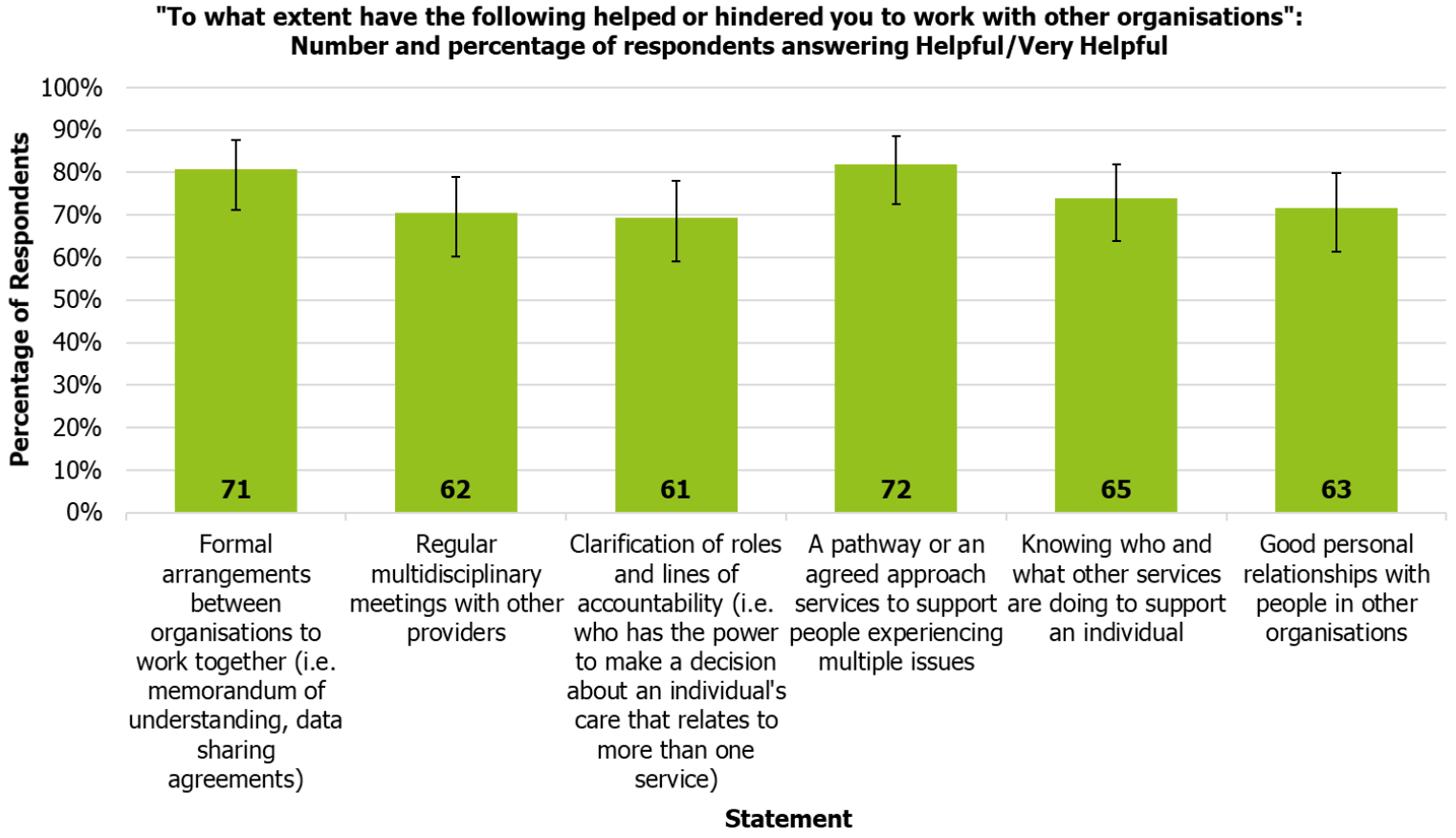
- Primary care (66%)
- Community mental health (65%)
- Adult social care (64%)
- Voluntary sector organisations (61%)
- Housing (57%)
- Drug and alcohol services (51%)

10% of respondents had not directly worked with other services.

Notes: Respondents who did not answer this question have been excluded
Source: Frontline Staff Survey, 2022

Factors which help collaboration across organisations

North Central London Integrated Care System

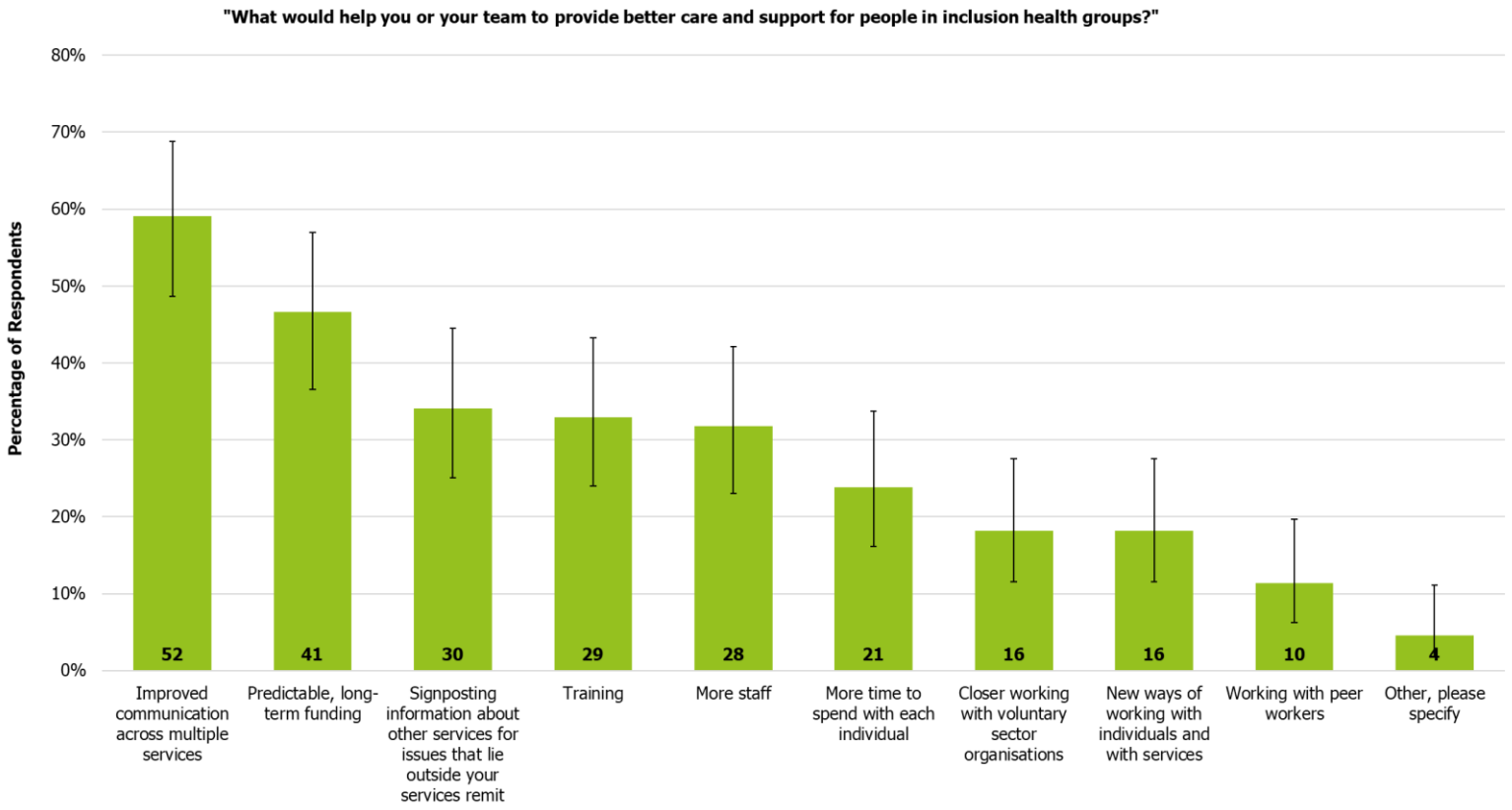


Note: Respondents who did not answer this question have been excluded
Source: Frontline Staff Survey, 2022

The majority of respondents would find each area listed helpful. The most popular responses were:

- A pathway or an agreed approach to support people experiencing multiple needs (82%)
- Knowing who and what other services are doing to support an individual (74%)

Factors which help frontline services provide better care and support



Note: Respondents who did not answer this question have been excluded
Source: Frontline Staff Survey, 2022

Over half of respondents (59%) said that improved communication across multiple services would help to provide better care and support.

The least popular answer was working with peer workers (11%).

In free text responses, frontline staff emphasised several of these factors and explained the relationship between them:

- More manageable caseloads and more staff would enable them to spend more time with clients.
- Longer term funding would help retain staff and enable longer-term planning.
- Better communication between services.
- Training was important, but frontline staff did not specify what kind of training would be most useful, beyond awareness of IHGs.

Partnership working - facilitating factors

North Central London Integrated Care System

Multidisciplinary team meetings where all professionals are valued

- Stakeholders reported that it was helpful to have both strategic and operational/case-conferencing meetings.
- Strategic meetings help set the direction and provide a vision for inclusion health care and opportunities to work through longer-term strategic issues.
- Operational/case conferencing meetings provide opportunities to work through complex individual cases to ensure residents are getting the right support from the right services.
- The best MDTs were described as ones which involved a range of different stakeholders and organisations.
- Stakeholders reported that MDTs often failed to be effective when different organisations did not feel respected or valued by other professionals. This was particularly acute amongst ASC, housing and VCS, who reported that clinicians such as GPs and consultants don't value their expertise and their deeper understanding of service users, based on the extended amounts of time they spend together.
- Stakeholders reported that understanding each others roles and services' remit might help strengthen collaboration and avoid friction. For example, primary care stakeholders in Islington explained that hostel key workers are very flexible and accommodating to their client's needs, whereas GPs and other healthcare professionals who work in less flexible environment and have to follow certain procedures and processes cannot work in this way unless they bend the rules.

"I see a lot of siloed working - some ok efforts between health and social care, but it takes a lot of time and seems bureaucratic from where I sit. A lot of MDT meetings, but it's never even considered that the person being spoken about should attend!" (Frontline staff survey)

"Heath very rarely participate in collaboration with the voluntary sector. They treat the voluntary sector as second class with no respect for their expertise." (Frontline staff survey)

"There also must be respect between different professional bodies. E.g.: GPs often don't listen to social workers. Social workers often hear 'you don't know what you're talking about because you're not a medical professional'. But social workers do know things and do notice things and react to real need. They need to be able to direct people to where those needs can be met, but if that person is a GP that doesn't listen, then instead of supporting a pathway, it is making it difficult. Instead, a GP could be linked directly to a homeless centre; there could be named specialists. There could be more strategic understanding of the different roles like social work and working together to figure out and meet need, instead of just dumping someone to social services."
(Haringey stakeholder interview)

Partnership working – barriers (1)

North Central London Integrated Care System

Short-term funding and staff continuity

- Stakeholders reported that a key issue hindering partnership working was keeping up-to-date on which services were available where and for whom.
- This information gap is linked to short-term funding of services and pilot projects. Stakeholders noted that short-term funded services can be confusing both for frontline staff trying to work with other services and for service users.
- Stakeholders reported that it can be difficult to build relationships with other organisations when staff or roles change, or services cease to exist after a pilot stage.
- They observed that service users disengage from all services because services spring up and disappear. They argued that that short-term funded services are not respectful to clients, who often have trust issues from the outset.
- Stakeholders felt that there are a lot of excellent services available across NCL, but that commissioners often set up new services, rather than ask existing providers about gaps or how current services can be improved.
- There is also a lot of learning from previous services which has not been shared. For example, there are stakeholders who have worked in NCL for a long time and seen many changes over the years. Their understanding and experience of what has worked previously and what didn't is helpful in avoiding the same mistakes and building on good practice examples.

"The short-term nature of these projects and the learning processes involved by all in getting up and running seems to mean they may finish just as they are getting up and running, which seems wasteful and a shame." (Frontline staff survey)

"Funding [is] very sporadic and piecemeal. This is true for the specific 'special' services. So then if those aren't consistently funded, how do we get mainstream, core services, to meet existing needs? The 'special' services are often required for engagement, but how do we maintain them and how to we ensure they're appropriate? We have to work in different ways than the core services; people are not always where you want them to be." (Haringey stakeholder interview)

"[We need] updating of staff information when people leave or when there is a new source to tap into." (Frontline staff survey)

Partnership working – barriers (2)

Lack of information sharing and communication

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- When services are funded, they often have specific boundaries and commissioners do not always understand the need to cross boundaries in order to support individuals with complex needs, which means services end up working in isolation. It also means residents having to repeat information again and again.
- Staff are unclear what data is allowed to be shared between organisations. Different services and sectors use different systems to record information about service users, which again can make information sharing difficult.
- Cases often close once a service user has been referred on from an initial service, so this prevents information between services being shared back and forth.
- It is not always clear which services are available for who and how services should interact with each other. Staff suggested that having clearer information about what services are available, as well key contacts for these services would be helpful.
- There is also massive variation in how the size of IHGs are recorded by source and sector which impacts on the planning around models such as Anticipatory Care/Proactive care, and highlights why it's so important to collaborate between health and Local Authorities. Appendix A (Pg89) highlights just how much figures can vary by source.

"It is often hard to get adequate information from referrers and cases will close once they have referred on, so there is no way to get further information. Workers are transient, so service users often see a rotation of new people. Trust is then eroded or their cases are just dropped when someone moves on." (Frontline staff survey)

"I think collaboration across services areas is beginning and has been successful in some instances, but geographic areas and sectors is still a work in progress and hasn't quite been achieved yet. I think this is largely due to issues with data sharing, e.g. not having access to other hospitals' medical records, not having a clear, named link person to contact, being unable to send patient identifiable data to non-nhs.net emails, etc." (Frontline staff survey)

"Different services and sectors use different health record systems and [it is] not uncommon for sectors to be involved in care/support for service users, but [be] unaware of one another's involvement." (Frontline staff survey)

"[We need] better understanding of who to contact to help with specific casework enquires regarding health problems and also an understanding of how the different teams and organisations in the borough interact." (Frontline staff survey)

Stakeholders who work directly with sex workers in a health promotion capacity commented on their relationship with the police. There is a general agreement in place that the police will inform their service if they become aware of areas where sex working is prevalent so they can provide outreach. There is a specialist police officer who manages this process. However, it is not the specialist officer who is patrolling the streets, but other officers who change every 6 months. This means that every six months they have to rebuild relationships to stop arrests. (Key stakeholder interview)

Outreach

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Providing outreach services was viewed as vital for inclusion health groups by nearly all stakeholders and frontline staff, bringing services to residents rather than expecting them to come to services. Outreach efforts target the most vulnerable residents who are the least trusting of statutory services. Outreach also offers an opportunity to spend extended time with residents, which helps to develop relationships and build trust.

- Stakeholders felt that outreach was needed for different types of service areas, including mental and physical health, social services and housing support.
- In terms of healthcare, stakeholders emphasised how important it was that outreach was not limited to screening and identification, but that staff could also initiate treatment there and then, if feasible, to capitalise on the encounter with the resident. Medically adapted vans were specifically mentioned.
- Stakeholders frequently reported that there are not enough specialist outreach services for different inclusion health groups, noting that as resources have been cut over the years, so too have outreach services. In particular, several stakeholders mentioned that specialist outreach services for sex workers were rare, and they had to rely on services aimed primarily at people experiencing homelessness, such as Find and Treat. Whilst many sex workers might also experience or be at risk of homelessness, stakeholders felt that sex workers' needs were quite bespoke. Stakeholders also commented on the need for primary care and mental health (both clinical and social work) to increase.
- Stakeholders who worked with GRT communities had similar views, that there was a need for bespoke outreach with these groups.

Specialist inclusion health hubs

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Hubs, community or accommodation settings, where multiple services including healthcare could be delivered face-to-face, were also highly valued by many stakeholders. Staff who worked with specific inclusion groups (asylum seekers, NRPF, sex workers, GRT communities and people experiencing homlessness) emphasised the importance of tailoring health services to individual inclusion health groups.

Sex workers

Stakeholders working directly with sex workers said that having specialist wraparound hubs dedicated to their health and support needs was important. Staff argued that sex workers have unique experiences because of the nature of their work, and because they often experience sexual violence or trafficking, live in precarious housing situations, may not have been born in the UK and do not speak English fluently, and fear stigmatisation. Staff also argued that from a sexual health point of view, sex workers are underserved relative to other groups, such as men who have sex with men. This means that supporting female sex workers with issues such as menopause is a real gap.

GRT communities

Stakeholders who worked with Gypsy, Roma and Traveller communities also argued that specialist wraparound services were vital. In Enfield, where they have a large Bulgarian Roma community, they have had great success through the Doctors of the World mobile clinics and drop-in sessions run by the Edmonton Community Partnership. Face-to-face engagement was perceived as vital.

Examples of good practice

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Stakeholders identified many examples of effective partnership working, of which these are just a selection. A useful next step could be developing and short profiles of each, exploring what made them particularly effective.

Covid-19 vaccination efforts and 'Everyone in'

Stakeholders commonly reported that the Covid-19 response had strengthened partnership working, especially around rough sleeping.

"The mix of targeted and universal approach[es] around the Covid vaccine efforts were the start of a new important way of working."
(Key stakeholder interview)

Find and Treat - UCLH

This specialist outreach team works alongside other NHS and VCS organisations to tackle TB amongst vulnerable populations, including those experiencing homelessness, substance use, vulnerable migrants and those in contact with prison. Stakeholders frequently noted the effectiveness of their proactive outreach and combined detection and onward care model.

Collaboration between Homeless Action Barnet (HAB), Barnet Homes & Public Health

throughout Covid-19 and beyond. In Barnet, two key meetings were set up. One was more strategic in nature, where staff are able to talk through key issues. The other is more operational, similar to a weekly case review meeting for complex clients. These fora provide the opportunity to problem solve issues and create links between people, so they know the right person to talk to about a specific issue.

Camden Adult Pathway Partnership (CAPP)

Stakeholders frequently mentioned this onsite nurse-led service for vulnerable single homeless adults living in supported housing services in Camden.

Doctors of the World clinics (DOTW) – Enfield

These mobile health clinics were viewed as an effective way to reach GRT communities and provide support with GP registration and health checks.

Central NW London CLASH & SHOC

CLASH (Camden and Islington) and SHOC (Haringey and on the border of Enfield) provide drop-in specialist clinics for sex workers: "clinic in a box" (CIAB) services, outreach to sex workers in flats and saunas, as well as engagement with on-street sex workers. These dedicated services for sex workers were highly valued by stakeholders.

Outreach nurse - Islington

Stakeholders and frontline staff frequently mentioned the value of the outreach provided by this specialist inclusion health nurse. The service is well linked with the Whittington Hospital and other non-healthcare services.

Afghan Bridging Hotels

Stakeholders mentioned the success of collaborative efforts to support Afghan refugees in bridging hotels.

Views on the role of the ICS[1]/ICB[2]

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- Overall, given that ICS' and ICB's are relatively new structures stakeholders found it difficult to comment on their role in relation to inclusion health.
- However, there was a general consensus that the ICS should provide strategic direction and facilitate and enable activities happening at borough level. Stakeholders generally believed that work should be happening at borough-level because that is where people are most in touch with local communities. Each borough is very different in terms of their populations, service landscape and philosophy.
- The ICS could play an important role advocating for inclusion health at strategic level, like ensuring it is part of the Population Health and Integration Strategy.
- A minority of stakeholders also argued for a longer-term, radical vision, suggesting that the ICB could play a pivotal role in commissioning longer-term services for these populations, a 10-year contract, for example, rather than non-recurrent short term funding.
- Stakeholders stated that it was important to recognise that different boroughs have different levels of resources and so were at different stages in relation to how health and care provision is provided for inclusion health groups.
- A minority of stakeholders reported that the ICB could help by continuing to raise awareness around need in different boroughs. In some areas, this might be to attract funding, whereas in other areas with more developed services, it might be about retaining funding and further developing existing services.
- A minority of stakeholders spoke about the ICB 'levelling the playing field' reflecting its responsibilities to ensure equitable service provision across NCL. In the boroughs which were viewed as having more resource, this was either not mentioned or worried stakeholders, being seen as creating difficulties around pooled budgets at borough level. They did, however, think it might be helpful to share resources around infrastructure, like IT or automated dashboards for data analysis.

"It would be great if inclusion health groups could be considered priority groups within the population health strategy. That's currently not happening – currently the idea is that it's more cross-cutting across other priorities. The challenge is how can we embedded inclusion health as a key priority within our strategies. The ICS sets strategies and priorities and that is important as its role, but a lot of the specific work needs to happen at a local level. Currently the ICS aren't set up to do the systematic oversight of everything that is happening, because they're still emerging and capacity is low and it's a small team, but that systematic oversight is the key opportunity. But the work has to happen on a local borough level, because that's where the people who are in touch with communities are. So the work needs to be happening locally, but the opportunity is in the ICS having the top-down endorsement, strategic oversight, and sponsorship. Though the challenge is then that people on the ground feel a lot of ownership over their work, so it will be tricky to figure out how can ICS can come in and give leadership to things that are already happening."
(Haringey Key Stakeholder)

1. ***Integrated Care Systems (ICS)*** *= partnerships of organisations that come together to plan and deliver joined up health and care services to improve the lives of people in their area. They are responsible for how health and care is planned, paid for and delivered.*
2. ***Integrated Care Board (ICB) =*** *holds responsibilities for planning NHS services and ensures that services are in place to deliver the integrated care strategy developed by the integrated care partnership.*

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Appendix A – Multiple disadvantage analysis

Background

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- Estimates of severe multiple deprivation come from the 2015 Lankelly and Chase “Hard Edges” report.
- In their report, severe multiple disadvantage is the term they use to describe individuals who are dealing with a combination of problems including homelessness, substance misuse, and history of offending.
- The focus of their study was to develop a statistical profile of severe multiple disadvantage using three key administrative datasets:
  - **Offender services –** Offender Assessment System (OASys). This dataset covers most of the prison population, and also those on parole and undertaking community service punishments.
  - **Substance use services –** National Drug Treatment Monitoring System (NDTMS).
  - **Homelessness services –** Supporting People (Client Record and Outcomes for Short-Term Services) (SP), augmented by ‘In-Form’ datasets maintained by selected major homelessness service providers in England accessed with the help of Homeless Link
- They developed three categories: SMD1= Experiencing one disadvantage domain (i.e. ‘homelessness only’ , ‘offending only’ or ‘substance use only’) ; SMD2 = Experiencing 2 out of three disadvantage domains; SMD3 = Experiencing all three disadvantage domains.
- The study uses data from 2010/11.

What did we do?

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- First, we calculated the national prevalence of homelessness, substance use and offending as well as the different SMD domains using 2010 population estimates.
- We then took the national prevalence estimates for each domain of disadvantage and applied this to local boroughs using 2022 projected population estimates. This produced **borough estimates of multiple disadvantage**.
- In the Lankelly and Chase report, they argued that there are elevated levels of homelessness, substance use and offending in London and this should be adjusted for in estimates. The main report provided adjustment factors of 1.88 and 1.85 for Camden and Islington respectively.
- The report did not provide figures for the other 3 NCL boroughs. Thus, a modest adjustment factor of 1.5x the national average was selected. This adjustment factor was chosen with the aim of encompassing the effect of the three boroughs being part of the London urban area, without overestimating numbers in each borough.
- The adjustment factors were then applied to the borough level estimates to produce **region-adjusted borough estimates.**
- **Limitations:** Although borough population estimates use 2022 projections, the Lankelly and Chase report data is from 2010/2011, thus the estimated numbers in each borough (and NCL total) may not reflect actual current numbers. Furthermore, the adjustment factor used in Barnet, Haringey and Enfield was informed by but not specified in the report and should be interpreted with caution.

National prevalence of severe multiple disadvantage

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SMD domain	N*	% of England population**
Substance use only	188,802	36%
Homelessness only	63,047	12%
Offending only	112,244	21%
Substance use + Homelessness	33,758	6%
Substance use + offending	99,289	19%
Homelessness + Offending	31,276	6%
Homelessness + Offending + Substance use	57,931	11%

*Figures taken from Lankelly and Chase report 2010/2022
** Denominator is England 2010 population estimates

Borough estimates of SMD

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SMD domain	Barnet	Camden	Enfield	Haringey	Islington	NCL Total
Substance use only	1,490	940	1,260	1,050	880	5,620
Homelessness only	500	310	420	350	290	1,870
Offending only	890	560	750	630	520	3,350
Substance use + Homelessness	270	170	220	190	160	1,010
Substance use + offending	780	490	660	550	460	2,940
Homelessness + Offending	250	160	210	170	150	940
Homelessness + Offending + Substance use	460	290	390	320	270	1,730

Note: Borough estimates are derived from taking 2022 population estimates for each NCL borough and applying this to national prevalence estimates seen in previous slide.

Region-adjusted borough estimates

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SMD domain	Barnet – Adjustment factor = 1.5	Camden – Adjustment factor = 1.88	Enfield Adjustment factor = 1.5	Haringey Adjustment factor = 1.5	Islington Adjustment factor =1.85	NCL Total
Substance use only	2,240	1,770	1,890	1,580	1,630	9,110
Homelessness only	750	580	630	530	540	3,030
Offending only	1,340	1,050	1130	950	960	5,430
Substance use + Homelessness	410	320	330	290	300	1,650
Substance use + offending	1,170	920	990	830	850	4,760
Homelessness + Offending	380	300	320	260	280	1,540
Homelessness + Offending + Substance use	690	550	590	480	500	2,810

Note: Region-adjusted borough estimates are calculated by applying adjustment factors between 1.5 and 1.88

Homelessness figures vary by source and borough

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Homelessness is a broad umbrella term and so figures vary by source. The overlap analysis presented in previous slides is based off estimated figures from a very specific data source accessed in 2011 (homelessness services data access via Homeless Link) and aims to show the extent of overlap between groups and is not intended to showcase levels of homelessness in each borough. More up-to-date figures are in the table below.

Borough	Individuals Rough Sleeping (CHAIN 2021/22)	Statutory Homelessness (2020/21)	HealtheIntent (GP)	NCL CCG report* (Oct-Nov 2021)
Barnet	173	2,030	77	282
Camden	666	1,098	916	847
Enfield	183	1,905	64	550
Haringey	268	2,383	113	633
Islington	238	1,623	155	533

* LA estimates based on RS, single homelessness and those in temporary accommodation

Crisis estimates that **62%** of homeless people are **hidden homeless** and 75% have never stayed in temporary accommodation organised by the local authority, nor stayed in a hostel (57%)[1].

Alternate approaches to calculating SMD

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- As part of a broader study, Tweed and colleagues (2022) calculated co-occurring homelessness, justice involvement, opioid dependence and psychosis in Glasgow by linking existing **administrative datasets**, which is an option that NCL boroughs could consider.
- A higher proportion of people with custodial justice involvement (50%) and opioid dependence (44%) fell into at least one other exposure category; those with psychosis had the lowest proportion of overlap (14%).
- These calculations underestimate the total number of people in each group, since the administrative data only captures residents who are registered with a GP and are in contact with these services.
- Neither this article, nor the Lankelly and Chase report, include the additional 3 inclusion health groups covered in our needs assessment (GRT, sex workers, vulnerable migrants). To our knowledge, there is a not a standard estimation method to quantify overlaps across all inclusion health groups.

Source: Tweed EJ, Leyland AH, Morrison D, Katikireddi SV. 2022. Premature mortality in people affected by co-occurring homelessness, justice involvement, opioid dependence, and psychosis: a retrospective cohort study using linked administrative data. The Lancet Public Health, 7(9): e733-43.

Acknowledgements

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About Public Health Intelligence

Public health intelligence is a specialist area of public health. Trained analysts use a variety of statistical and epidemiological methods to collate, analyse and interpret data to provide an evidence-base and inform decision-making at all levels. Camden and Islington's Public Health Intelligence team undertake epidemiological analysis on a wide range of data sources.

About Inclusion Health Needs Assessment – Final report

This report was prepared by Hannah Jones (Knowledge and Information Analyst) and reviewed and approved for dissemination by Dalya Marks (Public Health Strategist) and Anne Buffardi (Principal Knowledge and Engagement Specialist)

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We would also very much welcome your comments on this report, so please contact us with your ideas.