Hwb Cydlynu Arloesi Rhanbarthol Caerdydd A'r Fro

Cardiff And Vale Regional Innovation Co-ordination Hub

BWRDD PARTNERIAETH RHANBARTHOL CAERDYDD A'R FRO

CARDIFF & VALE REGIONAL PARTNERSHIP BOARD

The Story of Health Inclusion in Cardiff, the Vale of Glamorgan and beyond.

How real partnership working is vital for Health Inclusion

The gap in life expectancy between those people living in the most and least deprived areas in Wales is increasing. In the most disadvantaged areas, there has been a decrease in life expectancy for men and women since 2010 and addressing this is a national and local priority for all public services. Locally, there is a 19-year difference in healthy life expectancy in men across Cardiff and the Vale UHB. Averaging 55 years of age in most deprived areas to 74 years old in the least deprived. Women have 17 years difference in healthy life expectancy for women (58-75) [1] Measuring Inequalities, Public Health Wales, 2016.
Health Inclusion models of care often include the following groups who have some of the poorest health outcomes:

- Asylum Seekers and Refugees
- The Homeless
- Sex Workers
- Gypsy, Roma and Travellers
- Prison Leavers

The above groups often share a commonality of health conditions and challenges including Post-traumatic Stress Disorder, unmanaged chronic disease, Infectious diseases, safe guarding risks, complex social situations, housing issues and difficulty accessing traditional models of healthcare.

[1] Measuring Inequalities, Public Health Wales, 2016.

Dr Ayla Cosh is a GP and Clinical Director for Cardiff and Vale's Health Inclusion Service (CAVHIS). She was integral in establishing the rebranded service in September 2021 and has recently been working with colleagues on a project looking at what health Inclusion provision could look like across Wales with a place based care approach. The RIC Hub caught up with her to hear about the progress so far and ambitions to provide a person centred, fully integrated, sustainably funded service designed and provided in collaboration with local partners.

Ayla's team are the first in Wales to partner with the Pathway Programme hosted by the Faculty of Homeless and Inclusion Health in London. The Faculty is an inclusive membership organisation for people involved in healthcare of the aforementioned groups. The Pathway programme in particular focuses on developing hospital health inclusion in reach services.

"What we are trying to do is develop a truly integrated, potentially co-commissioned/ co-funded Health Inclusion Service which puts the person at the centre, identifying what assets they have to help them move forward and address any needs in partnership with the person."

What got you interested in health inclusion?

I've always enjoyed working in areas of high deprivation. Prior to moving over to work for the Health Board, I worked in Grangetown as a GP for nearly ten years and I really enjoyed my time there meeting people from all different backgrounds and cultures. I saw this job advertised at the Health Board, which was then the Cardiff Health Access Practice (CHAP). It was a service that was resourced to provide health screening to newly arrived asylum seekers. I applied for the job, then started in this service as a salaried GP. I took on the Clinical Director role in 2020. Since then, I've been trying to expand our services so we don't just serve people seeking asylum, but we also provide care for people coming via refugee resettlement routes, people with no recourse to public funds and then the five health inclusion groups, so sex workers, homeless, prison leavers and Roma Gypsy travellers also.

It has been, and continues to be a privilege, along with colleagues to advocate for those who don't have a voice, to try and amplify voices and be part of a team working towards a more just approach to providing healthcare.

Starting the Health Inclusion Network

I started a conversation between colleagues by emailing everybody I could think of who was working in different teams, in health, social care and third sector who had contact with these groups of people to try and start what we then called the 'Health Inclusion Network'.

At the time I didn't know where it would go but felt strongly that healthcare provision to these groups had to change and improve. I wanted to try to get people together across sectors, to highlight the poor health outcomes and issues that these groups face in accessing care with the aim of raising these issues at strategic level.

I wanted to discuss with colleagues who were invested in these groups what we could do collectively whether that was lobbying, piloting something a small change, formally reviewing existing provision to these groups etc. So, I invited a lot of colleagues across sectors to a regular meeting. It was great, lots of insights, reflections and ideas from colleagues with links through third sector colleagues into hearing from those with lived experience. We met every two months for about a year and then we linked up with Cardiff and Vale Local Public Health Team who led on producing a Health Inclusion Needs Assessment.

Our overall aims are towards reducing health inequalities across Cardiff, to work towards bringing a bit of justice and equity to health care provision and to respond to the well documented evidence that traditional models of healthcare are not working for those groups.

What is the Health Inclusion Service?

In September 2021, the new Cardiff and Vale Health Inclusion Service (CAVHIS) launched to provide evidence-based Health and Public Health screening for:

- new arrived people seeking asylum,
- people under Home Office refugee resettlement programmes,
- survivors of trafficking and those who are destitute and facing 'No recourse to public funds'.

The current model registers those newly arrived in Cardiff via the asylum 'irregular routes' for GP Services and offers registration when GP practices remove individuals from their lists as part of the 'Alternative Treatment Scheme'.

We are also resourced to provide limited urgent primary care for multiply excluded single homeless individuals via outreach clinics into various frontline hostels and an Alternative Treatment Scheme – primary care for individuals who due to episodes of violent behaviour, after formal risk assessment, are judged to need a security presence at GP appointments.

We had support from CAVUHB Executive Director of Public Health which was instrumental in raising the profile of the work. There was already a lot of work done with regards to stakeholder engagement work having previously written questionnaires with the Patient Experience team to give out to sex workers and the homeless, asking them about their experience of accessing healthcare and what suggestions they had for improving it. The report was then presented to the Health Board Executive in November 2022 which gave the opportunity to present the health issues, problems in accessing healthcare and the proposed future model of integrated care. The Executive Board then helped set up what is now our Health Inclusion Programme Board with representation at Executive level from Local Authority and third sector to work towards delivering the vision. It has been brilliant to have had such a supportive Executive Board who have given time to listen to the issues and given support where changes can be made.

A study lead by Public Health Wales showed that over a 6 month period during 2020, emergency department use by people experiencing homelessness in Wales cost £11 million more in healthcare costs than a general comparator group[2].

The people experiencing homelessness we see at the outreach clinics retain their GMS registration for all their other needs at present, so we're only addressing the acute/urgent needs. The aim of that is to try and give care in a more timely fashion, but also to try and prevent people from using unscheduled care unnecessarily. If they don't get seen at an outreach clinic there and then, they will generally end up using unscheduled care and turn up at the EU later that day or a few days later by which time their condition is worse potentially leading to the complexities and longer hospital stays associated with late presentation. They struggle to book and keep to GP appointments in traditional settings and many of the problems presented with require more than 10-15 minute appointments. A more appropriate model needs to be established and this is what we are working towards along with colleagues in the EU.

Providing health screening and public health screening such as Tuberculosis and Blood Bourne virus screening, as well as being of individual benefit to those we provide it for, will also work to reduce the risk of circulating TB and hepatitis in line with Welsh Government's desire to end TB. Putting adequate services in place to test and diagnose health inclusion populations opportunistically is much needed. Non-diagnosis is part of the problem.

[2] Health of Individuals with lived experience of Homelessness in Wales during the Covid-19 pandemic. https://phw.nhs.wales/publications/publications1/health-of-individuals-with-lived-experience-of-homelessness-in-wales-during-the-covid-19-pandemic-report/

Partnership working is key

I think changing the way we deliver care will reduce clinician and frontline admin staff burnout. Not working in partnership with local authority or third sector means you are presented with all these problems which you can't solve and which you don't have the skills to solve. So, all you end up saying is "OK, I'm really sorry you haven't got a home, adequate clothing or money for food.
All I can do is listen, prescribe you this and signpost you. Goodbye". Or "If you phone this number at such and such time someone may be able to help" that's all you can do, in the knowledge that many of the people do not have phones, cannot speak English and there is very little chance that some of them will make it to the signposted services. If you do that year after year, that leads to burnout. And that is why you get so many people who leave or in such a high turnover in front line/high stress services. Partnership working and co-location of essential services are key to addressing this.

"Traditional models of primary care do not always address the needs of people with multiple disadvantages and exclusion. Social factors such as homelessness, language barriers, dependence on substances also have a significant impact on individual experience and outcomes. These can create barriers for the most vulnerable and people from these groups often seek alternative pathways of care through urgent and emergency services that are not designed to meet their needs (with high costs that do not achieve the necessary outcomes)."

Partnership working is the mainstay with regards to the development and running of Health inclusion services, the multiple exclusion that these individuals face cannot be addressed by any sector alone.

We've also formally now partnered with the Faculty of Health, Inclusion and Homelessness in London. It's a multi-disciplinary network focused on health care for people experiencing homelessness and other excluded groups. They have a formal partnership program called Pathway and that is about putting health inclusion staff nurses or GPs in the Emergency Unit (EU). So, for anyone that comes in who is homeless or destitute, they can be met there by the health inclusion team. They can also be assessed in terms of their housing need to try and work towards a reduction in discharge into homelessness. It is also a chance to have other opportunistic tests done that they may need such as BBV or TB screening, outstanding vaccinations can be given also.

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Working in EU is one of our aims and we have started to do that here currently via pilot funding, it has taken us a little longer to secure the funding for formal partnership but now this has happened, the progress should be quicker. We are the first site in Wales to partner with the Faculty and that's really exciting because we are now part of a national network of health inclusion teams for learning and sharing information, we can import their best practice, share our practice, they'll help us with lots of advice regarding outcome measurements and the setting up of health Inclusion services from their wealth of experience across the UK.

What Next?

At the moment we are in the middle of a transitionary period. We have funding for some of the elements of the proposed Tier 3 model but there's a lot that we haven't got sustainable funding for. It's a huge project and for it to be a success support has got to come from all sectors.

We have the enthusiasm we just need to next steps which may involve co-funding, co-commissioning and colocation. We have the Health Inclusion Program Board to work through the details and practicalities of any such arrangement.

There are still elements of the Tier 3 model that we would like to work on developing with partners, those with lived experience and then implement in a sustainable way.

We would like to start GP/Nurse outreach to some of the sex parlours, having a nurse to go into sex parlours and to do any screening that's needed and to invite people back to CAVHIS to register, receive full screening and access healthcare. We realise that there may be people working in sex parlours who do not need a service like CAVHIS but there will also be people in who are completely undocumented from different countries and will have a fear of registering anywhere due to fear of deportation.

We would also like to provide care for mobile Roma, Gypsy and travelling people by partnering with Cardiff council so when people turn up in a lay by or at an unauthorised encampment, we've got a team that are ready to go out and say, "have you got any health needs, can we do any vaccinations"?

Another aim is for us to secure funding to be able take on all the high needs homeless, to be their GP, not to just provide that acute care. With funding we could be the primary care service for all the single persons front line, homeless hostels in Cardiff, at present there are 5-6 in total that we would like to target. This would make the current outreach we do far more effective as we would be able to address and aim to manage, along with the service users; chronic physical and mental health problems.

We're also hoping to bring partners together in probation services, prison, health and justice partnership and reoffending teams who are working with people under short term sentencing probation teams.

All the partners we've spoken with are really keen to make this happen and so the next stage is to find the funding to run a two-year pilot project where CAVHIS take on all people who are discharged from prison under the short-term sentencing team. There's about 313 in Cardiff and Vale. We would like to take healthcare to probation sites, go there with a GP and a nurse and run a clinic for men and women, three times a week, the idea being to close the gap between prison discharge and accessing healthcare, to try and increase the uptake of vaccinations, STI screening, BBV screening.

A recent report on deaths whilst under community supervision by Public Health Wales shows the annual number of people dying whilst under probation services in Wales has increased exponentially by 194% between 2018/19 and 2020/21, demonstrating a higher increase in deaths than Ministry of Justice (MOJ) figures for England and Wales combined.

A recent report on deaths whilst under community supervision by Public Health Wales[4] shows the annual number of people dying whilst under probation services in Wales has increased exponentially by 194% between 2018/19 and 2020/21, demonstrating a higher increase in deaths than Ministry of Justice (MOJ) figures for England and Wales combined.

- Probation cohorts in Wales would benefit from enhanced health support to prevent premature mortality, particularly around substance use, alcohol and mental health, with a particular focus in the areas of greatest deprivation. Probation services and Health Boards in Wales should work together to find solutions for healthcare provision that meets the needs of this cohort.
- Delivery of health interventions within Probation Delivery Units should be considered as an outreach model for those who attend probation services but often do not engage with primary health care services. Probation services and Health Boards in Wales should work together on models of health service delivery within probation.

The development of CAVHIS to better meet the needs of people who have some of the poorest health outcomes in Cardiff and Vale has a way to go, but we are very pleased with the progress so far and excited about working together with local authority services and the third sector to further develop the model.

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Click here more information about Cardiff and Vale Health Inclusion Service or get in touch with the RIC Hub.

[4] A review of deaths whilst under community supervision or probation services in Wales between 1st April 2018 and 31st March 2021, Public Health Wales, September 2023