Highlight Report Health and Multiple Disadvantage	
Report Author:	Michael Corbishley
Date:	September 2023
State which **Strategic Outcome/s** this project links to**:**	Healthy lives and wellbeing for all: Sheffielder's all have the opportunity to lead long, healthy, active and happy lives and can connect to the right health and wellbeing support at the right time

1. Executive Summary

This report outlines the health needs of the Sheffield Changing Futures cohort in order to provide a better understanding of the health needs of adults experiencing multiple disadvantage in Sheffield.

Learning from our programme highlights the high levels of unmet need around physical health for this cohort. This mirrors the outcome of other regional and national studies focused on homelessness and health outcomes that evidence high levels of physical health need but low levels of engagement in treatment.

This report highlights that:

- Males are less likely to access treatment than female counterparts, some up to three times less likely.
- Black British, Black African and Mixed: White and Black individuals are the least likely ethnic group to access treatment.
- The criticality of the years leading up to this cohorts 45th birthday given the increased likelihood of premature death or a successful support intervention
- How barriers to accessing community healthcare are driving this cohort towards urgent care

2. Headline Health Statistics: Changing Futures cohort

- 46% of the cohort have a recognised disability, 25% have a physical disability.

- 74% of the cohort have identified physical health needs that create limitations compared to 25% of the general population[1]

- On average the cohort have two health conditions each, the highest number of current health needs a single person has is six

[1] UK health indicators - Office for National Statistics (ons.gov.uk)

- The most common category of health need is musculoskeletal followed by vascular and then respiratory.

- 27% of those with enduring health needs are accessing treatment, the most common treatment accessed is medication via their GP.

3. Background and context

Changing Futures is a grant funded programme by the Department for Levelling Up, Housing and Communities (DLUHC) and The National Lottery Community Fund. In July 20221 Sheffield was successful in securing funding up to the end of March 2024.

Changing Futures acts as a change fund for the City, particularly in relation to how we can deliver improved outcomes for people experiencing multiple disadvantage and enable a greater shift towards prevention of abuse and neglect. The programme currently supports a cohort of 80 vulnerable adults with multiple and complex needs.

The programmes national definition of multiple disadvantage is any adult experiencing three or more of homelessness, mental health, substance use, domestic violence or contact with the criminal justice system. Despite health being excluded from the programmes multiple disadvantage criteria (three out of the five needs noted above) learning from the programmes work with 80 adults experiencing multiple disadvantage has demonstrated that it is an equitable area of need.

4. Evidence of Need

Adults experiencing homelessness experience some of the worst health outcomes in the UK, dying 30 years earlier than the general population and with a life expectancy of just 45 for men and 43 for women[2].

In 2019, the NHS Sheffield Clinical Commissioning Group commissioned a report by Pathway titled 'A Pathway Needs Assessment for Patients Experiencing Homelessness'. This report highlighted the difficulties homeless adults face when trying to access healthcare and when being discharged from hospital.

Research by Homeless Link and the Homeless Needs Health Audit[3] confirms this group face significant health inequalities. This work found 76% of homeless adults surveyed had a physical health condition with the main conditions being musculoskeletal followed by oral/dental.

Changing Futures Sheffield supports a cohort of 80 adults experiencing multiple disadvantage in the city. This cohort were targeted for support by the programme as they were often well known to support services but had histories of inconsistent and ineffective engagement with support. The programme deploys a community based, assertive outreach model which brings services to our clients. Since working with this cohort we have sustained high engagement rates of 86% and achieved a range of positive outcomes, more details can be found on our website changingfuturesheffield.info.

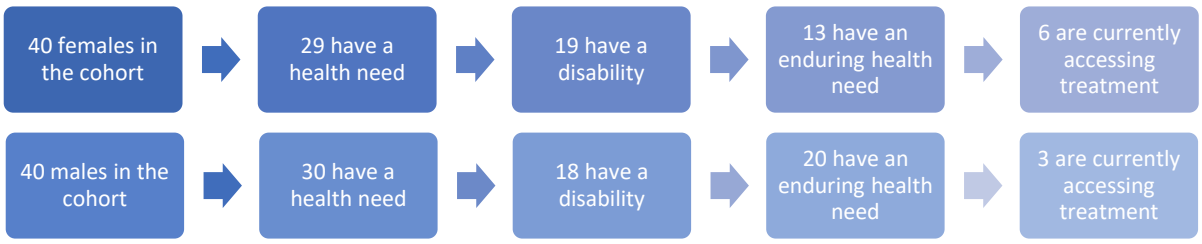
[2] Deaths of homeless people in England and Wales - Office for National Statistics (ons.gov.uk)
[3] Homeless_Health_Needs_Audit_Report.pdf (kxcdn.com)

5. Changing Futures Cohort Health Data

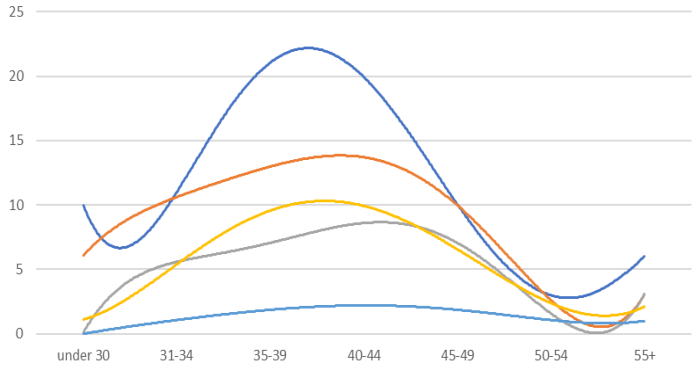
As part of the Changing Futures cohorts support planning, we collect data on a range of areas of need, including health. The data below provides an overview of the health needs of those supported by the programme in Sheffield:

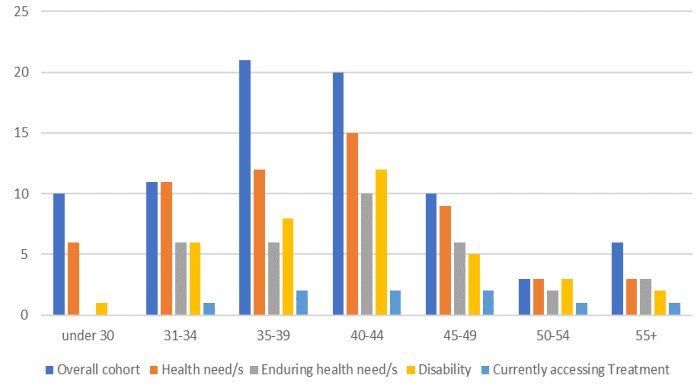
Demographics & Health

Health Need and Gender

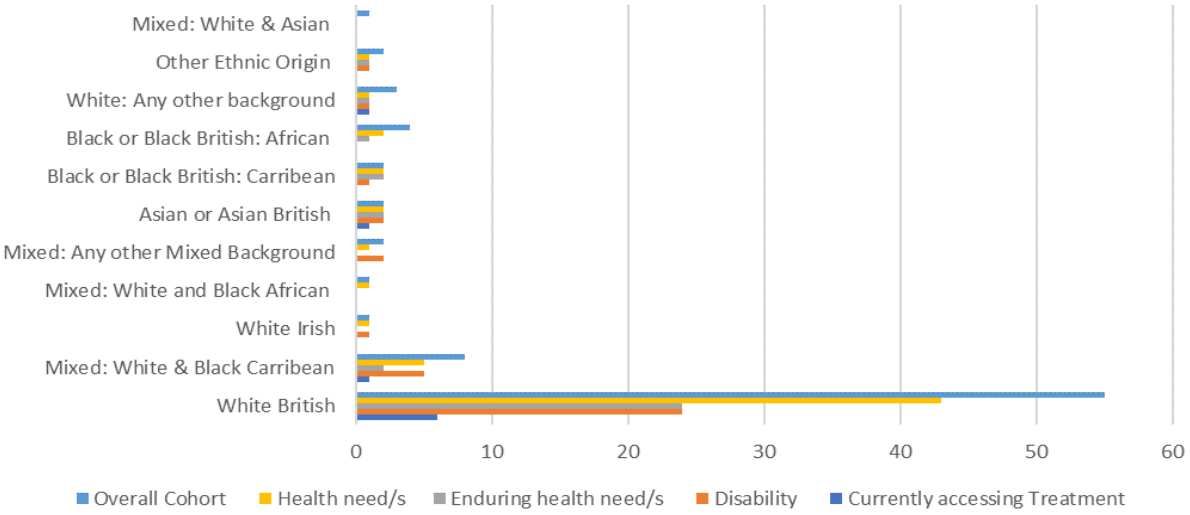


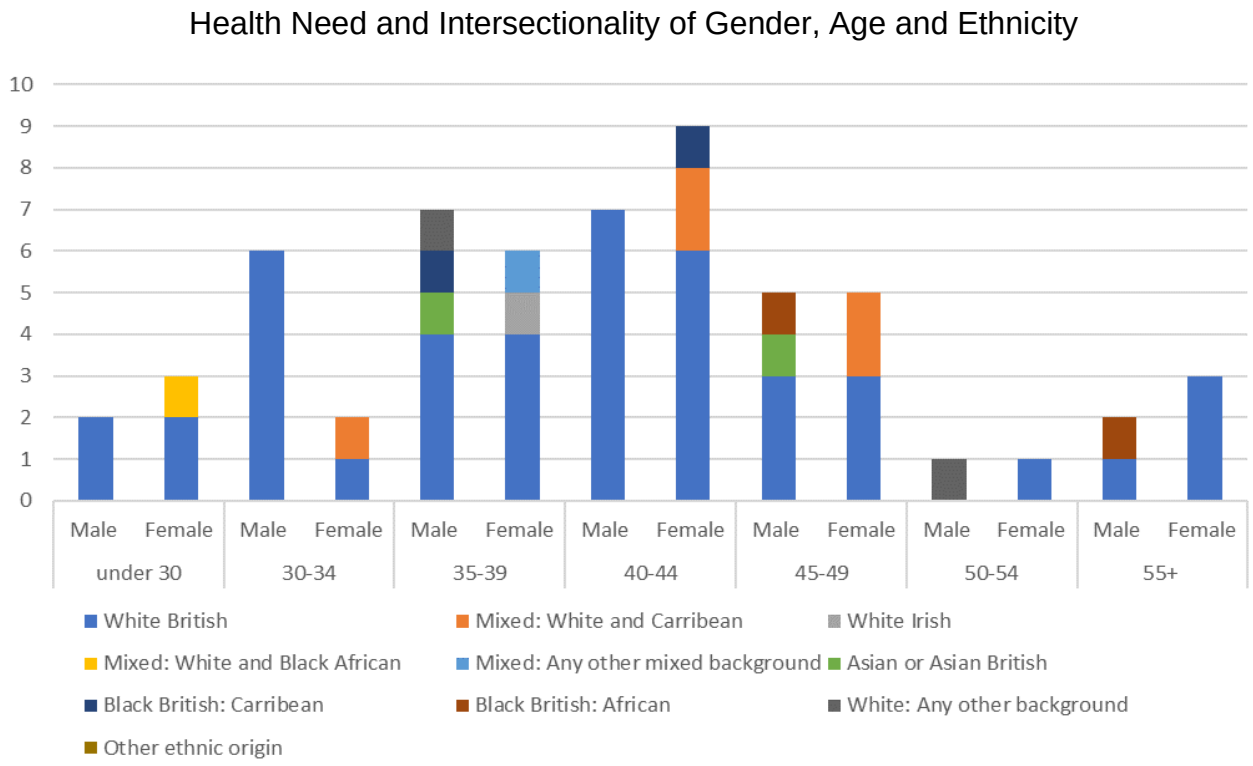
Health Need and Age





Health Need and Ethnicity





Categories of Health Need

Category	Health Need	Ongoing Health Need
Musculoskeletal	32	29
Vascular	15	8
Respiratory	12	10
Mobility	10	4
Podiatry	8	3
Neurological	8	6
Cardiovascular	4	1
Oral health/Dental Care	3	2
Visual Impairment	4	3
Gastric issues	2	2
Fibromyalgia	1	1
Diabetes	1	1
Human Immunodeficiency Virus	1	1
Cancer	1	1
Gynaecology	1	0
	103	**72**

Treatment

85% of the cohort are registered with a GP and 59% of those with a health need report accessing some form of support.

33% of the Changing Futures cohort attended A&E in financial year 2021/2022. 4% attended A&E 16 times or more between April 2021 and March 2022. Since the programme launched (March 2022) the cohorts A&E attendance has reduced by 4%.

29 of the 33 people on our cohort with an enduring health need have historically accessed treatment for their conditions; 4 people have never accessed treatment. Currently, only 9 individuals with enduring health needs are accessing treatment.

These 9 people had the following enduring health needs:

- Musculoskeletal Issues – 7
- Respiratory - 2
- Vascular – 2
- Neurological – 1
- Fibromyalgia – 1

And were accessing the following treatments:

- GP – Prescribed medication – 8
- Secondary Care – Inpatient treatment – 3
- Community Outpatient Services – 1
- Substance Use Service – Wound Care – 1
- Prison Healthcare – 1

6. Health Data Analysis

Data analysis completed as part of the Changing Futures programmes cohort identification process[4] found just under 3,000 people in Sheffield who meet the programmes definition of experiencing multiple disadvantage. Whilst the cohort supported by the programme is comparatively small, and therefore we must caveat any conclusions drawn from it, it does provide some indication of the health needs of this wider group.

It is also worth noting that this data is based off records held on the programmes data system and is not corroborated by individuals' health records. This means it is probable there will be gaps in our data set with need likely under reported.

The limitations of data sets on complex issues such as this means that it is unlikely to offer effective explanations of the topic but does provide areas of interest for further exploration. The health data from Changing Futures indicates the following:

[4] Changing Futures Learning Report - Cohort Iden.pdf (wsimg.com)

Gender:
Men with enduring health needs are three times less likely to access treatment then women with enduring health needs despite women in this cohort typically being less likely to access support services[5].

Whilst there have been no studies specifically focused on gender based health engagement differences for adults experiencing multiple disadvantage there have been numerous studies[6] of this kind for the general population. The consensus is that men are less likely to engage in health services, especially primary care with causality ranging from appointment availability to personal psychological barriers to seeking help and support.

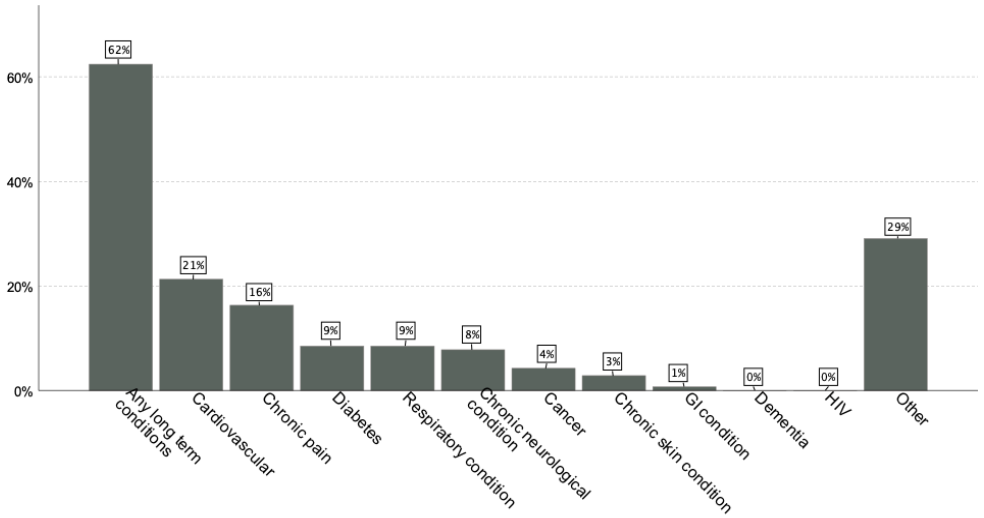
The disparity in engagement is significant enough that in the general population men are 6% more likely to die during working age and it is estimated that 36% of male deaths are preventable (compared to 19% for women).

Currently there is no specialist health offer in Sheffield aimed at men to improve their engagement rates with treatment.

Age:
Health needs become more predominant as the cohort ages yet the number of individuals aged 44 years and older significantly reduces. This may be linked to the overall life expectancy of this cohort (cross-gender average of 44 years) or due to the cohort addressing support needs and moving out of high-needs services like Changing Futures.

Data, both nationally and in South Yorkshire, shows that those aged 45-54 are the most likely age group to die by suicide. The majority are white British male which reflects the majority of known homeless adults in Sheffield. The most common drivers for suicide reflect the common experiences of our cohort (unresolved trauma, poor mental health, substance use, poor physical health, housing and finance issues, crime, a lack of social connectedness, lack of work and education).

The health data from Sheffield below shows the types of health needs those who died by suicide had:



[5] Changing Futures Learning Report - Women exper.pdf (wsimg.com)
[6] Men's help-seeking and engagement with general practice: An integrative review - Mursa - 2022 - Journal of Advanced Nursing - Wiley Online Library

Qualitative analysis of interviews with family and friends of the deceased in Sheffield identified key health related drivers for suicide were:

- Reduced mobility or disability
- Physical pain (particularly self-medication)
- Worry about their health
- Terminal diagnosis

Sheffield data on drug related deaths shows that an average of 75 people died from drug misuse each year and a further 193 die from alcohol specific mortality. A breakdown of age and ethnicity is not available from this data set. However, data from housing related support services (support services predominantly focused on those with a primary need of homelessness) shows that in the 2021/2022 financial year the average age of adults who died whilst in receipt of support services was 44 years old.

The table below outlines the age groups of those in receipt of Drug and Alcohol support as commissioned by Sheffield City Council. It shows that the majority of adults (40%) in drug and alcohol treatment in Sheffield are aged 40-49, with the second highest age group aged 50-54.

14.3 Age group (all in treatment)	1 Apr - 30 Jun		1 Apr - 30 Sep		1 Apr - 31 Dec		1 Apr - 31 Mar	
	No.	%	No.	%	No.	%	No.	%
Under 18	0 / 2470	0.0%	0 / 2676	0.0%	0 / 2946	0.0%	0 / 3169	0.0%
18	8 / 2470	0.3%	8 / 2676	0.3%	8 / 2946	0.3%	9 / 3169	0.3%
19	8 / 2470	0.3%	9 / 2676	0.3%	12 / 2946	0.4%	12 / 3169	0.4%
20-24	48 / 2470	1.9%	57 / 2676	2.1%	71 / 2946	2.4%	87 / 3169	2.7%
25-29	108 / 2470	4.4%	126 / 2676	4.7%	153 / 2946	5.2%	175 / 3169	5.5%
30-34	199 / 2470	8.1%	227 / 2676	8.5%	276 / 2946	9.4%	304 / 3169	9.6%
35-39	359 / 2470	14.5%	381 / 2676	14.2%	431 / 2946	14.6%	471 / 3169	14.9%
40-44	515 / 2470	20.9%	558 / 2676	20.9%	600 / 2946	20.4%	638 / 3169	20.1%
45-49	521 / 2470	21.1%	545 / 2676	20.4%	570 / 2946	19.3%	598 / 3169	18.9%
50-54	374 / 2470	15.1%	400 / 2676	14.9%	427 / 2946	14.5%	447 / 3169	14.1%
55-59	190 / 2470	7.7%	207 / 2676	7.7%	233 / 2946	7.9%	247 / 3169	7.8%
60-64	88 / 2470	3.6%	103 / 2676	3.8%	105 / 2946	3.6%	114 / 3169	3.6%
65-74	49 / 2470	2.0%	52 / 2676	1.9%	57 / 2946	1.9%	63 / 3169	2.0%
75-84	3 / 2470	0.1%	3 / 2676	0.1%	3 / 2946	0.1%	4 / 3169	0.1%
85-94	0 / 2470	0.0%	0 / 2676	0.0%	0 / 2946	0.0%	0 / 3169	0.0%
95 or above	0 / 2470	0.0%	0 / 2676	0.0%	0 / 2946	0.0%	0 / 3169	0.0%

Technical Notes: All clients in treatment within the date parameters and their age as recorded at the start of their treatment journey or the start of the date parameters stated (whichever is later).

Similarly, the average age of those living in Sheffield's supported living schemes for adults with a primary need of homelessness is 38. Combined this indicates that the cohorts drop off post age 44 could be linked to people accessing and engaging support services in the lead up to this marker reducing their need for high intensity services such as Changing Futures.

Collectively it is clear that for those experiencing multiple disadvantage, the period leading up their 45th birthday is critical given either the increased likelihood of death or the increased likelihood of successful support intervention.

Ethnicity:
Whilst men overall are less likely to engage in healthcare services (see above under Gender), based on the Changing Futures Cohort data Black British African, Black British Caribbean and those from Mixed ethnicities are the least likely to be accessing treatment. This is despite having comparatively equal levels of health need to other ethnic groups, namely White British.

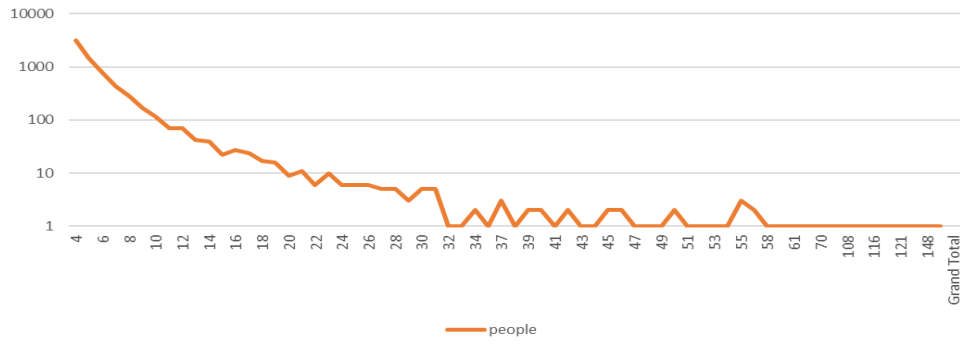
Other studies[7] have shown this underrepresentation in health services is not limited to Sheffield. The Sheffield Race Equality Commission Report[8], which flags Health as a key theme, does provide some explanations as to why this disparity in accessing treatment might exist:

"In Sheffield there are concerns with commissioning strategies for community health organisations (Ashiana), this is supported by the CCG who state that money allocated to Sheffield for GP services doesn't reflect the needs of deprived communities, cementing health inequalities, cultural competence and Eurocentrism in diagnoses, over-reliance on compulsory routes into services such as detention of Black men in mental health (SACMHA), health environment issues such as availability of Halal food in hospitals and food banks (Healthwatch Sheffield), availability of interpreter/translation services (Page Hall Medical Centre, and the Sheffield Roma Network)".

Work in 2014 by Muslim Women in Need provides evidenced based examples of how community based, culturally informed support services can improve access and engagement for marginalised communities. Whilst Sheffield does have some organisations whose focus is on marginalised communities, these are often led by third sector organisations and do not form part of statutory health pathways.

Health Need:
The majority (59%) of those with health needs are accessing the treatment they require but those with the highest level of need (enduring health needs) engagement with treatment is lower (29%). The most common treatment being accessed is prescribed medication from their GP (57%), even for those accessing treatment it is more likely the condition is being managed rather then treated. In the 2022/2023 financial year, nearly a third of the Changing Futures cohort have attended A&E, 4% of them attending 14 times or more (the highest number of attendances within the cohort was 29).

The following graphs and tables were developed from South Yorkshire Integrated Care Board data on high intensity users of urgent care in Sheffield:



This graph shows how quickly the number of attendances by individual decreases. 3000 people attended 4 times in the time period (Apr 21 – Nov 22), reducing to 114 people attending 10 times, 22 people 15 times, and 2 people 40 times. It also shows that Sheffield has several individuals (8) who have attended A&E over 100 times.

[7] Minority men's engagement with health promotion (Boyz2men): an exploratory cross-sectional study - The Lancet
[8] Sheffield Race Equality Commission Report

Count of nhsnumber	Column Labels							
Row Labels	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Grand Total
Active rewarming of the hypothermic patient	1							1
Anaesthesia		2	2	1	2			7
Blood product transfusion					1			1
Central line				1				1
Continuous positive airways pressure/nasal intermittent positive pressure ventilation/bag valve mask					1			1
Dressing	11	12	15	10	16	13	16	93
Guidance/advice only	21	18	20	21	18	21	30	149
Infusion fluids	4	5	6	9	5	4	1	34
Intravenous cannula	69	70	75	63	81	81	67	506
Lavage/emesis/charcoal/eye irrigation							1	1
Loan of walking aid (crutches)	1				2	1		4
Manipulation		3	2	1		1		7
Medication administered	82	83	79	93	60	62	68	527
Nebuliser/spacer	5	11	5	12	9	10	5	57
Observation/electrocardiogram, pulse oximetry/head injury/trends	9	19	17	10	11	16	16	98
Occupational therapy						1		1
Other (consider alternatives)	14	12	11	8	11	21	13	90
Other parenteral drugs	11	7	13	18	13	15	7	84
Plaster of paris	1		1	1				3
Prescription/medicines prepared to take away	17	24	18	19	21	28	24	151
Removal foreign body			1			1		2
Sling/collar cuff/broad arm sling	1				1	3	1	6
Social work intervention							1	1
Splint		2	2	1	2	1		8
Supplemental oxygen	6	4	7	9	6	18	8	58
Sutures	3	6	5	4	6	2	3	29
Urinary catheter/suprapubic	2	3		2	1	2	1	11
Wound closure (excluding sutures)	3	4	1	5	3	3	3	22
NULL	122	134	126	148	152	151	139	972
None (consider guidance/advice option)	283	284	279	295	302	310	279	2032
Grand Total	666	703	685	731	724	765	683	4957

The data in this table has been filtered for those individuals who have attended A&E more than 20 times within a 12 month time period and gives an indication of the treatments recorded. Similarly, to the Changing Futures cohort the most common treatment received is medication administered.

Whilst this provides some idea of how the cohort engage in healthcare services, their health needs and what type of support they access (including at A&E) it does not provide an explanation as to why engagement rates in community healthcare are so low.

7. Challenges in accessing Healthcare

The Changing Futures programme sought feedback from staff and clients involved in the Changing Futures programme to better understand their experience of accessing healthcare in the city. Below are some of the comments fed back to us:

"My client JM has been moved around a lot recently (through no fault of his own) and so is currently between GPs. He has not been able to access his prescribed medications for some time as a result" ***Worker***

"My GP's receptionist is really rude, she makes things difficult. On discharge I was told a nurse would come out to me because of my mobility problems, but the surgery decided that if I was capable of getting to an appointment (as I had previously done with help down the stairs and into a taxi, which was expensive) then I didn't have mobility issues and couldn't have a nurse come out" ***Client***

"WM has been banned from Fitzwilliam Centre and so cannot access his methadone script or having his leg wounds dressed. Fitzwilliam signposted him to his GP, but his GP are also considering banning him. We are unsure where to go if they refuse him" ***Worker***

"I had swollen legs but when I was in the doctor's office she wouldn't examine them because she knows I am a drug user – she wrote a prescription without even looking to see what was wrong. I felt really judged and dismissed" ***Client***

"RF also has a broken ankle. There have been significant barriers in arranging for him to go into hospital for the surgical intervention he required due to him being an alcoholic and Northern General seemingly

not being able to cope with this additional complexity. Writing a hospital passport for RF seems to have helped the situation a little" ***Worker***

"Hospital staff are condescending and keep telling you "5 minutes, 5 minutes" then ignoring you. Sometimes they will leave you rattling a whole day without methadone. Often it's easier to self-discharge than to put up with this" ***Client***

"Getting through to the GP to get an appointment is well-nigh impossible" ***Worker***

"A two-year waiting list to register for a dentist??" ***Client***

"GP's and receptionists not really listening or understanding about the anxiety faced by clients we work with in GP waiting rooms. They find waiting very stressful and appointments are running late often" ***Worker***

"I can never get through to my GP on the phone and when I do there are no appointments left" ***Client***

"ES went to Northern General for her arthritis injections and actually they were very good with her. It so often depends on the attitude of whoever they are seeing" ***Worker***

"That GPs receptionist is ignorant. They talk to me like dirt" ***Client***

"GP surgeries vary so much. Some are atrocious and some are really good with our clients" ***Worker***

"The use of digital appliances to access healthcare, for example, not may GP surgeries are flexible with ordering repeat prescriptions or booking GP appointments. Most of our clients do not have access to phones, are not confident in their digital skills or have limited literacy skills. Therefore, they are reliant on us but in the mean time are missing important medication or conditions are worsening" ***Worker***

"I need my methadone first, they won't care if I'm withdrawing" (In reference to hospital admission) ***Client***

"Quick discharges following specialist referrals once an appointment has been missed. This could be due to homelessness, literacy skills and/or mental health of the patient. Follow ups then get missed then condition deteriorates and they end up back in emergency departments" ***Worker***

"It takes real patience and talented staff to support some of our clients with insight to poor mental health and trauma related behaviours. A positive example of this was at Porterbrook GP practice where a nurse was very quick to understand what was happening for one of my caseload. Agitation was recognised and dealt with by finding them a room quite quickly for their consultation, and then accompanying (and sourcing a personal cigarette for) them outside afterwards. My SU felt seen and respected" ***Worker***

8. Current and planned homeless healthcare provision in Sheffield

The ICB has been working in partnership with Changing Futures as part of their Physical and Mental Health System Change Workstreams as well as delivering on its own organisation commissioning priorities. These priorities all broadly align to supporting better accessibility to health care services to meet the needs of this cohort and entail working with several support agencies in order to build robust, sustainable, collaborative relationships.

Through the relevant workstreams outlined above the following are examples of new projects & initiatives that have been recently introduced with monitoring and evaluation ongoing. This includes:

Homeless Hospital Discharge Service

- Jointly funded between ICB and Changing Futures commissioning Framework, a local third sector homelessness support provider, to deliver a 12 month test and learn pilot.
- This new services aims are to improve hospital discharge, reduce high intensity users of A&E and improve communications between colleagues in health settings & community services
- The above initiatives have entailed whole pathway reviews within Sheffield Teaching Hospitals and formal contractual conversations to ensure delivery helps inform ongoing planned service improvement plans.

ICB Locally Commissioned Service for the Homeless (LCS)

- Currently Sheffield has three citywide recognised GP practices working to an enhanced homeless specification – the ICB are currently reviewing this as part of ongoing priority work

NHSE / Mental Health - Rough Sleeper Mental Health Programme

- Sheffield and Doncaster Places were successful in securing NHSE regional mental health monies to roll out a 12-month test and learn Rough Sleeper Metal Health initiative.
- In Sheffield this funding is being used to recruit two new peer Mental Health support workers to the Homeless Assessment Support Team delivered by Sheffield Health and Social Care Trust.

ICB Discharge Initiatives – Winter pressures support

- The Medical room has been refurbished at The Archer Project, a local homeless day centre, to ensure compliance with Infection Prevention Control (IPC) most recent guidance at Level 2. GP, Dental, Wound Care and Chiropody outreach services will all be provided in this space alongside seasonal health campaigns e.g., flu vaccinations.
- An additional medical room has been installed at the Bens Centre, another local homeless day centre, compliant with IPC guidance at Level 1. Chiropody services are currently provided in this space and looking to secure more outreach.
- Additional detox support put into The Greens, local substance use residential support service, to support earlier discharge initiatives and link in transitional patients into more community support

Citywide Street Outreach Nurse

- Funding has been secured through the Rough Sleeper Initiative (RSI) by Sheffield City Council to recruit a Street Outreach Nurse who will be hosted by Primary Care Sheffield GP Federation (PCS)
- This role will work between the citywide GP practices commissioned to deliver the Locally Enhanced Service (LCS) for Prevention of Homelessness and will be co-located between the Devonshire Green Medical Practice and Framework (homeless outreach team) officers.

Personalisation support

- The ICB has secured a small amount of funding for financial year 22/23 to share between our voluntary services to support with personal needs under ‘personalisation’ initiatives.

An example of this would be to cover transport costs to ensure attendance at health appointments.

Marie Curie Palliative and End of Life for Homeless

- ICB Planned Care colleagues have drawn together local partners to support the roll out of Palliative and End of Life for Homeless training. This initiative, supported by Marie Curie, is aimed at staff working adults with primary needs around homelessness.
- The next step of this project intends to develop a community of practice to maintain engagement, evaluate delivery and continue to share best practice.

9. Summary and Next Steps

Sheffield has a strong homeless and health partnership network and has a strong commitment from colleagues in the ICB and health services to work with local partners to continue to review service provision gaps in health and work collaboratively to see these closed.

This report highlights:

- The need for a greater focus on the delivery of health services with a particular focus on gender and ethnicity of beneficiaries
- Further work is needed to reduce access barriers to primary care in the city for this cohort which is likely to reduce use of urgent care services
- Consideration to be given to enhanced packages of support targeted at this cohort as they approach their 45th birthday given the increased likelihood of successful intervention and the opportunity to prevent premature death

A 2023 report by Pathway 'Beyond Pockets of Excellence: Integrated Care Systems for Inclusion Health'[9] provides a route map for local systems wanting to improve their health inclusion offer for more marginalized groups.

[9] Pathway Commission for Inclusion of Health Report - August 2023