Urban Village Medical Practice

Service Review 2018

URBAN VILLAGE
MEDICAL PRACTICE

The Review

Urban Village Medical Practice

Urban Village Medical Practice (UVMP) is a GP practice based at Ancoats Primary Care Centre on the outskirts of the city centre. As well as providing primary healthcare to over 10,000 registered general patients since 1998 we have also provided a primary healthcare service to people experiencing homelessness in Manchester. Since 2012 the practice has also been commissioned to provide a hospital in-reach service at Manchester Royal Infirmary. The service is the only comprehensive healthcare service for people experiencing homelessness in Manchester and currently provides the following:

- Proactive engagement with homeless people including outreach and hostel drop-ins by clinical and non-clinical staff to enable registration and engagement with the practice or other health advice.
- Flexible and easy to access range of services including GP, nurse, tissue viability service, alcohol services, drug assessment and treatment, mental health services and dentist.
- A hospital in reach service by clinical and non-clinical team members offering assessment of medical and social needs and discharge planning for homeless patients that are admitted.
- Regular nurse-led clinics at The Beacon Day Centre and The Booth Centre to build relationships with people experiencing homelessness, addressing immediate health needs and supporting people to engage with mainstream healthcare.
- Case management of homeless patients that are frequent attenders at MRI A&E to address health and social needsin order to reduce the impact on secondary care.
- Additional support for all homeless patients in relation to benefits, outpatient appointments and housing options.

The Review

The aim of this review is to provide information on the key characteristics of the homeless population registered at Urban Village Medical Practice in 2018, including a review of their health needs and an analysis of the effectiveness of interventions. The review will highlight some of the activities undertaken by the Homeless Service in 2018 and provide an opportunity to make key recommendation for the future of the service.

Methodology

In order to provide a full overview of the demographic of the total homeless population at UVMP in 2018 information was obtained through interrogation of the electronic data recording system (EMIS) used by the practice. To evidence more specific health issues and effectiveness of interventions a random sample of 100 new patients registered in 2018 was taken and a full review of all clinical notes for these patients was undertaken.

The Results

Registrations

UVMP Homeless Service offers full registration to homeless single adults in Manchester using the broadest definition of homelessness.

- At the end of 2018 there were a total of 754 patients were registered as part of the Homeless Service
- 83% of registered patients are male and 17% female.
- 277 homeless patients were registered in 2018, an average of 23 new patients per month.

Accommodation Status (at the point of registration)

- 8% B&B
- 20% hostel
- 5% night shelter
- 49% rough sleeping
- 15% sofa surfing
- 3% squatting

Age

The age of new patients registered in 2018 ranges from 19-82.

- 25% of new registrations were under the age of 30
- 57% were aged between 30 and 50
- 18% were aged 50+

Appointments

Homeless patients registered at UVMP receive full GP registration and as such can attend appointments at any time. However, we do realise that the nature of homelessness can make attending appointments difficult. Therefore we also provide flexible appointment sessions with a GP and Practice Nurse for homeless patients in addition to the weekly, multi-disciplinary team drop in for homeless patients.

In 2018 homeless patients attended:

- 3990 GP appointments
- 1950 Practice Nurse or Healthcare Assistant appointments

Feedback from one of our partner organisations:

"Urban Village Medical Practice has been instrumental in our ability to support the homeless community in Manchester. The drop-in service has allowed us to make huge steps forward with entrenched rough sleepers and the range of other services on offer are excellent. Combined with staff who are very understanding of the issues facing our clients, we are very appreciative that such a service exists in Manchester."

The Review

New Patient Health Checks

The New Patient Health Check is a comprehensive healthcare assessment undertaken by a Practice Nurse or GP in the first 8 weeks of registration and collects vital information on physical health, mental health, sexual health, women's health and substance misuse issues as well as social issues that impact on a person's health and wellbeing. Interventions are offered and administered at this point including immunisations, sexual health screening, Blood Born Virus Testing, smoking cessation and contraception.

- 80% of the patients registered in 2016 received a New Patient Health Check (NPHC).

Vaccinations

In 2018 the homeless healthcare team were asked to deliver two vaccination campaigns for Hepatitis A and Flu. The delivery of Hepatitis A vaccines was in response to an outbreak of Hepatitis A amongst people sleeping rough in Manchester city centre and was a joint working initiative with Public Health England and Manchester City Council. Vaccines were offered to anyone who was sleeping rough or at risk of rough sleeping and given in drop in clinics at Urban Village, day centre clinics, needle exchange, hostel's and on the streets using a council outreach van. This campaign was successful in giving 239 Hepatitis A vaccines and was recognised by PHE as likely averting further infections with their associated morbidity & potential mortality. A second booster dose has been given to 68 of those people and Hepatitis A vaccines continue to be offered to anyone at risk of rough sleeping.

The homeless healthcare team were also commissioned by Greater Manchester Health and Social Care Partnership to deliver flu vaccines to homeless people accessing day centres, winter night shelters, evening provision, rough sleeping or in temporary accommodation. The aim being to offer flu vaccines more widely to homeless people not registered at Urban Village. 128 flu vaccines were given to homeless people in Manchester not registered at Urban Village at a variety of different settings. We hope to build on this in 2019 as we have been commissioned to deliver flu vaccines again during the next flu season.

In addition to these initiatives 222 flu vaccines, 82 pneumovacs and 46 hepatitis B vaccinations were administered to homeless patients in 2018.

Wound Care:

In response to increasing numbers of patients being diagnosed with leg ulcers in 2012 the Tissue Viability Service from Pennine Acute Trust ran a pilot to provide a flexible and accessible wound care service for homeless patients at Urban Village Medical Practice. The pilot was a great success and the service now runs 3 weekly clinics.

- In 2018 the clinic performed 629 dressings for homeless patients

Infectious Diseases

Due to the prevalence of Blood Borne Viruses (BBVs) in the homeless population the Infectious Disease department at North Manchester General Hospital have provided a shared care clinic for the treatment and cure of BBVs at UVMP since 2012. This is an innovative service designed to promote engagement with marginalised populations to reduce health inequalities. We have had significant success in commencing and completing Hep C treatment and commencing and stabilising patients diagnosed with HIV. This service has demonstrated the ability to effectively engage complex and often chaotic patients in treatment they would not otherwise access.

In 2018:

- 226 appointments were provided to homeless patients

Drug Treatment

UVMP have provided a shared care clinic for the treatment of opiate dependency with the relevant drug service provider for over 20 years.

In 2018:

- 2490 appointments were attended by homeless patients with a drug worker.
- Currently 154 homeless patients are in drug treatment at UVMP.

Mental Health

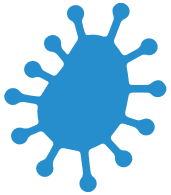
Through the weekly homeless drop in we provide homeless patients with access to mental health services. In 2018 Greater Manchester Mental Health Homeless Team provided support to patients with severe and enduring mental health issues and undertook 112 appointments with registered homeless patients at Urban Village Medical Practice last year.

Podiatry:

Urban Village Medical Practice are proud to work in partnership with the University of Salford to deliver a weekly podiatry drop in clinic for homeless people whether registered with the practice or not. This service is delivered each week by a clinical tutor and undergraduate students from the BSc Podiatry course who find the clinics to be a valuable learning experience. Some students have gone on to volunteer their own time to deliver foot care or education sessions on foot health in other settings for homeless people.

In 2018 130 homeless people accessed the podiatry clinics at Urban Village for foot problems including thickened or deformed toe nails, corns, callouses, painful feet, blisters, ulceration, wounds, fungal infections, neuropathy and trench foot. Many of these people regularly accessed the clinic until their foot problems were resolved, the podiatrist describes treating one young man:

"We were able to give a young man with trench foot new socks and trainers and a few weeks later, his feet were perfect".



Analysis

Analysis of a random sample of 100 new patients

Of the random sample of patients selected for the study 70% were male and 30% female. The experience of homelessness can be vastly different for men and women and health issues and engagement in healthcare also varies greatly. Therefore, for the purpose of this study the data for male and female patients was analysed separately and reported accordingly.

Male	Health Issues	Female
74%	Identified as drinking alcohol to a harmful level	79%
61%	Identified as primary heroin and crack users	67%
68%	Identified as having a mental health problem	83%
15%	Diagnosis of a severe and enduring mental health problem	16%
71% (80%)	Patients screened for BBVs were Hepatitis C antibody positive (Of these patients were Hepatitis C PCR positive)	60% (89%)
6%	HIV positive	4%
5%	Hepatitis B positive	4%
14%	Have a Sexually Transmitted Infection	16%
7%	Diagnosed with diabetes	4%
27%	Diagnosed with COPD	16%
6.5%	Diagnosed with ischaemic heart disease	1%
8%	Diagnosed with essential hypertension.	4.5%
12%	Identified as having cardiovascular risk > 10%.	3%
11%	Diagnosed with leg ulcers	4%

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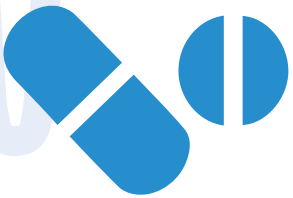
Male	Health Interventions	Female
74%	Diagnosed with a mental health problem were referred to a mental health service	78%
72%	Drinking alcohol to harmful levels were referred to alcohol services	75%
57%	Reporting opiate dependency had received a full assessment for their drug problem and commenced treatment	61%
97% (81%)	Offered BBV testing (Completed this)	98% (92%)
65% (48%)	Offered full sexual health screening Completed this	82% (63%)
99%	Received an NPHC, had information recorded on blood pressure, height, weight, BMI and smoking status.	98%
99%	Patients had smoking cessation intervention	94%
89%	Patients over 40 years old had a full cardiovascular risk assessment.	71%
no data	Patients received advice on contraception	75%
no data	Given a form of contraception	58%
no data	Female patients have an up to date smear	71%



Hospital and Community Services

'Mpath' Hospital Homeless Service

UVMP have been delivering an in-reach service to homeless patients admitted to MRI since 2012 based on the London Pathway model of integrated healthcare for homeless single people (www.pathway.org.uk). The aim of the service is to improve the experience of people who are homeless during their admission; to support hospital staff to identify, engage and treat patients who are homeless; and to support patients to engage with healthcare in the community to reduce pressure on acute services. The Mpath delivery model is provided by a GP and Case Manager completing daily ward wounds Monday-Friday to care plan patients during their admission, facilitate a safe discharge where possible and ensure patients know how to access healthcare in the community. In keeping with the rise in homelessness in Manchester and the increasing complexity of the patients being supported by the team we increased capacity in the Mpath team in 2018. We now have 2 Case Managers who are allocated set days to be hospital based while the other Case Manager has the flexibility to be based at the hospital or at the practice. Hospital discharges and inpatients of concern are discussed weekly at the MDT. We have also spent a lot of time developing recording and reporting systems and implementing performance and quality monitoring standards to ensure the effectiveness of the service.

In 2018 we supported 541 homeless inpatients at MRI, of which 261 were followed up in the community.

Feedback from MFT

"MPath provide a great support to staff and patients on the Acute Medical Unit. Having a good rapport with the team means that we are able to work together to ensure that the specific cohort of patients are effectively managed from a medical perspective, managed for risk factors and appropriately followed up after discharge from Acute services."

Barnabus

In September 2017 UVMP formed a new partnership with the homelessness charity Barnabus who run the Beacon centre, a busy day centre in Manchester city centre. Barnabus have a long history of providing support to rough sleepers and those at risk of homelessness in Manchester. The Beacon centre is a welcoming environment that offers food, clothes, showers, support and advice to around 80 people a day. The centre has a large, clean and bright dedicated health room and the Barnabus team wanted to maximise use of this resource at their busy drop ins. UVMP were looking for ways to make their high quality primary care service more accessible to the more vulnerable and chaotic. Barnabus were successful in a bid to the lottery to fund a nurse and a joint appointment was made for a nurse to be managed by UVMP to deliver primary care within the day centre.

The friendly environment of the Beacon centre helps people feel relaxed and willing to engage with a health worker in a place they already feel comfortable. Common presentations like trench foot, minor wounds and skin infections all present an opportunity to spend time with people and build relationships that enable underlying more complex concerns to be identified. People are usually relieved to be able to discuss their mental health concerns, respiratory disease, blood borne viruses and chronic wounds and over time to develop a plan on how to address these issues.

This case study shows how the Barnabus nurse clinic enabled a homeless man to gradually address his underlying health issues:

Liz Thomas, Nurse with the Homeless Team met this man in the Barnabus nurse clinic and saw him most days where he asked her to check his blood pressure. He was convinced he had a cardiac problem and presented very frequently to A and E departments across Greater Manchester who felt that his symptoms were related to anxiety. He had a very traumatic history and clearly needed support around his mental wellbeing. His GP practice had removed him from their list as they thought he had moved out of their area, although he was rough sleeping locally. Liz contacted his GP practice and was able to support him to re-register with them. She supported him to contact the mental health service the GP had referred him to. He had

missed a number of appointments but she arranged for his appointment letter to be sent to Barnabus. Liz saw him subsequently and he informed her that he had accessed the mental health service and had found it to be helpful in beginning to understand and manage his symptoms. Since September 2017 471 individuals have accessed the Barnabus nurse clinic over 1017 contacts. And 63 patients without a local GP have been supported to register.

Feedback from patients

"I was missing appointments with the specialist before but I'm now able to attend appointments and have consistency in my health services"

"Liz is lovely and helpful and answered questions I didn't think to ask"

The Booth Centre

The homeless healthcare team have been working closely with the Booth Centre, a long established day centre for homeless people in Manchester, for many years. Initially this was through a link worker going into the Booth Centre to register homeless people who needed a GP, and latterly through nurse drop in sessions again helping people to access healthcare and to also offer health interventions such as dressings, health checks, vaccines and advice. During 2018 these sessions for health interventions increased as drop in Hepatitis A vaccine clinics were held there in response to the Hepatitis A outbreak, and similarly flu vaccine drop in clinics later in the year. The Booth Centre found it beneficial for service users accessing the morning drop in and staff alike, to have a nurse at the centre offering a drop in clinic once a week and so at the end of 2018 Urban Village were approached by the Booth Centre to provide a nurse for three hours each week. Weekly nurse led drop in clinics at the Booth Centre began in 2019.

Case Studies

Case Study 1

Background

Patient D had a 6 year history of living chaotically; in and out of prison & hostels, broken up by long periods of rough sleeping. He relates this period in his life to finding his Mother dead (OD); he began using drugs & alcohol and soon after his marriage broke down, with his wife asking him to leave. During this 6 year period he was often without benefits; he found maintaining them impossible whilst sleeping on the streets, drinking & using drugs. He turned to begging and petty crime to fund his habit, and was in and out of prison as a result. He was often disengaged from support services. D was registered with Urban Village Medical Practice but did not regularly attend.

Mpath Interventions

D was admitted to the MRI on several occasions with the following problems:

- Community acquired pneumonia
- Deep vein thrombosis
- Leg ulcer
- Untreated heroin dependency/intravenous drug misuse
- Low BMI

The Mpath team were able to build a positive working relationship with him during these admissions, listening to what he was identifying as his main issues and supporting him to try to address/rectify them. Each time D was admitted the Mpath team liaised with the ward staff to ensure they were clear in regards to his social circumstances. They ensured he was written up for PRN Methadone and that he fully understood his health condition and the treatment plan for him during admission. Accommodation referrals were made for D and on one admission Riverside Housing Association were able to assess D on the ward and provide a bed for him at Brydon Court, a temporary supported housing hostel based in Ardwick.

In addition to D's presenting problems D also identified the following chronic health conditions which required reassessment in the community and follow up:

- Asthma
- Depression and anxiety
- Chronic hepatitis c infection

The Mpath service coordinated a clear discharge plan and follow up in primary care to reduce the chance of readmission including:

- GP follow up
- Drug services for continuation drug treatment programme
- Tissue viability/dressings service for leg ulceration

Primary Care Follow Up

- D achieved 3 months successful anticoagulation for his dvt and a repeat chest x ray 6 weeks post discharge showing a resolution of his pneumonia.
- His anxiety and depression was assessed and antidepressant medication commenced and monitored and he was referred for psychological therapies.
- D's low bmi was monitored and he received a defined period of nutritional supplements and achieved a normal BMI after 6 weeks.
- The patient required stable benefits to facilitate stable accommodation and was given a 13 week sick note enabling him to claim housing benefit .
- Hepatitis c infection –D had a long history of hepatitis c infection, the GP coordinated a comprehensive assessment of this and an appointment in the specialist satellite clinic at urban village medical practice and he has commenced a 3 months course of hepatitis c treatment
- Nursing intervention –D was vaccinated against hepatitis a and pneumonia , he underwent blood borne virus infection screening . He underwent an asthma review and started on regular inhalers
- Tissue viability service –D was seen weekly for regular leg ulcer dressing and after 12 weeks achieved a successfully healed ulcer
- Drug treatment –D underwent a comprehensive assessment by a shared care drug worker with formulation of a care plan for methadone prescribing and psychosocial interventions .

Outcome

Since his last hospital admission back in October 2018, D has maintained his accommodation and since moved into his own independent tenancy. D has maintained drug treatment, has engaged with primary care and there have been no further hospital admissions. D has spoken very highly of the Mpath service; he felt he was listened to and included in his treatment plan, and that his needs were met. He plans to continue reducing his Methadone and use his time in a meaningful way including signing up for a creative writing course and his goal is to return to work.

Case Studies

Case Study 2

Background

J had a long history of rough sleeping together with ongoing mild mental health issues and substance misuse problems. With this also came a long history of poor engagement with support services and inconsistent periods of drug treatment. In 2017 J was placed on the caseload of one of the Case Manager's for the Homeless Team who spent many months trying to engage J with drug treatment and primary care through outreach.

Social Interventions

It took until January 2018 for the Case Manager to develop meaningful contact with J and was able to make a referral to a local night shelter. J failed to attend and was not seen again until April 2018 when contact was made via outreach. J stated that he was going to access drug treatment through the local drug service. In May 2018 the Case Manager supported J with attending GP clinic at UVMP and then following this I arranged to meet via outreach with a drugs worker from the local drug service. This resulted in the completion of a drug assessment. During this month J was supported with attending UVMP and he then commenced drug treatment. He also was assessed by the homeless mental health team. In June 2018 J was supported to get an email address and open an online universal credit claim. Further support was then provided to attend subsequent DWP appointments until benefits where in place.

Although the Case Manager explored several supported housing options with J he failed to access accommodation consistently and continued to rough sleep. The Case Manager discussed Housing First with J, a housing initiate in which J would be able to access an independent tenancy with support tailored to his individual needs and preferences, J felt this would be a better option for him so referral was completed and in October 2018 J moved into a tenancy.

Primary Care Interventions

Following a long period of engagement with the Case Manager as detailed above, J agree to register at the practice. At the point of registration the J presented with the following significant chronic health conditions:

- Extensive chronic plaque psoriasis – involving 60% body surface
- Chronic leg ulceration
- Untreated heroin misuse/injecting drug use
- Chronic hepatitis c infection
- Depression and anxiety – severe

J attended one of the multidisciplinary drop-in sessions and underwent a comprehensive New Patient Health Check with a specialist homeless nurse for screening and health promotion. J was also able to see a GP to assess his physical and mental health need as well as being able to access a range of other healthcare providers on offer. This resulted in J receiving the following:

- Assessment of his psoriasis with and formulation of treatment plan which involved assistance and interventions with creams form the nursing service both in practice and in day centre settings.
- An initial assessments for chronic hepatitis infection and information provided about the service at UVMP in partnership with the Infectious Disease Team at North Manchester General Hospital
- An initial assessment of depression and anxiety with information provided about accessing the Homeless Mental Health Team drop-in at UVMP
- Given a 13 week sick note to facilitate a benefits claim and securing of housing benefit to facilitate and accommodation plan
- J was assessed by the Tissue Viability Nurse and engaged in regular leg dressings for his chronic leg ulceration
- J underwent a full assessment for entry into a drug treatment programme Primary care interventions

Outcomes

J continued to engage with primary care at UVMP through access to the drop-in clinics and achieved the following:

- Healed leg ulcer within 8 weeks
- Commenced methadone treatment 2 weeks after assessment and achieved illicit drug free status approximately 3 months after registering
- Homeless mental health team commenced antidepressant medication 2 weeks after registering , he was encouraged to engage with the HMHT who ran an flexible drop in session at urban village alongside the GP clinic , he engaged 6 weeks after registration and received care coordination for 6 months
- 3 months after registration J was accommodated , now stable in drug treatment with improved mental health , he felt he was in a position to engage with treatment for his chronic hepatitis C infection. He was seen in the north Manchester general satellite clinic at urban village and underwent treatment for 12 weeks – he is now cured

The above health care was achieved in the multidisciplinary flexible drop in clinics provided daily at Urban Village Medical Practice. These clinics are as a result of working in partnership with other community services to provide accessible healthcare under one roof for marginalised people. From the patients point of view they are attending a seamless service which meets a high proportion of their health needs in the same place on the same afternoon.

In 11 months J manged to turn his life around from being an entrenched rough sleeper with poor engagement to commencing and maintaining drug treatment & securing accommodation. Currently providing drug samples that confirm negative for illicit opiate use. J now has benefits in place stable in accommodation, engages with health providers and attends the gym. This made possible with the joint support from UVMP homeless team, CGL and Riverside Housing trust.

Training

Students & Training

Urban Village is an enhanced training practice offering placements to undergraduate student nurses, paramedics and medical students. The homeless healthcare team are committed to supporting students on placement at the practice and in 2018 we provided placements for two student nurses as part of their training course, and four elective placements for student nurses choosing to learn more about homeless healthcare. We have also offered various spoke placement days to undergraduate student nurses and post graduate student health visitors, district nurses & nurse practitioners. Feedback from students has been excellent demonstrating that they have gained a wealth of experience around homelessness, complex needs and accessibility of health care for homeless people. Nursing and medical students have also spent time in the nurse led clinics at Barnabus day centre and helped out in daily drop in sessions. To meet the ongoing demand for spoke placements both with the homeless healthcare team and at Barnabus, a teaching session is being developed for student nurses to both inform and educate around the work of the team and complexities of homelessness.

Feedback from one of our students

"I have loved every minute of my placement at Urban Village. The staff are so friendly and made me feel welcome from the minute I stepped through the door. The service that they provide for the homeless community is second to none! I've had the opportunity to sit in on the homeless drop in clinics, leg ulcer, general clinics and also do a number of outreach programmes including attending Barnabus and doing city outreach with a drug worker. The amount of knowledge that I have gained from this placement is amazing and it has really opened my eyes to the scale of homelessness in Greater Manchester and what is being done to help, both by Urban Village and other teams."

In 2018 Urban Village Medical Practice and Ruth Bromley from MHCC secured funding from Health Education England to develop training for GP practices to help them to develop skills needed to effectively deliver healthcare to homeless people. Over a period of 6 months 2 training packages were developed the first was a 2 day intensive course aimed at clinical staff based in primary care and the second was a condensed half day training programme aimed at all practice staff. In May 2018 20 clinicians from across Manchester completed the 2 day training over a weekend to become Homeless Health Champions, in addition to receiving the training they also worked over the course of the 2 days to develop an action plan for their practice to ensure that people experiencing homelessness were actively supported to access and engage with healthcare services and services were able to support the individual needs of their homeless patients.

In addition to the HEE training UVMP in 2018 UVMP also delivered training in homelessness and health to: the A&E and Pharmacy staff at Manchester Royal Infirmary; Care Navigators at University Hospital of South Manchester; students at The University of Manchester and Manchester Metropolitan University; Coalition of Relief; Greater Manchester Health and Social Care Partnership; NICE; and Manchester Health and Care Commission.

Public Health Initiatives

In 2018 the homeless healthcare team were asked to deliver two vaccination campaigns for Hepatitis A and Flu. The delivery of Hepatitis A vaccines was in response to an outbreak of Hepatitis A amongst people sleeping rough in Manchester city centre and was a joint working initiative with Public Health England and Manchester City Council. Vaccines were offered to anyone who was sleeping rough or at risk of rough sleeping and given in drop in clinics at Urban Village, day centre clinics, needle exchange, hostel's and on the streets using a council outreach van. This campaign was successful in giving 239 Hepatitis A vaccines and was recognised by PHE as likely averting further infections with their associated morbidity & potential mortality. A second booster dose has been given to 68 of those people and Hepatitis A vaccines continue to be offered to anyone at risk of rough sleeping.

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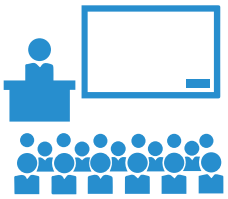
TB

In February 2018 Public Health England North West funded the London based Find and Treat Service to screen or TM in the homeless population of Manchester. The Find and Treat Team is a multi-disciplinary team that uses mobile technology and the use of a clinical van to extend screening services to marginalised and high-risk populations. In preparation for the project a number of planning sessions were held with organisations including UVMP, CGL, MCC, The Booth Centre, Barnabus, Coffee 4 Craig, Riverside and MFT to plan engagement with the project and to agree pathways for patients. It was agreed that over the course of 2 days 3 clinical sessions would be run at strategic locations including Urban Village Medical Practice, Coffee 4 Craig and The Booth Centre. In total 141 people were screened over the 3 sessions.



Service Development

Expanding access to healthcare

In January 2018 in response to feedback from patients and to improve access throughout the week for homeless people we increased the availability of drop in slots for registered homeless patients. Prior to the changes homeless patients were able to access a weekly multidisciplinary drop in on a Wednesday with access to 4 GPs, a Practice Nurse from Urban Village as well as a range of additional healthcare providers from partner agencies. We also provided dedicated appointmetnts from homeless people with a GP and Nurse 2 afternoons a week. As of January 2018 drop in appointments with 2 GPs and a Practice Nurse each afternoon Monday to Friday and appointments for more vulnerable patients are available with a GP and Practice Nurse on a Friday morning. Appointment times for homeless patients were also increased to 15 minute slots for GPs and 20 minute slots for nurses. In addition to primary care services provided by UVMP over the years we have developed a comprehensive integrated care model involving partner agencies to ensure we can provide a range of flexible and accessible services to meet the complex health needs of our homeless population. Services provided include: daily substance misuse access; weekly mental health appointments; weekly podiatry clinic; tissue viability service 3 times a week; weekly dental clinic; Hep C clinic twice a month; HIV clinic once a month; and we are also co-located with a needle exchange.

Weekly Homeless Health MDT

In September 2018 we established a weekly multi-disciplinary meeting to enable us to have sufficient time to discuss new patients, hospital discharges, hospital inpatients, safeguarding concerns and to allow for long-term joint care-planning for complex patients. The meeting is held for an hour and a half on a Wednesday morning with weekly attendance from representatives from UVMP, Mpath, GMMH and CGL with regular attendance from MCC Adult Social Care and Consultants from CGL. We also developed an MDT template to ensure correct coding and documentation of comprehensive joint MDT care plans. Since implementation 228 patients have been discussed 767 times.

Strategic Development

In 2018 UVMP continued to work to ensure homeless health remained a strategic priority across Manchester and Greater Manchester and actively participated in a number of strategic meetings and groups including:

- Homeless Health Task & Finish meeting
- GM Homeless Hospital discharge Steering group
- MFT Homeless Reduction Act Working Group
- Manchester Homelessness Partnership Driving Group
- GMMH Homeless Operational Group
- Northern Hub meetings
- Task and Target Meeting
- GM Homelessness Action Network

Homelessness Reduction Act

The Homelessness Reduction Act 2017 is an amendment to the Housing Act 1996 and places additional duties on public bodies to prevent and relieve homelessness. This includes placing legislative duty on some public authorities such as hospitals to offer to refer a person to a local authority if they are homeless or at risk of homelessness. To ensure these changes were reflected in hospital protocols UVMP worked with colleagues from MCC, MFT, PAT, Northwards Housing and GMMH to develop a comprehensive Hospital Discharge Protocol for homeless patients that could be used across all hospital sites in Manchester to improve the experience of patients attending hospital in Manchester. Working together we were able to ensure that the document contained concise and accurate information for hospital staff on areas such as Duty to Refer legislation, town hall presentations and additional support services. Discussions in the working group identified the benefits that homeless assessments carried out during admission would have on improving patient and discharge outcomes. Due to lack of capacity in the current Housing Solutions Service to enable this, a bid was put together for additional resource. Success of this bid has resulted in the appointment of a Hospital Housing Solutions Service comprised of a Teal Leader, 4 Housing Solutions Assessment workers and 3 Private Rented Sector Workers to work across all Manchester hospital sites.

Strategic Development

Following on from the completion of the Hospital Discharge Protocol a working group was formed at MFT to ensure that the protocol was being implemented correctly particularly the new legislation placed on hospitals by the Homeless Reduction Act. This meeting has also provided a platform to ensure better communication around homeless issues across the trust and to work together to develop solutions to these issues where possible.

Homeless access Hubs

In 2018 Urban Village Medical Practice worked with Manchester Health and Care Commissioners (MHCC) to develop a plan to improve accessibility of primary care to areas of Manchester with higher populations of people experiencing homelessness. MHCC commissioned Manchester Primary Care Partnership (MPCP) to identify a practice in each of the neighbourhoods with high populations of homelessness to provide accessible, flexible and holistic care to people experiencing homelessness in that area. 7 practices have been identified and will launch in Autumn 2019.

WCMT

In 2017 Homeless Service Manager for UVMP, Rachel Brennan was awarded a Winston Churchill Memorial Trust Fellowship to research different ways of delivering healthcare to homeless people with the aim to improve access to high quality healthcare, promote engagement with health services, encourage multi-disciplinary working and reduce pressure on acute health services.

Rachel travelled to Norway, Denmark and the USA to visit services that demonstrated best practice in models of healthcare delivery to homeless people that included:

Street Medicine

Provision of healthcare directly to those living on the street. Removing barriers to accessing healthcare for homeless people and developing relationships with patients where they feel comfortable.

Low-threshold clinic:

Flexible and accessible healthcare clinics based in the community that provide easy access to appointments and make few demands on patients

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Medical Respite:

Clinically supported intermediate care for homeless people in the community who are too ill to be on the streets or in temporary accommodation but do not require a hospital admission.

Mobile Health Clinics:

Use of vehicles to extend healthcare to homeless people in the community.

In 2018 the full report based on the findings of her Fellowship along with recommendations for improving homeless healthcare delivery was published and is available here

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