Integrated Health Care for the Homeless in Manchester: A Collaborative Approach

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NHS
Providing NHS services
URBAN VILLAGE
MEDICAL PRACTICE
HOMELESS HEALTH SERVICE

Pictured: Artwork on pillar within the Reception area of Ancoats Primary Care Centre

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Introduction

This report covers a period which has seen a continued and significant increase in households facing homelessness and increasing numbers of people experiencing all forms of homelessness.

At UVMP we are clear that we consider **HOMELESSNESS AS A HEALTH PROBLEM**. People who experience homelessness die on average 30 years younger than the general population (Crisis, 2012) and they die of untreated medical problems, not of homelessness, highlighting the stark health inequalities experienced in this population.

Research in 2023 has shown a 12% increase in homeless deaths compared to 2022 (Museum of Homelessness, 2024). Experiencing homelessness will predict your early death and a higher burden of health problems up until that point.

This is why the **NHS needs to have a robust and proportionate response to homelessness** with **specialised services** able to address the **stark inequalities.**

It is well acknowledged that the NHS is experiencing one of its most difficult periods and it is concerning that the ever-increasing numbers of people experiencing homelessness each year and their high health burden will have a direct impact on already stretched health services.

It is our hope at UVMP that the services we deliver go some way **towards addressing this need in the homeless community in Manchester.**

In this report we have taken the opportunity to consider **wider access to NHS services for homeless people**.

Our analysis of the health problems experienced by homeless people has enabled us to have a clear picture of the main **long-term conditions** they experience.

Addressing these long-term health conditions often requires **a response from more specialist services than primary care** but it is clear that patients experience **significant barriers** to accessing these services and therefore their need is unmet.

UVMP has spent many years attempting to **address this gap in services.**

We shine a spotlight on our partnership working with different aspects of the wider NHS to improve access for homeless people to more specialist services beyond primary care.

We aim to highlight the role that primary care providers can play in **collaborating** with different parts of the health service to work together to develop **bespoke solutions** for those living with **multiple and complex health needs and homelessness.**
This report hopefully illustrates the validity of this approach.

It is important to acknowledge the key roles our **commissioners and partners** have played in the development of a comprehensive service and our aspirations to continue to build on those relationships.

The service in its current format has taken commitment, innovation and willingness to work together and learn through doing.

In this report we have put the **patient at the centre** and have used evidence, practical approaches and patient stories to illustrate our interventions.

Most importantly it is often reported by patients and stakeholders that UVMP using this approach offers a **"one stop shop"** or **"health hub"** for homeless patients which hopefully represents a **positive patient journey, empowering patients to address their health problems and make the NHS accessible to the population and individuals that need it most.**

Pictured: Artwork on pillar within the Reception area of Ancoats Primary Care Centre

Bloodborne Viruses

Bloodborne virus (BBV) infections are spread by direct contact with the blood of an infected person. The main BBVs of concern are:

- Human immunodeficiency virus (HIV), which causes acquired immune deficiency syndrome (AIDS)
- Hepatitis B virus (HBV) and Hepatitis C virus (HCV) which cause Hepatitis

HIV infection damages the immune system increasing the risk of severe infections and certain cancers. There is no cure or vaccine, but treatment includes drugs that have proved very effective at improving the quality of life and extending lifespan. Individuals with HIV may not have any symptoms and may be unaware of their infection.

Hepatitis B causes an infection of the liver. The risk of developing chronic Hepatitis B infection depends on the age at which infection is acquired and the risk is increased in those whose immunity is impaired. Most infected adults recover fully and develop lifelong immunity. However, approximately 5% of previously healthy adults may remain infected and potentially infectious. Around 20-25% of people with chronic HBV infection worldwide have progressive liver disease, leading to cirrhosis in some patients.

Hepatitis C is a virus which can damage the liver. Most individuals with HCV have no symptoms and are unaware of their infection. Some may develop a flu-like illness and jaundice. About 1 in 5 people infected with HCV recover completely. The majority become chronically infected, about 10-30% of these will develop cirrhosis in 20 years and annually 1-3% will go on to develop liver cancer.

BBVs are treatable. Therefore, their devastating effects on health can be mitigated, if not eradicated entirely.

People who experience homelessness remain at increased risk from these three viral bloodborne infections for the following reasons:

- They are perceived as being "hard-to-reach" for important public health programs and interventions in this area due to the somewhat transient nature of the living situations.
- They face multiple barriers to adequate health care (e.g. timely diagnosis and proper treatment).
- They may face practical difficulties in complying with treatment regimes.

Our approach

At UVMP we proactively screen for BBVs within our new patient health check. We also routinely offer screening to patients who are at risk of acquiring BBVS.

In the last 12 months UVMP screened 87% of our new homeless patients who registered, this revealed:

- 46% tested positive for Hepatitis C (national population prevalence 0.5%)
- 4% tested positive for Hepatitis B (national population prevalence 0.3%)
- 3% tested positive for HIV (national population prevalence < 1%)

Treatment for BBVs is typically provided in outpatient departments in hospitals, where there are very rigid appointment based systems. This typically doesn't work for homeless patients who may not have the skills, means or ability to access regular hospital appointments.

UVMP has developed **partnership working with Consultant Dr Javier Vilar and the Infectious Diseases Team at North Manchester General Hospital** to provide access for homeless patients to high quality care and treatment for BBVs. Dr Vilar provides satellite services in partnership with UVMP, including clinical assessment and interventions that are then undertaken by GPs and nurses in the homeless service delivered by UVMP.

There is clear evidence that this has improved the quality of life and health of homeless people and contributing to the prevention of serious disease and the associated high costs of this to the health service. Helen Gee one of our homeless nurses has a specialist interest and wealth of experience in the treatment of BBV's. Dr Daniel O'Shea, one of our salaried GPs has also been appointed as a GP Hepatitis C lead by the Hepatitis C Operational Delivery Network to support the ongoing program to eradicate Hepatitis C.

This small team together deliver BBV services for homeless patients.

Pictured (L-R): Nurse Helen Gee, Dr Javier Vilar, Dr Shaun Jackson, Dr Dan O'Shea

Quote from Dr Javier Vilar Consultant in Infectious Diseases North Manchester General Hospital

"Thank you and your team for the incredible work that you have done in those homeless or with unstable housing who are living with viral hepatitis or HIV.

I can tell you that it would be most unlikely that most of the patients living with HIV in our cohort would be alive today without your service. We have clear evidence that their immunity is much higher than before we set up the clinic and the periods that they stay below detection (and therefore unable to transmit HIV to others) is much longer than before the clinic. The quality of the information that you provide us is such then I can assess those patients even when they do not attend my clinics. You bring their issues to our monthly MDT, discuss the barriers and we work to overcome them. Thanks to this work we have been able to start people on therapy that have declined it for years.

Those living with Hepatitis C you have taken further becoming the first primary care treatment centre in Greater Manchester and probably in the country.

Hepatitis B is particularly an issue with those experiencing homelessness coming from abroad. Traditionally those patients are referred to hospital and then discharged after numerous DNA. We have managed to assess at least intermittently all those referred to our shared service.

In summary you are improving both the survival and quality of life of the most vulnerable members of our society with innovative, groundbreaking, services. My wholehearted thanks to the whole team for all these years of work and I sincerely hope that many more will come."

Case Study - Gary

Gary is a 32-year-old man who had been rough sleeping on the streets of Manchester for approximately 3 months when he asked to see the nurse at a day centre. Gary knew that he was Hepatitis C positive as he had been tested and diagnosed whilst in prison but had been released before being offered treatment. Due to being homeless after release, Gary hadn't been able to access his GP or hospital services to get treatment. Gary's new patient health check confirmed this diagnosis.

Gary was worried about his Hepatitis C infection and what it might mean to his health and those close to him. He was aware it could lead to chronic illness and that he might infect other people. Gary was able to attend UVMP for further assessment with a GP and Dr Vilar. Following a pragmatic discussion, Gary elected to wait until he was in stable accommodation and drug treatment before starting his Hepatitis C treatment. This treatment would require him to take medication every day for 12 weeks, which is often challenging for people when they are street homeless.

Within the next 8 weeks Gary was able to get on a regular methadone prescription with support from UVMP and his shared care substance misuse worker, he then indicated that he would like to start his treatment. He completed this successfully and has subsequently found to be cured of this infection.

Case Study - Farida

Farida is a 34-year-old woman from Sudan who came to the UK 18 months ago seeking asylum, having experienced considerable trauma in her home country and throughout her journey to safety. Farida had recently been granted indefinite leave to remain and was made homeless from her Home Office accommodation. With no support network and limited means, Farida became homeless.

At first point of contact, Farida was rough sleeping in Manchester and had no registered GP. Farida's new patient screening revealed that she had chronic Hepatitis B infection of which she was previously unaware.

Farida was referred to see Dr Vilar at UVMP who recommended treatment for her Hepatitis B infection. This would require her to take medication long term and attend regular reviews in the specialist clinic. The aim of treatment was to reduce her risk of serious long term health problems such as cirrhosis and liver cancer.

Farida is able to regularly see Dr Vilar in clinic at UVMP. This means that Farida is able to access treatment in a primary care setting whilst she remains homeless and is empowered to understand and make choices about her healthcare, enabling her to live a healthier life with less risk of chronic illness.

Detection and treatment of Syphilis

Syphilis is a sexually transmitted infection caused by the bacterium Treponema Pallidium. Syphilis can be transmitted between partners during sexual intercourse and from an infected pregnant woman across the placenta to a developing foetus. Syphilis during pregnancy can result in serious complications. The signs and symptoms of syphilis depend on the stage at which it is detected.

Cases of syphilis in England have increased considerably in recent years. Public Health England (PHE) published the Syphilis Action Plan in June 2019 bringing together existing recommendations for PHE and partner organisations to address the continued increase in syphilis diagnoses which had tripled in the previous 10 years, with increases seen across all population groups examined. The upsurge in infections is attributed in part to unsafe drug use, increases in sex work and decreased use of condoms. A further contributing factor has been found to be socioeconomic deprivation. Case reports from investigations of clusters and outbreaks frequently describe socially vulnerable individuals with complex needs.

Similarly, a review of congenital syphilis cases in the UK (2010 to 2015) observed that social circumstances of mothers varied and some included injecting drug users, sex workers, those in the criminal justice system and those facing challenges accessing healthcare due to cultural barriers (UKHSA, 2017). Syphilis can be treated with antibiotics. However, if untreated the majority of people infected with syphilis will go on to develop serious and life-threatening consequences including heart and nervous system disorders. The implications of untreated syphilis on the health service can be vast, leading to prolonged hospital admissions.

Our approach

At UVMP we offer screening for syphilis as standard for all homeless patients. We aim to test as a minimum within the new patient health check and at an annual health check each year. For those with increased risks, we aim to test more frequently.

In the last 12 months we have diagnosed 18 patients with syphilis, which is a 44% increase in positive detection year on year, in line with recent Public Health England findings. The patients in whom this condition is diagnosed are often extremely vulnerable and marginalised in society and there is clear evidence they are not accessing mainstream health services for appropriate testing and treatment.

In response to this emergent need UVMP has developed an innovative way to address this health problem – bridging the gap with mainstream sexual health services for marginalised individuals. We have built a partnership with the sexual health department at North Manchester General Hospital and lead consultant in Genitourinary Medicine Dr Andrew Tomkins and developed a shared approach to treating homeless patients who test positive for syphilis. Dr Tompkins provides consultant overview and a treatment plan which can be administered by UVMP. This represents a partnership between specialist hospital care and primary care to deliver care to marginalised patients.

This innovative approach has been recognized by the **British Association of Sexual Health and HIV (BASHH)** and our team has been selected to present at their national conference 2025 and awarded the **Cathy Harman prize for innovation for our submission "An integrated approach to support enhanced screening and management of syphilis infection in individuals experiencing homelessness in a large metropolitan city"**

Case Study - Daisy

Daisy is a 31-year-old woman who is well known by the UVMP nursing outreach service. When the nurse team see Daisy it is usually when delivering nurse outreach to a women's hostel. Daisy does not access day centres as she finds the busy environment overwhelming.

Daisy has spent several years in homeless services with very little stability with regards to accommodation, she is not in contact with her family and has had 3 children removed from her care and she experiences crack and heroin dependency. She intermittently sex works to support her survival.

The nurse was able to offer Daisy full GP registration on outreach at a hostel and undertake a comprehensive new patient health check and sexual health screen in the privacy of the clinical van. Daisy agreed to see the nurse when she attended the following week to discuss her results. Daisy tested positive for syphilis infection and was informed of this by the same nurse who had tested her. Daisy had no idea she was infected with syphilis nor where she might have contracted it and didn't report any symptoms. Understandably, she was upset and perturbed by this diagnosis and found it difficult to consider the implications and treatment.

Upon receipt of Daisy's test results, our nurse had contacted Dr Tompkins at the Genitourinary Medicine department. She was able to formulate a treatment plan with him so that she could offer this re-assurance to Daisy. Our nursing team continued to work alongside Daisy to help her to understand the treatment options and support her to access this. Daisy arranged with the nurse team to attend UVMP for her treatment which involved 3 penicillin injections over 3 consecutive weeks. Subsequent blood tests indicated that she has been cured of her syphilis infection. She also understands the importance of routine screening to ensure that any asymptomatic infections can be identified and treated.

Daisy is a typical case that we diagnose in the service. It is clear from her case that if she hadn't been engaged by our nurse team on outreach, and received treatment in primary care she may not have been diagnosed for many years resulting in devastating consequences for her health as she developed syphilis complications.

Many women are hidden whilst homeless or rough sleeping. Hiding from harm means that women are also hidden from help. We know that women are underrepresented in homelessness statistics, experience homelessness differently to men, and have specific needs which are not always met adequately by services.

Whilst both genders experience serious barriers to obtaining health care, homeless women face an additional burden by virtue of their sexual and reproductive health needs. It's also important to recognise that women's experiences of homelessness – and the trauma they experience – are vastly different from men's. Their trauma is often rooted in gender-based violence and abuse. Research found that as many as 92% of homeless women had experienced violence or abuse during their lifetime or have been forced to sex work (St Mungos, 2024).

We therefore need to constantly review and develop how we can deliver a service which enables women to feel safe and empowered to make decisions in relation to their health. We know that trauma and abuse can impact women's attitudes and experiences when dealing with health services. It can leave women trapped in a cycle of homelessness and poor health as their problems are aggravated.

Our approach

In addition to our commissioned homeless health service, UVMP is contracted by **Manchester City Council's Public Health directorate to deliver local enhanced services for sexual health screening and long-acting reversible contraception.** The practice is also a pilot site for a **Women's Health Hub for Manchester.**

The combination of these three individual contracts is that UVMP has highly evolved services and expertly trained staff who are passionate about delivering health interventions to all women. The acquisition of the clinical van has enabled us to deploy this assertively to homeless women by going to hostels and working with partner organisations to identify and support marginalised women.
This is possible due to the resources of three separately commissioned services being integrated and combined into what the patient perceives to be a single service. We aim to empower women to make informed choices and optimise their safety and wellbeing.

Cervical Screening

In the UK there is a population-based cervical screening program. Those eligible are invited by mail. Despite their increased risk factors, women experiencing homelessness are typically screened for cervical cancer at a lower rate than women in the general population. Marginalised women living in unstable conditions and homeless women often fail to receive the invitation letter.

The QOF contract framework within primary care has enabled monitoring of cervical screening rates within the general population. Average cervical screening rates in the UK and within Manchester are around 70%. The implications of women not receiving cervical screening and subsequently developing cervical malignancy are devastating.

Cervical screening services are not accessible to homeless women, and we recognise this is a priority health area for this population. In response to this our specialist homeless nurses have undergone enhanced training and have developed the experience and skill set to assertively provide cervical screening to women in a variety of clinical settings, offering access and flexibility for homeless women to this clinical intervention. Our nursing team prioritise women's health and are able to assertively intervene according to individual need. They also recognise that the reasons for non-engagement with cervical screening are complex and can require a build up of trust between clinician and patient. In addition to this, they are trauma informed in their approaches to enable women to feel at ease and help them to understand the importance of cervical screening and what the process entails.

Our nurses have also advocated for homeless women within local services and have forged partnership working with colposcopy services within Manchester Foundation Trust to enable flexible access for the homeless women who need treatment for abnormal smears and any subsequent follow up that may be necessary.

We are extremely proud of our cervical screening rates. In 2023/2024 we achieved a screening rate of 71% of eligible homeless patients which is comparable to screening rates in the general population, evidencing the effectiveness of the approach at UVMP.

Contraception & Sexual Health

Our Lead Nurse, Liz Thomas, has undertaken advanced training to enhance access to contraception for homeless women. Liz is able to offer contraception advice and fit, remove and replace implants in a range of settings including on the clinical van, at day centres and hostels, as well as in her regular clinics at UVMP. Liz was recognised by the Faculty of Sexual & Reproductive Healthcare in May 2024 as their Nurse Spotlight Award Winner, they said

"Liz was the unanimous winner this year; her work was directed towards supporting vulnerable and often homeless women, working across an entire city, demonstrating an incredibly broad range of nursing skills, including providing supervision. Her skillset showcases the contribution the nursing profession makes to the FSRH Hatfield Visions 2030, and to the provision of high quality sexual and reproductive healthcare for everyone in society."

In 2023/24 homeless women had 8 long acting reversible contraception implants fitted, 6 replaced and 1 removed.

In addition UVMP has four GPs who are trained in coil and implant fitting who provide flexible responsive access to these services for homeless women, illustrating the value of homeless services being co-located in a primary care setting.

All of our nurses are trained and equipped to undertake sexual health screening in a range of locations, including on outreach and at UVMP. They play a vital role in detecting, treating and preventing further transmission of a range of sexually transmitted infections.

All this is enabled by the delivery of the **local enhanced service** within a primary care setting.

Pictured (L-R): Nurse Liz Thomas & Nurse Lisa Howard Jones

Case Study - Sarah

Sarah is a 34-year-old woman who was rough sleeping in Manchester City Centre, she had been homeless for approximately 6 months. She previously lived in another Greater Manchester Borough and when outreach services from UVMP encountered her she was registered with an out of area GP who she wasn't able to access. Sarah was also experiencing heroin and crack addiction.

Following a period of engagement with our outreach nurses, Sarah agreed to register with UVMP. During this period of engagement Sarah disclosed that she was compelled to sex work and had survived multiple abusive relationships and other traumatic experiences throughout her adult life.

Once Sarah was registered with the practice our nursing staff were able to review her primary care records including her cervical screening history. It was apparent that Sarah attended cervical screening at 25 years of age but had not attended since (she should have had at least 2 further screens in this time).

Our nursing team were able to nurture a trusting relationship with Sarah over a number of months, introducing the importance of having a cervical screening and the implications of not having had screening for 9 years. This relationship was built in different settings: hostels and day centres; within our bespoke mobile clinical facility; and at our main practice site.

After a number of months Sarah was resident in a women's hostel which is visited regularly by our outreach nursing staff who were familiar to her. Sarah agreed to have **cervical screening** during one of these sessions. The result did show significant **pre-cancerous** changes that needed **colposcopy** treatment at the hospital. The result was tracked by our nursing staff who were able to communicate it to Sarah and support her with the abnormal result. Sarah understandably was anxious but also vocalised that she was scared to undergo a colposcopy and wasn't sure whether she felt able to attend.

Our nursing staff were not only able to reassure Sarah by explaining the process, but they also worked with colposcopy services at St Mary's Hospital to arrange a suitable appointment and accompany her to it. Four weeks after her abnormal result Sarah successfully underwent treatment. Six months after her colposcopy Sarah needed follow up screening to check on the success of her treatment. Due to existing relationships and continuity of care, Sarah was pro-actively followed up by the same nurse and underwent her **follow up screening which came back as normal.**

Pictured: Long Acting Reversible Contraception equipment with interior set up of the Outreach Van

Case Study - Joanne

Joanne is a 32-year-old woman who had been rough sleeping on the streets of Manchester for 3 months when she had an initial meeting with the UVMP nurse lead at a day centre. At this initial meeting Joanne disclosed that she was experiencing heroin and crack dependency and felt forced to sex work to support herself, she also disclosed that she had a current partner with whom she was sexually active.

Joanne said she had not seen a GP or any form of healthcare service for over 12 months, and that she felt forced to leave her last accommodation due to an abusive former partner. This initial contact was brief, but the opportunity was taken to engage Joanne in the specific women's healthcare services available to her at UVMP. At this stage she declined to register with the practice or take up any health interventions.

Joanne was next encountered by the same nurse at a women's hostel where she had been accommodated on a temporary basis. She disclosed that she had left her partner due to domestic abuse, but still felt forced to sex work. She agreed to register with the practice and undergo a new patient health check. This was undertaken in the mobile clinical unit which visits the women's hostel regularly. The nurse noted that Joanne's cervical screening was overdue and Joanne agreed to have this done there and then whilst also having a sexual health check.

Joanne also discussed her current contraception methods. She disclosed that she had not menstruated for over six months and had been sexually active during this time therefore was quietly concerned that she could be pregnant. She had had three children who had been removed from her and with whom she had very limited access. Joanne talked candidly of the distress that this caused her and therefore her anxiety to avoid another pregnancy. The nurse was able to undertake a pregnancy test which was negative, and took the opportunity to discuss contraception options.

Joanne didn't feel she could make a decision there and then, so she was given some condoms in the interim and agreed she would speak with the nurse again once she had thought about the options. Four weeks later the outreach service was visiting the women's hostel and the nurse was able to engage Joanne again, initially with regards to her **cervical screening** and sexual health screening results. She was informed she had tested **positive for chlamydia,** for which she received antibiotic treatment. Joanne had also decided that she wanted to have a contraceptive **implant fitted.** The nurse was able to undertake this procedure straight away in the mobile clinical unit. Joanne was fitted with an implant which would provide her with contraception for 3 years.

This case is an example of how outreach services can engage with individual patients and develop therapeutic relationships. In this case it took a number of consultations but clear health interventions were made and Joanne's health needs were met. She was given the opportunity to consider her options and be reassured about her concerns.

In our health needs audit of new patients registering with the service it was found that:

- 74% men and 79% of women were drinking alcohol to harmful levels
- 61% of men and 67% of women were primary heroin and crack users

Statistics show that 35% of all deaths among homeless people in England in 2017 were a result of drug poisoning. 10% of deaths were atributed to alcohol. This compares with 1% for the general population (2022, ONS).

Furthermore, patients experience significant physical health problems associated with drug and alcohol misuse that are associated with significant morbidity and early death.

UVMP has a long history of working in **partnership with our local commissioned service, Change Grow Live,** to deliver flexible and accessible treatment options for registered patients. This partnership has also enabled us to make interventions with patients' physical health and long-term conditions whilst reducing harms associated with substance use.

Our approach

UVMP is commissioned by the **Public Health department at Manchester City Council via a local enhanced service specification** to deliver **drug treatment services** in a shared care arrangement with GPs. This enables GPs to work in partnership with drug workers employed and supervised by Change Grow Live and prescribe opiate substitute therapy (methadone/Subutex) as part of a comprehensive drug treatment plan. We are able to take patients directly into drug treatment in a GP practice setting.

This enables not only interventions to reduce levels of illicit drug use and drug related harm, but also interventions to improve patients physical and mental health, this is vital if patients are to live healthier lives. Our partnership working with our local drug and alcohol treatment service enables homeless people to access treatment plans for their substance misuse at the practice, bridging the gap between the two separate services whilst also enabling interventions for their significant physical and mental health problems in a general practice setting.

Pictured (L-R): CGL Drug Workers, Stephen Elcock & Anthony Verrall

Case Study - Jane

Jane is a 42-year-old woman who has experienced recurrent periods of alcohol dependency and homelessness over many years, but in between these periods has maintained sobriety and stable accommodation.

Jane has experienced multiple traumatic life experiences and gender-based violence. She is initially engaged with our health service during a nurse outreach session in a day centre. At this stage she is rough sleeping with her new partner of approximately 6 weeks. The nurse raises concerns around Jane's ability to keep herself safe and agrees with Jane to refer her to the local authority for an assessment of her needs.

Due to her high levels of intoxication Jane is at times difficult to engage in health interventions, but over a period of weeks the nurses see her in a number of settings including day centres, street outreach and temporary accommodation. It becomes evident that Jane is experiencing domestic abuse from her new partner and a further safeguarding referral is done for support to develop a multiagency plan to support Jane.

Jane is offered a place in a womens hostel where the nurse continues to see her on outreach. She remains alcohol dependent and is able to discuss this with the nurse who by now she knows well. Jane is referred to see the alcohol nurse who runs a clinic at UVMP. Jane feels able to attend this as she is familiar with the practice and can see a GP and nurse at the same time. She is able to work towards an **alcohol treatment plan** with the goal of **detoxification and rehabilitation.**

Case Study - James

James is a 34-year-old man who has been rough sleeping for approximately 6 months, he is heroin and crack dependent. He came to Manchester from another town where felt unsafe due to mounting drug debts and threats of violence.

James injects heroin and crack multiples times a day and has developed significant health problems as a result. He has lost weight, has a low BMI, has chronic leg ulcers on both his legs and struggles with recurrent abscesses from his injection sites.

James' first contact with the practice is when the attached CGL outreach workers encounter him begging. James is initially sceptical towards offers of support and declines to discuss his health needs and drug use. The outreach team gradually build rapport with James over a number of weeks and he gradually comes round to the idea of registration with UVMP.

UVMP is able to offer **direct access into drug treatment and methadone/Subutex** prescriptions as part of a **drug treatment care plan.** James is assessed for this and able to start opiate substitute treatment. As part of this he is required to attend the practice site for his prescription every week. James engages well with this and is able to titrate to a therapeutic dose of methadone, reduce his illicit heroin use and achieve an improved level of stability. As a result he is able to engage with a homelessness assessment, without his needs to use drugs overriding his ability to complete the process.

When James attends the practice weekly for his methadone prescription he also has the opportunity to see other health care professionals. James has a full new patient health assessment with a GP and nurse and the formulation of a comprehensive care plan which includes coming to the leg dressing clinic and seeing Dr Vilar for Hepatitis C treatment. All of these health interventions are undertaken at the UVMP site, however, as far as James is concerned he is attending a single comprehensive health service delivered from one site.

The most common types of wounds that people who are homeless and rough sleeping present with are skin and soft tissue infections. Injecting drug users often use the same injection site repeatedly which increases the risk of skin and soft tissue infections such as abscesses, cellulitis and **venous lower leg ulceration,** which can lead to more severe complications such as endocarditis, deep vein thrombosis, sepsis and even death.

People rough sleeping are prone to the development of **pressure-related skin injuries.** Pressure ulcers are defined as a break in the skin, which can be superficial in depth. These can evolve into deeper areas of ulceration where bone, tendon and fascia may be exposed. The development of pressure ulcers can be multifactorial, but common causes in those who sleep rough include a lack of adequate bedding, poor footwear and malnutrition.

People who sleep rough can experience extreme weather-related injuries, such as sunburn, windburn, frostbite and trench foot. They can also be prone to common foot injuries developing because of ill-fitting footwear, which include tinea pedis, foot pain and functional limitations. Foot problems in this group can be exacerbated in those who have diabetes, as these injuries can cause diabetic foot ulceration and nail pathologies.

Many homeless people with wound care needs seek this help through hospital emergency departments. This is because traditional health and care systems often fail to meet their needs for a multitude of reasons, including poor experiences or prejudice, feelings of shame, and difficulty complying with online or phone appointment based systems. Emergency hospital admissions, however, fail to achieve long-term management and a revolving door approach prevails.

A report from the Faculty of Homeless & Inclusion Health published in 2024 found that 48% of respondents had attended an emergency department in the previous 12 months, and 11.3% had attended 4 times or more. Our audit found that 6% of homeless patients experience chronic wounds or leg ulcers compared to a prevalence of 01- 0.3% in the general population (Wounds UK, 2010).

Our approach

To address this high prevalence in the homeless population UVMP has worked in partnership with specialist NHS services to reach these marginalised individuals. **Tissue viability nursing services** are commissioned and delivered by **Manchester Foundation Trust.** This service is usually a combination of district nursing services for housebound patients or appointment based community services in health centres. Neither of these is appropriate for homeless patients.

UVMP was able to collect significant evidence of the prevalence of wounds in the homeless population and also demonstrate how this population faced barriers to accessing commissioned services to address this health need.

The consequences were clear - high levels of morbidity experienced by patients and excessive costs resulting from emergency hospital admissions for infections which could have been prevented or treated earlier in the community. We were able to use this evidence and work with commissioners and community services to design a service to meet this need.

UVMP hosts the Tissue Viability Service for three afternoons per week where specialist nurses can deliver a drop-in clinic providing flexible access to all forms of wound care for homeless people. The sessions have high attendance rates and high patient satisfaction. This service is available to homeless patients regardless of whether or not they are registered with UVMP.

Case Study - Matt

Matt is a 30-year-old man who has experienced heroin and crack dependency since his teens, he is forced to inject drugs up to ten times a day to maintain his habit, he has spent many long periods sleeping rough on the streets of Manchester, interspersed with periods in accommodation services and in prison.

As a result of many years of injecting drugs, Matt has a multitude of health problems. He has been treated for multiple episodes of skin infections, cellulitis, abscesses and deep vein thrombosis in his lower limbs. Due to multiple deep vein thrombosis Matt has developed chronic venous insufficiency in both his lower limbs, this results in chronic swelling and oedema but also very poor skin condition and recurrent **leg ulceration.**

For many years Matt didn't feel he had anywhere to get his leg ulcers dressed. He often dressed them himself whilst sleeping on the streets using rudimentary dressings, or when he felt unwell he accessed accident and emergency services. He had been admitted a number of times with sepsis and had been told by hospital staff that the source of infection was likely to be his leg ulcers.

Matt also felt a lot of shame about his leg ulcers, he was aware that they smelt very bad and had received numerous comments from people with regards to this, contributing to further social exclusion when accessing support services. His leg ulcers made life very difficult, they leaked, ruined clothing and resulted in significant pain and embarrassment.

Since registering with UVMP, Matt has been able to attend a **dressing clinic** delivered from the practice close to the city centre. The clinic is accessible three afternoons a week and no appointment is necessary. The nursing team is consistent, enabling Matt to build a trusting relationship and leave behind his feelings of shame when seeking treatment. With ongoing and consistent treatment, Matt's leg ulcers may heal completely, reducing his risk of future infection, loss of limb and even death from associated complications.

Quote from Kathryn Taylor, Community Matron Specialist Nursing Services & Treatment Room Service

The specialist nursing input at the drop-in clinic is provided by the lower limb specialist nursing team and allows us to assess and support the homeless community who are living with complex wound care issues.

The experience that the staff gain by working in the clinic is very rewarding and the complexities of the patients that attend allows us to maintain and develop higher levels of assessment skills and decisions making. The drop-in clinic is also an excellent clinical practice placement for student nurses and newly qualified staff and provides them with an insight on the importance of equitable, safe and effective health care for a patient demographic that are very easily overlooked.

Mental Health and Homelessness

We know that mental health and homelessness are inextricably linked. Research has shown that 82% of people experiencing homelessness have a mental health diagnosis. They are more likely to access A&E for poor mental health, suicide and self-harm, and almost half self-medicate with drugs and alcohol. In 2021, 13.4% of recorded deaths of homeless people were attributed to suicide (ONS, 2022).

Mental illness can contribute to a person becoming homeless by impairing their ability to work, maintain relationships, and take care of themselves. Homelessness can exacerbate mental illness by exposing people to trauma, violence, and substance use.

The combination of mental illness, substance abuse, and poor physical health makes it difficult to maintain employment and residential stability.

Often, mental distress is directly related to, or exacerbated by, experiences of trauma. Many homeless people have experienced adverse childhood events, including abuse and neglect. Early neglect and trauma can impact every area of a person's life and continues to impact during adult life. It is associated with difficulty in developing relationships, low self-esteem, self-harm, substance misuse and mental health difficulties.

We also recognise that a proportion of patients registered under our homeless health service are refugees and asylum seekers who may have fled traumatic experiences in their home countries, and endured life-threatening risks and traumatic events in their efforts to seek sanctuary. Understanding trauma, and working in a trauma informed way, can be extremely helpful when supporting people with poor mental health. This might include understanding how to help someone feel safer, listening to them without judgement or feeling like you need to fix things, and helping them to meet their basic needs.

Our approach

The barriers to accessing healthcare are well documented and apply equally if not more so to mental health care for homeless people. UVMP recognises that mental health problems are very common in people experiencing homelessness in Manchester. We also recognise that homeless people have difficulty accessing **secondary care mental health services.**

Secondary mental health services in Manchester are delivered by **Greater Manchester Mental Health Trust** which includes a **Specialist Mental Health Homeless Team.** UVMP works in **partnership with the Mental Health Homeless Team** to deliver a face-to-face weekly clinic at the practice.

This provides flexible access to a **community mental health team** and a **consultant psychiatrist** in an environment which is known to the patient and where they can access other health care professionals at the same time. When a care plan is formulated, this can be delivered in partnership between primary and secondary care services.

Our clinicians work in partnership and have regular MDTs with clinicians in the mental health team to deliver care to patients.

Case Study - Mohammed

Mohammed is a 26-year-old man who at the point of registration with UVMP had been rough sleeping in Manchester for 5 weeks. He moved from another city in the UK as he was fleeing violence.

Mohammed presented to services in Manchester, including a day centre and another GP surgery, exhibiting unusual behaviour, both of which had referred him to UVMP to facilitate registration.

At the time of registration it was clear that Mohammed was exhibiting signs of a mental illness relapse. The team responded quickly to this presentation by identifying Mohammed's previous GP and mental health team, who were able to share information pertaining to his diagnosis and care plan.

Mohammed was able to see a GP on the day of registration for a **mental state assessment,** he was found to be presenting with **psychotic symptoms** consistent with how he had presented to mental health services previously.

Mohammed was referred to the **Mental Health Homeless Team** via the clinic delivered within the practice and was seen and reviewed the following day by a **Community Psychiatric Nurse.**

A **multidisciplinary team meeting** was convened with services in Manchester and services which had previously supported Mohammed to undertake a risk assessment. The Mental Health Homeless Team was able to facilitate an urgent review by a **consultant psychiatrist** who formulated a care and treatment plan.

Joint working between UVMP and the Mental Health Homeless Team resulted in Mohammed undergoing a **Mental Health Act assessment** and receiving the appropriate care.

Case Study - Paul

Paul is a 23-year-old man who was rough sleeping when he registered with UVMP. He was brought in to register by a support worker from Centrepoint, an agency which works with young adults who are experiencing homelessness. The support worker had been concerned with regards to some strange behaviour that had been observed on the streets and in the day centre.

On the day of registration Paul underwent an **assessment of his mental state** by his GP. The consultation was difficult as Paul was uncommunicative and left the room after a short period of time. The support worker was suspicious that Paul may be struggling with symptoms of a **psychotic illness** but no clear evidence for this was obtained that day.

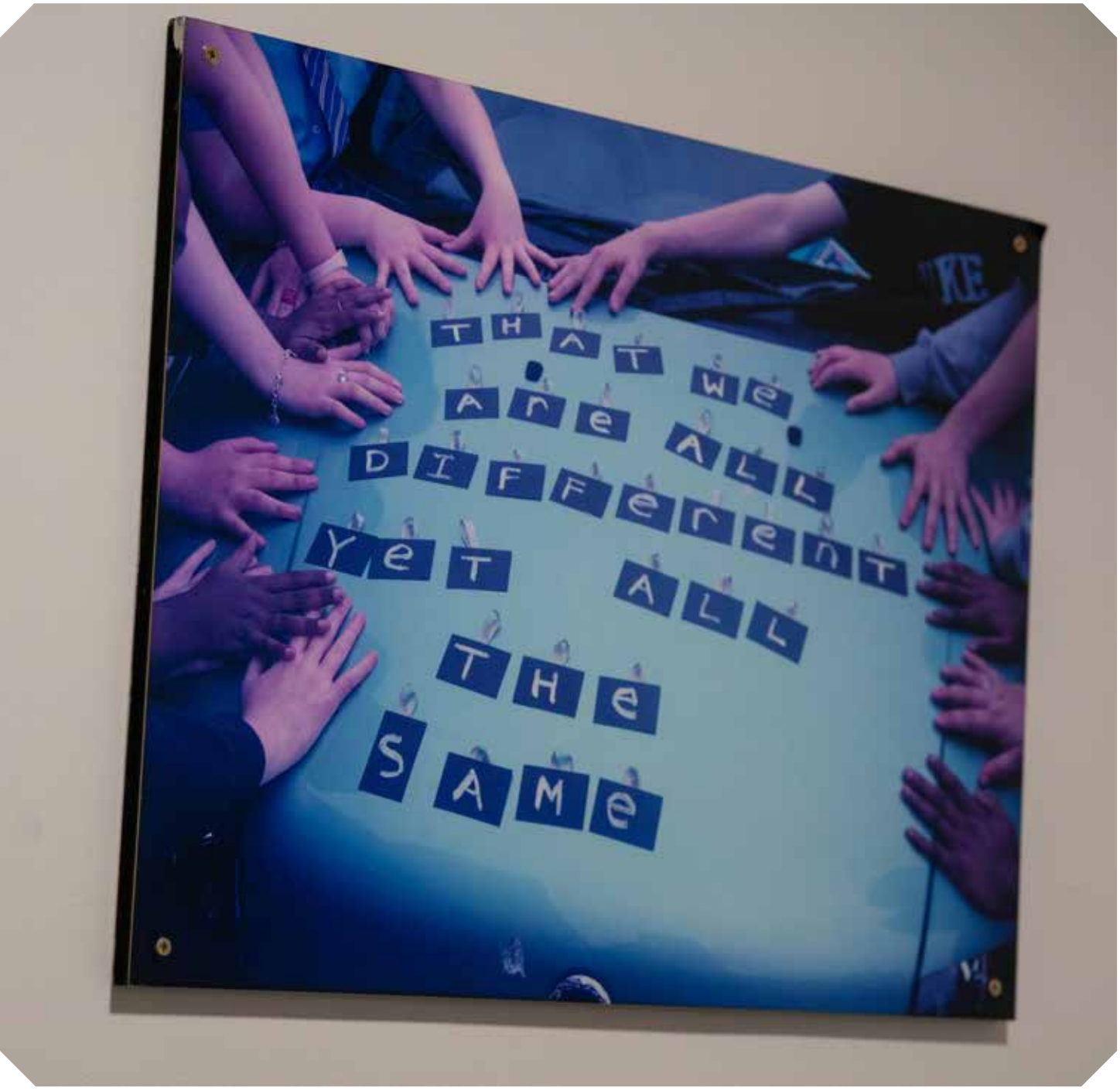
A plan was made with the support worker to offer flexible access to a GP at the practice to attempt further assessments and it was agreed that Paul could be brought to the practice any day to be seen by a GP. A note was placed on his records indicating that he should be booked straight in to see the GP if he came to reception.

Paul attended for a further assessment with a GP within 2 weeks. This time Paul felt able to communicate better and the GP felt there was clear evidence of a psychotic illness which had not previously been diagnosed. A plan was made in **collaboration with the Mental Health Homeless Team** for assessment which was undertaken at the practice as this was an environment Paul was familiar with and his support worker could help him to attend.

This initial assessment resulted in an agreement that he was presenting with **psychotic symptoms** and needed treatment. Unfortunately, Paul continued to rough sleep and did not attend his follow up appointments with the Mental Health Homeless Team. Further discussion between UVMP, the Mental Health Homeless Team and Paul's support worker resulted in a more assertive plan for treatment. It was felt that Paul's presentation and associated vulnerability and risk required an urgent assessment for application of the **Mental Health Act.** The assessment took place at UVMP and Paul was detained under the Mental Health Act. During his inpatient stay he was diagnosed with schizophrenia and prescribed medication. Paul was discharged from hospital to temporary accommodation and has continued to attend UVMP to access his medication and ongoing review in the community.

Quote from Zoe Holmes, Senior Social Worker/ Safeguarding champion, Manchester Mental Health Homeless Team

"Collaborative working within integrated care, such as the partnership between UVMP and the Mental Health Homeless Team, is essential for providing comprehensive and effective care to homeless individuals with mental health needs. By working together, we can offer flexible access to services, delivering personalised care plans that bridge primary and secondary care. This approach ensures that clients receive holistic support that meets their unique needs, leading to improved outcomes and better overall well-being. The collaboration between teams allows for a coordinated approach, enabling better communication, shared expertise, and streamlined care pathways, ultimately benefiting the clients by providing them with the best possible care and support."



Pictured: Artwork in Ancoats Primary Care Centre

People experiencing homelessness typically have more health problems than the general population. Due to their living situations, they are less able to manage these conditions in the community. As a consequence of these factors, they typically die a lot younger than the general population. The average age of death for homeless women is 42 in England. For homeless men, it is 46 (ONS, 2022).

People experiencing homelessness are at a higher risk of chronic health problems, including: mental health difficulties; problematic substance and alcohol use; heart and lung disease; liver disease; renal disease; stroke; diabetes; and cancer. Having physical and mental health problems as well as substance use problems is sometimes called tri-morbidity. It can make planning treatment and care very challenging.

People experiencing homelessness face many barriers to accessing health services. These barriers often mean that they do not access primary care, their health conditions are not well managed and their care is often crisis-led. They are more likely to use accident and emergency (A&E) and to have emergency admissions to hospital. They may leave hospital precipitously and with unclear or unrealistic care plans.

Access to palliative care and end of life care services

People who are homeless who have a terminal illness also face additional barriers to accessing **end of life care** services and being able to make informed decisions about where they will spend their end of life period.

Healthcare professionals can find it difficult to know when someone who is homeless would benefit from referral to **palliative care services.** This could be because the patient:

- has less interaction with healthcare professionals, especially in primary care;
- has complex health needs;
- has conditions with uncertain prognosis, such as drug or alcohol-related liver disease
- is younger than most people who are referred for end of life care.

Professionals working with people experiencing homelessness such as hostel staff or outreach workers may not have any training in recognising health needs, particularly those which require palliative care. They may also worry about discussing difficult issues for fear of removing hope in people who are already experience difficult lives and struggle for survival. As a consequence of these factors, advance care planning rarely happens with homeless people, meaning that what they wish for their care towards the end of their life is rarely known and therefore is not met.

Care in Hospitals or Hospices

For some people with a history of homelessness, staying in a hospice or hospital can be challenging. The medical environment which relies upon routine and patient compliance may feel very unfamiliar and uncomfortable. If someone feels that they are not being listened to or if their needs are not met, they might behave in a way that is hard to manage. People who smoke or use drugs and alcohol may find it difficult to stay in a place where this is not allowed. If addictions are not properly managed, the patient might experience withdrawal.

For these reasons, people who are homeless might leave hospital before their treatment is finished. Unplanned discharges often mean that the hospital team is not able to properly communicate a treatment plan with the community team or the patient.

Hospital or hospice staff may find it difficult to support and care for people with these complex needs. Working in partnership with local homeless and substance misuse services can be helpful. These services can provide support to people who are homeless and share their expertise with hospice or hospital staff. Having a person-centred approach to care that ensures the person is listened to and supported by a multi-disciplinary team can improve care and reduce the risk of self-discharge.

Care in the community

People living in homeless hostels often stay there as their health deteriorates. This can be for a number of reasons, including there being no other appropriate place of care, or because they view it as their home. In these environments, there may be little or no input from health or social care teams. Hostel staff try to support people with complex needs, however, they are rarely afforded specialist training. They can feel isolated and carry huge burdens of responsibility in supporting these individuals.

For healthcare professionals, supporting someone within a hostel is sometimes very different from the care that they usually deliver. There can be issues around a lack of privacy, social support and difficulties in safe storage of medication.

Social support

People experiencing homelessness are less likely to have support from family or friends. This means they are less likely to have family to advocate for them or manage their practical, financial, physical and emotional needs. Hostel staff, social work teams or outreach workers often provide some support with these needs and should be included where possible in discussions about the patient care.

Our approach

Our service is in a unique position to identify homeless patients who may be experiencing life **limiting illness** and **approaching end of life.** We know that sadly these patients present with unexpectedly poor health at an early age, and they may not present to health services as palliative patients. Sometimes we have known these patients for a number of years in the community and have supported them as their health deteriorates. Sometimes we meet these patients late on in their illness, in the community or in the hospital and have to quickly establish rapport to help them plan their care. Due to our knowledge and expertise of the complex lives of our patients, we understand that they may develop life limiting conditions at early ages and recognise the myriad of ways in which these conditions can emerge.

We find that **many deaths** which might have been anticipated have been **unplanned** and we see examples of care which is **crisis led** or presents barriers to appropriate care due to patients not falling within traditional demographics.

We have encountered significant challenges in supporting patients and **planning their palliative care.** Our aim is to change this and support patients to make informed choices about their **end of life care.**

UVMP recognises to achieve this we need to work in partnership with **specialist palliative care services.** We have forged working **partnerships with our local palliative care services** delivered by **Manchester Foundation Trust** providing access to homeless patients that they may not otherwise come into contact with and working together to enhance individual patients' care.

We have also been able to work jointly with the **St Ann's Hospice Homeless Palliative Care Service** which is coordinating an improved response to palliative care for homeless people across Greater Manchester and providing care planning for individual cases. By working together, we aim to reach people earlier on in their illness and improve the quality of care for those with advanced ill health.

All services that we work with recognise that this is a complex area of care and there are challenges to providing appropriate care to patients. We continue to advocate within health and care systems to meet this considerable unmet need.

Care planning for individual patients has been a powerful learning environment and we have had some successes but also recognise that change is needed to make provision of palliative care to homeless patients better.

Pictured: Members of the Homeless Health Service Team during their weekly MDT Meetings

Case Study - Jane

Jane is a 53-year-old woman who was admitted to Manchester Royal Infirmary following a domestic assault. Jane sustained significant injuries that required hospital admission. Jane had been subjected to a prolonged period of domestic abuse, she also had long standing health problems including heroin and crack dependency, severe Chronic Obstructive Pulmonary Disease and heart failure. She had extremely poor health for a woman of her age. This had been compounded by the barriers in accessing health care in the years leading up to this admission caused by the abusive relationship and complex lifestyle.

Jane was referred to our **Manchester Pathway (MPath) team** which provides in-reach support to homeless patients admitted to **Manchester Royal Infirmary** to help reduce health inequalities they may face on discharge. Jane had accepted that the extent of her injuries and the risk to her future safety were such that she could not return to her partner.

In addition to her homelessness, Jane had complex social and health problems that needed a robust holistic care plan and the hospital admission was an opportunity to address these. It was apparent that Jane's severe COPD and heart failure represented life limiting illnesses with a likely prognosis of less than 12 months.

The MPath team worked with Jane to co-ordinate a multi-disciplinary care plan for her discharge. They advocated for her to be assessed by **Manchester City Council** and accommodated under local authority homeless duties.

The MPath team completed the **Domestic abuse, stalking, harassment and honour-based abuse risk identification checklist** and referred this to the local authority for **Multi Agency Risk Assessment Conference.**

Jane was offered GP registration at UVMP for specialist primary care input and worked with the shared care substance misuse workers for her opiate substitution treatment.

A referral was made to the **homeless palliative care team** to help Jane to understand what her options were as her condition progressed. The team supported Jane to complete a fast-track application for Personal Independence Payment in light of her prognosis.

On review of previous medical records it was apparent that Jane had had multiple admissions to a variety of hospitals within Greater Manchester with similar scenarios where unfortunately **detailed care planning** had not happened and she had been discharged to unstable accommodation, ongoing risk of domestic abuse and unclear follow up for her severe medical problems.

On her discharge from hospital Jane was offered a place in a women's hostel. The **multidisciplinary team** supporting Jane, which included UVMP, St Ann's hospice, CGL, her housing provider, and adult social care, understood that she had **life limiting illnesses** and that any future planning must have this centrally placed.

Palliative care services were able to develop a care plan with Jane to support her in her last months of life, most importantly with the right support from the palliative care service, Jane was able to understand the severity of her illness and make her personal plan for what she wanted for the remaining period of her life. Jane subsequently died in a hospice which she had identified as her preferred place of **end-of-life care.**

Quote from Vicky Clare, Clinical Nurse Specialist

"North Palliative care team have been working closely with Urban Village to support palliative patients who are homeless and have substance abuse issues to ensure structural, organisational and professional barriers are collaboratively managed to deliver the best care for patients through shared care, this includes challenging professional discrimination that this marginalised group of patients sometimes encounter. Patients in this client group are sometimes reluctant to engage with healthcare professionals and are not always aware of the support and complex care that can be offered at the end of their life. I have found that by building a theraputic relationship with the individual, treating them with respect and being open and honest, gives the patient trust in the health care system. This type of care requires a comprehensive, creative and multi-disciplinary approach to provide the care the patient wishes and deserves, to facilitate their preferred place of care/death and achieve person centred outcomes. I believe as a service this has been evidenced with several patients we have jointly cared for and achieved their wishes at end of life."

Pictured: MPath Team (L-R) Dr Gill Bradbury, Nurse Liam Connolly, Dr Dan O'Shea, Care Coordinator Katie Martin

In 2019 **Manchester Safeguarding Partnership** commissioned a **thematic review on homelessness** which was subsequently published in 2020. This was a deep dive into local approaches to safeguarding people experiencing homelessness in Manchester. It is evident from the report that there is a **disproportionate need for safeguarding** in this population. The complexity of addressing this need requires a robust approach by all services and **co-ordinated multidisciplinary action.**

The **Homeless Health Service at UVMP** is a key frontline service coming into contact with vulnerable homeless people in Manchester and needs to demonstrate a robust approach to identifying and addressing safeguarding needs. We have policies and procedures in place for all our patients which enable us to work in partnership with local services to safeguard individual patients as well as ensuring that our approaches are in line with local procedures.

Our approach

Safeguarding homeless people is central to service delivery of the homeless health service, with the skills and experience within the team we are in a unique position to understand the needs and risks of individual patients. We recognise that vulnerable patients who experience homelessness are at risk of significant harm which often can be heavily underestimated. We are able to assess the impact of medical problems experienced by homeless people and use this assessment to advocate within **safeguarding frameworks** to bring about a more optimal outcome.

Our skilled and experienced clinicians look at an individual and their health in the context of their wider social situation and assess how health conditions may progress and how to optimise treatment outcomes. This advocacy is used within our primary care settings and hospital services via the MPath hospital in-reach service. We endeavour to actively participate in **multi-agency discussions** ensuring that patients' medical needs and associated vulnerability is central to assessments. We hope that this results in a reduction in risk experienced by homeless people at such a vulnerable stage of their lives.

Pictured: Members of the Clinical Team for the Homeless Health Service Team
Left Picture (L-R): Dr Shaun Jackson, Dr Emily Capper, Dr Dan O'Shea, Dr Gill Bradbury
Right Picture (L-R): Nurse Lisa Howard Jones, Nurse Liz Thomas, Nurse Helen Gee, Nurse Liam Connolly

Case Study - Svetlana

Svetlana is a 35-year-old woman who had been sofa surfing for six months when she first encountered the MPath team during a hospital admission. Svetlana had come to the UK from Poland in her twenties and had a limited support network. Svetlana was precariously housed, relying on friends and former partners, which often placed her at risk due to a history of domestic abuse and problematic alcohol use. On the face of it, Svetlana presented well, she took pride in her appearance, was independent and confident that she could manage independently on her discharge from hospital.

Svetlana had significant health problems associated with her alcohol dependency including cirrhosis of the liver, anxiety and depression and peripheral neuropathy. Despite her resilience, she displayed high levels of vulnerability. Over a period of time the team encountered Svetlana in other settings, such as hostels and day centres and on repeated hospital admissions. The team gradually gathered information from Svetlana and were able to take a holistic view of the risks posed to Svetlana. With Svetlana's agreement a r**eferral was made to the local authority for a safeguarding investigation.**

A **safeguarding planning meeting** was held which brought together the various professionals who had encountered Svetlana in different settings. Svetlana continued to experience a turbulent lifestyle, with further periods of homelessness, interactions with her abusive ex-partner and hospital admissions due to deteriorating health. The difference now was that there was a **coordinated response** from different parts of the system to support her during her periods of heightened vulnerability.

Svetlana developed a **trusting relationship** with the team at UVMP and was able to share her vulnerabilities. The MPath team advocated that the severity of Svetlana's ill health may result in her imminently nearing end of life. Over a number of months, Svetlana achieved increased stability: she was offered temporary accommodation by the local authority, she was allocated an **Independent Domestic Violence Advocate** and a care manager from the substance misuse service to formulate a plan for her alcohol dependency. She worked with the MPath team to retain her accommodation whilst admitted to hospital and for support to access health care when she was discharged, reducing unplanned hospital admissions; and ultimately Svetlana engaged with an alcohol care plan and an eventual planned detox and rehabilitation.

Case Study - Jim

Jim is a 46-year-old man who is registered with the homeless health service at UVMP and was well known to the team. Jim had a long history of injecting heroin and crack and associated dependency, he also experienced problems with recurrent drug induced psychosis. He had been evicted from his last temporary accommodation due to his drug use and behaviour and the local authority had ceased his accommodation duty so he was sleeping rough in the city centre.

Jim experienced very limited venous access following many years of injecting heroin and as a result developed an abscess to his hand. On initial assessment by a GP at UVMP, he was offered a treatment plan that would involve antibiotics and regular dressing changes with the tissue viability nurse. Jim was unable to follow up on this plan due to his level of chaos and complexity and drug use. Unfortunately, his abscess and hand infection worsened whilst continuing to rough sleep and inject drugs and became a chronic wound which was limb threatening and increasingly life threatening.

Jim repeatedly presented at A&E in crisis, however, would often leave the department before he was admitted due to withdrawal symptoms from his heroin and crack addiction. On assessment in A&E he was **deemed to have capacity** to make this decision. However, services encountering Jim in the community were becoming increasingly concerned. Clinicians at UVMP were also becoming concerned as they could see that Jim was repeatedly presenting at hospital and having previously seen the wound and understanding Jim's living conditions, recognised there was a very real risk of loss of limb or life.

Outreach workers encouraged Jim to access UVMP for assessment but he repeatedly declined this. It was evident that Jim was vulnerable and unable to keep himself safe. There was significant **evidence of self-neglect,** there were also concerns with regards to his **mental state and capacity.**

A **safeguarding referral to adult social care** was completed on the grounds of self-neglect. This resulted in a **multi-agency approach** to assess Jim's care and support needs and risks. The only effective treatment option to potentially prevent him from losing his hand was for him to be admitted to hospital, however, due to his complex substance use and mental health difficulties, he could not tolerate a prolonged wait in A&E.

Alongside the local authority, GMMH and Manchester Foundation Trust, UVMP contributed towards a **multiagency arrangement** whereby Jim would be directly admitted to a ward so he could undergo surgery. The MPath team supported communication between the hospital and the community and advocated for a more considered and nuanced assessment of mental capacity. This assessment resulted in **deprivation of liberties** safeguards being put in place as Jim was found not to have capacity in relation to his decision as to whether or not to undergo treatment.

Quote from Ellie Atkins, Safeguarding Lead & Manager: The Entrenched Rough Sleeper Social Work Team, Manchester City Council

"Multiple-exclusion homelessness refers to situations where individuals face homelessness alongside other severe social issues.

People experiencing multiple-exclusion homelessness often have difficulties that increase their vulnerability, such as childhood trauma, acquired brain injuries, chronic physical and mental health issues, limited mobility, and severe addiction.

These overlapping challenges make it difficult for people to access support and services, leading to a cycle of deep social exclusion.

This is where efforts to address multiple exclusion homelessness must involve interdisciplinary, team around the person approaches, that focus on safeguarding and provides comprehensive, assertive and proactive wrap around support to meet the complex needs of affected individuals."

Pictured: Artwork in Ancoats Primary Care Centre

Reflections and thoughts on the future

Our biggest hope is that this report clearly shines a light on the multiple complex health problems experienced by homeless people and goes some way to describe the difficulties homeless people experience in their lives.

When this is apparent it is clear with regards to the potential difficulties that homeless people may experience in accessing the healthcare they need.
At UVMP we have worked with commissioners and have had the opportunity to develop and evolve over many years a needs lead approach to healthcare for this population.

This has resulted in clear access for patients to a broad range of health services in a primary care setting. This range of services would ordinarily be delivered in different settings across Manchester immediately making it difficult for homeless patients to access.

Our approach and service delivery hopefully results in a superior patient journey with more positive outcomes and improvements in individuals' health.
At UVMP we continuously collect and analyse the health data of homeless patients enabling us to proactively plan and develop the service according to need.
We hope to continue to further evolve the service to meet the health needs of the population we serve in the coming years.

This has only been possible with the continued support of our commissioners in Greater Manchester and our partners in health and social care in Manchester who continue to collaborate with us.

Pictured: Outreach Van on location at a Day Centre

Our Team

Dr Shaun Jackson
GP Partner & Clinical Lead

Katherine Scott
Homeless Service Operations Manager

Dr Gill Bradbury
Salaried GP & Manchester Pathway Doctor

Dr Dan O'Shea
Salaried GP & Manchester Pathway Doctor

Dr Tina Bani
Salaried GP

Dr Emily Capper
Salaried GP

Dr Faye Marland
Salaried GP

Liz Thomas
Lead Nurse Practitioner

Helen Gee
Nurse Practitioner

Lisa Howard Jones
Nurse Practitioner

Liam Connolly
Manchester Pathway Nurse

Katie Martin
Homeless Care Coordinator

Martin Walkerdine
Outreach Van Driver

Gill Martin
Homeless Team Administrator

Anthony Verrall
Shared Care Drug & Alcohol Worker (CGL)

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