APPENDIX 6

HOMELESS HEALTHCARE TEAM

1. Aims and objectives

Solent NHS Trust holds a contract with NHS England to provide primary care provision to homeless people in Southampton. The service is provided by Solent NHS Trust. The contract has been in place since 2000 but the team itself has been in existence since 1992. In 2001 the provision was formally extended to include refugees and asylum seekers. This specialist, multi-disciplinary team provides care both to individual homeless people and families across Southampton. The team fulfils an important function by addressing health inequalities in the city and has a strong public health focus.

2. Target Group

The service is provided to homeless people across the city of Southampton. The description "homeless" encompasses people living in:

- hostels or night shelters,
- bed and breakfast,
- supported accommodation for those with mental health or substance misuse problems,
- refuge houses for women fleeing domestic violence,
- approved premises for offenders,
- bedsits or private rented accommodation without security of tenure,
- mobile homes, caravans or cars;
- as well as people with no accommodation who are residing on the streets.

In addition the team provides care to asylum seekers or migrants from abroad who find themselves without support.

Over the years of operation the team has expanded its work to meet the needs of new groups who are marginalised and who experience problems accessing health care. The team seeks to uncover and meet new areas of need within Southampton in a bid to address health inequalities.

3. Services provided

The Homeless Healthcare Team seeks to provide equity of provision for homeless people whilst recognising that a separate service is needed because many people are unable or unwilling to access mainstream provision despite having extremely complex needs.

3.1 Comprehensive new patient check for all patients prior to seeing GP which includes the following:

- Basic physical observations – height, weight, blood pressure
- Current health including completion of template for any long-term conditions
- Recent medication
- AUDIT-C questionnaire for alcohol use. Education and referral on.

- Fibrosis markers if appropriate (to determine the likelihood of liver damage)
- Drug misuse – sharing of works, risks. Education and referral on.
- Blood borne virus screening incl. pre-test counselling for HIV, vaccination for Hep B if appropriate
- MMR vaccination if appropriate
- Smoking cessation advice
- Quantiferon Test for TB and referral if active or latent disease is suspected
- Urine test
- Liaison with past providers (including prisons) to determine recent medication etc.

The new patient check takes between 30-60 minutes.

3.2 GP Provision

There are currently 3 sessional GPs employed by the Team who provide 6 sessions. There is 1 GP session per day. GPs provide both booked appointments and drop-in consultations. Appointments are booked for 15 minutes but in reality some consultations take much longer. GPs are very aware of the danger of compounding problems by prescribing additional drugs which may be misused. The GPs work very closely with the Nurse Prescribers within the team.

3.3 Long term conditions

Patients are offered time to discuss the management of their long-term conditions on an opportunistic basis. Patients rarely attend for planned appointments for this. Team members sometimes need to be creative in how they can support people. Support workers can provide assistance in ensuring patients attend secondary care appointments and screening tests.

3.4 Sexual health services

- Pregnancy testing
- Screening
- Discussion of contraceptive options
- Implanon insertion

3.5 Screening and Vaccination

The team conducts screening at each new patient check and thereafter on an opportunistic basis. Screening provided includes:

- TB Screening – following NICE guidance
- Blood borne virus screening – Hepatitis and HIV
- Screening for liver disease (Fibrosis Markers)

Vaccinations provided include Flu and Pneumococcal, MMR to complete course, Hepatitis B and any others required.

3.6 Asylum seekers and refugees – including people with no recourse to public funds
Victims of Human Trafficking

The Team is often the first to become aware of asylum seekers or refugees living in the City. From a public health perspective it is crucial that appropriate health screening is provided, for example TB screening. The Homeless Healthcare Team aims to provide this and then clients are registered with local GPs if they are permanently housed. The team has also secured a small fund to ensure that essential medication is available to patients with no recourse to public funds on the basis that prevention is cheaper than costly hospital admissions.

Recently the Medaille Trust, a voluntary charity, set up a number of house for victims of sex trafficking. The Homeless Healthcare Team is providing initial screening for these clients. Of those first screened 50% had positive quantiferon tests (meaning there is a strong suspicion they have latent Tuberculosis).

3.7 Ante-natal services

The team provides basic ante-natal care and also seeks to facilitate access to a midwife. This is not always easy because often the women have had experience of having babies removed at birth and therefore seek to hide their pregnancy and/or do not wish to engage with healthcare services. The Health Visitors provide care to women in temporary accommodation and support to new mothers.

3.8 Gypsies and Travellers on illegal sites

The Team drew up this work in conjunction with Southampton City Council. Members of the Team (usually a Nurse Practitioner and Health Visitor) attend illegal sites to provide health assessments and urgent care prior to the people being evicted.

3.9 Mental Health Service

Many people who are homeless have mental health issues. The team includes three part-time Community Mental Health Nurses (two whole-time equivalents) and an Associate Practitioner. The Community Mental Health Nurses are employed by Southern Health but their salaries are paid for by the Homeless Healthcare Team. They are based with the Team in the Two Saints Day Centre and they work jointly with other members of the team. They offer assessment, treatment (in the form of regular depot medication and CBT interventions) and support to clients with mental illness. They also offer advice to other members of the team about the most appropriate service.

The Associate Practitioner supports clients with day to day living, for example resettlement, budgeting, healthy lifestyles, management of long-term conditions including substance misuse and accessing healthcare.

The Community Mental Health Nurses and Associate Practitioner provide a service to any homeless person within Southampton, rather than only those registered with the Team for PMS services.

The team has been successful in ensuring that a practitioner from the IAPT (Improving Access to Psychological Therapies) team provides a face to face clinic on a weekly basis at the Day Centre ensuring equitable access for homeless people who often do not have adequate telephone or on-line access.

3.10 Health Visiting Service

The Health Visiting Team supports families and pregnant women who are homeless in Southampton. This includes families from the surrounding area such as Eastleigh and the New Forest who are placed in temporary accommodation in Southampton but who do not wish to re-register with a GP. Children are not allowed in the Day Centre where the Homeless Healthcare Team is based and therefore families are not able to register with the Team but are supported to register with local GP surgeries. The Homeless Healthcare Team health visitors remain involved until the family is settled.

Many of the clients they work with have suffered from domestic violence and some of the children have suffered physical, emotional or sexual abuse. Many of their families are on the Child Protection Register and they work closely with the Safeguarding Team and Social Services.

A Family Support Worker provides assistance with resettlement, obtaining sufficient food, access to schooling and childcare, registration with a GP and accessing healthcare.

The Health Visiting team works with asylum seeker and refuge families as well as families resident in the trafficking houses run by the Medialle Trust.

3.11 Complementary Therapies

A recent development has been the provision of Acupuncture and Hopi Ear Candling. These are provided by the Associate Practitioner with the aim of reducing anxiety and assisting clients in managing their substance misuse. A trained Osteopath also provides a weekly session on a voluntary basis.

3.12 Facilitation of access to other services

A podiatrist does a morning session once every six weeks at the Team base. This can be accessed by anyone who is homeless rather than just those who are registered. The Team also has a weekly session from an Improving Access to Psychological Therapies

practitioner. Staff also facilitate access to dental care. It has always been an important aspect of the work of the Homeless Healthcare Team to advocate for patients to ensure they have access to appropriate care. This has involved the presentation of patients to the Vulnerable Adult Board to ensure adequate care is provided. This level of advocacy on behalf of the most vulnerable and marginalised patients has impacted on many healthcare services over the past 20 years forcing managers and commissioners to consider how their service manages the needs of those with health inequalities.

3.13 Enhanced Services

The Homeless Healthcare Team aims to participate in all relevant enhanced services. This is the despite the fact that there is no specific remuneration involved. This is in order to ensure that patients registered with the Team are in no way disadvantaged.

3.14 Other work of note

GSF
The team has an active GSF register and are at the forefront of this work locally. The provision is palliative care for homeless people is a challenging are but one which the team strive to champion. End-stage liver disease is an area of particular interest.

Teaching and Advice
The Team provides a considerable amount of teaching for the health community and act as experts for the purposes of information on homelessness, asylum seekers, substance misuse, etc.

MAPPAs
The team attends Multi-Agency Public Protection meetings for clients registered with the Team. These seek to minimise the risk to the public.
Performance Indicators and the Faculty of Medicine

The Homeless Healthcare Team Lead GP and Nurse Consultant are members of the College of Medicine's Faculty of Homeless and Inclusion Health. This is a nationwide faculty bringing together experts in these fields. The Faculty have produced some standards for commissioners and service providers which we are seeking to work towards. There is a link here: http://issuu.com/collegeofmedicine/docs/homeless_health_standards

The Homeless Healthcare Team is striving to meet the standards set out in this document.

"London Pathway" research

Members of the team are currently involved in the very early stages of a research project which would seek to determine if having a Homeless Healthcare Team nurse visiting and assessing homeless patients in the local acute hospital and overseeing discharge arrangements would provide better health outcomes and reduce re-admissions.

Service user involvement

The Team strives to obtain the views of service users and runs focus groups every 2-3 years in locations accessible to homeless people. This is recognised as the best way to obtain reliable opinions in a way that seeks to be supportive of the users themselves. The views are discussed within the Team and used to inform service development. The need for pre-bookable appointments came from focus groups. The Health Visiting team are seeking to develop similar focus groups in the refuge houses.

Participation and Leadership in the areas of homelessness and asylum seekers /refugees

Team members participate in a wide variety of forums and meetings aiming to ensure that the focus is on the patients and their health outcomes. Links to accommodation providers, and the City Council as commissioners are extremely important. There is also significant input in areas of substance misuse (particularly drug related deaths) and domestic violence. Wherever possible a joined up approach is sought in the best interests of homeless people.

4. Locations of service

The Homeless Healthcare Team is based in a voluntary owned Day Centre for homeless people. This is a location which provides easy access for homeless people. It also means they can get all their basic needs met in one single location (the Two Saints charity provides food, clothing, washing facilities, accommodation and benefits support).

Over the past 20 years the Homeless Healthcare Team has provided GP and/or Nurse sessions in a number of different voluntary settings. These are reviewed as appropriate in terms of the numbers of clients seen and whether they would or could attend to be seen at the Day Centre.

At present a Nurse Practitioner visits Patrick House (the largest hostel in the city and assessment centre) twice a week to register new patients and to provide care to existing patients. In addition one of our GPs provides a weekly session there on a Wednesday morning. There is a fully equipped medical room at the hostel.

The Nurses visit other hostels as necessary to provide care, which may be on an on-going basis depending on the health needs of individual patients.

The Community Mental Health Nurses and Associate Practitioner also regularly visit Patrick House and a number of other hostels.

The Health Visitors and Family Support Worker visit the Emergency Accommodation at Millbrook Road East, all the Women's Refuge Houses (for women escaping domestic violence) and the Medialle Houses (for victims of trafficking) on a weekly basis.

5. Performance Indicators

The team participates in the Quality and Outcomes Framework, although some disease areas have very few patients on them. Mental health, Asthma and COPD, Diabetes and Epilepsy are significant disease areas. The management of long-term conditions is challenging because it is often exacerbated by substance misuse and/or mental health conditions as well as by the poor social conditions in which patients reside.

The issue of having specific performance indicators has been addressed in the past but never reached fruition. Pertinent areas have been screening for blood borne viruses, substance misuse, management of liver disease (particularly end stage) and Tuberculosis screening. This is why the team has focussed on the Faculty of Medicine's standards.

Client profile and health / housing needs & inequalities

Age range	Male	Female	Total
18-24	58	13	71
25-34	149	26	175
35-44	121	15	136
45-54	87	9	96
55-64	35	4	39
65-74	6	0	6
75+	0	0	0
Total	456	67	523

Health needs

Substance misuse (alcohol &/or drugs which impacts daily life) - 326
Mental health (schizophrenia, bi-polar and psychoses only) – 47
Depression – 98

Clients with no recourse to public funds and those who are unable to access hostel provision are present particular challenges in terms of providing healthcare.

Key client solutions

Vigorous outreach
Liaison with acute trust & identification of frequent attendees
Suitable accommodation, particularly post-hospital admission
Joint working with professionals from other agencies, voluntary & statutory