London Health Observatory

inclusion health

Vulnerability: Visible, measurable, engaged?

International Conference on Homelessness and Health Inclusion, Feb 27th 2013

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Director, London Health Observatory.

Thanks to Peter Aspinall, University of Kent, for comments

" Pre-requisites for good health"

New hostel in Ballymena

St Mungos – Social enterprise

Roma children at Primary School

Fun at Christmas

What do we mean by vulnerability?

The Government's 4 priority groups :

- **Refugees and Asylum seekers**
- **Gypsies and Travellers**
- **Homeless people**
- **Sex workers**

Why focus on these groups?

Among the groups with the poorest health in the country/ Govt policy is to "improve the health of the poorest fastest"

- Extremely poor mental and physical health outcomes
- Very poor access to health and social care compared with the general population
- Need for greater policy focus.
- Evidence from some studies of health experience that is worse than even the most deprived segments of the population

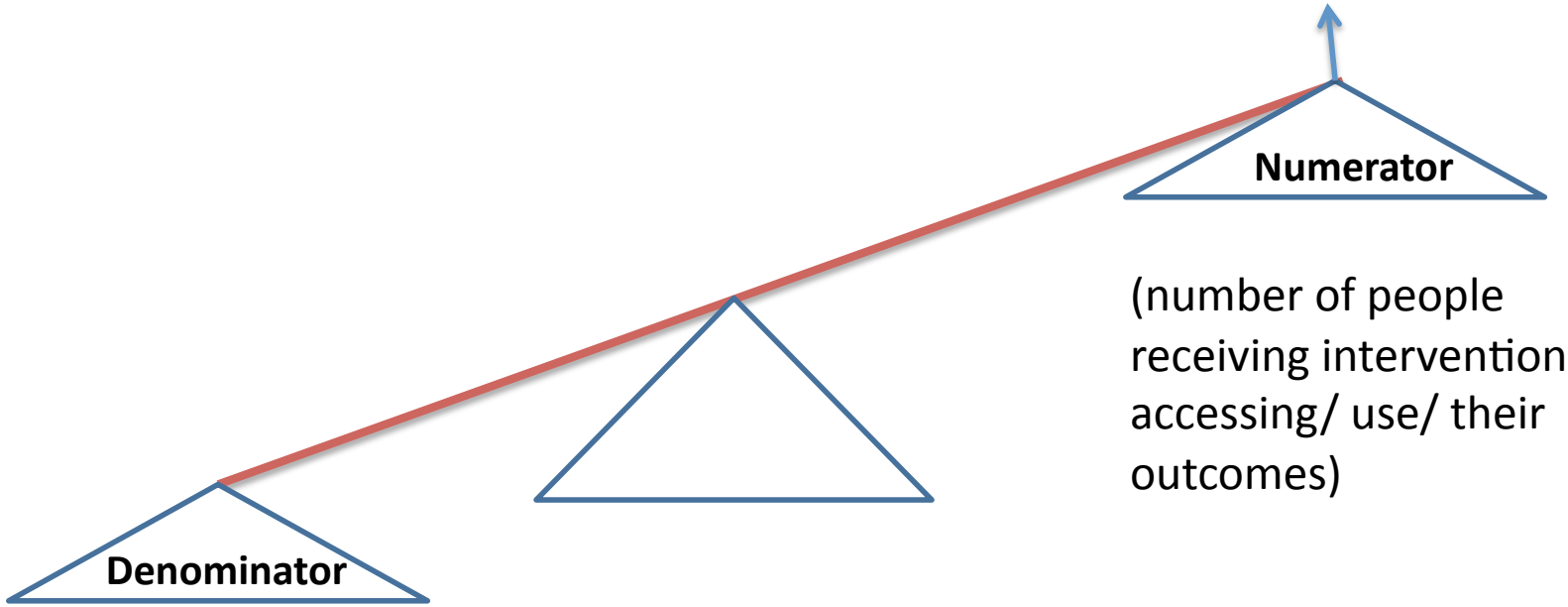
The Spectrum of vulnerability

Population	Vulnerable sub-groups
Refugees & Asylum seekers	•Failed asylum seekers •Mental health problems •Trafficked /undocumented migrants • children •Rough-sleeping A10 migrants •Migrants with serious illness
Gypsies & Travellers	•Whole group at risk of poor mental/physical ill health •Inadequately housed on unauthorised sites •Male Irish travellers
Homeless people	•Concealed homeless •Street homeless •Rough sleepers /sleeping in a hostel/insecure accommodation •Single homeless
Sex workers	Young women in care Women victims of domestic violence Problem drug users Street workers Trafficked children

What we need to measure *routinely* and why?

- **What is the size of the population we are concerned about?**
- **What is its geographical distribution?**
- **How does it change over time?**
- **What are the social, health and care needs of the population and are there inequalities within groups?**
- **What interventions ensure fair access and outcomes in relation to need (are they cost –effective?)**
- **What outcomes are we achieving?**

What basic measures do we need?



(number of people receiving interventions/ accessing/ use/ their outcomes)

(number of people at risk in a defined local/national population)

The population denominator?

Population	Size?	Sub-Groups?	Local distribution?	Regular Measurement of change?
Refugees and asylum seekers	Census measures migrants	Very poor/ children better	Very poor/no regular survey info	No
Gypsies and Travellers	Census 2011 Census: 57k Ests:250-330k)	Included as ethnic grp -1st time	Yes, but undercounted	Limited to census and LA housing assessments
Homeless	Census/CLG/LAs	Street homeless only	Different definitions used across govt	Yes, census seriously undercounted/ other intercensal counts better (eg CLG)
Sex workers	Not known –est. 36-80k	No	No	No

The numerator: Need/Access/ Use /Outcomes?

Population	Health and social care?	Mental health?	Outcomes?	Health Surveys?
Refugees & asylum seekers	Limited primary care/not hospital /lim'd social care	Adults	No	Limited/Ad hoc only, and country of birth only
Gypsies/travellers	education/ employment/ housing needs assessments/ Looked after children; no health care info	No	No	Small numbers
Homeless people	Specialised primary care only/Only NFA in hospital care	No	No	Ad hoc only
Sex workers	Sexual health services only/ removed from drug support	No	No	Ad hoc only

Research: do we know what works?

Emerging issues:

- Fair access and intervention: Specialised vs mainstream services?
- Size of population served
- Embedded community advocates/health advocacy
- Bilingual/translation services
- Use of contractual/commissioning incentives

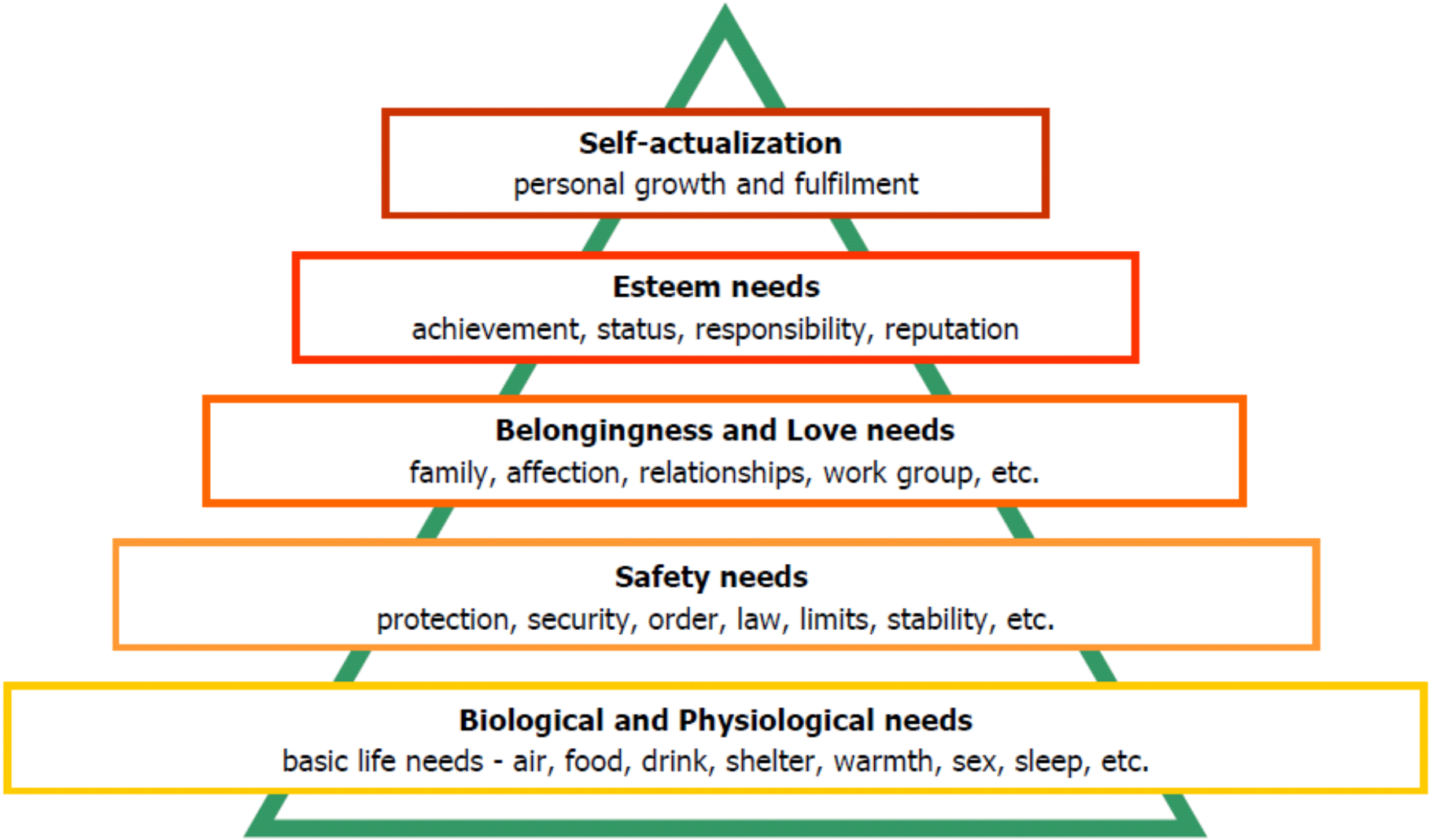
Research: do we know what works?

Suggested Evidence of effectiveness	Questions/Uncertainties
Dedicated services for large populations	What is the model for small populations?
	Are dedicated services more cost –effective than mainstream or supplementary?
Active involvement/advocacy of user community in design/delivery	Handheld patient notes
Trusted /trained providers	
	How to systematise services for mobile populations
Use of Local Incentive schemes	
	Lack of evaluation
	Overcoming charges(refugees/asylum seekers) **Overcoming stigma**

For discussion

- **What are the priorities for ensuring better visibility nationally and locally to support JSNAs?**
- **How can we make better use of what we already have and who should be responsible for regular analysis and reporting in the new system?**
- **What are the research priorities and whose responsibility is it to ensure they are reflected in future commissioning?**
- **Do we need to focus further upstream- employment, education , housing?**

Maslow's Hierarchy of Needs



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Inclusion Health - evidence gaps

Background: barriers to healthcare for the homeless

History of Homeless Health Care in Watford

Evidence needed to justify service

- in 2000
- in 2010

Evidence : what is known – by at least some

Evidence : gaps

Barriers to health care

- Chaos of being homeless
- Reduced agency
- Vulnerability and low trust in professionals and institutions
- Stigmatisation
- Staff attitudes
- Mental health and substance dependence
- Appointment systems and waiting
  leading to late presentation and neglect

Health problems for the homeless

- Fundamental loss of self esteem
- Self neglect
- Physical health problems

  nutrition, trauma, infection, dentistry
- Mental health problems

  depression, paranoid feelings

  complex trauma - personality disorders
- Drug and alcohol problems
- “Trimorbidity”

Access threatened when people struggle to establish their candidacy for care

- failure to recognize oneself as a candidate for care
- lack of awareness of service
- lack of accessibility of services
- difficulty formulating a claim to care
- difficulty in being assessed as eligible for care by health professionals
- refusals of services deemed inappropriate or unhelpful

- From 2006 DoH 'Vulnerable groups and access to health care' based on Dr Mary Dixon-Woods et al Leicester University

High permeability services

- are those that are easiest to ‘get in’ to - that demand the fewest qualifications for candidacy, and that require less work - eg A&E

- Services that are less permeable require much more work in order to gain a point of entry and sustain engagement with the service

  e.g. registration, appointments, referral, transport

Effective appropriate care is care that

- Is accessible - geographically
  - open access – walk in & booked appointments
- Engages with patients
- Respects patients – non discriminatory and non stigmatising
- Cares

Key values in patient-centred care are:

- **Listen to the patient**
- Provide a setting where that can happen
- Non judgemental
- Motivational Interviewing

Challenges for staff
Who works with the homeless?

- Not everyone: patients can be very challenging, and the experience can be very stressful for staff
- Need services with “Intelligent Kindness”
- People with
  - Compassion and respect
  - Communication skills
  - Motivational Interviewing
  - Patience
  - Resilience
  - Courage
- Violent patient schemes
- Service organisation and capacity essential: e.g. what happens once waiting-room gets full and patients are kept waiting
- “intensive primary care”

Watford Demographics

- **Watford and surrounding Three Rivers councils**
- **Population** 160,000
- **Density** 9,638.6/sq mi
- **Ethnicity** 83.0% White
  - 9.2% South Asian
  - 3.5% Black
  - 2.5% Mixed Race
  - 1.6% Chinese or other

Indices of Multiple Deprivation:

3rd most deprived in Herts, 18th out of 48 in eastern Region of England

the most ethnically diverse district in Hertfordshire

3 wards that rank as highly deprived wards – Meriden, Central and Holywell. South Oxhey scores similarly in Three Rivers District.

Watford Homeless Primary Care
History 1: 10 years before opening

- 1990 Day Centre for the homeless opens
- 1993 Public Health Herts ? New provision for the homeless needed
  Mainstream reactions to disruptive patients
- 1997 Drop in at Local Day Centre 2 years
  HImP (Health improvement) programmes
- 2000 PMS pilot bids
- 2001 PMS 4b 2001 successful
  DH £235K input
- 2003 Meadowell opens, PCT Provider Services
  new purpose built building
  ideal location
  steady uptake of services from start

Zone
ENDS
E457 WBK

Meadowell Centre, Watford, Herts

TO LET
NO SMOKING

Suggestion Board
Newstowell Centre
Dates & Times
MINNESOTA

RECEPTION
These premises are under constant CCTV surveillance for your personal safety and security
back and wait you
turn
to all Patients
booked in, please
room.
will lose

Access and engagement

- Access is key
- Appointment and flexibility:
  Book ahead 35%, on day 65%
- Calm waiting area
- Seen quickly
- Multidisciplinary team -
  Dr, Nurse, Drug worker/s, Counselling

Availability

- Monday to Friday 9am to 5pm
- Consultation sessions 9am -1pm 2pm – 5pm
- Out of Hours service Herts Urgent Care (CIC)

- Staff:
  - GP initially 1wte, now 1.8 wte
  - Practice Nurse 0.5 wte
  - Substance Misuse Nurse 0.8wte
  - Reception/admin 1.8 wte
  - Manager 1 wte
  - Minimum 2 admin staff at any one time

Initial Case Proposal: evidence

April 2001 PMS 4a application quoted:

- Homeless/Housing data:
  - National, local authority, third sector
- Health data:
  - policies
  - pilot study
  - local services experience
  - precedents elsewhere

Time intensive, out of working hours

The first report on rough sleeping by the office of the Deputy Prime Minister in 1999 listed Watford amongst the top 20 towns and cities in England for numbers of people sleeping rough

- **Table 1: Highest concentrations of rough sleepers in England, as at June 1999**

London (11 boroughs)	525
Oxford	52
Manchester	44
Birmingham	43
Brighton and Hove	43
Bristol	32
Nottingham City	31
Stoke-on-Trent	31
Liverpool	30
Chester	26
Croydon	25
Cambridge	31
Slough	20
Gloucester	20
Exeter	19
Bournemouth	18
York	18
Leeds	17
Penwith	17
Watford	**15**
Total 1047	

Homeless/Housing data April 2001 PMS 4a application

National data

- Coming in from the Cold' 1999 Rough Sleepers Unit: Watford amongst the top 15 towns or cities in England with the largest homelessness issues, based on the 1998 Rough Sleepers Count.

Local authority homelessness data

- 175 households currently in temporary accommodation (around 500 people)
- 1856 people on the local authority waiting list considered statutory homeless
- Numbers of homeless households accommodated by Watford Council risen by 250% between 1997 – 2001
- 503 hostel type bed spaces catering for needs of single homeless people
- Affordable Housing Survey - 1960 households in housing need, 2760 could not access any form of housing on the basis of their income.

Third Sector Homelessness data

- Contact and Assessment Team (CAT) saw 200 clients Oct 2000 - Sept 2001; on street or in Day Centre.
- 220 referrals to Emergency Night Shelter per year
- 50 – 70 people attending Day Centre daily

Health data April 2001 PMS 4a application

Policies

- PCT policy towards socially excluded in local HImP (Health Improvement Plan)
- Mental Health National Service Framework (NSF).

Health data from 2 year pilot clinic at a local day centre (1997 - 1999)

- 2 lunchtimes a week drop-in clinic
- 230 patients
- 2307 consultations in 184 sessions,
- 13 patients per session, and 5.2 consultations per patient per year, 88 only seen once
- 187 (81%) male, 43 (19%) female
- average age 31 (1 – 62)
- 20 - 30 patients on methadone

Health services experience

- Disruptive patients including threatened or actual violence against staff or other patients
- Precedents for dedicated homeless services elsewhere - Leeds, Oxford, London and Bristol
- Survey of Local GPs: 48 respondents: 95% in favour of development of service, 93.7% would refer to it

Watford Homeless Primary Care History 2: 10 years since opening

- 2003 Meadowell opens, PCT Provider Services
- 2005 Review, PCT in financial crisis – provider services budget cuts proposed: largest, at 26%, for Meadowell
- 2006 PCT Competitive Tender process for APMS collapses

  New PCT investigates: service continues - no budget cut
- 2009 Further review by PCT Provider Services: 'not core'
- 2010 Right To Request Expression of Interest
- 2011 Integrated Business Plan "Health Inclusion Matters CIC"

  October: Health Inclusion Matters takes over

Social enterprise request process

- Staff decide to exercise right to request
- Application to form social enterprise submitted to PCT
- PCT Board agrees to right to request application
  PCT adds unexpected caveat when submitted to Department of Health
- SEIF Social Enterprise Investment Fund support for consultancy help
- IBP (Integrated Business Plan) written and submitted to PCT Board
- PCT Board approves IBP
- APMS contract negotiated complete with last minute legal hitches
- Process started July 2010….. Signed contract September 2011
- Official launch with Mayor, MP, Chair of PCT 28th February 2012
- Board: 2 Executive Directors 6 Non-executive Directors – Chair ex FT and PCT CEO, 3 GPs, 1 Pharmaceutical company director, Baroness Brinton

Evidence 2011

- Operational data
- Stakeholder consultation
- Patient Consultation and feedback
- Plans to meet needs and innovate

A patient writes

- *This is the only surgery that looks after drunks, drug addicts, mental health and homeless people that I know of in the Herts area. I am or was an alcoholic for over 40 years. I was not registered with any doctor as I was looked upon by the general public as a parasite, as any one homeless is classed.*
- *I registered with a doctor…. but when I went there it was like I was a disease. People spoke in whispers, would not sit anywhere near me and kept looking at me. After two visits I would not go there anymore.*
- *I was taken to hospital a number of times and told I must register with the doctor. I was told by New Hope Trust that a new surgery was to be built in Cassio Road mainly for people like me. I thought I would try it and was surprised at the warm welcome by the receptionist and staff, these people cared. 90% of the patients were street people and I never heard a cross word of complaint about the staff or doctors at the surgery.*
- *After 50 years on the street I had finally found people who really cared, genuinely cared.*

A few of many similar comments from our patients

- *I think Meadowell offers a unique service to people who suffer with the diseases of alcoholism and addiction. I feel that if it closes Watford will become a worse place with crime rising and even suicides*
- *If the bid is not accepted and I have to go back to a local GP it will make a significant difference to me. I feel I have an excellent one-to-one service for issues I feel comfortable discussing at Meadowell with both doctors. It is excellent to have a nurse and drugs worker on site and all aspects of my issues are covered. If we lost the centre it would be an absolute disaster and I think an awful lot of people would suffer. Please keep this service open.*
- *The Meadowell Centre is a haven for a whole range of people in the community and accepts and cares for people which no others will.*
- *I have been turned away from 4 different GPs before being accepted here. What will people like me do if this facility was no longer here?*
- *The doctors is a vital part of getting people with addiction clean. It is safe and good place - without it we would be on drugs and life would be harder.*
- *Without Meadowell I would be " DEAD" simple*

Activity

- 1300 patients in 7 years, 600 currently
- (81%) male,(19%) female,10 under 18, 8 over 65

- **147 (33%) drug dependence problems**
- **120 (22%) currently on opiate replacement treatment**
- **180 (35%) significant alcohol problems**
- **395 (88%) mental health problems**

Annual activity 2010

	GP	Nurse	Drug Worker
Booked appointments	10280	1603	1557
Attended appointments	8938	1092	1176
Did not attend	1342	471	350
DNA%	13%	29%	22%

- 1700 episodes of patient registration of 1290 individuals in 6 years: currently 600 registered
- Turnover: during 2010 220 patients registered and 166 left

During 2010 – list of 550 patients:

- 152 received opiate substitution treatment (28%) –
  109 methadone, 74 buprenorphine
- 93 alcohol problems (17%)
- 359 recorded mental health problems (69%) – a broad category - mostly depression with paranoid feelings
- Referrals:
  43 Community Mental Health Team
  15 Primary Care Enhanced Mental Health Service
  9 Community Drug and Alcohol Team
- 105 A&E attendances

Consultations 2010

- 60 consultations daily average
- 40 GP
- 12 practice nurse
- 8 substance misuse nurse
- average of 20.3 consultations per patient per year (11206 for 550 patients over a year),
- activity of each patient is nearly 10 times that of an 'average patient in normal general practice'. Thus our list of 500 patients generates the activity normally associated with a list of 4500 - 5000 'average' patients.

Blood borne virus screening since 2003

- 371 patients screened for hepatitis C, 68 Hep C positive
- 371 patients for HepB (HepBsAg), 369 were negative, 1 positive and infectious, 1 positive and non-infectious
- 142 patients for HIV - all HIV negative
- 244 patients immunised against Hepatitis B using an accelerated course regime – a majority, but not all, complete the course.
- 96 patients checked after Hepatitis B immunisation - 33 achieved adequate HepBsAb protection (i.e. > 100 iu/ml Hep)

Integrated Business Plan (IBP) March 2010 for Meadowell

trading as Health Inclusion Matters CIC

- 1 EXECUTIVE SUMMARY
- 1.1 Vision and strategy
- 1.2 Rationale for Social Enterprise
- 1.3 Alignment with National and Regional Policy
- 1.4 Governance & Risk
- 1.5 Financial Plan
- 1.6 Contractual Arrangements
- 1.7 Leadership & Management
- 1.8 Consultation
- 2 PROFILE
- 2.1 Overview
- 2.2 Our Local Population
- 2.3 Our Commissioners and our Income
- 2.4 Range of Services
- 2.5 Activity
- 2.6 Protected Assets
- 2.7 Financial Performance
- 2.8 Performance against Key Healthcare Targets
- 2.9 Joint Ventures and Partnership Arrangements
- 2.10 Education and team development
- 3 STRATEGY
- 3.1 The mission of Meadowell
- 3.2 Vision
- 3.3 Service Strategy
- 3.4 Strategic Objectives
- 3.5 Rationale for Social Enterprise
- 3.6 The Consultation Process
- 4 MARKET ASSESSMENT
- 4.1 Meadowell catchment and the Watford Health Economy
- 4.2 Key Factors Driving Demand
- 4.3 Illustrative Map of the Watford Health Economy
- 4.4 Demography
- 4.5 Commissioning Factors
- 4.6 Major Changes in the External Environment – Summary PEST Analysis
- 4.7 Partnerships and Joint Ventures
- 4.8 The Competitive Environment
- 5 SERVICE DEVELOPMENT PLANS
- 5.1 Introduction
- 5.2 SWOT Analysis (Strengths, Weaknesses, Opportunities, Threats)
- 5.3 Service Development Strategic Alignment
- 5.4 Fit with other strategic commissioning priorities
- 5.5 SDP No.1: Core business
- 5.6 SDP No.2 Expansion of existing additional income streams
- 5.7 SDP No.3 : New Services
- 6 FINANCIAL PLAN
- 6.1 Overview
- 6.2 Historic & Current Performance
- 6.3 Income and Expenditure
- 6.4 Balance Sheet
- 6.5 Cash Flow
- 6.6 Activity Levels
- 6.7 Cost Improvement Programme
- 6.8 Investment Strategy and Start-up funding
- 6.9 Taxes
- 6.10 Pensions
- 6.11 Sensitivity Analysis
- 6.12 Risks
- 7 RISK MANAGEMENT
- 7.1 Key Challenges
- 7.2 Risks to the social enterprise
- 7.3 Financial Management and Efficiency
- 7.4 Liability and Indemnity
- 7.5 Clinical Risk Management
- 7.6 Quality
- 7.7 Risk Assessment
- 8 LEADERSHIP AND WORKFORCE
- 8.1 Introduction
- 8.2 Board of Directors
- 8.3 Leadership and Management Arrangements
- 8.4 Workforce Profile
- 8.5 Key Performance Indicators
- 8.6 Organisational Development
- 8.7 Workforce Planning
- 9 GOVERNANCE
- 9.1 Legal form
- 9.2 Company Name
- 9.3 Objects
- 9.4 Outline Governance Structure
- 9.5 Shareholders
- 9.6 The Board
- 10 TRANSITION PLAN
- 10.1 Overview
- 10.2 Detailed Transition Plan
- 11 APPENDICES
- 1 Financial Models
- 2 Consultation and comments from patient
- 3 The London Pathway Standards for The Health Care of Homeless People
- 4 Risk Register

Costs of specialist primary care

- **Meadowell costs £500K pa for 600 patients**
  = £830 per head vs £75- £100 per head in GMS
- **If each patient brings the activity of 10 = £83 per head**

- **Process – "Who is commissioning whom to do what?"**
  - **Eg drug budget**
  - **hepatitis C outreach treatment clinic**

- **Questions faced by Commissioners:**
  - **Is it necessary?**
  - **Is it effective health care?**
  - **Is it safe good clinical practice?**
  - **Is it value for money?**
  - **Can it be delivered more cheaply?**
  - **Does it fit in the local health care economy?**

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GP and manager form social enterprise to save practice for homeless

Marina Soteriou, 27 February 2012

A GP a ave saved the PCT-led specialist homeless practice they run from being put outto tender by setting up a social enterprise to take it over themselves.

Meadowell, in Watford, Hertfordshire, which runs a drop-in service alongside booked appointments, was due to be officially opened this week by the mayor of Watford after GP Dr Tim Robson and practice manager Julie Madley won a 'right to request' bid to take it over.

The right to request scheme allowed staff to apply to run services offloaded by PCTs when the last government split NHS purchaser and provider functions.

Dr Robson said Meadowell was among the country's smallest social enterprises. He said taking on the practice was initially about protecting the existing service, but the practice has now bid for extra funding to improve. 'We are going to set up hepatitis C treatment as an outreach service. Patients are more likely to comply with treatment here, the long-term savings are huge,' he said.

Ms Madley said: 'It has been a struggle because it is something new. The PCT had to make a choice to put the service out to tender or could have changed the service so we employed our right to request and had no competition. Patients say they like to come here because nobody judges them.'

Former patient and designated patient champion **Stan Burridge**, 46, was sleeping rough when he first went to Meadowell in 2003; he now has a flat and has had several jobs. He said: 'If I hadn't got that care I would not be in the position I am now.

'The biggest difference between being managed by a PCT and being a social enterprise is that it gives them the freedom to develop services based on the needs of the patients.'

Watford Homeless Primary Care History 3: the next 10 years

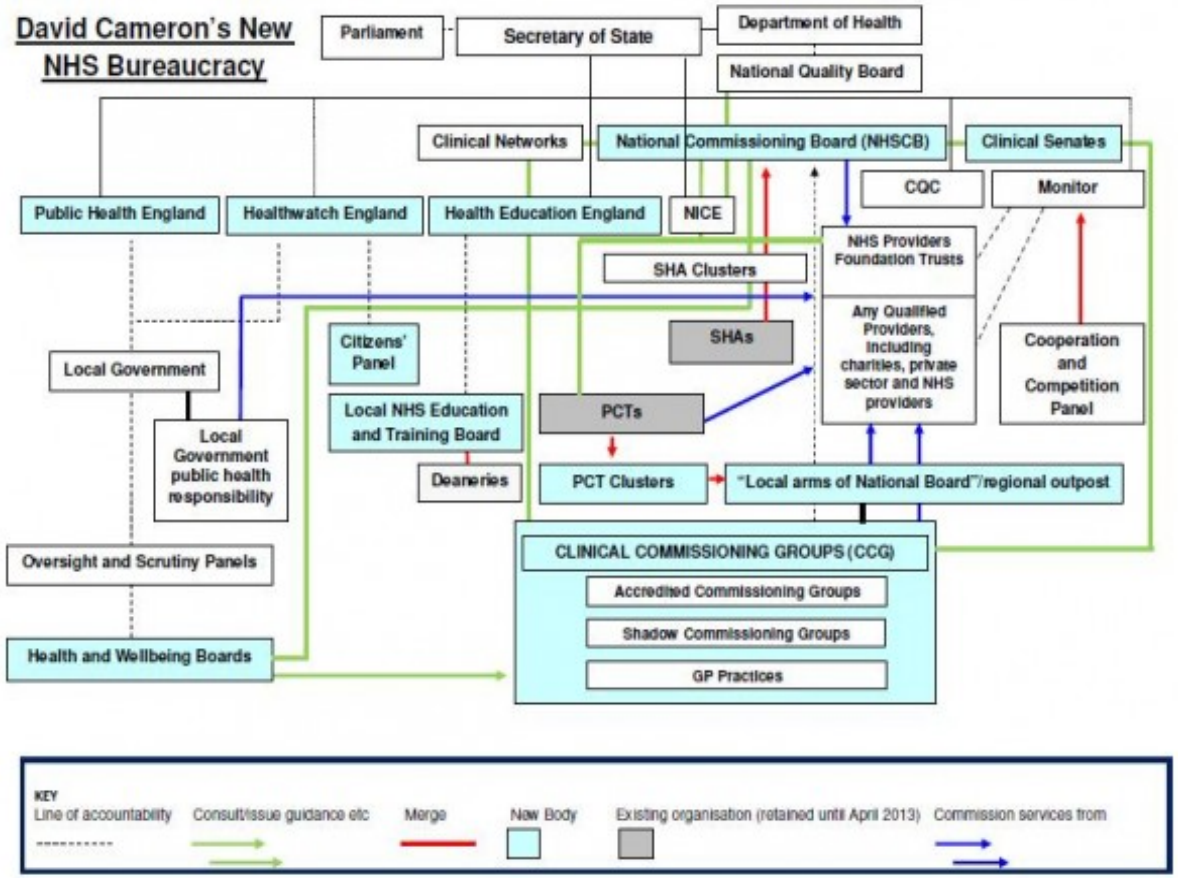
Facing the future in uncharted CCG land

- 2003 Meadowell opens, PCT Provider Services
- 2011 Health Inclusion Matters CIC
- 2012 Health and Social Care Bill
- 2013 Herts Valleys Clinical Commissioning Group
- 2016 Contract expires: ? Competitive tender
- Specialist Clinical Governance needed for
  - Homeless medicine and advocacy
  - Management of substance misuse in primary care
  - Mental health support for eg personality disorder
- Future plans: Hepatitis C clinic, satellite services, more partnership working…..

Challenge for staff in specialist primary care

- Stressful - broken lives, child protection work
- Rapid working and flexible access essential if tensions are not to build up in the waiting room
- Developing expertise can mean deskilling in general care - need to keep up general skills
- Clinical governance an issue - isolated small practices with small numbers of staff
- Specialist staff and staff training required
- Support versus recovery mode
- Do no harm

Health and Social Care Bill
Your NHS…. new, improved..



Herts Valleys Clinical Commissioning Group

HVCCG Constitution:

- *"strong commitment to accountability between the board, localities, patient groups and the constituent members of the Clinical Commissioning Group"*

"The members have a vision for the CCG, which is working ***towards achieving perfection*** *in commissioning health care for the people of West Hertfordshire with:*

- ***No inequality in service delivery***
- *No needless pain, disease or death*
- ***No feelings of helplessness amongst users and staff***
- *No unwanted delay or waste*

Existing evidence

Extensive research literature on homelessness

mostly unknown to clinicians: **Training need**

NB: Post Graduate Certificate Provision of Primary Health Care to People Experiencing Homelessness
Angela Jones, Oxford University 2002/2003

DH reports

- **Systematically in addressing health inequalities**
  June 2008 National support team to health inequalities
- **Inclusion health: improving primary care for socially excluded people**
  March 2010 High Quality Care for All worldclasscommissioning
- **Inclusion Health Evidence Pack**
  March 2010 Cabinet Office Social Exclusion Task Force

Existing resources

- **Homelessness strategies**: a good practice handbook
  Jeffrey Randall Susan Brown
  2002 Dept for Transport, Local Government and the Regions (DTLR)
- **Addressing the health needs of rough sleepers**
  Sian Griffiths
  2002 Officer the Deputy Prime Minister
- **Drug Services for Homeless People**: a Good Practice Handbook
  Geoffrey Randall, Jill Britton
  2002 Officer of Deputy Prime Minister/ DrugScope
- **Dental care for homeless people**
  December 2003 British Dental Association policy discussion paper
- **Delivering Health Care to Homeless People: An Effectiveness Review**
  Deborah Quilgars and Nicolas Pleace
  May 2003 Centre for Housing Policy University of York
- **Personality disorder: no longer a diagnosis of exclusion**
  policy and the mentation guidance the development of services to people with personality disorder
  2003 National Institute of mental health in England
- **Getting through - Access to mental health services** for people are homeless or living in temporary or in secure accommodation A Good Practice Guide
  2007 Randall Britten Craig
  DH ODPM Care Service Improvement Partnership
- **Tackling homelessness and exclusion: Understanding complex lives**
  Theresa McDonagh
  September 2011 Joseph Rowntree foundation
- **Homelessness kills: an analysis of mortality homeless people in in early 21st century England**
- Bethan Thomas
- 2012 Crisis, University of Sheffield

What we know

- Homelessness health problems such as trimorbidity
- Populations involved
- Barriers to healthcare – access
- Stigmatisation
- Patient satisfaction
- Models of specialist provision
- Staff skill mix and training

What do we need to know now?

Engagement: what proportion of homeless patients do not engage even with specialist services?

Outcome measures – especially capturing time intensive work and 'soft' outcomes

- QoF, ? ' homeless QoF'
- Advocacy
- Prevention
- Recovery
- Social Capital
- Employment

Models of service provision

- Is it possible to effectively address homelessness health inequalities in mainstream care?
- Is specialist primary care effective and if so how many such services are needed across the country?

Financial Savings

- Can A&E attendance be reduced and how?
- Hospital admission
- Out patient appointment DNA rate
- Quality, Innovation, Productivity and Prevention (QIPP)…..

What works?
6 possible approaches

- 1 Exclude
- 2 Do nothing
- 3 Adapt current practice
- 4 Outreach
- 5 Dedicated service
- 6 Dedicated service and Outreach

Exclusion: an example

- **From a surgery 'agreement':**

  "It is also agreed that no doctor will register and treat patients who are likely to disrupt the smooth running of the practice by virtue of their antisocial behaviour.

  It is also agreed that we will not knowingly register and treat patients who are dependant on alcohol, opiates, opiate like drugs, benzodiazepines or any other drugs of addiction."

A bereavement referral

Dear colleague,

- I would be very grateful if you could see X. X has a very long history of opiate dependence. He is currently a on methadone 100mls daily….
- He was very upset at the end of last year when he found his father was dying of cancer. When his father died … there was quite a significant family row about X's long term behaviour. This has left a family rift and he is very cut up about it and he thinks a great deal about his father.
- He has, therefore, requested to have some bereavement counselling and I do think he is in a mental state where he could benefit from this. He has been on Methadone a very long time and it does not reduce his capacity for thinking at all.
- I would be very grateful if you could consider taking him on. As long as he attends I think he could benefit a great deal.

Reply:

- Dear Dr
- I have read your referral letter for the above client; unfortunately I do not feel we can provide the appropriate support service for this gentleman. I feel he is best supported by the Meadowell Centre and note his long history of opiates dependency.
- As you will know from the past we can offer one-to-one counselling, if appropriate to the service level we provide. Our service is aimed at clients whom (sic) have uncomplicated bereavements.

2: Do Nothing – normal service as usual

- Lack of engagement
- Stigmatisation
- Late presentation
- A&E ‘frequent flyers’
- Neglect
- Early death

3: Adapt current practice

- A sympathetic doctor….or two
- Access and waiting room problems
- Manage staff and patient expectations
- Designated surgery times
- Where there is a will there is a way

4: Outreach

- Meets people on their home territory
- Permission to engage
- Builds relationship – highly valued by patients
- Reaches those who won't come to a centre, or are not involved in a hostel
- Opens door for advocacy and signposting
- In UK mostly housing workers
- Very common in USA – "Street Medicine"
- A base of some sort is also needed

5: A dedicated centre can provide

- Peaceful and respectful welcome
- Safe working
- Open and easy access
- Long-term relationships with professionals
- Engagement and retention
- Relief of pressure on other services
- Development of expertise
- Multidisciplinary team
- Participation in local partnerships and advocacy
- Management needs to keep a watchful eye

6: Dedicated service and outreach

- ? Best of both worlds
- Picks up those who do not engage with any services -including dedicated services
- Staffing costs a real issue - especially if no lone working
- Need to not duplicate housing outreach teams and floating support

What do homeless people think?

- **Groundswell UK** is a registered charity that believes that homeless people are not the problem, but must be part of the solution to homelessness.
- It provides training in service user involvement, conducts research to ensure homeless people's opinions can help shape policy and gives out small grants to groups of people with experience of homelessness who want to start up their own projects. **www.groundswell.org.uk**.

Barriers and issues accessing health care cited from bad personal experience

- waiting times,
- negative attitudes and stereotyping,
- lack of trust in staff, - the fear that you could find out things you didn't want to know and difficulty in managing appointments
- many asserting that the expectation of discrimination and stereotyping would stop them from accessing services

Groundswell spoke with 34 people

12 at the Meadowell Centre in Watford,

10 at Wellfield Court - Welwyn YMCA residents

10 at the Open Door Night Shelter in St Albans.

- The focus groups were promoted using posters produced by Groundswell and staff at the projects took responsibility for booking a maximum of 12 people into each group.

- Each participant received a cash incentive for participating in the group, which lasted approximately 1.5 hours.

Best places where healthcare is delivered:

All focus groups found that services provided specifically for them gave the best Service. Participants felt that:

- staff in such places understood their issues, and had empathy with them.
- experienced medical staff acknowledged the experience of the homeless people themselves.
- staff took time build relationships with them, which they valued
- individual practitioners' personal qualities were valued
- it was significant that the staff had 'chosen' to work with them.
  Such personal commitment was something that they valued.

Waiting

- A general and common complaint was that people had very long waiting times at Accident and Emergency departments.
- Participants also discussed the issues of waiting to get appointments with GPs and dentists and the possibility of having to restart treatment as a result of missing appointments.
- Of particular concern were systems where people had to get up in the morning or ring and book an appointment early in the morning. People felt this did not take account of their often nocturnal lifestyles and difficulties with access to phones.

Time given and attention received

- Another concern, which people saw as a positive aspect of dedicated services, was the length of time that people were given for a consultation.

- People felt that there was not enough time to discuss their often complex issues. Interestingly people also felt that it meant that the doctors did not get to know them, and in turn that they did not learn to trust the doctor.

  Such trust has been identified by many authors (Rowe 1998, Seal 2005) as crucial for many people who have been long term homeless and lost trust in professionals generally.

Best places where healthcare is delivered
(from Groundswell report December 2008)

As well as these personal issues, people felt that the services were responsive to them.

Others mentioned and valued the drop in nature of the service and the fact that you are seen relatively quickly. Warnes notes that many homeless people 'cannot cope with registration forms, appointment systems, busy waiting rooms and long waits' (Warnes et al 2003, p.117).

A final factor that people found positive about specialised services was that they followed up other services for them.

Because of the precarious nature of the housing most participants were in, they found that they could not always be contacted for follow up issues, such as blood test results, and were not in a position to prioritise following things up themselves.

Disadvantages of dedicated centres

- The main disadvantage that people saw with dedicated services was that there were not enough of them and they could be resourced better.

- This was both on a personal level, where workers should be rewarded, and on a structural level – in St Albans there was a real feeling that more staff were needed.

- At Meadowell people felt that such a service should be available in all areas of Hertfordshire.

Community treatment of Hepatitis C

- Hepatitis C - a silent killer
- 300,000 cases in UK, IVDUs a majority of these
- At least half unaware that they have it
- Around 1% in treatment
- Difficult to receive treatment whilst homeless
- Engagement with hospitals and outpatient services erratic
- Royal Free Hospital Hepatology service keen to set up community services
- 30% tariff saving versus hospital based treatment
- Treatment 'close to home' more effective
- Addresses health inequalities
- A public health imperative
- Treatment at Meadowell due to be the first significant clinical innovation of health inclusion matters early 2012

Blood borne virus screening at Meadowell since 2003

- 371 patients screened for Hepatitis C
- 68 Hepatitis C positive
- 142 patients screened for HIV - all HIV negative,
- 371 patients for HepB (HepBsAg)

  1 positive & infectious, 1 positive non-infectious
- 244 patients have been immunised against hepatitis B using an accelerated course regime –

  a majority completed the course.
- 96 patients checked for hepatitis B sero-conversion (HepB sAb) after immunisation:

  33 achieved protection (> 100 iu/ml)

Amongst the population of
570 currently registered patients:

- 39 positive for hepatitis C
- 8 spontaneous virus clearance
- 31 active infection, 12 female 19 male
- 6 have not agreed to be referred – not feeling ready
- 25 have been referred
    - 9 DNA'd appointments,
    - 5 assessed but then disengaged
    - 11 attending clinic
    - 2 are currently being treated