NHS Standard Contract

2018/19

Particulars – Enhanced Homeless Health
SCHEDULE 2 – THE SERVICES

A. Service Specifications

<table>
<thead>
<tr>
<th>Service Specification No.</th>
<th>OOHS_011</th>
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<tbody>
<tr>
<td>Service</td>
<td>Enhanced Homeless Health</td>
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<tr>
<td>Commissioner Lead</td>
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<td>Provider Lead</td>
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1. Population Needs

1.1 National/local context and evidence base

CCG’s in North West London have begun the implementation of both Shaping a Healthier Future and each of their Out of Hospital (OOH) strategies. Shaping a Healthier Future is a reconfiguration that requires a fundamental change in the way both acute and community services are delivered with a focus on delivering care as close to patients’ homes as is possible.

Central London, West London, Hammersmith & Fulham, Hounslow and Ealing CCG’s have elected to work together as a collaboration of CCGs: CWHHE. Each of the CCG’s is currently delivering an ambitious OOH programme intended to ensure that patients are at the centre of care, with the registered GP providing, managing and coordinating the care received. A key part of each OOH strategy is the intent in each CCG to support the continued development of high quality primary care at both a practice level and network of practices level.

There is conclusive evidence that people who have a history of homelessness have significantly higher levels of premature mortality and poor physical and mental health compared to the general population.1 People living in hostels in the London borough of Hammersmith and Fulham account for high rates of unscheduled hospital admissions, A&E attendances, ambulance callouts and missed GP and outpatient appointments.

Recent findings from the health needs assessment2 across the three inner CCG’s, found homeless clients:

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1 Healthcare for Single Homeless People, DoH, 2010
- Access A&E 7x more than the general population
- Are more likely to be admitted to hospital as emergencies (which costs 4x more than elective inpatients)
- Are 4x more likely to attend outpatient health appointments compared with general population
- Have more co-morbidity. 1 in 5 rough sleepers who had contact with hospitals had 3 or more diseases
- Nearly half of those rough sleepers who attended to hospitals have attended outpatient, inpatient and A&E hospital services.

The research findings also concluded that there are a number of attitudinal and structural barriers to homeless people accessing healthcare, for example, a lack of motivation, negative experience of healthcare services and being denied access in the past. By providing accessible services in a familiar environment this proposal will help break down some of these barriers and facilitate improved access to primary healthcare services.

This service is aimed at people who are homeless and may find it more difficult to access mainstream General Practice Provision. This service is intended to provide a more accessible and responsive service to homeless people. It is intended to drive improvements in the way in which primary care delivers care to homeless patients. It should foster continued quality improvement and will expect providers to deliver clear and formal accountability processes and structures to ensure a safe, effective and integrated continuity of clinical care for all patients.

Hammersmith and Fulham has developed a primary care strategy which sets out a vision to integrate primary care with its health and social care partners to improve care and achieve better outcomes and experiences for local residents. Under this specification, GP providers will be required to work with other care partners to deliver more proactive care via outreach clinics to the homeless health population.

### 2. Outcomes

#### 2.1 NHS Outcomes Framework Domains & Indicators

<table>
<thead>
<tr>
<th>Domain 1</th>
<th>Preventing people from dying prematurely</th>
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<tbody>
<tr>
<td>Domain 2</td>
<td>Enhancing quality of life for people with long-term conditions</td>
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<tr>
<td>Domain 3</td>
<td>Helping people to recover from episodes of ill-health or following injury</td>
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<tr>
<td>Domain 4</td>
<td>Ensuring people have a positive experience of care</td>
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<td>Domain 5</td>
<td>Treating and caring for people in safe environment and protecting them from avoidable harm</td>
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2.2 Local defined outcomes

The London Homeless Health Programme (LHHP) was developed to address the large and growing issues associated with homelessness and rough sleeping. The purpose of the LHHP is to support the delivery of better health, improved health services and access to those services for people experiencing homelessness.³

The LHHP has published commissioning guidance for health services in London for people who are affected by homelessness. This includes 10 Commitments⁴ listed below which will underpin the model of delivery of services for people who experience homelessness. The Commissioning Guidance was developed in response to issues identified by people who were homeless in London as reported in More than a Statistic⁵; a research and consultation exercise carried out by Groundswell using peer researchers.

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<tbody>
<tr>
<td>1</td>
<td>People experiencing homelessness receive high quality healthcare</td>
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<td>2</td>
<td>People with a lived experience of homelessness are pro-</td>
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<td>actively included in patient and public engagement activities,</td>
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<td>and supported to join the future healthcare workforce</td>
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<td>3</td>
<td>Healthcare ‘reaches out’ to people experiencing homelessness</td>
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<td>through inclusive and flexible service delivery models</td>
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<tr>
<td>4</td>
<td>Data recording and sharing is improved to facilitate outcome-</td>
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<td></td>
<td>based commissioning for the homeless population of London</td>
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<td>5</td>
<td>Multi-agency partnership working is strengthened to deliver</td>
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<td>better health outcomes for people experiencing homelessness</td>
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<tr>
<td>6</td>
<td>People experiencing homelessness are never denied access to</td>
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<td></td>
<td>Primary Care</td>
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<td>7</td>
<td>Mental Health Care Pathways, including Crisis Care, offer</td>
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<td>timely assessment, treatment and continuity of care for people</td>
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<td></td>
<td>experiencing homelessness</td>
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<td>8</td>
<td>Wherever possible people experiencing homelessness are</td>
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<td>never discharged from hospital to the street or to unsuitable</td>
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<td></td>
<td>accommodation</td>
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<tr>
<td>9</td>
<td>Homeless Health advice and signposting is available within all</td>
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<tr>
<td></td>
<td>Urgent and Emergency Care Pathways and Settings</td>
</tr>
<tr>
<td>10</td>
<td>People experiencing homelessness receive high quality, timely</td>
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<tr>
<td></td>
<td>and co-ordinated End of Life Care</td>
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3. Scope

3.1 Aims and objectives of service

The CCG is commissioning a service for homeless people that supports its strategic commissioning intentions to reduce health inequalities by improving the health care and social inclusion of homeless populations.


⁵ https://www.healthylondon.org/homeless/more-statistic-report
The service will do this by:

- Improving access to appropriate health and social care services for people experiencing homelessness
- Providing proactive and personalised care to homeless people
- Reducing inappropriate use of secondary care services for people experiencing homelessness
- Reduce unnecessary ambulance callouts through working in close partnership with local hostels
- Increasing the proportion of homeless people in drug and alcohol treatment programmes where appropriate
- Increasing use of mental health services by the people on the caseload
- Improving patient experience amongst people with a lived experience of homelessness
- Proactively engage with the patient, as appropriate, to support uptake for screening, medical review and attendance at forthcoming appointments.
- Developing good working relationships with other providers to support the delivery of more integrated health and social care intervention for homeless people (e.g. delivery of joint assessment and clinics, hosting of specialist services, increase in drop ins and outreach/in-reach to city spokes, reduced handoffs and smooth transitions of care between e.g. acute units, emergency treatment services, ambulance services, intermediate care, primary care, social services and the voluntary and independent sector)

This specification is designed to cover the enhanced aspects of clinical care of the patient, which are considered beyond the scope of essential services and additional services. The service provider must ensure that primary medical services are aligned with the overall model set out in this specification as described in sections below.

### 3.2 Service description/care pathway

#### Improving access to general practice services

The service provider shall:

- Provide GP registration to homeless people regardless of their length of stay within the catchment area
- Work actively with local hostels and other agencies to enable homeless people to be registered with a general practice.
- Provide services to homeless people who are registered with a general practice (that is not the service provider) but who require immediately necessary treatment or have requested temporary registration with the service provider.
- Ensure that newly registered homeless patients are seen for an initial health assessment appointment within 24 hours of registration.
- Offer patients flexible ways of making appointments and communicating with the service.
- Ensure a minimum level of bookable and drop in-appointment capacity during opening hours and that appointment lengths are tailored to the clinical needs of patients. The service provider must provide extended hour appointments (i.e. outside core hours and during evenings or weekends) in order to meet patient’s health and support needs in a proactive and reactive manner.
- Offer and utilise a full range of consultation methods according to clinical need including, but not limited to, web-enabled communication, telephone, e-mail, and face to face.
Enable homeless patients to consult an appropriate health care professional on the day of request or at an agreed future appointment time appropriate to their clinical need;

Enable patients to access an appointment on the same day in an emergency

Work with the local peer advocacy support services to support individuals to attend health appointments

Provide access to clinical care through outreach to other homeless services such as local hostels or temporary emergency accommodation, day centres and drop-ins.

Work with Groundswell to support dissemination of the ‘my right to access healthcare’ card to the homeless population and accept any homeless patient registrations

Work with other agencies, Groundswell and CEPN to deliver education and training to clinical and non-clinical frontline staff for example GPs and GP practice managers (as well as nursing forums, and any other health/medical meetings).

Improving health outcomes for people experiencing homelessness

The service provider shall:

- Provide an initial health assessment to homeless people who register with the practice. This will include a thorough review of medical history and cover the following areas:
  
  - General physical health assessment
  - Drug and alcohol screening assessment.
  - Mental health / dementia assessment.
  - Recording of different agencies already involved with the person’s care
  - Thorough review of medicines.
  - Administration of vaccinations for flu, pneumococcal and hepatitis B vaccinations, where clinically indicated
  - Administration of Vitamin B (Pabrinex) IM injections, where clinically indicated
  - Screening for blood borne viruses including HIV and risk of TB and provide interventions as necessary.
  - Identification of housing status. The service provider must regularly review the patient’s housing status and when appropriate support transition to other services including registration with other GP practices.
  - Identification of ethnic origin, sexual orientation and gender identity.
  - Recording of smoking status.
  - Sexual health screen including chlamydia screening assessment where appropriate.
  - Assessment of foot care needs.
  - Assessment of dental needs.
  - Patient education/self-care advice.
  - Development of a care plan that reflects the person’s health needs requirements and goals. The service provider will ensure that this is shared with all relevant agencies, subject to patient consent.
  - Explanation of health and care services available both within and outside the practice that are relevant for the patient and refer
appropriately.

- An overview of how services should be accessed by patients mentioning use of A&E, NHS 111 and urgent care.
- Identification of any communication issues including: need for an Interpreter service, literacy issues and learning difficulties.

The above list is not exhaustive as the initial health assessment must be relevant for the patient’s needs and it may not be possible to deliver the entire assessment within a single appointment;

- The service provider shall provide clinical interventions in line with its primary medical services to homeless patients as required
- The service provider shall provide review appointments to homeless patients every six months following initial assessment, to review patient’s health and progress on personal goals (as set in the patient’s care plan)
- The service provider will provide referral to specialist services including Drug and Alcohol services, Counselling, Community Mental Health Nurse (CMHN), and Health Support Team etc.
- The service provider shall encourage self-care and prevention wherever appropriate, including provision of self-care information and encouraging support and signposting patients into relevant services, such as smoking cessation, screening programmes and the health trainer service as well as groups such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, Groundswell and the Expert Patient Programme, health promotion and harm minimisation

Delivering proactive outreach for the benefit of homeless populations

This specification should be considered as part of the wider homeless health pathway. The service provider is expected to work in partnership with homeless agencies (as locally commissioned) as well as a range of health and social care services to ensure a seamless service to homeless patients.

The service provider shall:

- Provide a minimum of six outreach clinics per week to designated local hostels as agreed with the commissioner. The provision of outreach clinics may be delivered through sub-contracting arrangements as agreed with the Commissioner.
- Participate in the development of new models of care, shared protocols and pathways for homeless health in line with Hammersmith and Fulham CCG’s ambition for integrated care working
- Develop good relationships with relevant services to ensure effective delivery of care
- Work in conjunction with appropriate agencies to support people to access and maintain suitable accommodation.
- Seek opportunities to host services relevant to the needs of the homeless population e.g. drug and alcohol service and smoking cessation etc.

3.3 Population covered
This service must be delivered by a group of GP providers to all patients registered with these practices ensuring equitable access and quality of service to the entire CCG population group. Where there is more than one group of GP providers within the geographical boundaries of their CCG, the groups may operate collectively to ensure equitable access and quality of service to the entire CCG population group. The GP provider grouping and location(s) of delivery of the service (number of delivery points) must be agreed with the commissioning CCG.

The GP Federation will ensure that the service is offered across GP networks/localities between 08:00 and 18:30 Monday to Friday, excluding Bank Holidays, as a minimum requirement.

3.4 Any acceptance and exclusion criteria and thresholds

Acceptance:
The service provider will target people (aged 18 years and above) who fall into the below categories:

- People who are experiencing homelessness, this includes people with or without GP registration as well as those who require temporary registration or immediate and necessary care
- People who spend a significant amount of time on the street or in other people areas (i.e. rough sleepers)
- People who live in hostels or supported accommodation including refuge and night shelter residents
- The hidden homeless i.e. people in ‘squats’ or ‘sofa surfers’

Exclusion criteria
The following areas are considered out of scope from this service:

- The provision of Nurse-led prescribing as part of the homelessness outreach nurse provision
- Any function over and above that of a clinic based nurse
- Drug and alcohol detox programmes remain being provided using current methods

3.5 Interdependence with other services/providers

Key interfaces will include:

- Acute Care, including hospital discharge teams
- Advocacy including peer advocacy
- Outreach teams
- Community Health Services.
- Dental, Pharmacy and Optometry services
- Doctors of the World.
- Housing assessment services/Housing Options
- Temporary and Emergency accommodation including winter night
shelters, CRISIS at Christmas
- Wellbeing and primary mental health services.
- Adult Social Care assessment
- Adult Social Care services
- Housing Related Support services for single homeless people services which include:
  - Rough Sleepers Service
  - Supported accommodation
  - Community Safety and police
  - Public Health and health improvement services
  - Substance Misuse Services
- Mental Health services
- Voluntary and Community services (including Money Advice and Employment Support) day centres and food banks
- Prisoner and ex-offender services
- Forensic services
- Local Authority Access Point for Safeguarding queries and concerns
- Community Safety Partnership and subgroups
- Home Office and Reconnection teams
- Find & Treat – conducting screening TB and BBV – notification system
- EoLC – hospices, palliative care teams, St Mungo’s EoLC Coordinator
- Social prescribing providers

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)

London Homeless Health Programme Commissioning Guidance:

4.3 Applicable local standards

The service provider shall use relevant guidelines on the prescription of drugs in particular if medication has street value or potential toxicity

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements (See Schedule 4A-C)

5.2 Applicable CQUIN goals (See Schedule 4D)
6. Location of Provider Premises

The Provider’s Premises are located at:

The service provider’s delivery points should be from sites where GMS/PMS services are delivered or where APMS services are delivered, where the primary function of the APMS contract is for the delivery of primary medical services.

In addition, clinical services will be made available from designated hostels as agreed with the commissioner.