	Agenda Item:16 Appendix 6
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**30th July 2019**
TITLE:	**HOMELESS HEALTH EXCHANGE - A HOMELESS PRIMARY CARE SERVICE**
Organisation	**Birmingham & Solihull Mental Health NHS Foundation Trust (BSMHFT)**
Presenting Officer	**Charlotte Bailey, Executive Director Strategic Partnerships**

Report Type:	**For information as requested by the HWBB**

1. Purpose:
To update and assure the Birmingham Health & Wellbeing Board on the provision offered to the homeless population centred around Birmingham city centre. The Homeless Health Exchange provides a fully functioning Primary Care General Practice Medical Service to a targeted population living in and around the practice area, specifically servicing those people identified who are rough sleeping, in temporary accommodation via direct access hostels or those at risk of becoming homeless, who require access to a GP Practice, who can support their often complex needs.

2. Implications:		
BHWB Strategy Priorities	Health Inequalities	✓
	Childhood Obesity	
Joint Strategic Needs Assessment		
Joint Commissioning and Service Integration		✓
Maximising transfer of Public Health functions		✓
Financial		
Patient and Public Involvement		

Early Intervention	✓
Prevention	✓
Homelessness	✓

3. Recommendations
To note for information.

4. Background
The Homeless Heath Exchange Service was transferred to Birmingham and Solihull Mental Health Foundation Trust from Heart of Birmingham PCT in April 2008, following the cessation of the PCT. The service was transferred with **564** patients registered and a budget of circa **£620k** and was made up of the following staff groups: General Practitioners Service Manager Practice Nurses Specialist Substance Misuse Nurses Community Psychiatric Nurse Primary Care Mental Health Worker Support Worker Administration staff Today the practice has **1032** patients registered, a direct budget of **£615k**, slightly reduced from the original budget of which 90% relates directly to staff pay costs. The Homeless Health Exchange support two specific homeless projects within Birmingham, that link up to the Homeless Prevention Strategy: **Local Authority Street Intervention Team (SIT) -** the service provides a Specialist Nurse Prescriber from the Homeless Health Exchange 4 hours each day to work alongside the SIT, to identify those rough sleepers who need physical and/or mental health support by immediate examination and prescribing, also encouraging new homeless rough sleepers to register at the Homeless Health Exchange and often by supporting the person in need to attend A&E, where indicated and acting as an advocate the ensure the correct care is given. **Stone Road Asylum seekers project –** funded via S&WB CCG, a Psychiatric Nurse from the Homeless Health Exchange supports mental health assessments for asylum seekers who are temporarily placed at Stone Road, whilst their 'right to stay' is reviewed by the Home Office. Our nurse supports this vulnerable patient group by assessment of mental health needs, providing a support package and

linking the group into appropriate care pathways or advocating on their behalf with the Home Office in relation to their ongoing mental health needs, if remaining within Birmingham our nurse will ensure appropriate and ongoing mental health follow up and offer registration at the Homeless Health Exchange, as required.

5. Discussion

What are the health needs of the homeless population within Birmingham. The Homeless Health Exchange have been instrumental in a recent study, published in July 2019 – "Healthcare issues amongst the homeless in Birmingham" in conjunction with West Midlands Combined Authority, Public Health England (West Midlands), University of Birmingham and Robert Green University, Aberdeen.

The study looked specifically at the registered patients of the Homeless Health Exchange, to understand the needs of the Birmingham homeless population, some of the key areas noted are as follows:

- Based on **928** patients at the time of the study, 831 (89.5%) were male with 97 (10.5%) female, between the ages of 17 and 81 years.
- Average age of males 39 and females 34, the majority White British
- 33% of Health Exchange registered patients attended A&E at least once within 12 months
- 21.3% of Health Exchange registered patients were alcohol dependent at a harmful level
- 13.5% of Health Exchange registered patients were drug dependent
- 6.5% of Health Exchange registered patients had treatment for leg ulcers, national average less than 1%
- 52.3% of Health Exchange registered patients were smokers
- Lower levels of mental health issues at Health Exchange against other specialist homeless practices
- Substance misuse issues at Health Exchange at lower levels against other specialist homeless practices
- Low cancer rates levels at the Health Exchange than expected
- High prevalence of multi-morbidity e.g. mental health, substance use and infectious diseases with the Health Exchange population.

The mean age of the general population experiencing these types of illnesses between 60-69 years the mean age of those registered at the Homeless Health Exchange experiencing these illnesses 38 years old.

6. Future development

The service focus for the next twelve month's is as follows:

- to agree joint pathway plans, with the wider homeless stakeholder group, including other healthcare provision, to incorporate not only current rough sleepers, but also those at risk of rough sleeping via links with criminal justice, diversion and liaison services
- to work alongside BSMHFT services within HMP Birmingham to identify those released without accommodation and GP registration, back to Birmingham.
- To support 'housing first' initiative.

7. Compliance Issues

7.1 Strategy Implications

BSMHFT is a member of the Birmingham Homeless Board and has contributed to the development and planning for the city. It has provided data and statistics to help understand the matters related to homelessness and have supported piloting new initiatives.

The service has worked hard to link with other services as described in section 7.3

The service will be looking at how it continues to support the prevention strategy and specifically housing first, when issues of mental health, homelessness and drug and alcohol support is required.

7.2 Homelessness Implications: -

There is a growing number of homeless people within the city; not just those who are in the street but the 'hidden homeless'. The numbers supported by the services have nearly doubled in the last ten years. The service has had a budget reduction despite providing for more people whom are homeless.

There is a growing number of projects for the service to interface with and opportunities for the service to work with others including drug and alcohol services.

7.3 Governance & Delivery

The Homeless Health Exchange, delivers a Monday to Friday service, currently between 9am and 5pm with both booked and drop-in appointments with GP's and Practice Nurses on a daily basis for both those already registered at the practice

and those who self-refer for new registration or those referred by other homeless providers, the service provides outreach provision to all local direct access homeless hostels and 'on street' support.

The Homeless Health Exchange provides a range of primary care services for homeless patients with some enhanced services to meet the specialist requirements of the homeless population, which includes:

GP Services

General Practitioners (GP's) work from the service, providing 8 sessions per week from Monday to Friday. The Practice closes each day between 12.30 and 13.00

Phlebotomy

A full range of physical health conditions are tested for using staff trained in phlebotomy. In addition a significant number of homeless substance misusers will have a history of previous intravenous drug use or will be currently injecting. It is widely accepted that injecting drug use is common amongst the homeless population and that up to 50% of intravenous drug users have Hepatitis C virus infection. Hepatitis B infection is also common amongst this group. The service provides:

- Testing for presence of blood borne viruses and immunity status
- Immunisation check and catch up
- Screening for Hepatitis A, B and C
- Vaccination against Hepatitis A and B viruses as required
- Health education and harm reduction advice
- Referral to and close liaison with hepatology services and the Liver unit as appropriate
- Support to attend hepatology appointments.

Nursing in-reach and out-reach clinics

A Practice Nurse provides drop-in clinics at Sifa Fireside each week.

The clinics cover:

- Minor Illnesses and Injury to include prescribing
- Chronic Disease Management/Support
- Cervical Screening
- Smoking Cessation
- Wound Care/Management

Clinics with the Health Exchange cover specific nurse appointments are available for:

- New Patient Health Checks
- Chronic Disease Management
- Wound Management

- Specialist Nurse Prescribing.
    - Signposting, co-ordination and facilitating of referrals to appropriate statutory/non-statutory/secondary care agencies e.g. Specialist Mental Health, Diabetes Clinics, Drug and Alcohol Agency referrals
    - Referral to secondary care outpatient clinics e.g. Epilepsy, Neurology, Cardiac and ENT outpatients.
    - Medication Reviews

The following specific women's services are available through the Homeless Primary Care Service:

- Pregnancy Testing
- Advice about Contraception
- Provision of Contraception (including implants)
- Cervical Cytology

Substance Use

The Homeless Health Exchange has two specialist primary care substance use nurses who work with homeless individuals to reduce the physical health harm incurred through individuals' substance use and homelessness to provide access to treatment of alcohol and substance problems with related physical health concerns, through the delivery of high quality evidence based services. These staff do not provide substitute prescribing in relation to substance use, but support those requiring this into local substance use services, whilst ensuring the physical health concerns are addressed.

The service will offer an appointment or domiciliary contact immediately prioritising those individuals with urgent health needs and rough sleepers who may have little or chaotic contact with local substance use services and who may be 'lost to follow-up' if there has been delays by local substance use provision offering an appointment.

The nurses work in an outreach capacity with the entrenched street sleepers to deliver street based health interventions and engagement of individuals to access primary care in order to address their physical and mental health issues. They offer clinic based appointment and assessments and domiciliary visits to hostels and other venues across the city, such as:

- Salvation Army
- Washington Court
- St Ann's Hostel
- Trinity Hostel
- Waterside House
- Holiday Road, MNU
- Lancaster Street, MNU
- Helen Dixon House
- Zambezi
- South Road Hostel
- Long Street Hostel

The nurses' work closely with the local substance use treatment provider to facilitate individual's access to their services and jointly work with keyworkers to manage the complex physical health care needs of chaotic homeless substance misusers.

Primary Mental Health Care

The Homeless Primary Care Service strives to provide access to a primary mental health care service to all patients who meet the referral criteria. The service work in partnership with BSMHFT Homeless Mental Health Outreach team to provide:

- Support for homeless people registered to the Practice to access secondary mental health services as required, in both a routine way and for those in a psychiatric emergency via the Trust's Single Point of Access service.
- Manage people within the Primary Care Service who no longer need secondary mental health support for primary mental health issues.
- Case management, care planning and relapse prevention planning for those patients who regularly move between primary and secondary mental health provision.

The Homeless Health Exchange psychiatric staff are responsible for:

- Assessment of primary mental health problems
- Assessment and management of primary care psychological and social needs
- Monitoring of patients in the community
- Medication management in liaison with the GP and where necessary in relation to joint case management the Psychiatrist from BSMHFT
- Relapse prevention and patient education
- Effective two way communication between primary care and other agencies involved in the patients care (A&E, GP's, CMHT and non-statutory agencies)
- Psychological Assessment
- Short term psychological intervention

The team see clients within 2 weeks of referral from within the Primary Care Service (16 weeks before national target requirements), the team also have a drop-in clinic weekly for patient registered patients to refer themselves to which enables easier opportunistic access for patients.

Health Promotion

Health Promotion is generally provided on an individual opportunistic basis and may include:

- Sexual health
- Diet & Nutrition
- Smoking Cessation
- Winter wellness support (Flu vaccination)

Wound Care

Numerous risk factors predispose homeless people to develop acute and chronic wounds of the skin and subcutaneous tissue. Many of the same conditions that give rise to such wounds also impede healing, the service provides:

- Regular wound care and dressing as part of the open access or specialist clinic.
- Prescribing of specialist dressings.
- Support to other homeless service providers on wound care.

The nurses based with the Homeless Primary Care Service have up to date knowledge about tissue viability and ongoing access to the CCG Tissue Viability Team.

Podiatry

Foot problems are one of the greatest sources of infection amongst the homeless, who are almost constantly on their feet, often wear inappropriate footwear and rarely have the opportunity to wash or care for their feet. These conditions range from skin disorders and wounds to trench foot and ulcers which can become infected and lead to gangrene, amputation and even death.

A Podiatry Service is available weekly, each via Birmingham Community Health Trust each Thursday, between 13.00 and 13.30.

Referral into Dental and Oral Care

Many factors contribute to poor dental and oral health amongst homeless people and ensure that they remain a high-risk group for oral and dental disease. The chaotic nature of a homeless person's lifestyle can prevent them from developing routines of eating and personal hygiene.

On top of this, many homeless people suffer from mental health or substance use problems. This can seriously undermine oral and dental health due to a lower interest in oral hygiene or the effects of drugs or tobacco and increased risk of oral cancer. The service is able to refer patients to a Dental and Oral Care Service available at Attwood Green Health Centre.

Service Model

The Homeless Primary Care Service adopts an assertive engagement approach in its work with individuals. The 'assertive outreach' mode of working originates from within the mental health field. It is an approach that is employed when the relationship between services and an individual is complex and chaotic. The flexibility of this approach enables the service to be provided to those who may not otherwise access it. The overall aim in working within this approach is to develop trusting relationships with individuals in a needs-focused way, employing flexibility and creativity, so enabling the delivery of a care package that is specific to client need. The service aims to stay in contact with individuals, making repeated assertive

attempts to make contact with people if they miss appointments. this is a service especially focussed on this patient group, many of who would not attend a standard general practice.
7.4 Management Responsibility
The practice's service delivery and governance arrangements are monitored via formal CQC registration, with direct reporting into BSMHFT and BSol CCG governance structures, with the service is linked into the wider homeless stakeholder group, through its membership of the multi-agency and sector Homeless Partnership Board.
7.5 Diversity & Inclusion
Section 5 outlines the profile of those whose use the service, as determined by a recent study.

Signatures	
Chair of Health & Wellbeing Board (Councillor Paulette Hamilton)	
Date:	