SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	Newcastle 8
Service	GP Support for the **Homeless** Service
Commissioner Lead	NHS North East and North Cumbria ICB
Provider Lead	GP practices within Newcastle Place
Period	1 April 2023 – 31 March 2024
Date of Review	March 2024

1. Population Needs

1.1 National/local context and evidence base

1.1.1: National

Homelessness is known to exacerbate existing health conditions as well as give rise to new ones including circulatory disease, cardio-vascular problems, epilepsy and neurological problems, gastro-intestinal disorders, liver disease, inflammation of the joints and pulmonary disease. Many of these can be effectively managed in primary care however, due to the difficulties in access, homeless people have historically used A&E departments for health care which is expensive and inappropriate.

Enhanced access to health care services for homeless people is essential to addressing health inequalities.

1.1.2 Local:

Rough sleepers - *(Newcastle Homelessness Review 2013: A Part of the Newcastle Future Needs Assessment)*

Other

Newcastle Homelessness strategies
http://www.newcastle.gov.uk/housing/housing-advice-and-homelessness/information-for-professionals

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	✓
Domain 2	**Enhancing quality of life for people with long-term conditions**	✓
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	✓

Domain 4	**Ensuring people have a positive experience of care**	✓
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	✓

2.2 Local defined outcomes

2.2.1 Improved access

2.2.2 Reduced inequalities

2.2.3 Provide flexible person-centred healthcare arrangements that meet the primary health needs of the vulnerable homeless populations within Newcastle

3. Scope

3.1 Aims and objectives of service

3.1.1 The aim of this service is to support GPs provide homeless, isolated, and socially excluded adults who have a range of vulnerabilities and complex health issues, with access to a range of specialist healthcare services. By providing the services to meet a variety of specific needs, the service aims to reduce the number of deaths and/or long-term illness in this vulnerable group, as well as reducing the demand and pressure on other emergency/crisis services.

This service also aims to prevent further exclusion of patients, through mental health intervention, drug and alcohol support services, medical treatment, hygiene services and appropriate signposting, referral and inter-agency working.

The Service provider will therefore ensure that;

- homeless people have equal access to appropriate levels of service from practices designed to ensure that their health needs are effectively tackled.
- all appropriate practice staff provided with the knowledge, training and resources to enable them to deal effectively with homeless people's health needs
- GP services are empowered to tackle the health needs of homeless people holistically by working with relevant services (e.g. housing & social services) to integrate homeless people into local communities.

3.2 Service description/care pathway

3.2.1 Treatment:

The service provider will:

- provide a basic primary care service for homeless people.
- provide regular outreach clinics in agreed local hostels and drop-in centres.
- provide a patient health check and specialist assessment (after presenting problem has been addressed first) which will consider both physical and mental health and well-being. This should include review of any identified long-term conditions.
- Arrange appropriate clinically informed assessment and screening which should include a higher index of suspicion for TB, Hepatitis B & C & HIV, other STIs and substance misuse, as well as blood glucose and cholesterol measurement as necessary. Referral as appropriate should follow
- Review whole immunisation status including routine imms plus flu/pneumococcal. Immunisation and boosters for Hepatitis A and B should be offered in line with national guidance for high-risk groups.

- Provide assessment of psychological wellbeing and referral if necessary
- Offer reviews of the following:
    - BMI
    - Blood Pressure
    - Cardiovascular risk check
    - Smoking status and advice if appropriate
    - Alcohol & Drug use screening i.e. AUDIT 'C' or Full AUDIT (depending on score after asking first 3 questions)
    - Screening for depression – use a validated quality screening tool i.e. HADS/Rosenberg Score etc.

- meet the locally agreed protocols for management of blood borne viruses and work with specialist partners to enable treatment compliance with TB, Hepatitis C, Hepatitis B and HIV medications.
- offer a health promotion and harm minimisation programme.
- embrace' the Making Every Contact Count (MECC) concept which aims to improve lifestyles and reduce health inequalities i.e.
    - Brief Advice (3-5 mins)
    - Leaflets
    - Signposting
- provide a flexible appointment systems and longer appointment times for people with multiple needs.
- ensure they maintain suitable patient records which detail contact with homeless patients. Should any information need to be shared electronically the service provider must use secure email i.e. NHS.net.
- be responsible for any onward referrals i.e. counselling, CPN, drugs & alcohol etc. and completion of paperwork in connection with this.
- ensure robust dispensing arrangements with local pharmacies that allow for the administration of single or daily doses of prescription drugs. The provider will have an understanding of relevant guidelines on the prescription of drugs in particular if medication has street value or potential toxicity.
- establish treatment protocols for homeless patients and they will be fully operational within practice.
- be able to produce an up-to-date register of patients who are homeless
- actively seek to offer treatment to refugees, asylum seekers, migrants and those with no recourse to public funds.
- ensure that no patient should be excluded (turned away) from this service i.e., it may be their only point of access at any given time. An exception report of patients **not seen** should be provided to relevant NENC ICB and Local Authority contacts on an on-going basis.

3.2.2 Care-planning

Multi-disciplinary collaborative care is central to effective care because many homeless people present with multiple healthcare needs.

The service provider will:

- ensure and be able to demonstrate proactive care planning, so encouraging a move away from gate keeping (spending time assessing and rationing entitlement) towards proactively planning to meet people's needs.
- ensure and be able to demonstrate horizontal, patient-centered integration i.e., care planning and continuity across community settings and service provider boundaries, so that people can continue to receive continuity of care even if they lose the address that originally gave access to that care.

- ensure and be able to demonstrate vertical integration i.e., care planning and continuity of care into secondary care and back into the community i.e., supported discharge including housing. A clear expectation of compassion, communication and continuity of care between secondary, primary and community care.
- ensure to work in partnership with the Multiple Exclusion Common Case Management Group and in accordance with Newcastle City's Homelessness Strategy. This group provides a coordinated and holistic response to the issues facing some of the most vulnerable and multiply excluded people in the city.
- ensure to work with Active Inclusion Newcastle around the homelessness agenda.
- be available to participate in weekly multi-agency care planning meetings for complex homeless patients.
- ensure to feed any homeless service issues/updates into the Newcastle City's Homeless Prevention quarterly reviews and Homeless Strategy Action Plan.
- have regular involvement in, and where necessary leadership of, multi-agency planning for homeless people. Visible patient involvement in planning and evaluation of services will also be required.
- coordinate the health care of homeless people as they move between different organisations (hostels/drop-ins, shelters for homeless families, etc.).

3.2.3 On-going Preventative Support

The service provider will:

- have an awareness of and participation in local homelessness forums and strategies.
- liaise with homeless organisations and/or Commissioners of services that can feed into this provision i.e., Local Authority and other local GP practices to ensure that they are made aware that they can signpost homeless people to their practice where they will have access to a range of specialist healthcare services.
- support homeless people in the provision of a health promotion and a harm minimisation programme.
- ensure that professionals delivering this service have should accessed cultural awareness training to support patients to build confidence and self-respect to support their process of building a gradual road of recovery back into mainstream services. This should include awareness around Domestic and Sexual Violence Abuse. This training should support the provider in the understanding of, and sensitivity towards, particular problems faced by homeless people.
- ensure continuity by providing a trusting relationship formed with a familiar clinician.
- work closely with public health departments particularly Public Health England (PHE) around important communicable diseases (e.g., TB or blood borne virus transmission).
- produce a yearly joint development plan in conjunction with their local homeless organisations/shelters and regularly review progress of actions contained therein.
- conduct an annual review which could include:

    - Feedback from homeless patients
    - An audit of physical and mental health problems experiences by homeless people
    - The length and number of consultations for each homeless patient
    - Referrals to and use of other services both within and outside the practice by homeless patients
    - Number of clients that have registered with a GP
    - Details of provision of regular outreach clinics in agreed local hostels and drop-in centres
    - Details of any partnership working with Newcastle City council (i.e., Active Inclusion Team/Multiple Exclusion Outreach Team/Newcastle City's Homeless Prevention Quarterly Reviews etc)

- have a consideration of security, including the set up and location of clinical services, access to notes and alerts, and chaperones where necessary. The lone worker policy should be operational where appropriate.
- promote and encourage accessible provision of oral health promotion and podiatry care.

Please note that this list is not exhaustive

3.2.4 Days and hours of operation.

The service provider will:

- offer a flexible service to enable patient choice around dates and times of appointments.
- ensure clinical input is available normal practice opening times. This input should consist of GP led drop-in sessions, in-reach into local homeless shelters, allowing homeless people the opportunity to resolve existing medical issues and obtain medical advice. This arrangement allows for maximum flexibility for delivery and responsiveness to the individual's requirements.

3.3 Population covered

3.3.1 This service will be available to all homeless people. However, in order to target health services on the most difficult to engage homeless people, it is necessary to consider a wider range of clients. Many of the most chaotic and vulnerable may not be in contact with housing authorities. Groups to consider are:

Residential Status
Rough Sleeping
Hostel/Supported Accommodation
People staying temporarily with family
People staying temporarily with friends (sofa Surfing)
Bed & breakfast residents
Squatters
Custody/approved premises i.e. bail hostel

3.4 Any acceptance and exclusion criteria and thresholds

This service will be available to all presenting homeless people. No patient should be excluded (turned away) from this service i.e., it may be their only point of access at any given time. An exception report of patients **not seen** should be provided to relevant NENC ICB and Local Authority contacts on an on-going basis.

3.5 Interdependence with other services/providers

The service provider will;

- work effectively with key professionals to support patient management.
- demonstrate partnership working with local homelessness agencies and hostels to proactively support access and provision of primary care.
- collaborate with other specialist services regarding the moving on of patients, ensuring appropriate access to records and ongoing collaboration around case management.
- engage with the Specialist Primary Care Service by having an Annual Practice Liaison Meeting to review working arrangements.

Please note that this list is not exhaustive

4. Applicable Service Standards

4.1 Applicable national standards (e.g., NICE)

4.1.1 Treatment and care should take into account patients' needs and preferences. Patients should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals including advanced care planning. If patients do not have the capacity to make decisions, healthcare professionals should follow the Department of Health guidelines – 'Reference guide to consent for examination or treatment, second edition 2009' (2009) (available from www.dh.gov.uk). Healthcare professionals should also follow the code of practice that accompanies the Mental Capacity Act (summary available from www.publicguardian.gov.uk) and the 'Deciding Right'/advanced care planning Guidelines. If the patient agrees, families and carers should have the opportunity to be involved in decisions about treatment and care. Families and carers should also be given the information and support they need.

4.1.2 The provider is required to have a formal complaints procedure. All complaints will be managed as per the provider's complaints procedures and those of NENC ICB. All patients, their representatives or their carers must be given the opportunity to ask questions as they arise.

4.1.3 The provider must hold appropriate professional indemnity to undertake the service.

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g., Royal Colleges)

N/A

4.3 Applicable local standards

4.3.1 The Provider undertaking this service will:

4.3.1.1 Ensure patients are fully informed regarding their treatment and have given consent

4.3.1.2 Put in place an admission and discharge process and documentation including onward referrals if appropriate.

4.3.1.3 Give the patient evidence based verbal and written information in a format which meets their individual needs, including information in languages other than English where required, which is culturally appropriate. The information should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English. This will include information on the nature of their condition and information on after care, including information on who to contact (for example 111 telephone number) should the patient have any concerns about their aftercare. If the patient agrees, families and carers should have the opportunity to be involved in decisions about treatment and care. Families and carers should also be given the information and support they need.

4.3.1.4 Produce and maintain a valid up-to-date register of patients being treated as part of the service; the number of patients who did not attend an appointment, and the number of referrals received that did not fit the referral criteria and where they originated from.

4.3.1.5 Fully complete the required dataset for every patient referred to and accessing the service.

4.3.1.6 Be responsible for the provision of all special equipment and consumables relating to the delivery of this service.

4.3.1.7 Maintain records of the service provided, incorporating all known information relating to any significant events e.g. adverse reactions, hospital admissions, and relevant deaths of which the practice has been notified. These must be reported to the commissioner in accordance with

Policy and Procedure Guidance for Reporting and Management of Serious Untoward Incidents (SUIs).

4.3.1.8 Participate in all quality and clinical governance initiatives and work in partnership with the commissioner of this service. Additional quality indicators may be put in place in discussion with the provider.

4.3.1.9 Ensure that all information be transmitted safely and securely for example by using an encrypted email account.

4.3.1.10 Demonstrate contingency plans and business continuity plans for:

- The management of services during expected and unexpected leave. It is the responsibility of the service provider to arrange and ensure cover for staff sickness and absence.
- Capacity and capability to manage peaks in demand.
- Failure of electronic systems, telephony or other infrastructures.

4.3.1.11 The service provider is expected to manage all referrals, assess patient referral suitability, and make patient appointments, whilst ensuring effective systems and business continuity.

4.3.1.12 Costs for any training required by the service provider to deliver the service will be borne by the service provider.

4.3.1.13 Activity for this service will be monitored by information supplied by the service provider in accordance with section 6.

4.3.1.14 The service provider will attend contract review meetings with the commissioner of the service for the duration of the service at a frequency which will be defined on commencement of this contract and will provide any additional information reasonably requested by the commissioner for the purpose of contract monitoring at no additional cost to the commissioner.

4.3.1.15 The provider should ensure sufficient capacity to meet agreed expected levels of activity. The commissioner and provider will jointly review actual levels of service demand and the commissioner has the right to call a capacity review should activity levels exceed or not meet the expected levels of demand.

4.3.1.16 The provider must also comply with the guidance laid down in the Health Act for Prevention and Control of HCAI 2008.

4.3.1.17 This service will commence on 1st April 2023 and will run until 31st March 2024. It is the service provider's responsibility to ensure all chargeable activity relating to this service is undertaken during the service period only. The service provider is expected to manage all referrals and activity to ensure that all service activity ends on 31st March 2024. Any activity which is undertaken by the service provider after the end date will not be paid by the commissioner. The service will be reviewed during the 2023/24 financial year.

5. Location of Provider Premises

The Provider's Premises are located at:

GP practice within North East and North Cumbria ICB - Newcastle Place.

Appendix 1. Quarterly Activity Data

Activity data should be recorded in Excel (see example below) and submitted to CQRS Local on a quarterly basis.

Monitoring%20Form%20-%20Homeless%2

Appendix 2. Annual Report

Annual Review report should be submitted to nencicb-ng.newcastle.qualityandperformance@nhs.net at the end of Quarter 4 2023/24

1. The provider should conduct an annual which should include (but not exclusive to):
2. Feedback from Patients
3. An audit of physical and mental health problems experienced by homeless people
4. The length and number of consultations for each homeless patient
5. Referrals to and use of other services both within and outside the practice by homeless Patients
6. Number of clients that have registered with a GP
7. Details of provision of regular outreach clinics in agreed local hostels and drop-in centres
8. Details of any partnership working with Newcastle City council (i.e. Active Inclusion Team/Multiple Exclusion Outreach Team/Newcastle City's Homeless Prevention Quarterly Reviews etc