| Service Type – Locally Commissioned Services (LCS) | |
|---|---|
| **Service Specification No.** | TBC |
| **Service** | Primary Care Medical Services to People who are Homeless across Great Yarmouth and Waveney |
| **Commissioner Lead** | NHS Great Yarmouth and Waveney Clinical Commissioning Group (Primary Care Directorate) |
| **Provider Lead** | TBC |
| **Period** | 01 October 2018 – 30 September 2022 |
| **Date of Review** | Annually |

## 1. Population Needs

### 1.1 National/local context and evidence base

Homelessness is commonly used to describe a wide range of circumstances where people have no secure home. Groups to consider are rough sleepers, hostel and night shelter residents, bed and breakfast residents, squatters and people staying temporarily with friends and relatives. Homelessness is defined in legislation for the purpose of determining entitlement to help from local authorities and certain groups are defined by law as being in priority need of housing. These include pregnant women, families with children, all 16 and 17 year olds, those who have enduring physical and mental health problems people who have experienced domestic or racial violence and people who are vulnerable following a stay in institutions. Although the nature and extent of health problems that face homeless people will vary according to their particular experience of homelessness, research has shown that people who are homeless face an increased risk of mental illness, physical illness including long term conditions, infectious disease and alcohol and drug misuse.

The Herring House Trust operates one open access hostel for street homeless across Great Yarmouth and there are also a number of other homeless shelters across Great Yarmouth and Waveney.

Overall this service aims to provide more accessible and responsive services for people who are homeless and may find it more difficult to access mainstream general practice. It is intended to drive improvements in the way in which primary care delivers care for these patients. It should foster continued quality improvements including health promotion in addition to delivering safe, effective holistic clinical care. We expect providers to deliver services in an integrated, multi-disciplinary stream lined approach that provides? Can demonstrate the best outcomes for patients.

## 2. Outcomes

### 2.1 NHS Outcomes Framework Domains & Indicators

| | | |
|---|---|---|
| **Domain 1** | **Preventing people from dying prematurely** | **X** |
| **Domain 2** | **Enhancing quality of life for people with long-term conditions** | **X** |
| **Domain 3** | **Helping people to recover from episodes of ill-** | **X** |

| | | |
|---|---|---|
| | **health or following injury** | |
| **Domain 4** | **Ensuring people have a positive experience of care** | **X** |
| **Domain 5** | **Treating and caring for people in safe environment and protecting them from avoidable harm** | **X** |

### 2.2 Local defined outcomes

**Benefits to Patients-:** The purpose of this LCS is to support the delivery of better health, improved integrated health and social care services and access to those services for people who are homeless.

As a minimum the benefits to patients are expected to include:

- improved patient experience; the patient will be given appropriate medical input, active referrals and signposting to local agencies who will be integrated with primary care services to meet their psycho- social and medical needs;
- improved dignity; and equality of access to services
- assessment of specific healthcare needs of vulnerable homeless and traveller populations including identification and management of long term physical health conditionssubstance misuse.
- GPs with a special interest in mental health, drug and alcohol issues and specific experience in dealing with this specific population.
- people who are homeless receive high quality holistic? healthcare
- Healthcare 'reaches out' to people who are homeless through inclusive proactive and flexible service delivery models
- Robust Data recording and is agreed to facilitate data sharing and outcome-based commissioning for the traveller and homelessness population of Great Yarmouth and Waveney
- Multi-agency partnership working is strengthened to deliver better health outcomes for people who are homeless

**Benefits to the Health and Social Care System -** As a minimum the benefits to the system are expected to include:

- reduced numbers of emergency acute contacts;
- reduce the number of emergency call outs from homeless hostels
- continuity of care in a safe and trusted environment;
- collaborative working with local agencies to ensure a joined up service;
- continued and improved services and relationships building on existing work.
- Address health inequalities experienced by and people who are homeless.
- Reduce the risk of communicable disease and spreading of infections

## 3. Scope

### 3.1 Aims and objectives of service

**Strategic Objective:** The CCG is commissioning this service for people who are homeless people because it supports the CCGs priority of reducing health inequalities and improving the poor health outcomes affected by this cohort of the population.

- To target patients who may otherwise not receive appropriate medical care due to social circumstances and who may be suffering from self-neglect and undiagnosed or monitored Long Term Conditions
  .
- To provide services on the basis of a comprehensive assessment, resulting in structured individual care plan management, diagnosis, active referral and signposting.

- To work collaboratively with other local agencies to improve local services in Great Yarmouth and Waveney

- To provide Health promotion, access to wellbeing, screening, vaccination, medication optimisation and smoking and alcohol services in addition to other prevention services

- To deliver primary care services and health assessments outside of traditional practice settings, including delivering outreach clinics at homeless hostels and other homelessness shelters.

**The service will do this by:**

- Improving access including on the day services to appropriate health and social care services for people who are homeless.
- Provide proactive and personalised care to people who are homeless
- Reduce inappropriate use of secondary care services by this cohort of the population
- Reduce unnecessary ambulance callouts through working in close partnerships with homeless hostels and emergency accommodation providers.
- Proactively engage with the patient, as appropriate to support uptake for screening, medical review and attendance at forthcoming appointments
- Develop good working relationships with other providers to support the delivery of more integrated health and social care intervention for people who are homeless (e.g. delivery of joint assessment and clinics, hosting of specialist services, increase in drop ins and outreach/in-reach services) peer support
- Ensure adequate winter plans are in place for people who are homeless, these plans should be worked up jointly with the CCGs Winter Planning arrangements.

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**

The Provider will provide general medical services to a list of patients that meet the criteria set out in 3.3. The Provider will also:

- Provide GP registration for people who are homeless regardless of their length of stay within the Great Yarmouth and Waveney areas.
- Work actively with homeless hostels and other agencies to encourage people to be registered with a GP.
- Hold weekly outreach clinics at homeless hostels and identify and ensure new patients receive an appropriate health assessment according to their need and registration with a GP.
- Where necessary provide end of life care and work proactively with the patient and their palliative care provider.
- Provide services to people who are homeless who are registered with a general practice (that is not the service provider) but who require immediately necessary treatment or have requested temporary registration.
- Work with the local peer advocacy support services to support individuals to attend health appointments
- Ensure that newly registered people who are homeless are seen for an initial health assessment within 24 hours of GP registration.
- Maintain an up to date register of patients who are homeless.
- Maintain an up to date register of organisations providing services for the homelessness.
- Actively utilise any Social Prescribing Schemes as relevant to support the health and social care outcomes for the identified population.
- Make available flexible appointment systems and longer appointment times for people with multiple needs; including availability of drop in appointments, including providing extended appointments outside of core hours including evening and weekends (Improved Access Core requirements) in order to meet the patient's health and support needs in a proactive and reactive manner.
- Establish dispensing arrangements with local pharmacies that allow for the administration of single or daily doses of prescription drugs.
- Ensure that staff demonstrate understanding and sensitivity towards homeless people.
- Provide appropriate and regular screening assessments based on current research in relation to the health needs and problems of homeless people.
- Review medication against best practice and Use relevant guidelines on the prescription of drugs in particular if medication has street value or potential toxicity including reduction regimes..
- Provide a health promotion programme appropriate to the needs of people who are homeless.
- Ensure appropriate assessment of mental health and ensure parity through referral to counselling and mental health services that is timely and flexible including access to dual diagnosis, trauma, sexual abuse and personality disorder services. ..
- Ensure that the physical and mental health of people who are homeless are assessed at registration.
- Ensure that the specific vulnerabilities of the patient group to TB, hepatitis B and C, HIV and substance misuse are recognised and prioritised and that screening, assessment, vaccination and onward referral is available where indicated.

- Ensure provision of MSK services that are timely and proactive to meet ongoing needs.
- Attend multi-agency meetings across Norfolk and Waveney to support and improve services provided. Which should include the provision of any lessons learnt or on going improvements.
- Have data sharing protocols in place with all relevant partners and agencies that meet current GDRP regulations.
- Hold out reach clinics at least once a week within homelessness hostels and shelters. A minimum of 2 weekly outreach clinics across 2 homeless hostels and other emergency accommodation providers.
- Ensure there is access to and rapid prescribing arrangements for newly released ex-offenders. (Subject to prison discharge letter). If this is not available liaise with the Housing Options and Prevention team to obtain information.
- Ensure daily and adequate handover of information to the Out of Hours service provider for patients particularly those that lead chaotic lifestyles and are likely to access out of hour's service provision.
- Accept same day referrals from partner agencies not limited to but including Housing Prevention and Options teams, temporary and emergency accommodation providers.
- Proactively participate in multi-disciplinary team (MDT) arrangements to obtain the best outcomes for the patient.
- The provider offers the patient use of the providers address as a home address where the patient requires access to other health related services or there is a risk that the patients registered address may lead to loss of mail.
- The provider will establish relationships with local prisons to obtain prisoner discharge information and medical history and any current prescribed medications.

**3.2.1**
***In addition to the above the provider shall for where appropriate for each individual patient (according to their needs) carry out the following:**

- Provide an initial health assessment for the patient which 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
- Provide antenatal and postnatal care where appropriate
- Offer and administer vaccinations for flu, pneumococcal, shingles, meningitis and hepatitis A and B vaccinations, where clinically indicated in line with national guidance for high risk groups.
- 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
- Indication of housing status and regularly review this and actively refer and work with housing agencies
- Identification of ethnic origin, sexual orientation and gender identity
- Record smoking status and were appropriate provide or refer to smoking cessation services

- Sexual health screening for STDs including chlamydia screening assessment, where appropriate and relevant onward referral.
- Offer contraception advice and services including provision of LARC
- Provide a cervical screening service targeted to meet the needs of the identified patient population and engage in proactive/opportunistic follow up
- Review patients BMI and blood pressure
- Cardiovascular risk check
- Assessment of foot care needs
- Assessment of dental needs and onwards referral where appropriate
- Patients self-care and education advice
- Development of Care and support plan that reflects the patient's health needs, requirements and goals. Subject to patient consent these should be shared with all relevant agencies
- Information on social prescribing and other services available to patient to be made available
- An overview of how services should be accessed by patients, mentioning the use of A&E, NHS 111 and out of Hours Service provision
- Identification and recording of any communication/access needs of the patient, including a need for an interpreter service, literacy issues and learning difficulties.
- Where patients meet both the eligibility for this service and / or severe mental Illness (SMI) and Learning Disability then the patient should be registered across all appropriate primary care registers and regular physical health reviews should be conducted.

The service provider shall carry out a case review with 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 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.

### 3.3 Population covered

Residents of, or individuals residing within the borough of Great Yarmouth and Waveney that are:

- Identified as homeless, living in temporary accommodation or at risk of losing their home;
- People staying temporarily with friends and relatives who do not have a permanent address.
- Rough / street sleepers
- Hostel or night shelter residents
- Other people that may be considered homeless registered with another practice within the CCG catchment areas. (The prime provider will act as a specialist advice and resource to the practice seeking advice).

### 3.4 Any acceptance and exclusion criteria and thresholds

Those with all types of condition and aged 16 years and over are eligible under the

terms of this specification, providing they meet the criteria set out in 3.3.

Any breakdown in relations with the patient must be addressed and only in extreme circumstances with the agreement of the commissioner can the patient be referred to the Special Allocations Scheme (SAS).

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.

### 3.5 Interdependence with other services/providers

The service will access appropriate specialist support and input for patients through wider system services such as:

- Safeguarding Teams and social services
- Mental Health
- Local Drug and Alcohol services
- Pharmacies
- Housing Departments
- Benefits Advisors
- Charitable and Voluntary Groups
- Police
- Disease Specific Nurses
- Disease Specific Therapists
- Community services
- Palliative Care and McMillan Nurses
- Public Health Departments
- Adult Social Care Departments
- Sexual Health Services
- Life style services i.e. smoking, weight management etc.
- Secondary care

## 4. Applicable Service Standards

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

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

- The Faculty of Homeless and Inclusion Health Revised (Feb 2018) - Standards for Commissioners and Service Providers.
- National Enhanced Service Specification – Enhanced Care of the Homelessness

### 4.3 Applicable local standards

The Provider is required to assure the Commissioner of performance against the below:

- That all CQC quality outcomes and registration requirements are met and

maintained

- The Provider shall endorse and support the development of a Safeguarding Champion that will demonstrate and implement the Department of Health's principles of Empowerment, Protection, Prevention, Proportionality, Multi agency working and Accountability.
- The Provider will be comply fully with the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards".
- Be fully compliant with all requirements of the core (General Medical Services, Personal Medical Service or Alternative Personal Medical Services) and the requirements of the additional service.
- Practices are to report any incidents (including near misses, significant events, incidents and Serious Incidents (SIs), complaints and patient feedback relating to this local enhanced service to Camden CCG Quality & Safety Team via secure email: gywccg.information@nhs.net. SIs must be reported within 24 hours following identification.
- Have a named lead clinician for the service
- Have staff and clinicians with experience knowledge and understanding of homeless peoples' needs.
- Have up to date knowledge and understanding of local statutory services
- Be able to demonstrate partnership working with local homelessness agencies and hostels to proactively support access and provision of primary care services.
- Able to provide flexible appointments including outreach clinics and same day drop in appointments.

**4.3.1 IT and Data standards**

- The provider must use the latest clinical templates using the appropriate SNOMED codes.
- The provider must have in place appropriate data sharing protocols which meet the new GPDR regulations.

## 5. Applicable Performance and Quality requirements and CQUIN goals

### 5.1 Applicable Performance and Quality Requirements

See draft Performance and Quality Requirements

### 5.2 Applicable CQUIN goals

Not applicable for this service or associated contract

## 6. Location of Provider Premises

**The Provider (s) Premises are located at: TBC**

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 homeless hostels and as agreed with the commissioner. |
| **7. Individual Service User Placement** |
| Not applicable |
| **8. Funding** |
| TBC |

## Appendices

| Supporting documents and information | |
|---|---|
| Provider checklist (also at the end of this document) | See below |
| Primary Care Read codes (to be changed to snowmed) to enable data collection and verification<br>(also at the end of this document) | See below |

| Draft - Performance and Quality Requirments | | | | | |
|---|---|---|---|---|---|
| **Ref** | **Performance / Quality Requirements** | **Threshold** | **Method of Measurement** | **Consequence of Breach** | **Timing of application of consequence** |
| 1 | Provider maintains an update to date homelessness register | 100% | Quartley data submission | In accordance with GC9 *(Contract Management)* | monthly |
| 2 | Minium of 2 weekly outreach clincis are held at hostels and emergency accommodation providers across Great Yarmouth and Waveney | 95% | Quartley data submission | In accordance with GC9 (Contract Management) | weekly |
| 4 | The % of patients who have been assessed for mental health issues | 100% | Number of patients on homeless register who have received a MH assessment/Number of patients on homeless register | A formal meeting will be held with the Provider and an action plan agreed. | Quarterly<br><br>Performance will be measured through submission of a quarterly performance report to gywccg.information@nhs.net |
| 5 | The % of patients who have been asked and referred if appropriate for smoking/drug and/or alcohol issues | 100% | Number of patients on homeless register who have been referred to relevant service/Number of patients on homeless register | A formal meeting will be held with the Provider and an action plan agreed. | Quarterly<br><br>Performance will be measured through submission of a quarterly performance report to gywccg.information@nhs.net |
| **3** | The % of patients who have had a physical medical, including BMI/BP/Urine dipstick and a documented chest and feet examination | 95% | Number of patients on homeless register who have had a physical medical/Number of patients | A formal meeting will be held with the Provider and an action plan agreed. | Quarterly<br><br>Performance will be measured through submission of a quarterly performance |

| Draft - Performance and Quality Requirments | | | | | |
|---|---|---|---|---|---|
| **Ref** | **Performance / Quality Requirements** | **Threshold** | **Method of Measurement** | **Consequence of Breach** | **Timing of application of consequence** |
| | | | on homeless register | | report to gywccg.information@nhs.net |
| 4 | The % of patients who have been referred to local hostels and support services | 100% | Number of patients on homeless register who have been advised of local hostels and services/Number of patients on homeless register | A formal meeting will be held with the Provider and an action plan agreed. | Quarterly<br><br>Performance will be measured through submission of a quarterly performance report to gywccg.information@nhs.net |
| 5 | The % of patients who have been screened for chronic disease | 90% | Number of patients on homeless register who have been screened for chronic disease/Number of patients on homeless register | A formal meeting will be held with the Provider and an action plan agreed. | Quarterly<br><br>Performance will be measured through submission of a quarterly performance report to gywccg.information@nhs.net |
| 6 | 100 % of patients are offered an influenza vaccine with take up at 85% | 85% | Number of patients on homeless register who have had an influenza vaccine/Number of patients on homeless register | A formal meeting will be held with the Provider and an action plan agreed. | Quarterly<br><br>Performance will be measured through submission of a quarterly performance report to gywccg.information@nhs.net |
| 7 | The % of female patients who have been | 95% | Number of patients on homeless register who have | A formal meeting will be held with the | Quarterly |

| Draft - Performance and Quality Requirments | | | | | |
|---|---|---|---|---|---|
| **Ref** | **Performance / Quality Requirements** | **Threshold** | **Method of Measurement** | **Consequence of Breach** | **Timing of application of consequence** |
| | given contraceptive advice | | been given contraceptive advice/Number of patients on homeless register | Provider and an action plan agreed. | Performance will be measured through submission of a quarterly performance report to gywccg.information@nhs.net |
| 8 | Number of drop in appointments made available for people who are homeless | 5 | Manual self reporting | GC9 contract management | monthly |
| 10 | Number of patients that are offred<br><br>a full physical health check | 100% | Data reporting from provider and evidenced by snomed code utilisation | GC9 contract management | monthly |
| 11 | Same day rapid prescribing for newly released ex-offenders (subject to prison discharge information) | 98% | Data reporting from provider and evidenced by snomed code utilisation | A formal meeting will be held with the Provider and an action plan agreed. | Quarterly |
| 12 | Number of patients with a health and social care support plans that have been followed through and delivered measurable outcomes | 100% | Provider data submission and audit of sample plans | GC9 Contract managment | Quarterly |
| 13 | Winter Planning Arrangments for People who are homeless | Compliant yes/no | | To be jointly agreed with the CCG and aligned with the CCGs winter planning | Quarterly |

| Draft - Performance and Quality Requirments | | | | | |
|---|---|---|---|---|---|
| **Ref** | **Performance / Quality Requirements** | **Threshold** | **Method of Measurement** | **Consequence of Breach** | **Timing of application of consequence** |
| | | | | arrangements. | |

| **Appendix A - Provider checklist** | | |
|---|---|---|
| | **Action** | **Progress** |
| | | |
| Produce and maintain an up to date register of homeless patients | Register patients and use appropriate snomed codes. | |
| | | |
| Develop a proposal that identifies how the service will bring about innovation and achieve better outcomes for patients | Work with the commissioner on drawing out lessons learnt and implementation of service improvements | |
| Take a detailed medical history and appropriate examination to identify new and ongoing problems and initiate treatment, follow up and/or referral The assessment should be recorded in the patient record together with a summary of needs and an individual patient plan. | Comprehensive patient health assessments in line with service specification and patient needs. | |
| Conduct a simple annual audit of care for people who are homeless | Agree audit template with commissioner and publish findings | |
| Work with local statutory services and homeless agencies | Produce and maintain a directory of partner and statutory agencies | |
| Ensure that provider staff demonstrate understanding and sensitivity towards homeless patients | Ensure staff are suitably qualified and have up to date training | |
| The provider will be able to produce an up to date register of patients who are homeless | Manual register and using right snomed codes | |
| The provider will be able to produce an up to date | Yes, very good detailed response and of which organisations the | |

| | | |
|---|---|---|
| register of organisations providing services for the homeless | provider are aware of. | |
| The provider will establish and maintain flexible registration procedures allowing for permanent registration to anyone who wants it | Performance monitoring and patient feedback. | |
| The provider will make available flexible appointment systems including walk in surgeries and longer appointment times for people with multiple needs | Yes, as the provider have stated that they are clear that they would not turn patients away, clarification on how this will be implemented is required. | |
| The provider will establish dispensing arrangements with local pharmacies that allow for the administration of single or daily doses of prescription drugs | Partnership arrangements | |
| The provider will provide appropriate and regular screening assessments based on current research in relation to the health needs and problems of people who are homeless | Commissioner Reporting requirements | |
| The provider will use relevant guidelines on the prescription of drugs in particular if medication has street value or potential toxicity | Yes, comprehensive response demonstrating that the provider has clinicians with enhanced skills relevant to this area of prescribing. | |
| The provider will ensure appropriate assessment of psychological wellbeing and instigate referral to counselling and mental health services where indicated | Dedicated Mental Health Nurse Prescriber? | |
| The provider will ensure that the physical and mental health of people who are homeless is assessed at registration | Qualified staff | |
| The provider will ensure that the specific vulnerabilities of the patient group to TB, hepatitis B and C, HIV and substance misuse are recognised and prioritised and that screening, assessment and onward referral is available where indicated | Qualified staff and full physical health assessment | |

Appendix B – Read Codes

*Recommended READ codes for recording patient assessments

*(please note these are changing to SNOMED codes from April 2018)

The commissioner will agree with the provider appropriate new Snomed codes to enable accurate data collection.

| **Essential information** | | | |
|---|---|---|---|
| | | | **Version 3** |
| No code | | No code | Patient Review |
| No code | | No code | Individual Patient Plan |
| Demographic Information | | | |
| No code | | 9152. | Surname |
| 1K... | | XC00J | Gender |
| No code | | 9155. | DOB |
| No code | | No code | Asylum Seeker |
| No code | | No code | Failed Asylum Seeker |
| 13D.. | | Xa805 | Homeless |
| 13D1 | | 13D1 | Homeless family |
| 13D2 | | 13D2 | Homeless single person |
| 13D6. | | Xe0P3 | Living in a squat |
| 13FL. | | Ua0Lq | Sleeping out |
| 13D7. | | XaPxo | Sofa Surfing |
| 13F9. | | XE0p2 | Hostel |
| 13FA. | | 13FA. | Lives in bed and breakfast accommodation |
| No code | | No code | Contact |
| No code | | 9159. | patient phone no |
| 9T… | | 9T… | Ethnicity |
| No code | | XaLN0 | Ethnicity not known |
| 9i2D. | | XaJSC | Traveller ethnic category 2001 census |
| 13l.. | | Ua0Hj | Main spoken Language |
| No code | | 13X4. | Previous Countries lived in |
| 13D8. | | XaQ0m | Time homeless |
| 14... | | 14... | Past medical history |
| 12... | | 12... | Family history |
| 1151. | | 1151. | No known allergies |
| **Mental Health** | | | |
| E.... | | E.... | Mental Health disorder |

| | | | |
|---|---|---|---|
| No code | | No code | Contact with CMHT in past |
| 9N2a. | | XaAUA | Seen by CPN |
| 9NNM. | | XaAQo | Under care of CPN |
| 13cM. | | Xa1bX | Substance Misuse |
| **Observations** | | | |
| 229.. | | 229.. | O/E Height |
| 22A.. | | 22A.. | O/E Weight |
| 22K.. | | 22K.. | BMI |
| 246.. | | X773t | Blood pressure |
| 461Z. | | 46... | Urine examination |
| 3395. | | XE2wr | PEFR |
| 1371. | | Ub0oq | Non-smoker |
| 137R. | | 137R. | Current smoker |
| 8H7i. | | XaItC | Referral to cessation |
| 13c.. | | Ub0mt | Drug User |
| **Other Agencies Involved** | | | |
| 03AQ. | | Ua0bS | Social worker |
| 9NN7. | | Ua0um | CMHT |
| 8Hl6. | | XaMzM | Referral to Drugs worker |
| 8H7x. | | XaIvc | Referral to drug abuse counsellor |
| 13F.. | | 13F.. | Housing dependency scale |
| 03FJ. | | 03FJ. | Health Visitor |
| 03F.. | | Xa0rf | Midwife |
| 679S. | | XaKuU | Health education - safe sex |
| 679K. | | XaIyP | Health education - sexual health |
| 8CE.. | | 8CE.. | Self-help advice leaflet given |
| 8CEC. | | XaLoH | Safer sex leaflet given |
| **Screening testing and immunisation** | | | |
| | | n4s. | Hepatitis A+B vaccine |
| n4s1. | | | |
| n4s3. | | | |
| 43X5. | | XaILN | Hepatitis A antibody level |
| Q4090 | | Q4090 | Congenital hepatitis A infection |
| 65FA. | | 65FA. | 1st hepatitis A vaccination |

| | | | |
|---|---|---|---|
| 65FB. | | 65FB. | 2nd hepatitis A vaccination |
| 65FC. | | 65FC. | 3rd hepatitis A vaccination |
| 65FD. | | 65FD. | Booster hepatitis A vaccination |
| 8I3q. | | XaLIG | Hepatitis A immunisation declined |
| 65W4. | | 65W4. | Requires a hepatitis A vaccination |
| 68No. | | XaKzM | No consent for hepatitis A vaccination |
| n4mz. | | n4mz. | Hepatitis A vaccine prefilled syringe 1mL |
| n4mx. | | | |
| F034H | | F034H | Post hepatitis A vaccination encephalitis |
| 65MD. | | 65MD. | First combined hepatitis A and B vaccination |
| 65ME. | | 65ME. | Second combined hepatitis A and B vaccination |
| 65MF. | | 65MF. | Third combined hepatitis A and B vaccination |
| 65MG. | | 65MG. | Booster combined hepatitis A and B vaccination |
| | | | |
| 677R. | | XaLTv | Hepatitis B screening counselling |
| 6828. | | 6828. | Hepatitis B screening |
| 9Op2. | | XaLFK | Hepatitis B screening offered |
| 813u. | | XaLND | Hepatitis B screening declined |
| 8I3r. | | XaLIH | Hepatitis B immunisation declined |
| 68Nm. | | XaKiz | Hepatitis B immunisation refused |
| 68Nm. | | XaKiz | No consent for hepatitis B immunisation |
| 65W5. | | 65W5. | Requires a course of hepatitis B |
| 65WC. | | XaMe9 | Hepatitis B immunisation recommended |
| 14b0. | | XaN0g | History of one hepatitis B immunisation |
| 14b1. | | XaN0h | History of two hepatitis B immunisations |
| 14b2. | | XaN20 | History of three hepatitis B immunisations |
| 65F1. | | 65F1. | 1st hepatitis B immunisation |
| 65F2. | | 65F2. | 2nd hepatitis B immunisation |
| 65F3. | | 65F3. | 3rd hepatitis B immunisation |
| 65F6. | | 65F6. | 4th hepatitis B immunisation |
| 5F7. | | 65F7. | 5th hepatitis B immunisation |
| 665FM | | XaKXg | Sixth hepatitis B immunisation |
| **Hepatitis C** | | | |
| 677Q. | | | |

| | | | |
|---|---|---|---|
| 6829. | | XaJh4 | Hepatitis C screening |
| 90p1. | | XaLDh | Hepatitis C screening offered |
| 813v. | | XaLNE | Hepatitis C screening declined |
| 677Q. | | XaLTu | Hepatitis C screening counselling |
| **Tuberculosis** | | | |
| A1… | | A1... | TB - Tuberculosis |
| F4A55 | | Ayu1. | Tuberculosis |
| 6831. | | N018. | Tuberculous arthritis |
| ZV12B | | AyuJ4 | [X]Sequelae of respiratory and unspecified tuberculosis |
| | | Jyu93 | [X]Tuberculous disorders of intestine and mesentery |
| | | K43.. | Female tuberculous pelvic inflammatory disease |
| | | L173. | Maternal tuberculosis during pregnancy, childbirth and the puerperium |
| | | N22yD | Tuberculous infection of tendon sheath |
| **HEAF** | | | |
| 33M.. | | X77eX | Heaf test |
| 745F0 | | XaBAN | Observation of Heaf test |
| | | XaKcR | Heaf test done |
| **Mantoux** | | | |
| 332.. | | XE1Ou | Mantoux test |
| R1550 | | Xa6nl | Observation of Mantoux test |
| | | R1550 [D] | Abnormal Mantoux test result |
| | | 332Z. | Mantoux test NOS |
| | | 3321. | Mantoux test done |
| | | 3321. | Mantoux test not done |
| **BCG** | | | |
| 653.. | | 653.. | Tuberculosis (BCG) vaccination |
| 68ND. | | 68ND. | No consent – BCG |
| 745F1 | | TJJ0. | Adverse reaction to BCG vaccine |
| 2FG6. | | U60J0 | [X]BCG vaccine causing adverse effects in therapeutic use |
| SLJ0. | | SLJ0. | BCG vaccine poisoning |
| 65WD. | | X502J | BCG ulcer |
| TJJ0. | | n42.. | BCG vaccine |