NHS
Tower Hamlets
Clinical Commissioning Group

Pre-procurement Engagement event

NHS City & Hackney and Tower Hamlets Clinical Commissioning Groups.

23.5.18

Setting the scene for the day

Aims and Objectives of the session

City & Hackney CCG

Support the campaign by tweeting using the hashtag #HiddenHomeless

The man in charge of housing policy at London's City Hall has revealed £50million has been set aside to provide "move-on housing" for people in homeless hostels and refuges.

service for homeless patients

What we have now

- The Greenhouse Practice – one of the country's 28 specialist GP practice for homeless people; started 2007
- Co-located with Thames Reach and LBH Housing Advice as part of the Single Homeless Hub
- Services provided at The Greenhouse include: full health assessments; GP registration; housing advice; welfare and benefits support; help with access to employment, training, and volunteering; legal advice for people registered at the medical practice; and links to other support services
- APMS Contract – block payment; KPIs monitored but performance not currently tied to payment
- Previous providers – various; ELFT
- Current provider AT Medics
  - On caretaking contract
  - Outstanding CQC rating Aug 2017
  - Good on a range of outcomes/above CCG average on many (partly supported to deliver through a range of locally enhanced contracts + no penalties for missed targets)
- CCG took on full delegation for primary care 1/4/17; prior to that the services was commissioned by NHS England

The Greenhouse open day 14 Feb 2018

Pictures courtesy of AT Medics

Lunch at the open day

Stalls at the open day

What we are moving to

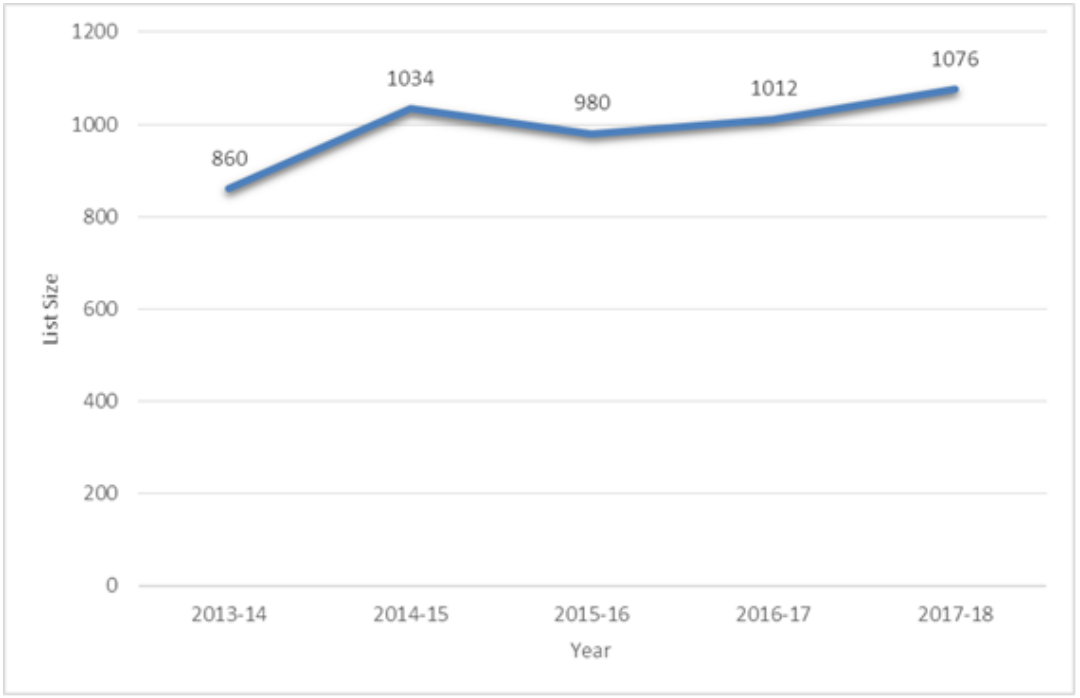
- Current contract expires 31/3/19
- Reprocuring a new service to start 1/4/19
- Draft model/spec/outcomes/KPIs informed by:
  a) Local engagement with key stakeholders – principally the four integrated commissioning workstreams (planned care; unplanned care; prevention; women and children) – engagement is on-going, e.g., talking with City of London re need for 'outreach'
  b) Consultation with current patients – key themes included the need for staff that can make them feel comfortable; need for timely/good access; need for continuity
  c) Consultation with the current provider - suggested some new potential KPIs linked to the 10 London Commitments
  d) Guidance/resources produced by London Health Homeless Programme/Pathway/Groundswell, etc
  e) Further engagement with other stakeholders and providers including today's event

The high level outcomes we want to achieve

- Support for all eligible based on broad definition of homeless - people who sleep rough, live in hostels, ‘surf’ on sofas, or who are chronically insecurely housed
- A specialist practice as the local leader for health and homelessness
- Build in flexibility to take into account future recommendations, guidance, resources – e.g. outputs from the HEARTH study, new consultation methods, etc

Model

- Staying with a specialist GP practice based on increasing local demand – list size up from 860 to 1076 in 4 years – average 6% increase p.a.
- Discussions happening with City of London re potential outreach model and Integrated Commissioning workstreams



Outcomes and KPIs #1 (draft)

Outcome	Description	Measure
Proactive registration	The practice should be making efforts to register all homeless persons in C&H e.g. working actively with local hostels and other agencies to enable homeless people to be registered with a GP	The % of homeless patients attending Homerton A&E OR having an unplanned admission to Homerton, who aren't already registered with the Greenhouse
		Minimum 5% increase in list size p.a.

Outcomes and KPIs #2

Outcome	Description	Measure
Proactive inclusion in engagement	At the start of each year the practice will agree an inclusion and improvement plan with its PPG and then deliver it over the remainder of the year. Suggestions for the inclusion plan include an annual open day, a dedicated patient engagement area in the waiting room and a range of ways of seeking feedback	PPG approved inclusion plan by end of Q1 End of Q4 report detail delivery against plan, signed off by the PPG. To include summary of outcomes of all activities, e.g. summary of patient feedback, summary of improvements made in relation to patient feedback

Outcomes and KPIs #3

Outcome	Description	Measure
Responsive service delivery models	The service will provide a responsive model of service delivery. Actual model to be agreed with PPG and commissioner and could include phone consultation, walk in service, etc. Need for morning, evening and weekend provision to be established The response model will support continuity as much as possible Outreach to hostels and drop- in centres? Street visits? Using EMIS mobile?	??? FFT??? Measures of continuity???

Outcomes and KPIs #4

Outcome	Description	Measure
Multiagency partnership	Facilitating external support and agencies to provide on-site support to homeless patients	% of patients who have been offered access to these services
Initial Health Assessments	New homeless registrations will have an enhanced new patient check within 1 month of registering Include: General physical health assessment; dental/oral problems; ; blood borne viruses; smoking; drug and alcohol problems; TB; mental health problems; diet; exercise	% new registrations who have had NPC within 1 month as % of total new registrations

Outcomes and KPIs #5
- all taken from LHHP's London dashboard

Outcome	Description	Measure
Prevention and early treatment for HIV, Hepatitis B and C	Number of homeless patients offered screening HIV, Hepatitis B and C	% patients/ new patients offered screening for HIV, Hep B and C
	All non-immune patients will be offered and take up Hepatitis B vaccinations	Proportion Hepatitis B non-immune patients that complete course (3 vaccinations)
Improved access- decreasing avoidable secondary care	Reduced A&E attendances for homeless patients	Number of A&E attendances per 1000 registered population from the baseline year
	Reduced unplanned admissions for homeless patients	Number of unplanned admissions per 1000 registered population from the baseline year
	Reduced readmissions for homeless patients	Reduced readmissions within 30 days per 1000 registered population from the baseline year

Outcomes and KPIs #6 – misc.

- Food, pet care, laundry, mail, phone lending/recharge (all currently provided by AT Medics)
- Evidence the staff have been trained using Pathway/LHHP training modules
- Evidence that staff are acceptable to pts
- Minimum no of consultations per 1000 pts – these need not be face to face
- Implement Pathway model
- Implement Pathway's/Faculty of Homeless Health's clinical governance and accreditation services for specialist homelessness primary care providers. This will be based on the Faculty's standards and include both peer and service user reviews
- Follow good practice in the training and resource pack on end of life care and homelessness being developed by Niamh Brophy (End of Life Care Co-ordinator, St Mungo's), Marie Curie and Pathway – launched Summer 18
- % of homeless pts supported to volunteer/work in the practice

The Homelessness Research Programme is based within SCWRU.

Its aims are:

- To contribute to theory development, by exploring the causes of homelessness, and transitions into, through and out of homelessness.
- To understand better the problems and needs of people who are or have been homeless, and the effectiveness of services for disadvantaged and socially excluded groups.
- To influence policy and practice development regarding the prevention and alleviation of homelessness, and the improvement of services for people who are or have been homeless.

HEARTH study: Delivering primary health care to homeless people: an evaluation of the integration, effectiveness and costs of different models

Primary health care for homeless people is delivered in various ways: health centres specifically for homeless people; mobile teams in homeless services such as hostels; GP practices with special services for homeless people; and generic GP practices that provide ‘usual care’ to homeless people. There is no evidence, however, about which schemes are more effective in addressing homeless people’s health needs. This exciting new study aims to evaluate the effectiveness and cost-effectiveness of these different models, with special reference to their integration with other services and how this impacts on a range of health, social and economic outcomes.

The objectives are:

- To identify the extent of provision of specialist primary health care services for homeless people in England, and the types of models that are found in different NHS Area Teams and in areas with different population sizes
- To examine the integration of the primary health care services with other services, particularly primary dental care, mental health, secondary health, substance misuse, homelessness sector, housing and social care
- To examine the effectiveness of the different models in engaging homeless people in health screening, in responding to their health and social care needs, and in providing continuity of care for health problems including long term conditions
- To evaluate over time the impact of the different models on service-users’ health and well-being, and their utilisation of other health and social care services including dental, emergency and secondary care
- To investigate the resource implications and costs of delivering services for the various models
- To compare the various models across a range of outcomes, reflecting service-user and NHS perspectives, using a cost-consequences framework
- To provide evidence for local commissioners of NHS services and service providers regarding cost effective organisation and delivery of primary health care to homeless people

Funded by NIHR.

Methods

- A mapping exercise will be undertaken to identify the location of specialist homeless health services in England and the services they provide. Eight case study sites (CSS) that represent the four models (described above) will then be evaluated to assess their effectiveness in providing care and treatment to homeless people
- A case study design based on the principles of 'realist evaluation' (context + mechanism = outcome) will examine the effectiveness of the different models in terms of 'what works, for whom, how and in what circumstances?' The primary outcome is the engagement of homeless people in health screening, and this will be measured using six 'Health Screening Indicators'. One of the secondary outcomes is continuity of care and outcomes over 12 months for five 'Specific Health Conditions' (hypertension; chronic chest disease; depression; alcohol related problems; drug problems). Other secondary outcomes are: oral health status and receipt of dental care; self-ratings of general health status and wellbeing; satisfaction with the CSS; and utilisation of health and social care services and costs
- Differences in outcomes between models will be investigated in relation to the particular contexts and mechanisms of care, and the resource implications and costs. Outputs include a Guide on the integration, effectiveness and cost-effectiveness of the various models, targeted at health and social care service-commissioners, managers and practitioners

Health care & people who are homeless Commissioning Guidance for London

10 commitments for London:

How to improve health outcomes for people experiencing homelessness

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

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Tower Hamlets CCG

Chima Olugh, Primary Care Commissioner

Current Landscape

Tower Hamlets CCG commissions 3 homeless services which help it to fulfil its statutory duty to address health inequalities by improving health outcomes for one of the borough's most vulnerable groups.

Specialist APMS Primary Care Service (1)

Tower Hamlets has one specialist Homeless practice that provides **primary medical services** to its street homeless and vulnerably housed patients.

Specialist APMS Primary Care Service (2)

The practice delivers its services through an Alternative Provider Medical Services (APMS) contract which has a suite of Key Performance Indicators.
List size = 1,300.

The practice operates a transient patient list where patients are assessed at various intervals of their care to ascertain their suitability to be transferred and registered with a ‘regular’ GP practice.

Specialist APMS Primary Care Service (3)

The practice offers 20 minute GP appointments as opposed to regular 10 minutes.

It also offers a walk-in service, mental health nurses on site, a blood-borne virus testing service, and substance misuse workers from the drugs and alcohol service RESET.

Hospital In-reach Service

The service provides hospital ward rounds using an accredited Pathway GP, supported by a specialist homeless health nurse practitioner.

They visit every homeless inpatient whose admission is known to the service.

Hospital In-reach Service (2)

- The service regularly has discussions with the responsible Bart's clinicians to ensure treatment and discharge planning of homeless people benefits from the specialist healthcare input.

- Liaise with the relevant Bart's Health clinical team and make plans with the patient for discharge, and enact these.

Advocacy Service

Provides a Homeless Health Peer Advocacy (HHPA) programme, where **people with a lived experience** of homelessness help people who are currently homeless navigate the healthcare services.

The service has a core service and a more targeted service.

The Journey so far

- User engagement as part of the JSNA – May 2017.
- Stakeholder workshop - September 2017.
- User engagement in conjunction with Providence Row – January & February 2018.
- Business Case for the new service approved – February 2018.

New Integrated Service

A single integrated homeless service with an APMS Primary Medical Service at the core. This service will align and work with other existing homeless services across the borough.

The Service will commence April 2019.

Target population – patients registered with the Homeless Practice, Homeless people admitted to the Royal London Hospital, sofa surfers, Rough sleepers & people living in hostels or supported accommodation.

Expected Benefits of the New Service

- Early identification of homeless patients in both primary, secondary and social care.
- The provision of specialist advice to acute medical teams, coordination of care for homeless people, support discharge planning, and continuity of care between hospital and out of hospital care.
- Improved in-reach services into hostels in the borough.

System Benefits

A reduction in the number and frequency of unplanned A&E attendances, A&E admissions and unscheduled readmissions.

A reduction in the number of LAS call outs to hostels, especially for people with mental health issues.

A reduction in number of missed outpatient appointments in homeless people.

Critical Success Factors

- To ensure an integrated, personalised service model designed around the needs of the patient, and responds to their holistic needs.

- To ensure care is integrated at the point of delivery and delivers seamless, efficient and effective care, eliminating barriers and gate-keeping and improving access to appropriate care.

Expected Outcomes

- Work with local hostels and other agencies to enable homeless people to register with a GP.
- Clearly defined pathways into primary, secondary & social care services.
- Early identification of housing status/need and support to get suitable accommodation.

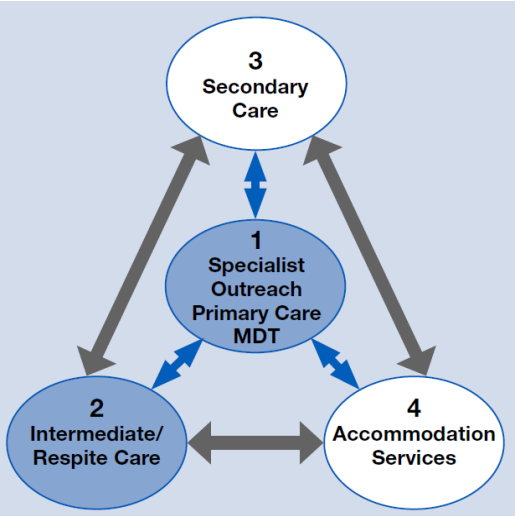
Expected Outcomes

- A specialist, proactive and systematic service as the local leader for health and homelessness.
- The service must facilitate a safe hospital discharge protocol into appropriate accommodation with multi-agency support planning.
- Homeless patients discharged from hospital must be seen by the service within 48hrs of discharge.

Homeless health – intervention

Ten commitments (Healthy London Partnership)

1. High quality healthcare
2. Patient and public engagement
3. Integrated and flexible models
4. Better data
5. Partnership working
6. Access to primary care
7. Effective mental health care pathways
8. Avoiding discharge from hospital to street
9. Homeless health advice/signposting in all acute settings
10. High quality end of life care

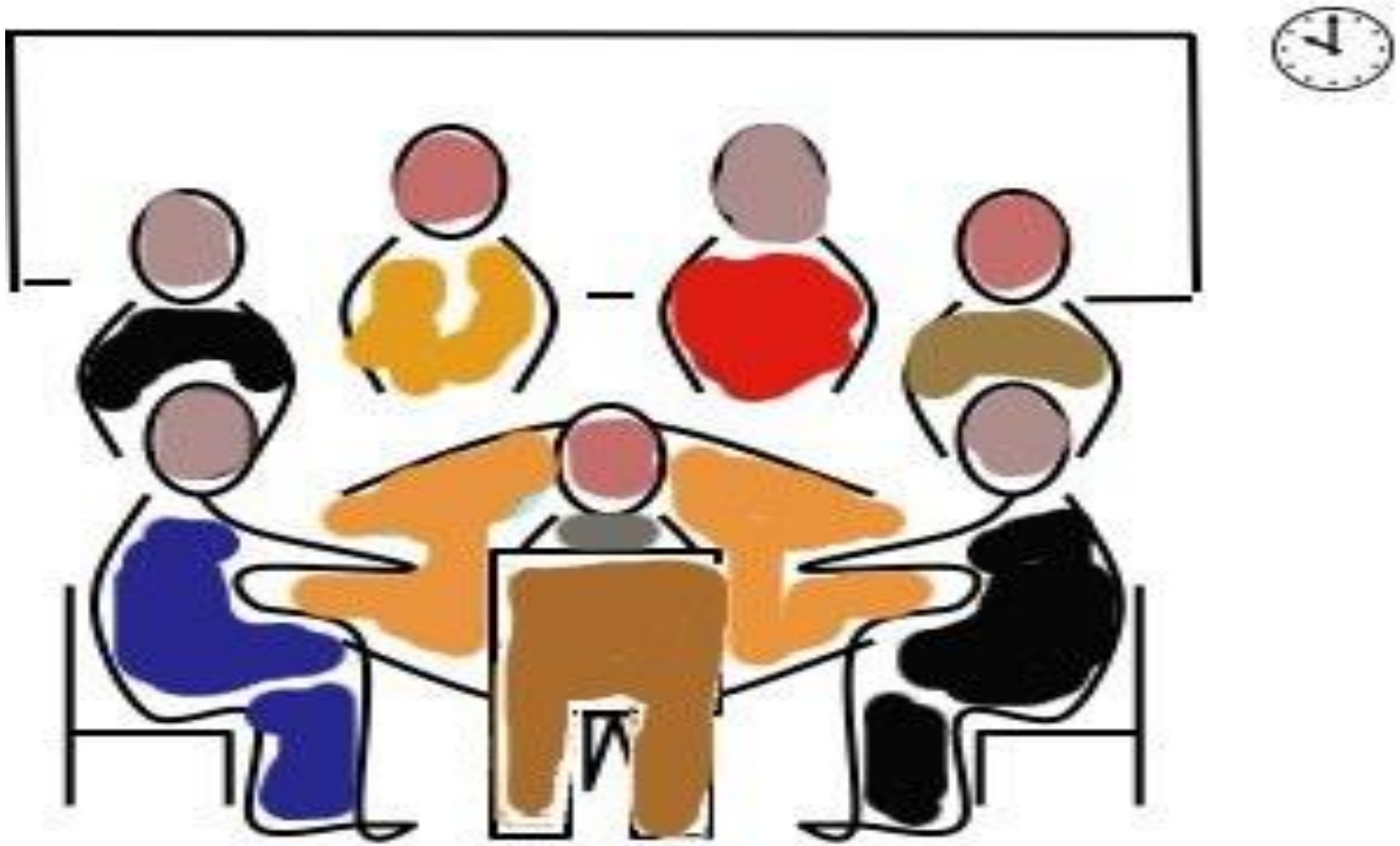


Recommendations from JSNA

- Flag for homelessness on health care records
- Plan for Homelessness (Reduction) Act 2017
- Develop specific homeless health outcome measures
- Ensure integrated provision
- Promote registration to mainstream general practice
- Promote training of frontline engaging with homeless populations
- Review access of NHS Dentistry by homeless population

Service User Experience & Feedback

GROUP WORK SESSIONS



Workshop 1 – Homeless Service Outcomes

- 1) Are these the right outcomes?
- 2) Can they be developed or refined further?
- 3) How achievable are these outcomes?
- 4) Are these outcomes measurable?
- 5) How will outcomes that involve multiple providers be delivered?

1) What specific services are needed to ensure the service model supports homeless people achieve optimum health and social care outcomes?

2) How will the service ensure that homeless people with multiple, complex needs (housing, mental health, drugs and alcohol etc.) have timely access to the appropriate services?

3) How will the service achieve a reduced reliance on secondary care services?

4) How will the service provide leadership, coordination, training and development across GP practices and other services?

5) Are there any constraints with this service model?

Workshop 3 – Contract & Finance

- **What are the advantages in a longer contract term for potential bidders?**
- **As a potential bidder what things will you do to ensure a longer term contract benefits homeless people?**
- **Would you at some stage during the contract consider a review and inclusion of more complex outcomes in order to work more effectively with this cohort and improve service delivery?**
- **Is there an appetite amongst providers to enter into a risk – reward sharing arrangement with the CCG and make bold changes to service provision?**

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Summary & Finish

Thank You For your time today.