# Oxfordshire Primary Care Commissioning Committee

| **Date of Meeting:** 4 June 2019 | **Paper No:** 5 |
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**Title of Paper:** Recommissioning of specialist homeless primary care services

| **Paper is for:** (please delete tick as appropriate) | **Discussion** | | **Decision** | ✓ | **Information** | |
|---|---|---|---|---|---|---|

**Purpose and Executive Summary:**
This paper provides an update on the ongoing recommissioning of specialist homeless primary care services (currently Luther Street Medical Centre, LSMC) and a request for endorsement to proceed with the procurement of a new service with a contract start date of 1st April 2020.

**Financial Implications of Paper:**
£700,000 per annum for the years 2020-2025

**Action Required:**
OPCCC are asked to:
- Note the report
- Approve the proposal to proceed with procurement in line with the model described within the paper

| **OCCG Priorities Supported** (please delete tick as appropriate) | |
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| ✓ | Operational Delivery |
| | Transforming Health and Care |
| | Devolution and Integration |
| ✓ | Empowering Patients |
| ✓ | Engaging Communities |
| | System Leadership |

**Equality Analysis Outcome:**
While people with protected characteristics are not over-represented amongst the homeless population, homeless people experience very high levels of deprivation, morbidity and early mortality.

The proposed service is intended to improve access and outcomes for this cohort across the county.

**Link to Risk:**
AF26 – Delivery of Primary Care services

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**Date of Paper:** May 2018

# Recommissioning of specialist homeless primary care services

## 1.0 Purpose

The aim of this paper is to provide an update on the recommissioning of specialist homeless primary care services in Oxford and to propose next steps in relation to the procurement of future services.

It will provide the context to the proposed service in relation to the wider development of an integrated homeless health pathway, as agreed by the OCCG Executive Board.

Homelessness is commonly defined as lacking secure accommodation, including living on the streets, in hostels or in temporary accommodation without access to other permanent housing. These service developments focus on homeless people who are rough sleeping or who are currently in the Oxfordshire adult homeless pathway (assessment, complex, progression and move-on hostel accommodation).

## 2.0 Background

### 2.1 The Impact of Homelessness

Chronic homelessness is an associated marker for tri-morbidity (the combination of physical ill health with mental ill health and drug or alcohol misuse), complex health needs and premature death[1]. The average age of death for homeless patients in the UK is between 40 and 44 years old[2].

People who are homeless:

- Are estimated, on average, to receive care costing five times the average of the general population[3];
- Are five times more likely to attend ED when compared to a housed age-matched population. This is likely due to an increased risk of injury, ill-health, addiction, vulnerability, barriers in access to general practice and the difficulties faced in planning appointments around an unsettled routine;

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[1] Faculty for Homeless and Inclusion Health (2018). Homeless and Inclusion Health standards for commissioners and service providers
[2] Office of the Chief Analyst (2010). Healthcare for Single Homeless People. Department of Health
[3] Brodie, C et al. (2013). Rough Sleeper: Health and healthcare. Review of the health needs and healthcare costs of rough sleepers in the London boroughs of Hammersmith and Fulham, Kensington and Chelsea, and Westminster

- Use four times as many acute health services and eight times as many inpatient health services as the general population, but receive lower levels of follow-up care[2];
- Are more likely to be readmitted to hospital due to the difficulties recovering from illness without adequate housing;
- Are five times more likely to have a co-morbidity[4].

Homeless people do not commonly die as a result of exposure or other direct effects of homelessness. They die of treatable medical problems, HIV, liver and other gastro-intestinal disease, respiratory disease and acute and chronic consequences of drug and alcohol dependence[5].

## 2.2 Homelessness in Oxfordshire

There has been an upward trend in the number of people presenting as homeless in the past six years, rising from 457 in 2011/12 to 482 in 2016/17.

There has also been an increase in people who are accepted as statutorily homeless and in priority need, from 279 in 2011/12 to 304 in 2016/17[6].

Between Autumn 2016 and Autumn 2017 the number of people estimated to be rough-sleeping in the county has increased by 48%, with an 89% increase in Oxford city:

| Description/ District | CDC | City | South | Vale | West | Total |
|---|---|---|---|---|---|---|
| Number of people estimated to be sleeping rough (Nov 16) | 17 | 47 | 7 | 8 | 0 | **79** |
| Number of people estimated to be sleeping rough (Nov 17) | 9 | 89 | 2 | 10 | 7 | **117** |
| *Percentage change (Nov 16 to Nov 17)* | *-47%* | *+89%* | *-71%* | *+25%* | - | ***+48%*** |

Source: Exception Report by Housing Support Advisory Group, report on the number of people rough sleeping in the City of Oxford to Health Improvement Board 8th February 2018

## 2.3 Luther Street Medical Centre

Luther Street Medical Centre (LSMC) is a specialist homeless primary care practice based in the centre of Oxford, adjacent to O'Hanlon House (a 56 bed complex needs hostel). It will accept temporary or permanent registration from homeless people and does not distinguish between people with or without a local connection[7].

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[4] Public Health England (2018). Homelessness: applying All Our Health
s[5] O'Connell JJ. (2005) Premature Mortality in Homeless Populations: A Review of the Literature
[6] http://mycouncil.oxfordshire.gov.uk/documents/s41624/Executive%20Summary%20JSNA%202018.pdf
[7] In order to qualify for certain statutory services, including access to the Oxfordshire homeless pathway, a person must be able to demonstrate having a "local connection". This is defined as living in a council area for either 6 out of the last 12 months or 3 out of the last 5 years.

A number of services are co-located in LSMC, providing a multi-disciplinary approach to meeting the typically complex needs of its patients:

- GP services (mix of prior appointment and drop in)
- Mental health
- Drugs and alcohol misuse
- Dentistry
- Podiatry
- Midwifery

LSMC provides a point of access in the community for the delivery of a number of health programmes which seek to address issues which are particularly relevant to the homeless population, e.g. prevention and treatment of hepatitis and other blood-borne viruses, TB.

The service has 480 registered patients currently. Analysis of LSMC patients presenting to OUH secondary acute care in 2017-18 found:

- 46 patients had had 1,076 GP appointments
- Average number of appointments was 23 per person, range 1 to 94
- Patients had had 95 additional hospital attendances in addition to the 45 known ED attendances at OUH
- Alcohol abuse was recorded in 23 patients
- Of these, 16 also had at least one significant comorbidity including Hepatitis C, Diabetes or mental health problems including schizophrenia, depression, anxiety, bipolar disorder and personality disorder
- Drug abuse was recorded in 28 patients whilst 13 patients had a history of both drug and alcohol abuse
- 20 patients had a history of mental health problems

The team supports the transition of patients back into mainstream general practice when they no longer need the enhanced services provided by LSMC.

The service meets many of the best practice requirements set out in the Homeless and Inclusion Health standards for commissioners and service providers and is rated as outstanding by CQC.

A number of issues have been identified that are being addressed in the recommissioning:

- Specialist homeless GP services are currently based within the Luther Street premises. The value of greater street outreach and hostel inreach is being considered;
- The location of the Luther Street premises next to the city's main complex needs hostel may create a barrier to certain groups accessing the service. The immediate environment can be intimidating and the easy availability of drugs and alcohol can create risks for patients in recovery;

- The homeless pathway has become increasingly dispersed in Oxford. The new service will need to account for these changes;
- Support to primary care practices outside of the city who may be managing complex patients;
- Role of primary care hospital in-reach as part of an integrated homeless healthcare pathway across primary and secondary care.
- The place of Luther Street within an Oxford City Primary Care Network will need to be considered

2.4 View of OCCG Executive

In November 2018 the OCCG Executive endorsed the following recommendations, as part of a proposal to develop an integrated healthcare pathway for homeless people in Oxfordshire:

- Support the development of an integrated homeless pathway across primary and secondary care;
- Support the ongoing recommissioning of specialist primary care services;
- Maintain £150,000 per annum investment in the homeless housing pathway for the years 2020-2022:
    - Negotiating priority access to the pathway for rough sleepers and homeless people with complex needs in hospital beds
    - Working with health and housing partners to improve delivery of intermediate care in hostel settings
- Consider a business case for developing a specialist homeless team in hospital settings, following the evaluation of the Trailblazer project in September 2019.

## 3.0 Proposed model for specialist homeless primary care provision

3.1 Evidence Base

There is evidence to suggest that primary healthcare programmes specifically tailored to homeless individuals are more effective than standard primary healthcare[8].

Key principles include:

i. Access to co-located, multidisciplinary services
ii. Specialist expertise in managing physical and mental health conditions often associated with homeless people
iii. Co-ordinating care around the patient
iv. Longer and more flexible appointments
v. Appointments which address multiple needs, in addition to the main presenting need

[8] Hwang SW, Burns T. Health interventions for people who are homeless. Lancet 2014;384:1541–7

vi. Hospital in-reach to facilitate effective discharge

A number of services exist across England, typically configured in one of the following ways:

i. Single specialist practices, e.g. LSMC, Morley Street surgery (Brighton)
ii. Specialist hub and spoke models, with various elements of services provided in multiple locations
iii. Drop in clinics in mainstream practice
iv. Mobile teams in homeless services such as hostels
v. Generic GP practices that provide ‘usual care’ to homeless people
vi. A variety of the above

Services have developed to meet local needs and there is no clear “one size fits all” approach.

4.2 Proposed approach

The evidence suggests specialist primary care services improve health outcomes for homeless people, manage a cohort of high need complex patients who would otherwise have to be managed in mainstream practice and provide preventative primary care which can reduce system costs “upstream”.

Homelessness data suggests the cohort within the homeless population with the most complex and acute health needs remains overwhelmingly concentrated in Oxford City, either rough sleeping or in complex needs hostel accommodation.

Therefore the proposal is to recommission a specialist primary care service which operates within Oxford City, targeting patients with the most complex and acute health needs. The service will be funded within the existing budget of £700k per annum.

The service will provide specialist support to other practices within Oxford and across the county who are supporting homeless people, alongside providing hospital in-reach and liaison, care-coordination and improved in-reach into hostel settings.

OCCG does not intend to prescribe a specific model for the service. An outcomes based commissioning approach will be taken to ensure OCCG benefits from the expertise and innovation within the provider market, including the voluntary and statutory sector partners existing providers may be working with.

Bidders will need to address the issues identified in section 2.3 above, with responses forming part of the scoring methodology.

The draft aims and objectives which will inform the service specification are at appendix 1.

4.3 Key milestones

June 2019: completion of engagement activity
August 2019: publication of invitation to tender documents
December 2019: Evaluation and contract award
January 2020: contract mobilisation
April 2020: contract start

## Appendix 1: Draft Aims and Objectives

<table>
<tr><th colspan="2">Overall Aim: To improve the health and wellbeing of homeless people in Oxfordshire</th></tr>
<tr><th colspan="2">Preventative<br>(Prevention and the promotion of health and wellbeing)</th></tr>
<tr><td>Embed a recovery approach which empowers patients to make decisions about their health and wellbeing, and involves them in the design and delivery of their care</td><td>Utilise evidence-based decision support tools to embed a Shared Decision Making (SDM) approach, maximising patient engagement in decisions about their health and care</td></tr>
<tr><td>Improve prevention of – and early intervention in - common conditions associated with risks of homelessness and rough sleeping</td><td>In addition to addressing a patient's presenting problem, provide screening, assessment and access to treatment, for (but not limited to):<br>- Physical health problems<br>- Mental health problems, including personality disorder<br>- Dental / oral problems<br>- Alcohol and substance misuse problems<br>- Blood borne viruses<br>- Tuberculosis<br><br>Provide a holistic health assessment for all new homeless registrations within 1 month of registering, using a template to be agreed with OCCG<br><br>Support Public Health initiatives as appropriate, including (but not limited to):<br>- smoking cessation<br>- healthy eating<br>- physical exercise</td></tr>
<tr><td>Improve provision of services for homeless people across Oxfordshire</td><td>Provide clinical leadership in the care of homeless people and rough sleepers on behalf of the Oxfordshire health and social care system:-<br><br>Provide a dedicated information, advice and guidance service for primary care in Oxfordshire<br><br>Provide specialist support to GP practices supporting homeless people across Oxfordshire, particularly those practices supporting patients in the Oxfordshire Adult Homeless Pathways<br><br>Provide training, information, advice and</td></tr>
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| | guidance to primary and secondary healthcare, housing and social care providers on effectively meeting the health needs of homeless and vulnerably housed people in Oxfordshire[9], including how to deliver services in line with the Psychologically Informed Environments (PIE) and Trauma Informed Care (TIC) models |
| **Proactive (Promoting and supporting independence)** | |
| Ensure timely and effective transfer to mainstream primary care (when the client is in settled housing and no longer needs specialist primary care services) | Support the handover of patients to local non-specialist GP practices |
| **Responsive (Rapid access to the right care in out of hospital settings)** | |
| Improve access to assessment, treatment and support for:<br><br>- physical health needs<br>- mental health needs<br>- alcohol or substance misuse issues | Provide permanent or temporary GP registration for eligible patients<br><br>Provide General Medical Services<br><br>Support referrals into secondary physical and mental health services<br><br>Support referrals into alcohol and substance misuse services<br><br>Create digital personal care plans for all clients |
| Improve management of long term health conditions | Manage long term conditions appropriately and in line with NICE standards<br><br>Provide individualised care co-ordination (including shared integrated care plans / formulations with individualised goals and strengths) for:<br>*Cohort tbc* |
| Improve integration of health, care and housing services to facilitate delivery of a | Facilitate integration of health and care services at the point of delivery |

[9] E.g. Working with homelessness - Standards for GP receptionists in primary care, Mental Capacity Act

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|---|---|
| holistic, person centred approach to meeting needs which addresses the underlying causes of poor health | Support development of an integrated, multidisciplinary approach to meeting the health, care and housing needs of homeless people by working in partnership with external agencies |
| **At / In Hospital<br>(Reduced admissions to hospital and / or care homes)** | |
| Reduce unplanned and emergency hospital admissions and readmissions | Provide a service which is accessible at times and locations to meet the needs of the target population |
| **Returning Home<br>(Returning home and promoting and supporting independence)** | |
| Reduce delayed discharges of people with ongoing treatment needs who can be discharged from acute beds<br><br>Improve pathways and care interface between primary and secondary care | Provide a primary care in-reach service to support discharges from secondary care (acute and mental health beds) and safe transition from hospital to community<br><br>Ensure that appointments are made for all homeless patients being discharged from acute or mental health hospitals to attend within 48 hours of discharge<br><br>Provide a community location for ongoing treatment / outpatient appointments |