URBAN VILLAGE MEDICAL PRACTICE

ANNUAL REPORT 2021

Primary Care Service for people experiencing homelessness

URBAN VILLAGE
MEDICAL PRACTICE

Introduction

Urban Village Medical Practice (UVMP) is a GP practice based in Ancoats, Manchester.

The practice delivers primary healthcare services to over 13,000 general patients. For over 20 years the practice has also delivered a primary healthcare service to people who experience homelessness in Manchester.

The practice has long recognised the fact that health inequalities exist in our practice population and that specific proportionate responses are required to address this. Our service recognises that homeless people experience some of the most significant health inequalities in the population and that a specialist approach to address these is required.

We have worked with partners including MHCC and Manchester City Council to commission and design a healthcare service for homeless people in Manchester.

The service adheres to the principles of individual entitlement to healthcare, equitable access to healthcare and a proportionate response to address health inequalities

The service has continued to evolve over the last 20 years and now delivers:

- Proactive engagement with people experiencing homelessness in Manchester including nurse led outreach sessions in a clinical van on the streets and at day centres and hostels
- Full registration with Urban Village Medical Practice for patients that need it and care navigation for patients that are registered with a different GP
- Flexible and easy to access range of healthcare services including the full range of comprehensive primary care available to all registered patients including GPs, nurses, tissue viability nurses, sexual health, blood borne virus treatment, drug assessment and treatment and mental health services
- A hospital in reach service delivered by clinical and non-clinical team members offering comprehensive discharge planning in partnership with hospital teams for homeless people who are admitted to Manchester Royal Infirmary
- Working with partners agencies to increase the understanding of the importance of equitable access to healthcare for homeless people and encouraging homeless people to access care and address their health needs

The Impact of the Pandemic

This is the first annual report and analysis of the service that has been undertaken since the start of the pandemic in 2020.

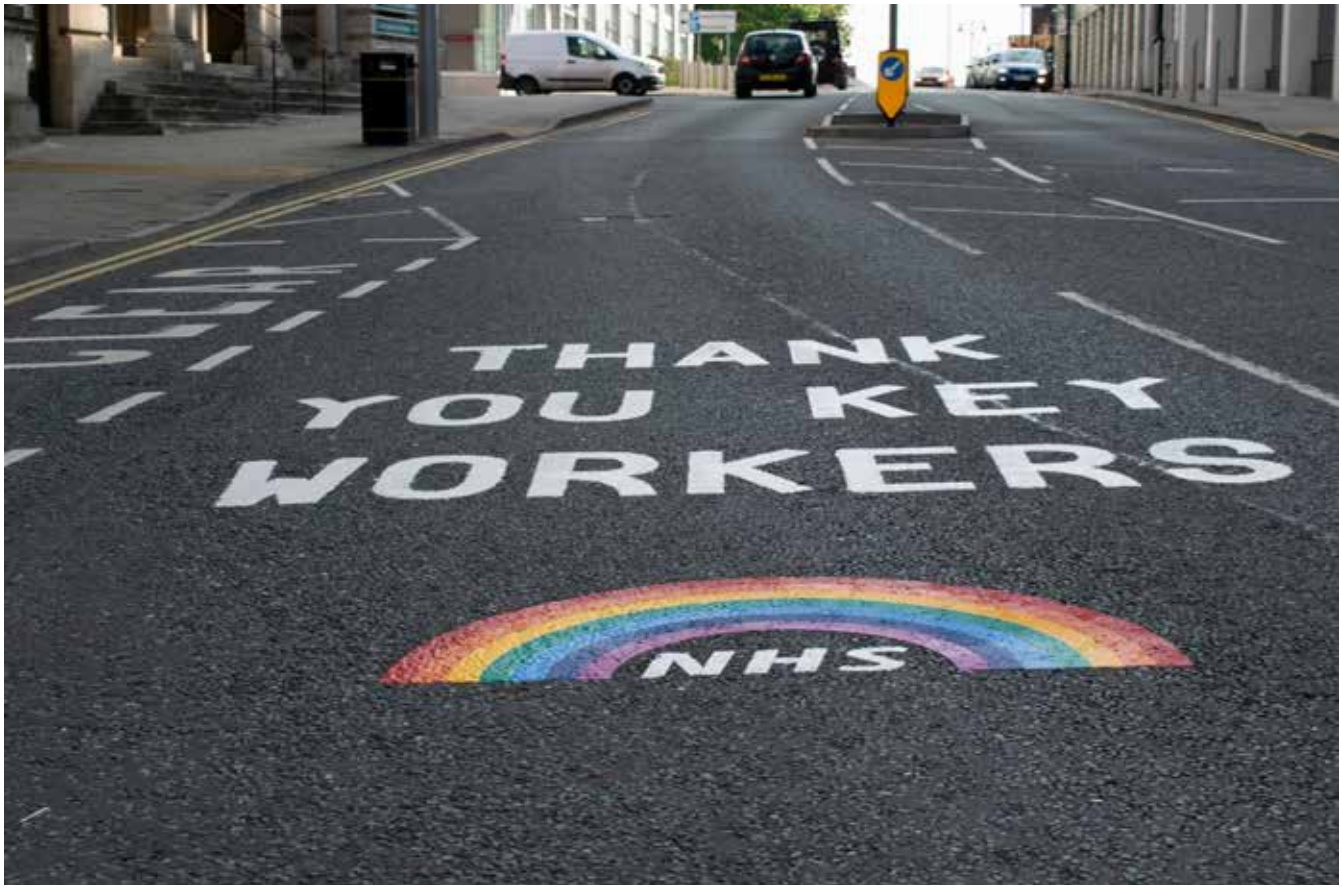
Standard operating procedures for primary care during this period were fundamentally modified to address patient and staff safety. It was clear early on that there was a significant potential for these modifications to perpetuate the health inequalities experienced by homeless people and to significantly reduce access to care. The Homeless Healthcare Team critically appraised the evidence for safe service delivery and modified it further to ensure continued access to healthcare during this difficult period.

Modifications included:

- A low clinical threshold for face-to-face consultations for patients with the multidisciplinary health team throughout the pandemic
- Developing clinical outreach services including purchase of a fully equipped mobile clinical unit staffed with an expanded specialist nursing team and delivery of care in out of practice settings. This enabled us to develop and deliver a covid vaccination programme across the city for people experiencing homelessness.
- Developing new ways for patients to access healthcare including digital healthcare and telephone consulting during the pandemic
- Continuing to work closely with partner agencies to promote continued access to primary care including partnership working with the "Everyone In" response.

We are incredibly proud of the whole team who worked hard to deliver accessible and inclusive healthcare during one of the most challenging times in recent history, every member of the team demonstrated dynamism and commitment to develop and deliver our offer in response to specific requirements of the people experiencing homelessness in the City.

As we begin to look beyond the pandemic, we will use this report to examine the specific impact of the pandemic on the homeless healthcare service and help us plan the recovery of the service in 2022.



Service Activity in 2021

New Patient Registrations

The Homeless Healthcare Service offers full registration to single adults experiencing homelessness in Manchester.

At the end of 2021, the service had 764 people registered

During 2021 the service registered 203 people, an average of 17 people a month.

The registration figure is a lot lower than previous years; we think in part due to the Government's "Everyone In" programme during 2021 which enabled local councils to offer people accommodation and support during some of the pandemic.

Alongside this, although health services remained open to patients, we were unable to ask people to attend the Practice to register, and this was undertaken by phone. These factors significantly reduced the requests for registration and meant a large number of initial requests were not completed.

Our nurse led outreach service has also impacted on registration figures, as it has enabled people who aren't registered with us to access initial healthcare and be supported to access their current GP.

Accommodation Status

Accommodation status at the point of registration.

These figures show the impact of the Government funded "Everybody In" programme which accommodated people experiencing homelessness in hotels and hostels during the pandemic - the figures are an increase in B&B/hostel accommodation and a reduction in rough sleeping at the time of registration from previous years. Night shelters, which offer shared facilities were closed in Manchester during the pandemic.

17% Bed & Breakfast

39% Hostel

1% Night Shelter

16% Sofa Surfing

27% Rough Sleeping

Allied Homeless Health Care Professionals

The service has historically hosted drop-in sessions for people experiencing homelessness by the **Homeless Mental Health Service & Podiatry.**

Although these face-to-face sessions had to be suspended during the pandemic, the services continued to work closely during that time and the sessions have now restarted.

Age

Age of the 203 people registered in 2021:

27%
were under 30

55%
were aged between 30 & 50

18%
were over 50

67% of people identified as male & 33% as female

These figures show a slight reduction in the number of people under 30, and a slight increase in the number of patients over 50 in comparison to previous years

The experience of homelessness can be vastly different for men, women and trans and non-binary people and engagement in healthcare also varies greatly.

Appointments at the Practice

Homeless patients registered with the Homeless Service receive full GP registration and can attend appointments at any time, but we also provide flexible appointment sessions with our GPs, nurses and other clinicians.

In 2021 people experiencing homelessness attended :

2,277

GP APPOINTMENTS

Includes Both Phone and Face to Face

Comparison: 3,990 (2018)

732

NURSE APPOINTMENTS

Comparison: 1,950 (2018)

It is testament to the resilience and tenacity of the clinicians working in the service that the number of patient contacts remained so high during the pandemic

New Patient Health Checks

A common experience of people experiencing a period of homelessness is that they have not accessed primary care for a period of up to 6-12 months at the point of registering with our service.

Therefore, we have designed a process to address this gap in care which aims to offer and deliver a comprehensive health check for patients when they register. This is undertaken by a nurse and the service aims to get this completed within 8 weeks of registration.

This process ensures a clear baseline for patient's individual health needs and the development of a health plan which is agreed with the patient. It also collects vital information on physical health, mental health, sexual health, substance misuse, men's and women's health as well as social issues that impact on a person's health and well-being.

Interventions are offered and administered at this point including immunisations, sexual health screening, blood borne virus testing, contraception and smoking cessation.

In 2021, **58% of the people that were registered** received a full new patient health check (our aim is to achieve 80%).

Although this is a reduction in people receiving a check on previous years, this is a robust figure considering this is during a pandemic.

Wound Care

The service has worked in partnership with Pennine Acute Tissue Viability Services and latterly MFT to provide access to wound care and leg ulcer services for people experiencing homelessness by hosting a clinic three times a week at the Practice.

People do not need to be registered with the Practice to access this offer.

During the pandemic this service continued to provide a comprehensive service for patients with the face-to-face clinic continuing throughout the pandemic

This is demonstrated by the high number of **566 appointments** attended by patients which compares favourably with pre pandemic figures (629 in 2018).

Drug Treatment

Urban Village Medical Practice has been providing drug treatment in partnership with CGL Services, in a shared care arrangement to patients who experience problems with heroin dependency for over 20 years.

135
average number of patients in drug treatment each month

185 patients were provided access to drug treatment by the service in 2021. This compares favourably with pre-pandemic periods, which demonstrated similar levels of activity.

98%
of patients received a health review by GP which included a review of their drug treatment and their physical health.*

48
new patients taken into treatment (this includes hospital discharges and transfers as well as new patients)

38
patients received continuation of care following hospital discharge

89%
of patients in drug treatment had been blood borne virus tested, informed of their result and a treatment plan formulated if required

The covid pandemic and associated changes to healthcare delivery resulted in a requirement to overview how we delivered care to maintain patient and staff safety, this process began in early 2020 and we continued to deliver a modified service in 2021 – this overview reflects work done during these times.

Covid Pandemic Response

The pandemic required the service to overview delivery of drug treatment to its patients we used the following basic principles to guide us in this unprecedented situation

- Maintenance of patient safety
- Ensuring continued timely access to care for patients
- Individualised patient care plans according to their needs
- Maintenance of staff safety

During the pandemic the service was required to reduce footfall of patients into the service and developed safe systems to enable continued care.

The service continued to provide face to face services throughout the pandemic where this was indicated, with regular access to a CGL keyworker but also health services including GP, nurse and other allied healthcare professionals as required.

According to individualised care plans the range of dispensing options to patients were maintained including daily dispensing and observed dispensing as required, ensuring effective risk management and maintenance of patient safety.

We worked closely with pharmacy colleagues to enable continued safe access to opiate substitution treatment during the pandemic and we were able to support patients to continue to receive safe daily and observed dispensing during the pandemic which enabled them to maintain safety and reduce risk.

This brief analysis shows that the service was able to maintain a safe effective service during 2021 despite the complexities and challenges of the covid pandemic.

** UVMP delivers the Local enhanced service for care to drug using patients which requires that patients receive a comprehensive review of both physical and mental health and a review of their drug treatment care plan every 6 months*

Presenting Health Problems and Interventions for New Patients

76 patients selected for the audit
55 identified as male and 21 as female

% of patients identifying as male		% of patients identifying as female
4%	Hep B/HIV	0%
68%	Hep C (antibody positive)	61%
22%	Alcohol Misuse	21%
43%	Heroin/Crack Misuse Intervention	58%
100%	NPHC offered	100%
60%	NPHC received	71%
0%	Contraception advice offered	56%
0%	Contraception advice provided	33%
0%	Cervical Screening	62%
94%	BBV testing offered	83%
63%	BBV testing completed	75%
56%	Mental health identified	46%
12%	Severe mental illness diagnosis	5%
40%	STI screen offered	71%
55%	STI screen completed	71%

The health problems experienced by this new cohort of new patients in April to September 2021 mirrors that of the analysis in 2018. High levels of substance misuse, mental health problems and blood borne viruses.

The service continues to work in partnership with services who can provide access to specific interventions for these health problems - including CGL substance misuse services, GMMH mental health services and the infectious disease department at MFT.

The findings of the analysis also demonstrate the access to primary care offered by the service, with high levels of comprehensive new patient health checks and associated interventions and health promotion.

There are differences and reductions in interventions compared to the pre-pandemic 2018 analysis. This is to be expected but will enable us to focus on recovery of the service to provide optimal specialised health care post pandemic.

MPATH (Manchester Pathway)

The **IN REACH SERVICE** engaged with and assessed **384** patients

We made **137** referrals to local authorities or other services for homeless assistance.

34% (127) of the patients we saw were registered with UVMP at point of discharge

46% (176) of the patients we saw retained housing placements whilst in hospital

22% (82) were offered a new accommodation placement on discharge from rough sleeping or sofa surfing

Launched in partnership with the Pathway charity almost a decade ago, this part of the service is a hospital in reach service which exists predominantly to reduce health inequalities and ensure continuity of health care across primary and secondary care for people experiencing homelessness who have been admitted to hospital.

Evidence suggests that this service leads to better health outcomes, reduced hospital admissions / readmissions and reduced length of stay for this cohort of people.

The team provides a daily hospital presence Monday to Friday of a GP and specialist non clinical case manager who works alongside the hospital teams to develop safe discharge plans for people experiencing homelessness who have been admitted to Manchester Royal Infirmary.

During 2021, the MPath team was supported by Real Change Manchester (formerly, Big Change) which provided funding for the service to purchase clothing and other essential items to supply to homeless patients leaving hospital. This is an invaluable contribution to the service as it enables our patients to leave hospital with dignity.

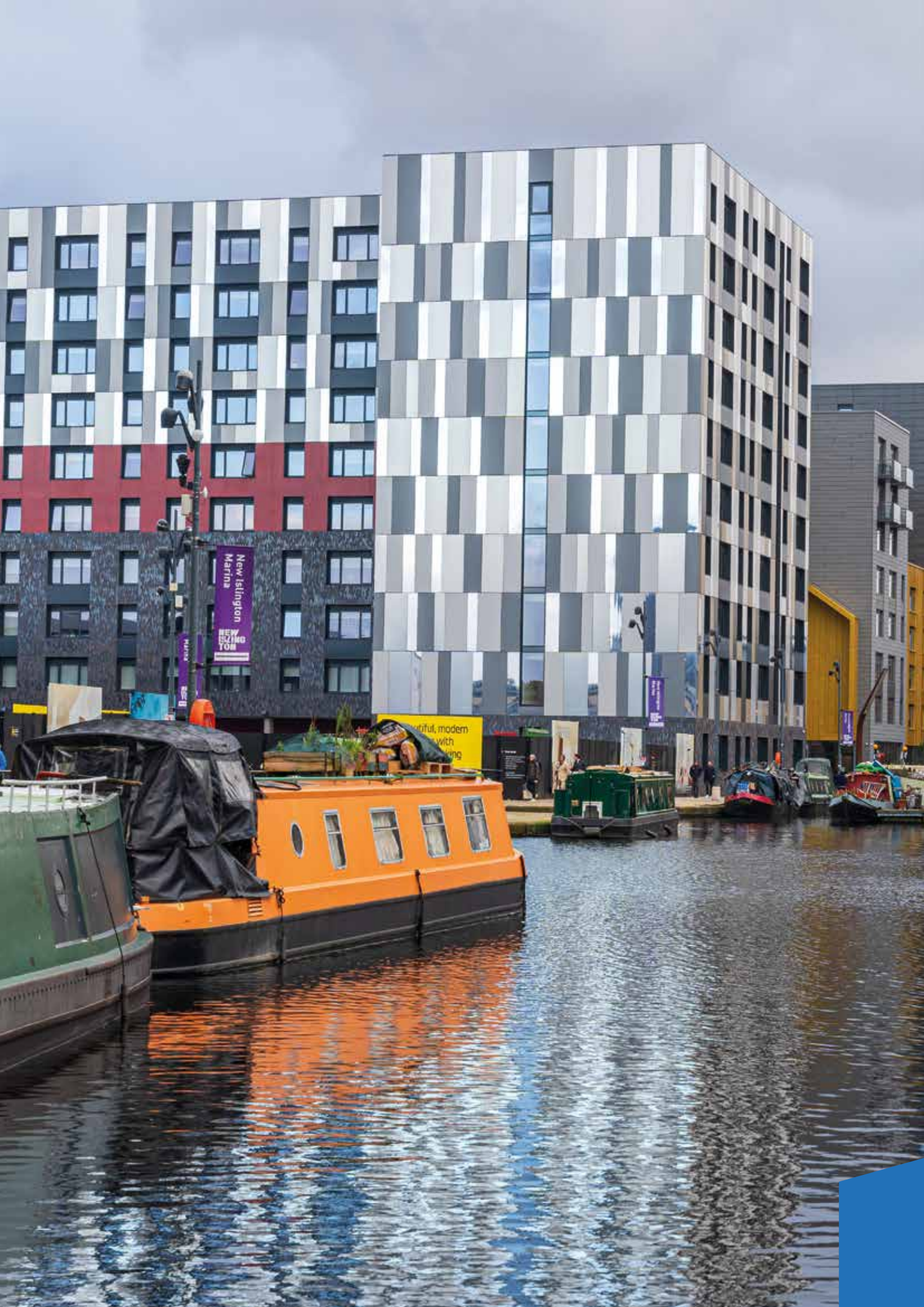
SUPPORTING CONTINUITY OF CARE ON DISCHARGE

The team can offer registration at UVMP to people where appropriate, or support patients to register with a local GP as required. This ensures that patients can access follow up healthcare once discharged.

The team works alongside our shared CGL workers to facilitate access to substance misuse services on discharge.

SUPPORTING ACCESS TO ACCOMMODATION ON DISCHARGE

The team works alongside Manchester City Council's Housing Solutions Service workers in the hospital to ensure access to statutory housing support. Where the patient is not eligible to get homelessness assistance, the team advocates for the patient for other accommodation, or signposts to services that can offer support.


New Islington
Marina

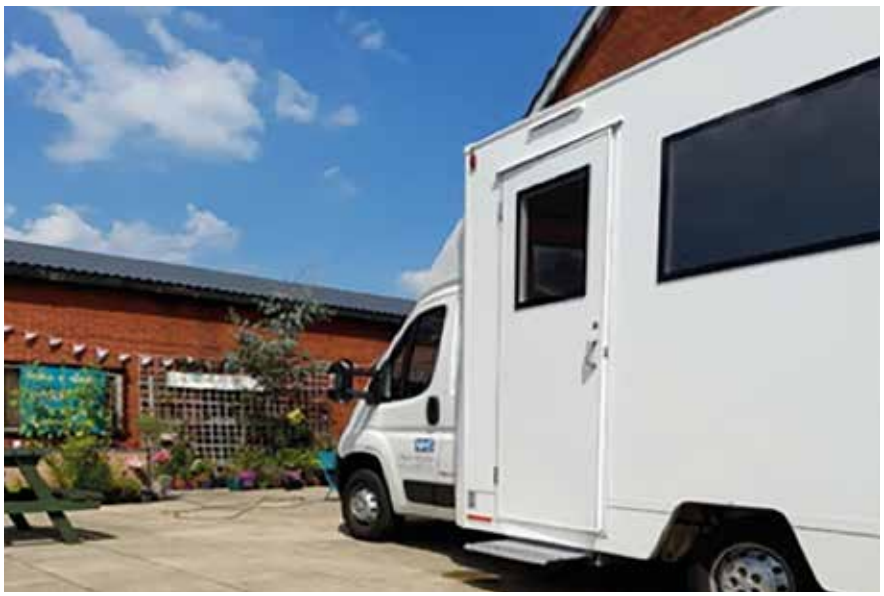
Nurse Led Outreach Programme

Our service has always worked hard to enable homeless people to access the health care they deserve and have the right to.

The 2020 lockdown and the need to avoid busy waiting rooms at homeless clinics meant that we had to think differently about how homeless people could see their health care team. Thus, in that very difficult year, a brand new and very exciting way for us to work was developed.

We purchased a mobile clinical unit to enable us to take health care out to where people are. The van means that we can provide mobile health care in an environment that is clean and private for people.

Homeless health outreach helps us build relationships with people and to help them to consider their health care needs. Being able to see people on outreach means they can access health care in a dignified way at a pace and in a place they feel comfortable.



The van in the booth centre garden where the nurses do a twice weekly clinic

For our homeless patients building trust with a nurse on outreach is often a first step to engaging with other health services. We offer full GP registration with UVMP or can support people to access other primary care services if needed.

We used the van to run nurse drop-in clinic sessions at the Booth centre and to provide regular nurse clinics in some hostels. We also run a weekly nurse clinic in a fully equipped health room at Barnabus homeless day centre.

The addition of the clinical van to our team has revolutionised the way we have been able to engage with people experiencing homelessness and offer accessible and responsive healthcare. We are able to offer signposting, health promotion and other advice for homeless people (including those who are not registered with us) about how to access their healthcare. The nurse led outreach, and the clinical van have become a cornerstone of our service delivery which we will continue to develop as we come out of the pandemic.

Inside the van we have hand washing facilities, clinical waste, safe sharps disposal and remote access to peoples health records. It has everything you would expect in a bespoke health care clinic but the difference is it can move!

Nurse Led Outreach Programme Patient Stories

Paulo has been coming to Barnabus homeless day centre for many years.

He had moved from the streets into his own tenancy where he felt isolated and his mental health had deteriorated in the lockdown

He had not been able to engage with his local GP practice and had missed a number of appointments with drug services.

He began to see homeless nurse Helen regularly at the Barnabus nurse clinic and she registered him with UVMP.

He has found it much easier to manage appointments as his drug treatment has now been transferred to UVMP so we can plan his GP and drug appointments on the same day.

As his substance use has reduced, his underlying mental health problems have become more of a problem for him. He has been able to see a GP to begin to address his mental health needs.

Helen still sees him regularly at Barnabus so she can remind him of his appointments.

He has recently told Helen that beginning to see her at the Barnabus nurse clinic was a turning point for him.

Maggie is currently staying in a bed and breakfast, she suffers from anxiety and physical health problems.

Although she is concerned about her physical health and understands the need for screening, she usually accesses the doctors when she is unwell and never feels like accessing health screening at that time.

Maggie saw the nurse when she was at the Booth centre, where she feels relaxed and supported.

She had eaten breakfast and had a shower at the day centre so when she saw the nurse she felt able to come onto the van for a full sexual health check and cervical screening test.

She told the nurse how happy she was that she had been able to do something positive for her health.

Her cervical screening result showed some abnormalities and the nurse went with her to a colposcopy appointment where she received appropriate treatment.

When Suzy was seen by outreach worker Phil when she was begging on a busy shopping street, she was cold and tearful.

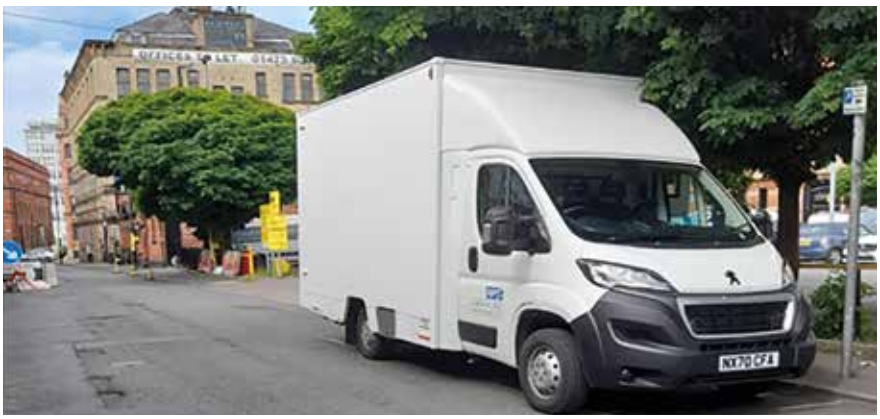
She came with Phil to the van where she was glad to find we have heating, a supply of dry socks and a tin of chocolate biscuits!

Although she was already registered with UVMP she had never attended due to her complex needs.

She was happy to have a full check up with the nurse on the van including height, weight, blood pressure, smoking, alcohol and substance history, full sexual health screen, covid and flu vaccines.

She came to the practice the next day to see a GP to discuss her mental health and saw the nurse again for a smear test.

New team member of the homeless health team on outreach in the city centre



Vaccine Programme

Vaccine programme for people experiencing homelessness in Manchester

The Team will forever remember 2021 as the year we delivered the covid vaccine programme to people experiencing homelessness in Manchester. We were determined to ensure that this cohort of people had equal access to the covid vaccine programme delivered by the NHS at national scale and used our clinical van to take the vaccine to where people were: in hostels, hotels, day centres and out on the streets. Our outreach experience gained from years of delivering the flu vaccine to the homeless population meant that were able to work quickly with our partners to pilot and then deliver a successful programme.

The vaccination programme was made possible by responsive and proactive partnership working between Manchester City Council, Manchester Health and Care Commissioning (MHCC) and our service. We lobbied for people experiencing homelessness to be identified as a 'vulnerable' cohort in the vaccine rollout, despite this not being identified at a national level.

This was agreed at a local programme level, and we received extremely responsive support from the MHCC Medicines Optimisation Team to work out the practical steps needed to enable us to received vaccine supply and use this in our outreach sessions safely.

We found that people we saw were overwhelmingly positive about the vaccine and were relieved that we had made it easier for them to receive it.

Many people we saw described the barriers they had faced accessing the mainstream vaccine programme and their relief that we had made it easier for them.

During the course of the vaccination programme which started in February 2021 and continues to date, the team delivered

over 1500 vaccines

to people experiencing homelessness in the City

(made up off approx. 750 first does, 500 second does and 300 boosters)

Comments we received included:

> *"Living with so many other people here I've been really scared I'd catch covid.*

> *"I was released from prison the day before I was supposed to have my jab so I thought I'd missed out on it.*

> *"I missed my appointment because I was arrested and then lost my phone so couldn't book another. I wouldn't have had this if it hadn't been for you.*

> *"I've got anxiety and can't use public transport so wouldn't have had it if you hadn't come here to see me.*

> *"The jab didn't even hurt!*

We are grateful to all the hostel and day centre staff and volunteers who helped us to achieve the high take up of the covid vaccine in the homeless population.

We are still working hard to ensure that homeless people can access the evergreen offer which means that people who have not yet been fully vaccinated can easily receive a covid vaccine should they wish to.

AN EXAMPLE OF THE HOMELESS COVID VACCINE PROGRAMME IN ACTION

We met Paul in April when we did his covid vaccine in the van when he was in temporary accommodation during the lockdown. Although he was nervous about the vaccine he said that because he knew us already that made him feel more confident having it. In August we saw him again on street outreach and he was happy to come onto the van to have his second vaccine. In November we saw him at the Booth centre and he had his booster. He told us that we have done all 3 of his vaccines and if it wasn't for us he wouldn't even have had 1!

This winter we have also delivered

183 flu vaccines

alongside the covid vaccine programme, protecting Manchester's homeless population from two potentially serious infections.

Blood Borne Virus (BBV) Testing and Treatment

The practice has a long-established partnership with the Infectious Diseases Department at North Manchester General Hospital for the provision of community services to homeless and marginalised patients suffering from blood borne virus infections.

The lead consultant is Dr Javier Vilar. There is GP and nurse input from the surgery.

We actively screen for BBVs in this population many of whom have risk factors and have developed a comprehensive and easily accessible shared care model promoting the benefits of screening and treatment and reducing the stigma of BBV infections.

HIV

The practice offers services to patients with HIV who are homeless and marginalised and who might not otherwise access care. There is a monthly HIV specialist nurse clinic supported by Dr Vilar as well as a monthly consultant led mixed BBV clinic.

Patients can access these clinics flexibly and we facilitate treatment by allowing patients to have their medication delivered to and stored at the surgery. This not only provides safe storage but helps where patients would not wish to have large quantities of medication in a temporary accommodation situation where it might be seen by other residents and identify their status.

Staff are trained in taking bloods from the external jugular vein and we offer full screening and immunisation services to patients with HIV who are identified as being in need of the service.

By engaging and treating this group of patients we not only improve their health but also aim to reduce the spread of infection in the population. We have a particular focus on re-engaging those who are lost to treatment many of whom are the most high-risk patients.

Hepatitis C

We have been involved in Hepatitis C treatment for over a decade and have successfully treated many patients in our shared care clinic with Dr Vilar.

We have used the principles of locally available flexibly accessible services. As with HIV care, medications are delivered and stored the surgery which is particularly useful when patients are homeless. More recently we have embraced the new treatments available and we have just implemented a new shared care model placing the surgery at the centre of the management pathway.

Hepatitis B

Homeless and marginalised patients with Hepatitis B are accommodated and treated by Dr Vilar in our monthly shared care clinic.

In 2021 the service treated **30 people**

(confirmed test of cure for 22)

Patient Feedback

Urban Village… They are fantastic... They help you with what you need and that. And when you need to see a doctor, they book you in to see him or you get a phone call, straightaway, the same day.

I have got a doctor at Urban Village… They know exactly where I am coming from. And then being with the same doctor for the last seven or eight years, he knows me inside out.

I can't lie to him; he can't lie to me. I can't be in denial. I am quite happy how its run."

Very good service, staff I seen were very helpful, listen to my problems and help me with them.

I got seen straight away despite being late, nurse very accommodating and knew my history

UVMP do everything they say they will

Training Sessions

Despite the limitations of the pandemic, the team were able to deliver some online training sessions about homeless healthcare. These included:

TWO

TEACHING SESSIONS FOR STUDENT NURSES

PRESENTATION ABOUT OUR NURSE LED OUTREACH PROGRAMME AT MANCHESTER'S HOMELESS CONFERENCE

Conclusion

This report analysed service activity during 2021at the height of the coronavirus pandemic.

Therefore it needs to be considered in this context. The homeless healthcare service has produced annual reports for a number of years prepandemic.

Therefore this enabled us to assess the impact of the pandemic on our service and help us plan our recovery.

It is accepted that the pandemic perpetuated and exposed health inequalities therefore there was a high risk that health inequalities in the homeless population would be made worse during this difficult period.

The service used its expertise and experience to critically appraise pandemic guidance and adopt the service to provide accessible but safe healthcare . The success of this strategy is demonstrated in the report with evidence of high levels of access face to face consulting and the development of an outreach service, taking healthcare to hostels, day centres and the street.

The service has delivered an innovative and effective covid vaccination programme to homeless people who normally would have significant difficulty accessing the vaccination programme in its mainstream setting, building on our experience of delivering flu vaccines to this population.

The report illustrates that the fundamentals or primary care continued to be delivered during a very challenging year - both health promotion and clinical interventions.

The service continued strong partnership working with Manchester Royal Infirmary to ensure safer discharges for homeless people and worked in partnership with Manchester City council to deliver healthcare to homeless patients brought into hotels during their 'Everyone In' initiative, as well as ongoing collaborative working with voluntary agencies in the city.

When compared to the report produced in 2018, there is some obvious reductions in health interventions during 2021 - this is to be expected, but has enabled us to focus our recovery on these areas going forward.

In summary we hope this report for 2021 demonstrates that the service has a continued commitment to addressing health inequalities experienced by homeless people.

Our continued commitment will use this report to develop a robust recovery plan and attain prepandemic healthcare delivery in 2022/2023.

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