Outreach & Community-based healthcare to homeless people with complex needs

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Great Chapel Street Medical Centre

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Health & Inclusion
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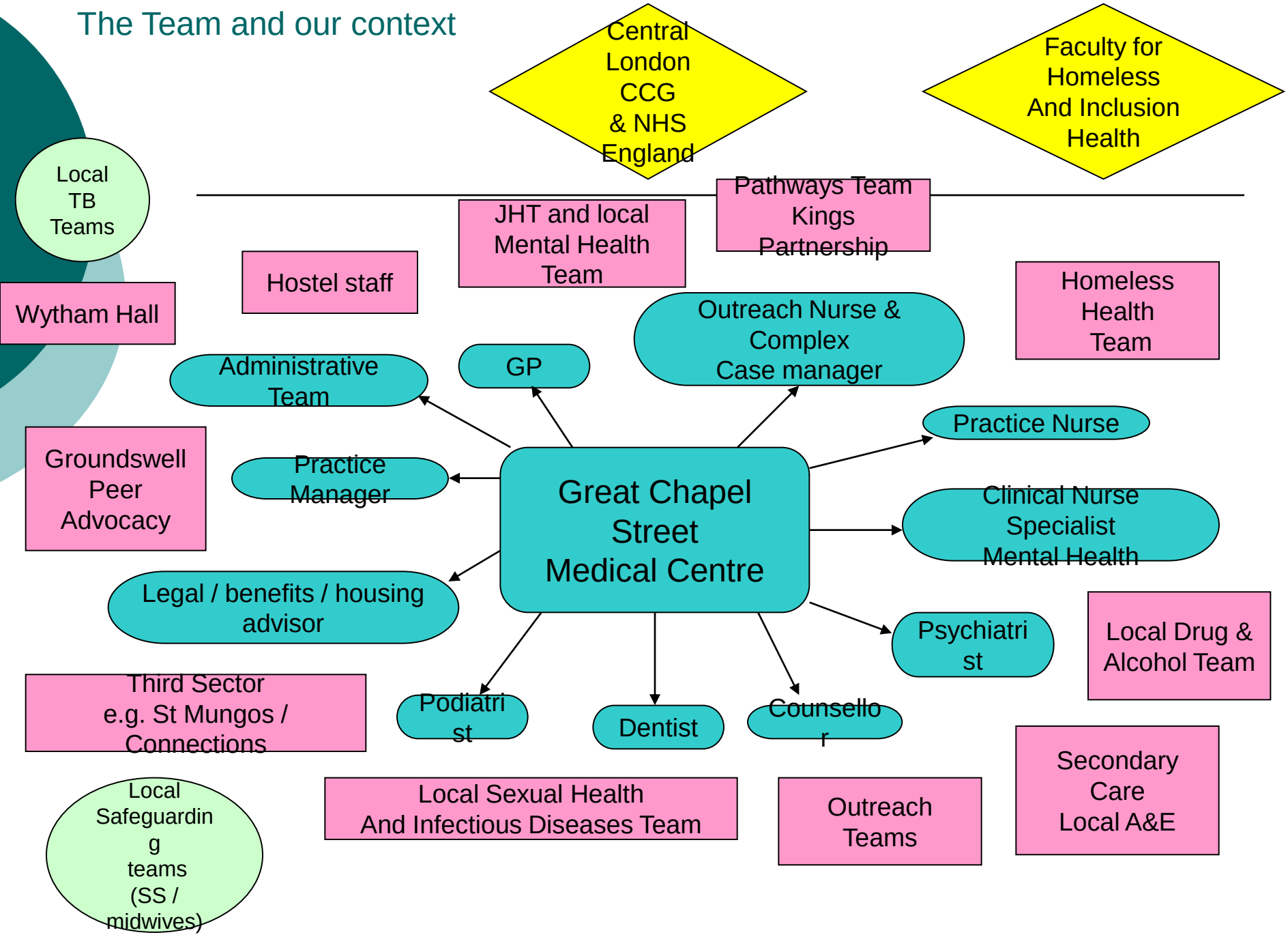
What this workshop will cover

- The Great Chapel Street team
- Partnership working at the practice
- Case Management at the practice
- Outreach
- Case examples

Great Chapel Street Medical Centre

- Based in Soho in hostel basement
- Started in 1970s following specialist grant
- Longest running specialist homeless GP practice in Europe
- Multidisciplinary team ‘one-stop shop’
- Links with local teams – named contacts
- Shared clinical notes

The Team and our context



What do we mean by Case Management?

- Case finding and planning
- Focus on complex needs and high demand on services
- Provide management overview and liaise with all services involved

What do we mean by Outreach?

Work outside existing clinic; can be divided into:
Hostel and day centre based
Street based working with existing street outreach teams
Night shelter visits e.g. Churches and other voluntary sector rolling shelters

What do we do on outreach that's different?

Can be more opportunistic, gradual engagement
Often can be 'targeted' so we can case find as needed.

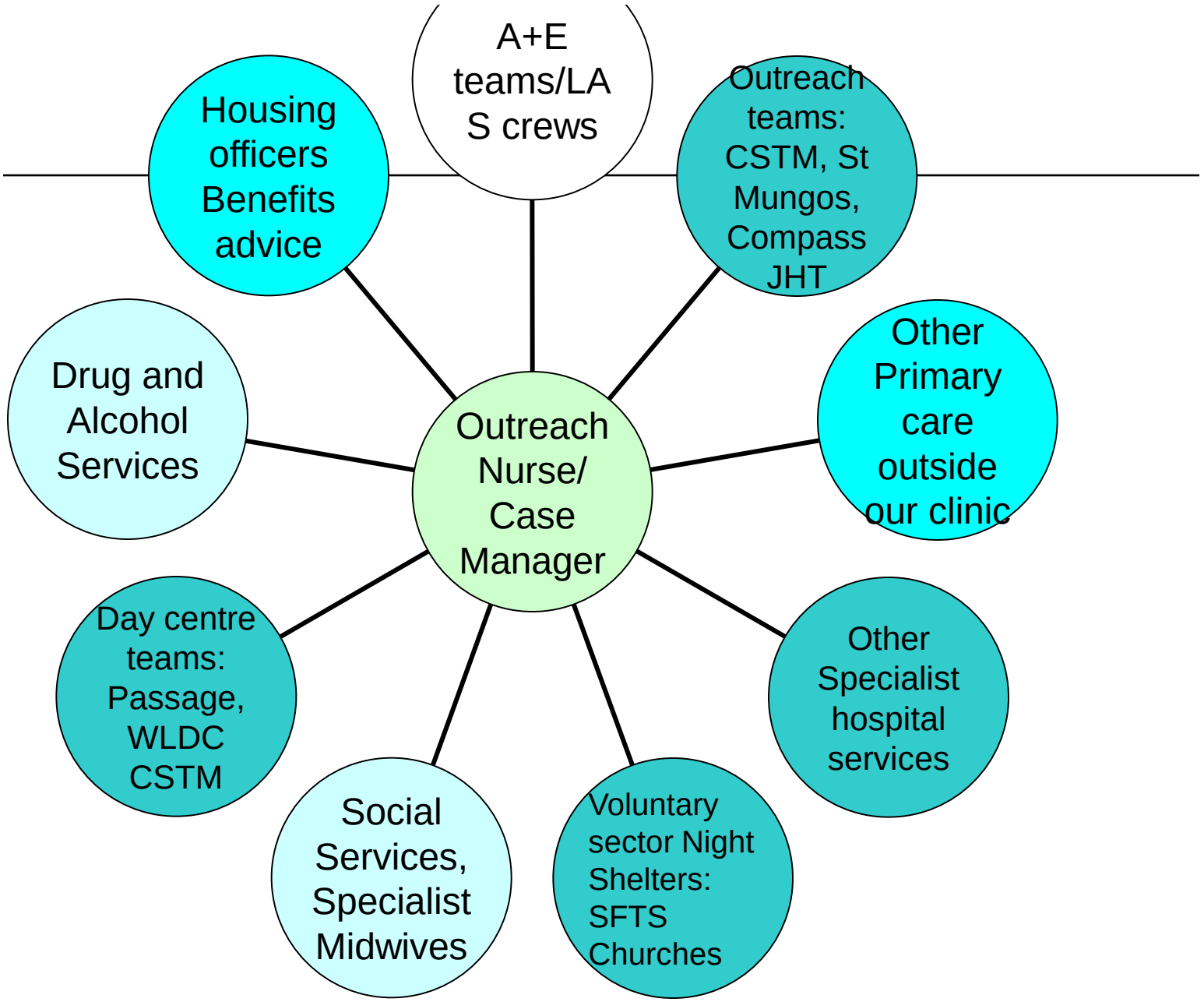
For example recently asked to see 7/7 overdue pregnant woman who was refusing to engage with statutory services and rough sleeping. As a result of street outreach able to engage provide basic antenatal care and facilitate managed delivery through liaison with specialist midwives.

Provides less threatening environment for people to discuss things, breaks down barriers to access:

Why do outreach at all when we have a clinic ?

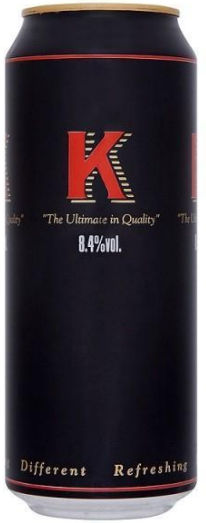
•Many people do not access building based services for a whole variety of reasons
• We can target specific individuals that agencies have health concerns about
•Builds rapport and trust with client group. Sometimes get peer referrals

Typical teams that I liaise with during Case Management of a single patient



Case 1: The Behavioural Medical Nightmare

- Mr PC 44yr old Irish man
- Hostel
- Substance misuse
- Alcohol misuse
- Oedema (nephrotic syndrome)
- Amyloidosis
- Osteomyelitis
- Difficult personality



Case 1: Mr PC

- Presented to us September 2012. Previously known in 2006
- On methadone
- IVDU incl large veins, crack, benzos
- Alcohol dependence
- History of drug-induced psychosis
- DVT, anaemia, peripheral oedema
- Loud, demanding, rude, abusive. Banned from local chemists.
- Multiple A&E attendances

Case 1: Mr PC

- Challenges
  - Managing behaviour in surgery
  - Addressing physical health concerns
  - Concordance with medications
  - Leg ulceration and worsening oedema
  - Concerns over mental state / capacity / memory
  - Conflicts of agendas between healthcare practitioners and patient

Case 1: Mr PC

- Requirements
  - Multidisciplinary team
  - Involvement of other agencies
  - Case manager
  - Team meetings and wider case conferences
  - Proactive liaison with secondary care, social services and mental health teams
  - Boundary setting
  - Assistance from key workers in hostel

Case 1: Mr PC

Outcome

Prolonged admission to hospital
Improvement in physical health
Stabilisation of substance and alcohol use
Care Package
Placement in residential nursing care in Somerset

Case 1: Mr PC

- What went well?
  - Team working within GCS and with wider agencies
  - Positive outcome for patient
  - Improved quality of life for patient
  - Prolonged life and decreased morbidity of patient
  - Involved patient in management decisions
  - Managed behavioural challenges without banning / violence / etc
  - Team worked through differences in opinion re how to manage

Case 1: Mr PC

- What could have been done better?
  - High level of workload and involvement?
  - Balance of resources?
  - Emotional pressure too high?
  - Boundaries set too late?
  - Case conference could have been set sooner?
  - Team working – split team at times- more consistent approach?

Ms G

Initial presentation Sept 2011
Assessment of needs - review 26 year old street homeless

1) Chaotic and chronic poly-substance misuser.
2) Associated alcohol abuse. Recently engaging with Turning Point on daily pick up of methadone if breathalyser negative.
3) Leg ulcer. Reluctant to allow assessment. Plan assess and engage as and when possible. Offer blood tests and immunisations.

Ms G – Collateral from Psychiatrist

RE: Ms G and Mr S

I think you have met Ms G and her partner Mr S in the past. After some effort we have started them both on methadone this week; they are currently injecting crack and heroin - at least £30 of each, they struggle to give exact amounts - daily as well as buying between 60 and 100ml of street methadone between them. They are also dependent drinkers and drink between 6 and 8 litres of sherry daily. The plan therefore is that they attend our service every day for breathalysing before going to the chemist for dispensing. In terms of their accommodation there is a possibility, as they have burnt most available bridges in Westminster, that they may be able to access a hostel in Lambeth - if they address their physical health and manage to stay on this methadone script.

They said today that they are planning to attend your surgery tomorrow. As you know they both have leg ulcers and Mr S are particularly severe. I have explained to him that if he were to go to hospital he could continue methadone and would be given an alcohol detox: it might be worth your reiterating this if hospital is felt to be the best option.

Their legs are the priority at present but if they do engage with you they should really be prescribed thiamine & vit B, and LFTs would be very helpful.

Best wishes Consultant Psychiatrist

Ms G Case study - discuss

- What would you do now?
- Who would you involve at this stage?
- What are the main issues?

Ms G: what happened next

Seen on targeted street outreach. Health advice given. Declined to engage. On and off methadone prescription.
Not seen again in surgery until Jan 2013: had accessed Lambeth services, other GP services

- Housed in the hostel upstairs
- On and off rough sleeping
- Physical health deteriorated further
- Child in foster care relocated
- New on and off relationship: multiple episodes of Domestic Violence and assault reported

What would you do next?

1) What is the priority now?

2) Who needs to be involved

Further events

- Endocarditis: refused to stay in hospital after 1 dose of antibiotics
- London wide alert as cultures Strep G+ve

- Fractured # ribs suffers multiple assaults from new partner

- Reports of R sided weakness and slurred speech – declining to access care

- Off methadone script, reports of crystal meth use and increasing chaos

Finally..

Reports of inability to mobilise, lying stairwell for over a week
Multiple visits to assess in stairwell by multiple agencies

Able to use mental capacity act to bring into hospital after 2x visits with assistance and joint working with 2x outreach teams, LAS, Met Police JHT, KHP team

The stairwell sleep site

Ms G Multi agency communication

Face to face Meetings

- MARAC Oct 13
- Multi agency professionals meetings
- Sept 13, Dec 13

Other communication

Following Alert re endocarditis creation of email distribution list with key workers from all relevant agencies involved so that updates shared

Summary of case

Required multi-agency approach from GCS in primary care partners we work with – 2 different borough outreach teams, LAS, Met police, Hospital team

Assertive case management approach. Case conferences and information sharing key to success

Now hospitalised last 4 weeks on ITU with septic emboli but improving

Still unable to mobilise independently but looking forward to discharge in the near future to supported housing with key work support

Summary of workshop

- Multi-disciplinary team-working is key
- Liaison with other agencies and communication is vital
- Having a named case manager (clinician) to be a liaison point is very valuable

Some References

- Nicholson, T.R.J., Cutter, W., Hotopf, M., 2008. **Assessing mental capacity: the Mental Capacity Act**. BMJ 336, 322–325.
- Ross, S., Curry, N., Goodwin, N., 2011. **Case management. What it is and how it can best be implemented.**