Service	NHS Nottingham & Nottinghamshire ICB Primary Care Homeless & Severe Multiple Disadvantage (SMD) Local Enhanced Service
Commissioner Lead	Rachael Harrold, Primary Care Commissioning Manager
Provider Lead	GP Practices of Nottingham & Nottinghamshire ICB
Period	1 April 2023 – 31 March 2024
Date of Review	December 2022

1. Population Needs

1.1 National/local context and evidence base

Severe Multiple Disadvantage (SMD) refers to people with two or more of the following issues: homelessness, mental health issues, offending and substance misuse. It can also include other sources of disadvantage, for instance poor physical health and, particularly for women, being a victim of domestic and sexual abuse.

Homeless people experience some of the poorest health in our communities. Without good health, it can be hard to leave homelessness behind. Improving the health of people who are homeless is central to reducing health inequalities and achieving the goal of ending homelessness. Our National Health Audit found that eight in ten have one or more physical health need, and seven in ten have at least one mental health problem. Research by Crisis in 2011 estimated the average age of death of a homeless person to be 43-47 years of age. People who sleep rough are 35 times more likely to commit suicide than the general population.

The other 'dimensions' of SMD compound the problems of homelessness and make it difficult to engage with single issue treatment and support. For example, substance misuse may lead to exclusion from a mental health service. Nottingham has among the highest rates in the country with an estimated 4650 people in Nottingham City and 5770 people in the County facing SMD.

Given the nature of SMD there is insufficient cross sector collaboration and coordination between mental health, housing, criminal justice and substance misuse services – as well as social care and the DWP. This lack of coordination and collaboration exists at all levels from ground level staff to strategy and commissioning. Part of this lack of collaboration is a lack of data sharing which causes people facing SMD to have to keep repeating their story and this contributes further to their alienation from services.

As SMD is primarily a consequence of trauma, a mental health response is central to meeting needs but often people facing SMD cannot get access to the mental health services they need especially psychological intervention. Nor is there sufficient psychological understanding of people facing SMD from the wider workforce.

The purpose of this Local Enhanced Service is to improve primary care services for people facing SMD. The aim is to increase awareness and understanding among primary care staff and to facilitate the provision of accessible high quality care, in liaison with other agencies and providers across Nottingham and Nottinghamshire.

The key policies related to this service include:

- Everyone Counts: Planning for Patients 2013/14
- Our health, our care, our say: a new direction for community services (2006)
- Our NHS, Our Future (2008)
- Severe Multiple Disadvantage Joint Strategic Needs Assessment: Nottingham City 2019
- Health & Homelessness Joint Strategic Needs Assessment: Nottinghamshire County 2019

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-health or following injury**	**X**
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

- Improving access and choice for patients
- Providing care closer to home
- Supporting care delivery

3. Scope

3.1 Aims and objectives of service

Aims

- To provide accessible primary care to people who experience SMD
- To improve the physical and mental health of people who experience SMD
- To improve partnership between the practice and specialist SMD services
- Reduce inappropriate ED attendances and secondary care admissions

Objectives

- Enable access to core GP practice services and community and secondary care services
- To provide a service at an appropriate time, location and environment
- To follow local pathways and management based on NICE guidelines
- Support patients to self-manage their long term conditions within the community
- To contribute, through partnership working to joint case management plans to stabilise health, housing and independence for people experiencing SMD.
- Provide services in line with Care Quality Commission standards
- Facilitate access to secondary care services while working to reduce unnecessary ED attendance and admissions to hospital

3.2 Service Description / Care Pathway

3.2.1 Service Description

The provider shall:

- Provide a GP practice based service for investigations and follow up arising from the management of patients in primary care.
- Identify a ‘named lead’ for the provision of this service
- Develop a protocol for the provision of this service which is reviewed annually. This should include a description of the ‘culture’ of the practice in responding to clients’ needs and practice arrangements for patient registration, flexible access and MDT working. An example protocol to support practices in developing their own is available via the SMD & Homeless Information Portal

Recording

- Produce an up-to-date register of patients who are homeless or face SMD (see section 3.4).
- Ensure an appropriate record of activity is developed and maintained for audit and payment purposes. This will include a computer record of patient encounters and annual reviews offered and completed.

Access

- Ensure they operate flexible registration procedures allowing for permanent registration to anyone who requests it, including patients from 'out-of-area' if appropriate.

  There is no contractual duty to seek evidence of identity, including photo ID; immigration status or proof of address at registration. The patient is not required to provide their National Insurance number and/or NHS number in order to register.

  Homeless patients are entitled to register with a GP. The home address that needs to be recorded should be an actual address for the patient, a hostel address or prison address and not a temporary address.

  For rough sleepers, those in hotels and sofa surfers, the home address should be the GP Practice address.

  A day centre should never be used as a home address as it risks discharges to that address. A day centre can be used as a 'correspondence' address.

  Appendix One - A Health Screening Form has been developed by Changing Futures and Nottingham City GP Alliance for the early identification of patients as SMD from the point of registration that practices can adopt.

- Operate flexible appointment systems that offer 'walk in' appointments and longer appointment times for people with multiple needs. Demonstrate flexibility in managing appointments e.g. for patients arriving late or requesting immediate attention, whilst ensuring clear boundaries for consultations are in place. Recognise the benefit of working with the patient's support worker to aid attendance.

  https://www.cqc.org.uk/guidance-providers/gps/gp-mythbusters/gp-mythbuster-29-looking-after-homeless-patients-general-practice

  The practice is required to be flexible in terms of registering patients facing homelessness / SMD and managing their consultations. It does not require registration of ALL patients out of area or the provision of walk-in services throughout contracted hours: rather practices should consider registering patients who are temporarily out of area, if appropriate, and be flexible in managing patients who present late or outside regular clinic times.

- Facilitate access to the practice for care / support workers and other professionals that may be involved in the patient's care. This may be through providing details of the practice's direct access 'phone line, secure email, or sending a 'task' through the clinical IT system.
- Facilitate communication between the practice and other agencies, including secondary care (recognising that this has to be reciprocated by the other party)

Prescribing

- Facilitate dispensing arrangements that allow for the administration of single or daily doses of prescription drugs, keeping prescriptions as short a duration as possible
- Adhere to relevant guidelines on the prescription of drugs in particular if medication has street value or potential toxicity, for example prescribing smaller volumes.

Assessments & Screening

- Provide for appropriate and regular screening assessments based on current research in relation to the health needs and problems of people facing SMD.
- Carry out assessments over the course of 12 months of the social, physical and mental health needs of patients registered for the service. Key elements should include:
    - A high index of suspicion for conditions of TB, hepatitis B and C and HIV and ensuring that screening is made available where appropriate
    - A high index of suspicion of substance use and, where appropriate, initial assessment and/or referral
    - Assessment of psychological wellbeing and referral if necessary.
    - For patients with serious mental health issues, provide an annual physical health check in line with current recommended practice.
- The expectation is that all patients will be supported by annual review assessments, undertaken over the course of several contacts, including virtually but ideally face to face, during the 12 months following registration / identification.
- Different elements can be offered by different staff, for example PCN 'Additional Roles' staff, on a regular or ad hoc basis throughout the year
- Provide opportunistic health promotion and a harm minimisation approach

MDTs, Networks & Signposting

- Ensure good communication links with local statutory services and agencies and where appropriate develop joint protocols, e.g. with the Street Outreach Teams, Homeless Health Team, shelters, local addiction services and mental health teams, as well as links with local Emergency Departments (ED) where appropriate.
- Ensure they are aware of local forums and strategies to address SMD.
- Ensure they proactively promote health services to the local community ensuring that they are aware of the range of services available to them.
- Signpost, or refer, as appropriate, to other services or agencies which may include street outreach, homeless health, IAPT and CPN services, community mental health, addiction services.
- Maintain access to an up to date list of available services to facilitate signposting by practice staff.

  SMD & Homeless Information Portal to Support NHS Professionals
  Developed by Changing Futures and Nottingham City GP Alliance to provide advice, guidance and support to practices. Whilst some information is specific to Nottingham City, Nottinghamshire County practices would also benefit from the general information provided.
  NHS Digital Platform: For Professionals (clarity.co.uk)

  https://teamnet.clarity.co.uk/qt1-stp-ncgpa/Topics/View/Details/f26ff332-85f4-4e8b-9b23-aec400e20d99

- Liaise, as requested, with multi-disciplinary teams involved in the care of registered patients.
- Ensure each patient is given, if they wish, information in writing detailing the reason for any tests, how to get the results of the tests, how long they are likely to wait, and who to contact with any queries by the service provider.

Workforce Development

- Facilitate access to training to all practice staff that is appropriate to their role ensuring an understanding of and sensitivity towards the particular problems of people facing SMD. Training should provide staff with a general understanding of the range of problems faced, e.g. access to appropriate housing and problems with benefits, in addition to health issues. It should also include specific training e.g. Psychologically Informed Environment (PIE), Trauma Informed Care (TIC). This may include on-line training and attendance at a regular local Forum, if available.

  Nottingham Practice Development Unit (PDU): A partnership between Opportunity Nottingham and the Nottingham Community & Voluntary Service is available as a free resource for Nottingham & Nottinghamshire GP practices. Practice log-in required.
  https://www.pdunottingham.org

- **If not completed prior to April 2023;** Providers are required to support all staff groups to view the webinar as part of a practice meeting and read the briefing:

  Webinar: Introduction to Multiple Disadvantage (1 hour)
  Delivered by Opportunity Nottingham
  https://www.pdunottingham.org/my-activity/work-streams/multiple-disadvantage/webinar-introduction-to-multiple-disadvantage/

  An Introduction to Psychologically Informed Environments and Trauma Informed Care: Briefing for homelessness services (March 2017). Available via Nottingham PDU website and TeamNet.

  Appendix Two lists resources for practice staff who wish to further their knowledge and understanding of this patient group.

General

- Ensure there are adequate back up / contingency plans in place for key staff absence.
- Provide all premises, staffing, equipment and consumables required to carry out the service
- Ensure that all equipment used is maintained and calibrated in accordance with the manufacturer's guidelines.
- Deal with any complaints received from patients about the service and reporting the complaint and the response to Nottingham & Nottinghamshire ICB. Complaints will be dealt with according to timescales.
- Provide Nottingham & Nottinghamshire ICB with such information as it may reasonably request for the purpose of monitoring performance of the providers obligations under the plan.

3.3 Population covered

The service will be available to adults (aged 16+) who are registered with a Nottingham & Nottinghamshire ICB GP Practice and meet the acceptance criteria.

3.4 Any acceptance and exclusion criteria and thresholds

The service will be available to citizens aged 16 or over registered with a Nottingham & Nottinghamshire ICB GP practice and who are either:

- Homeless: people who are homeless or are 'vulnerably housed' and at significant risk of homelessness – the definition includes rough sleepers, sofa surfers, those of 'no fixed abode' or living in short term hostel or refuge accommodation. This also covers prison leavers who are in approved premises or bail hostels.

- Or Facing SMD: defined as 2 out of 4 of the following criteria:

  - Homelessness; as defined above

  - Mental illness; defined as currently experiencing a mental illness, personality disorder or learning difficulties severe enough to consider referral* for specialist intervention or support (at a higher level than IAPT), within the last 6 months

  - Drug or alcohol use; defined as 'problematic', currently misusing drugs or alcohol requiring offer of referral* to specialist addiction services, or with recent (within the last 6 months) engagement with relevant services

  - Victim of interpersonal violence or abuse; defined as recent (usually within the past 6 months) or historic, victim of significant domestic violence / abuse or coercive control by a partner or ex-partner which represents an ongoing need for specialist intervention or support

*Clarification: 'to consider' or 'requiring offer of' referral into services – patient meets the criteria threshold for referral into specialist services. There will be individuals within this patient group who refuse consent to refer into services and / or there are barriers to access; the patient has recently been discharged due to no contact / engagement (DNA).

The definition does not apply to all patients with a mental health condition and / or a substance misuse problem, but only to those with problems which are **currently active and severe enough to warrant referral or specialist intervention**.

Identifying, registering, and reviewing these patients will be a significant task as part of this LES.

Patients may be identified and registered for the service opportunistically, or by conducting a search of practice computer records. Patients may also be identified through discussion with specialist agencies, e.g. Homeless Health Team. Appendix Three sets out case studies to support the practice in identifying patients facing SMD.

As patients' circumstances change, it is expected that the criteria for acceptance onto this service will be regularly reviewed by the practice against the criteria in this specification, not less than annually, and patients excluded if they no longer meet the threshold. This will be recorded on the clinical computer system and may be audited as detailed under Section 7.

3.5 Interdependence with other services/providers

The service is expected to work closely with other healthcare professionals (this list is not exhaustive):

- Primary care (GPs and Practice Nurses)
- PCN Pharmacy staff and ICB Prescribing Team
- PCN Additional Roles Reimbursement Scheme workforce
- Community healthcare
- Community mental health team
- Homeless agencies
- Homeless nursing team
- Addiction services
- Secondary care, including ED

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

The provider must ensure that they are aware of, compliant with, and can provide evidence if required, to demonstrate compliance with all relevant standards including adherence to the relevant NICE guidelines where applicable.

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

4.3 Applicable local standards

The provider must ensure that they are aware of, compliant with, and can provide evidence if required to demonstrate compliance with all local policies, procedures and guidance. CQC registration is completed and the essential standards achieved. Staff involved in delivering this service should be adequately trained and supervised as determined by the provider and must have suitable indemnity.

Serious Incidents (SI's) and Patient Safety Incidents (PSI's)

It is a condition of participation in this service that providers will report all incidents where a patient has experienced harm that relate to primary care medical services to the appropriate ICB, in line with the Patient Safety Incident Response Framework (PSIRF). Providers and commissioners must engage in open and honest discussions to agree the appropriate and proportionate response. If deemed to be a Serious Incident the incident will be logged by the ICB on the current serious incident management system STEIS (the Strategic Executive Information System) or any other data base as directed by

national guidance.

Safety Alerts
Providers must ensure that they are aware of and have a process in place for managing any safety alerts from the following sources that apply to any equipment or patient safety concerns associated with this enhanced service and that these are acted upon:

- Medicines and Healthcare products Regulatory Agency (MHRA) http://www.mhra.gov.uk/#page=DynamicListMedicines
- Local or national clinical guidance
- National and local formularies

Where requested details of action taken must be reported back to the ICB within the designated timescale.

4.3.1 Infection Prevention and Control

Good infection prevention and prudent antimicrobial use are essential to ensure that people who use health and social care services receive safe and effective care. Effective prevention of infection must be part of everyday practice and be applied consistently by everyone (The Health Act 2008) Registered providers should meet the requirements of The Health and Social Care Act 2008. The provider should:

- Have systems in place to manage and monitor the prevention of infection, including regular audit and training. Infection prevention and control training for all staff every 2 years and hand hygiene yearly for all clinicians
- Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections and meets national estates guidance and local IPC guidance
- Ensure appropriate antimicrobial use to optimize patient outcomes and to reduce the risk of adverse events and antimicrobial resistance
- Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely manner
- Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to others
- Systems to ensure that all care workers are aware of and discharge their responsibilities in the process of preventing and controlling infection
- Provide adequate isolation facilities
- Secure adequate access to laboratory support
- Have and adhere to infection prevention and control policies that are based on national and local guidance
- Have a system in place to manage the occupational health needs and obligations of staff in relation to infection
- Have robust systems and processes in place to manage pandemics at a practice level including the management and reporting of staff outbreaks

Safeguarding
All staff working in this service area will be trained and competent in safeguarding children and adults as outlined in the Intercollegiate Guidance: -

Children: https://www.rcpch.ac.uk/resources/safeguarding-children-young-people-roles-competencies

Adults: https://www.rcn.org.uk/Professional-Development/publications/adult-safeguarding-roles-and-competencies-for-health-care-staff-uk-pub-007-069

Looked After children Looked After Children: Roles and Competencies of Healthcare Staff | Royal College of Nursing (rcn.org.uk)

All staff will comply with Nottingham and Nottinghamshire safeguarding children and adult procedures which can be accessed via these links: -

Safeguarding Children Procedures City & County: https://nottinghamshirescb.proceduresonline.com/

Safeguarding Adult Procedures Nottinghamshire : - https://nsab.nottinghamshire.gov.uk/procedures/

Safeguarding Adult Procedures Nottingham City: - https://www.nottinghamcity.gov.uk/information-for-residents/health-and-social-care/adult-social-care/adult-safeguarding

On the request of the commissioner, the provider will provide evidence to give assurance of compliance with safeguarding standards.

5. Applicable quality requirements

5.1 Applicable quality requirements

The provider will offer an annual review of the patients' social, mental and physical wellbeing and record this on their clinical computer system. This can take place opportunistically and over the course of several encounters.

The quality requirement is that the full review is completed for every patient over the course of 12 months from the point of initial registration for the service, and annually thereafter. The provider will provide evidence, in the form of an audit, or computer search, to demonstrate that this requirement has been met. The audit requirement will be adjusted to reflect that this is a hard to reach group.

6. Location of Provider Premises

The Provider's Premises:
The Service will be provided within the boundaries of Nottingham & Nottinghamshire ICB. Providers must have adequate mechanisms and facilities including premises and equipment as are necessary to enable the proper provision of this service.

Location(s) of Service Delivery
The Provider is required to carry out the service within a recognised primary care setting registered for the purpose of healthcare.

Days/Hours of operation
As a minimum the service will operate Monday to Friday 8am to 6.30pm, GP core opening hours. The service will be expected to provide a variety of clinic times providing choice for the patient and will vary from provider to provider. The provider will be expected to demonstrate flexibility

7. Contract

The contract will run from 1st April 2023 to 31st March 2024 subject to review at nine months (January 2024) at which time the ICB's future commissioning intentions will be confirmed

2023/24 updates following review are highlighted in yellow throughout this document

The notice period is three months for termination under General Condition 17.2 in writing to the Primary Care Commissioning Team nnicb-nn.primarycarenotts@nhs.net

Remuneration and Outcome Measures

Payment
The payment is £120 per patient registered for the SMD service per annum. Payments are made quarterly, in arrears, based on receipt of the quarterly LES Claim Form within deadlines set. The price includes all consumables

Quarterly LES Claim Form Submission Deadlines
Completed claim forms to be submitted by the deadline date to the Primary Care Commissioning Team

nnicb-nn.primarycarenotts@nhs.net

- Q1 deadline 31 July
- Q2 deadline 31 October
- Q3 deadline 31 January
- Q4 deadline 30 April

LES Claim Forms will not be accepted after the deadline date and will lead to loss of practice income.

Quality requirements for quarterly reporting

- Number of SMD patients registered for the service who have been offered annual review assessments (social, physical and mental health) within 12 months of registration / identification for the service and offered annually thereafter.

Information Requirements

- Number of SMD patients registered with GP practice (see above)
- Number of annual review assessments completed within 12 months of registration / identification for the service and annually thereafter (see above)

SMD1: Severe Multiple Disadvantages (SMD)
SystmOne
For SystmOne practices, as part of F12 there is a report for SMD in the F12 Local Enhanced Services Claims folder which make it simple to find the numbers for claiming. These reports show patients coded as below (consider using the F12 LES templates for the service where green stars indicate the codes to add for claiming purposes). The F12 reports *will* account for any current active patients AND any deducted *within* that quarter where you have been caring for them.

EMIS
Unfortunately, EMIS reports cannot be shared centrally in the way we as SystmOne, therefore practices will need to write these searches for themselves currently– the same codes and criteria should be used for reporting purposes, however.

Report Name	Criteria and requirements	F12 Template
HOM1: Patients Assessed	Any patient with a code of (166461000000103*) **added this quarter** ***Note this continues to use the homeless enhanced service code for consistent collection about those homeless and /or with other disadvantages**	SMD Data Entry Template

If you have any queries on the searches or coding, please contact the F12 Team support@nottsf12.freshdesk.com

Providers will be required to:

- Undertake patient satisfaction survey annually. This should include at least a small number of patients registered for this service and cover the registration processes, access to primary medical care and the reception experience.
- Comply with requests from Nottingham & Nottinghamshire ICB to provide information as it may reasonably request for the purposes of monitoring the providers' performance of its obligations under this service
- Participate in an audit relating to this service as requested by Nottingham & Nottinghamshire ICB

Appendix One: Example Health Screening Form

New Pt Health Screening Form - SM

Appendix Two: Additional Resources for Practice Staff

Severe Multiple Disadvantage (SMD) Workshops (Nottingham City Practices)
Funded through Changing Futures and Nottingham City GP Alliance. Short sessions delivered to frontline staff at your practice or workplace. Each session is tailored to individual needs. Group or 1:1 slot from 15 to 60 minutes in length.

Training available:

1. SMD awareness & understanding complex needs
2. How to navigate system one F12 and make referrals to services for complex needs (Changing Futures / City Wrap Around MDT)
3. Customised training request – for example, de-escalation training for receptionists

Target Audience: Nottingham City Practice & PCN Roles

Managed & Delivered By: Mr Martin Marcus, Severe & Multiple Disadvantage (SMD) Practitioner, Head of Social Prescribing - PCN Development 1,3,5,6,7,and 8
To book a slot or for further information Tel: 07587- 826525

Nottingham Practice Development Unit (PDU): A partnership between Opportunity Nottingham and the Nottingham Community & Voluntary Service is available as a free resource for Nottingham & Nottinghamshire GP practices. Practice log-in required.

https://www.pdunottingham.org monthly e-bulletin enquiries@pdunottingham.org

Relevant training and resources are held within the PDU's Workforce Development section under "LES Training Primary Care".

Understanding Severe and Multiple Disadvantage (PDU/Changing Futures Presentation)

This short course is designed to offer primary care staff an introductory understanding of severe and multiple disadvantage (SMD). This will include awareness of current definitions and thresholds of SMD, as well as how this relates to the LES contract. Learners will gain an insight into the local and national picture of SMD and find out what it is like to experience SMD and access mainstream support and services. This also includes an introduction to the PDU learning offer, and the Nottingham Changing Futures Programme.

Additional Videos:
NCGPA Live - Severe Multiple Disadvantage (SMD) Part 1 - YouTube

NCGPA Live - Severe Multiple Disadvantage (SMD) Part 2 - YouTube

Introduction to Psychologically Informed Environment (PIE) + Trauma Informed Care (TIC)

This short course is designed to offer primary care staff an introduction to trauma and psychologically informed approaches improve understanding of how this approach can benefit their practice. Learners will gain an insight into complex trauma and typical trauma responses, as well as awareness of key concepts such as the window of tolerance.

Additional Videos:
Opening Doors: Trauma Informed Practice for the Workforce

Access to Primary Care- What are the barriers? Examples of good practice (PDU/Changing Futures Presentation)

This short course is designed to identify key barriers to primary care access for people experiencing SMD and homelessness, as well as examples of good practice to overcome this. The training draws on recommendations from the National Institute for Health and Care Excellence (NICE) guidance on Integrated health and social care for people experiencing homelessness.

Additional Videos:
Clarissa on Vimeo

Accessing Health Services- Barriers and Success
Video: Mental Health Services; Barriers and Success - YouTube
Video: Lived Experience Video - Sheffield Changing Futures - Sheffield City Council - YouTube

Understanding Stigma
Video: Stop the stigma - YouTube
Video: Less? - a film of personal stories from people who have experienced and overcome homelessness - YouTube

Introducing Trauma Informed Care: Training from Dr Ray Middleton (Jan 2020)
https://www.youtube.com/watch?v=QC_nz-1aHdo

Trevor's Story: A journey from offending to prison to recovery (Nov 2019)
Opportunity Nottingham
https://www.youtube.com/watch?v=il82H0tiCgM

Appendix Three: Example Case Studies to Support Identification of SMD

Case Study One: Ex-Offender

23-year-old, ex-offender recently released from prison placed on a three-year order and arrangements though prison release pathway for him to live at Trent House Probation Hostel in Nottingham, as a Temporary settlement. The service user is under the wider definition of 'Homelessness' identifiable as Severe Multiple and Disadvantage under the criteria of 'living in short term hostel' and coded for example as 'lives in residential hostel'. It is best practice to ask / check residential status and have a list of codes to compare against to hand.

Case Study Two: Support Worker

56-year female, new registration - attends with support worker (flag for patient requiring additional support), upon completion of Health Screening Form and over course of appts identified as SMD.

The patient was involved in a car crash and has experienced flashbacks. She has used alcohol previously, as a coping mechanism. She has symptoms of post-traumatic stress disorder and a referral is put into secondary mental health team, the patient admitted to taking cocaine for the last three months whilst drinking. The patient is taking these even though the increased risks of mixing these substances and the potential correlation on her decline in metal health. The GP records harm reduction advise on the notes, and the referral to a special support service, as the patient is willing to commit to a reduction plan.

The patient can be identified as Severe Multiple and Disadvantage, firstly because as her mental illness is current, and severe enough to consider referral for specialist intervention. The patient's usage of substances is also current, problematic, and a referral to specialist addiction services is discussed.

Case Study Three: Historic Abuse

Dorothy is 59, has type two diabetes, learning difficulties, cognitive impairment, and depression. Dorothy was groomed as a child and is a survivor of sexual abuse. Dorothy is registered as Severe Multiple and Disadvantaged on the patient record due to historic abuse that represents an ongoing need for specialist support, and her learning difficulty.

Dorothy is in supported accommodation and health visitors monitor her care. Dorothy's health is declining and recently had a number emergency care hospital admission.

The specialist geriatric and community nurse have concerns about the last discharge plan, medication side effects and case management. The general practitioner from the practice invites his team members; care coordinator, pharmacist, mental health nurse, and health & wellbeing coach to meet with both health and social care representatives, and community health teams, to coordinate care.