GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales

A Healthier Wales: Improving Equity through the development of Inclusion Health Services

A blueprint for needs-based services for Inclusion Health

Version 1.0

Commissioned by the Welsh Government

Mae'r ddogfen yma ar gael yn y Gymraeg/This document is available in Welsh

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Contents

1 Introduction

1.1 Inclusion health is a concept that describes services designed for people who experience multiple severe and overlapping disadvantage, often finding it difficult to access healthcare despite experiencing extremely poor physical and mental health in comparison to the general population.

1.2 A local Inclusion Service should contribute to an overall plan for the population that considers current universal provision, local need and the options for how needs can be met. Commissioners must ensure that appropriate support services are available to meet the needs of the population and where necessary commission additional support to address service gaps.

1.3 The **aim** of the Inclusion model is to identify and meet the needs of people traditionally excluded from mainstream primary care in a place-based approach and to help individuals integrate into universal Tier 1 services when appropriate.

1.4 The length of time an individual requires the support of an Inclusion Service will vary from person to person, but it is important that regular reviews are undertaken for individuals who are registered to ensure they are receiving care from the most appropriate service.

1.5 This guidance should be read in conjunction with the relevant Welsh Government policy expectations and UK guidance including:

- A Healthier Wales: long term plan for health and social care
- Health and Homeless Standards
- 2018 Guidance for Health Boards on the Health and Wellbeing of Asylum Seekers (soon to be updated)
- Rapid Rehousing Transition Plans: Guidance for Local Authorities and Partners- Developing a Rapid Rehousing Transition Plan 2022-2027
- NICE guideline [NG214]: Overview | Integrated health and social care for people experiencing homelessness | Guidance | NICE

1.6 This guidance outlines additional support that should be considered which is beyond the scope of universal Tier 1 services. Every citizen has the right to register and have their needs recognised within universal services, but where complex support is required more specialist provision may be needed. Please see appendix (5) for description of provision of universal/unified services. Evidence shows that service models specifically designed for people with complex needs with dedicated staff, drop-in clinics and other onsite services can achieve better outcomes.

1.7 No part of this guidance by commission, omission or implication defines or redefines essential or additional services.

1.8 In areas of high and/or complex needs, service provision (tier 2 and tier 3) may be combined as a 'specialised' service. Access criteria for the service and the arrangements for transition between universal (unified), supplementary and specialist tiers must be clearly defined in local plans.

1.9 When planning service models, consideration must be given to the needs of service users for whom access is a critical determinant of their ability to benefit from care. Population needs assessment and mapping of current provision will be key steps in the development of appropriate local plans and delivery by all partners.

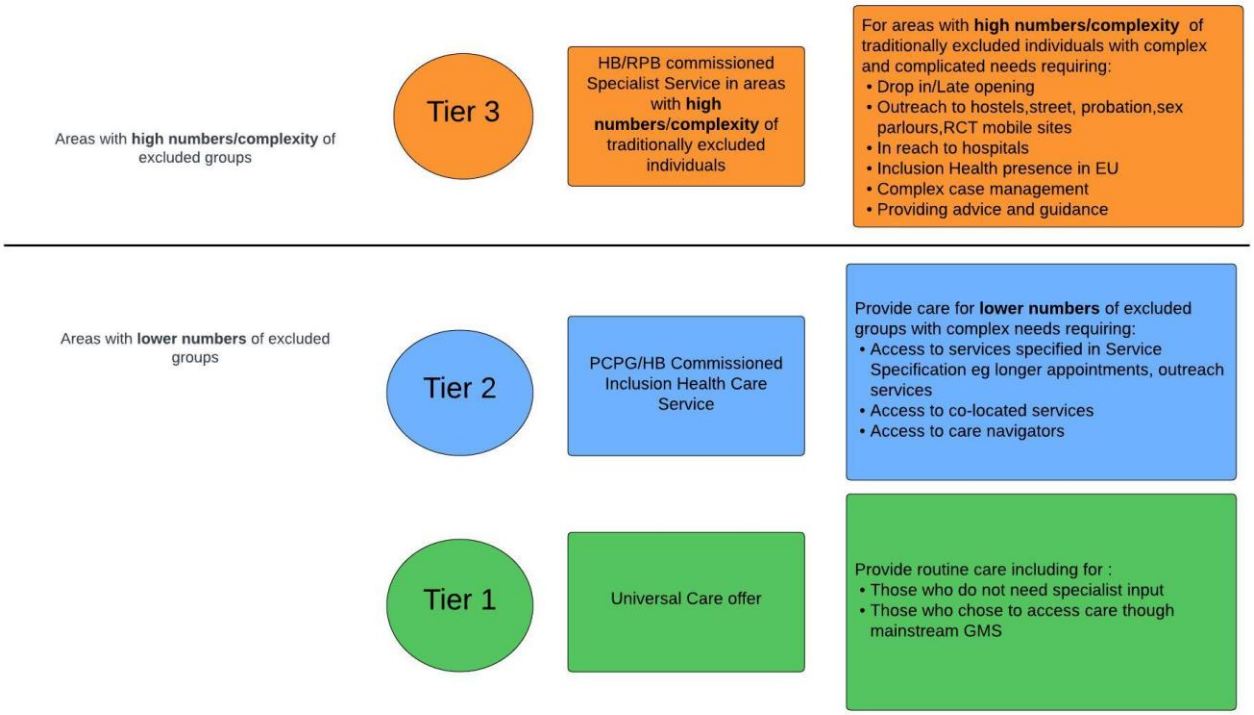

Figure 1 Provision of healthcare at universal (Tier 1), proposed Tier 2 (intermediate)and Tier 3 (Specialist Inclusion Health services).

2 Eligible Populations

2.1 Eligible populations include people who have severe and multiple disadvantages, experience social exclusion and health inequalities:

- People experiencing or at risk of homelessness, including:
  - Those in temporary and unstable accommodation,
  - Young people or care leavers at risk of homelessness.
- People in regular contact with the criminal justice system.
- People seeking asylum, refugees, vulnerable migrant workers and undocumented or trafficked migrants.
- People engaged in sex work.
- Roma, Gypsy and Travelling people.

Appendix 1 describes where more complex needs in these groups will require management in specialist or unified services.

3 Values and Approach

a. Person centered, empathetic and non-judgmental.
b. Continuity of care with trusting respectful relationships formed.
c. Services designed to reduce barriers to access – outreach, self-referral, low threshold, flexible appointment times, one stop shop.
d. Psychologically and trauma informed care and environments.
e. Cultural sensitivity.
f. Exploring 'living well' insights and wishes of the patient promoting shared decision making.

4 Requirements for Inclusion service provision

4.1 Registration and Coding

- An open-door approach to multiply excluded groups with a warm welcome based on the principles of trauma informed care and environments with cultural competence and sensitivity.
- Reception staff to be skilled in their approach acting as the patients' champion or advocate ensuring the most vulnerable can access care.
- Reception staff to be skilled in their approach to de-escalation.
- Register service users without insisting on evidence of identification.
- Allow registration via presenting face to face at reception.
- Allow non 'face to face' registration with GMS1 forms being handed in by support workers or relatives if the individual is unable to attend the surgery to register.
- Provide translation services at reception for example by language line or video translation services.
- Information sharing protocols in place with local services.
- Provide help with filling in registration forms as required and with due care given to privacy.
- Aim for full registration at first consultation unless the patient is already registered with another primary care provider when temporary registration is acceptable. Nurse led community services should have achieved GP registration as a primary goal.
- Place a pop-up alert on the registered individuals' notes identifying them as an individual at risk of exclusion to facilitate timely and appropriate management through the system.
- Code in the clinical notes at registration (as summarised in Appendix 3):
    - Care group
    - Language spoken
    - Literacy levels – is the individual able to read and write?
    - Housing status – such as street homeless, unstable accommodation, temporary accommodation
    - Any support or care needs – documentation and contact details of any support agency worker/key worker.
- Practice information to be given in a format and language that the patient can understand. This may involve easy read versions or translation of practice documents into multiple different languages.

- Patients to be given information on their rights to healthcare and community orientation to emergency, unscheduled care and Out of Hours health services in a format they can understand.
- Patients to be given information about how they can feedback concerns or make a complaint in a format they can understand.
- Consenting patients to be referred into homeless/housing services if present homeless or at risk of homelessness.
- If a person is street homeless, every effort should be made to obtain a 'care of' address, contact and emergency contact details as for all patients. If no 'care of' address is available, the practice to consider using their address as a 'care of' address for health-related correspondence.
- Visibility in the local community as a health inclusion practice with appropriate signage and website.

4.2 Access

- Flexible access arrangements for patients providing opportunity to make appointments by:
  - Presenting at reception
  - Telephone
  - Website
  - Carers/relatives to be able to make appointments on behalf of the patient
  - Individuals support worker (where they have agreed in advance).
- Flexible access to appointments and services providing:
  - Walk in appointments
  - Booked appointments
  - Late opening if appropriate
  - Longer appointment times to account for complexity, a minimum of 20 minutes per patient
  - Proactive and persistent outreach.
- Use communication methods based on the persons preferences and give clear information about contacts, appointments, reminders etc.
- Management of those who miss appointments/DNA (Did not attend) to involve proactive follow up and liaison with other services who are involved in care.
- No punitive action or 'off listing' for those who frequently miss appointments.
- Outreach provision where there is need, for example homeless hostels, community groups, probation offices.
- Availability of care navigators or care managers to assist where appropriate.

5 Healthcare Provision

5.1 Principles of Care

- Holistic primary medical services to include prevention, diagnosis, and management of acute and chronic diseases.
- Offering care with a trauma and psychologically informed approach based on the six principles of trauma informed care: safety, trust, collaboration, empowerment, cultural consideration, and choice.
- Integrated multicomponent care supported by a multidisciplinary team.
- Offering of translation services where needed.

- Extra support for people with low literacy.
- Consider involving an advocate to support communication.
- Time scheduled for a comprehensive holistic nurse led initial health assessment of physical and mental health needs, acute and long-term conditions including examination appropriate for individual need. Baseline investigations including for infectious and chronic diseases with appropriate screening and immunisations to be offered to all if not recently taken place (see appendices 2+3 for assessment tools and coding guidance).[1]
- Time scheduled for clinicians to attend MDT meetings, child protection strategy, adult safeguarding and MARAC meetings as appropriate.
- Training and protocols in place to support active identification and referral of victims of human trafficking and modern slavery using sensitive initial approaches leading to referral to 'first responder' organisations for referral through to the National Referral Mechanism.[2]
- Training and protocols in place to support active identification and referral of victims of human trafficking and modern slavery using sensitive initial approaches leading to referral to 'first responder' organisations for referral through to the National Referral Mechanism.[3]
    - Apply Making Every Contact Count (MECC) and providing on site or bespoke referral to healthy weight, National Diabetes Prevention Programme and smoking cessation as appropriate.
    - Provide access to Social Prescribing in-line with national framework.
    - Review the person's needs, strengths and aspirations whenever their circumstances change, or they request a review.
    - Clinical staff to seek advice and make onward referrals to specialist care as appropriate.

5.2 Clinical Aspects

- Offering of health protection screening as appropriate to the individual and their situation (appendices 1 and 2) This could include BBV, STI, TB and parasitic screening.
- Shared integrated Healthcare plan documented from the initial assessment.
- Completion and provision of catch-up immunisations and annual programmes.
- Sexual Health and family planning onsite or bespoke pathways.
- Enhanced requirements:
    - Provision of Hepatitis B and Hepatitis A vaccination where appropriate,
    - Provision of yearly public health vaccination programmes.
- Proactive approach in engaging service users with routine screening programmes such as bowel screening, cervical screening, breast screening.
- Holistic alcohol and substance use management services.

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[2] Approximately 1 hour recommended for all including for newly arrived asylum seekers or refugees who have not been through health assessment prior to being placed locally by the Home Office.

[2] National Referral Mechanism Guidance: https://www.gov.uk/government/publications/human-trafficking-victims-referral-and-assessment-forms/guidance-on-the-national-referral-mechanism-for-potential-adult-victims-of-modern-slavery-england-and-wales#Section-9

- Proactive approach in engaging service users in harm reduction strategies.
- Opioid Substitution Treatment prescribing (if not present on site, the development of seamless links and bespoke pathways) with linked mental health support.
- Provide access to Social Prescribing in-line with national framework.
- Review the person's needs, strengths and aspirations whenever their circumstances change, or they request a review.
- Clinical staff to seek advice and make onward referrals to specialist care as appropriate.
- Regular MDTs with all those involved in frontline care to offer wrap around health and social care support and reflective practice.

6 Planned Registration and Transfer to Universal Services

- Annual review of all registered individuals to ensure they are receiving care from an appropriately tiered service.
- Timely discharge from Health Inclusion Service into universal services where appropriate.
- A comprehensive discharge summary completed with any outstanding actions or needs highlighted. This document to be shared with the GMS practice and uploaded to the Welsh Clinical Portal.
- Access to care coordinators/care navigators/peer mentor programs to facilitate registration in GMS and to support the 'settling in' period.
- Availability for advice and acceptance of transfers where transfers into GMS has not been successful or sustained.

7 Partnership Approach

7.1 Development of good working relationships with partners in health to provide in-reach clinics co-located in the practice as needed or bespoke referral pathways and easy lines of communication:

- Counselling/Psychology services
- Community Mental Health Teams
- Primary Mental Health Services including care for those with complex Post Traumatic Stress
- Substance misuse services
- Infectious Disease services including Tuberculosis (TB)
- Sexual health and family planning
- Sexual assault and referral centres
- Unscheduled care service such as Emergency Units/Out of Hours
- Chronic pain services
- Musculo Skeletal Services
- Podiatry
- Optometry
- Dietetics
- Oral Health Care and Dentistry
- Occupational Health
- Trauma informed physiotherapy services
- Midwifery services
- Health Visiting services.
- Collaboration with case tracking, contact tracing, community treatment and public health measures including TB, HIV, Hepatitis C
- Wound Care Team
- Speech and Language Therapy
- Health Promotion Services (smoking cessation, Healthy weight etc)

7.2 Development of good working relationships ideally collocated in multi hub centres with cross sector partners who are providing the full range of health, benefits, and housing support. If possible, providing in and outreach services or bespoke referral pathways and easy lines of communication:

- Social Care and Housing
- DWP
- Debt Advice
- Legal advice
- Citizen's advice
- Home Office
- Home Office accommodation providers
- Prison service and Probation
- Police
- Appropriate third sector partners
- Recognising that statutory services, third sector and advocacy services may have different roles within these broad headings

7.3 For people who struggle to engage with services develop a long-term engagement plan giving priority to building trust through taking time with a person, having regular contact, ensuring consistency of practitioner aiming to meet expressed needs.

8 Education and Skills required

8.1 Clinicians who provide Inclusion services should reflect on their learning needs in relation to this service and ensure that those are discussed at appraisal and addressed through their personal development plan.

8.2 Clinical staff must maintain and update knowledge in relation to the health and social care issues faced by those who are traditionally excluded with particular attention to safeguarding, substance use, mental health and traumatic stress, infectious disease, and unmanaged chronic diseases.

8.3 Commissioners and service leads should consider and support the education and training needs of team members. The education and training should cover the following broad domain areas:

- Person-centeredness
- Communication
- Collaboration
- Evidence-informed practice
- Personal Conduct

8.4 Support undergraduate and postgraduate training of medical and allied Health professionals developing links with professional bodies promoting Inclusion Healthcare as an attractive career choice for staff.

9 Clinical Governance

9.1 Services must have robust processes to ensure quality and safety of provision. This must include regular reviews of:

- Service user experience and patient and public engagement

- Patient concerns, complaints, and compliments
- Near misses and significant events
- Clinical audits
- Service Risk Register

9.2 Organisations undertaking service reviews may wish to use the Inclusion Health Self-Assessment Tool to audit engagement with service users[4]. Service providers complete a self-assessment template against 9 core values of the Standards. This can be followed by a peer appraisal visit by a clinician, a service user and a faculty moderator who rate the practice as "aspiring", "achieving" or "excellent" against each of the values.

10 Key Service Outcomes / Auditable Standards Suggested by Pathway/ Faculty standards:

10.1 The measures described are not an exhaustive list. Adaptations will need to be made based on the specific demographics and services in local areas.

10.2 Information required to manage the service:

a. Numbers of individuals registered and supported within each service user group using agreed codes for specific inclusion groups.

b. Number of individuals seen in the last 12 months.

c. Number of individuals permanently registered.

d. Number of individuals temporarily registered.

e. Patient demographics checked and any multiple NHS numbers consolidated.

f. Documentation of next of kin and how best to contact the patient including any 'care of' address.

g. Country of birth, ethnicity and language spoken documented and coded.

h. Literacy levels.

i. Coding of housing status.

j. Documentation of immigration status such as 'asylum seeker' refugee, undocumented or 'no recourse to public funds' as an indicator of potential vulnerability.

k. Number of multi-agency review meeting attended.

[4] Welcome to the VCSE Inclusion Health Audit Tool! (inclusion-health.org)

l. Translation services offered as routine.

m. Information provided in different languages.

n. Outreach clinics in suitable settings where target population are likely to be e.g., probation offices, temporary housing, drop-in centers, traveller sites

o. Assertive outreach for non-engaged individuals using MH and Safeguarding alerts for adults not attending appointments or refusing care

p. Reflection on the standards for specific group

q. Drop-in clinics.

10.3 Quality Indicators:

a. Number of or percentage of appointments provided on the same day as requested.

b. All staff trained in trauma/psychologically informed care.

c. Patients seen within psychologically informed environments.

d. Co-location of partner services

e. Regular service user engagement in planning and evaluation

f. Proportion of cases with a recorded personalised care plan including referrals made to statutory services and third sector organisations.

g. Uptake of routine screening; percentage of individuals up to date with breast, cervical, bowel and retinal screening as advised.

h. Active identification and management of chronic diseases

i. Proportion of caseload discharged to registration in universal GMS services each year with a discharge summary completed and uploaded to Welsh Clinical Portal

j. Proportion of immunisation schedules completed including catch up immunisations and others as appropriate, e.g. Hepatitis B, Flu etc.

k. Number of individuals with a mental health review in the last year

l. Proportion of individuals screened for BBV and proportion positive.

m. Proportion of individuals screened for STI and proportion positive.

n. Proportion of individuals screened for Latent and Active TB and proportion positive.

o. Proportion of individuals using opiates receiving opiate substitution therapy

p. Number of individuals in receipt of Long-acting reversible contraception

q. Streamline care pathways e.g. oral healthcare

10.4 Secondary Outcomes:

These outcome measures can be selected to support personalised care plans for service users. They demonstrate the wider impact of a health inclusion service beyond the health-related outcome measurements.

Secondary outcomes include:

1) Healthy Relationships with family, friends, and peers. Connected into local community. Not feeling isolated.
2) Feeling Safe from emotional or physical abuse in home, accommodation, and environment
3) Independence and control over day-to-day life with money management skills and practical skills to live independently.
4) Engagement in meaningful activity that contributes to wellbeing.
5) Active management of physical health including ability to access physical health care.
6) Managing impact of dependency/substance use to reduce associated harms and accessing support to do this where needed.
7) Positive mental Health and wellbeing management, optimism and resilience to cope with day-to-day stresses.

The above outcomes can be measure on a simple 1-5 Likert scale:

1) None of the time
2) Rarely
3) Some of the time
4) Often
5) All the time

11 Services Reviews

There should be regular reviews of provision and outcomes. A focus on service user and professional experience will help to highlight the shared aims of all agencies to reduce inequity and improve population health. Collaborative reviews should include: -

- Evidence of service user involvement in planning and evaluation of services
- A summary of service developments
- Service outcomes
- Regular assessment of gaps in service provision and feedback to the Pan Cluster Planning Groups to inform the local risk register and continual service improvement/development.

Appendix 1: Complex needs requiring Specialist Service Provision and/or Complex Case Management

1. People experiencing Homelessness who are multiply excluded
    - Multiple Exclusion Homelessness (MEH) is defined as: homeless and experiencing one or more of the following domains of deep social exclusion:
    - Institutional care (prison, local authority)
    - Substance misuse
    - Street culture activities (street drinking, begging, survival shoplifting or sex work)

2. Prison Leavers
    - Individuals who go through a regular cycle of admission and discharge from secure estates with rapidly changing accommodation under short term sentencing probation teams
    - Individuals leaving prison who are discharged into homelessness / front line temporary homeless accommodation.
    - Individuals leaving prison who are known to the Homeless services and Single Persons Gateway

3. People seeking asylum and Refugees (Initial public health and health screening to be offered to all)
    - Individuals seeking asylum who are under section 98 of the Immigration and Asylum Act 1999
    - Individuals seeking asylum who are under section 95 of the Immigration and Asylum Act 1999 but who are not stable enough or too vulnerable to be able to navigate traditional GMS, e.g., those with active infectious disease who DNA and present a risk to themselves and a public health risk, those with deteriorating mental health linked to asylum system and need co-located 3rd sector support, those with active safeguarding problems involving linking in with multiple external partners.
    - Destitute asylum seekers
    - Individuals with 'No recourse to public funds' because their application for asylum has been turned down, but who have not been repatriated.

4. People engaged in high-risk sex work (can be trafficked individuals whose passport has been confiscated by their 'guardian'):
    - Those engaged in street-based sex work
    - Those working in sex parlors with unclear immigration status and fear of authorities/Home Office
    - Sex workers experiencing homelessness.
    - Sex workers with substance misuse problems

5. Roma, Traveller and Travelling people:
    - Those will mobile lifestyles who camp for short periods of time before moving on and experience fear of discrimination, stigma from authorities and the public.

Appendix 2: Health Equity and Inclusion Health Self – Assessment Toolkit for Primary Care

This toolkit is designed to help those working in or with primary care to consider inequalities in all areas of planning and/ or implementation of services, programmes, or specific and targeted interventions.

Place based primary care; inclusion health services tool is for colleagues responsible for planning, delivering, or commissioning inclusion health services.

Appendix 3: Inclusion Health Services Clinical Coding

Category	Coding options	Comments
Experiencing or at severe risk of Homelessness	The code for Homeless: 13D.11 The code for Sofa surfer/NFA: *13D7	There is no code for 'at risk of homelessness'. There may be confusion as homeless doesn't just mean sleeping rough Could be coded as homeless if they are in Temporary/hostel accommodation and those who are sofa surfing or sleeping rough coded as so?
People in contact with the criminal justice system	On probation: *03A5 Prison Sentence: 13HQ. Problems related to release from prison: *ZV4J5	not all will be on probation… perhaps 'prison sentence' would be the best one as it covers all?
People seeking asylum, refugees, vulnerable migrant workers, and undocumented migrants.	Refugee: 13ZB.00 Asylum Seeker: 13ZN.00 Victim of Human Trafficking: *14XF. Vulnerable Adult: *133P.	There are no codes for vulnerable migrant worker or undocumented migrant, could they be coded as vulnerable?
Person engaged in ~~lower risk~~ sex work	Sex worker *QAL..	This is then coded as an occupation specifically; the other option is 'prostitutes' which is not the term to use!
Roma, Gypsy or Travelling person	Roma Ethnic Group: *9TC..Traveller/Gypsy: 9TC..	It would depend how the patient identifies.

Appendix 4: Inclusion Health Service Resources

Classification of vulnerable groups
https://scanmail.trustwave.com/?c=261&d=-PG44sS2TXFSGiWcfGrn5eSCH9tX4jeDX98niAozfA&u=https%3a%2f%2fwww%2encbi%2enlm%2enih%2egov%2fbooks%2fNBK435787%2f Exploring levers and barriers to accessing primary care for marginalised groups and identifying their priorities for primary care provision: a participatory learning and action research study | International Journal for Equity in Health | Full Text (biomedcentral.com)
Homelessness
Overview | Integrated health and social care for people experiencing homelessness | Guidance | NICE Integrated health and social care for people experiencing homelessness | Health topics A to Z | CKS | NICE https://phw.nhs.wales/publications/publications1/health-of-individuals-with-lived-experience-of-homelessness-in-wales-during-the-covid-19-pandemic-report/ ending-homelessness-high-level-action-plan-2021-to-2026.pdf (gov.wales)
Prison discharge
Microsoft Word - PCN_manuscript (qub.ac.uk) Who can help? (prisonreformtrust.org.uk)
Refugees
HEAR-Report-ES-English-FINAL.pdf (phwwhocc.co.uk) Sanctuary | Health and well-being (gov.wales) Caring for trafficked persons https://publications.iom.int/system/files/pdf/ct_handbook.pdf
Substance misuse
https://sbuhb.nhs.wales/about-us/key-documents-folder/quality-and-safety-committee-papers/quality-safety-committe-september-2020/3-4-appendix-1-pdf/
Traveller communities
travelling-to-better-health.pdf (gov.wales)
Trauma Informed Care
The Trauma- Informed Framework provides a Wales definition of trauma-informed approach
Welsh language: delivery of services in the Welsh Language for vulnerable groups


Appendix 5: Excerpts from NICE guidance and Faculty of Inclusion Health

BOX 1 - UNIVERSAL SERVICES:
All primary care practitioners in all settings should:

- Provide care of the same standard and quality as others in the general population.
- Be aware of the impact of their experience and the health problems that are common.
- Promote shared decision-making.
- Consider providing a psychologically informed environment and trauma-informed care.
- Consider the person's capacity, rights to autonomy and self-determination, and any safeguarding issues.
- Involve peers or advocates as appropriate.
- Recognize that long-term support will be required to promote recovery, stability, and lasting positive outcomes.

Universal services reception standards (reference Standards for Commissioners and Users, Faculty of Inclusion Health).

- Receptionists should be the patients' champion, ensuring that the most vulnerable patients in a practice's catchment area are able to access care.
- If a patient does not have ID this should not be a barrier to registration. Refusal of registration should occur only if a practice list is closed or may be given if a patient lives out of area and the practice feels unable to accommodate this. All registration refusals should be recorded, and the patient should be given a letter to evidence the refusal.
- Receptionists should routinely ask if patients need assistance to fill in forms, and give help as required.
- Homelessness should be identified as early as possible in the registration and recorded in the records.
- Even if a patient is street homeless every effort should be made to obtain a "care of" address, contact and emergency contact details, as for all patients.
- Every effort should be made to assist patients to be able to obtain and attend appointments with ease. Consideration should be made of personal or organisational barriers that may exist because of language or literacy issues; mental health or addiction problems; lack of access to a phone/credit; or individual difficulties, e.g. the patient having a dog that they cannot leave.
- Patients should be made aware that they can bring support workers with them to appointments (and/or be referred to peer advocacy services as appropriate).
- Professional interpreting services should be used unless a patient is fluent in English. Interpreting services should be used in preference to family or friends, and face-to-face interpreting should be used in preference to phone interpreting wherever possible.
- Longer appointments should be routinely offered to all with communication difficulties and/or complex needs.
- Practice staff should become familiar with common cultural practices found in the practice population and develop practice protocols to accommodate these.
- Leaflets signposting homelessness and other relevant services, in simple language, should be available within practice.

Appendix 6: Codes/descriptions for Homelessness

Legally there are four states of housing or homelessness:

- Not homeless (i.e. have a home)
- Homeless but ineligible (i.e. due to immigration status).
- At risk of homelessness; and
- Homeless

There is a subset of homeless or 'street homeless' which could be viewed as the following:

- At risk of homelessness (this includes people who have been assessed as at risk of homelessness within 56 days (see page 366 for clarity). Could also include people who are being supported by Housing First (often presenting with multiple, complex needs and have experienced significant periods of sleeping rough and, although in permanent accommodation, are still 'at risk' due to circumstances)
- Homeless – in temp/emergency accommodation
- Homeless – street homeless
- Homeless – sofa surfing
- Homeless – homeless at home

Appendix 7 Glossary

BBV	Blood Borne Virus
DNA	Did not attend
DWP	Department for Work and Pensions
GMS	General Medical Services
MEH	Multiple Exclusion Homelessness
MDT	Multi-Disciplinary Team
MECC	Making Every Contact Count
OOH	Out of Hours
PCPG	Pan Cluster Planning Group
RPB	Regional Partnership Board
STI	Sexually Transmitted Infection
TB	Tuberculosis

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Gweithio gyda'n gilydd i greu Cymru iachach

Working together for a healthier Wales