Promising Practice

Enabling better access to primary care for vulnerable populations – examples of good local practice

Acknowledgements

My thanks to Peter Aspinall, author of ***"Inclusive Practice***", and to members of the Data and Research Working Group. Especial thanks to all those busy staff who took the time to provide vital information and comment on the case studies cited.

Foreword

"Trust one who has gone through it"

Virgil, The Aeneid"

Promising Practice", was commissioned and overseen by the Data and Research Working Group of the Inclusion Health programme and approved for publication by the National Inclusion Health Board. It is one of a series of reports from the Inclusion Health programme which has been committed to making the invisible needs of four of the country's most vulnerable groups visible and promoting evidence-based changes in the system in order to reduce inequity in health service access and outcomes.

It is a privilege to present the five case studies of "*Promising Practice*" within this report. They are truly designed with their vulnerable users' needs in mind. They are clearly not the only examples of dedication and commitment to high quality care for some of our most disadvantaged communities, but they have been selected because they reflect key elements of good practice cited in an independent review of the literature: ***"Inclusive Practice***"- that is also part of the Inclusion Health Programme. Many more examples exist around the country, largely unsung and invisible - reflecting perhaps the lack of power of the people they serve. The case studies presented here are not just remarkable for their accessibility and quality of service, but also for their tenacity and ability to keep going during the stormy seas of system reform. An outstanding feature central to their success is in earning the trust of their users through effective engagement, good training, and expert care.

I hope this report will help both commissioners and providers to emulate these excellent examples where they are most needed.

Dr Bobbie Jacobson OBE

Chair, Data and Research Working group

National Inclusion Health Board.

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Background and introduction

Four vulnerable and excluded groups have been prioritised by the National Inclusion Health Board, as they experience some of the poorest health prospects of all disadvantaged groups. They are:

- *Vulnerable migrants, including asylum seekers and refugees*
- *Gypsies and Travellers, including Irish and Roma groups*
- *People who are homeless, including those sleeping rough or in transient accommodation*
- *Sex workers*

The National Inclusion Health Board (NIHB) was established in 2010 to coordinate and drive work to enhance the health outcomes for the four groups and to promote improved equity of access to health care.

Identifying gaps in our knowledge and approaches and health interventions that work on the ground

The Data and Research Group of the NIHB was asked to examine evidence of good practice and identify gaps in the collection, reporting and analysis of data about use of health services by the four groups. Independently-led research found a number of troubling gaps in the data as well as a few under-used sources of good information. This work has been summarised in a report ***Hidden Needs***, https://www.gov.uk/government/publications/effective-health-care-for-vulnerable-groups-prevented-by-data-gaps

A second major report, ***Inclusive Practice (URL TBCby DH)***, undertook a comprehensive survey of the literature on evidence of local models that can improve access to primary care and prevent avoidable hospital use. Examples in this short report build on and update those drawn from ***Inclusive Practice*** through discussions with local services.

The focus of "Promising Practice'

This short report focuses on models of primary care that are designed to promote registration with and access to good primary and continuing care on an equitable basis. It highlights the components of good practice identified in ***Inclusive Practice*** for the four groups and explains why the chosen approaches are successful in enhancing access to primary care. Measuring the health impact of such models on local patients and on local hospital use has not often been addressed, but the Department of Health's Policy Research Programme is currently commissioning further much-needed research on the effectiveness/cost-effectiveness of the different models of current service; for individual or combined vulnerable groups. The examples we have chosen reflect promising approaches, but are also selected because they provide snapshots of sustainable services that are still in place in 2014 after a period of great change in the English health system. They demonstrate characteristics that appear to be critical for success as defined in the literature (See also Appendix 1).

Supporting Vulnerable Migrants

Vulnerable migrants – elements of good practice identified

- Promising service models (eg in London, Sheffield, Nottingham) feature strong elements of good practice, though they are mainly without robust evaluation
- Bi-lingual health advocates are used to reach vulnerable groups
- "Locally Enhanced Schemes" (LES) and other 'levers' harness local GPs in improving registration
- "New entrant" schemes facilitate registration/access – for instance, bussing new arrivals from induction/ reception centres to health centres

Case Study 1: The Sheffield health mini-bus and The Mulberry Practice)

http://www.sct.nhs.uk/our-services/clover-group/Mulberry

This is a multi-agency approach, which those involved believe is the only model of its kind in England and Wales. On the health side, the Mulberry practice in the centre of the city, based in the Central Health Clinic in Mulberry Street. It is an NHS-funded aPMS practice. ***It serves asylum seekers, as well as victims of trafficking and the homeless.***

Its staff work with the housing providers (G4S), which provide accommodation for all new asylum seekers when they first arrive in Sheffield. The Mulberry practice is provided with lists of names of new arrivals on a weekly basis and a mini-bus service picks up those who wish to register with the practice from their accommodation to Mulberry Street for an initial appointment, assessment and full screening which leads to NHS registration and continuing primary care. All registrations are permanent.

The mini-bus service was, for several years, operated by Sheffield City Council, originally provided the majority of asylum seeker accommodation in the city. G4S has now taken over this responsibility.

The mini-bus arrangement was first established in 2002 and caters solely for asylum seekers. The number of asylum seekers dropped for a time but, in recent times, there has been an increase. Although some GP practices have asylum seekers registered with them, the Mulberry Practice is a city-wide service with no practice boundary. It therefore has the majority and deals with all those brought in by the mini-bus, as well as those who make their own way.

Mulberry Practice offers a full range of primary care services, with language support,

and its GPs, nurses and support staff are highly experienced in meeting the needs of asylum seekers. What sets it apart from similar practices in other cities, though, according to Julie Mather, its practice manager, is the mini-bus arrangement. "We believe we are the only ones doing this and it's a shame it isn't more common. In our experience, it is vital to reach new arrivals *at the time they enter the city*, to ensure appropriate and comprehensive access to health care and immunisation and screening. We believe we capture a substantial number of new asylum seekers supporting public health and meeting the complex needs of this client group."

Contact Julie Mather on 0114 305 1929 or at julie.mather1@nhs.net

(see also Case study 4 below: Health E1 Homeless medical Care also supports homeless asylum seekers)

Supporting Gypsies and Travellers

Gypsies and Travellers – Elements of good practice

- Gypsy/Traveller engagement and costed into the design and delivery of services
- Building confidence in NHS core care through a named "trusted" professional
- GP contract levers can be used to deliver an enhanced care model
- Hand-held records for patients are viewed as good practice-although the evidence is mixed

Case Study 2: The Market Harborough Medical Practice, Leicestershire

http://www.marketharboroughmedicalcentre.co.uk/

This is a mainstream GP practice in a busy market town in south Leicestershire, close to the Northamptonshire border. Through local NHS funding arrangements, ***it offers an enhanced service to Gypsy and Traveller communities.*** This enhanced service, which began eight years ago, meets the needs of people on two large Traveller sites close to the A6 near Market Harborough. The focal point, after registration of patients, is a nurse-led minor illness clinic.

Market Harborough's success has been founded on hard work over a number of years to build trust in its service among travelling communities, particularly at the two major sites. This has involved practice nurses and community health visitors

regularly going to the sites, introducing themselves, and encouraging families to register. Over the years, all staff at the practice have been trained in the health needs of the Gypsy and Traveller communities. A major challenge to be overcome in the early year was to match patients – who might have used several names – to NHS numbers. Market Harborough staff have become self-trained experts in this area.

New registrations grew rapidly in the early years and have now tailed off because many people are effectively permanent residents of the sites. (It is thought about 80 per cent of those on the sites in 2013 lived there most of the year and the practice believes it has registered virtually all of the permanent residents.) In the summer months, many travel to find work. Equally, there is a constant flow of relatives from elsewhere in the country visiting the sites. Permanent local residents are registered permanently, whilst visitors are welcome to register on a temporary basis. In January 2014, there were 198 permanent registrations and 54 temporary registrations from the two traveller sites, as well as a few people living in houses in Market Harborough who have their ethnic origin recorded as Gypsy or Traveller.
Permanent site residents who travel at times are offered hand-held health record print-outs to take with them when they travel. However the practice reports that some prefer to drive hundreds of miles back to Market Harborough if they need a doctor or primary care practitioner. Sarah Parker, senior nurse in the minor illness clinic, says building trust was critical. “I drove to the sites in my uniform, in my Shogun, and at first we’d talk about vehicles, or delivering puppies or whatever. Gradually, though, I’d be recognised, trusted and welcomed. If a local Traveller dies, a nurse will attend the funeral in uniform. We now have many families registered, which is good for immunization. We’ve learned to be sensitive to the particular needs of our patients – for instance, the reluctance of some women to discuss health matters in the presence of men.”

The Medical Centre takes a “more relaxed” position on appointments with Travellers, if they turn up without an appointment. Rather than forcing them to make an appointment, staff will see them at the end of the clinic - an arrangement that works well and suits both parties, according to staff.

(CONTACT: David Bell, Medical Centre business manager, on 01858 464242 or at David.Bell@GP-C82009.nhs.uk)

Supporting Homeless People

Homeless people: elements of good practice identified

- **Multidisciplinary care across sectors**
- **Person-centred care**
- **Service user engagement and influence**
- **Inclusion of linked primary, hospital and respite services**
- **Coordinated care and effective discharge planning in hospital**
- **Specialist services/facilities in areas serving high concentrations of homeless people**

Case Study 3: York Street health practice, Leeds.

http://www.homelessuk.org/details.asp?id=UK29595

Based in Leeds city centre, close to the bus station, the York Street practice was created three years ago from the merger of previously separate services for homeless people and asylum seekers - as there was a 'cross-over in destitution'. ***It currently serves those groups exclusively*** but is working with partners in the city to create inclusive health services specifically for sex workers and Gypsies and Travellers. Its patient list has grown to around 1200, around one third asylum seekers. Its registrations are permanent. Most patients are men, aged 25-40. York Street has historically been a 16+only practice, but is piloting services for children, particularly of asylum seekers. It is currently an Alternative Provider of Medical Services (APMS) under the NHS, with its drugs and alcohol teams commissioned by the local authority. York Street offers the full range of medical/health care to be found in a standard general practice, but also provides specialised mental health and alcohol and drug treatment services, therapeutic interventions and substitute prescribing for heroin and crack cocaine. It also provides – free – a welfare rights clinic; physiotherapy; psychological care; legal clinics and housing advice. The service works closely with a social worker to provide integrated care plans for users. Workers provide outreach clinics in a number of partner agencies, but also work with clients from cafes and on the streets.

Catherine Hall, head of service, says: "We know that homeless people find it very difficult if you refer them out of the building to another service. And it's unlikely that they will get there. We have tried to bring as many services as we can under one roof, so people don't hear the word referral. They are literally sent down the corridor to a different door. We try to offer appointments on the day. Sometimes we have to tell people we can't fit them in but mostly they are able to see someone. We may de-register a permanently housed and stable person, but we keep those with a history of only staying stable for a while. We are close to agencies who work with our patients, who mostly come to us through word of mouth."

York Street's success is built on being accessible - with repeat prescriptions requested in the morning available in the afternoon, for instance - and strong relationships with patients. There is a focus on 'welcome and wellbeing', for both patients and staff. Catherine Hall says: "We know some patients have been through significant trauma in their lives. Our approach is to be welcoming and non-judgmental, to build trust. In user-groups patients say we are like family."

(CONTACT:http://www.leedscommunityhealthcare.nhs.uk/our_services_az/york_street_health_practice/ or yorksteet@nhs.net, Catherine.Hall@nhs.net or 0113 295 4840)

Case Study 4. Health E1 Homeless Medical Centre, London

Based at 9-11 Brick Lane, in Tower Hamlets in East London

http://www.homelessuk.org/feedback.asp?HUKid=UK29595

Based at 9-11 Brick Lane, in Tower Hamlets in East London, this is a well-established medical centre catering **exclusively for homeless people, including homeless migrants,** and attempting to address their primary, mental healthcare and substance misuse needs.

The practice has a list of around 1600 patients, mostly hostel dwellers, those in temporary accommodation, and street homeless people – the most vulnerable groups – as well as a number of homeless and destitute asylum seekers. Most remain registered, as there is often a cycle of stability followed by relapse into vulnerability. Its 'catchment area' is Tower Hamlets and London E1, though it now has links with a similar specialist practice in neighbouring Hackney – The Greenhouse Practice.

Health E1 produces leaflets but, mostly, its patients know of it through word-of-mouth. It has close links with local hostels, day centres and charities working with

homeless people. It registers patients fully and provides interpreting services as its list is truly multi-national, with people from – among others - Britain, Ireland, Eastern Europe, China and Africa.

The Practice runs a combination of open access (walk-in) clinics, along with booked appointments, as this flexible approach best suits the needs of people who often find it difficult to keep to rigid timetabling and appointments.

Health E1 is a nurse-led practice with nurses and GPs who specialise particularly in mental health and substance misuse. It offers drug, alcohol and mental health services including psychological and psychiatric care; blood-borne virus checks and treatment; as well as treatment for other chronic diseases such as diabetes, chronic heart disease and asthma. These may, in the past, have gone untreated or, if exacerbated, led to visits to an A&E department. The practice works with prison and the criminal justice system so it can carry on vital treatment for those who have been recently released from prison.

There is a recognition that dealing with destitute or homeless people can be demanding. Staff at all levels, though, are trained to understand and meet the needs of patients, some of whom may have suffered significant trauma in their lives. Amanda Troughton, the practice manager, says: "The keys are trust and expertise. Some people feel they have not been treated well elsewhere, but we are welcoming and non-judgemental. We've been going since 2000 and we have a stable staff, so we have a lot of experience and knowledge about our patients' needs. They trust us and often tell us how pleased they are that we are here for them."

(CONTACT: www.healthe1practice.nhs.uk or Amanda.troughton@nhs.net, and on 020 7247 0090.)

Supporting Sex Workers

Sex workers – elements of good practice identified

- Sustainable, joined up multi-agency services covering general health and personal safety, as well as specific health needs
- Good access to specialist medical and other staff
- Active, non-judgemental engagement with sex workers and their key networks

Case Study 5. The Armistead Street night time health outreach model, Liverpool)

http://www.armiSteadcentre.co.uk

The night time Armistead Street health outreach modelis the primary health care dimension of the overall Armistead project, which is based at The Beat Centre, Hanover Street, Liverpool 1, and offers a wide range of support services under the banner of "a free and confidential sexual health promotion service for Gay, Bisexual and Transgender people and for male and female sex workers."

Armistead Street describes itself as a 'bespoke primary and social care provision' that operates through three outreach sessions per week in the Liverpool area. Non-medical staff from Armistead Street go out to areas of the city three nights a week to talk to sex workers. Their aim is to 'reduce the barriers to accessing primary care' by inviting the women and men they meet on the streets to visit the Beat Centre where they can receive a range a health care services. In some cases, if the health problems are acute, they may take the individual immediately to the local A&E.

The three out-reach sessions generate a great deal of follow-up work at the Armistead/Beat Centre, where sex workers' needs are assessed and treatment is provided and/or patients are referred for more specialist care. The service is nurse-led but those who use the service can see a GP for general health needs. They can access mental health care, be assessed for drug treatment and gain access to specialised sexual health services. Staff also act as advocates for patients and users of the service in helping them with continued GP care or visits to hospital.

Armistead staff place particular emphasis on giving sex workers access to preventive care for HIV. This includes a proactive focus on what is known as "post-exposure prophlaxis treatment (PEP)" after possible exposure to the HIV virus in sex work. PEP , if given within 72 hours after HIV exposure, can help protect the health of their patients, as well as potentially save the health service substantial sums of money which might otherwise have been spent on treating HIV disease. .

At times, Armistead helps individuals to register with GPs. However, ensuring access to primary health care *when it is needed by people working on the streets* is the primary aim, rather than increasing the numbers registered. (Some individuals lead such 'chaotic' lifestyles that registration makes little difference; others *are* already registered, but do not want to approach the family GP and disclose health problems associated with sex work.)

This reflects the reality that the primary care health outreach work is part of a truly multi-agency, holistic approach in Liverpool. The Armistead outreach model is NHS-led but staff work closely with the city council, for housing and hostel provision, a range of other agencies - and Merseyside Police. Rape and violence are daily threats to sex workers and there is considerable support for the local police policy that treats violence against sex workers as a hate crime. This approach – to be used nationally as good practice – has led to increased reporting of violence. Armistead staff say that police receiving these reports advise individuals of the primary health care available at Armistead.

The Armistead Street health model, in its evolving forms over recent years, has built up considerable expertise on the health needs and life-styles of sex workers and staff have been able to share important knowledge with Accident and Emergency doctors, nurses, and reception personnel.

(Contact**: Louise Benson, Armistead Street - Team Leader, Armistead Centre, 56 – 58 Hanover Street, Liverpool L1 4AF. Tel: 0151 247 6560).**

Reflections for the future

This short report includes case studies which deal exclusively with a vulnerable population and others where there is an extra ‘enhanced’ service linked to a mainstream model. ***Inclusive Practice*** advocates further evaluation of the merits of the different models. There are a number of key characteristics of our case studies that deserve highlighting:

- Irrespective of their structure, our selected case studies share a key common characteristic – commitment and dedication, verging on the heroic at times, from staff at all levels. They have weathered recent financial storms and major organisational change, keeping alive services in which they passionately believe. Their low staff turnover is an indicator for this and has added a much-needed degree of stability to their services.

- The promising models are also characterised by success in engaging with – and winning the trust of – groups which have been traditionally regarded as “hard to reach”. The selected five, and others in *Inclusive Practice,* demonstrate that trust can be won in different ways, often through years of hard work. It may involve outreach and the use of ‘ambassadors’ or ‘champions’ in the community, or both. *Inclusive Practice* is clear that harnessing members of the community as ambassadors has worked particularly well in the Gypsy and Traveller arena. Equally, though, Market Harborough shows that if the service is well run and accessible patients will return from far and wide.

- Staff in the selected case studies are all proud of their work and believe they have lessons they can pass on to others. They would welcome independent evaluation, though this would have to be managed carefully, as staff are extremely busy.

- There is clear potential for universities, especially those locally based, to aid with evaluation in this area - particularly those linked to local hospitals that might benefit from successful primary care interventions. Our ***Inclusive Practice*** report *highlights* the success of the nine-university South East Coastal Communities project between 2008-11, which worked successfully with the Gypsy community in Swale in Kent.

- York Street practice in Leeds has found many of its patients have been on the list for so long many now speak good English. This may be true elsewhere. Overall, though, there is still a significant and increasing demand from new arrivals for language services – sometimes linked to the bilingual health advocate system. ***Inclusive Practice*** highlights the good work of the East of England INTRAN partnership, a multi-agency, not-for-profit partnership providing language services throughout the Eastern region.

- The overall need for specialist services for the four identified groups is strong, and may well grow. There will continue to be unique or distinctive health needs in individual groups – be it maternity care and immunisation for Gypsies/Travellers, or sexual health services for sex workers. But there is overlap between the groups, particularly when it comes to accommodation needs. York Street and Health E1, for instance, now cater for *all* homeless people-including migrants. Sex workers may also be homeless or in transient accommodation. Staff in our five selected case studies all show a willingness to respond to the often-complex needs of each individual who walks through their doors. Whilst categories and definitions are important for health planning and monitoring, on the ground, it is individuals’ needs which come first.

Appendix 1. A note on evaluation

Inclusive Practice is a study of the published literature identifying promising interventions to improve the health of the four vulnerable groups through improved access to primary care. Our five chosen case studies have, therefore, been noted previously in the literature. The report identified 4 grades –G1-4- of the comprehensiveness of evaluation –with G1 as the most comprehensive.

Four of them – Sheffield, Leeds, E1 London and Liverpool – are graded as **G4**, which indicates "*descriptive accounts of the intervention, or expert opinions, but without an explicit focus on evaluation (process or final outcomes). Although descriptive, a significant proportion of grade 4 interventions have been cited as good practice examples and in some cases have been the recipients of awards for innovative practice."* Market Harborough is graded **G1 (NIE)** – indicating no independent evaluation but *"previous assessment of process (intermediate outcomes), user-assessed final outcomes, and cost evaluation."*