**Document Purpose**  
Best Practice Guidance

**Gateway Reference**  
13636

**Title**  
Inclusion Health: improving primary care for socially excluded people

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**Publication Date**  
22 Mar 2010

**Target Audience**  
PCT CEs, Directors of Finance, Communications Leads, PCT Directors of Commissioning, PCT Directors of Primary Care, SHA Primary Care leads, SHA Directors of Commissioning, SHA Directors of Finance

**Circulation List**  
PCT CEs

**Description**  
This is a practical guide to support PCTs in commissioning improved primary care services for socially excluded people.

**Cross Ref**  
This is the latest in a series of guides - see back cover for further information

**Superseded Docs**  
N/A

**Action Required**  
N/A

**Timing**  
N/A

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For Recipient’s Use
Inclusion health: improving primary care for socially excluded people
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Executive summary

Whilst significant progress has been made in delivering improvements in health outcomes across the population, meeting the needs of the small population of people with the most complex health needs remains a considerable challenge. A world class health service needs to deliver high quality and affordable care to all, and the ambition of driving services from good to great must be an ambition for all our citizens.¹

‘Our vision for primary and community care’² describes four strategic aims for primary care and community services:

- people shaping services;
- promoting healthy lives;
- continuously improving quality; and
- underpinned by locally led change.

In support of the implementation of this strategy, we are producing a series of best practice guides to help PCTs become world class commissioners of primary care. This guide ‘Inclusion health - improving primary care for socially excluded people’ is the latest in this series.

This guidance is also directly linked with the Social Exclusion Task Force in the Cabinet Office and Department of Health joint study ‘Inclusion Health’³. This study includes new analysis⁴ into the primary health care needs of socially excluded groups⁵, which identifies a series of challenges.

People from socially excluded groups experience poor health outcomes across a range of indicators including self-reported health, life expectancy and morbidity.

- Just 30% of Irish travellers live beyond their 60th birthday
- 85% of street sex workers reported using heroin and 87% using crack cocaine
- People with learning disabilities are 58 times more likely to die prematurely than the general population
- Hepatitis B and C infection among female prisoners are 40 and 28 times higher than in the general population

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¹ Cabinet Office March (2010) Inclusion health: Improving the way we meet the primary health care needs of the socially excluded http://cabinetoffice.gov.uk/social_exclusion_task_force/short_studies.aspx
⁴ For the inclusion health evidence pack please go to: http://cabinetoffice.gov.uk/social_exclusion_task_force/short_studies.aspx
⁵ For the purpose of the inclusion health project (and this guide) a broad definition of social exclusion has been taken, and is concerned with those who experience multiple, complex problems, and enduring disadvantage
The study also highlights that socially excluded people often make chaotic and disproportionate use of health care services, and experience a range of barriers and issues relating to their access and quality of care.

**Who is this guide for?**

It is acknowledged that meeting the complex needs of socially excluded people requires all commissioning partners, particularly PCTs and Local Authorities, to work together across health, social care, housing etc. to support the delivery of comprehensive support to individuals. This guidance, however, is aimed at supporting PCTs to improve access to, and the quality of, primary care services for socially excluded people. It has been developed for health and partner authority managers responsible for commissioning primary care (and other joint services). Service providers, including third sector partners, should also find it useful. It has direct relevance for:

- **PCT Boards** – are you aware of your local patterns of social exclusion and are you confident that current primary care services are effectively meeting the needs of socially excluded people at best value and achievable quality?

- **Commissioning teams** – do you have adequate data and analysis to be able to incorporate the needs of local socially excluded people into the commissioning cycle? Are the most vulnerable people across local communities benefiting from current service provision and being enabled to shape services to best meet their needs? To what extent can this be best delivered within existing services, and to what extent does it require local transformation to secure more focussed specialist provision alongside mainstream primary care services?

- **Local providers** – are you confident that your current service offer proactively seeks out and enables socially excluded people to benefit from it? Are you aware of the barriers to, and the complexity of, the care required to improve health outcomes for socially excluded groups? Are commissioners working with you to improve the quality and value of the service you provide?

- **Staff and professionals working with socially excluded people** – do you have the right information and analysis to be able to achieve the engagement and improvements in health outcomes that local patterns of social exclusion require? Are you supported within wider training and education networks to deliver care in this arena?
What does the guidance contain?

This guidance sets out the case for change by outlining the poor health outcomes experienced by socially excluded people and (the often high costs of) their current patterns of access to services. It supports PCTs to routinely identify the needs of socially excluded people and assure appropriate access to high quality primary care services for these most vulnerable groups.

The guide highlights best practice case studies and identifies a series of underlying principles and features which are present in services which successfully meet the needs of socially excluded people.

Throughout the guide you will find brief cross-references with the relevant world class commissioning competencies. Chief amongst these is the meaningful engagement of partner organisations and service users throughout. (In particular, local government and third sector partners who will also be working extensively with the same people.) PCTs which demonstrate high quality commissioning for socially excluded people are likely to be able to demonstrate high quality commissioning across the board.

Many existing services aimed at socially excluded people focus on particular groups, for example people who experience homelessness. The ‘Inclusion Health’ study has shown, however, that many of the more accessible and successful services share common features, irrespective of the group being served. This has important implications for commissioners who can achieve a critical mass with resulting economies of scale and purpose by identifying common needs and service specifications across groups.

Traditional services tend to engage poorly with socially excluded people and vice versa. Frequently, the complex challenges they face can mean many socially excluded clients lead chaotic lives. Reducing lifestyle risks, or maintaining the relationships with primary care providers that lead to continuity of care, is not commonly a priority. The challenge facing commissioners and providers is how we work with people living in such circumstances to assure that all opportunities are optimised to help stabilise their care needs, and that they are supported into pathways to recovery. Once this is achieved, there is potential to secure not only better health outcomes for those who need our help the most, but also to deliver better value.

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6 http://cabinetoffice.gov.uk/social_exclusion_task_force/short_studies.aspx
Introduction
Introduction

Socially excluded groups

Every community will have its own pattern of socially excluded groups and individuals. Traditionally, the term social exclusion is applied to those people who are:

- suffering multiple and enduring disadvantage
- cut off from the opportunities most of us take for granted.

This definition can therefore include a very broad range of groups including:

<table>
<thead>
<tr>
<th>Those with no recourse to public funds</th>
<th>Asylum seekers and refugees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care leavers</td>
<td>People who experience homelessness (particularly rough sleepers)</td>
</tr>
<tr>
<td>Ex-servicemen/women</td>
<td>People living in remote rural areas</td>
</tr>
<tr>
<td>People with mental health problems</td>
<td>People with learning disabilities</td>
</tr>
<tr>
<td>People with physical disabilities</td>
<td>Substance misusers</td>
</tr>
<tr>
<td>Gypsy, Roma travellers</td>
<td>Ethnic or religious minorities</td>
</tr>
<tr>
<td>Sex workers</td>
<td>Non-English speaking linguistic minorities</td>
</tr>
<tr>
<td>Long-term unemployed</td>
<td>Those in severe and persistent poverty</td>
</tr>
<tr>
<td>Migrant workers</td>
<td>Those in severely deprived neighbourhoods</td>
</tr>
<tr>
<td>People over 18 years not in employment, education or training, (NEETs)</td>
<td>Old people (particularly those over 85 years of age)</td>
</tr>
<tr>
<td>Men/women suffering domestic violence</td>
<td>Offenders and ex-offenders</td>
</tr>
</tbody>
</table>

(NB this list is not exhaustive)

Clearly, these groups can overlap and individuals often have multiple and complex needs with a range of clinical and social challenges. In particular, the incidence of mental health problems amongst socially excluded people is very high. Local needs assessments can be used to identify which vulnerable and socially excluded groups are most prevalent locally.

The guidance, however, is primarily aimed at addressing the needs of the most vulnerable people such as homeless and traveller populations, ex-offenders, sex workers, refugees and asylum seekers etc., who often face discrimination and a double disadvantage of both health inequality and difficulty of access to health services generally, and primary care in particular.
Section 1: Why this matters – acknowledging the case for change
Section 1: Why this matters – acknowledging the case for change

Social exclusion is an issue which affects all PCTs. The most excluded and vulnerable people locally will almost certainly have the poorest access to primary care services in your area and among the poorest health outcomes. Acceptance of this - and ‘buy-in’ to take action to address this challenge - needs to be at the highest level, that is, from PCT Board level downwards.

PCTs and providers are working hard and making significant progress in improving the accessibility and quality of primary health care in order to keep people healthier for longer and reduce health inequalities. There is now evidence, however, which demonstrates that we need to go further to improve the way we meet the primary health care needs of the most socially excluded people within our society. Inclusion Health[^7] highlights a number of challenges which illustrate the need for commissioners to tackle this issue in a robust way:

<table>
<thead>
<tr>
<th>Challenges</th>
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</thead>
<tbody>
<tr>
<td><strong>Clients</strong></td>
</tr>
<tr>
<td>• complex needs and chaotic lifestyles make it difficult for socially excluded people to access services and navigate systems</td>
</tr>
<tr>
<td>• many socially excluded clients have low health aspirations, poor expectations of services, and limited opportunities to shape their care</td>
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<tr>
<td>• they often report feeling ‘invisible’ or discriminated against</td>
</tr>
<tr>
<td><strong>Practitioners</strong></td>
</tr>
<tr>
<td>• many practitioners (especially in non-specialist settings) lack awareness, skills and training to cope effectively with the most excluded</td>
</tr>
<tr>
<td>• in many mainstream settings, there is a tendency to focus on treating presenting symptoms – rather than supporting recovery and sustained behaviour change</td>
</tr>
<tr>
<td>• specialist practitioners often work in isolation or lack the support networks and supervision to deal effectively with high need clients</td>
</tr>
</tbody>
</table>

### Challenges

<table>
<thead>
<tr>
<th>Providers</th>
<th>Commissioners</th>
<th>Leaders</th>
</tr>
</thead>
<tbody>
<tr>
<td>• there is a limited evidence base on what works for these clients, and sometimes a lack of capacity/capability to evaluate</td>
<td>• there is considerable variation of provision of specialist services between different areas of the country</td>
<td>• there is no national voice for the socially excluded and the diverse range of professionals who work with them</td>
</tr>
<tr>
<td>• services often lack the flexibility to respond to complex needs and chaotic lifestyles</td>
<td>• socially excluded clients often do not show up on needs assessments</td>
<td>• health care for socially excluded groups is of low priority and the needs of these groups tend not to be at the forefront in strategic planning</td>
</tr>
<tr>
<td>• few incentives to promote partnership working around clients with complex needs</td>
<td>• some groups are very small or geographically dispersed, and there are important differences between and within groups</td>
<td>• health and wellbeing outcomes do not adequately reflect the specificity and complexity of socially excluded clients’ needs and circumstances</td>
</tr>
<tr>
<td>• it is easy for clients to fall between the gaps of different services</td>
<td>• often there is limited join-up between PCTs, LAs and the Third Sector in sharing knowledge about the most excluded clients</td>
<td></td>
</tr>
<tr>
<td>• there are key gaps in and barriers to provision (e.g. access to mental health services for those with dual diagnosis)</td>
<td>• limited focus on health promotion, prevention and recovery</td>
<td></td>
</tr>
<tr>
<td>• there is an artificial divide between clinical and social models of care</td>
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</table>

The ‘Inclusion Health’ study has also produced an excellent supporting evidence pack which commissioners can use to help build the case for improvement.

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Demonstrably poorer health outcomes

National data show poorer health outcomes for socially excluded people on a range of indicators including self-reported health, life expectancy and morbidity. For example:

- self-reported chest pain and respiratory problems are more prevalent in the traveller population compared to a similarly deprived comparator sample.\(^9\)

- the average age of death for homeless people is 40.2 yrs.\(^10\) (In US research, these deaths are shown mostly due to treatable illnesses and there is no reason to expect this to be different in the UK)

- 63% of women in prostitution experience violence. Street based sex industry workers experience significantly worse outcomes than those based from home or working from parlours.\(^11\)

- 33% of offenders are assessed as having some or significant psychological problems.\(^12\) Learning difficulties are also very common

- 50-75% of rough sleepers have Axis I disorder (anxiety disorders, depression, dementia and psychosis disorders) and as many as 30% have schizophrenia.\(^13\)

- both adults and children with learning disabilities are at an increased risk of early death. Those under the age of 50 are 55 times more likely to die prematurely. For those under 50, the risk is 58 times more likely.\(^14\)

Less appropriate and often poorer access to services

Typically, socially excluded people find it easier to access unplanned care settings than traditional primary care. Evidence from the literature suggests over-utilisation of emergency and acute care. For primary care, whilst some socially excluded people consult their GP and practice nurses more regularly than the general population, there is also evidence that some vulnerable people under-utilise mainstream primary care and community services. For example:

- homeless people each consume an estimated eight times more hospital inpatient services than an average person of similar age\(^15\) and their secondary care costs around £85 million in total per year. Compared to the general public, they are 40 times more likely to be unregistered with a GP and have about five times the utilisation of A&E. 81% of GPs interviewed by Crisis thought that it was more difficult for a homeless person to register than the average person.

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\(^9\) Parry, G et al, 2004 The Health Status of Gypsies and Travellers in England, Sheffield, University of Sheffield
\(^12\) SETF Analysis of OASys 2005/06 and 2006/07
\(^13\) UCLH ref on mortality stats: Morrison, DS, Homelessness as an independent risk factor for mortality: results from an independent cohort study, Int J Epidemiol. 2009 Jun
\(^14\) Hollins et al, op cit.
street sex workers, who have the most acute health needs, are more likely to be in contact with health care services than the general population. They are over five times more likely to report visiting a GP in the past year: 58% reported seeing a GP; 29% had visited A&E; 24% had been to an STI clinic; 21% to inpatient clinics; and 17% to outpatient clinics in the previous year. They are also more likely than the general population to use acute care, but are less likely to have taken up routine screening, health checks and vaccinations.

some 26% of people with learning disability are admitted to hospital each year, compared with 14% of the general population.

**Key policy drivers**

The recently issued *Marmot Review: Fair Society, Healthy Lives (2010)* sets the wider context for working to improve health outcomes for socially excluded people. Within health specifically, there are a number of national policies and priorities which drive the need to address this issue. In particular it sits firmly within one of 5 national policy drivers within the *Operating Framework 2010/11*; ‘keeping adults (and children) well, improving their health and reducing health inequalities’. It can also be a key contribution towards meeting the QIPP agenda (see overleaf). In addition, PCTs are supported in delivering this agenda by a number of national initiatives and programmes including; Transforming Community Services, Family Nurse Programme, National Support Team for Health Inequalities etc.

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17 Understanding Patient Safety Issues of people with learning disabilities, national Patient safety Agency, 2004
19 Details of these initiatives and programmes can be found on the Department of Health Website [www.dh.gov.uk](http://www.dh.gov.uk)
Meeting the QIPP agenda and the financial case for change

By taking action to improve access to services for socially excluded people, PCTs can contribute significantly to their local quality and productivity challenge.

<table>
<thead>
<tr>
<th>Quality</th>
<th>The most vulnerable people with the worst health outcomes often have the poorest access to primary care. Tackling this inequality will improve the quality of care and health outcomes for this group. Promoting ‘inclusive practice’ across the board i.e. encouraging all primary care to be more accessible and inclusive for socially excluded people. Get it right for these vulnerable minorities and you will get it right for all.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Innovation</td>
<td>Socially excluded people often don’t use services well at present, and the existing patterns of access are often unnecessarily complex and fragmented. Local leadership for innovative approaches to resolving this and improving access is required. Partnership approaches for these people should be at the forefront of service reform (e.g. personal budgets).</td>
</tr>
<tr>
<td>Prevention</td>
<td>By working with local partners, and jointly focussing on more ‘upstream’ interventions, more individuals can be supported into less chaotic lifestyles or supported to prevent the fall into homelessness etc. It will rely on partnerships between organisations and the skills of those who are ‘at the front door’ of prevention, such as health visitors, and will require PCTs to maxime the impact of the services and professionals who are ‘touch points’ for the vulnerable (such as pharmacists, housing officers and A&amp;E).</td>
</tr>
</tbody>
</table>
| Productivity     | Clearer, more integrated care pathways will prevent the current fragmented and crisis-led use of services which often incur higher costs. This includes working with providers to better use existing resources to change the current service offer to better meet the needs of socially excluded people. Services that are designed to ensure that people can retain their independence and quality of life can deliver cost savings through the prevention of hospital admissions and residential placements. There is a growing body of evidence to suggest that integrated health and well-being services can realise significant financial benefits. In particular, studies have illustrated that integrated early intervention programmes can generate resource savings of between £1.20 to £2.65 for every £1 spent.  

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Given the health outcomes experienced by socially excluded people, the ‘ethical’ case for trying to improve this is clear. Case studies like the example below, however, also demonstrate that it makes financial sense for PCTs to address these needs further ‘upstream’ by improving access to primary care services and avoiding unnecessary use of A&E and acute services. Commissioners will want to understand local patterns of use by these patients with complex needs and the associated costs. Better coordinated care, led ideally from a primary care network, or in certain areas by local unplanned care providers and networks, will identify where savings are achievable and quality can be improved.

**Case history**

- David is a chronic alcoholic. He has liver damage, is immobile and has fluid on the lungs which lead to him needing a two-week hospital admission on a monthly basis. He also has fungal infections which are very painful.
- David receives no support from social services, has been banned from respite care, and has no GP.
- He has been ‘red-flagged’ by the local PCT, which means he is not able to use their services due to his aggressive/abusive behaviour.
- David rings an ambulance two-to-three times a week. The police have to accompany the ambulance crew when they attend his house. No taxis will take him to A+E, so the ambulance is his main method of transport. His stays in hospital are cut short when he discharges himself without warning. He has a wide range of medication for his conditions, but does not take them. His condition deteriorates until he requires re-admission.
- In the course of a year David calls the ambulance 2-3 times, 26 weeks of the year.

**Costs of David’s ‘care’**

<table>
<thead>
<tr>
<th>Description</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>70 ambulance calls @ £337 each</td>
<td>£23,590</td>
</tr>
<tr>
<td>The Police attend each call 70 calls @ £184 each</td>
<td>£12,868</td>
</tr>
<tr>
<td>Stay in hospital 182 days@ £223 per day</td>
<td>£40,586</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td><strong>£77,045 per annum.</strong></td>
</tr>
</tbody>
</table>
Section 2: Assessing your local needs and priorities
Section 2: Assessing your local needs and priorities

“Looking at how equitably services are delivered, and whether they meet local needs has to be a proactive process that draws in people who, traditionally, have not had good access. Working with local third sector groups may be a way of assessing those groups.” (RCGP)

Every area will have its own unique pattern of exclusion and, within this, people whose primary care needs are not being fully met. Accurately assessing this need is challenging for commissioners due to the complexity and depth of need, the relatively small numbers of some groups, and the involvement of multiple agencies. In addition, socially excluded people are often not picked up in traditional data sources and surveys. Understanding need, however, is crucial to efficient and effective design and delivery of services, and driving improved outcomes for the most vulnerable. Commissioners should feed these needs into priority setting processes to enable the commissioning of services that meet common needs across groups within mainstream services as well as the unique needs of communities whose critical mass requires a specific service offer. These people are not ‘hard to reach’, as they are often clustered around particular services or locations, but their small numbers can make them easy to ignore.

The needs of socially excluded people are poorly reported in current national data sets, in part owing to the impact of their transient lifestyles and multiple complex problems, and also because their lack of inclusion to primary care means that they are invisible to the system. In the same way as the balance and nature of the people affected will vary from area to area, the data required to understand these unique needs and commission against these will also vary.

The labels that we use for socially excluded groups often result in assumptions and can significantly mask the complex problems and needs that are experienced. Data needs to get beneath the label, for example describing people as ‘homeless’ can on the face of it appear as a housing need. In reality, it is often more of a mental health need with the majority of people accessing homelessness services having experienced complex trauma and/or mental disorder. Understanding this kind of underlying complexity will be critical for the development of services and how people access them.
Sources of data

Recent years have seen huge improvements in the availability of public health data at ever smaller units of geography. Assessing the needs of those experiencing multiple disadvantage, however, requires commissioners to go beyond the routinely available local data and work creatively with partners to identify the pattern of needs and experiences of socially excluded people in the local community. We would suggest the following:

- use public health departments, local GP systems, and hospital data sets as a starting point. There are problems with separately identifying some of the most disadvantaged and vulnerable people within available data sets, but these data sets will yield information regarding high cost individual patients, use of A&E, ‘frequent flyers’ etc.

- current JSNA data sets do not always effectively capture the needs of socially excluded people. Clients at greatest risk typically do not show up on area-based assessments. They do, however, tend to be visible locally and cluster around services or places. Commissioners can use these ‘locations’ as a starting point for gleaning further information.

- work with providers (particularly third sector providers) at these services and places in order to obtain local information on need.

- socially excluded groups rarely have identifiers in NHS administrative data. For some groups, however, there are methods by which they can be identified, allowing administrative data to be used to improve understanding of current patterns of health care utilisation and to uncover particular needs.

- one way to do this is to look at data specific to patients who access an existing specialist service. For example, records for patients who are registered with a particular service might be analysed to find out about the needs of the group using the service.

- there are a few socially excluded groups which might be identified using place of residence. A principal example is people who experience homelessness who use hostels and night shelters, and will often (although not always) give this address when using secondary care. The charity Homeless Link (www.homeless.org.uk) holds a database of homeless hostels and night shelters including addresses and post codes which they are able to share with PCTs.

- other groups which may be identified in this way include those in very deprived neighbourhoods, men/women suffering domestic violence and care leavers.

- a further method which applies to the homelessness population is to use the NFA (no fixed abode) identifier which is used in HES data and which, in the main, corresponds to those who are homeless.
• PCTs could also consider how local academic institutions can contribute to gathering information

• it may be helpful to establish a document database to compare and contrast information collated, and to reduce the possibility of double counting for particular people with multiple or complex needs

• local authority commissioned services, especially housing and social services, (Supporting People: www.spkweb.org.uk) are also rich sources of relevant data.

This process of triangulating information held by traditional health sources with the information held by knowledgeable partners is a rich source of data to inform local health needs assessments. Much of this can be done as a desk-top exercise.

**Homeless Link audit tool**

Homeless Link is piloting a health needs audit tool which will enable (homelessness) agencies to record and evidence the health needs of their clients. This evidence will be used to inform commissioning of future services, through local strategies such as LA and JSNAs. Although based on feedback from individual service users, the audit tool is not a means to assess at an individual level, but rather to audit overall need in an area.

Contact details: Helen Mathie, Tel 020 7840 4430, helen.mathie@homelesslink.org.uk

**Moving forward with ‘good enough’ information**

Even given the above, your information/data on socially excluded people is likely to be incomplete at this stage. Incomplete data, however, need not prevent non-executive and executive teams from leading progress to improve access to primary care for the socially excluded. As described later, information gathering can be built-in and improved through service specifications when commissioning services and, as it becomes available, it will help to build a clearer picture of the needs of these people. Most importantly, service providers can then be supported to adapt and change in response. This can also be a way of encouraging more innovative solutions to problems.
Section 3: Identifying suitable service solutions
Section 3: Identifying suitable service solutions

Be ambitious in your aims. Address traditional ingrained patterns of care, re-engineer services and care pathways to deliver more socially and culturally competent services that benefit those who most need our help. Relatively small ‘reasonable adjustments’ to services and care pathways can have a big impact on how accessible services are for socially excluded people. Successful approaches are likely to require an integrated approach, and may involve a combination of adapting ‘mainstream’ services, together with developing and supporting specialist provision.

Models of service provision

This section provides an overview of the spectrum of effective service models, which range between clinically-led services to those with more of an emphasis on social care. In addition, services could either be more specialist or mainstream in nature. This could mean specifically serving one or more socially excluded group due to the local critical mass of service users, or practices and services seeing some socially excluded clients within a mainstream setting, sometimes on behalf of practices around them. This is illustrated in the diagram below.
Commissioners will want to optimise the capacity and capability of mainstream primary care to meet socially excluded people’s needs. Excluded people may be more willing to engage with primary care services where relationships and trust can be built that can aid successful referral to other services. This may be supported by ensuring that currently commissioned services understand their duties and responsibilities under the equality and human rights legislation and the NHS Constitution. When case load or case complexity requires bespoke service responses however, this may be best achieved by commissioners working closely with effective providers to drive innovation and shape better health outcomes.

Although no single model of service design will suit all communities, those services which can offer access to a balance of specialist socio-medical support with generalist provision, and which have a fully integrated approach across care pathways, are most likely to prove effective for those people with complex needs. The balance of where the emphasis is on the spectrum of specialist-led to mainstream-led services should be locally determined.

A summary of the range of models is contained in table below.

<table>
<thead>
<tr>
<th>Model “Type”</th>
<th>Description</th>
<th>Issue to consider</th>
<th>Case studies (See p57)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mainstream-led Services</td>
<td>These services/projects seek to incentivise primary care service providers to make reasonable adjustments for excluded people to enable them to more readily access a mainstream environment and still have their complex needs met.</td>
<td>Costs of incentivising practices although they do not need to be financial eg offering to co-locate support services. Difficulty of getting wide enough coverage via participating practices to assure equality of choice and access.</td>
<td>NHS Suffolk (see p49)</td>
</tr>
<tr>
<td>3rd Sector-led Services – (Facilitating Access to Mainstream)</td>
<td>These services are embedded within communities and help to establish relationships between health practitioners, providers and clients. These services often also couple medical care with other positive activities.</td>
<td>Often ‘single issue/group’ services, therefore, higher number of organisations for commissioners to deal with for a relatively small number of patients. Funding can be precarious, or feel precarious to service providers, which results in difficulties in long-term planning and willingness and ability of other partners to align care pathways. Main focus often not primary care.</td>
<td>Homeless Link services (see p21)</td>
</tr>
</tbody>
</table>
‘Pilot’ and ‘one off’ Services/Innovations

These services are often led by individual practitioner/leaders incubating change or solutions. For this model, and the 3rd sector led models, the main drive to set up services often comes from practitioners rather than from a strategic level. This perhaps reflects the invisibility of socially excluded people in traditional health needs assessment processes and information flows.

The continuity and sustainability of such services can be put at risk when key individuals move on or if there is ‘burn-out’. Funding is typically short-term in nature, which again, leads to uncertainty for both clients and staff which undermines the ability to build trust with clients and also the opportunity to build sustainable and robust care pathways with other services.

Clinical Specialist Services (often primary care based)

Often aimed at addressing the needs of particular groups of people. Given the common issues facing excluded people, the projects often see a cross section of clients. Focus on making measurable differences to health outcomes. Often have close links with partner services. This category also includes some ‘specialist’ general practices who often see patients that other practices will not see.

Can sometimes provide less choice for individuals as they are directed to specific services, rather than having a choice of mainstream service providers. Increased danger of stigmatisation, but this can be reduced with an emphasis on recovery and supporting patients to move to mainstream. Difficulty in applying QOF and other measures to such services due to unusual characteristics of their patient population.

Integrated Socio-Primary Medical Services

These services aim to provide an integrated approach to service provision which can meet both the health care and social care needs. Often these services seek to co-locate services within the same building or in adjacent buildings.

Sourcing & funding estate and ensuring an appropriate physical environment for a wide range of services and clients - including those with chaotic behaviours. Which services to include. Quality of the service should help to make it the service of choice for patients to reduce danger of stigmatisation as above.

Case study 4: TB van - mobile X-ray unit
Case study 5: St Mungos Cedars Rd, Intermediate Care Pilot
Case study 6: Walsall Pacesetters Breast Screening for LD

Case study 7: St Praed St Project
Case study 8: Maple Access Partnership

Case study 9: Dawn Centre, Leicester

Case study 3: The Quays, Hull
Case study 1: Open Door, Grimsby

Mapping existing pathways and funding streams

The best service solution for an area will depend upon a number of elements including identified needs, existing service provision, the particular range of socially excluded people and the issues they face in the local area. Commissioners will want to map existing local services and also identify the current funding streams which support these. With this information, commissioners can then look at how close this is to the service model(s) they would ideally like to have in place in order to achieve the appropriate continuum of care. There are a number of tools and approaches which PCTs can use to support this work. The most effective approaches to pathway analysis are those which include existing service providers, service users and local community members. Often they are in an ideal position to identify any blocks, duplications and opportunities within current systems. This includes highlighting opportunities for greater efficiency and also where more training and cultural awareness would be of most use.
Connected care - Turning Point’s community-led mapping and commissioning

Connected Care is Turning Point’s model for community led commissioning; one that integrates health, housing and social care service delivery. Launched two years ago it is now successfully working with commissioners across the UK to bring community-led solutions to health and social care problems. Connected Care supports commissioners by:

- improving patient experience through a programme of community engagement
- delivering better health and social outcomes through a change management programme to guide commissioners on service redesign
- reducing costs to the population by looking at models of integration and early intervention across health, housing and social care.

Connected Care is currently working in ten areas of the country, including Hammersmith and Fulham, Bolton, Essex, Hartlepool, East Lancashire, Suffolk and East Sussex. Projects are undertaken in different geographical areas and a number also focus on specific communities of interest, for example the Gypsy, Roma and Traveller population in East Lancashire and carers in Suffolk. They have recruited and trained over 150 community researchers. The work in ten projects has reached populations of up to 120,000.

Connected Care offers a robust methodology adapted for each local area. This is because the research is designed in consultation with the community and commissioners and reflects local need and issues. The change management approach enables bespoke service reconfiguration to take place to ensure local solutions to identified need. Service responses vary in every area so different models of integration as well as the promotion of individual budgets are looked at. In Hartlepool, the Connected Care service has a number of different elements:

- a team of navigators work to improve access and navigation within health and social care services and operating at the interface of primary care and social care
- a virtual complex care team integrate specialist health, social care and housing support
- a range of low level support services that focus on maintaining independence are also being developed
- delivery is through a social enterprise managed by residents and local community organisations.

Connected Care Hartlepool won an award in 2009 from In Control for their work on community engagement and participation and its progress on promoting self directed support.

Contact details: richard.kramer@turning-point.co.uk
Mapping pathways and services

Capturing the processes

Identify current access point eg A&E, Walk-in centres, Primary Care, third sector etc.
Identify how these services are funded

Identify which socially excluded people are accessing services and why they access them where they do.
(link this to work on identifying the barriers to access)

Identify what happens at each access point:
- are people referred on?
- are they offered a contact for further support?
- is only ‘immediate and necessary’ treatment offered?
- is any follow-up offered?

Tips and issues

Involve service users in the mapping process - both as interviewers and interviewees

Can the PCT learn from the way in which partner organisations deliver services and support socially excluded people?

Consider how the PCT can link with other services who can offer additional routes into healthcare, or other options for onward referral

Remember some existing GP practices may currently be offering some unique services to socially excluded people on their list - include these in your mapping

Consider whether there are any other existing networks with local authority or third sector partners which you can link

Involve current service providers in the pathway mapping - including third sector providers

Consider how you might capture the needs/barriers for those socially excluded people who do not commonly access health services

Involve current service providers in the pathway mapping - including third sector providers
Section 4: Designing and specifying services based on best practice
Section 4: Designing and specifying services based on best practice

Whichever service solutions PCTs wish to adopt, it is important that they are commissioned in a way that takes into account the best practice features outlined in this section. Many current primary care and third sector providers are likely to have significant existing experience and expertise – capture this and work with them to shape and define services as they develop.

Critical mass

A number of existing services aimed at the socially excluded tend to focus on one particular group. The evidence demonstrates that the features which make services more accessible and successful are often very similar across providers, irrespective of the group being served. This is important for commissioners, as, for some PCTs, the numbers of people within individual groups can be relatively small. The opportunity to commission service(s) which serve a number of people can therefore create a critical mass and economy of scale which may not previously have seemed appropriate or feasible. This could take the form of a single service which serves a range of different people, and which provides specialist support to a series of networked general practices, helping to make mainstream services more accessible to socially excluded people.

Common barriers to accessing services and receiving optimal care

To improve access to primary care for socially excluded people it is important for commissioners to have a clear understanding of why access to services is currently poor and what is preventing people from accessing them. The NHS Constitution gives people the right to access services, which should be universal, and which will treat them with respect and dignity.

“The NHS provides a comprehensive service, available to all irrespective of gender, race, disability, age, sexual orientation, religion or belief. It has a duty to each and every individual that it serves and must respect their human rights. At the same time, it has a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population.” NHS Constitution Principle 1

Qualitative research and fieldwork carried out by the joint DH and Cabinet Office Social Exclusion Task Force\(^\text{22}\) which engaged experienced practitioners, suggests that the difficulties of access and use of services experienced by socially excluded people are significantly worse than those experienced by the general population.

\(^{22}\) Cabinet Office March (2010) Inclusion health: Improving the way we meet the primary health care needs of the socially excluded http://cabinetoffice.gov.uk/social_exclusion_task_force/short_studies.aspx
The barriers identified vary in nature, and the extent to which each individual group experiences these barriers varies. Most socially excluded people, however, experience several of these barriers at once. In addition, barriers are encountered both when initially accessing care, and also once in the system and at all stages along the patient journey (and commissioning cycle), and these are outlined below/overleaf.

**Common barriers to access**

- **Health not a priority**
- **Low levels of cultural competency in staff**
- **Communication, language and literacy**
- **Negative previous experiences of services**
- **Discrimination, stigmatisation**
- **Case complexity, diagnostic and other overshadowing**
- **Inflexible processes, Including registration and Appointment systems**
- **Lack of understanding of ‘system’, rights and responsibilities**
- **Transport and other costs**

**Underlying features/principles for commissioning successful services**

**Local leadership**
Prominent and clear local leadership at the highest level, including Board sign-up, will greatly enhance the likelihood of a successful approach to improving access to, and the quality of, primary care services for the socially excluded. This is particularly true when seeking the support and engagement of partner organisations.

**Integrated approaches**
Socially excluded people commonly experience a range of complex health issues in addition to wider life challenges. In order for healthcare professionals to successfully support such individuals, it is imperative they have access to a range of care pathways which span physical, psychological and social care and, ideally, access to welfare support advice.
Co-location of services to promote integration is often a feature of the most successful integrated models. Where key services are not or cannot be co-located, clients must be supported in very practical and hands-on ways to access these services. Integrated approaches seek to provide service users with a coherent and well coordinated programme of care, with primary care as the foundation of these services. This requires that protocols for referral/acceptance of new patients for key services, such as substance misuse and mental health, are clear and are aligned with the realities of the people involved. This is particularly true where co-location of services is not an option.

Integrated approaches often incorporate shared information systems (although this is not essential for service start-up). Good information sharing is, however, essential. There is sometimes confusion amongst staff regarding the rules around patient confidentiality, and there are a number of myths surrounding this issue. The sharing of information within agreed protocols is perfectly possible and it should not be a barrier to good information sharing and more integrated care. Training on this issue can help instill confidence in staff and enable them to work through these unnecessary barriers.

Future studies exploring integrated care need to consider the long term financial benefits. Indeed, many of the studies that concluded that integrated care was not cost effective were conducted over relatively short time periods, and many of the benefits of integration will accrue as individuals remain independent well into the future. In particular, those integrated services that have a focus on early intervention are designed to prevent needs escalating in years to come, and therefore the real benefits will be realised over time.  

**Proactive approaches – support workers, advocacy and peer support**

Successful services demonstrated a pro-active approach to supporting socially excluded individuals. Effective services often incorporate resources such as assertive outreach, patient tracking etc. Such pro-active approaches were one of the key factors in overcoming many of the barriers to access experienced by socially excluded. In particular, for excluded individuals, ‘sign-posting’ is an inadequate way of supporting access to the other services they require to meet their complex needs. Instead, the use of support personnel and advocates to accompany people to make and keep appointments for services was viewed as more successful and more efficient use of resources.

As described above, full integration will not always be possible. In these circumstances support in navigating across services becomes even more important. Advocates and support workers can be key in making best use of existing resources by helping individuals become linked into existing service provision and reducing complexity.

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Engaging clients and building trust
This is closely linked to the proactive approach described before. Socially excluded people often have negative previous experience of services. They will often list a history of bad experiences, each time they get pushed further away and become harder to engage. The direct involvement of service users themselves (in addition to advocates), and the ability to build trust and good relationships with clients and wider communities was a feature of successful service approaches. Methods of engaging with clients may differ, dependent upon the preferred service delivery method and numbers of clients. Good engagement with many socially excluded people, however, can be a time-consuming and long-term undertaking. Some of the most successful models studied had lead times as long as 1-2 years in order to build trust and enable services to develop in an appropriate way.

Engagement can be conducted at both individual and ‘community’ levels, and is most successful if it happens as early in the planning process as possible, by involving communities in the design of services. Community groups may need resources and support to help them properly and equally involve their communities. PCTs may wish to consider how grants may provide a resource that supports such involvement. Once a service is up and running individual clients should also be encouraged to be involved in the design of their own care via involvement in management of services and personalised care plans.

Engaging with people from socially excluded groups can include a range of approaches, including:

- use of individuals from socially excluded groups as expert patients
- use of health trainers, peer educators, health ambassadors
- use of advocacy in engaging patients which can help service users to:
  - make clear their own views and wishes;
  - express and present their views effectively and faithfully;
  - obtaining independent advice and accurate information;
  - to take more responsibility and control for the decisions which affect their lives.24

24 Primary care service framework: Gypsy & Traveler communities, 19 May 2009
Engaging communities – things to consider

- Which communities are to be targeted as part of the engagement? (We strongly suggest that you choose to start with groups who are seldom involved.)
- What are the most appropriate methods of engagement to be used?
- What decision(s) will be informed as a result of the engagement activities?
- What mechanisms will be in place to enable ongoing community input into the decision making process?
- What other factors, information, opinions and research will also be considered in making decisions?
- What forum/mechanism will make the decision(s)?
- Who will be involved in this?
- What will the timescales be?
- How will the decision(s)/outcomes be communicated?  

Continuity of care

Continuity of care is a critical issue for the delivery of effective care, but given the ways in which health services are currently accessed by socially excluded people it is often very difficult to deliver. Supporting continuity both in terms of longevity of care, and as people navigate between health (and other) services, is an essential feature of successful services.

Service models which register patients are far more likely to provide continuity of care. Registration is not simply a way of accepting an individual into a service and gaining necessary preliminary information, but also demonstrates a commitment to the client and signals the intention to provide continuity of care. When commissioning adaptations to existing (GP) services, where registration is the norm, it is important that the registration process is made easier for socially excluded patients. (See ‘flexible and responsive services’ section overleaf.)

PCTs could also consider options for facilitating entry and registration via multiple access points including A&E, walk in centres, pharmacies, local authority help points etc. This could be done by ensuring that other services have details of the local practices/services which have signed up to accepting patients via these routes, offering patients a choice. By working closely with partners it should be possible to establish reciprocal benefits for both services in such an arrangement, for example immediate access to benefits rights advice, housing support etc.
Children and families
It is important to recognise that children’s health needs are often different from those of their parents. Children can be neglected when the focus is on their parents’ problems. They can sometimes be in situations where they are exposed to violence or neglect and the service model will need to reflect this e.g. a designated health visitor for vulnerable families may be helpful to provide intensive and comprehensive input for all children coming into the area. This is particularly important for asylum seeker families.

Physical environment
Most successful services give some thought to the impact of the physical environment in the delivery of services. This is particularly important where there is a mix of client group. The waiting areas for example may need to be able to accommodate clients who are more chaotic, without disturbing other clients who may have progressed to a more stable phase, or where there may be families or individuals with recent experience of trauma. People with learning disabilities can find waiting very distressing, particularly in noisy and busy environments. In such cases, the ability to provide a separate area of some kind may be helpful. Some service models have very visible physical security for staff, whilst others had no noticeable additional security and rely on staff training on monitoring and managing the reception environment.

Other basic considerations such as clear, simple signage (e.g. simple language, use of images, large text etc.), can make a big difference to reducing the confusion and anxiety felt by socially excluded people which can sometimes lead to them leaving before their appointment.

Partnership working
This is a theme which runs throughout this guidance. Achieving a comprehensive and integrated response to the needs of socially excluded people is dependent upon good partnership working with other agencies, (i.e. between commissioning organisations and also between commissioners and potential providers). The most successful services are those which have achieved a higher level of partnership working.

A joint focus on meeting the needs of the most vulnerable individuals by promoting stability, continuity of care and reducing chaos for individuals, will prevent case complexity and reduce long term costs. PCTs should consider the cross-public sector economic case when looking at service re-design/investment or when making business cases.

Successful projects use the links with partners who may already be engaged with clients to make sure that health needs are addressed – especially where it is clear that health is not presently a priority for particular individuals. They also use such links to build information and knowledge. This does not require new structures, it means getting this issue onto the agenda of existing local strategic partnership structures, people and committees, and re-focusing current approaches. This could include; local Learning Disability Partnership Boards, Children’s and Young People’s Partnership, the Drug and Alcohol Partnerships (often related
to the Crime and Disorder Partnership Boards), the Mental Health Partnership Boards etc. PCTs could consider how existing initiatives of partner organisations could be adapted to support improved access to primary healthcare, for example a number of authorities are trialing the use of floating support services to sustain people in housing tenancies, and giving them access to local health services is a key part of this.

**Supported workforce/networked services**

Both clinical and non-clinical staff working with socially excluded people face significant challenges every day. It is important, therefore, that services have a supported workforce. This can take a number forms:

- supervision and support networks with protected time for reflective practice
- ensuring that these organisations are set up and operate as ‘learning organisations’
- training and education including training rotations, induction, clinical supervision and networking support
- including front-line staff and other non-clinical staff in clinical team updates
- helping to prevent burn-out and create ‘hopeful’ services for staff where they have a reasonable expectation of being able to meet the needs of the clients they see.

**Reasonable adjustments - flexible and responsive services**

The NHS constitution applies to all and enshrines patients’ rights to choice. The ability of the socially excluded to exercise this choice, however, is often limited or non-existent due to the various barriers to access they face. As has been described elsewhere, small changes in attitude or systems can reduce many of these barriers significantly.

The concept of reasonable adjustments is one which features in successful projects from mainstream to specialist. It is important to note that what may be a reasonable adjustment for one service may be a change which cannot be accommodated in another. These reasonable adjustments enable the service providers to become more flexible and responsive to individual patients and should demonstrate an appreciation of the differences between and within different socially excluded people (and also minorities within socially excluded groups). Some adjustments we have encountered are:
• flexible approaches to appointments e.g. open slots
• relaxing any ‘local’ requirements, (there are no official DH requirements) for registration regarding proof of identity or address, e.g. use of ‘proxy’ addresses
• thoughtful, easy to read leaflets and alternatives to form-filling
• practical, portable health records for those with transient lifestyles
• opportunities for patients to familiarise themselves with examination equipment etc. before actual procedures/tests are conducted
• training staff in understanding firm-but-fair, boundaried management of people with challenging behaviour
• the provision of effective equality and diversity, human rights, training and development, with a particular emphasis on understanding the cultures of the socially excluded people they are most likely to encounter in their local area.

By involving clients in considering barriers and in designing services and care pathways, other reasonable adjustments are often identified. Crucially, this also provides an opportunity to manage expectations of clients.

**Personalisation**

Whilst the guide is not condition or group specific, success will depend largely upon the understanding that the workforce have over the special circumstances of individuals and people. It is important that services are commissioned and developed in a way which promotes the ability of the service providers to respond to individual needs. This requires a level of sophistication with regard to the training needs and understanding of providers, and also a high level of integration between co-dependent services.

**Common clinical issues**

In designing these services it will be important to identify any specific health care interventions/service functions which the PCT feels will be required for a particular local socially excluded population, taking into account the particular vulnerable people within it. Mental health and substance misuse problems are widely recognised as common problems for many socially excluded people. In addition, the following health problems are common amongst socially excluded people:
Additionally, particularly for people who experience homelessness, foot care problems and poor dental health are also common unmet health needs.

**Oral health**

The Department of Health is committed to reducing oral health inequalities across the population of England. It is doing this via a range of initiatives, including supporting commissioners on initiatives for hard to reach groups that have tended to suffer from poorer oral health. Special efforts are required to make services accessible to disabled and socially excluded groups, and to encourage uptake among deprived and some BME communities. Given the split between the majority of children who are orally fit, and the minority who are not, PCTs need to reach out to the minority. PCTs can do this in a number of ways:

- commission outreach services for disabled and socially excluded groups, perhaps in partnership with third sector organisations. (See Westminster Community Dentistry Case Study 2, Additional Case Studies Section p58)
- factor continuity of care, prevention, quality and outcomes into dental contracts. Many PCTs are seeking to do this with the new PDS plus dental services agreement, or via the new Steele pilots www.dentistry.co.uk

<table>
<thead>
<tr>
<th>Condition</th>
<th>Example of evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>TB</td>
<td>High prevalence of latent TB amongst homeless (Wright and Tompkins, 2005; Health Protection Agency MXU review, 2007)</td>
</tr>
<tr>
<td>Hepatitis C</td>
<td>A considerable proportion of Problematic Drug Users will have chronic physical health problems such as hep c and cardiovascular pathologies (Beynon &amp; McVeigh, 2007)</td>
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<tr>
<td>Respiratory problems</td>
<td>Self reported chest pain, respiratory problems more prevalent in traveller population ‘compared to a similarly deprived comparator sample’ (Parry et al, 2004)</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Alcohol misusers are more likely to suffer from diabetes than those not misusing alcohol (SETF analysis using HES 2007)</td>
</tr>
<tr>
<td>Injuries from violence</td>
<td>63% of women in prostitution experience violence (Church 2001 – note small sample)</td>
</tr>
<tr>
<td>Depression</td>
<td>Being in care leads to 20% higher likelihood of depression at age 33 (Buchanan, 1999)</td>
</tr>
<tr>
<td>Malnutrition</td>
<td>Malnourished patients stay in hospital for much longer, are 3 times as likely to develop complications during surgery, and have a higher mortality rate (the “MUST” report, BAPEN 2003; Age Concern 2006; BBC 2006 Age Concern 2006; BBC 2006.</td>
</tr>
</tbody>
</table>
• engage with local communities to understand needs and perceptions of oral health and dentistry; develop appropriate messages and materials to promote oral health and attendance at the dentist. For example the London pilot launched in November 2009.

This initiative brings together information on specialised dental services running for homeless people at three locations across London in one leaflet. It also includes information on emergency dental services and tips on oral health. Leaflets are being distributed through the existing mobile tuberculosis screening service which reaches thousands of homeless people each year and also at homeless organisations. Further details are available from Rellet Bailey relletb@1greekstreet.org.uk.

Mental health

The range of actions set out in this guide provide an effective support to New Horizons, the new cross-government programme for improving mental health and well-being. New Horizons[^26] sets out a twin-track approach to both improving population mental health and ensuring the delivery of effective, evidence-based treatments and services in primary care and secondary mental health services. It is aimed at people with common mental health problems, such as anxiety and depression; and also people with more severe mental illnesses including schizophrenia and affective bi-polar disorder. Both elements of this approach are inclusive of people who are socially excluded where the range of risk factors leading to social exclusion can also leave people at greater risk of mental ill-health. As with this guide, New Horizons emphasises the need to ensure commissioned services intervene early to prevent people accessing services at a stage of crisis, through taking ‘up-stream’ actions (for example through proactive employment or housing support - in line with Public Service Agreement 16), and also through active service specification across multi-agency service pathways - to provide for ‘reasonable adjustments’ to universal services, including housing and leisure and employment services.

Section 5: Procurement and contractual approaches
Section 5: Procurement and contractual approaches

Current legislative and contractual frameworks offer sufficient flexibility for PCTs to commission and fund the services and pathways required to meet the needs of socially excluded groups, and certainly should not be a barrier to achieving this. This is true even where PCTs wish to work with partners to commission and fund these services. This section outlines the main contractual frameworks for services with primary care provision at their heart.

Contractual framework options

The type of contractual arrangement being offered by the PCT may determine the type of provider and vice versa, so it is important that PCTs give careful consideration to this. We would encourage PCTs to take a flexible approach to the contractual arrangements for services for socially excluded people. It is likely that commissioners (and providers) will need a framework which will allow an opportunity for the service ‘offer’ to flex and change in response to changing need and an improved understanding of those needs (see opposite page). There are a number of contractual options which are set out in the table opposite.
<table>
<thead>
<tr>
<th>Contract Type</th>
<th>Comments</th>
</tr>
</thead>
</table>
| GMS                                              | • Primary care services for excluded people can be provided by practices within the terms of their existing GMS contract. (See guidance re support, networking, training etc which are likely to be required by practices to achieve an accessible service.)  
• NB GMS Contracts continue and are not time limited. |
| PMS                                              | • Locally agreed subject to PMS Regulations.  
• Services can be provided within the existing PMS Contract. (As with GMS, however, see guidance re support, networking, training etc which are likely to be required by practices to achieve an accessible service.)  
• Suitable for the procurement for more ‘specialist’ services. |
| Enhanced Service Agreements                      | • This option can be used in conjunction with GMS and PMS, where PCTs wish to provide financial incentives to practices willing to provide services, over and above general medical services, to people from SE groups, to an agreed standard and set of outcome measures. |
| PMS Plus                                         | • Locally agreed subject to PMS Regulations.  
• No Department of Health Standard Document.  
• Suitable for the procurement for more ‘specialist’ services. |
| SPMS                                             | • Locally agreed subject to Regulations.  
• No Department of Health Standard Document.  
• No requirement to provide essential services.  
• No patient list requirements. |
| APMS                                             | • Offers the most flexibility in terms of providers, term of the Agreement and the of scoping services.  
• No patient list requirements. |
| PCTMS                                            | • enables PCTs to directly employ health care professionals to provide primary medical services and gives PCTs the opportunity to provide primary medical services themselves or employ salaried staff to deliver services.  
• may be useful where there is difficulty in identifying a provider via normal procurement routes. |
| ‘Apex’ Contract with supporting agreements        | • An innovative agreement whereby there is an overall ‘apex’ contract with a provider which is supported by a range of supporting agreements.  
• Enables a range of services to be specified and provided e.g. medical, dental, community services, specialists services. This may particularly lend itself to co located/integrated services e.g. those based around an Equitable Access GP-led health centre. |
| Joint Venture/Community Services Contract         | • Appropriate where there is a significant range of community services. |
PCTs can enter into the contractual options as a single organisation. Partners may wish to agree funding streams to support these contracts from many different sources. Lead contracting arrangements, supported by multiple funding streams, can be a practical way of procuring comprehensive and integrated service responses to the needs of the most vulnerable groups. Assuming that the service(s) have clear outcome measures, this approach can support a range of different partners to achieve their aims.

**Sustainability**

In order to achieve improved health outcomes and assure access to primary care for socially excluded people, commissioners’ plans need to be sustainable. This does not mean that service models and resource deployment need be fixed, rather that there is a long term commitment to this issue where both commissioning and service provision can be responsive to changing needs over time.

In most cases, PCTs will wish to avoid short-term funding. The Compact\(^{27}\) for example commits Government to working towards longer term funding arrangements with third sector organisations, 3 years being the accepted period with options to extend where appropriate. Even where a service approach is being piloted, this should incorporate a clear commitment to pick up long term funding if the evaluation is favourable. Another option for consideration, is the use of grant aid, (see working with the 3rd sector p46).

**Payment mechanisms and contractual currency**

The payment mechanisms and contract ‘currency’ will vary dependent upon the contract type being used. For some contract types PCTs will have less flexibility to adapt the payment mechanism and contract currency to suit the particular aims of the service and reflect the necessary outcome measures.

Existing providers working under GMS or PMS contractual arrangements have identified that the QOF process and the GP patient survey can potentially act as disincentives for practices taking on socially excluded people. We have, however, encountered services which have overcome these difficulties.

\(^{27}\) Strengthening partnerships with voluntary and community sector: Compact code of good practice on funding and procurement, DH 2007
Where there is no tie-in to the limitations of existing contracts, PCTs will want to consider contractual arrangements which support a flexible ‘design and build’ approach to establishing services for socially excluded people. Initial funding of these contracts establishes or supports a service within existing wider social and healthcare networks, and investments are used flexibly to allow service offers to flex and respond to generic and specific client groups. This may have a number of features and advantages including:

- services are designed around users needs rather than diagnostic or clinical category
- potential users, or communities of users, are involved in service design and outputs
- contractual arrangements commission for ‘capacity’, rather than units of activity in the first instance (This helps to reduce risk for the provider, and ensures that the commissioner is not paying a premium for service change within the life of the contract)

To overcome this problem some PCTs have agreed local QOF frameworks which better fit the particular needs of these specific practice populations and enable practices to be rewarded for achieving these targets. See case study 10

The same issues can also be applied to the GP patient survey. In addition, there can be further problems with communication including literacy and language which are more prevalent amongst socially excluded people than the general practice population. Some existing providers have still found however that persevering with patients and advocates to support them in completing the survey provides very valuable feedback. See case study 9

### QOF

Practices with high numbers of people from socially excluded groups report difficulties in meeting QOF indicators for a number of reasons including:

- low numbers of patients on certain registers leading to easily skewed results
- the level of engagement of these patients is often lower as health is not necessarily their priority
- these patient groups are often highly mobile making long-term intervention difficult.

### GP Patient Survey

The same issues can also be applied to the GP patient survey. In addition, there can be further problems with communication including literacy and language which are more prevalent amongst socially excluded people than the general practice population. Some existing providers have still found however that persevering with patients and advocates to support them in completing the survey provides very valuable feedback. See case study 9

**‘Design and build’ approaches to commissioning**

Where there is no tie-in to the limitations of existing contracts, PCTs will want to consider contractual arrangements which support a flexible ‘design and build’ approach to establishing services for socially excluded people. Initial funding of these contracts establishes or supports a service within existing wider social and healthcare networks, and investments are used flexibly to allow service offers to flex and respond to generic and specific client groups. This may have a number of features and advantages including:

- services are designed around users needs rather than diagnostic or clinical category
- potential users, or communities of users, are involved in service design and outputs
- contractual arrangements commission for ‘capacity’, rather than units of activity in the first instance (This helps to reduce risk for the provider, and ensures that the commissioner is not paying a premium for service change within the life of the contract)
• ‘capacity’ payments provide an income guarantee sufficient to cover the provider’s core costs for the first stages of the contract. (This enables providers tendering for new services to submit more reasonable bid prices as commissioners are sharing the risk)

• in exchange for assuring stable funding for the provider, commissioners and patients benefit from more responsive services with fewer boundaries for acceptance

• providers have an obligation to collect specified data and information to inform future commissioning and service design and to allow appropriate monitoring of agreed outcome measures

• innovation and best practice shapes service change alongside achievement of best value for local public service investors.
Section 6: Working with and developing providers
Section 6: Working with and developing providers

There are a range of potential providers of primary care services for people from socially excluded groups. This section outlines the potential issues when working with the various providers and the opportunities afforded when commissioners work with them to develop and adapt to meet changing needs.

A number of different types of provider organisation can be involved in the delivery of primary care services for socially exclude people, including:

- existing local GP practices (and other primary care contractors)
- ‘specialist’ practices
- third sector organisations
- local ‘provider’ arms
- local acute trusts
- a partnership/enterprise or network involving some, or all, of the above.

The range of services provided by these organisation types will vary, as will the extent to which they include specialist clinicians and enhanced services. By incorporating the key features described in Section 4 into strategic plans and commissioning processes, PCTs can enable appropriate access to the range of high quality services socially excluded people require, and have a right to expect, whatever the provider.

As with any area of commissioning, but particularly in this field, it is very important to provide support to providers and market development opportunities which are appropriate to the local circumstances and the long-term strategic vision of the commissioner – whilst still encouraging innovation. The issues and opportunities for working with a range of potential provider types are outlined below.

Working with third sector providers

In an environment where clients are often suspicious of statutory services, third sector providers are key players and perform a significant role in providing services which engage people. Commissioners, however, can often find it particularly challenging to engage successfully with this sector. Often this is because there are several different small organisations to deal with, which cater for quite specific people. Many PCTs do not have the capacity to manage the level of engagement required to involve these expert providers in developing the strategic approach generally, or to support them in developing their responses to commissioning needs. Equally third sector providers often report great difficulty in engaging with PCTs at the correct level, or at all.
Smaller third sector providers have also frequently reported that the formal procurement processes are inflexible and over complicated. They do not have the capacity to cope with the work required to complete bids to the standard required. They are often also cut out of the pre-tender stages in the mistaken belief that such involvement would undermine the procurement process. PCTs can involve providers in the design of services and service specifications without jeopardising the integrity of the procurement process by means of such approaches as competitive dialogue, and more general market communication approaches.

The Compact

Established in 1998, the Compact is an agreement between Government and the voluntary and community sector in England. It recognises the vital role that the sector has in society, working alongside the state and the private sector. The Compact provides the framework for how both parties should work together, with overarching principles and then commitments that each side will undertake in order to ensure productive partnership working. It is built on trust, mutual goodwill and the belief that working together will produce better outcomes than working in isolation.

The Compact is not statutory guidance, its authority derives from the fact that it is signed up to by government and the sector. The Compact applies to central Government Departments, including Government Offices for the Regions, and Executive Non-Departmental Public Bodies that have a relationship with the voluntary and community sector. All English local authority areas are covered by a ‘Local Compact’. These compacts, along with regional compacts that support them, provide a jointly agreed framework of principles to guide the working relationship between local authorities, primary care trusts and other public bodies and the third sector in the area, with the aim of deriving mutual, purposeful and positive benefit.

The Department of Health has recently issued guidance for commissioners in the use of grants as an alternative to commercial contracting. This is seen as particularly appropriate with the current emphasis on the move to more self care support. Commissioners could consider the use of grants as a legitimate funding mechanism when used appropriately for third sector organisations.

“There is a common misunderstanding that in the move towards ensuring service provision is properly purchased through procurement processes and contracting, there is no longer a role for grant funding. This is not the case.”

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28 Strengthening partnerships with voluntary and community sector: Compact code of good practice on funding and procurement, DH 2007
29 PCT Grant Making Powers to Commission Long Term Conditions Self Care Support from Third Sector Organisations Gateway Ref: 12947
Commissioners can encourage collaboration between organisations in the third sector, ensuring that specific expertise and ‘reach’ into local communities is achieved as part of both specialist and mainstream services. Service specifications, commissioning and tendering briefs can encourage and weight towards partnership approaches. Commissioners can also invest their time and resources in establishing forums that encourage partnerships to emerge.

Resources for supporting third sector capacity building, including collaboration and partnership, can be found at www.improvingsupport.org.uk. The housing action charity (HACT) has also produced a range of practical resources for developing collaborative working between large and small organisations – www.hact.org.uk/collaborate-publications/717

**Commissioning from mainstream primary care contractors**

There are many practices up and down the country which currently provide high quality services for socially excluded people. Coverage is patchy, however, and PCTs will wish to work more closely with their local practices to reduce the barriers experienced by socially excluded people when trying to access general practice - especially where these can be overcome by relatively simple and no or low cost adaptations. There is no reason why primary care services for socially excluded people cannot be provided under the terms of existing contractual arrangements including GMS and PMS. The more specialist requirements of socially excluded individuals, however, are likely to require that mainstream services work within a wider network of service providers with direct access to specialist support when required.

Health professionals often find the sheer complexity of problems – particularly those outside immediate health needs – a daunting prospect. They do not have the immediate access to other services clients need, and may not feel confident addressing complex problems which relate to the excluded client’s life circumstances. It is important, therefore, that mainstream providers feel supported as part of a wider network and have access to support and advice from ‘specialist’ providers. Such an approach will help individuals to continue to be supported within mainstream, and will also facilitate the move from ‘specialist’ to mainstream.

‘Improving Access, Responding to Patients’[^30] is a ‘how-to’ guide recently issued to PCTs and practices. Whilst this has not been compiled with the needs of socially excluded people primarily in mind, many of its principles and tips can be readily applied to overcoming the problems socially excluded people encounter. These include:

- the engagement of service users – the concept of ‘outreach’
- training staff to raise ‘awareness, increase cultural competency, not judge on appearance, manage the waiting area, the use of quiet areas, auto alerts etc.
- adaptation of the access diagnostic tool to assess current state of access for socially excluded people.

[^30]: Improving access, responding to patients – a how to guide for GP practices
http://practicemanagement.org.uk/introduction
Suffolk PCT - improving access for marginalised communities

In general NHS Suffolk has excellent primary care access but concerns were highlighted about access for specific and marginalised groups. Suffolk has become increasingly diverse over the last decade and the PCT needed to identify if healthcare needs were being met and identify any issues or barriers to primary care access. The PCT believed that by looking at improving access for marginalised groups they would also address wider issues, such as reducing the health inequality gap. The Healthy Ambitions Suffolk initiative is also a key driver led by Suffolk Strategic Partnership, to help reduce inequalities and make Suffolk the healthiest county in the UK by 2028.

A consultancy firm (Ararna) was commissioned by the PCT to carry out secondary research on the prevalence and types of marginalised communities in Suffolk, as well as identify issues faced by these communities when accessing primary care. To identify and establish the marginalised groups across the county Ararna reviewed Suffolk’s Public Health reports, County Council data and other documents from the PCT and third sector organisations on work that was related to socially excluded and marginalised groups.

Overall, 14 marginalised communities were identified within the scope of the project. However it is acknowledged that this figure is not exhaustive and more marginalised groups may reside across the county. Nine main issues with primary care access were identified that were common across many of the marginalised groups, for example language barriers and communication inefficiencies. Literature and evidence collected from other PCTs across the UK, with similar demographics, was also reviewed to establish good practice examples. Face to face and telephone interviews with key individuals from Suffolk County Council and other PCTs were conducted to gain a good understanding of the issues and policies surrounding access for socially excluded groups.

From the research findings a number of practical solutions were developed to improve access for the marginalised communities. The recommendations include a mixture of both PCT level and GP practice level solutions, as it was felt that initiatives would have little impact on improving access if only implemented at one level. It was also evident that from the NHS Suffolk Single Equality Scheme (2008) that high level leadership is necessary to achieve sustainable and effective change. The PCT and practices need to work in partnership to achieve an improvement in access.

Solutions put forward included the development of a commissioning guide for the PCT and a GP practice toolkit including a ‘how to’ guide. A key feature of the ‘how to’ guide is that it explains and demonstrates how the nine common issues impact upon marginalised groups who access primary care. The PCT are now in the process of launching this ‘toolkit’ across mainstream general practice within Suffolk. A further recommendation was the implementation of a customised training programme for NHS staff to ensure staff at all levels become more culturally competent in order to effectively address healthcare needs of the diverse population of Suffolk.

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Practice based commissioning clusters and federations of practices

Practice based commissioning (PBC) clusters potentially provide an ideal opportunity for achieving improved access to primary care services for the most excluded people. This is especially true where there is an emphasis on local multi-disciplinary clinical partnership. PBC groups have wider responsibilities than individual practices and more opportunity to effect change. They can consider problems from a larger population perspective, including the needs of those not currently permanently registered, and work together to meet their responsibilities to the most vulnerable people.

Those with responsibility for acute services and community services budgets will be able to make the links between meeting the needs of the socially excluded and achieving wider targets eg reducing inappropriate use of A&E, reducing emergency admissions, by identifying high cost patients and providing more upstream interventions.

PCTs can work with influential local leaders to make the case for change with PBC consortia. Groups of practices can also work together to support the reasonable adjustments practices may need to make to meet the needs of the socially excluded. For example they could support PBC-wide training programmes, align referral practices to support re-designed, integrated care pathways. They would also be more able than individual practices to accommodate such initiatives as advocates, support workers etc. Working closely with other partners is also easier as part of a wider consortium than as an individual practice.

“PBC presents primary care with a number of opportunities to reduce inequalities by allowing the primary care team’s unique knowledge of the area to influence the provision of care. GP practices can use their significant knowledge of the population to identify and target specific individuals or groups with particular needs. Such knowledge can be used to provide a stronger focus for commissioning, working jointly with appropriate community partners. Practices must consider themselves as serving the whole of the local population – not just those who come through the surgery door.”

Developing integrated ‘specialist’ services

As described in Section 4, the complex needs of socially excluded individuals are likely to be best met by services which provide an integrated socio-clinical response are far more likely to be successful in meeting these needs. PCTs may not have the means to establish new, co-located and integrated services, but will wish to consider the opportunities available to work with providers to improve the integration of existing local services across service providers. PCTs should aim to build integrated services with a clear reputation for welcoming socially excluded people and with a philosophy of excellence and high prestige. This will in turn encourage individuals to access the service as a matter of choice and will also make such services more attractive for staff.

GP-led health centres
The new GP-led health centres (established under the equitable access to primary medical care’ programme) provide an ideal opportunity for PCTs to improve access to primary care services for socially excluded people. They provide a focus around which additional services and care pathways can be built. Their underlying ethos is one of accessibility, where traditional barriers to access are reduced:

• they are usually situated in highly accessible, central areas, (some alongside A&E departments)
• they are open, with a GP present, 8am until 8pm, 7 days per week, 52 weeks per year
• they have the facility to register patients
• they can treat unregistered patients
• walk-in services and pre-bookable appointments are available to both registered and unregistered patients
• many have co-located services such as sexual health services, dental access centres.

It is important that such centres are well integrated into the local sector and are committed to sharing information on vulnerable clients and following existing care plans.

“PCTs need to work hard to ensure that the new GP-led health centres do not repeat the recent experience of walk-in centres with regard to the most vulnerable i.e. walk-in centres have improved access for white, middle class patients but it is possible that in so doing they have widened the gap in health inequalities.”

Our recent survey of commissioners and providers of GP-led health centres has shown that a number of PCTs have already tried to build in a focus on meeting the needs of the most vulnerable people into their service specifications. Many specifications actively encourage innovative approaches from providers. Even where this was not specifically built-in to original service specifications, providers are reporting that their services are beginning to be used by socially excluded people. Commissioners can maximise the ability of GP-led health centres to help meet the needs of socially excluded groups by:

• incorporating the use of ‘outreach’ approaches and support workers with service specifications
• increasing the involvement of partner authorities and organisations to expand the range of co-located services and facilitate supported onward referral
• putting in place a clear reciprocal arrangement with A&E services
• applying ‘reasonable adjustments’ set out in Step 4 of this guide.

32 Addressing Health Inequalities: a guide for general practitioners. RCGP health inequalities standing group. Feb 2009
Commissioning around ‘touch-points’ with local services

When mapping current service provision and usage by socially excluded people, it will be important for PCTs to identify and understand the key service ‘touch points’ for these people. Often these will be with services which are not designed to offer primary care or continuity of care e.g. A&E departments and pharmacies. It may take time to change these patient flows, as these are services which clients are clearly comfortable with. PCTs will want, therefore, to recognise these ways of accessing services when drawing up their commissioning plans and change service responses to take the opportunity of intervening when people attend for one reason and ‘present’ with another. PCTs may wish to plan for a gradual change towards more ‘appropriate’ use of services e.g. by supported re-direction or reciprocal arrangements between services and agencies and encouraging more vertical and horizontal integration of services. Alternatively, PCTs may wish to use these touch points opportunistically to provide a wider range of health interventions, or to build new services around these locations, in order to maximise opportunities for longer term care and advice.

Collaborative commissioning approaches

There is an argument that some aspects of services for socially excluded people are too specialist for individual PCTs to commission in a cost effective way. In addition, particularly for some large urban areas, socially excluded individuals will frequently access services across a number of different PCTs. In these cases there may be merit in considering whether a ‘specialist’ service approach, or a ‘lead commissioner’ approach. This would enable a consistent approach across commissioners which will be helpful both for patients and provider services.
Section 7: Monitoring performance – flexing and changing services
Section 7: Monitoring performance – flexing and changing services

In addition to specifying the range and nature of services, PCTs will want to set out the standards they wish provider to achieve and be clear too about the outcomes required, to incentivise the behaviours of providers and influence the style of service they wish to see provided.

Incentivising continuous improvement

A key underlying theme for the commissioning of services which promote inclusion will be a philosophy of continuous improvement for individuals wherever possible, with models of care that allow stabilisation of clients with complex needs alongside positive pathways to recovery. Outcome measures should seek, therefore, to encourage services to work in this way.

For ‘specialist’ services in particular, commissioners will wish to have measures which assure that services working with complex client and case loads can maintain clear pathways to mainstream services as part of the journeys to appropriate care and recovery for individuals. PCTs will wish to monitor specialist services to assess whether they are ‘locking’ clients in to service offers rather than using more generic and widely available primary care locally.

For mainstream services, PCTs may wish to consider incentivising providers to treat these people – or reduce disincentives for reluctance to treat, by placing emphasis on individual rights to care and equity of access.

As described in Section 5, with a ‘design and build’ approach to service development, improving results, quality and outcomes justify light touch monitoring and evolving risk sharing agreements linked to clear outcome based specifications.

Commissioners will want to assure themselves that not only the range of services provided is appropriate, but that this is supported by best available evidence. Good comparative information for socially excluded people is very difficult to find. PCTs may therefore want to establish a clear set of measures specifically designed for these people.

PCTs will wish to consider including more detailed requirements regarding the gender, language and skills mixes of provider workforce within service specifications to reflect the needs of the people accessing the service. PCTs may also wish to align some performance measures to the ‘reasonable adjustments’ they wish service providers to make, or simply specify these as requirements.
Service user feedback

Ensuring meaningful feedback from service users and utilising this to monitor performance is essential for informing service change and development. Commissioners will wish to consider supporting providers to develop appropriate methods for gaining this feedback from people where ‘mainstream’ methods, such as standard patient surveys are unlikely to be helpful.

Assurance and reporting performance

In order to maintain momentum and focus on improving access to services and health outcomes for socially excluded people, PCTs will wish to consider:

- where is the most powerful place to report - both within the PCT and with other partner organisations?
- who will be the champion for this issue within the PCT? Is there a named Director with responsibility?
- what information will be required to do this job well? Which Key Performance Indicators and exception reports will have the most impact and provide the most meaningful measures?
Recommendations – Summary

- Acknowledge the issue and gain support at senior level
- Work with partners, including third sector, to:
  - better identify need
  - jointly reduce instability of individuals and make more use of resources
- Be pro-active and employ methods of ‘outreach’. Including:
  - The use of advocates/support workers to improve navigation around the system and help individuals access treatment by keeping appointments, securing medication etc
- Integrate Services and/or service pathways
- Support (Primary Care) Providers to:
  - train frontline staff
  - make reasonable adjustments to services
  - build networks which support workforce
- Be opportunistic and build services around existing ‘touch-points’
- Involve clients from start to finish
- Build in an ethos of continuous improvement for individuals wherever possible
Additional case studies

Case study 1: Open Door, Grimsby

The Open Door centre in Grimsby aims to provide a range of health and social services for socially excluded groups. Comprised of approximately 12 clinical and social care staff, the project is a niche service provider that supports patients to move on to mainstream services. It currently has approximately 800 registered patients.

Key service points:

- it offers a wide range of services such as English language classes, access to Citizen’s Advice Bureau, holistic and alternative therapies, as well a nearby medical centre
- it uses direct advocacy e.g. accompanying patients to A&E and other appointments to improve access and compliance
- it has strong partnership working. The centre works closely with other providers e.g. A&E or drugs projects to harness local services
- a collaborative approach to design, with community input into design of services has been critical to its success
- the service is flexible and constantly evaluates and re-designs its service provision to ensure client’s needs are met
- the service is supportive. Open Door aims to case manage the most challenged clients
- it has a welcoming atmosphere. Despite being in one of the UK’s worst wards for reported crime, physical security measures are low-key to provide a calm and friendly atmosphere
- the service has a health and social care record, which can be shared with other practices
- Open Door visitor numbers have doubled for each of the last two years
- 190 patients have been returned to mainstream services over the past two years.

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Case study 2: community dentistry for people with learning disabilities – Westminster PCT

In Westminster PCT a local baseline audit of GP registers of LD patients, highlighted that only 10% had a record of their oral health and only 4% had seen the dentist in the last year. As a result of this, the Community Dental Service, (CDS), with a team of two dental therapists reviewed their dental pathways and began to take a targeted and tailored approach, contacting people with learning disabilities and encouraging them with accessible literature to register with the CDS and have regular check ups.

Key service points:

- dental therapists have been proactive and have gone out to build relationships with local organisations and contact people with oral health needs
- the project has had strategic support and leadership from the Westminster Learning Disabilities Partnership and the needs of learning disabled were highlighted in the JSNA
- more learning disabled people are now registered with the CDS (231 contacted by the CDS of which 225 were seen)
- the oral health of these people has improved
- the Oral Health Action Plan raises oral awareness in people with Learning Disability and carers and support workers.

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Case study 3: The Quays Clinic, Hull

The Quays clinic offers a service to a wide range of clients with drug and alcohol problems, asylum seekers and refugees, sex industry workers, homeless, patients with mental health problems and patients unable to be managed in other GP surgeries. It currently has approximately 1,800 registered patients.

It was originally a PMS pilot, established in 2001, although it is now a PCTMS. Its aims are:

- improving access to appropriate and effective care for the target groups of patients
- better integration of primary care with community and secondary care
- development of strong and sustainable partnership working.

Key service points:

- in addition to routine general medical services, the practice offers multi-disciplinary, complex treatment teams deal with more chaotic clients to provide short, intensive interventions
- the service has shared posts allowing clinicians to work at the Quays and other clinical settings
- co-located services eg local addiction service
- an holistic approach to health and social issues facing clients
- a flexible appointments system responsive to more immediate demands
- staff use the same clinical system across all client groups
- clients build trusted relationships with staff and feel supported
- the clinic undergoes a regular review process.

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Case study 4: TB van – mobile x-ray unit, London

Established in 2005, the mobile X-Ray Unit, (MXU), provides a mobile tuberculosis screening service from a van that visits London homeless hostels, as well as prisons. The ‘find and treat’ model was based on a mobile x-ray unit that operated in Rotterdam and aims to address the high prevalence of TB in London amongst homeless people, raise awareness of and promote the importance of screening over the long-term.

The project is staffed by a social worker, nurses and an outreach worker. It has a peer advisory group to ensure service user involvement. Over the course of 21 months, over 20,000 individuals have had chest x-rays, with very high rates of undetected TB (per 100,000 screened) found among problem drug users, homeless people and prisoners.

Key service points:

- the MXU visits hostels twice a year, working closely with them to try to ensure that all residents are screened
- refreshments are offered and people are able to see their x-ray
- staff are able to x-ray and identify possible TB infections within a few minutes
- where a possible case of TB is identified, it is explained to clients and, ideally, they are taken to one of London’s 30 specialists TB clinics, (the number and fragmentation of these clinics eg varying systems, opening hours etc, is a key challenge for the service)
- as x-ray and sputum sample already being taken, referral to treatments is reduced from 2 weeks to within 1-2 days
- the approach is proactive, client focussed and has a quick turnaround
- the ability of skilled workers to inform and motivate, and the timing of the intervention leads to a far better uptake among homeless people.

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Case study 5: St Mungo’s homeless intermediate care pilot – Cedars Road Hostel

Based in St Mungo’s Cedars Road hostel and established in 2009, the Intermediate Care pilot provides intensive support to patients for a 6-12 week period. Its aim is to reduce the mortality and morbidity in clients residing at the hostel, in tandem with reducing their secondary care usage. The project team has 3 members of staff – a nurse, a support worker and care doctor.

There are 10 beds available and clients must meet a set of criteria:

• must be resident at Cedars hostel, when accepted onto the project
• registered, or consent to register with local Courtyard surgery
• not independently meeting their own health needs
• has a deteriorating medical condition which will benefit from intensive nursing intervention
• at imminent risk of unplanned hospital admission
• is judged to be at most imminent risk of death/increasing disability by the intermediate care team
• willing to engage in and consents to take part in research data collection.

The service has the following key elements:

• outreach work: building trusted relationships with clients
• clinical interventions: administering medication, taking blood tests, wound dressing, personal care etc.
• liaison and referrals: helping clients to engage with all of the specialist services they should be accessing
• screening and prevention: carrying out Comprehensive Health assessments, cervical and sexual health screening, blood screening, vaccinations etc.
• escorting clients for appointments/visits
• Research data collection.

Contact details: http:www.mungos.org/enews/health-homelessness/intermediatecarepilot
Case study 6: Walsall Pacesetters Project – breast screening services for women with learning disabilities

Walsall integrated learning disability service took the lead on increasing the number of women with learning disabilities in Walsall undergoing breast screening, as part of the DH Pacesetters programme, after evidence showed that uptake amongst this group was much lower than the general population.

The majority of service users found the initial screening process distressing, which led to future failures to attend. Walsall integrated learning disabilities service engaged with service users to enable them to contribute to the design and delivery of the project. Patients were identified by cross checking the registered patients database with the LD service caseload. (This is regularly updated). Patients were then targeted with easy read letters. Several health education groups were held, entitled ‘Looking After Our Bits’. These raised awareness about breast and cervical screening. Collaborative clinics were held by the breast screening service.

Many women with LD have additional mobility problems – access to mobile units is difficult and there is not enough room for carers. Appointments at the mobile unit are 6 minutes. To overcome these problems, 20 minute appointments were offered at the hospital clinic. This allowed time for a full and clear explanation of the process and for the client to become familiar with the radiographer. Familiarisation pre-visits were made available and facilitated by a LD nurse and radiographer to discuss, touch and see machinery in action.

Outcomes to date:

- 40% of women eligible for screening attended. (For 20% of these it was their first visit)
- 33% of these had previously failed to attend appointments – with advice and support all attended and continue to do so.

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Case study 7: Praed Street Project – supporting female sex workers

The Praed Street Project provides sexual health and support services for women who work, have worked or are associated with the sex industry. Launched in 1985 and based at St Mary’s Hospital in Paddington, the project is the UK’s first dedicated sexual health service for female sex workers.

The project has 7 members of staff, including a consultant, project manager, nurses, project workers and an interpreter. The service is funded by the PCT as part of the core services provided by the GUM clinic in the hospital.

There are 3 main elements to the service:

- **GUM clinic**: with rapid point of care testing, fast track walk-in service, teaching/clinical observation for staff from other agencies, referral to project sexual health and drug use issues
- **drop-in service**: informal setting with opportunities to discuss a range of issues including sex work and safety, sexual health, condom use, legal issues, child protection, and exiting the industry
- **outreach**: engages new clients, re-engages existing clients by visiting flats, contacting via the internet, and newspaper ads or word of mouth. Builds relationships with workers, provides condoms and offers basic health promotion advice.

Key elements which work:

- they build trusted relationships with clients via continuity of staff and working 1:1
- advocacy. Being an NHS service on a hospital site gives staff credibility and enables them to represent clients more effectively
- partnership working. Praed St works with and provides referral to a range of other projects including the TB team, Westminster drug project etc.
- evaluation. Outcomes are measured using the patient satisfaction survey; attendance at the clinic/drop-in; comment box; and meeting clinical targets eg attendances, contacts etc.

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Case study 8: Maple Access Partnership, Northampton

Started in 2001 as a PMS+ practice in Northampton town centre. Set up with the aim of providing a service to all those who had difficulty accessing primary care eg the homeless, travelers, sex-workers and the increasing numbers of asylum seekers and refugees. The PCT encouraged and supported this venture and additional support also came from a variety of central and local government sources. They now have over 5000 patients.

Key service points:

- the demographics have changed over time e.g. Kosovans who formed a significant part of the list originally are now very few in number. Key groups now include Somali refugees, Latvians, Poles and Romanians who have increased in number in recent years
- interpreting services are crucial
- the numbers of homeless and those in unstable accommodation such as bail and other hostels and temporary housing remains and includes sex-workers and many with major drug, alcohol and mental health problems
- the Maple service sees patients with complex needs patients (many of whom have personality disorders) who have often have found conflict with staff in standard practices. The Maple practice has tried to develop ways of engaging, managing and stabilising them
- the practice holds the “Violent Patient Contract” for the county on a temporary basis and is currently assessing how best to construct this for the future
- at present the practice has additional mental health specialist Nurses and a clinical support worker, 280 patients for whom they provide structured drug treatment for opiate dependency from the drug and alcohol action team (DAAT) through the adult pooled treatment budget. The DAAT also funds a drug worker for the sex workers
- currently funded through two main streams; PMS+ contract with NHS Northamptonshire, and contracts with Northamptonshire DAAT which cover the substance misuse shared care work. The PMS+ contract includes an additional amount per patient to take account of the additional complex work the practice provide in-house.
Next steps for the services include:

- working with the local PBC consortium and PCT to agree a standard payment per patient. This would then be supplemented by a local enhanced service payment to cover the complexity of the work provided by the practice and the particular patient mix. This will then enable a series of outcome measures to be agreed and allow both the practice and commissioners to better monitor the service. This will, in effect, also enhance the local QOF and allow the practice to be rewarded for this work. By approaching it in this way, this is a model which could be adopted by other practices if they wish to provide services to socially excluded people. In addition, the PBC will support discussions to enable practice to practice referral and facilitate a more supported network of clinicians working with socially excluded people.

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Case study 9: Dawn Centre, Leicester

First established in 1990 with two half-day GP clinics a week at the Night Shelter and a drop in centre. In 1998 an outreach service was proposed with clinics provided in drop-in centres and hostels across the city with the aim of making primary health care more accessible to homeless people. The service went through a number of configurations and in January 2006 the service moved to a new base at the Dawn Centre. This multiagency one-stop-shop allows the service to maintain easily accessible outreach provision within a drop in centre and night shelter, while working in closer collaboration with partner agencies in purpose built premises.

Key service features:

The target population for the service is made up of single homeless people in the City of Leicester. Including; rough sleepers, residents in four of the City’s direct-access hostels for single homeless people and the Dawn Centre, street sex workers, those vulnerable to homelessness (e.g. in the resettlement stage) or of no fixed abode, residents of bail hostel. In January 2007 the service was selected from 840 applicants to be one of 25 social enterprise pathfinder projects around the country.

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Case study 10: Wakefield Integrated Substance Misuse Service - WISMs

WISMS NHS is a component service of Wakefield District Community Health Care Services, and is a key part of a multi agency partnership (Wakefield Integrated Substance Misuse Services) which includes the third sector, (Turning Point, Crime Reduction Initiatives), South West Yorkshire Partnership Foundation Trust, the Local Authority and criminal justice organisations in the Wakefield District. WISMS NHS was established 4 years ago. WISMS NHS provides treatment and care for substance misusers and offenders (adults and young people) working directly with and on behalf of GPs. The service includes primary care and substance misuse provision into HMP/YOI New Hall and HMP Wakefield (Integrated Drug Treatment System), and services for people dually diagnosed with mental health and substance misuse needs.

Contact details: mail@wisms.org.uk

Case study 11: St Werbergh’s, Chester

St Werbergh’s Medical Practice was established in 2002 as a local Health Improvement initiative to meet the needs of homeless people and those in insecure accommodation in the city. The service has evolved from a predominantly nurse-led service to a full GP practice and is now a PCTMS. They presently have a small list of approximately 200 registered patients, with a further 50 temporary residents at any one time.

Key service points:

- the service is staffed by a part-time GP, full-time nurse, a health care assistant and receptionist. They also have sessional support from a mental health nurse specialist and link in to the local community drug service (and offer a shared service for drug misusers)
- they run a drop in clinic at the local homeless day centre on an outreach basis
- they offer both bookable and drop in appointments at the practice
- they also do outreach health promotion sessions at the local hostels
- they provide the violent patients service for the PCT
- they have agreed a number of measures with the PCT in addition to the normal QOF measures and produce a report annually. The supplemented areas include: mental health, substance misuse, sexual health and TB.

Contact details: St Werburgh’s Medical Practice, For The Homeless, St Martin’s Clinic, St Martin’s Way Chester, CH1 2NR  Tel: 01244-356800
Useful reference documents


‘The engagement cycle: a new way of thinking about patient and public engagement (PPE) in world class commissioning’ www.dh.gov.uk

(Draft) Commissioning Framework and Guidance for Women in Contact with the Criminal Justice System

Primary care service framework: Gypsy & Traveller communities 19 May 2009 www.pcc.nhs.uk

‘Improving Access, Responding to Patients’, a how-to guide for GP practices http://practicemanagement.org.uk/introduction

PCT Grant Making Powers to Commission Long Term Conditions Self Care Support from Third Sector Organisations Gateway Ref: 12947

You’re Welcome quality criteria: Making health services young people friendly


New Horizons; A shared vision for mental health, Department of health, Dec 2009 http://www.newhorizons.dh.gov.uk/index.aspx


Benefits Realisation: Assessing the evidence for the cost benefit and cost effectiveness of integrated health and social care Human Rights in Health – A Framework for Local Action Turning Point 2010


Healthcare for Single Homeless People, DH Office of the Chief Analyst, March 2010
“Over 70% of PCT commissioners have asked for practical tools, techniques, and best practice case studies from other PCTs to help commission primary care more effectively.” PCCS Survey, Dec 2009

The following set of guides along with the Primary Medical Care online commissioning application, have been produced to help you and your PCT reach level 4 in the world class commissioning assurance process, and improve quality and productivity across primary care.