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Gatekeepers

Access to Primary Care for those with Multiple Needs

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> "To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. We call this proportionate universalism. Closing the gap in health inequalities requires outcomes for the *most disadvantaged to improve faster than the most advantaged."*
>
> Marmot Review : Fair Society Healthy Lives 2010

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Healthwatch Stoke is a local consumer champion, empowered with statutory powers to strengthen the voices of health and social care services.

Their website can be found at: www.healthwatchstoke.co.uk

The Expert Citizens are a group of individuals who have experienced different variations of homelessness, offending, mental ill-health and addiction. Using their life experiences to advocate for change and improvements in services that support the most vulnerable in society.

There website can be found at: http://www.expertcitizens.org.uk/

Funded by the Big Lottery's Fulfilling Lives campaign for 8 years, VOICES are committed to supporting change in the systems and services that support people with multiple needs (homelessness, offending, mental ill-health and addiction). We do this through the service coordination of specific individuals with multiple needs, but also through supporting organisations on an operational and strategic level.

Their website can be found at: http://www.voicesofstoke.org.uk/

Executive Summary

VOICES of Stoke-on-Trent[1], Healthwatch Stoke-on-Trent[2] and the Expert Citizens[3] have worked in partnership to produce this report. It describes experiences of those with multiple needs when accessing primary care in the city of Stoke-on-Trent.

There is no shortage of third sector organisations supporting the needs of this group of marginalised people, indeed their needs seem to be well understood. However, it is questionable as to whether this learning translates effectively to all institutions and disciplines. Indeed, as the Faculty for Homeless and Inclusion Health pointed out,

"For too long, the NHS has dismissed these vulnerable minority groups as simply an issue of housing and social care, but there is a growing body of evidence that long-term 'dispossession' is fundamentally an issue of health."[4]

There is now a focus upon closing this gap in varying ways. For example, St Mungo's Broadway has focused upon Health and Wellbeing boards with their 'Homeless Health Matters, the Case for Change'[5]. Others, such as VOICES and Homeless link gather the opinions of experts by experience with the hope of bringing about service change through partnership with NHS organisations. There is indeed, much good practice. This work is intended to bridge the gap locally through encouraging the combined maximisation of stakeholders, intelligence and experience.

There are ways to build upon existing good practice across the city. There are the resources to help with this in the third sector, specifically in co-designing with patients and the training of staff in a way that develops community assets whilst working in a solutions-focussed way.

Strategically, there appears to be gaps in the understanding of health inequalities within health institutions which could be plugged using effective partnership working. This appears to be a known issue with the new draft Homelessness Strategy[6] from Stoke LA pointing out that measures should be *imposed* to tackle such issues. It is hoped that this paper may be used as a tool that inspires a conversation across different organisational/departmental perspectives, working in partnership to address the needs of this vulnerable group.

[1] http://www.VOICESofstoke.org.uk/
[2] http://healthwatchstoke.co.uk
[3] http://www.expertcitizens.org.uk/
[4] http://www.pathway.org.uk/wp-content/uploads/2014/01/Standards-for-commissioners-providers-v2.0-INTERACTIVE.pdf
[5] http://www.mungos.org/documents/5390/5390.pdf
[6] http://www.stoke.gov.uk/ccm/cms-service/download/asset/?asset_id=1081608

What We Found

- In Stoke-on-Trent GP practices are far from consistent in their approach to registering those of NFA (no fixed abode);
    - 47.8% said they wouldn't take an NFA patient when asked;
    - Those who answered 'maybe' (26.09%) said that they would have to refer to colleagues for advice;
    - 26.09% of practices said they would take the patient;
    - 21.7% of practices (none of them willing to take the patient on) signposted in the direction of Snow Hill Surgery or walk in centres.
- People of NFA status are likely to receive a differentiation in service offer, risking stigmatisation. There is a way to go to reach proportionate universalism;
- With so many being unsure of what the correct procedure is, it is unclear how much autonomy gate keeping staff have when it comes to making decisions such as this;
- Barriers to care for patients are many, including stigma, distance to travel and substance abuse;
- Staff experience shows that gate keeping (receptionist etc) staff do not understand the needs of this group;
- Local GP practices are often not aligned with Care Quality Commission expectations with regard to access.
- Not being registered with a GP prevents homeless people accessing other services they need such as a social care, mental health, drug services.

Recommendations

- **Homeless people should be registered in accordance with the NHS England guidance by all practices;**

- **This guidance should be communicated to inform GP Practices of what is expected of them in relation to registering NFA patients;**

- **Gate keeping staff (receptionists and others) may need training to understand the needs of this client group and how best to build relationships with them;**

- **Training could be delivered by experts by experience to help break down any latent misconceptions or stereotypes;**

- **More work could be done to better understand any disincentives for practices and staff with regard to NFA patients, including registration fraud, attendance requirements;**

- **Systematic monitoring arrangements should be in place to ensure that practices are adhering to best practice;**

- **Commissioners could revisit their monitoring of and how they record their duty to reduce health inequalities. This could include a review and introduction of KPIs. Including a KPI measuring the satisfaction of support services registering NFA patients.**

- **Further partnership working between Health, the Local Authority and third sector organisations on initiatives such as the Joint Strategic Needs Assessment may help in identifying health inequality issues such as this in the future;**

- **Although commissioners use the Equality Delivery System (EDS2) to support their work around equality and reporting, this offers an opportunity to develop ways in which work can be done around identifying and acting upon local health inequalities;**

Introduction

2

Evidence has emerged that there are problems in Stoke-on-Trent regarding access to primary care for those with multiple needs. This report gathers together this evidence and compiles it, along with guidance on best practice and recommendations for moving forward.

I welcome this report which highlights some of the issues I have encountered in practice. Having spent a number of years providing health care to homeless individuals I have encountered significant frustrations.

Homeless link (2014) recognised the need for flexible, community-based services to prevent poor health worsening and help avoid unplanned use of acute care. There needs to be significant investment in high quality primary care, working in partnership with housing agencies so that a patient's housing need can be assessed and addressed alongside any medical needs, and which provides personalised, on-going support so everybody gets the help they need. Services can and should be more flexible in order to meet the health care needs of vulnerable groups who are most in need of health care.

> *"To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. We call this proportionate universalism."2 Closing the gap in health inequalities requires outcomes for the most disadvantaged to improve faster than the most advantaged."*

Marmot Review : Fair Society Healthy Live 2010

If primary care does not effectively support homeless individuals with their health care needs the current situation of frequent attendances to accident and emergency and significant mortality will continue.

Jane Morton – Former Community Matron for the Homeless and Senior Lecturer at Staffordshire University.

Ref - Homeless link (2014) The unhealthy state of homelessness: Health Audit Report

What We Did

Methodology

VOICES, Expert Citizens and Healthwatch Stoke-on-Trent are well aligned in their focus upon service design. This enables the pursuit of common goals and interests. In this case all agreed that these would be:

- Clients are enabled suitable access to a suitable service;
- The understanding of the needs of this client group is cascaded to staff in the health economy;

More detail regarding the development of these goals and the methodology can be found in the appendix (project spec p26).

A mixed methodology[7].

- Case studies from service users;
- Case studies from staff;
- Testimonies from experts in the field;
- Mystery Shopping Exercise;
- Desktop Research;

Mystery shopping data was analysed using Microsoft office applications and statistical software IBM SPSS.

[7] Full project specification is available in the appendix.

Narrative

Barrier 1 – Gatekeepers

Case Study - Jane Morton (former Community Matron for the Homeless).

There have been difficulties in getting individuals registered (primary care), there has been a much lower level of tolerance to exclude individuals from practices and a general reluctance to seek alternative methods of communication/ treatments to best meet client's needs. I have been told by practice staff that a client has been removed from the panel because they had not made an appointment for an asthma check the conversation went a little like this

Me – "Could I make an appointment for "X"?"

Practice- "I'm sorry "X" is has been removed from the practice"

Me – "oh he wasn't aware of this … Why"?

Practice - "he has been invited to attend for a review …. we have sent letters out 3 times and he hasn't made an appointment …."

Me - "…. but "X" was homeless so didn't receive the letter"

Practice – "practice policy is that if someone doesn't attend and engage with reviews they are invited to leave the practice, as we have not received any communication with "X" they have now been removed from the list"

Me – "but "X" was not aware of this and as you now state he is no longer registered with your practice he now does not have a GP and needs medical assessment."

Practice "We sent a **letter** out stating he is now longer registered with the practice and needs to register with a new GP"

Me – puts phone down

The above scenario was not uncommon. There were different outcomes to these occurrences, sometimes when I explained to staff I could get the individual reviewed or I negotiated with practice manager and managed to get the situation resolved. Unfortunately, on occasions there was no resolution. This required me to try to get registration which was not always easy and if I did get someone registered they could not see the doctor until either the individual had undergone a health check or records had been received from previous practice. Legislation allows for individuals to be treated as an emergency even if not registered with practice or to attend a walk-in centre but many will not treat if patient is not registered with a GP elsewhere. **"It is no surprise that individuals resort to utilising Accident and Emergency services as a default measure."**

"People experiencing homelessness are entitled to treatment in primary care services, whether they currently have an address or not. Primary Care services are well positioned to identify and treat people at risk of or experiencing homelessness and link them to the support they need." - Queens Nursing Institute[8]

As gatekeepers to not only primary care but other services that may be of use to this group, the GP practice (or homeless service) is a critical *touchpoint*[9]. This for many is a key interface between themselves and services, a possible route out of exclusion. However, access is not guaranteed. For example, the recent Homeless Needs Audit carried out on behalf of Stoke-on-Trent local authority found that 41.9% of those who needed a medical examination for a physical health problem in the last 12 months didn't receive it. Also, 16% of people said that they had been refused access to a GP/Homeless service in the last 12 months. This broadly reflects the national audit findings[10], illustrating a problem beyond Stoke-on-Trent. Doctors of the World reported that when they attempted to register patients who had presented, 39% of cases were refused[11]. The Citizens Advice Bureau carried out a study that found that only 42% of practices were willing to register without proof of address/photo ID[12].

The current local Homelessness Strategy 2016 – 2020[13] (currently in draft) also identifies this;

" . . . .homeless people tend to have a much greater need for health and care services than the general population, but they generally find it much more difficult to access"

The strategy finds poor access may have its consequences. It finds that between 2012 and 2015 that there were 1200 admissions to hospital with half of this related to mental health. In the same period there were 405 attendances at Accident and Emergency. Indeed, in the local Homelessness Needs Audit, 56% had attended A&E (13.6% over 3 times). All of this serves to further illustrate the importance of access. These barriers only add to the exclusion faced by this group.

[8] Assessing the Health of People who are Homeless – Queens Nursing Insititute – Accessed on 23rd May 2016 from http://www.qni.org.uk/docs/HAT_final_web.pdf
[9] A touchpoint is an interface between services and service users.
[10] http://www.homeless.org.uk/sites/default/files/site-attachments/The%20unhealthy%20state%20of%20homelessness%20FINAL.pdf
[11] Doctors of the World, Report: Registration refused: A study on access to GP registration in England https://www.doctorsoftheworld.org.uk/blog/entry/vulnerable-people-are-being-wrongly-turned-away-from-gp-surgeries
[12] Citizens Advice Bureau Report: Registering Frustration https://www.citizensadvice.org.uk/Global/CitizensAdvice/Public%20services%20publications/Registering_frustration_Citizens_Advice.pdf
[13] http://www.stoke.gov.uk/ccm/content/housing/council-housing/housing-options/homelessness-review.en;jsessionid=aL5KFHuQ6kG_

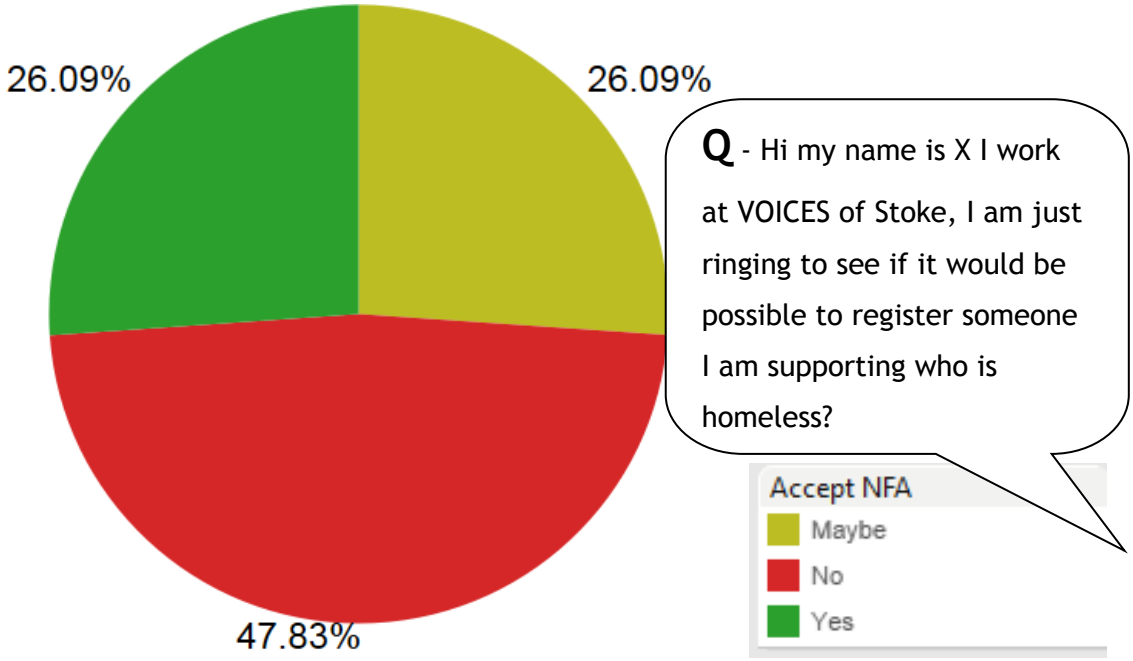
In 2014 and 2015, VOICES of Stoke-on-Trent customers anecdotally reported difficulty accessing GP Surgeries due to their status being of 'no fixed abode' (NFA). This culminated at the end of 2016 with a service user in temporary accommodation being unable to access several GPs in the local area.

> *" . . . local GP practice close to Martin's temporary accommodation, they declined due to Martin being NFA, and refused for him to register as a temporary patient. This occurred on 29/10/15"*
>
> **VOICES – Case Study**

Staff working with service users also reported being unable to refer customers from supported accommodation to local GP's due to a large amount of identification being required. The rough-sleepers team for the area reported that they had been advised to signpost customers to one GP surgery. This surgery, Snow Hill, is no longer funded to provide a specialist service for the homeless.

In order to better understand the extent of the issue locally, partners in this project embarked upon a mystery shopping exercise. An attempt was made to contact all of the GP surgeries in the city with a set of questions (see appendix). The results are below.

VOICES of Stoke - Mystery Shopping Results[14]



n=46 (practices contacted)

- When asked if they could register a homeless person, 26% (n=12) answered 'maybe', a notable near-half (47.8%) said 'no' with just over quarter (26% n=12) saying that they would;

- Of those that answered maybe, all staff (n=12) said they would have to defer to colleagues for advice. It is unclear how much autonomy gate keeping staff have when it comes to making decisions such as this;

- Of those who said they would (n=12), there was still a lack of clarity with 2 of them saying they were unsure what ID was needed;

- 10 practices, none of them willing to take the patient on, signposted to Snow Hill Surgery (n=4) or walk in centres (n=6).

[14] Identification of practices has been deliberately protected.

Barrier 2 - Exclusion and Stigma

As already described, Primary Care is a key touchpoint for those in need of services. However, barriers go beyond simple gate keeping and understanding other ways in which this group can become excluded is important as it identifies training needs for potential gate keeping staff and others.

A study by Wood et al[15] (1997) found there to be a variety of disincentives described by practices when considering registering a homeless patient. These included (from a survey of 155 GP practices);

- Associated social problems (90% of respondents agreed);
- Lack of medical records (88% agreed);
- Complex health problems (79% agreed);
- Associated drug or alcohol abuse (78% agreed);

At the time of the publication of Wood et al (1997) document there were calls for practices to be incentivised to take on these patients. This chimes well with the (draft) Stoke-on-Trent Homelessness Strategy suggesting a need to 'impose measures'.

It certainly is true that this group does need special consideration. In the appendix (p29) is enclosed some guidelines for locum staff at a practice in Bradford which illustrates some of the specific measures taken.

Also, it could well be that the way in which practices are funded means that having patients who are at high risk of failing to attend is in itself a disincentive alongside other funding streams that may be affected.

> *" . . .attempted to register with Martins's (a customer) at his previous practice. However the practice declined due to Martin being NFA and due to the level of Doctor Call outs he had requested"*
>
> VOICES – Case Study

A study conducted by Chuck et al (2007)[16] (in Canada) which explored how 'welcome' patients felt in healthcare encounters, found that "participants perceived their experiences of unwelcomeness as acts of discrimination" (ibid).

[15] Wood N, Wilkinson C, Kumar A, 1997, Do the Homeless Get a Fair Deal From General Practitioners? - http://www.ncbi.nlm.nih.gov/pubmed/9519661

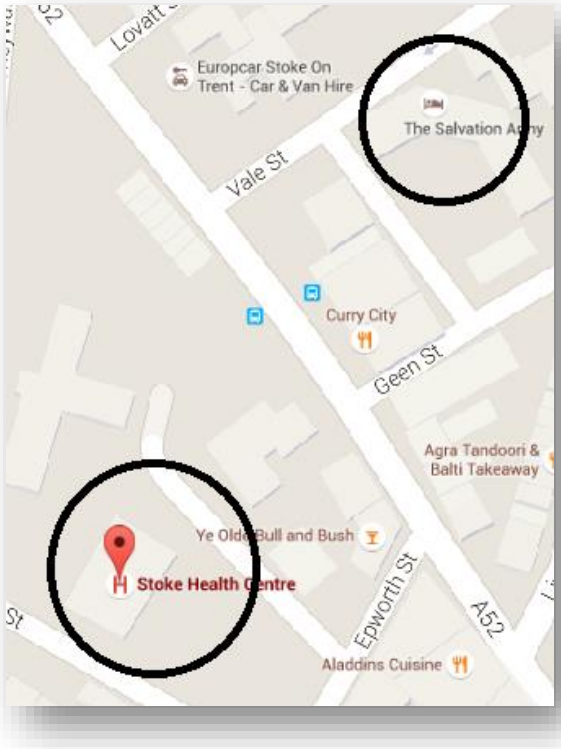
"On two occasions I have had reason to believe that because I am in a shelter, it's like secondary treatment . . ." (ibid)

Many studies have found strong correlations between homelessness and a multiplicity, and increased severity, of both physical and mental health conditions[17]. There is evidence that this in itself can impact upon access. For example, Earnshaw and Quinn[18] (2011) carried out research into the impact of stigma on people living with chronic diseases. They found that

"People living with these illnesses report feeling shame, guilt, and diminished self-worth." (ibid), and that;

"Internalised, experienced and anticipated stigma within healthcare settings likely act as barriers to care access" (ibid)

Indeed, the recent Homeless Health Audit found that 43.3% described drug and alcohol abuse as the reason they might not seek help.



Some staff working with this group have been told that the Salvation Army isn't in the catchment area for Stoke Health Centre.

This was confirmed with Health Centre staff in a phone call on 14/6. The staff member also stated as they were unsure in what catchment area it falls, but suspected it was Shelton Primary Care Centre.

When measured on Google Maps, this is a distance of about 120m (straight line)

[16] Chuck K Wen, Pamela L hudak, Stephen W Hwang, 2007, Homeless People's Perceptions of Welcomeness and Unwelcomness in Healthcare Encounters, Society of General Internal Medicine

[17] http://www.mungos.org/documents/4153/4153.pdf

[18] Earnshaw V, Quinn D, 2011, The Impact of Stigma in Healthcare on People Living With Chronic Illness, Journal of Health Psychology

Health Inequalities – A Legal Duty

According to guidance[19] for commissioning produced by NHS England, CCG's and themselves have legal duties in regards to health inequalities. This is aside from equality issues and includes all service users, not just those with protected characteristics under the Equality Act 2010. **"Any group experiencing health inequalities is covered"** (ibid).

Since 2013, under the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012), the local clinical commissioning group has a duty to have due regard to reduce inequalities between patients in access to health services.

> *Guidance for NHS Commissioners on Equality and Health Inequalities Legal Duties - CCG's and NHS England must -*
>
> *"Have regard to the need to reduce inequalities between patients in access to health services and the outcomes achieved;"*

It is noted that the Stoke and North Staffordshire CCG's Equality and Inclusion Strategy 2015-17[20] is currently in draft form and out for consultation. However, this document appears to make reference to protected groups without adequately addressing the legal duties as described in the above guidance.

The draft strategy states –

"To date, the reach of the health inequality duty has not been defined, but it will likely extend to equality comparisons on measures other than deprivation." (p9)

Guidance states that "the CCG's and NHS England must consider the whole of the population for which they are responsible and identify inequalities within that population group". To do this requires intelligence gathered through partnership working and full engagement with initiatives such as the Joint Strategic Needs Assessment.

[19] Guidance for NHS Commissioners on Equality and Health Inequalities Legal Duties.
[20] Accessed 24th May 2016 from http://www.stokeccg.nhs.uk/e-and-i-strategy-2015-17

Care Quality Commissioning (CQC) – Expected Standards of Care[21]

The CQC sets out expected standards of care.

"CQC expects practices to register people who are homeless, people with no fixed abode, or those legitimately unable to provide documentation living within their catchment area who wish to register with them. Homeless patients are entitled to register with a GP using a temporary address which may be a friend's address or a day centre.

"The practice may also use the practice address to register them."

"Practices should try to ensure they have a way of contacting the patient if they need to (for example with test results). Some areas will have special services for homeless patients and practices may refer homeless patients into those services in line with local arrangements where it is in the best interests and with the agreement of the patient."

[21] Taken verbatim on 10/5/16 from - http://www.cqc.org.uk/content/nigels-surgery-29-looking-after-homeless-patients-general-practice

Best Practice – CQC

There has been much work done around best practice in this area. Nigel Sparrow from the Care Quality Commission points out some key learning in the box below.

"The Faculty for Homeless and Inclusion Health Standards for commissioners and service providers set out some standards for planning, commissioning and providing health care for homeless people and other multiply-excluded groups. This includes some specific standards for GP practices which include:

- *pro-active management of selected patients with high needs*
- *hospital in-reach ward rounds/visits for homeless patients where necessary*
- *regular outreach clinics in local hostels and drop-in centres*
- *drop-in clinics with presenting problem addressed first, with extended services (e.g. screening) offered*
- *training to help medical staff understand homeless people's needs for example ensuring receptionists are 'gate openers' for excluded groups rather than 'gatekeepers'"*

Actively engaging with NFA patients, is seen as a model of best practice. Where practice staff are trained to understand the issues around homelessness and ensure that they have equal access to services. Keeping a directory and actively ensuring that people on the list are care for. Going further, practices that are visiting people with multiple needs in hostels, and in hospital are delivering a service that the CQC would see as the higher levels of practice."

Nigel Sparrow Senior National GP Advisor and Responsible Officer for the CQC.

(12) Taken verbatim on 10/5/16 from http://www.cqc.org.uk/content/nigel%E2%80%99s-surgery-61-patient-registration

Conclusion

Primary Care is a critical touch point for those who might not otherwise access services. It is an essential gateway and every effort should be made to enable access. Not being registered with a GP is a significant barrier to accessing other services that people who are homeless often need e.g. social care, mental health, addiction recovery services. This inevitably and unnecessarily adds to the pressures on acute services such as A and E.

Registering with a GP is a national problem for this group. What is happening in Stoke-on-Trent, illustrated by the evidence gathered in this report is a reflection of this national picture. An issue specific to the city is the fact that surgeries may signpost towards a specialist service in Snow Hill (or walk in centres) although this isn't funded at the moment (April 2016). Far from proportionate universalism, this means that these patients could receive a differentiation in service from other users which is unlikely to improve their health outcomes.

This differentiation potentially builds upon the stigma that the homeless already live with. There is a perceived double deviance. For example, that stigma is delivered both externally and internally regarding the service user (the service user stigmatising themselves as well as staff doing the same). Evidence shows that this process emphasises pre existing barriers such as substance abuse, ability to travel and those generated by chaotic lives. Expert patients could work with surgeries so that they can better understand their needs and break down any stereotypes.

Previous studies have shown that GP surgeries may have disincentives to accept these patients although it is unclear as to the extent of this today. Other questions can be asked about reception staff and to what extent they may make unilateral decisions based upon little knowledge of correct procedures and grounded in stigma. The way in which practices are funded, as well as staff expectations of working with the group, may conspire to create barriers for patients. However, the CQC have clear expectations of practices.

There appears to be more work to be done in understanding health inequalities in the city. Initiatives such as the Joint Strategic Needs Assessment need effective partnership working to generate the sort of data essential to identifying and tackling health inequalities.

There is a lot of good practice nationally. Much of this could be incorporated into any new service(s). This could start with implementing the recommendations of this report, which compiled the basic foundations for such a service.

Appendix

Case Study – Gary

Case Study: Gary trying to regain access to mainstream primary healthcare.	
Background	Gary has a history of drug and alcohol dependency. Which are linked to his poor mental wellbeing and behavioural issues. Gary has been placed at the Phoenix practice for 9 years after an aggressive outburst with his previous GP.
Key engagement milestones	Gary has felt that he has made steps to adjust his behaviour at the practice. When requesting to move. The GP stated that this was Gary's responsibility. Gary and his service coordinator advocated with GP surgeries to take on Gary, however lack of endorsement from his current GP, left Gary unable to move to a new community GP. Gary has struggled with his behaviour, and has been identified as selling his own medication. Whilst this behaviour must be addressed. The lack of transparency of how he can change his behaviour to leave the practice, has caused Gary a lot of frustration. It has left him without any goals to work towards.
Outcomes and Learning	Removing people from mainstream primary healthcare can be beneficial for both patient and practices. However when there is a lack clear public/professional guidance, transparent processes and knowledge about this system. It can leave support workers and patients unclear on how patients can avoid this system and how they can change their behaviour to move back to mainstream primary healthcare. Which can exacerbate the frustrations of patients, and leaving them feeling further alienated from primary healthcare.

Case Study – Martin

Case Study: Martin- Accessing primary healthcare	
Background	57 year old veteran. Poor mobility, missing part of his foot, diabetic, epileptic, alcohol dependency, with a history of rough sleeping, social care needs, self-neglect, severe malnourishment, due to mental health and alcohol dependency. Moved out of area for 6 months, then returned to the area after eviction (illegal). Discharged from hospital NFA, since he stated he would be able to pay for a night or two or temporary accommodation himself. This was not verified, he was unable to, and began rough sleeping.
Key engagement milestones	Senior Practitioner attempts to register Martin at 4 separate primary health care facilities. Which began on 30/09/15. 1. Attempt to reregister with Martin's previous practice. However the practice declined due to Martin being NFA and due to the level of Doctor Call outs he had requested. 2. Local GP practice close to Martin's temporary accommodation, they declined due to Martin being NFA, and refused for him to register as a temporary patient. This occurred on 29/10/15. 3. Accepted temporary accommodation, but requested evidence of his stay at temporary accommodation by the Council. His temporary accommodation address was finally accepted at the third practice but required additional evidence such as a birth certificate. This registration occurred on 04/11/15. This surgery had also requested that the previous surgery take Martin, since that was his closest practice. 4. 4th practice wanted photo ID, even though Martin was already registered at practice number 3, advocacy was needed to remove this condition, and was substituted with other identification.
Outcomes and Learning	Martin only was accepted into the 3rd and 4th practice after advocacy and evidence being gathered by the Practitioner. If this advocacy was not present, it is reasonable to presume that Martin would not have been able to access any Primary Healthcare. It took just over a month for Martin to be registered at a practice. The barriers that Martin and support staff encountered would have been During this time Martin's health was deteriorating when he finally accessed his own property. With Martin finally being hospitalised due to the severity of his physical health conditions.

Case Study - Tom

Case Study: Tom- Support needs affecting access to primary healthcare	
Background	During a labouring accident Tom suffered multiple back and leg injuries, which can leave him with pain around these injuries. Tom also had developed an opiate dependency, alcohol dependency, severe anxiety, memory lapses and sometimes poor cognition and confusion. Tom also suffers from epilepsy which is exacerbated by his alcohol dependency, and his sporadic rough sleeping.
Presentation	Tom with his current conditions finds it difficult to access his current GP. His memory difficulties and poor physical health can leave him struggling to remember appointments, which can result in missed attendances. When Tom tries to book appointments again, he is met with resistance, reminded of his past missed attendances with no constructive solution for the problem. Tom has also reported attending the GP for a prescription on the week he needs a new sick certificate. Forgetting to ask for the certificate, which the Doctor can see on Tom's notes. Leaving the surgery and having to book an appointment. This can leave Tom without benefits for a number of days increasing his chances for withdrawing from alcohol. With drawing from alcohol has caused Tom to have seizures in the past and be admitted to hospital. During January whilst rough sleeping Tom developed a chest infection and accessed A&E due to this. Tom is a frequent attender of A and E, using the service for frequent injuries and when he has under gone frequent epileptic fits.
Outcomes and Learning	The GP could work with traditional support services to support Tom to attend appointments, ring him for a reminder, try a flexible model of working with Tom, or offer call outs to his supported accommodation. Tom can present in a disorientated and intoxicated state. Whilst this would not be the preferred state of presentation for any patient. Taking more time, working with support services, and acknowledging Tom's needs. This could reduce A & E attendance and the use of blue light services. Which could possibly address Tom's underlying pain and mental health self-management which could factors in his addiction. Epilepsy and seizures are a large cause for admissions of alcohol dependent and homeless people. According to crisis people experiencing homelessness are 5x more likely to report being epileptic. If the aim of the CCG is to create a primary care network with GPs with special interests. It would be wise to develop GPs with special interests in alcohol dependency and epilepsy.

Legal Duties - On the CCG[22]

• Have regard to the need to reduce inequalities between patients in access to health services and the outcomes achieved (s.14T);

• Exercise their functions with a view to securing that health services are provided in an integrated way, and are integrated with health-related and social care services, where they consider that this would improve quality and reduce inequalities in access to those services or the outcomes achieved (s.14Z1). (health-related services can be any services which impact on health, including those outside health and social care);

• Include in an annual commissioning plan an explanation of how they propose to discharge their duty to have regard to the need to reduce inequalities (s. 14Z11); • Include in an annual report an assessment of how effectively they discharged their duty to have regard to the need to reduce inequalities (s. 14Z15).

Legal Duties – On NHS England

• Have regard to the need to reduce inequalities between patients in access to health services and the outcomes achieved (s. 13G);

• Exercise its functions with a view to securing that health services are provided in an integrated way, and are integrated with health-related and social care services, where it considers that this would improve quality and reduce inequalities in access to those services or the outcomes achieved (s.13N);

• Include in an annual business plan an explanation of how it proposes to discharge its duty to have regard to the need to reduce inequalities (s. 13T);

• Include in an annual report an assessment of how effectively it discharged its duty to have regard to the need to reduce inequalities (s. 13);

• Conduct an annual assessment of CCGs, including an assessment of how well each CCG has discharged their duty to have regard to the need to reduce inequalities, and publish a summary of the result (s. 14Z16).

[22] Guidance for NHS Commissioners on Equality and Health Inequalities Legal Duties

What is meant by "...have regard to..." in the duties?

• *Lawyers advise that "have regard to the need to reduce" means health inequalities must be properly and seriously taken into account when making decisions or exercising functions, including balancing that need against any countervailing factors.*

• *Part of "having regard" includes accurate record keeping of how the need to reduce health inequalities has been taken into account when making decisions or exercising functions.*

• *The duty must be exercised with rigour and an open mind and should not materialise as an afterthought in the process of reaching a decision.*

The body/person subject to the duty must be able to demonstrate that:

• *they are fully aware of the duty;*

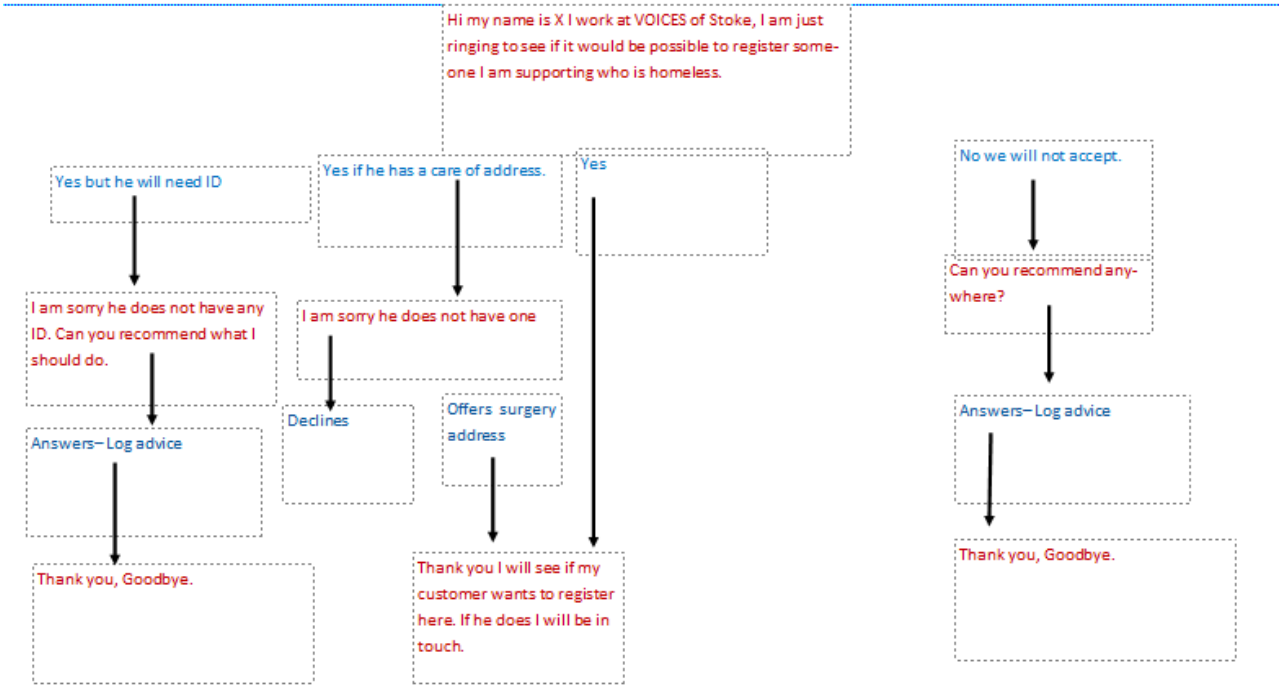
• *the duty was considered during the appropriate stages of work, from the beginning of the decision making process and throughout;*

• *the appropriate amount of weight has been given to factors which would reduce health inequalities in the decision making process.*

• *they have actively considered whether integration would reduce inequalities and act with a view of securing such integration where it would do so.*

• *accurate records have been kept to show that the need to reduce health inequalities was taken into account throughout decision making processes.*

Mystery Shopping Script



Project Specification

Title	Voices and Healthwatch – GP Access Project (Gatekeepers)
Purpose	Voices of Stoke (VC) and Healthwatch Stoke (HW) are working in partnership to improve the experience of patients with multiple needs when they attempt to access primary care. Voices have received word from their clients and those that support them that accessing GP services can be difficult. They are sometimes asked for ID which can prove difficult to provide or may be offered services at a GP not of their choice and of some distance away. The GP Access Project has been devised in partnership to better understand the experiences of service users, what service are currently available and what best practice looks like.
Context	This work is being conducted in a context of change across the health economy with a primary care strategy currently being developed. A homeless service run from Snow Hill Surgery has also had its funding removed, leaving the city without a specialist service. This client group will have multiple needs and it is understood that there is a lack of knowledge of how to manage these needs within the Stoke-on-Trent health economy. This could be seen to be leading to health inequalities (that the Clinical Commissioning Group have a duty to address) and potential equality of access issues.
Strategic Links	Primary Care Strategy; Cooperative Working Program; Health Literacy; Voices and Healthwatch are also working in partnership regarding hospital discharge of this client group;
Key Goals	• Clients are enabled suitable access to a suitable service; • The understanding of the needs of this client group is cascaded to staff in the health economy;

Item	Resp	Activity	Purpose	Deliverable(s)	Verification
1	**HW**	Contact staff undertaking Primary Care Review	To ensure that there is opportunity for the project to contribute to the primary care strategy (including pan staffs).	Phone call/Email	Healthwatch CRM entry/Email Trail.
2	**VC/HW**	Homeless Data	To be able to identify common themes that affect NFA clients in Stoke-on-Trent.	Obtain results from Homeless Audit and analyse for information about health services.	Written Report.
2	**HW**	GP contacts	To support in conducting mystery shopping (item 3)	List of GP's and contacts	Spreadsheet.
3	**VC**	Mystery Shopping	To identify common practices of enrolling patients.	Voices volunteers to phone surgeries (receptionists) as faux support officers asking standardised questions about the process of enrolling. Including- • How (without ID) • How (temp address)	Written report of responses.
4	**VC**	Client interviews	To identify common problems experienced by clients in GP surgeries with a focus upon	Voices volunteers and staff to speak to their clients and gather written accounts.	Written report of interviews.

			registration.		
5	**VC/HW**	Homeless Matrons	To identify current provision in the city and potential for improvement.	Staff to meet with previous and current matron(s) to discuss current practice and identify any gaps.	Minutes.
6	**VC**	Best Practice	Understand what best practice looks like.	Trip to (or teleconference with) service in Leicestershire. • Spec of service; • Gaps they identify; • Leaflets they may have;	Minutes; Spec; Leaflets.
7	**HW/VC**	Summary Report	Summary Report of the above, to share with the primary care strategy team (including pan staffs).	• Identification of key themes-current practice; • Identification of key themes – best practice;	Written report;
8	**HW/VC**	Full Report	Full report written in collaboration with Expert Citizens. • To explain key points but also to cascade learning, in particular to 'gatekeepers'.	• Identification of key themes-current practice; • Identification of key themes – best practice; • Development of best practice in the local context	Written report; Session plans.
9	**HW/VC**	Impact Reporting	To ensure the impact of the project is captured and properly evaluated	TBC	TBC

GUIDELINES FOR LOCUM STAFF WORKING AT THE PRIMARY CARE CENTRE FOR HOMELESS PEOPLE - Bradford[23]

1 Previously one of the problem areas at the Centre was the volume of demand from heroin addicts for Methadone maintenance treatment. Currently we have between thirty and forty addicts registered, the vast majority of these are stabilized on Methadone and, therefore, requests (demands!) to have their dose of Methadone increased should be resisted.

2 Occasionally a new patient presents at the Centre each week requesting to start a Methadone programme. Under no circumstances should these patients be started on a programme. If they are registered in a homeless hostel then the patient should be referred to Luke Turnbull who is the Addiction Therapist working at the Leeds Addiction Unit. He does sessions twice a week at our practice and does all first assessments on opiate dependent patients prior to them being started on any medication. For patients who are just giving a vague history of nfa (no fixed abode), they should be reminded that we are only taking on. patients who are resident in homeless hostels and and they should be directed to the Leeds Addiction Unit. Occasionally I agree to provide symptomatic relief medication for, patients who are undergoing, opiate withdrawal prior to their assessment by the drugs worker. This takes the form of up to a maximum thioridazine 50mg tds and 2 node, and buscopan 10mg tablets 2 tds. Obviously all of this medication is non-addictive

3 Patients on a blue script often request Methadone on a white script with reasons that they are going away or working away. Because this can so easily lead to abuse of Methadone, I tend not to agree to provide Methadone for more than five days on a white script. Remember to cancel the blue script outstanding by telephoning the relevant pharmacist. Check with the pharmacist to see ifthe patient has had a dose that day and, if so, make sure that you don't double the dose by prescribing on the white script for that day.

4 For patients who present with a history of Benzodiazepine and/or Amphetamine addiction, emphasize that a urine sample, passed on the premises, must be obtained prior to providing prescription. Also, before being given a prescription, they must provide the phone number of the last doctor who prescribed medication in order that medication,

[23] Retrieved on 7th June 2016 from - http://www.bradfordvts.co.uk/wp-content/onlineresources/0500promotinghealth/homeless%20people%20-%20guidelines%20for%20locum%20staff%20working%20at%20the%20primary%20care%20centre%20for%20homeless%20people.pdf

dosage etc can be checked prior to issue of prescription. 5 For stories about lost/stolen-scripts etc, it should be explained to the patient that the practice now operates a policy of not replacing scripts and that they will have to wait until their next prescription is due. In reality, the patients know that they will be able to buy opiates and benzodiazepines on the black market.

5 For patients who. attend the clinic to restart an opiate programme, if there has been a gap in the prescribing ten resist restarting the prescription, It could be that they have previously been removed from the bat or been in prison, therefore, they will require a full assessment by myself prior to restarting treatment.