# Aldenham Primary Care Network's guide to tackling health inequalities amongst Inclusion Health groups.

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## Introduction

Welcome to your own unique and tailored guide which has been designed to help your Primary Care Network to embed action on tackling health inequalities into its everyday activities. This guide has been developed by Friends Families and Travellers, Homeless Link, National Ugly Mugs, Doctors of the World and Stonewall Housing with support from NHS England and NHS Improvement, people from inclusion health groups, specialist inclusion health charities and representatives from Primary Care Networks.

## Inclusion Health

Inclusion Health is a field which seeks to prevent and address the health and social inequalities experienced by groups of people at risk of or living with extremely poor health as a result of poverty, marginalisation, multi-morbidity and social exclusion. The reasons vary by group, but include the effects of stigmatisation and discrimination, the complex nature of health systems and the effects of the wider social determinants of health.

The four groups originally defined under the term "Inclusion Health" include Gypsies, Roma and Travellers, homeless people, vulnerable migrants and sex workers. However, the term is widely used to refer to populations at the sharp edge of health inequalities as a result of social exclusion and stigmatisation. This includes people in contact with the criminal justice system, people with learning disabilities and mental health needs and more.

## Why are health outcomes for Inclusion Health groups so low?

There are a number of explanations which contribute to this, including:

- The effects of stigmatisation and discrimination on socially excluded groups;
- The complex nature of health systems and other barriers which prevent Inclusion Health groups from using them; and
- The effects of the wider social determinants of health (including income, education, accommodation and more) on Inclusion Health groups.

## Why is it important for your Primary Care Network to improve your engagement with Inclusion Health groups?

The severe health inequalities experienced by Inclusion Health groups are unjust and avoidable – your Primary Care Network has an important role in addressing these at a neighbourhood level. Across England, Primary Care Networks are working in innovative and impressive ways to improve engagement with Inclusion Health groups. By reviewing the services your Primary Care Network provides and how these are provided, you can make small changes which will have a significant impact on the health and wellbeing of those at sharp edge of health inequalities in your neighbourhood.

*Thank you for taking the time to complete the Inclusion Health Audit Tool. We hope that you will find this tailored guide useful in advancing your organisation's engagement with Inclusion Health groups.*

**Please note that you can save this document to your computer and share with colleagues by right clicking and selecting "save as" OR by entering the command ctrl + s OR by sharing the URL.**

**Question 1 – We asked, "Do your practices have a clear understanding of inclusion health groups in their patient population and their needs?"**

**You said, "No, we need support with this"**



From 2020/21, PCNs are expected to assess local population risk of negative health outcomes and make provisions for support in response to these findings (link). The population in your area will include people from inclusion health groups, even if these groups are hidden. An inclusive Primary Care Network will have an understanding of who inclusion groups are, the barriers that these groups face, as well as the intersectional barriers for people that belong to more than one group. Understanding and meeting the needs of inclusion health groups will be essential to your efforts to tackle inequalities in healthcare access and outcomes in your local area.

## How to develop your PCN's understanding of inclusion health groups

Inclusion health groups face particularly stark inequalities and some of the greatest difficulties in access to and engagement with public services (link). In addition, these populations remain largely invisible in datasets, and services are therefore rarely designed or developed with the needs of inclusion health groups in mind (link).

Routine data collection does not capture the needs of all sections of local communities. Existing healthcare datasets on socioeconomic inequalities measure area-level deprivation only, and do not pick up on

structural, population-based inequalities ([link](#)). This means that existing healthcare data alone is not sufficient to develop a clear understanding of your local population, or their needs.

Some of your practices may be based in more affluent areas. But despite this, there may still be pockets of deprivation, or hidden deprivation, facing particular patient groups across your PCN neighbourhood. JSNAs and routine data collection often fail to identify these groups. Seeking further insight into the inclusion health groups in your local population, and their needs, will be central to successful efforts to tackle inequalities.

Some general considerations when developing your understanding of the local population include –

- **Recognise that many JSNAs and available information on population size for inclusion health groups often undercount and are therefore not reflective of the actual size of the population.** Due to fear of stigma, discrimination, or criminalisation, many people from inclusion health groups may not provide identifying information and may actively avoid involvement in routine data collection.

- **The VCSE sector can be key to understanding local population need and gaining insight into inclusion health groups experiencing hidden inequalities.** It is useful to link-in with charities and community groups, who have often built trusting relationships with local communities and can offer key insights into local populations and their needs

- **Develop and use Patient Participation Groups (PPGs) effectively and recruit from diverse communities**. Ensuring that your practices' PPGs are representative and include people from inclusion health groups can help to identify local needs and gaps in service provision. PPGs can be dynamic and flexible, reaching out to people in communities rather than expecting people to come to join a meeting. PPGs are not the only way to work with people and communities so develop an engagement plan to reach those people highlighted in your population from health inclusion groups and those people you are aware that you are not hearing their voice.

In order to ensure that your PCN has a clear understanding of inclusion health groups in the patient population, these groups must be considered by each network partner and a forward planning approach maintained, so that inclusion health groups can access primary care, pharmacy, social care, mental health services and voluntary sector support without having to repeat their stories or face barriers at any point. Key to this will be the approach taken to assessing the needs of these communities.

## Guidance and information

There are a number of ways in which a local area can identify inclusion health groups in their local population and carry out a health needs assessment –

## People who are homeless

As homeless populations are often transient and may be hidden, it is difficult to determine accurate, irrefutable figures about the size of the homeless population nationally. Homeless Link provides useful information on [counts and estimates](#) for evaluating the extent of rough sleeping at the local and national level.

According to research by Shelter, an estimated 320,000 people are homeless in the UK ([link](#)). This includes both people who are rough sleeping and people living in temporary accommodation but does not include information on people at risk of homelessness or people living in insecure accommodation.

## Health inequalities experienced by people who are homeless

Homeless populations experience severe inequalities in healthcare access and outcomes, and some of the poorest life expectancies of any population group.

- The average age of death for homeless patients is just 43 for women and 47 years for men ([link](#)).
- Standardised mortality ratios for excluded groups, including homeless people, are around 10 times that of the general population ([link](#)).
- Homelessness is an independent risk factor for premature mortality and is associated with extremes of deprivation, multi-morbidity, and early onset of age-related illness such as frailty ([link](#)).
- Chronic homelessness is associated with tri-morbidity, complex health needs and premature death. Tri-morbidity is the combination of physical ill-health with mental ill-health and drug or alcohol misuse ([link](#)).

## Identifying people who are homeless, and their needs, in your local population

Carrying out a homeless health needs audit is a way of taking a partnership approach to understanding the health needs of your local homeless population.  As well as health and social care partners, it is vital that the voluntary, community and social enterprise (VCSE) sector are equal partners in the audit team. Below are some useful resources to support in conducting a needs assessment for homeless patients in your local population.

Useful guidance and tools include –

- Homeless Link guidance on Carrying out a health needs audit
- The Queen's Nursing Institute Homeless Health Assessment Tool
- Pathway and the Faculty for Homeless and Inclusion Health example of a local homelessness health needs assessment.

## Gypsy, Roma and Traveller communities

The 2011 census recorded 63,193 people as Gypsy or Traveller in 2011 across the UK, with 54,895 people in England ([link](#)). However, the Government acknowledges that this is likely to be an undercount, with estimates of up to 300,000 Gypsy and Traveller people ([link](#)). It is possible to access data on Gypsy and Traveller population by local authority area across the UK here.

The 2011 census did not collect data on Roma populations, but a report published by the University of Salford in 2013 estimated that a conservative calculation of the migrant Roma population of the United Kingdom was 197,705 individuals ([link](#)).

Around one quarter of Gypsies and Travellers live in a caravan or other mobile or temporary structure, and around three quarters live in bricks and mortar housing ([link](#)). Of those who lead a nomadic way of life, around 85% of people live on local authority managed or privately managed Traveller sites and around 15% of people live on unauthorised encampments or developments ([link](#)).

## Health inequalities experienced by Gypsy, Roma and Traveller communities

Gypsy, Roma and Traveller communities are known to face some of the most severe health inequalities and poor life outcomes amongst the United Kingdom population, even when compared with other groups experiencing social deprivation or exclusion, and with other ethnic minorities ([link](#)).

- Gypsy and Traveller communities are estimated to have life expectancies between ten and 25 years

shorter than the general population ([link](#)).

- Before the significantly shorter life expectancy of Gypsy and Traveller communities is taken into consideration, Gypsies and Travellers experience six less Quality Adjusted Life Years (that is, years spent in good health) than age and sex matched members of the population ([link](#)).

- Gypsies and Travellers are significantly more likely to have a long-term illness, health problem or disability, which limits daily activities or work ([link](#)).

- The suicide rate for Traveller women is six times higher than women in the general population and is seven times higher for Traveller men than men in the general population ([link](#)).

- Between 2005 and 2012, Roma Support Group found that 60% of their Roma beneficiaries had poor physical health including cancer, diabetes, epilepsy, hepatitis B, cardiovascular and respiratory alignments and multiple sclerosis ([link](#)).

- Further to this, 43% of Roma beneficiaries of the above, were suffering from mental health problems including depression, personality disorders, learning disabilities, suicidal tendencies, self-abuse or dependency/misuse of drugs ([link](#)).

### Identifying Gypsy, Roma and Traveller communities, and their needs, in your local population

The NHS does not routinely collect data on Gypsy, Roma and Traveller communities so you may wish to collect your own data or carry out analysis of other available data locally to build a greater understanding of population size of Gypsy, Roma and Traveller communities in your area. This may include the following data sources:

- **Census 2011: Gypsy and Traveller populations by local authority area** – the Office for National Statistics holds data on population size and demographic details for people who self-identify as 'Gypsy or Irish Traveller'. This is the largest available dataset on health, living conditions and working conditions of Gypsy and Irish Traveller communities, however, it does not include any data on Roma communities and is recognised widely an undercount (by around five times) for Gypsy and Traveller communities. [View here](#).

- **Gypsy and Traveller Accommodation Needs Assessments (GTANAs)** – the majority of local planning authorities gather population information on Gypsies and Travellers (housed and travelling) in their area, to assess need for pitches. This often brings together a list of Traveller sites in an area, instances of unauthorised encampments and can draw on other available local data. However, GTANAs are often an undercount of local Gypsy and Traveller populations, some local authorities fail to carry out GTANAs and this does not include Roma populations in an area. If a GTANA is carried out, it is usually available online.

- Department for Education data disaggregated by locality and ethnicity – schools collect information on population of children and young people in their area who identify as 'Gypsy/Roma' or 'Traveller of Irish Heritage'. This information tends to be routinely collected across the education system; however, is often not publicly available, only represents children in school and families may be afraid to disclose ethnicity leading to an undercount. This data may help to give you a broad understanding of population size of Gypsy, Roma and Traveller communities in your area. You can approach your local authority to share this information with you.

- **Ministry of Housing, Communities and Local Government Traveller Caravan Count** – this count is carried out twice a year and measures the number of caravans on Traveller and Travelling Showpeople sites, unauthorised encampments and unauthorised developments. This contains number of all caravan types by local authority; however, it is recognised as an undercount and only includes details of nomadic Gypsies and Travellers. [View here](#).

- **Migrant Roma in the United Kingdom: Populations size and experience of local authorities and partners** – a University of Salford study which estimates migrant Roma population by local authority and region. This includes information on characteristics and geographic distribution of UK's migrant Roma population. Figures are an estimate based on available data and undertaking new empirical research. View here.

A good start towards engaging with communities is to identify a local Gypsy, Roma or Traveller voluntary sector organisation. Friends, Families and Travellers have created a Services Directory of voluntary sector organisations who work with Gypsy, Roma and Traveller communities who may be able to help you on your journey. View here.

If there are no local organisations, it is useful to consider the services that Gypsies and Travellers may be accessing locally. For example, there may be local welfare advice drop-in services or community groups that are accessed by Gypsies and Travellers. It is also important to consider that levels of trust between Gypsy, Roma and Traveller communities and services will impact on the amount and quality of data collected.

## Sex workers

It is difficult to estimate how many sex workers there are in the UK, as sex work is often hidden and the population may be transient, with people moving in and out of sex work. Recent studies have suggested that there are between 70,000-110,000 people engaged in sex work, representing all genders, sexualities and forms of work (link).

Online sex work has grown exponentially and is the now the largest sector of the UK sex industry (link). However, a study by the Beyond the Gaze project highlights the unique difficulties of mapping the online sex work population. The study finds that, given the proliferation and transience of online sex work, it is not possible to provide a reliable population size estimate of online sex workers in the UK.

According to Home Office figures, 50% of London sex workers are migrants and 5% of these enter the UK against their will (link). Women from Eastern Europe and the Former Soviet Union are currently estimated to make up 25% of all female sex workers in London, the largest non-UK group (link). Migrant sex workers may face a number of additional barriers to accessing support from statutory services, including those relating to immigration status, language barriers, fear of criminalisation, and difficulty navigating complex systems to access relevant support (link).

## Health inequalities experienced by sex workers

Across all modes of working, factors such as poverty, financial insecurity, inadequate access to housing, criminalisation and reduced access to justice and social protections, all contribute to poor health outcomes and limited life-chances among sex workers (link).

Sex workers, which may include people working in the porn industry and those doing online work, regularly need to access NHS sexual health testing, as well as access to wider health and care. PCN teams need to create a non-judgmental and inclusive culture and ensure that there are no financial or attitudinal barriers to accessing relevant services.

- Street workers have a high risk of health problems, including sexually transmitted infections, long term conditions such as diabetes and back pain, mental illness, and drug and alcohol dependency disorders (link).
- Studies show that street sex workers have significantly higher rates of health service use compared with the general population, reporting visiting the GP 8.5 times (compared with 4 times for the general population), A&E 2.5 times, an STI clinic 2.7 times in the previous year (link).

- Despite frequent use of health services, a comparatively low percentage of female sex workers have had routine health checks such as cervical screening or attend antenatal checks when pregnant (link).
- There are a number of institutional and systemic barriers to accessing healthcare include including fear of criminalisation, institutional factors such as opening hours and location of services, stigmatisation and discrimination (link).

## Identifying sex workers, and their needs, in your local population

It is important to note that personal identification as a sex worker may vary depending on the nature of the work and on the individual. For instance, whilst porn performers can be considered as sex workers, particularly in regard to shared barriers to services and other impacts, some porn performers do not identify as sex workers. Similarly, many male sex workers, for instance, instead identify as escorts.

It is essential that staff across your PCN are equipped to understand the varied circumstances of sex workers without making immediate judgements about their needs. For instance, clinicians may rely upon assumptions that porn performers are wealthy compared to sex workers in other parts of the industry.

Despite this, income levels of the majority of porn performers is very low, as many self-filming performers are part of payment pyramid schemes, and a large proportion of profits made by studios end up with "tube sites"; international organisations notoriously hard to access money from. As such, the majority of porn performers face financial hardship, and may also rely on in-person work for greater financial security.

There is therefore need for a person-centred, non-judgmental approach to care provision, with recognition of how low income and financial insecurity may impact wider health outcomes and engagement with health and care services.

Examples of relevant local needs assessments for sex workers include –

- Sexual Health Needs Assessment Leeds 2018-19
- Public Health Rapid Needs Assessment: Sex work in Brighton and Hove

For further information –

- National Ugly Mugs provides further information on the needs and experiences of sex workers.
- The University of Leicester Beyond the Gaze project explores the working practices, safety and regulation of internet-based sex work in the UK.

## Vulnerable migrants

Groups of vulnerable migrants living in the UK can include asylum seekers and refugees, unaccompanied children, people who have been trafficked, undocumented migrants (those who are living in the UK with no legal status), and low paid migrant workers (link).

In the year ending March 2020, the UK had received 35,099 asylum applications from main applicants only, which was an 11% increase from the previous year (link). According to UNHCR data, by the end of 2018 there were 126,720 refugees, 45,244 pending asylum cases, and 125 stateless persons in the UK (link).

## Health inequalities experienced by vulnerable migrants

Health problems of vulnerable migrants are frequently related to destitution, conditions during migration, and lack of access to services, rather than long-standing illness or poor health (link). Barriers and charges vulnerable migrants face when accessing care significantly contribute to poor health among some vulnerable

migrant populations ([link](#)).

Refugees and asylum seekers may have high levels of mental health need, which may be caused both by conflict and traumatic events in origin countries, and the socio-political conditions in host countries, which can lead to experiences of criminalisation and discrimination ([link](#)).

- Immigration detainees have been found to have high levels of post-traumatic stress that frequently leads to anxiety, depression, self-harm, suicidal ideation and suicide attempts ([link](#)).
- Survivors of trafficking or torture have often been exposed to uncontrollable and unpredictable events, which can result in severe and longer-term post-trauma disorders ([link](#)).
- Vulnerable migrants may have fallen sick whilst migrating or when arriving in new countries, due to poor living conditions such as camps with poor shelter and sanitation, or inadequate access to food, water and sanitation, and increased, ongoing stress ([link](#)).
- Vulnerable migrants may be travelling from origin countries with a high prevalence of infectious diseases and may test positive for conditions such as tuberculosis for the first time upon entering the UK ([link](#)).
- Cancer is more likely to be diagnosed at an advanced stage among refugees, which can lead to considerably worse health outcomes compared with the general population ([link](#)).
- Refugees and migrants also have a higher incidence, prevalence and mortality rate for chronic conditions that may be uncontrolled, such as diabetes ([link](#)).

## Identifying vulnerable migrants, and their needs, in your local population

There is need to consider that many vulnerable migrants may be fearful of engaging with statutory services as a result of being charged or facing criminalisation. In addition to this, many vulnerable migrants are fearful of data sharing, and may be concerned about accessing health services due to fear information will be shared with the Home Office. It is therefore imperative that staff across your PCN consider this when undertaking routine data collection, and that you offer clear information around how data will be shared across your PCN, and the wider ICS.

In order to understand the needs of vulnerable migrants within your local population it is useful to refer to information provided VCSE organisations such as Doctors of the World. They have previously estimated that there were between 50,000 to 500,000 people in the UK in need of their support to access necessary health services. [These services ](#)include medical check-ups and STI screenings, and monthly TB screenings, provided in partnership with University College London Hospital's Find and Treat Team.

For further information –

- Doctors of the World have conducted a [rapid needs assessment](#) of excluded populations during the coronavirus pandemic, including vulnerable migrants, people experiencing homelessness, and sex workers.
- The UNHCR provides a [handbook](#) on conducting needs assessments
- The [PHE Migrant Health Guide](#)is a useful resource for national statistics on migrant populations and may provide useful insight on migrant populations from specific origin countries in your neighbourhood.

## Section 2: Systematically adapting services to meet the needs of people most likely to experience health inequalities

**Question 2 – We asked, "Are all services systematically adapted to meet the needs of people most likely to experience health inequalities?"**

**You said, "Not really as this would be difficult to achieve"**

Inclusive health services need to be responsive to the ongoing and emerging needs of anyone in the local population who is experiencing health inequalities. Without tailoring and adapting services with inequalities in mind, those at the sharp edge of inequalities are at risk of facing continuing barriers to accessing services and a range of poor health outcomes. Early detection of health exclusion, and proactive adaptation of services to address unmet needs, is key to protecting patients from avoidable harm. Focused work on making services accessible for people at the sharp edge of health inequalities is likely to improve the experiences of all patients across the board.

### Systematically adapting your services

*"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."*

Marmot, 2010 (link)

Throughout this guidance, we offer a range of information and advice to support your PCN to systematically adapt services to the needs of the inclusion health groups. Despite experiencing the greatest inequalities, inclusion health groups remain too often excluded by efforts to address the health gap, and services may not be adapted or delivered with these populations in mind. To ensure that you reach those with the greatest need in your efforts to tackle inequalities, it is imperative that the needs of inclusion health groups are at the forefront of decision-making.

It is well documented that healthcare services in England follow an "inverse care law", where the availability of accessible primary healthcare varies inversely with the level of need for it (link). Whilst inclusion health groups face some of the greatest challenges in accessing services, many of these barriers are shared by other populations to varying extents. Focusing on the most disadvantaged solely through targeted services for these groups will not reduce health inequalities sufficiently; to tackle the social gradient there is need for action that is universal, but with a scale and intensity proportionate to the level of disadvantage across all services. This approach is also known as "proportionate universalism" (link).

A proportionate universal approach is not an add-on but a value that needs to be at the heart of every service. Services which are configured around a proportionate universal approach have the best chance of tackling health inequalities and meeting the needs of patients across the gradient of health inequalities. A proportionate universalism approach means within your PCN:

- All services are accessible and responsive to inclusion health groups, and that patients are not only directed to specific targeted inclusion health practices in order for their needs to be met.
- Consideration of the needs and experiences of patients experiencing varying degrees of health inequality should be included in all levels of decision-making and service provision.
- Inclusion health groups and populations across the gradient of health inequalities are considered in

how you structure the delivery of your services.

- Inclusion health groups and populations across the gradient of health inequalities are considered in the amount of freedom and support health professionals have to adapt the level of support they provide on a day-to-day basis according an individual's level of need.

For more information on Proportionate Universalism and how you can incorporate this into your service delivery see 'Towards health equity: a framework for the application of proportionate universalism'.

## Considering the impact of health literacy and psychosocial factors

Throughout this guidance, we have embedded a focus on the wider determinants of health and have highlighted the steps that your PCN can take to take action to address these. When adapting services, it is also important to consider that a person's position in society also influences health outcomes as a result of a number of psychosocial factors. The nature and extent of social stratification across society has a significant influence on the psychosocial drivers of health and wellbeing (link).

- Socioeconomic status is associated with psychosocial factors such as social isolation, self-esteem and self-worth, health aspirations, perceived level of control, sense of meaning and life purpose (link).
- Those who have faced social exclusion and inequalities in access to education may also have lower levels of health literacy, or the social resources needed to access, understand and use information relating to health (link).
- Lower socioeconomic status is associated with lower levels of "patient activation", which relates to a person's level of skills, knowledge and confidence to manage their health and care needs long term (link).

It is important to consider that, for those at the sharp edge of inequalities facing chronic exclusion, these factors are likely to have a significant and pervasive impact on experiences of health and care. Similarly, these psychosocial drivers can exacerbate the power imbalance between the professional and the patient, meaning that patients are further disinclined to engage with services.

## Legal duties to reduce inequalities

It is important to note that health and care services have clear legal, as well as moral, reasons to tackle health inequalities in their everyday work. Staff across your PCN should all be aware of their legal duties to improve access to services and to reduce inequalities. This includes –

The Equality Act 2010 prohibits unlawful discrimination in the provision of healthcare services on the basis of "protected characteristics" and imparts a duty on services to advance equality of opportunity. This includes both direct discrimination where a person is treated worse than another person because they have a protected characteristic or indirect discrimination when there is a policy that applies in the same way for everybody but disadvantages a group of people who share a protected characteristic.

The Health and Social Care Act 2012 also sets out specific legal duties on health inequalities which require NHS England to "(a) reduce inequalities between patients with respect to their ability to access health services; and (b) reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services".

Public Sector Equality Duty imparts a responsibility to remove or minimise the disadvantages suffered by people due to their protected characteristics; take steps to meet the needs of people from protected groups where these are different from the needs of other people; and to encourage people from protected groups to participate in public life.

## Section 3: Developing targeted services to address unmet need amongst patients from inclusion health groups and/or groups experiencing deprivation

**Question 3 – We asked, "Have targeted services been developed to address unmet need amongst patients from inclusion health groups and/or groups experiencing deprivation?"**

**You said, "No"**

While it is essential that patient choice remains at the core of the relationship between services and patients from inclusion health groups and that all services are available to everyone, targeted services which support patients with specific needs could greatly contribute to the reduction of health inequalities in your neighbourhood. Therefore, in addition to systematically adapting all services in your PCN to ensure accessibility for inclusion health groups, you may also wish to consider the potential for developing targeted services to address unmet need for inclusion health groups.

**Implementing targeted services**

Although your PCN's key focus will be on service delivery, and responsibility for the planning and funding of services remains with the CCG, it is important to note that your PCN is expected to become a key mechanism by which to offer targeted support to those facing inequalities ([link](#)). Identifying the need for targeted services, and advocating to deliver these in the local area, can play a key part in this.

When supporting the development of targeted services, PCNs must be clear on the desired outcomes and the structure needed to achieve those outcomes, remembering that different groups will have different unmet needs. It is important to consider that targeted services may only fit one inclusion health group and not all; just because one particular way of working works with one group, does not mean this approach will work for others, so flexibility in approach is key.

Many pilot projects are only funded for a year, which does not always allow sufficient time to build a service and gain the trust of people from Inclusion Health groups. A PCN that successfully implements targeted services will consider the sustainability of any new projects and have a plan in place so that if project funding is cut, there is an alternative way to support the patients targeted by the service.

**Different models of targeted service provision**

There are a number of differing approaches that can be taken to support the development of targeted services for patients from inclusion health groups. Your PCN can consider linking in with existing VCSE organisations to consider how targeted services could be co-produced and co-delivered. Types of targeted services you may want to consider developing include:

- **In-reach, and drop-in services in places that people are already attending** – placing in-reach and drop-in clinics at community centers, mosques, and hostels with a flexible in-service delivery will mean that you are reaching communities who may otherwise may not consider using services within your PCN. Engaging with people in their own communities offers services within your PCN and opportunity to build trust with people rather than expecting initial engagement at a surgery level, especially for patients from communities who often fall through the gaps in traditional appointment systems.
- **Outreach services** – many people from inclusion health groups report having poor past treatment in

health services, where they often have experienced stigma or have felt like a square peg in a round role within a mainstream service. Past poor experiences of services can mean that even where services have improved and would be welcoming now, individuals can feel like the service is not for them or don't feel safe there. Targeted outreach services can enable services to move beyond a "door open" approach to service delivery. By actively reaching out to groups facing barriers to services in environments where they feel comfortable, health and care services can build trust and bridge people back into services. Trust building often takes time and it's important that outreach services take time to understand the areas in which individuals would like to receive support.

- **Multi–disciplinary hubs –** bringing a number of services together could enable the provision of holistic care in one place which makes services more accessible for people with multiple competing health needs and/or multiple competing demands in other aspects of their lives. In particular, collaborations within PCNs between clinical services and advice or advocacy organisations can enable patients to address clinical health needs at the same time as addressing issues across the wider determinants of health which ultimately affect their health.

- **Peer support** – having peers as patient advocates is a proven way to increase engagement with patients from underrepresented groups and can also ensure that patients are offered the right information and support, from someone with lived experience. This can help to build trust and improve engagement with services going forward

- **Specialist practices** such as those for homeless communities can support in improving access and outcomes for some inclusion health groups. There are a number of examples in the good practice section below where homeless GP practices have been able to demonstrate significant impact in addressing health inequalities amongst populations experiencing homelessness. However, it is important that these services supplement existing services, and do not replace them. It remains imperative that all services are accessible to inclusion health populations, and that additional targeted services support greater patient choice. It is also important to note that specialist practices may not operate across the same geographic footprint as PCNs, therefore, these services may benefit from being members of more than one PCN. The economic drivers and models of delivery for homeless health GP practices often differ significantly from traditional models of GP practices, but the expertise and insight these practices can bring to a PCN are significant.

Community and asset-based models to developing services recognise that sustained positive health and social outcomes will only occur when people and communities have the opportunities and facility to control and manage their own futures. It's essential that the intended recipients of a service are involved in the decision making and the development of the service. Services that employ staff or are led by people from the intended target group of the service are often more successful as those involved in delivering and developing a service are knowledgeable about the realities of peoples' lives and therefore where there are opportunities to improve peoples' lives.

**Good practice examples**

**People who are homeless**

Groundswell, Care Navigation – The Integrated Care Network is a three-way partnership between Groundswell and two specialist GP surgeries in Westminster. The service uses a peer-advocacy programme model and aims to reduce A&E attendance by people experiencing homelessness, by supporting people to engage with primary care services, thus reducing the need to obtain secondary care.

Co-Lab Exeter is an innovative hub that works with a range of people with multiple disadvantage and complex needs, including vulnerable housing and homelessness.  Co-Lab works with health partners including Exeter Primary Care, and people are able to access a variety of services, support, learning and social experiences in one place that contribute towards their recovery, belonging, rehabilitation and

wellbeing.

## Gypsy, Roma and Traveller communities

Friends Families and Travellers' (FFT) team of frontline workers from the Gypsy and Traveller communities carry out assertive outreach to offer support with issues individuals face across the social determinants of health. FFT connect people to services, provide advocacy and advice to people who are struggling to access the support they are entitled to, deliver training in health improvement and behaviour change, deliver brief health interventions and more. Find out more.

Roma Support Group provide a mental health advocacy team, which offers one-to-one support to clients in understanding mental health issues, identifying appropriate mental health services and explaining health needs to professionals. Roma Support Group additionally run monthly peer support group meetings in which project beneficiaries can come together and discuss issues and coping strategies in an open and supportive environment. Find out more.

Leeds GATE is an award winning organisation based in Leeds, which works alongside local health bodies and services to deliver strategic advocacy, community development and outreach services to the local Gypsy and Traveller population. Responding to what Gypsy and Traveller communities told Leeds GATE, a community outreach nurse was employed to outreach to individuals on a one-to-one basis to offer support for their current health needs, in reach to organisations to improve relationships between the healthcare system and Gypsies and Travellers and to generate insight on the communities' health profile, connectivity to services, and the effectiveness of healthcare interventions. Find out more

## Sex workers

56 Dean Street, Soho describes itself as a friendly, convenient and free NHS sexual health clinic in the heart of London. They offer clinical, non-judgmental services, providing a range of HIV and sexual health services. This includes free health tests for sex industry and porn workers, whereas usually this can cost up to £30. Find out more.

All Welcome, All East host 'Clinic S' which offers a free and confidential service to women, men, trans and gender non-binary individuals, working in the sex or adult entertainment industry. This is a space where sex workers can be confident, they will not be met with stigma when accessing sexual health services. Find out more.

Spires Streetlink works with homeless people and sex workers in Lambeth, south London on an outreach basis, providing women only spaces alongside their outreach service. Their outreach service engages with female sex workers on their own terms and at times that coincide with their working hours so that trust can be built. Find out more.

CLASH (Central London Action on Sexual Health) and SHOC (Sexual Health on Call) services are located at the Mortimer Market Centre and Archway Centre in London. CLASH provides free and confidential sexual health outreach services for sex workers, homeless people, drug users, Black Asian and Minority Ethnic people (BAME) and men who have sex with men (MSM) living or working in Camden and Islington. SHOC provides free and confidential sexual health outreach services for sex workers in Haringey. Services are open to all genders and include one-to-one advice and information and informal counselling for sex workers, and a specialist sexual health clinic for all sex workers.

## Vulnerable migrants

Bevan Healthcare CIC host an after-school club for young refugee and asylum-seekers that would benefit from a safe and friendly space to be supported with their schoolwork, as well as English for Speakers of

Other Languages (ESOL) classes to support non-native speakers of English to improve their language skills in order to cope with everyday life in the UK. Based in Bradford, Bevan Healthcare is a health service that provides responsive NHS GP services and more to a number of inclusion health groups and populations experiencing inequalities. Find out more.

Doctors of the World Clinics offer primary care and health and social advice from volunteer doctors, nurses and support workers for excluded people such as asylum seekers, undocumented migrants, homeless people, and sex workers. This includes a permanent clinic in East London and a mobile clinic for London. In partnership with Vision Care for Homeless People, Doctors of the World have started to offer a bi-monthly eye health clinic. Alongside these clinics, Doctors of the World empower vulnerable people to overcome barriers to the health system by, for example, helping them to register with their local GP. Find out more.

**Guidance and useful information**

NHS England's Menu of evidence-based interventions and approaches for addressing and reducing health inequalities holds useful information, guidance and examples of support health and care services can offer to inclusion health groups.

## Section 4: Ensuring that your practices collect information from patients on how wider societal issues may put them at high risk of poor health or may affect outcomes of health interventions

**Question 4 – We asked, "Do your practices collect information from patients on how wider societal issues may put them at high risk of poor health or may affect outcomes of health interventions? This might include information on housing status, benefits, country of birth and more"**

**You said, "No"**

It is crucial that the particular wider societal and economic issues facing inclusion health groups are taken seriously, and that their impact on health and care is acknowledged. Systematic collection of data on education, deprivation, housing, access to public funds, economic stability, and the immediate environment, can help in providing a holistic treatment plan. Deprivation for example, which is common between members of inclusion health groups, is an important social determinant of health and a major contributor to the health gap in England. It is important to remember that some patients might be hesitant to share this information, so building trust is key.

**Benefits for reducing inequalities and improving inclusion health**

*"At present most health records don't capture individual level indicators of socioeconomic deprivation that affect health – a person's housing situation or economic poverty, for example. We therefore rely on area-level deprivation data to monitor socioeconomic inequalities in health care. However, this is an imprecise measure as many socioeconomically deprived individuals don't live in socioeconomically deprived areas. Without individual socioeconomic data, we won't know if PCN initiatives reach those with the greatest social needs and not just the more advantaged patients in the more deprived areas."*

Previously, distinct providers across the health and care system have tended to hold their data, preventing the opportunity to follow a patient's journey throughout the system. However, data sharing agreements have been built-in to the establishment of PCN information systems, which provides an opportunity to improve understanding of patient experience across the health and care system. How measures are implemented and developed, and the types of datasets produced, will be essential to the role your PCN can play in reducing health inequalities.

Some key benefits of routinely collecting information across wider societal issues include –

- This can help to identify pockets of deprivation in otherwise affluent areas to enable services to target energy into addressing health inequalities amongst those with the greatest need.
- This may shed light on circumstances that might be directly contributing to a health problem a patient presents with and can help to identify trends in particular health needs shared among specific groups.
- This can help to identify patients who are likely to have lower levels of uptake of preventative care to enable targeted initiatives or opportunistic interventions.
- This can help services to identify a range of factors that may impact engagement, and to adapt support accordingly.

## How to collect relevant information

The type of information you collect, and the approach you take to obtaining this information, could have a significant impact on how effective your datasets are, and how willing patients will be to provide this information.

It is useful to consider how you could collect this information in an inclusive and unobtrusive way at the first point of contact with services. Directly asking a patient what type of accommodation they live in, or whether they are in receipt of benefits may automatically dissuade someone from providing information in case stigma related to this may detrimentally affect the care they receive.

As part of registration procedures, you can ask patients the question *"Are there any things that it may be helpful for us to know about which may affect your health, wellbeing or experience of care? This may include that you lead a nomadic way of life; you don't have entitlement to specialist care; you are currently in receipt of benefits; you may not be able to commit to appointments far in advance because of shift patterns and son on."* After requesting this information, it should be made explicitly clear to patients that this information will not affect the care they receive in any way within the service but will instead provide the opportunity to best support the patient based on wider circumstances and needs**.** Specific factors you can collect information on include –

## Housing status and accommodation type

## Good practice example

[Ealing CCG ](#)has initiated a Homeless 'Out of Hospital' contract within primary care to incentivise GP practices to register patients who are currently experiencing homeless, and ensure they receive appropriate holistic healthcare that they may otherwise have difficulty accessing, including comprehensive screening, and appropriate vaccination. GP practices receive an enhanced per capita amount for homeless patients that they meet the contract requirements for.

Collecting data on housing and accommodation status can help to identify patients who would benefit from

this type of targeted healthcare provision. Your PCN may benefit from liaising with your local CCG to secure funding to incentivise enhanced care provision for patients from inclusion health groups, and to ensure that additional needs are addressed.

## Welfare and benefits

Collecting information on welfare and benefits can help to identify patients who may have low incomes, and who may be facing financial hardship. This can support clinicians to identify patients who may benefit from additional support and advocacy across the wider health and care system and help to build a clearer picture of hidden or pockets of deprivation within your practice localities.

Those in receipt of welfare and benefits should be encouraged to apply for either a HC2 or HC3 certificate through the NHS Low Income Scheme which offers help with NHS costs, including prescription costs, dental costs, eyecare costs, healthcare travel costs and wigs and fabric supports for patients with a low income. Find out more.

## Access to public funds

Primary healthcare services can be accessed by everybody in England, regardless of immigration status, and no additional costs should be incurred for those with no access to public funds (link). Whilst identifying those patients who have no recourse to public funds will not change the care they are entitled to with your practices, awareness of this can support clinicians to identify those patients who may face charges on accessing specialist and secondary care services. This can prompt practice staff to look for local services and organisations that may be able to provide additional support, financial or otherwise. Be clear with patients before they disclose information on immigration status where and how this information will be stored and who will have access to the information. It is not appropriate for primary care settings to be used as an extension of immigration control and breaches in trust relating to immigration can deter people from accessing healthcare altogether, with potentially deadly consequences.

## Employment

It may be useful to collect information about whether a patient is currently in employment and the type of employment. For instance, if a patient is on a zero-hours contract or is self-employed, this could impact their ability to attend routine appointments, and patients in these employment types may therefore benefit from proactive offers of flexible appointment times and drop-in appointments.

## Information that patients may be reluctant disclose

It is important to consider that the collection of data on the wider determinants of health may reap the greatest benefits for inclusion health groups who may be most affected by issues across the wider determinants of health. Despite this, members of these groups may also be the most reluctant to disclose this information for fear that this may result in stigma or discrimination on accessing services.

It is essential that practices take steps to ensure that this information is asked in a sensitive way and that it is made explicitly clear to patients that this information will be used to improve the delivery of care to them.

In addition to this, many groups may be afraid of sharing information due to fear that this will be shared with other statutory services. For instance, some Gypsy and Traveller communities may be fearful of information sharing with social services because of lack of cultural understanding within Children's Services, and some vulnerable migrant patients may be particularly reluctant to share information due to fears that information will be shared with the Home Office. Ensure that your PCN offers clear guidance about how the information you collect will be used, and about your data sharing agreements across the wider ICS.

## An inclusive culture

Whilst many of the steps you take to identify and consider the impact of societal issues will involve practical action, there is also a need to consider that encouraging a cultural change across services may also be key to addressing inequalities. Many people from inclusion health groups report that fear of, and practical experiences, of discrimination significantly influence their engagement with health and care.

*"When I was growing up I didn't go to a single GP. We had our uncles and aunties around us and they'd look after you instead. We would never go to the doctors because you'd get nasty comments. I rarely visit the GP now, you still get nasty looks".*

Paul, a Romany Gypsy community member

There are some key considerations your practices can make when addressing the psychosocial factors associated with wider societal issues.

- **Health services achieve better outcomes if people are treated with empathy and compassion**– There is notable evidence pointing to the fact that doctors and nurses who are empathetic provide better care. Studies suggest that being treated with dignity and respect is more important to patient satisfaction than factors such as pain control. The effectiveness of your efforts to address inequalities will be supported if steps are taken to foster welcoming and truly inclusive services across your PCN.

- **Acknowledge and allow for trusting relationships with GPs** – Many people would willingly travel a long distance to see a trusted GP. Services can build trust by giving patients the choice to do so. This may be particularly vital for Gypsies and Travellers and sex workers, who may prefer to travel to see a GP they trust, rather than risk stigma or discrimination on accessing a new service.

- **Ensure that your services offer trauma-informed care** – Research shows that adverse childhood experiences have lasting impacts and a significant influence on health outcomes throughout life. By ensuring that your practices adopt trauma-informed approaches to care, you can help mitigate those risks and improve health outcomes.[5] For more information, refer to Homeless Link's Basic Introduction to Trauma Informed Care.

## Personal story

Simon had been experiencing a persistent, unexplained headache, dizziness, nausea and tiredness. Concerned about this, he attended his local GP for an assessment. On registering with the surgery, Simon had been asked to provide information about his accommodation status and the nature of his accommodation. Simon was formerly street homeless but was now living aboard a small fibreglass boat along the local canal. He registered with a "care of" address at the surgery but provided details about his accommodation status and type when requested.

On seeing that Simon was a liveaboard boater, the GP queried about the conditions on his boat. The GP discovered that Simon had a homemade wood burner aboard, with no smoke or carbon monoxide alarm, and blood tests confirmed that Simon had been exposed to high levels of carbon monoxide. The GP recognised that the collection of information around accommodation status and type was key to early identification and treatment in this instance and considered that there was a large population of liveaboard boaters along the nearby canal, many of whom were registered patients. Recognising that this could be a broader issue, the GP flagged this with the management team. The practice linked in with a local charity offering outreach to boaters and supported the development of targeted health promotion and awareness raising of this risk among the boater population.

**Guidance and further information**

- The International Journal for Equity in Health have published an open access article 'A Systematic Review of reasons for and against asking patients about their socioeconomic context' which you may find helpful when weighing up the benefits and risks of collecting information on how wider societal issues may put patients at high risk of poor health.
- The Health Foundation have also created a helpful resource 'Social inequalities and primary care networks: realising the potential through advancing data and analytics'

## Section 5: Working collaboratively across your PCN to identify and address issues across the wider determinants of health in your neighbourhood

**Question 5 – We asked, "Do you work collaboratively across your PCN to identify and address issues across the wider determinants of health in your neighbourhood?"**

**You said, "No, we have not taken this approach"**



Primary healthcare services have an important role to play in tackling neighbourhood inequalities which lead to poor health, particularly among those experiencing the greatest disadvantage (link). The NHS Long Term Plan highlighted key ambitions for services to become more proactive and preventative across the health and care system. This includes ambitions for primary healthcare services to move beyond a focus on curing

illness, to also incorporate a focus on promoting and protecting health. To support this, your PCN can play a system leadership role in encouraging initiatives that aim to tackle the social determinants at the root of health inequalities and prevent ill-health throughout the life-course.

## How primary healthcare can address inequalities in the wider determinants of health

Whilst accessible healthcare is essential to health and wellbeing, it accounts for as little as 10% of a population's health and wellbeing (link). The conditions in which we work and live powerfully influence our health and whilst issues across the wider determinants remain unaddressed, the effectiveness and benefits of medical intervention are diminished (link).

At the individual level, for patients experiencing inequalities, primary healthcare services can act as a natural hub across the wider health and care system and can help to offer support to those who may otherwise be unsure where to turn. Qualitative research in deprived areas has highlighted the role of primary care services to advocate for patients, and to provide a "holding environment", or a space in which people can reflect on their options as they search for appropriate support to help to resolve the issues they're facing (link). In particular, the role of social prescribing link workers within Primary Care Networks can be utilised to support individuals to tackle issues across the social determinants of health, including social isolation, debt, housing insecurity and more.

At a population level, primary healthcare is situated in an important position to influence wider parts of the system to take action to address inequalities. Expertise and knowledge held within Primary Care Networks can support other local organisations to understand the health impacts of their decision making and to take these into account in order to mitigate against health inequalities. Primary Care Networks can play an important role in supporting other statutory organisations in their neighbourhood to take a Health in All Policies approach to decision making.

Across each of the wider determinants of health, there are a number of different approaches your PCN can take to addressing inequalities at both the individual patient, and wider population level.

## Accommodation and environment

According to the Health Foundation, 1 in 5 dwellings in England do not meet the Decent Homes standard (link). The environment in which we live can greatly affect our health – from damp and mould affecting our respiratory system, to overcrowding affecting our mental health. High levels of poverty within inclusion health groups can limit the affordability of quality homes, which in turn can affect the health of inhabitants of those homes. This is most acutely felt by populations experiencing homelessness and those living on unauthorised encampments as a result of the chronic shortages of places for nomadic households to stop.

The solutions to poor housing, homelessness and the lack of places for nomadic communities to stop do not rest with Primary Care Networks alone, however, services within PCNs can play an influential role in highlighting the health impacts of decision making relating to accommodation with local authorities and the voluntary sector. By working in partnership with other organisations and utilising a population health approach, PCNs can build an understanding of the specific accommodation related issues faced by their patients and be part of the process of identifying whole system solutions for addressing these.

For instance, services may identify a significant number of unauthorised encampments in their neighbourhood and a high level of urinary tract infections and bowel problems amongst patients living on unauthorised encampments. The PCN can then work together to highlight the need for the local authority to ensure people living on unauthorised encampments have access to basic water and sanitation, either by implementing a Negotiated Stopping approach or identifying land for a site where Gypsy and Traveller families can stop. Your PCN can therefore encourage strong multi-agency links to support a concerted, integrated approach to housing need in your locality.

In recent years, there has been an increased national policy and legislative focus on the links between health and homelessness. In April 2018, the Homelessness Reduction Act 2017 came into force, introducing the Duty to Refer, which places a duty on Hospital Trusts, NHS walk-in centres and Accident and Emergency departments to refer someone who is homeless or at risk of homelessness to a local authority housing/homelessness team of the individual's choice. Whilst the Act does not yet extend to many of the services within Primary Care Networks, it does indicate the benefits of a more joined up approach around housing and health. Find out more.

## Guidance and information

- Pathway guidance and posters, 'Homelessness Reduction Act Duty to Refer' in health and care settings.
- The Department of Health, Public Health England and NHS England's 'Quick Guide: Health and Housing'contains information on innovative projects, such as a project by Gentoo Group and Sunderland CCG which enabled GPs to 'prescribe' double glazing, boilers and insulation.
- The Kings Fund have created a useful report, 'Delivering health and care for people who sleep rough: going above and beyond'

## Income, employment and debt

Income, employment and debt all have strong correlations with health and wellbeing. In order to build your understanding of levels of deprivation and poverty within your area, the Ministry of Housing, Communities and Local Government's English Indices of Deprivation 2019 Tool will allow you to drill down to available data on deprivation at a postcode level. If data for your area suggests a high level of deprivation in locations within your PCN boundary, then this could prompt your PCN to advocate for action across your neighbourhood to address financial hardship and debt.

For example, across your PCN neighbourhood, you may become aware that many high levels of debt and/or poverty are causing a disproportionately high level of poor mental health. While services will generally have some tools to address this from a clinical perspective, it may become clear that preventative interventions to reduce poverty and debt could have a major impact in reducing mental health inequalities in your neighbourhood and therefore burden on services within your PCN.

Availability of space through buildings in the primary care estate could enable you to provide rooms or space for voluntary sector organisations to provide debt advice, workshops on budgeting or deliver mentoring programmes to increase access to employment. In addition, services across your PCN could enable health and care workers to work in proximity of advice and information workers to make both services easier to access for people with more than one issue. This can reduce the number of prescriptions that GPs issue, and the number of GP consultations needed (link).

## Education

For those who have experienced structural inequalities in access to and experience of education, this has long-lasting impacts on life chances and access to employment, and also impacts access to services. There is increasing recognition of the importance of supported self-management approaches to equip people with the skills, knowledge and confidence to manage their health and care needs. These approaches include health education programmes, peer support, and coaching and can be delivered as part of, or alongside, primary health care services (link).

For those who have faced particularly negative classroom experiences, offering a standardised approach to this type of health education will not be sufficient to address inequalities. Your PCN can create strong links with local charities and community groups and help to secure funding to support in the development of

relevant supported self-management programmes for communities experiencing inequalities.

If appropriately tailored to the needs of communities, these types of programmes can not only improve health literacy and engagement with services but can also provide wider educational and employment opportunities for patients. This can have significant and long-lasting impacts on health and wellbeing long-term.

### Guidance and information

For further information on embedded community approaches to health education refer to information on Nesta and The Health Foundation's 'Realising the Value' programme.

### Working collaboratively

It is important to maintain a collaborative systems leadership approach to tackling health inequalities by:

- Establishing strong links with VCSE organisations who can help to support effective support and social prescribing for needs across the wider determinants of health.
- Supporting clinicians to take part in multidisciplinary meetings, including MARACs.
- Working collaboratively across drug and alcohol services and mental health groups to ensure patients don't fall into gaps between services.
- Leading on establishing local data-sharing governance arrangements between local partners to improve intelligence and support collective action across the wider determinants (link).
- Using the Making Every Adult Matter approach to ensure that those experiencing multiple disadvantage do not fall through gaps in the health and care system.

### Guidance and information

- Citizen's Advice's report 'A Very General Practice' provides guidance on embedding advice and information services in GP settings.
- The Kings Fund's report on 'Tackling Inequalities in General Practice' contains useful and relevant information.

## Section 6: Supporting all staff members within your PCN to confidently signpost patients from inclusion health groups to relevant local voluntary sector organisations who can support them with their non-clinical health needs

**Question 6 – We asked, "Can all staff members within your PCN confidently signpost patients from inclusion health groups to relevant local voluntary sector organisations who can support them with their non-clinical health needs?"**

**You said, "No, staff need support and training around how to do this"**

Inclusion health groups experience chronic exclusion across the wider determinants of health (link). Factors such as financial hardship and deprivation, insecure or inadequate access to accommodation, or difficulty

accessing sustainable employment, directly impact upon patient health needs and outcomes, as well as engagement with health and care ([link](#)). In many instances, clinical health needs cannot be fully addressed without recognition of the impact of these wider needs. Providing relevant signposting and social prescribing can therefore be a vital means of ensuring that patients from inclusion health groups are offered meaningful support around non-clinical needs that directly and powerfully impact health.

## Providing relevant signposting

It is important to be flexible and person-centred when engaging with the non-clinical health needs patients may have. As a result of high levels of deprivation and financial hardship among inclusion health groups, patients may require the use of a food bank, or advice and advocacy around debt; they may require support to access employment or support from a trade union; they may benefit from a referral to a community group to address social isolation, or the opportunity to meet with others with shared experiences. It is therefore valuable to link in with specialist services locally who can offer support across a wide variety of needs.

It is useful to consider how effective signposting can support your PCN to embed a [Make Every Contact Count](#)approach across your services. As a result of barriers to care relating to factors such as nomadic, transient or chaotic lifestyles, or previous experiences of stigma and discrimination, many patients from inclusion health groups may experience minimal or fragmented involvement with services. Offering relevant signposting, advice and support around non-clinical health needs supports your practices to maximise the benefits of an encounter for patients experiencing social exclusion, and to offer valuable information to patients who may otherwise be unsure where to turn for advice or support.

The decision to direct an individual to another service needs to be a collaborative one made with the best interests of the patient at heart. It is important to remember that VCSE organisations and other external services will have limited capacity and funding, so balance this alongside what your service can provide, and consider opportunities for some provisions to be facilitated as part of your service, such as a support group.

## How to develop effective signposting and social prescribing

Your PCN can work with local voluntary sector organisations to create a comprehensive list of services available to those living in your area which is accessible by all members of staff. This can include both national and local resources, and in-person, telephone and online services. This document should contain:

- Name and contact information for each service
- What the service is
- Who can use that particular service (be specific here; for example, if a service is for female sex workers, do not refer a male sex worker to this service)
- How the referral process works for each service
- What each service can specifically do

This document can be regularly reviewed, incorporating feedback from patients and ensuring that details are kept up to date. Many patients may receive initial information or advice and then experience difficulties accessing services, or there may be facing complex circumstances with competing priorities, so it is important to follow up after signposting to a service. Follow-up appointments are one way of doing this and can be an important means of ensuring that the social prescribing you offer is effective.

Successful social prescribing around non-clinical health involves recognition that those with the greatest needs are also likely to have lower self-efficacy to engage with services and may therefore require signposting to flexible services that have an understanding of this context. Asking patients how they have found the service so far and documenting any difficulties that they have had in accessing it, can support your

practices to continue to provide signposting that is person-centred and appropriately addresses patient need.

To ensure voluntary sector services you signpost to are offering an inclusive service to inclusion health groups, you can encourage services to complete our Inclusion Health Audit Tool for VCSE services: https://www.inclusion-health.org/

**When to signpost**

There are four key questions to ask before providing signposting as part of your patient care:

- **Has your patient asked for signposting?** Have they indicated that they require help in any way that your PCN does not provide? You can ask your patient whether they need any support with a particular thing, but it is important to trust their answer rather than making assumptions.
- **Is there a specific issue that your patient would like to be signposted about?** Some signposting services may be targeted at a particular inclusion health group, while others may meet more general needs. What sort of signposting has the patient asked for?
- **Can you trust the organisation you're signposting to?** It is important for organisations to be vetted to ensure that the person you are referring will be supported and receive appropriate care. It is important not to rely on Google to tell you whether a service is right for your individual patient.
- **Is the service accessible for the individual you are referring?** Is the service appropriate for the person to access? If your patient uses a wheelchair, can they access the building? If they rely on public transport, how easy is it to reach the service from where your patient is based? If the service is a women's service, do they accept trans women? Does the service require particular resources, such as an internet connection or phone, to access them?

Ultimately, it is important to centre the patient as an individual and support their needs accordingly, rather than simply labelling them as a member of an inclusion health group. Everyone's individual needs will differ, and these should be the primary focus of practitioners in providing the best patient care.

**Personal story:**

Stephen is from the Romany Gypsy community and lives in bricks and mortar accommodation. He has been registered with the same doctor's surgery for the last year and has visited the practice a handful of times. At his recent visit, Stephen's GP noticed that his blood sugar levels were particularly high, and he noticed that Stephen's diabetes had always been well managed previously. The GP asked Stephen why his blood sugar levels might be higher than normal. Stephen informed the GP that he had been unable to manage his diet as usual, as he was experiencing financial difficulties.

From further discussion, the GP found that Stephen was self-employed, but that he had been recently been having more and more difficulty working as a result of physical illness. Stephen was not in receipt of any benefits and wasn't sure how to access these. The GP noted that Stephen had low levels of literacy and did not have access to a computer.

The GP referred Stephen to a link worker at a local charity that works with Gypsy and Traveller communities. The link worker supported Stephen with completing application forms for relevant benefits and referred Stephen to a local food bank whilst he waited for these to be approved. When Stephen visited his GP a few weeks later, his blood sugar levels were normal, and Stephen stated that he'd been able to access the financial support he needed. The GP recognised that this referral had made a key difference to Stephen's health and wellbeing and had prevented his health from deteriorating without the right support in place.

**Personal story:**

Lucy is a professional submissive who attended her local sexual health clinic for a routine smear test. Following a session, she had a couple of faded bruises across her thighs. Her notes at the clinic mention that she is a sex worker.

As the nurse is taking her smear test, she notices the bruises on Lucy's thighs and asks her how she got them. Lucy discloses the nature of her work; however, the nurse is still worried. While Lucy is redressing, the nurse gathers leaflets for a local women's shelter and domestic violence support lines. She hands these to Lucy – "just in case you need any support". While Lucy takes the leaflets and leaves, she feels patronised by the nurse – did they not believe her? She does not feel taken seriously or supported by the service and is now unsure whether she will return there.

This is an example of signposting being used in an inappropriate way. The service provider did not trust Lucy's autonomy, and has provided her with incorrect signposting as a result. She also asked the question while Lucy was in a vulnerable position, creating a further power inequality between them. To have signposted more effectively, the nurse may have asked Lucy, "is there anything you need any help with?" and may have instead chosen to signpost her to local and national sex workers' safety and community groups.

**Guidance and useful information**

- Nesta, The Health Foundation and National Voices' report on 'Realising the Value' provides valuable information on social prescribing and embedding local charities and communities within the health and care system .
- Public Health England have produced guidance 'Social prescribing: applying All Our Health' to help frontline health and care staff use their trusted relationships with patients, families and communities to promote the benefits of social prescribing.
- The 8th Report from GPs at the Deep End offers valuable insight into the benefits of social prescribing for patients experiencing deprivation.

# Section 7: Supporting all staff members with templates and advice on providing medical evidence for housing, benefits and more

**Question 7 – We asked, "Do all staff members within your PCN have access to up-to-date and comprehensive advice and templates to support people with benefits claims, housing claims and other things that support people with issues they are experiencing across the wider determinants of health?"**

**You said, "No, this isnt the case"**

For patients experiencing a range of challenges across the wider determinants of health, including difficulty accessing accommodation, issues around employment, deprivation and debt, healthcare professionals are often called upon to provide information to other statutory bodies on key considerations about an individual's health and wellbeing to take into account in decision making. The evidence offered by healthcare professionals within your PCN can have a significant impact on decision-making across statutory services. Providing clear guidance and templates around this can support health professionals in your PCN to make a

crucial difference to patients experiencing the greatest inequalities when accessing support for needs across the wider determinants of health.

## General measures your practices can implement

To ensure that your practices are equipped to efficiently and easily support patients across a wide range of non-clinical health needs, there are a number of general measures that can be implemented across the board. Putting in place clear processes can ensure consistency and quality in response across your neighbourhood and offer key benefits to patients experiencing inequalities.

- **Liaise with the Local Authority and Citizen's Advice to create letter templates** – this can make it easier for GPs to help patients access entitlements without this detracting from other clinical responsibilities ([link](#)).
- **Train reception and support staff to support people to access their own medical records** – this can enable patients to self-advocate and share this information across systems as they chose ([link](#)).
- **Consider obtaining written patient consent for advice workers to access medical records** – this can help to facilitate ongoing engagement between advice workers and GPs, and the production of supporting medical statements and letters that can be signed off by GPs ([link](#)).
- **Ensure that those in receipt of welfare and benefits are encouraged to apply for support via the NHS low income scheme as standard practice** – many patients may be unaware of their entitlements or how to access financial support ([link](#)).

## Letters to support patients with unmet needs across the wider determinants of health

There are a range of non-clinical health needs for which patients may request medical evidence or supporting letters. To support practices to deliver these as efficiently as possible, and to minimise the time that this detracts from other clinical responsibilities, we provide key guidance below on relevant letters and what can be included. Across all areas, it is important that letters provide information on the consequences of what will happen if relevant support is not provided, highlighting the key difference the decision will make for the overall health and wellbeing of the patient.

### Accommodation needs

### Housing priority need for those experiencing homelessness

A clear and comprehensive medical letter can play a central role in the outcome of a decision about priority need for housing for patients experiencing homelessness. For instance, GP letters demonstrating priority need whilst a patient is in hospital could prevent patients from being discharged back to the street. A medical report may be particularly useful where the client has mental health diagnoses or physical health conditions that may not obviously appear to have an impact on their capabilities or how they will cope when experiencing homelessness ([link](#)).

The same information can be applied to supporting letters to demonstrate priority need for a place on a council site for Gypsies and Travellers with no place to stop.

Support letters for housing priority need should include –

- How the doctor or health professional knows the client and for how long;
- Any formal diagnoses;
- Any medications that have been prescribed and the dosage;

- What the consequences of not doing anything will be –i.e. hospitalization;
- Impact on health conditions including mental health of housing/homelessness;
- If the person should be prioritised, why that is i.e. if the physical environment isn't suitable, why it isn't suitable; and
- Professional opinion as to whether the person would face greater difficulty than others in the same position, and why this is.

It is important to ensure that content is factual rather than emotive throughout – housing departments will only respond to those elements of a support letter that are factual.

The National Homelessness Advice Service provides detailed guidance on Vulnerability and Priority Need: Advising clients.

## Letters opposing evictions for those on unauthorised encampments

A chronic national shortage of Gypsy and Traveller sites in England means that over 10,000 people have no lawful place to stop (link). This makes it difficult for families to access water and sanitation, education and healthcare, which has a significant impact on the health and educational outcomes of Gypsies and Travellers. Despite this, Gypsies and Travellers living on unauthorised encampments are liable to be moved on by the police and/or evicted by the landowner.

Before a local authority can take any action to evict Gypsies and Travellers living on unauthorised encampments there is a requirement that welfare enquiries are undertaken and that the authority considers whether there are circumstances that require further consideration or mean that the eviction should be postponed.

A letter from a medical professional demonstrating the key impact this will have on the individual/family's welfare and how this might impact engagement with health and care services, could have an important impact on decision-making. Letters can include the following –

- How the doctor or health professional knows the client and for how long;
- Any formal diagnoses;
- Any medications that have been prescribed and the dosage;
- What the consequences of eviction and the impact on health will be – i.e. hospitalization;
- What the consequences of interrupted access to water and sanitation will be;
- Impact of health conditions, including mental health, on the decision and why the LA should delay the decision to evict;
- Professional opinion as to whether the person would face greater difficulty than others in the same position, and why this is; and
- Any relevant information regarding current involvement with health services etc. that would be detrimentally impacted if the person is evicted.

## Letters to help appeals against dispersal to UK Border Agency accommodation in other areas

Asylum seekers may only be granted access to temporary accommodation in a particular location, and a review of this may result in a patient being relocated to a different area. For patients with health and care needs, this can have a significant impact on access to social networks for support with daily tasks, and on continuity of care. GP letters can therefore play a significant role in supporting an appeal against this decision. Particular reasons that a patient may be granted an exemption from dispersal include suffering from a having a disability or medical condition that can only be treated in the local area (link).

### Benefit claims and welfare

Due to the high levels of debt and financial hardship experienced by inclusion health groups, many patients may require evidence to demonstrate entitlement to state benefits. This can include Department for Work and Pensions medical assessment forms or reports for entitlement to benefits such as Personal Independence Payments (PIP), and Employment and Support Allowance (ESA).

The Westcountry Community Psychology Group, in partnership with Citizens Advice have developed guidance on writing a letter of support for PIP and ESA applications for clients with mental health difficulties or disabilities. View here.

### Safeguarding

Another useful letter to provide is one for a Multi-Agency Risk Assessment Conference (MARAC) meeting; this has high impact when coming from a health professional. Again, it may be useful to liaise with Local Authorities, Citizen's Advice, and specialist charities, to develop clear templates so that these can be efficiently produced.

The Legal Aid Agency also provides a range of sample letters to get evidence of domestic violence – this includes letters to be provided by GPs and healthcare professionals.

### When proof of health professional viewing ID is required for sex workers

It is important to note that, porn performers are required to demonstrate that their ID has been seen by a health professional when obtaining sexual health certificates for professional porn studios. Certificates may be rejected if there is no proof that ID has been seen, and the legal name of the performer is not provided, and it is important for patients to be aware of this.

If patients are concerned about providing their legal name in case of their identity being exposed, PCN staff can offer information and guidance around this. The exposure and public broadcasting of this personal information is known as "doxying", and there are legal protections in place for performers around this. Performers can also request that a legal name protection clause be added to all filming consent forms. For further advice on this issue, staff can refer patients to National Ugly Mugs, who can help in cases of doxying, or signpost to other relevant organisations.

## Section 8: Providing letters relating to benefits, homelessness and other essential needs for free

**Question 8 – We asked, "Do your practices give letters relating to benefits, homelessness and other essential needs for free?"**

**You said, "No practices do"**

For patients experiencing high levels of unmet need across the wider determinants of health, accessing the right support across public services often requires supporting letters or medical evidence from a GP. When GP surgeries request payment for these, those experiencing financial hardship may face an immediate barrier to accessing support from wider services. Your PCN can ensure that patients at the sharp edge of inequalities are able to access the support they require by waiving charges for relevant letters or medical reports for patients from inclusion health groups. This can be essential for accessing necessary benefits and

housing, which can be key to ongoing engagement with services, and can have a significant impact on health.

## The benefits of offering letters and medical reports free of charge

The Senior National GP Advisor to the CQC, Professor Nigel Sparrow, highlights in his guidance on [Looking after Homeless Patients in General Practice](#) that best practice for homeless patients includes *"waiving any charges for housing letters or medical reports"*. The same principle applies to other inclusion health groups, who often similarly experience particularly high levels of deprivation and high levels of unmet need relating to welfare, housing, and more. To ensure a universal and equitable approach, Primary Care Networks can consider the provision of information at no cost as standard practice for inclusion health groups across the board.

Whilst clinicians may have varied opinions on whether this work should be considered discretionary, there is need to balance this with a consideration of inequalities in access and outcome in your local population. Providing letters and medical evidence free of charge to those experiencing significant financial hardship can have a notable beneficial impact on access to wider support, and can help to build trust with patients who may have previously had negative experiences of engagement with statutory services. In the long-term, supporting patient access to support around areas such as benefits and housing can play a crucial role in preventing a deterioration in health.

To support practices to provide letters free of charge, there is need to offer support to improve the efficiency of this process. Previously in this guidance we have offered key information on the range of letters that clinicians and practice staff can send on behalf of patients, alongside information on what can be included.

Key benefits of providing letters for free include –

- For inclusion health groups facing chronic exclusion across the wider determinants of health, supporting evidence for applications to benefits, housing applications and so forth, can have a meaningful and significant impact on health. This reduces inequalities and improves health outcomes.
- Overcoming financial barriers to support for those facing significant financial hardship helps to build trust with patients; this is particularly vital for patients from inclusion health groups who may have high levels of mistrust in statutory and public services as a result of fear of, and practical experiences, of stigma and discrimination.

## Waiving charges attached to sexual health certificates for sex workers

Many porn performers are required to provide evidence that they have accessed sexual health testing every 28 days, and will be unable to work, or unable to work safely, without this information. Despite this, as a result of a lack of understanding of the wider circumstances and barriers to services porn performers may be facing, many services may refuse to provide this, or charge patients for access to this information.

It is imperative that services consider the important impacts that refusing, or charging for this information may have on a performer's health and wellbeing. Charging for information on sexual health testing is unlikely to encourage sex workers to reconsider their work, but is instead more likely to further exacerbate financial hardship, and may lead to greater risk taking. An example of this is using fake STI test certificates in order to continue to work in the industry. Performers often "clinic-hop" when denied a test certificate in order to meet their official studio work requirements of a 28-day test certificate.

Porn performers are likely to be experiencing low incomes and financial insecurity, and charging for sexual health results can compound this issue. Often, a significant proportion of the profits from porn studios ends up with "tube sites", which do not offer contributions towards performer testing costs. Similarly, many self-

filming performers are involved in pyramid schemes/multi-level marketing schemes, which limit the profits performers actually receive. In practice, organisations like "OnlyFans" pay most reliably when performers focus on signing up new performers to the platform, rather than performers selling their own content. This is known as "referral payouts" and it is why some performers seem very wealthy on the platform.

It is essential that staff across your PCN ensure that patients engaged in sex work are offered non-judgmental care, and that assumptions are not made about income based on the mode of work the patient is engaged in. Given the financial hardship many porn performers may be experiencing, deferring patients to private sexual health testing services is not a solution to this issue. You can therefore offer significant benefits to sex workers in your local population by ensuring that staff across your PCN are aware that this information should be offered free of charge.

Private testing should only be considered for the situations where a performer has 14 day testing demands of them by the internationally owned productions doing so; in these instances, it is useful for practice staff refer the performer to UKAP.info so that they can access the discounted private testing that the union has negotiated.

**Guidance and useful information**

- Refer to National Ugly Mugs for further information on issues experienced by sex workers
- Pathway and the Faculty for Homeless and Inclusion Health has produced a helpful guide on Inclusion Health Standards for commissioners and service providers that covers all inclusion health groups and includes guidance on providing supporting letters.

## Section 9: Carrying out disaggregated monitoring of inclusion health groups for satisfaction

**Question 9 – We asked, "Do your practices carry out disaggregated monitoring of inclusion health groups for satisfaction?"**

**You said, "No practices do"**

The way that people experience health and care services is an important aspect of the quality of care provided, and knowing what patients think of the care that they receive is therefore a central component of service improvement initiatives (link). When monitoring patient satisfaction, disaggregated monitoring of inclusion health groups is important because it is rooted in the recognition that people from inclusion health groups may experience your services differently to others. If certain structures or processes in your PCN mean that inclusion health groups are inhibited from fully benefitting from your services, monitoring can support your practices to identify these and rectify them. By monitoring patient satisfaction in this way, you can ensure that you strive towards and maintain effective support for people from inclusion health groups.

### Benefits of disaggregated monitoring

Measuring patient satisfaction can be a key means of identifying population based inequalities in quality and experience of care across your PCN. Different social groups may be experiencing systematically different experiences to others when accessing services across your PCN. This can be in terms of quality of care received, whether they are receiving welcoming and inclusive care, and whether they are treated with dignity and respect (link).

Previous research around patient satisfaction has revealed substantial disparities in experiences of care. For instance, a 2017 British Social Attitudes survey found that respondents who identified as Black reported lower levels of satisfaction with the NHS at 44%, than respondents who identified as White at 58% (link). In a recent study by Stonewall, 13% of LGBT respondents reported experiencing unequal treatment from health care staff because they were LGBT, 32% of people who are transgender reported unequal treatment, and 19% of Black, Asian and minority ethnic LGBT people reported unequal treatment (link).

It is important to consider how these types of monitoring processes can be adapted to specifically identify the experiences of patients from inclusion health groups. Using disaggregated data, or data that has been broken down into sub-categories, can support you to develop a more robust sense of the ways in which inclusion health groups can be better served. To support this, you can take a holistic approach to service

user satisfaction, and introduce a "you said, we did" approach to assure people using services that their voices are being heard.

**Key benefits for inclusion health groups**

- Marginalised or social excluded groups who experience your service differently than others are recognised in your data.
- You can gain key understanding of what causes inequality in patient experience when accessing your services.
- Your practices are provided with key information that can support to rectify those areas where inclusion health groups don't fully benefit from your service.
- Your service can be improved to enable inclusion health groups to access services in a specific way that may not be applicable to other groups.

Whilst some barriers to care may be shared by inclusion health groups, specific factors that impact patient experience and engagement with services may differ. For instance, the priorities and experiences of patients from Gypsy and Traveller communities are likely to have key distinctions from those of patients experiencing homelessness. Similarly, patients who are sex workers will likely have differing priorities and circumstances to patients from vulnerable migrant groups. Taking a disaggregated approach supports you to address clear inequalities issues that are evident across all inclusion health groups, as well as identifying changes you can implement that will enhance accessibility for specific groups.

**Areas of patient satisfaction to consider for inclusion health groups**

There are a number of key areas of interaction within your services that may present barriers to services for inclusion health groups and where it is useful to monitor patient experience –

- **Accessibility at first point of contact with services** – interactions with reception staff present a key opportunity to build trust for patients from inclusion health groups. Identifying any issues around patient experience at the first point of contact can be a key means of identifying systematic inequalities that may impact engagement with your practices.
- **Responsiveness of the service** – there are a number of factors around care delivery that may be of particular significance for some patient groups. For example, the availability of and flexibility of appointments offered may be of particular relevant to those who are living nomadically who may only temporarily be in the local area, or for sex workers and those on zero hours contracts who require appointments that fit demanding and often changing schedules. Measuring differing factors can support to understand how to improve patient experience for inclusion health groups based on their priorities and experiences.
- **Support to understand information within, and satisfaction with, the consultation** – patients may experience barriers to care relating to low literacy, low or no English language, and low levels of health literacy, they may have complex or multiple needs, and they may be seeking guidance and advice around non-clinical health needs. Monitoring patient satisfaction of consultations can help to address areas where additional attention may be needed to improve patient experience.
- **Communication** – across all areas of the service, it is important to ask patients whether support has been provided to ensure effective communication to all groups, including those experiencing communication barriers relating to low literacy, low levels of English etc.

**Guidance and useful information**

- The Health Foundation provides guidance on different approaches and methods of Measuring Patient

Experience, including those that may benefit groups with low levels of literacy or English language skills

- The Kings Fund guidance 'What are Health Inequalities?' provides key insight into the benefits of disaggregated patient experience and satisfaction monitoring to support in understanding of inequalities

# Section 10: Using codes to manage patient data and specific needs

**Question 10 – We asked, "Do services within your PCN routinely use codes when managing patient data to enable you to identify and reach those with the greatest needs?"**

**You said, "No practices do"**

For many patients from inclusion health groups, engagement with health and care services can often be fragmented and intermittent. As such, patients may receive reactive care with limited opportunity for prevention or advance care planning. Using codes to manage patient data can be a key means of supporting your PCN to offer more preventative and proactive healthcare to inclusion health groups; coding can enable services to quickly and effectively identify patient needs and thereby provides the opportunity to offer relevant support. Coding may also aid in data collection for a service to assess its engagement and provision for a particular group of people and work alongside patient feedback to evaluate and improve services. This can support the development of more personalised care and, in the long run, save money and time.

## The benefits of coding patient data

Effective coding and the sharing of relevant datasets across your PCN can support staff to offer proactive and relevant support based on need. Codes may act as a flag to prompt GPs to ask when patients had last screening tests, where they are living, or what support they need around communication. It may also mean that a patient does not need to disclose sensitive or traumatic information at each appointment. Examples of the benefits of coding include –

- Coding can support practices to offer holistic support to those with multiple diagnoses and complex needs
- Coding can allow for targeted preventative care for cohorts with typically low levels of uptake
- Coding can help your PCN to achieve the key service specification of improving early identification and diagnosis of cancer among young people and adults
- Coding can support staff to offer discrete and appropriate support without need for patients to request this or disclose sensitive information at each appointment
- Coding can help to identify patients who may benefit from relevant signposting and social prescribing for support across the wider determinants of health

In considering the needs of inclusion health groups it is important to note that these labels may carry social stigma, which can act as a barrier to people accessing services or to receiving appropriate care. All patients, regardless of whether they are affiliated with an inclusion health group or not, are deserving of respect and care. The process of coding, however well-intentioned, applies a label to an individual which carries a number of different connotations.

It is therefore essential that the codes used reflect the temporary nature of many of the labels applied. For instance, a patient may only temporarily experience homelessness or housing insecurity. Coding should highlight the potentially temporary nature of these needs, for instance; "person experiencing homelessness" rather than "homeless person", and so on. Coding processes, alongside overall organisational services, must be routinely evaluated and improved to ensure that your service continues to meet the needs of the communities it serves. Importantly, any coding mechanism must be supported with whole organisation training to ensure that patients accessing your service from inclusion health groups feel understood, respected and supported.

### How to code patient data

There are a number of different ways that coding can be used to support the delivery of services to those from inclusion health groups. Practices within a PCN can agree on flags to use locally on EMIS or SystmOne. These can be kept simple and highlight needs such as –

### Deprivation

Coding around deprivation can allow additional targeting of preventative services towards patient cohorts who historically have lower levels of uptake. Evidence from across preventative services suggests that uptake is often lower amongst populations experiencing socio-economic deprivation. While the reasons behind this are multiple and complex, using patient codes to identify patients in postcodes with higher levels of deprivation using the English indices of deprivation 2019, could enable your PCN to target additional opportunities for uptake of preventative services towards members of these groups.

### Multimorbidity

Coding highlighting multimorbidity for those with two or more diagnoses can support to flag patients who may require longer consultations and holistic condition reviews. Flagging multimorbidity can also support your practice pharmacy leads to undertake structured and comprehensive medication reviews for patients who may be at high risk of experiencing polypharmacy, and of experiencing this earlier in life (link).

### Tri-morbidity

Tri-morbidity is the combination of physical ill-health with mental ill-health and drug or alcohol misuse (link). Highlighting tri-morbidity can support to flag patients who may be experiencing complex schedules across the health and care system, who may be at particularly high risk of social isolation, who may benefit from longer appointments, and who may benefit from relevant social prescribing and signposting to support with non-clinical health needs.

### Accommodation status and type

 If a patient has no fixed address or is living nomadically, they may only have transient involvement with services and may face particular barriers to accessing preventative care. Patients who are travelling or experiencing homelessness may miss out on routine screening, with screening programmes currently inviting patients via their GP registrations. Accommodation status coding can therefore flag to clinicians when patients may benefit from proactive referrals for screening and immunisations. This can also help to identify patients who may benefit from advocacy across the wider health and social care system, and relevant social prescribing.

### Communication needs

Coding around communication can support staff to identify patients who may require additional support, for instance, patients with low literacy who may benefit from discrete support with filling out forms. Coding on

communication needs can support automatic offers of additional communication support at the first point of contact, and longer appointments.

**Considerations when coding patient data**

- Labelling particular needs among patients can only go so far in providing appropriate care. All staff must be trained in how to apply each code used in a clinical setting, to understand the needs of particular inclusion health groups, be aware of what additional services may be available to them and continue to create a welcoming, non-stigmatising environment where members of inclusion health groups feel safe, respected and supported.

- Generally, we wouldn't advise that it is appropriate to code patients as being from inclusion health groups. However, there may be instances in which a patient may request this; this code may benefit the patient and prevent them from having to re-explain their context and circumstances at every appointment. However, it is important to weigh up this decision with patient, recognising that the use of this code could be labelling and considering carefully the pros and cons of this.

- Service users must consent to having any given inclusion health group label on their records; they cannot have a label applied to them without their permission. Control of information should be in the hands of the patient, and they should be made aware that this label is being applied.

- Whichever of these strategies you choose to use, continue to review this process with the relevant communities and evaluate and respond to their experiences. Use their feedback as an opportunity to improve your provision for them and work collaboratively to ensure that your approach is appropriate for everyone involved.

- Consider the permanency of these labels and ensure that labels can be removed or changed where necessary.

# Section 11: Ensuring your practices routinely offer longer appointments to patients with multi-morbidities, complex care needs, or communication needs

**Question 11 – We asked, "Do your practices routinely offer longer appointments to patients with multi-morbidities, complex care needs or communication needs?"**

**You said, "No practices do"**

For patients with multiple needs across the wider health and care system, primary care services can act as a natural hub. However, due to short appointment times, patients may be unable to discuss or articulate the extent of their concerns in a single consultation. This can be further exacerbated by communication barriers relating to low levels of English language or low literacy. Ensuring that your practices routinely offer extended consultations to patients who would greatly benefit from this provides the opportunity to offer holistic assessment of patient need. This supports patients to better manage their health and care needs long-term and can thereby minimise the need for additional consultations and prevent poor health outcomes (link).

**The benefits of extended consultations**

Chronic social exclusion and deprivation are strongly associated with multimorbidity and complex care needs

([link](#)). Although the NHS long-term plan outlines clear ambitions to move towards a more integrated system, many services rely upon a single-condition model of healthcare provision ([link](#)). This siloed approach means that patients from inclusion health groups often face complex, fragmented care schedules, which can lead to withdrawal from services.

There have been a number of studies and projects that have demonstrated the benefits of routinely offering longer primary healthcare appointments to those with multiple, complex or communication needs. This approach has been demonstrated to be a cost-effective means of improving healthcare delivery, and of improving patient experience. Some of the key benefits of offering extended consultations include –

- Extended consultations for patients with complex needs have been demonstrated to decrease GP stress levels during consultations, increase patient enablement, and improve opportunities for coordinated care ([link](#)).
- Patients from inclusion health groups often would benefit from advice and information around non-clinical health needs such as benefits, employment and housing, but GPs often do not feel they have time to support with these concerns. Extended appointments for patients with complex needs offers the opportunity to engage with these wider concerns and offer key advice or signposting that can prevent future poor health outcomes ([link](#)).
- Longer appointments have been demonstrated to provide opportunity for better planning and coordination of individual patient care as well as also providing a basis for driving change through local arrangements for integrated care, based on the needs of patients ([link](#)).
- Previous studies have demonstrated that enabling practices in deprived areas to provide longer and more patient-centred care for patients with multimorbidity may protect quality of life in a cost-effective way ([link](#)). This same approach can be applied to support for population groups experiencing deprivation across your PCN.
- Longer appointments provide the opportunity for more holistic engagement with patient needs; this can help to support and empower self-management for patients ([link](#)).

For patients from inclusion health groups experiencing exclusion across the wider determinants of health, extended appointments are likely to have significant benefit. Patients may be otherwise unsure where to turn for advice and support, may be reluctant to engage with statutory services due to fear of and practical experiences of stigma or discrimination, may significantly benefit from the opportunity to discuss both clinical and non-clinical health needs holistically, and express anxieties and concerns.

**Routinely offering longer appointments**

- **Ensure that reception and support staff at your practice record communication needs/preferences at first point of contact with the service.** This can support practices to flag patients who will benefit from longer appointments as a result of communication barriers relating to low literacy and low or no levels of English language. This will give health professionals who would otherwise have shared a leaflet with a patient time to go through and explain information that was on the leaflet or time to allow a translator to interpret information they are sharing.
- **Offer double appointments to patients who have diagnoses of two or more long-term conditions, including mental health diagnoses.** Patients may receive information from services across the health and care system on how to manage individual conditions, but may be unsure how to manage these concurrently. Patients may also be at risk of adverse effects from multiple medications or non-adherence to treatments, and extended primary care appointments offer a key opportunity to gain key insight and support with this.
- **Consider wider non-clinical health needs such as housing, financial issues and debt etc.** Longer appointment times can allow the time to provide relevant advice, information and signposting.

Providing valuable signposting and information around relevant services to support with wider non-clinical health needs can be a key means of preventing future poor health outcomes related to factors such as deprivation and debt, inadequate access to accommodation, or employment.

- **Consider the valuable role pharmacy teams can play within your PCN to support those with complex care needs and multimorbidity**. Patients with multimorbidity and complex care needs may also be at higher risk of polypharmacy and premature frailty. Medication reviews to prevent polypharmacy and private consultations also offer key opportunities to provide additional information and advice to those with multimorbidity or complex care needs. This can also provide the opportunity for signposting to local charities and community groups for wider needs.
- **Consider reframing your approach to annual single-condition healthcare reviews**. The 2018 3D study trialled an intervention based on a patient-centred care model that seeks to improve continuity, coordination, and efficiency of care. The intervention replaced single-condition focused annual healthcare reviews in primary care with one 6-monthly multidisciplinary review, and patients with two or more conditions were identified via data from Quality and Outcomes Framework register. Patients involved in the study noted significant improvements in their experience of care, and reported that their care was more joined up, and they better understood how to manage their health and care needs.

### Guidance and useful information

- The Health Foundation has previously published useful guidance regarding health and care for patients with multimorbidity – Understanding the health care needs of people with multiple conditions
- Useful tips on improving healthcare delivery for patients with multi morbidity can be found here: Multimorbidity – the biggest clinical challenge facing the NHS?
- The Scottish Deep End Project provides an overview of useful guidance and information relating to extended consultations for patients experiencing deprivation – Consultations
- The Deep End Project also provide guidance on Complex Consultations and Trauma and Multiple Exclusion/Complex Consultations

## Section 12: Ensuring your practices make routine adjustments for people to support diverse communication needs

**Question 12 – We asked, "Do your practices make routine adjustments for people with low literacy, people who have low or no fluency levels of English and those experiencing digital exclusion?"**

**You said, "No"**

Failure to offer accessible communications for patients with low levels of literacy, low or no fluency levels of English, or patients experiencing digital exclusion, can be a key barrier to health and care for inclusion health groups. If communications and registration procedures are inaccessible, this can prevent patients from ever getting their foot in the door of primary care services. Your practices can make straightforward, routine adjustments to communications, and thereby improve accessibility for a significant number of patients. Overcoming these barriers supports your PCN to fulfil legal duties under the Accessible Information

Standard (AIS), and ensures that the services you provide are welcoming and inclusive for all.

## Making routine adjustments

The Accessible Information Standard (AIS) states that people in England have the right to accessible information and communication support and provides guidance on how to fulfil this (link).  Whilst the Standard is specifically targeted at patients, service users, carers and parents with a disability, impairment or sensory loss, many of the principles apply to communication with people with low literacy or low levels of English.

Although many barriers to communication will be shared by those experiencing low literacy, low levels of English language and digital exclusion, there are some specific adjustments that your practices can make to ensure that they offer a flexible, person-centred approach to communications with all patients.

## Patients with low literacy

Resulting in part from structural inequalities in access to and experience of education, inclusion health groups are more likely than the general population to have low literacy levels (link). For example, 45% of Friends, Families and Travellers beneficiaries from Gypsy and Traveller communities have low or no literacy (link), and previous research conducted with 139 homeless adults found that 55% had low literacy (link). Whilst barriers to services relating to low literacy are felt disproportionately by inclusion health groups, in fact, 16% of the population in England have low or no literacy levels (link). Making improvements in this area can therefore improve the accessibility of your services to a significant proportion of the patient population.

Adjustments staff members in your PCN can make include:

- For patients with low literacy, completing lengthy registration forms can create an automatic hurdle to accessing primary healthcare services. Patients may feel on display in busy waiting rooms and therefore reluctant to request additional help. Ensuring that your staff routinely and discretely offer support with completing forms to all patients can ensure that patients with low literacy are automatically offered additional communication support. Instead of saying "Can you read and write?", staff should say, "Can I offer you help with filling out the form?"
- Consider the needs of patients with low literacy when you create content and information for website and social media. Ensuring that video/audio versions of communications, as well as easy read documents, are provided, will help to ensure that people with low literacy levels are able to access this information.
- Displaying names on screens in waiting rooms can be a barrier to those with low literacy; consider using a ticket system or alternative method of signalling to patients.
- Build in time within appointments or consultations to explain written information across all services within a PCN.

## Patients with low or no fluency in English

Simple, straightforward adjustments can overcome language barriers and improve access to and experiences of care for people with low or no fluency in English, who may be facing significant challenges when navigating the health and care system. Many patients from these groups will also be experiencing additional barriers to services related to homelessness or insecure accommodation.

Adjustments staff members in your PCN can make include:

- If a patient has difficulty communicating in English, an interpreter should be used both at reception and in consultations. Easy access to telephone interpretation services is therefore essential, and all

staff should be trained to be fully competent and confident using these services. Please keep in mind that some groups, such as Roma communities, can experience high levels of discrimination within their origin countries. It is therefore important for care providers to consider this when offering interpreting. In addition, if using face-to-face interpreting or local services, within some communities and locations, patients may know the interpreter for their language, and may not be comfortable for this person to provide translation. In these circumstances, patients would benefit from the opportunity to access to interpreters who are out of area.

- If a patient is accompanied by an English-speaking friend or relative, consider carefully whether allowing them to join a consultation might prevent the patient from speaking openly.

- Whilst practices may offer access to interpreting services, they may not be offering hard copies of relevant information and correspondence regarding the surgery, or regarding patient care. Based on understanding of local population need, practices can ensure that hard copy information is available in relevant languages.

- Routinely offering support with the completion of registration forms can also support those with low or no English to access registration; if registering over the telephone, ensure that access to interpretation services can be offered at the first point of contact.

When offering training and guidance on the use of interpreting services, it is important that all healthcare professionals strive to primarily use language that is conversational, and not just clinical language. This helps to ensure that key messages are delivered and understood, and patients are provided with clear information regarding their care. Whilst verbal translation services are crucial, face-to-face interactions are also important and it is important that services consider additional communication methods such as sign language and Makaton.

## Patients experiencing digital exclusion

The high levels of digital exclusion experienced by inclusion health groups stems from a range of factors. This includes barriers resulting from low literacy and English language levels, as well as practical barriers associated with deprivation, such as a lack of access to data or devices (link). As a result of the impact of COVID-19, many primary care services are rapidly moving towards digital systems to support with access to and delivery of primary care services. In order to ensure inclusion health groups are not further excluded by these developments, it is vital that your practices consider how patients experiencing digital exclusion can also be supported to access services.

- "Digital by default" processes for registration present an automatic barrier to care for those experiencing digital exclusion. Ensure that alternatives are offered, such as providing details for registration over the phone. Some patients may also require support from a telephone interpreter in order to register.

- Ensuring that your practices have briefed all reception and support staff to query whether patients are able to access online registration or appointment booking and to ensure that alternative options are offered. People experiencing digital exclusion should have access to the same number of appointments as people who are able to book appointments online.

- To support your practices to provide a person-centred service, requesting information at the first point of contact on communication preferences, and providing a flexible approach to this, can support people to access services. Utilising different approaches, such as text messages, can help to ensure that messages reach patients who may otherwise face difficulty receiving critical information.

## General communications adjustments for inclusion health groups

There are general steps your practices can take to improve communications with inclusion health groups, as

well as wider groups experiencing inequalities.

- Practices can routinely record communication preferences at the first point of contact with services. This flags to staff those patients who may require additional support with filling in forms, arranging appointments, and managing correspondence. This can also support GPs to identify those patients who would benefit from extended consultations.
- When creating new media or updating information, practices can work together to create easy read versions of these materials, as well as materials in languages suited to the local population
- Patients experiencing communication barriers may miss out on key health promotion messages or opportunities to engage with preventative care; your PCN can create more accessible forms of media and health promotion. It is useful to consider displaying this in varied locations that patients will be visiting, and not just the wall of the surgery. Many people experiencing exclusion and barriers to care will engage with community pharmacy services, and therefore this can be utilised as a key point at which accessible health promotion messages can be shared.

**Guidance and useful information for accessible communications:**

- Friends, Families and Travellers have created Health Help Cards which make it easy for people with low levels of literacy to discreetly let health and care professionals know that they may need support.
- Consider the use of audio tools such as Browsealoud for websites and communications. Browsealoud adds speech, reading and translation to websites for people with dyslexia, low literacy, mild visual impairments and those have low or no levels of fluency in English.
- Consider signing up to a telephone-based interpreting services such as Language Line for quick access to interpreting in a wide variety of languages.
- The Doctors of the World Safe Surgery initiative includes a toolkit which provides posters and other resources available in a number of languages.
- Valuable guidance for providers is available in NHS England's Guidance on Interpreting and Translation Services in Primary Care.
- Although it is not considered best practice to use family members (but not children) as interpreters, there are practical circumstances in which practitioners may make individual judgements around this. Useful information on this topic is included in the BMJ article 'Can patients use family members as non-professional interpreters in consultations?'
- NHS Digital provides guidance Digital Inclusion for Health and Social Care
- Pathway provides guidance on Improving Digital Health Access for Excluded Groups

## Section 13: Ensuring your PCN meets the appointment needs of people from inclusion health groups

**Question 13 – We asked, "In order to meet the needs of people from different groups, does your PCN offer extended hours appointments, walk in services and flexibility in appointments for people who live unpredictable lives?"**

**You said, "No"**

Members of inclusion health groups may struggle with the practicalities of making and attending

appointments for a variety of reasons. They may be working on zero hours contracts, have a chaotic lifestyle, have physical or mental health needs which prevent them from making or maintaining appointments or struggle to access means with which to communicate with a particular service. For those with multimorbidity, tri-morbidity, or complex needs, difficulty attending appointments can be further exacerbated by complex and demanding appointment schedules across the health and care system. Offering flexible, walk-in, and extended hours appointments can therefore improve accessibility across your PCN and increase opportunities for engagement with services. This will help non-attendance figures drop and increase trust between your service and its users.

## Enhancing access across your PCN

There are many barriers that prevent groups experiencing social exclusion from accessing healthcare, and there is need for services to enhance access to actively address these barriers. As a result of complex circumstances or chaotic lifestyles, patients may have difficulty accessing services if there are restricted opening hours and a lack of drop-in appointments.

It is important that services reflect a recognition of the fact that, as a result of barriers to care, as well as fear of and practical experiences of discrimination, patients from inclusion health groups may not access primary healthcare until needs have already escalated. For instance, some vulnerable migrants may not access services until a late stage due to concern about coming to the attention of the authorities. Patients living nomadically or with no fixed address may have previously experienced a battle to register at local surgeries and registration refusal, and therefore may not attempt to access an appointment until needs have escalated.

Taking a flexible approach to appointments can improve access for patients who may otherwise face barriers to engagement with services and can help to ensure that healthcare needs are addressed before they reach an acute stage. Ways in which you can make sure your PCN meets the appointment needs of people from inclusion health groups include –

- **Ensuring drop-in services are offered, as well as same day appointments** – this ensures that patients who require urgent attention can access primary care. It also ensures that people who find it difficult to organise appointments in advance, for example, a patient living on an unauthorised encampment threatened with eviction, can make opportunistic appointments to address minor health issues before they reach an acute stage. Please keep in mind travel cost and time between practices in your PCN when asking people to visit another practice, which may prove more challenging for people with low or no incomes.
- **Offering flexible timing of sessions** – this can support your PCN to meet the needs of particular groups. For example, late evening or early morning clinics may support access for street sex workers and may benefit patients who are self-employed or on zero hours contracts. When reviewing implementation of NHS England's requirement for PCNs to offer extended opening hours provision, consider how your PCN's extended hours offer might improve access for patients experiencing inequalities.
- **Ensuring people experiencing digital exclusion, low levels of literacy or low levels of fluency in English can easily book appointments** – while innovation around the use of digital in primary care settings has made it easier for many people to access appointments and for practices to manage this process, the opposite may be true for people from populations experiencing inequalities. It's important that patients experiencing digital exclusion, low levels of literacy or low levels of fluency in English can easily book appointments have the same chance of securing an appointment as patients who feel confident booking these online. This may mean holding aside a proportion of appointments from your online booking system and reserving these for people who would be unable to use this system.

**Other considerations**

**Providing a range of options is often the best way to meet multiple complex needs within inclusion health groups and the wider community.** It is important to let service users know the range of options that they have with regards to booking and attending appointments and for communicating with the service more generally, so that they can continue to make informed decisions about how they can best handle their care.

**Even in the most well set-up of systems, there will still be times when patients do not attend appointments.** The circumstances behind these will vary, and it is important to foster an understanding and supportive environment to ensure that patients remain confident in accessing services when necessary.

**Try to follow up on DNAs and explore reasons for non-attendance and consider working with service users to find workable solutions for any issues.** Do not charge for DNAs, as members of inclusion health groups may not be able to afford these payments, and they may become alienated from your services and no longer seek help when needed, placing their health at greater risk. If possible, try to set out expectations with patients which allow them to feel confident in communicating with your service. For example, you may wish to say, "If you don't show up and don't let me know three times in a row, I'll presume you're no longer interested." This way if people cannot attend it due to circumstances out of their control, they are encouraged and feel supported to let you know. Consider the wider relationship between patients, practitioners and services within this; could their barriers to attending lie with the organisation rather than its users?

**Regular engagement with patients and service users around what would improve access can support you to enhance the accessibility of your service.** Seeking feedback on the accessibility of practices across your PCN can help to identify further approaches that may improve accessibility for your local population.

**Personal story:**

Alex is a part-time pornography performer who often receives notice of studio shoots at short notice. They fit their performing work around another part-time job with flexible hours, so cannot always be tested regularly, but this time they require a 28-day certificate so that they can complete the work they have been offered.

When Alex is asked for their availability to shoot, they need to be able to provide test results quickly. They are not out as a sex worker at their other job, so if they are there when they receive notice, they cannot phone the clinic to ask for an appointment. They may be able to discreetly look at the app for their local sexual health centre and see if there are any appointments at a time they can attend, but these may be booked up quickly or far in advance.

However, their local sexual health centre also provides early-morning walk-in provision before Alex begins work and makes it possible for them to receive their results certificate within 72 hours. Alex is grateful for this service, as it allows them to maintain their income from both jobs as well as their privacy.

**Guidance and useful information**

- NHS England provides guidance on Improving Access to General Practice.
- Pathway and The Faculty for Homeless and Inclusion Health guidance on Homeless and Inclusion Health Standards for Commissioners and Service Providers which refers to the benefits of drop-in appointments.
- The Institute of Health Equity guidance on Reducing Health Inequalities Through New Models of Care highlights that failure to provide flexible options for appointments also prevents carers from

accessing care.

**Question 14 – We asked, "Are all services within your PCN available to patients, irrespective if they are able to provide proof of identification, proof of address and proof of immigration status?"**

**You said, "Unsure"**



*"When applying to become a patient there is no regulatory requirement to prove identity, address, immigration status or the provision of an NHS number in order to register"*

NHS England, 2015 ([link](link))

The first principle of the [NHS constitution](NHS constitution) sets out that the "NHS provides a comprehensive service, available to all". In particular, the principle highlights that the NHS "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."

The UK's primary care services are, in principle, open and free to everyone in the country. This principle is enshrined in law as well as in the contracts which govern GP services. NHS England guidelines, in interpreting GP services' duties in relation to equalities and non-discrimination, protect the right to GP

registration for those who are not able to provide proof of address or identification. As there is no requirement under the regulations to produce identity or residence information, the patient must be registered on application unless the practice has reasonable grounds to decline. Inability by a patient to provide identification or proof of address would not be considered reasonable grounds to refuse to register a patient.

Despite this, the results of a research exercise launched by Friends Families and Travellers in 2019 found that 24 out of 50 general practices mystery shopped in England refused to register a member of the Traveller community because they had no fixed address and/or no proof of identification (link). In keeping with these findings, in a report released in 2018, Doctors of the World shared that out of a total of 2189 attempts to register patients, patient registration was refused on 419 occasions (link)

## Ensuring all staff are aware of patient entitlements

*"I only persisted with attempting to register because I knew I actually had cancer. It has turned out to be a stage 3 cancer. There were three tumors and five affected lymph nodes. Despite the fact that I knew my rights, provided information on registering at a GP's address and articulated my case, I had to compromise my confidentiality on two occasions to access belated care for an aggressive, life threatening disease which could have been caught years earlier."*

Kit, 2019 (link).

Wrongful refusal of access to primary healthcare services has significant implications for access across other areas of the health and care system. Those who are refused registration are also denied access to screening programmes, immunisations, and other preventative interventions, that patients are only invited to via GP records. Improving access to screening, early detection of cancers among at risk groups, and reducing A&E admissions are all key aims for PCNs; achieving these aims can result in additional funding via the shared savings scheme (link). A simple and incredibly effective way of supporting each of these goals would be to ensure that no person is wrongfully refused registration as a result of no ID, no proof or immigration status, or no fixed address.

It is essential that everyone working in your PCN is aware of these regulations. Improved internal communication on such issues will help as a regular reminder; particularly to reception staff.  It is also essential that new staff are trained on this to ensure that staff turnover does not impact the accessibility of your practices. There are some key things your surgeries can do to ensure that all patients are able to access the care they are entitled to –

- **Provide training to all reception and support staff on access rights** – training is available from Doctors of the World on entitlement to health care in England. This training can take place in person or remotely via Microsoft Teams. Pathway and the Faculty for Homeless and Inclusion Health also provide a training package for reception staff on access for those with no fixed address

- **Sign up as a Safe Surgery** as part of Doctors of the World's Safe Surgeries Initiative – you can join the Safe Surgeries Network to be part of a growing number of GP surgeries, PCNs and CCGs who are committed to promoting inclusion in their practice.

- **Use posters in a range of languages** from the Safe Surgeries Toolkit to visibly display information on entitlement to primary care – this will help patients understand their rights and will encourage them to seek medical care without fear.

- **When processing registrations for patients from Gypsy, Traveller and Boater communities, don't assume that the patient always wishes to be registered as a temporary patient** – in

many cases, practices assume all nomadic patients should be registered as temporary patients, however, this can restrict access for patients to non-urgent care, invites to routine screenings or referrals to specialist care. In order to determine what is best, listen to the patient on whether they would prefer to be registered as a permanent or temporary patient and ensure they are aware of the repercussions of any decision they may choose to make. You should also inform the patient on their entitlement to home visits depending on where they are located at any given time. Where a patient becomes well outside of your geographic catchment area and requires a home visit, you can and should contact GP practices in that area to register the patient and arrange a home visit.

Health needs which should be met within general practice, but are not met will eventually need to be dealt with at some point in the healthcare system – this might be in A&E where the issue may be more acute, or within pharmacies, where pharmacists may be approached by patients attempting to purchase or access medication for undiagnosed health issues because they are unable to access diagnosis through their GP. Within your PCN, you can and should work to raise awareness of rights around GP registration across all partners so when this issue arises, a wide range of health and care professionals feel confident in challenging it.

**Guidance and useful information**

- The NHS England Menu of Evidence Based Interventions includes a section on improving GP registration amongst socially excluded groups, covering all inclusion health groups and evidence such as barriers to GP registration for victims of human trafficking.
- NHS England/NHS Improvement produced a leaflet for asylum seekers and refugees on registering with a GP, which covers best practice and guidance on registering with no fixed abode. Services across PCNs can ensure this leaflet is available to their service users.
- Groundswell have produced 'My Rights to Healthcare Cards' to help get people registered with a GP practice.

## Section 15: Ensuring patients can use their GP practice as a "care of" address

**Question 15 – We asked, "Can patients use their GP practice as a care of address?"**

**You said, "No, not that I am aware"**

*"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 if they wish."*

*NHS England, 2015 (link).*

It is highlighted within the NHS England guidance on Practice Registration, that "care of" addresses can be one means of registering patients who are homeless. The same principle also applies for other inclusion health groups who similarly face barriers to accessing primary healthcare services.

Offering your practices as a "care of" address ensures that you are meeting your duties to register patients with no fixed address, and supports patients to access relevant correspondence. This can have a number of

benefits across wider clinical and non-clinical health needs.

Some of the key benefits of using practice addresses include –

- Offering support to patients to receive correspondence they may not otherwise receive can build trust with patients who may otherwise be facing barriers to health and care.
- This ensures that you are meeting your duties to register patients with no fixed address, and helps to actively demonstrate that your services are welcoming and inclusive.
- Using your practice as a "care of" address and supporting with correspondence can help your practice to act as a hub within the wider health and care system for those with complex health and care schedules
- For people with low or no literacy, offering discrete support to receive and read correspondence with patient consent can be a key means of ensuring that patients receive information from the wider health and care system.

## Personal story:

Ann is from the Irish Traveller community and leads a nomadic way of life. She has previously experienced difficulty registering with a number of GP surgeries as a result of having no fixed address. Ann has been very anxious to register; she has a family history of cancer, and she is worried about her own risk. She wants to make sure she attends all screening appointments she is eligible for, but she has previously not received invitations, as patients eligible for screening are picked up through GP records.

Concerned about this, Ann recently requested to register at a GP surgery in an area she travels in regularly. The GP surgery agreed to register Ann as a permanent patient, and offered to use the practice as a "care of" address in order to register her, and to support with receiving her correspondence. Where requested, staff now provide support with updating Ann about her letters, and remind her about upcoming appointments. Ann feels that the staff have taken time to understand her circumstances and her needs; she feels a lot less anxious knowing that she will be invited to screening appointments, and it makes a huge difference knowing that staff at the surgery are there to collect correspondence that she may have otherwise been unable to receive.

## Guidance and useful information

- Voices of Stoke has produced guidance which clearly states that patients may use the practice address as "care of" address, and highlights that otherwise practices must have a way of contacting the patient.
- The Care Quality Commission also provides guidance, which reflects the NHS England guidance and notes that patients *"can also use the practice address to register."*
- Pathway, who host the Faculty for Homeless Inclusion Health and the Care Quality Commission have produced joint guidance on reception standards for primary care.
- The NHS England Menu of Evidence Based Interventions includes a section on improving GP registration amongst socially excluded groups, covering all inclusion health groups and evidence such as barriers to GP registration for victims of human trafficking.

# Section 16: Ensuring your practices have clear processes for contacting patients who have no fixed address or have no phone

**Question 16 – We asked, "Do your practices have clear processes for contacting patients who have no fixed address or have no phone?"**

**You said, "No practices do"**

A significant number of patients from inclusion health groups may have no fixed address or no phone. In these instances, establishing clear communication processes will be essential to ensuring continuity of care and ongoing support. It is essential that contact methods and preferences are identified to ensure that patients are able to receive key information about their health and care. This may be of particular importance for patients with long-term conditions, multimorbidity, or complex care needs, as they may require regular updates about appointments and results. Your practices can request information on and regularly update contact details and preferences to support engagement with services for patients from inclusion health groups.

## Developing clear processes for contacting patients

In order to ensure that having no fixed address or no phone is not an automatic barrier to receiving key information about health and care, practices can adapt their communication procedures and put in place clear, straightforward processes.

Patients from inclusion health groups may have no fixed abode for a wide variety of reasons; they may be living nomadically; they may be rough sleeping or be hosted by family and friends; or they may not have the right to rent, which is now a requirement for rent contracts (link).

Similarly, patients may not have access to a phone, or may only intermittently have access due to financial barriers to data. In addition to this, some patients prefer not to share their phone number because of fear or lack of trust, such as survivors of domestic and gender-based violence.

Demonstrating a commitment to inclusivity by offering a flexible approach to communication methods, and taking time to find practical solutions, can be key to successfully building a trusting and positive rapport with patients experiencing exclusion. Straightforward adjustments include –

- **Offer a flexible, person centred approach to communication method based on patient need.** Practice staff can ask patients which methods of communication work for them at the first point of contact and clarify this on an ongoing basis. Some patients may have concerns about others accessing letters or emails; some may benefit from text appointment reminders; some may prefer to supply a number of a family member. Flexibility is key.

- **Offer to use a "care of" address for those with no fixed address.** This can be for example the address of a friend, the local community centre, a local shop, or the address of the GP practice.

- **If using the practice as a "care of" address, query whether there is another way to reach the patient.** For some patients, using the practice address as a "care of" address may be the best way for them to receive correspondence. It is useful to query whether there is an alternative means that the patient can be contacted, to ensure that they can receive updates on urgent information, test

results, or a change in appointment.

- **Patients who do not have phones can provide a phone number of a family member, a friend, a community leader, or a neighbour.** Provide the opportunity for patients to register with another number but ensure that this is clearly recorded, so that staff can consider confidentiality when calling or sending text messages and reminders.
- **Ensure that it is standard practice across practices to regularly ask if contact information needs to be updated.** Some patients from inclusion health groups may be experiencing chaotic lifestyles, with quickly changing circumstances. Relevant address or contact details may change and it is therefore important that practice staff frequently query whether information is up to date.

## Section 17: Appointing a named person whose job it is to drive Inclusion Health within your PCN

**Question 17 – We asked, "Do you have a named person whose job it is to drive Inclusion Health within your PCN?"**

**You said, "No we dont"**

It is important to consider that driving forward inclusion health should not be perceived as an optional endeavour; it is an absolutely essential task if we are to address inequalities in primary healthcare access and outcomes. Inclusion health groups persistently face some of the greatest difficulties in accessing primary healthcare services and continue to experience the poorest health outcomes and life expectancies across the population. Appointing someone to focus their energy on inclusion health can support in developing a clear agenda and strategy to address the issues and barriers that inclusion health groups face.

**The benefits of appointing an Inclusion Health lead**

Appointing an individual to drive forward inclusion health will support your practices to successfully embed an effective approach to engagement with inclusion health groups. Having a named person in post who is the "inclusion health champion" is helpful as they can be the expert voice and support colleagues throughout the organisation towards achieving new and improved ways of working.

Whilst a named inclusion health representative can help to develop and drive forward a clear strategy across your PCN, it is also important that inclusion health becomes "everyone's business". All staff within the PCN should be enacting legal, and moral, responsibilities to reduce inequalities. Ensuring that the onus to improve inclusion is placed on all levels of your PCN also means that in the event of a change in personnel, good practice in place is not lost or de-prioritised. Key benefits of appointment an Inclusion Health lead include –

- **Having a driving force to enact an improvement strategy can help to ensure action is taken across the board.** Centralised leadership can help to ensure that aims and objectives are not diffuse and that responsibilities across all levels of the PCN are clearly outlined.
- **An inclusion health lead can share good practice with partners and between practices.** Sharing best practice, and what is already working across your PCN, can be a key way to drive forward positive solutions and share learning across practices
- **An inclusion health lead can highlight key priorities for inclusion health to the Clinical**

**Director to support influencing and advocacy across the wider Integrated Care System.** PCNs can play a leading role in influencing across the wider ICS and in supporting to build a coordinated response to the health needs of inclusion health groups

- **An inclusion health lead can outline key objectives to practice managers and service leaders.** A high-level overview of the strengths and areas for improvement on inclusion across your PCN can help to identify key objectives for practices.

- **An inclusion health lead can take leading role in establishing local data-sharing governance arrangements.** This can improve data linkage, intelligence on the needs of groups experiencing exclusion, and local collective action to address health inequalities.

- **An inclusion health lead can drive forward changes that can improve access to services and help to meet key targets.** It is important to consider that improved access for groups experiencing the greatest inequalities will also support improvements such as reduced A&E attendances, which can lead to access to additional funding for PCNs via the shared savings-scheme (link)**.**

## Examples of good practice

- The South Yorkshire Integrated Care System received one year funding in 2019-20 for three GPs to act as Inclusion Health Champions in the area. The three GPs provide leadership across their practice areas with defined outcome aims such as reduced use of A&E, access to management of long-term conditions, access to mental health services and screening.

- Primary Care Sheffield have an Inclusion Health Champion GP in the team to drive forward inclusion health. Further information about Primary Care Sheffield's team can be found here.

# Section 18: Providing service leaders and managers with objectives on their role in address-ing health inequalities in their locality

**Question 18 – We asked, "Are service leaders and managers given objectives on their role in addressing health inequalities in their locality?"**

**You said, "No"**

Clear and effective leadership across your PCN is imperative to tackling health inequalities. As well as leadership at the wider PCN level, there is need to ensure that clear leadership is in place to drive forward inclusion health at the service level. Clear "system leadership" that supports people to take leading roles at all levels of the PCN will be key to effective change. PCNs should agree clear and achievable goals with all practices in their catchment area. As part of this, it will be useful to identify inclusion health and inequalities leads within each practice, and to develop strong links of communication where both "top-down" and locally identified objectives can be set.

## Establishing key objectives

Establishing key objectives for inclusion health needs to start with evaluation of the local populations' realities and needs, and by identifying clear objectives for improvement. Whilst the Inclusion Health

Champion for your PCN can support in identifying "top-down" aims for improving access and outcomes for inclusion health groups, it is also useful to consider how service leaders and managers can identify localised objectives for inclusion.

Although there may be broad needs across your neighbourhood, and it is important to consider all subsets of the local population, specific practices may have larger patient populations from particular groups and may therefore need to tailor their objectives and goals accordingly.

There are some key steps towards achieving strong leadership at the service level –

- **Service leaders and managers can be encouraged to develop strong relationships with local charities and community groups, who have a clear understanding of some of the key issues locally, and how these can be addressed.** Voluntary sector organisations can be a useful partner because of the established communication and trust they have with affected communities. Identifying relevant objectives can be based on such analysis.

- **Broad PCN plans to tackle health inequality and inclusion health can be discussed, shared and well-communicated with service leaders.** Ensuring that service leaders are up to date with the wider goals of the PCN can help to delineate the relevant actions they can be taking to support with overarching plans, or to determine how localised objectives may differ.

- **Assigning a key figure from each practice who can link in with the PCN's Inclusion Health lead can help in the systematic follow-up and monitoring of any measures in place.** Ensuring that there is a key member of staff identified at each practice can help to ensure that objectives set for the PCN are followed up on and proactively addressed. Leaders in each practice can support to develop a culture that fosters an emphasis on equalities and inclusion.

- **Service leaders can proactively organise meetings with patients from inclusion health groups and set priorities in their locality.** Service leaders can be tasked to link-in with local VCSE and community groups to organise meetings with patients from inclusion health groups to proactively identify needs and areas for improvement.

- **Service leaders, managers and senior staff can develop systems to tackle issues identified in their locality.** Leaders appointed at the service level can create a localised strategy for inclusion health, based both on the key objectives identified by the Inclusion Health lead, and any specific unmet needs in their locality.

- **Service leaders and managers can agree on clear metrics to measure improvements in engagement with inclusion health groups.** Once a clear plan has been established, leaders at the service level can monitor and evaluate their success in addressing inequalities issues and inclusion health needs, whilst updating the Inclusion Health Champion on any issues or key insights.

**Guidance and useful information**

- The Medical Director for Primary Care for NHS England and Improvement, Nikki Kanani, has previously written a Kings Fund blog on 'The role of GPs in leading local health system change'

# Section 19: Making sure the diversity of your

**Question 19 – We asked, "Do you have mechanisms in place to make sure the diversity of your neighbourhood is reflected in your PCN's staff team, leadership and patient engagement?"**

**You said, "We dont have clear mechanisms to achieve this"**



It is essential that your PCN's commitment to identifying and tackling inequalities issues is also reflected by a commitment to diversity and inclusion in decision-making and representation within services in your PCN. Ensuring diverse leadership and patient engagement is not simply a tick-box exercise but is underpinned by a commitment to adapting your working practices so that they are effective in engaging all communities. By ensuring diverse and inclusive leadership and patient engagement across your PCN, you can ensure that those with lived experience of some of the challenges in accessing primary healthcare services are also able to directly influence decision-making.

## Reflecting the diversity of your local population in your PCN's staff team

People from inclusion health groups often hold unique insights into how services can best respond to their communities, but their voices may also be seldom heard in decision-making. Ensuring there is a diverse representation at strategic and engagement levels, and incorporating people with lived experience of inequalities in decision making, can help to inform service redesign and improved practice. Ensuring diverse leadership and engagement offers recognition of the fact that those with lived experience are able to offer invaluable understanding of the key drivers of disparities in healthcare access and outcomes. At the very core of this, there is need to ensure that your staff team is diverse.

**How to include inclusion health groups in recruitment**

- **Base recruitment for non-clinical roles on competency, rather than qualifications.** Structural and systemic educational inequalities mean that many people from inclusion health groups may not have formal qualifications but may be very competent and capable. For instance, the ONS 2011 Census found that Gypsies and Travellers were the ethnic groups with the highest proportion of people having no qualifications, at 60%. Requesting formal qualifications, such as GCSEs, for all positions can automatically exclude those from inclusion health groups.

- **Agree to an Inclusion and Diversity Strategy for staff and volunteers.** Developing a clear strategy across your PCN can be key to implementing system change. We also encourage you to network with partner services that are "doing diversity" well, in order to access advice and existing good practice that can be adapted for your PCN.

- **Members of inclusion health groups may feel that they are unwelcome from applying to particular positions or organisations that are not directly related to their identification with an inclusion health label.** Those who have gained skills through formal and informal work as part of inclusion health communities may be put off from applying for jobs if they do not feel able to express how they acquired and demonstrated these skills.

- **In your application process, you may wish to explicitly state that you welcome applications from inclusion health groups.** However, just because an applicant may not disclose their affiliation with a particular inclusion health group, it does not mean that they are not part of an inclusion health community.

- **Inclusion health groups often have stigma or stereotypes attached to their group label, and it is up to each individual to assess their level of risk in disclosing their experiences at all times in the recruitment and employment process.** Consider also how you may be able to make your application process more inclusive; for example, are there different ways for people to apply if they do not have access to a computer?

While the NHS has focused at both the national and local level to improve staff diversity, there is still a great amount of work to do to ensure workplace opportunities are accessed equally across all members of society, in particular for leadership roles. For example, there is substantial evidence that people from minority ethnic groups are underrepresented in leadership positions, with the 2018 NHS Workforce Race Equality Standard report revealing that over half of trusts (52%) have no BME representation in the 'very senior manager' pay band (link). The same problem persists for other groups experiencing inequalities and social exclusion. Later in this guidance we offer key advice on ensuring that people from inclusion health groups are able to progress within your PCN.

**Reflecting the diversity of your local populations in Patient Participation Groups**

Whilst PPGs are useful in ensuring that patients' voices are heard, in many areas, the demographics of people who volunteer on PPGs are often lacking in diversity. In order to understand and improve patient experience for inclusion health groups, stakeholders from inclusion health groups, who often find it harder to access services are often the most valuable people to have on board.

*"The Patient Participation Group should be developed in the most appropriate way to ensure regular engagement with a representative sample of the practice population, and it should have a structure that allows it to reach the broadest cross section of the patient population"*

NHS England, 2015 (link)

There is no specific guidance on how PPGs should be structured, but it is important to consider that seldom heard groups most likely to be underrepresented by PPGs may be likely to have lower self-efficacy to engage

in the process if consideration isn't given to how structure may impact inclusivity.

It is important to consider whether opportunities are provided to ensure that all voices are heard and if consideration is given to different methods of input. Some key considerations include –

- Steer clear of setting structured agendas and providing paperwork to ensure that those with low or no literacy or low levels of English language are able to fully participate.
- Try to avoid meeting in formal spaces or wearing formal attire – creating a relaxed and informal environment will support everyone to feel more comfortable to share their views.
- Consider different ways of providing input to make sure that all members of the group feel able to actively participate in discussions and challenge things when they disagree.
- Ensure that processes for organising meetings and providing updates are not digital by default so that those experiencing digital exclusion are included.

If a PPG doesn't accurately reflect your local population then it will not accurately reflect the views of those experiencing inequalities. For people from inclusion health groups, being involved in initiatives such as a PPG will improve engagement, and signal to others in those communities that their priorities and interests are reflected in their PCN.

**Guidance and useful information**

- Homeless healthcare charity Pathway have produced a really useful 'Expert by Experience: Involvement Handbook' which you may find helpful.
- The Kings Fund 'The Practice of System Leadership: being comfortable with chaos' draws on the stories of 10 senior leaders to identify the skills needed to work as a system leader.
- In their 'Five tips for leading a successful Primary Care Network' the King's Fund discuss developing a shared vision and direction and how the work of a PCN can be creative and inclusive.
- In addition, the Patient's Association have created a 'Patient Participation Group Information and Support Pack'.

## Section 20: Ensuring that there are pathways for your staff and volunteers to progress in their careers

**Question 20 – We asked, "Do you ensure that there are pathways for your staff and volunteers to progress in their careers, in particular those from inclusion health groups?"**

**You said, "No, we dont"**

In order to develop welcoming and inclusive services, it is important that your PCN also instills these values across all practices, both as a service provider and an employer. Ensuring that there are pathways for staff and volunteers from inclusion health groups to progress in their careers helps to foster an organisational culture that is non-judgmental, compassionate, and offers dignity and respect to all members of society.

**Explicitly including people from inclusion health groups**

Members of inclusion health groups bring unique skills and experiences to your organisation and may have valuable insights into your service. Furthermore, employing those from inclusion health groups can help to

increase the diversity of knowledge within your organisation and provide new perspectives. Incorporating the voices of current and former service users throughout your organisation supports organisational evaluation, development and improvement, and demonstrates a clear appreciation of service user knowledge and experiences.

However, members of inclusion health groups may also face additional barriers throughout the application and employment process: they may feel impeded by stigma; unable to express their skills and knowledge truthfully; feel the need to have a cover story for gaps in employment; lack the means with which to apply; or otherwise be worried about the potential for a lack of understanding and acceptance in a workplace environment. As such, it is necessary for organisations to create an environment which facilitates the inclusion of all within the workplace, including those from inclusion health groups. People need to be appreciated for the skills and knowledge that they have, regardless of how they acquired these.

*"It's important to bring diverse experience to an organisation but it is also important that those who do are able to challenge the system rather than existing as a token. They need to be respected as a member of their community and their experiences, ideas and knowledge to be at the forefront of their inclusion rather than simply a diversity checkbox."*

Jason, 28, sex worker

## Role of the organisation

While employing members of inclusion health groups can be beneficial for your service, it is also important that the relationship between employees and the organisation is reciprocal. What would you like staff to gain from their time working with you? What will they take away from working for your service? Given the role of PCNs as anchor institutions within their local communities, the organisations within a PCN can and should make a commitment to offer meaningful opportunities for social mobility and professional growth to individuals within their local community who may have experienced disadvantage in education and employment. Some things you may wish to consider in facilitating development for all staff within your organisation may include:

- Offering a mentoring or shadowing programme to support employee development, in particular for individuals who are less likely to have role models in the area of work they are interested in within their existing social or family networks.
- Providing additional support and training to help those who may not have formal qualifications, in particular investing in "Levelling Up" training for staff members within the PCN who do not have Level 3 Qualification.
- Regularly reviewing opportunities for progression for people at all levels of your PCN and building in opportunities for people to learn skills from one another.
- Allocating a training budget to support staff in gaining formal qualifications and additional knowledge for personal and career development.
- Recruiting and promoting staff in non-clinical roles based on competency, not on qualifications.
- It is important that recognition is given to the fact that those who have experienced educational inequalities may face additional barriers to employment, such as low literacy levels, digital exclusion or lack of formal qualifications. Consider how additional support can be provided in these areas.

## Organisational considerations

In hiring and employing members from inclusion health groups, it is important to foster a supportive and welcoming organisational culture to ensure that all employees feel able to grow and thrive within your service. Consider adding inclusion health groups as explicit considerations to your organisation's Equality

and Diversity Policy to support their safety and acceptance in your workplace. Some inclusion health groups (such as people from minority ethnic groups) are already included in broader equality considerations under the Equality Act 2010, but this same respect must be given within your organisation to groups who are not explicitly included under legislation. This helps individuals to feel confident that they can take action if they face any adverse situations at work, and the knowledge that their identity and experiences are valued within your organisational culture.

An individual's affiliation with an inclusion health group should only ever be disclosed by them – do not "out" them to others without their consent.



Make No Assumptions: Can you identify from this image which people belong to inclusion health groups?

## Section 21: Developing the staff teams' knowledge of inclusion health groups

**Question 21 – We asked, "Have you taken steps to ensure that the staff team is developing its knowledge of inclusion health groups?"**

**You said, "No we have not looked into doing this"**

The WHO recommends that services remain accessible and acceptable "based on the principles of avoidance of stigma, non-discrimination and the right to health" (link). Developing staff knowledge of inclusion health groups is important from the perspective of both a service provider and an employer. Your knowledge of inclusion health groups can be used to inform all parts of your operations, helping to ensure that members of these groups are truly respected, welcomed, and understood within your service.

**Why developing knowledge of inclusion health groups is important**

Inclusion health groups face high levels of discrimination and stigma in their daily lives. For example:

- Vulnerable migrants, and particularly undocumented migrants, are highly vulnerable to racism, xenophobia and discrimination ([link](#));
- Discrimination against sex workers is widespread and is institutionalised through criminalisation ([link](#));
- People experiencing homelessness are subject to high levels of stigma and there is evidence that the public perceives discrimination against homeless people as legitimate ([link](#));
- According to research released by the Equality and Human Rights Commission, Gypsy, Roma and Traveller communities face more prejudice than any other group protected under the Equality Act 2010 ([link](#)).

Ensuring that your services are truly inclusive to all requires recognition that these wider social issues also pervade professional settings. Detrimental beliefs or values held by staff can directly or indirectly impact how staff engage with patients, and can thereby have a significant impact on ongoing patient engagement with healthcare. Taking steps to ensure that the staff team is developing its knowledge of inclusion health groups can be vital to ensuring that negative, stereotypical or stigmatising views are overcome. Relevant training and guidance can offer key insight into the realities of the lives of inclusion health groups. This can help to support the provision of compassionate healthcare, and helps to build understanding of the contextual factors and circumstances that may shape patient engagement with services.

**Training to develop relevant understanding across your PCN**

Training to develop knowledge and understanding is vital for each specific inclusion health group to promote their health and interests, increase engagement with services and aid the eradication of stigma. This training should not just be a one-off, but part of continuous personal and organisational development. Key things to consider when offering training –

- **It is important that any cultural awareness training is delivered by someone with lived experience of that specific culture.** Training around inclusion health groups should not view communities as subjects to be studied, or offer insight into "hard to reach" groups. Training should be delivered by those with lived experience to ensure that the circumstances and wider context that may influence patient interaction with services is fully understood.
- **Any external training should be paid for, so that the knowledge and experiences of inclusion health groups are respected and valued.** This also supports local organisations and builds capacity to deliver training across services.
- **You may wish to look at trauma informed care, cultural awareness, access and registration and managing health problems of specific groups as possible starting points for this.** Building knowledge around these key areas can help to support the delivery of compassionate and inclusive primary healthcare provision
- **Embed good training into staff continuous professional development, especially for receptionists who are the first person to engage with patients.** It is at this point that trust can be lost easily for vulnerable people trying to access a GP or other health care service. Receptionists are in high pressured positions so there is need for human resources to be put in place in this role.

It is important to consider that many patients from inclusion health groups may have previously experienced adverse childhood experiences or trauma. The high prevalence of adverse childhood experiences and their significant impact on health provides a strong rationale for developing a trauma-informed approach to primary healthcare. There is substantial evidence that routine health and care provision, such as physical

examinations and assessments (link), screening procedures such as smear tests (link), and dental care (link), can be retraumatising for people who have experienced adverse childhood experiences such as sexual violence, abuse or neglect. Training can support healthcare providers across your PCN to understand the complexity of factors that can trigger traumatic memories or responses, and can help to build compassion for the range of ways in which a patient may respond.

**Relevant training, guidance and information –**

There are a number of local and national organisations which can provide training on various inclusion health groups and their needs –

- Friends, Families and Travellers provide online training on Delivering inclusive services to Gypsy and Traveller communities.
- Pathway and the Faculty for Homeless and Inclusion Health offers Homeless Training for GP Receptionists, which provides information on duties to register patients with no fixed address.
- The Faculty for Homeless and Inclusion Health offers an Online Inclusion Health Course for professionals with an interest in the health needs of people who are homeless, people who sell sex, Gypsies and Travellers and vulnerable migrants.
- Doctors of the World provide a range of training programmes to support primary healthcare services to improve accessibility for vulnerable migrants.
- IRIS is a domestic violence and abuse (DVA) training, support and referral programme for General Practices that has been positively evaluated in a randomised controlled trial. This programme includes ongoing training, education and consultancy for the clinical team and administrative staff, care pathways for primary health care practitioners and an enhanced referral pathway to specialist domestic violence services for patients.
- Homeless Link provide training on Complex Trauma and Trauma Informed Care for Frontline Staff.
- National Ugly Mugs' website provides additional information on the rights and experiences of sex workers.

**Other approaches to support knowledge of Inclusion Health groups**

There are other ways that you can develop knowledge of inclusion health groups throughout your organisation. These include –

**Training using internal resources**. Internal resources may be developed with external groups to ensure that your service is able to meet the needs of inclusion health groups. These may include leaflets or handbooks which provide important information which is necessary to provide the most appropriate care.

**Knowledge development through feedback**. By collecting knowledge from service users who are part of inclusion health groups, the success of any initiatives can be fed back and used in an iterative process of development to evaluate and improve provisions for patients. It is important that feedback received is valued and that patients feel empowered to be able to provide it, particularly when that feedback may be critical.

*"Feedback doesn't need to be a criticism. It can be an opportunity for development and improvement. You can't give people the best care without knowing how to give them the best care. You have to understand your patients."*

Cat, 45, sex worker

**Considerations in developing organisational knowledge**

- It is vital that you create an organisational culture that encourages continued learning and where training is understood as an important part of personal and organisational development. A view of training as a 'tick box exercise' may mean that staff struggle to actively engage with it.
- While every member of your organisation should receive training on inclusion health groups, anyone who may be a first point of contact (such as reception staff) should be prioritised in receiving this, as it is at this point that trust can be lost easily for vulnerable people trying to access a GP or other health care professional.
- If staff are expected to work additional hours to attend or participate in training activities, ensure that they are paid for this.
- Learning resources must be financially and educationally accessible for all members of staff.

## Section 22: Ensuring all staff members are on a real Living Wage

**Question 22 – We asked, "Are all staff members within the PCN on a Living Wage?"**

**You said, "No"**

Given that the various organisations that make up your PCN have substantial geographical reach and collectively act as a significant local employer, it is valuable to consider how you can play a leading and central role in the development of an inclusive local economy. You have indicated that you have taken steps to ensure that some of your staff members are on a real Living Wage, but that there is still more to be done. By championing and paying the real living wage across the board, including for contracted workers, your PCN can lead by example and help to end in-work poverty.

### The benefits of ensuring a living wage across the board

*"The NHS offers reliable, stable employment: it is not going to withdraw from an area at scale, even if local services are realigned, making it uniquely positioned to provide economic opportunity at a time when the employment rate has never been higher and more uncertain in nature."*

The Kings Fund, 2020 (link).

The 2018 NHS contract refresh was a key turning point in pay for NHS staff; from 2019/20, every worker employed directly through the NHS is paid at least the real living wage. However, your PCN also has an opportunity to contribute to improved wellbeing for more workers by going beyond this and providing the real living wage to all contracted employees.

Your PCN can fulfil its role as an anchor organisation by ensuring fair pay, so that all staff are able to live with financial security. In addition to health professionals, this should include all practice staff such as receptionists and cleaners. When also ensuring that your staff teams are diverse and representative, the impact that the real living wage can have on living standards can also drive wider benefits relating to social inequalities more broadly within the local economy.

Key benefits include:

- Helping to end in-work poverty

- Supporting your PCN to maximise its potential as an "anchor institution"
- Supporting your PCN to play a key role in the development of an inclusive local economy
- Addressing poverty and inequalities more broadly

## Guidance and useful information

- The Living Wage Foundation provides useful information on the real living and national living wage in comparison to the minimum wage, and the benefits of being a real living wage champion
- The Health Foundation provides key guidance on implementing the real living wage in their report on Building healthier communities: the role of the NHS as an anchor institution
- The Kings Fund sets out clear information on the importance of fair pay in their guidance on The economic influence of the NHS at the local level