

Research papers

Ensuring primary care reaches the 'hard to reach'

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ABSTRACT

The provision of primary care services to homeless people, travellers, sex workers, victims of domestic violence, asylum seekers and refugees is a recognised problem in the UK. It is of national importance to explore new and innovative approaches to improve this situation.

Following the creation of a new primary care service for 'hard-to-reach' groups in Norwich, a consultative approach to its evaluation was initiated. Methods were review of local and central policy documents, semi-structured interviews with local health service managers for context, interviews with agency workers in close contact with the client groups, and questionnaires to access the views of

the healthcare professionals providing front-line clinical services.

Five evaluation criteria emerged that embraced all views. These address access to healthcare for the target groups; service responsiveness to the healthcare needs of the client groups; the efforts of the service to overcome any existing barriers; effective involvement of service users and their representatives, and promotion of multi-agency co-operation; and successful (re-)integration of patients into mainstream general practice. These criteria will be employed in the ongoing evaluation of the service.

Keywords: hard-to-reach groups, primary care, vulnerable groups

Introduction

'Hard-to-reach' groups tend to suffer high levels of morbidity and premature death, and experience the least satisfactory access to a full range of preventative services.¹ For example, medical care for homeless people is a major concern as, with no address, many are unable to be registered with a general practice.² They may actively evade health provision, with resulting poor physical and mental health.³ Similarly, access to healthcare is a major problem for 'travellers', and their health status has been found to be worse than that experienced by the lowest socio-economic classes living in an urban deprived area.⁴ Despite the entitlement to free NHS healthcare, many asylum seekers have difficulties in understanding the UK health system and how to access it.⁵ Unable to register with a doctor, they frequently end up visiting hospital casualty departments

for routine complaints.⁶ Their immediate health needs include considerable physical and mental health problems.⁷ Domestic violence victims may have difficulty with consistent use of mainstream services, even though they have considerable physical and mental health problems including depression, anxiety and phobic symptoms, as well as post-traumatic stress syndrome with intrusive memories of traumatic events, exhaustion and sleep disorders.⁸⁻¹⁰ For sex workers, access to traditional primary care services is 'virtually nil' due to general practitioners' (GPs') refusal to register them, and the women's antisocial working hours.¹¹

Local context

When the only GP in Norwich willing to see homeless people announced his retirement in early 2002, and the night shelter where he had held his clinics closed down, the local healthcare provider (Norwich Primary

Care Trust (PCT)) could not find another health practitioner to take on this service. The provision of primary care to homeless people had completely broken down and needed to be comprehensively re-invented. At the same time a single health visitor was struggling to reach the traveller community, and the trust was informed that Norwich would become a distribution centre for asylum seekers and refugees in the near future. The arrival of crack cocaine on the streets of Norwich three years earlier had changed the face of the local sex industry, with many more women being involved, most being extremely vulnerable. Finally, a women's refuge approached the trust because many of their clients had difficulty in becoming registered with local GPs. For all these groups the provision of primary care was unsatisfactory, and the local view was that the needs of all these 'hard-to-reach' groups could not be met using conventional approaches. A decision was therefore made to set up specific services which could have a more flexible approach.

In the UK, attempts to improve the health situation of these groups are frequently focused at only one needy population at any one time. Rather than create several services with distinct but frequently overlapping approaches, Norwich PCT aspired to reduce local inequalities in health by establishing one combined service.¹² 'City Reach' (CR) opened in May 2002 as a primary care service for these 'hard-to-reach' groups. Four GPs, eight nurse practitioners, a health visitor and five other health professionals (altogether 2.5 whole-time equivalent (WTE)) aim to provide care for their patients in easily accessible places, including shelters for the homeless, a women's refuge and travellers' sites. Provision for asylum seekers and refugees is integrated into mainstream GP surgeries, with the CR professionals supporting the GPs and surgery staff. Sex workers are approached using a specifically designed mobile unit.

All PCTs are expected to monitor the outcomes of their interventions in order to ensure that gains in learning will emerge and that the new-found knowledge will be shared with relevant stakeholders.² The reviews are also expected to aid any decision making concerning their long-term future.¹³ In this case, funding for the project is restricted to a three-year period, at the end of which it will be evaluated. The purpose of the research was to establish a set of criteria by which the service would be evaluated in order to secure recurrent funding.

The research was approved by the local research ethics committee and all participants gave informed consent.

Methods

The researchers agreed to develop the evaluation criteria with the service providers and users through

a participatory research framework, defined as a 'systematic enquiry with the collaboration of those affected by the issue being studied'.¹⁴ As with all participatory research, the focus of the project was on the collaboration and the reciprocity of the process as well as 'on the production of local knowledge to improve interventions or professional practices'.¹⁵ In this case 360° participation was required. Managers with responsibility to the strategic health authority were anxious to ensure that all preset targets and obligations were met within the given financial constraints. The health professionals expected to be consulted as part of the research process in order to enable them to employ their experience in providing care in the formulation of the criteria. Patients have frequently not used services they found to be too difficult to access or unacceptable to use.

The research process included an initial feedback of policy expectations, as well as a review of the literature surrounding issues of health inequalities and the provision of personal medical services.

Three semi-structured interviews with relevant trust management staff (some in operational and others in strategic roles) established what goals the service was expected to achieve within the PCT as a whole. Each interview included the following questions:

- 1 what objectives do you expect CR to achieve?
- 2 how could CR demonstrate 'efficiency'?
- 3 how could CR demonstrate 'success'?
- 4 should any patients be consulted before deciding how to improve CR?

Consultation was also undertaken to establish the aspirations of core CR members for the provision of their service. In order to allow anonymity within this close working group, an open-ended questionnaire was used (return rate 11/15) which included the following questions:

- 1 what do you want to provide and how do you want to achieve it?
- 2 do you regard your clients as recipients of care or as partners in care?
- 3 what have you as a team done so far and how have you done it?
- 4 have you encountered any difficulties that prevent(ed) you from achieving your goals?
- 5 what support (continuous professional development/day-to-day support) do you need and what support do you get?

The data were used to draw up provisional criteria. These were then enhanced by exploration in a focus group with representatives of the service users' interests. The intention to consult users directly was explored in detail, but considered to be unrealistic due to their dispersal and extreme vulnerability. Representatives of those agencies that co-operate most closely with CR and work in their own capacity

with and for CR clients were considered to have the best available knowledge of their clients' views. They were, therefore, asked to represent their clients. The most important criterion for their inclusion was their experience and knowledge of their client group rather than their seniority. The representatives included a:

- vendor support worker for The Big Issue Foundation
- support services manager of a housing trust
- support worker of a crime reduction scheme for sex workers
- team leader in a women's refuge
- child care worker of a family welfare association for travellers.

In a series of five semi-structured interviews they considered the following questions:

- 1 what do your clients believe CR provides for them?
- 2 has CR made a difference in their lives?
- 3 what do your clients want from CR (and why)?
- 4 how do they want it done (and why)?

The last source of data was the field notes that were taken by the researcher throughout the project, including his attendances at team meetings where relationships were established, methods finalised, and findings reviewed.

Analysis

All transcribed interview data were checked for accuracy with the interviewees. An anonymised summary of the questionnaire data was corroborated by presenting the summarised data as well as the researcher's (MP's) conclusions to the CR team and inviting them to discuss and amend inaccuracies.

All data were examined for emerging themes, patterns and trends, and all findings were justified through verbatim quotes. The use of a single interviewer who was unrelated to CR staff reduced any bias, and helped to increase the consistency as well as the internal validity of the data obtained. The inclusion of all relevant managers and the whole healthcare team as well as all volunteering client representatives contributed towards eliminating selection bias in the sample. Inviting interviewees to add any issues not covered by the interviewer's questions, piloting the questionnaire with some team members, and corroborating all data improved the validity of the method.

Results

Reaching the 'hard to reach'

The health professionals viewed it as their first and foremost objective to ensure that these vulnerable

groups did engage with and use the new primary healthcare service. The team aspired to 'improve healthcare, lifestyle and if possible the future of vulnerable groups'. This aspiration was mirrored by the managers' assertion that during the first year the fact that access to primary care for vulnerable groups now existed was seen as an indicator of success.

Overcoming barriers

Both groups clarified that the client group represented a challenge for healthcare providers and difficulties with the client group were acknowledged. Therefore, new ways to provide healthcare had to be found: these included the service coming to its users and working as part of a multidisciplinary and multi-agency team as well as working with clients as active participants who have a voice to express their needs. The client representatives wanted CR to provide easy access by bringing clinics to homeless hostels, travellers' sites, the women's refuge and, with the help of a specially designed van, the 'red light districts'.

Beyond the physical service provision the attitude displayed by health workers is important. Visits to a GP surgery were often described as 'humiliating' due to thoughtless comments by GPs, raised eyebrows of practice staff, and being stared at by other patients. This had deterred patients from all groups from seeking help, and the existence of a new service 'for us' was seen as valuable and effective.

Recognising and responding to the needs of the client groups

The trust managers were very aware how 'limited' the provision for vulnerable groups was before the advent of CR. Services had initially targeted homeless people and travellers, but the service was 'expected to develop according to the need of its [other potential] users'. Those needs were initially unclear, and managers therefore acknowledged the specific identification of further needs, and development of appropriate service provision as an indicator of success.

Joined up thinking

The trust management asserted that to achieve its goals, CR had to co-operate with other agencies and that 'multi-agency co-operation' included recruiting representatives of outside agencies onto the project board. The establishment of a 'reference group' consisting of representatives of all agencies working with clients (and eventually clients themselves) was a success criterion. This would enable relevant outside agencies and, potentially, users to influence future developments.

Constant improvement

Both managers and health professionals recognised the importance of service efficiency in terms of health effects. This was to be monitored by the collection of data on healthcare needs. The clinics would have to provide data relevant to the clinical governance agenda of the trust. Among client representatives, this was seen as an internal CR process, which was of no concern to them. There was, however, an expectation that CR would continue to improve, and most groups did have ideas of how the service available to their clients could be developed further. This included the provision of podiatry and dentistry for the homeless, sex education for young travellers or nurse prescribing for sex workers. For their own agencies, the client representatives wanted close co-operation with CR. They requested half-yearly 'reference group' meetings as a forum where 'anything can be talked about and where there is no closed agenda'.

Re-entering mainstream services: a varying priority

It was always the trust's intention that CR would eventually re-introduce patients into the normal primary care set-up. To demonstrate a measurable transition of clients to normal primary care services was the trust's ultimate gauge for success. The transition to mainstream services was of high overall importance for most but not all patients. For asylum seekers and refugees, as well as the service provided to the women's refuge, this was not seen as an area of concern as both groups were already being served in part within mainstream services.

For homeless clients, however, (re-)integration is a major issue. Both client representatives noticed that CR 'will have a problem there', mainly because the service is already meeting their patients' needs 'so well'. Most homeless patients are very 'apprehensive about going to a normal GP' because of 'years of bad experiences'. CR, however, appeared to be taking away the fear of how they might be treated. It is 'the best service they ever got' and therefore, they 'don't want to go to a normal GP'. Forcing previously homeless clients into mainstream provision was seen by both interviewees as undesirable. The potential for nearly re-integrated clients to 'fall back into crisis' was feared.

Although they have similar problems, travellers pose another challenge in terms of integration. They already view CR as their normal primary care service. Similarly, the re-integration of sex workers into mainstream services does represent a 'real problem' as the 'girls do not trust other doctors'. This lack of trust could translate to omitting important information

when consulting a GP, and the health consequences of sex work would then be neglected.

Discussion

The participants' ideas regarding the evaluation criteria for CR showed considerable agreement. No major differences were discovered between the views expressed by managers and practitioners. However, the managers' views were longer term and strategic, and included structured plans for organisational improvements, while the practitioners were more concerned with the 'here and now'. Both groups also agreed with trust and government documents. The client representatives did find it difficult at times to forget their agencies' preferred positions on health issues. Nevertheless, their comments enhanced the overall picture, ensuring that the emerging seven evaluation criteria (see Table 1) did not clash with their clients' real or perceived needs.

One issue, however, did stand out. The re-integration of three patient groups into mainstream NHS provision was seen as a potential problem that presents potentially far-reaching implications to the PCT. Sex workers were still so far away from re-integration that this remains a desirable but remote goal. For travellers and homeless patients, the issue is much more immediate. They experience CR as a positive service that they do not want to leave. This could easily result in CR having to stretch its resources too far. The trust therefore needs to consider any implications this could have for CR and, together with the health professionals, consider potential group-specific solutions. This could, for example, be a surgery set up by CR where staff are aware of the special needs of the client groups. In this 'halfway house' patients could grow in confidence and settle into normal health service routines while potentially upsetting situations are avoided. Re-integration would therefore have to be measured in a group-specific way. For asylum seekers, refugees and domestic violence victims in the women's refuge, success would be expressed in the patients remaining within mainstream services. For homeless people, re-integration is expressed in patients successfully changing over from CR into the care of a mainstream GP. For sex workers the gradual increase in the acceptability of the service as demonstrated in the frequency and quality of its use would also indicate success in this category. Most problematic is the interpretation of this criterion for travellers. Depending on how CR decides to deliver the service, success could either be the unproblematic and continuing registration of patients with GPs or, if CR

Table 1 Criteria to be used by City Reach for the evaluation of its service provision

Does City Reach	Evidence				
	Government documents (reference number)	PCT documents	Management	Professional team	User representatives
Reach the 'hard to reach' (i.e. provide access and overcome barriers)?	17, 18	X	X	X	X
Recognise and respond to the needs of the client groups: <ul style="list-style-type: none"> • collect data on healthcare needs of client groups? • develop according to the needs of its users? 	16, 19, 20, 21	X	X	X	–
Show constant improvement (i.e. ensure the efficiency of the service)?	22	X	X	X	–
Demonstrate/promote joined up thinking: <ul style="list-style-type: none"> • co-operate with other agencies? • establish and maintain a reference group (initially representatives of all agencies working with clients and eventually clients themselves)? 	15, 16	X	X	X	X
Enable patients to re-enter mainstream services?	–	X	X	X	X

Evidence: the individual government documents can be found under the respective number in the reference list. Internal PCT documents emphasise the importance or desirability of the area represented by the individual criterion. The columns labelled 'Management' and 'User representatives' represent the viewpoints expressed during the interviews with these groups, while questionnaire data were used to represent the opinions of the 'professional team'.

decides to provide a long-term GP service for travellers, the uptake of such an arrangement.

Conclusion

The study has some limits as it addresses only one service, and does not seek to apply this evaluation framework to other similar services. Nevertheless it provides a useful case study of how a diverse group of people with very different world views can generate and 'own' a robust evaluation framework against which they are willing to be assessed. The outstanding aspect of the criteria is their acceptability to all involved groups due to the 360° participative approach taken by this research. This agreement will ensure that management and health workers can combine their efforts more efficiently to achieve their common goals. The inclusion of patients' perspectives will not just play a role in safeguarding the quality of the service but, by increasing the acceptability of the service to the patient groups, play a major role in the provision of access to healthcare for 'hard-to-reach' groups.

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CONFLICTS OF INTEREST

None.

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