

# PRIMARY HEALTH CARE FOR PEOPLE WITH MULTIPLE AND COMPLEX NEEDS

## WHAT DOES BEST PRACTICE LOOK LIKE?



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# 1. EXECUTIVE SUMMARY

## 2. Introduction

The Fulfilling Lives South East Project is funded for an eight-year period and committed to improving the way in which systems and services meet the needs of people with multiple and complex needs (MCN). One key theme of their work are health inequalities and within this theme one commitment focuses on better access to and coordination of primary health care (PHC). Currently, the healthcare needs of people with MCN are not met. They struggle to access PHC and the majority of services are not adapted to their needs. Innovations and best practice are therefore a way to improve people's lives and health. This research projects aims at identifying a list of recommendations for best practice in PHC for people with MCN by drawing on literature and professional support workers' experiences.

## 3. Literature Review

The current PHC system in the UK does not meet the needs of people with MCN. They experience profound health disparities (Weinstein et al., 2013). There are multiple barriers that keep people with MCN from accessing PHC which results in inappropriate use of the A&E (Rosengard et al., 2007) as well as poor physical and mental health (Davies & Wood, 2018) and low life expectancy (St. Mungo's Broadway, 2014).

Current innovations in PHC for people with MCN point to new models of care, namely outreach and integrated care and work force development, i.e. innovative new roles and changes in the way of delivering care.

## 4. The current project

Three semi-structured interviews were conducted with support workers from March-April 2020. The interviews followed the Appreciative Inquiry method and focused on best practice examples in the PHC field for people with MCN. The interviews were recorded, transcribed and analysed using thematic analysis. Underlying themes were identified and brought together with findings from current literature.

Analysis revealed two overarching themes, 1) Structures of the Health Care System with the subthemes forms of PHC provision, processes and funding and 2) Way of Delivery which includes flexibility, attitude & behaviour of health care professionals, professionalism of health care workers and continuity, consistency & collaboration. A third theme, Positive Outcomes, was added to give room to the specific benefits people with MCN experiences when they receive best practice PHC. Results from this research project and findings from literature review coincided greatly.

## 5. Recommendations

Best practice recommendations for better access to and coordination of PHC for people with MCN include revolutionizing models of PHC towards specialized, localized & outreach services as well as increasingly implementing 'one-stop-shops'. Moreover, PHC should be delivered in a more flexible, continuous way and knowledge & awareness of professionals working with MCN should be expanded.

# 2. Introduction

## 2.1. FULFILLING LIVES

“People with MCN will have improved access to, and coordination of, primary care to better address their needs”

Manifesto of Change, p. 9

### Manifesto of Change (2019)

- Outlines six key themes based on work so far
- States focus of work for the remaining time of the project
- Commitments for change for each of these themes
- One key theme: Health Inequalities

### Fulfilling Lives South East Project (Brighton & Hove, Eastbourne and Hastings)

- National Lottery Community Fund project, 1 of 12 projects across England
- Eight-year project, 2014 - 2022
- Project delivered by three agencies, cooperation with multiple stakeholders
- Evidence-based approach
- Peoples’ lived experiences with MCN are at the heart of the work, Fulfilling Lives strives to co-produce at all levels

## MISSION

”LEGACY  
OF THE EIGHT YEAR PROGRAMME WILL  
BE THAT SYSTEMS AND SERVICES IN  
[EAST SUSSEX] WILL BETTER MEET THE  
NEEDS OF THIS GROUP”

FULFILLING LIVES WEBSITE, MARCH 12TH, 2020

”... TO BRING ABOUT  
LASTING CHANGE IN HOW  
SERVICES WORK WITH  
PEOPLE WITH MCN”

FULFILLING LIVES WEBSITE, MARCH 12TH, 2020

# 3. Literature Review

## 3.1. MULTIPLE AND COMPLEX NEEDS & PRIMARY HEALTH CARE IN THE UK

### People with MCN

- Experience profound health disparities (Weinstein et al., 2013)
- Homeless people and substance users are among the people that experience the most difficulties in accessing health care (Hewett, 1999; Poulton et al., 2006; Islam et al., 2012) and are frequently completely disengaged from these services (Davies & Wood, 2018)
- Experience more and more severe physical and mental health conditions than the general population (Davies & Wood, 2018)
- Links between homelessness and ill health are well established (Poulton et al., 2006)
- These findings also apply to the East Sussex area (Murdoch et al., 2016)

“EXHIBITING AT LEAST THREE OF:  
HOMELESSNESS,  
CURRENT/HISTORICAL  
OFFENDING,  
PROBLEMATIC SUBSTANCE OR  
ALCOHOL MISUSE, AND  
MENTAL ILL-HEALTH”

### DEFINITION

BY THE FULFILLING LIVES  
SOUTH EAST PROJECT

“THE  
SYSTEM IS BROKEN FOR  
PEOPLE WITH MCN”

FULFILLING LIVES WEBSITE, MARCH 3RD, 2020

## 3.2. ACCESS TO PRIMARY HEALTH CARE

### Barriers to PHC for people with MCN

- Most public services are designed to deal with one problem at a time and to support people with single, severe conditions (Fulfilling Lives, n.d.)
- Behaviour and attitude of health care professionals (Lester & Bradley, 2001)
- Difference in social status to health care professionals "can leave patients feeling inadequate, regardless of the intentions of the health practitioner" (p. 231, Davies & Wood, 2018)
- Competing needs and priorities (Davies & Wood, 2018)
- Physical access (Davis & Wood, 2018)
- Difficulty in contacting services (Davis & Wood, 2018)
- Medication security: people who are homeless are often given medication when being discharged from the hospital, have no secure way to store it, have it stolen, resulting in deterioration and hospital readmission (Davies & Wood, 2018)
- NHS required people to have an address to access services, this is not the case anymore, however some health care professionals think it is and act accordingly and homeless people believe they aren't able to access a GP because of this (Groundswell, 2020; Poulton et al., 2006)
- East Sussex Audit (2016): 50% of Participants struggled to be seen for a physical or mental health problem within the past year, some were refused registration with GP due to lack of ID

### Outcomes of poor access to PHC

- People with MCN are inappropriately accessing A&E departments for non-urgent health issues (Riley et al., 2003; Davies & Wood, 2018; Rosengard, 2007)
- Low life expectancy for people with MCN (St. Mungo's Broadway, 2014)

# WHY DO WE NEED CHANGE?

1

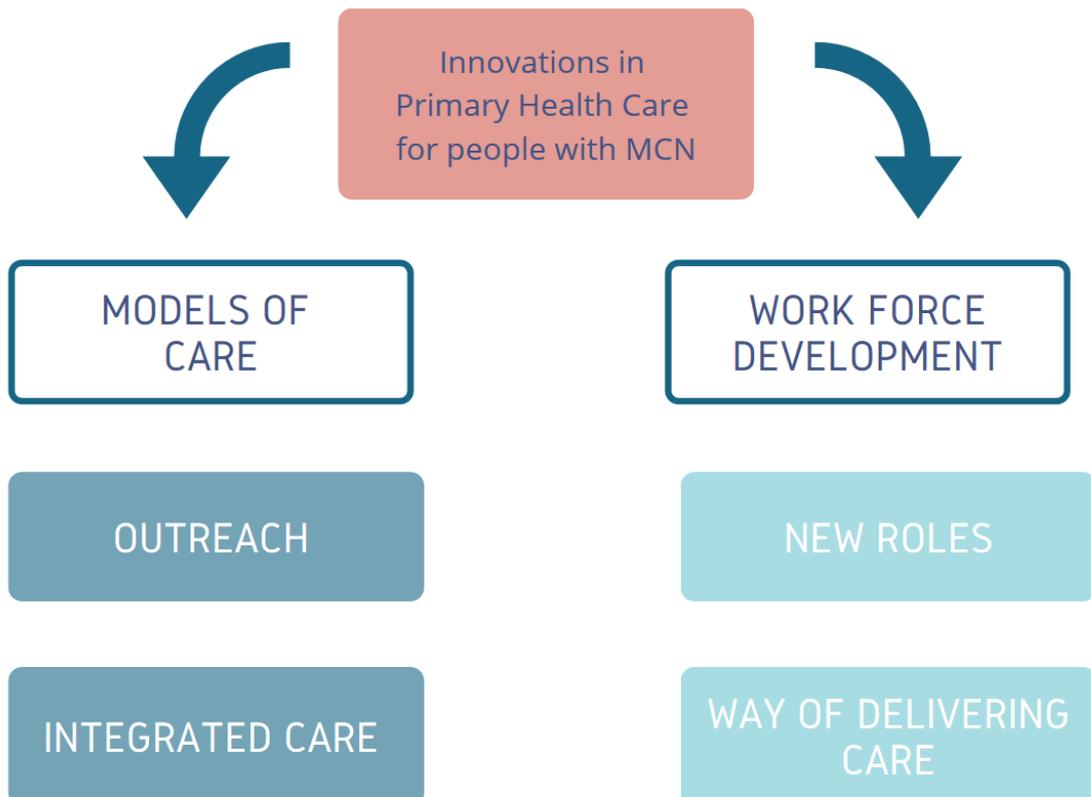
TO BETTER MEET THE NEEDS OF PEOPLE WITH MCN

2

TO REDUCE COSTS

- Overuse of A&E
- Frequent readmission
- Late 'point of arrival' in health care (crisis)

## WHAT COULD/SHOULD CHANGE LOOK LIKE?



# 3.3. INNOVATIONS

## STRUCTURAL

### 1) Models of Care

- Outreach: "services that actively seek out clients, rather than waiting until existing or potential clients find them" (p. 72, Rosengard et al., 2007)
- Exclusive services: Developed for and adapted to a specific client group (e.g. rough sleeper initiative) (Riley et al., 2003)

### 2) Integrated Care

- Single access points and 'one-stop-shops' (Rosengard et al., 2007)
- Specialist schemes, e.g. GP services in night shelters or hostels (Riley et al., 2003)
- Partnership: primary care & patient centred home and a non-profit housing first agency -> clients much more engaged in their health and become advocates for similar services (Weinstein et al., 2013)
- Assertive Community Treatment (ACT) for homeless people with mental illness -> fewer psychiatric inpatient days, fewer A&E visits, more days in stable community housing, greater, improvements in symptoms, life satisfaction (Lehman et al., 1997)
- Not PHC specific: 2 examples of integrated care show reduced costs, improved outcomes and client satisfaction (Thomas-Henkel et al., 2015)
- For elderly patients with multiple chronic conditions: the IMPACT clinic (Tracy et al., 2013) (Interprofessional Model of Practice for Aging and Complex Treatments), positive results
  - comprehensive team: physicians, community nurse, pharmacist, physiotherapist, occupational therapist, dietitian, community social worker; 1.5 - 2h appointments

## WORK FORCE DEVELOPMENT

### 1) New Roles

- registered nurses / midwives that function outside the traditional hospital and community clinical structures (Poulton et al., 2006)
- non-traditional health workers (Thomas-Henkel et al., 2015)
  - lay health workers: reductions in hospital readmissions, better perceptions of their care
  - peer support services: better outcomes, cost savings

### 2) Way of delivering care

- workforce training: understand context of patients with MCN lives, techniques to successfully engage with these clients
  - e.g. trauma-informed approaches: may improve engagement, quality and cost outcomes (Thomas-Henkel et al., 2015)
- GPs: more awareness of differences in social status, non-judgemental attitude, 25-30 minutes appointments ideal, clear, visual explanation of information (Davies & Wood, 2018)
- accessible formats for information, address 'whole person' needs, personalized & person-centred services, involve service user in planning, development and delivery (Rosengard et al., 2007)
- participative, collaborative teams are more likely to achieve patient-centred care, work as a team, be more efficient
  - clarity of and commitment to team (Poulton & West, 1999)
- East Sussex: re-establish homeless health service, improve access e.g. through outreach service, explore housing first models, establish psychologically informed environment in all health and social care settings (Murdoch et al., 2016)

# 4. The current project

## 4.1. METHODS

### FOCUS & AIM

The aim of this research project is to

1. Identify existing innovations and models of best practice in the field of PHC for people with MCN
2. Reveal common aspects of best practice
3. Develop recommendations for providing good PHC to people with MCN that can be applied in the East Sussex area by drawing on current research on innovations in the field of PHC and the perspectives of experienced support workers working with MCN clients.

### APPROACH & RATIONAL

Literature review and qualitative research in form of semi-structured interviews was chosen as the approach for this research project as this has been proven valid and is frequently used in community psychology (Banyard & Miller, 1998; Willig & Rogers, 2017).

The project is based on the Appreciative Inquiry (AI) model which is "a change methodology that aims to create change through a focus on elevating strengths" (Boyd & Bright, 2007, p.1020) and is therefore a valuable framework to reveal best practices in the field of interest. AI was originally developed as a tool for organizational development and has since been adapted to various contexts, including one-on-one interview settings (Scerri et al., 2015) which this research builds on.

### PARTICIPANTS

Local support workers, volunteers and health practitioners were invited via email to participate in this research. The recruitment email outlined the project and participants' rights in detail. A total of three professionals, two support workers and one area lead, participated. This number was lower than originally intended and was in part due to the development of Covid-19 in March 2020 and resulting different priorities of key workers. The researcher ensured to let ethical considerations inform this project. Participants were informed that they would only indirectly benefit from participation and were made aware of limits to their anonymity due to the specific research process. Measures to avoid or, if necessary, accommodate arising distress as well as safe-guarding guidelines were put in place. Ethical approval was obtained from the module ethics board.



## DATA COLLECTION

Data was collected through 35-45 minute interviews with each of the participants and took place between March, 17th and April, 7th. Interviews were chosen as they elicit rich data (Guion et al., 2001) and were intended to be conducted face to face but had to be rescheduled to take place online due to Covid-19. Interviews were conducted over the phone (1) and Microsoft Teams (2) and were recorded. The interviews were semi-structured, following an interview guide developed based on the AI model by the researcher in consultation with the community partner and approved by the researcher's supervisor (see Appendix). The questions asked during the interview followed the format suggested in the encyclopedia of positive questions (Whitney, 2002).

## DATA ANALYSIS

The interviews were recorded, transcribed and analysed following Braun and Clarke's (2006) method of thematic analysis. Thematic analysis is well suited for analysing rich, qualitative data. It provides a way of 'identifying, analysing, and reporting patterns' (Braun & Clarke, 2006, p. 6). Thematic analysis revolves around identifying reoccurring ideas, concepts and patterns in order to unveil deeper themes that lay within the participants' responses.



An additional aspect that was stressed repeatedly is a revolutionized, client centred and psychologically informed environment as opposed to the still frequently prevalent institutionalized setting. These attributes were seen to be crucial to providing best practice care.

## 1.2. PROCESSES

The process most commonly referred to as positive examples with regard to the structure of PHC is a single, clear pathway into healthcare. A system like The Veterans' Mental Health Transition, Intervention and Liaison (TIL) Service was suggested to have the potential of greatly benefitting people with MCN. A triage system where you present in one place, are assessed holistically and then referred to the appropriate services and treatments is thought to be ideal. This aligns with the best practice recommendations of single access points and 'one stop approaches' made by Rosengard et al. (2007) as the result of their literature review on MCN.

## 1.3. FUNDING

The interviews clearly indicated that best practice care can only be realised when there is long-term, reliable funding for health and social services as well as better pay for health care and social workers.

## 2. WAY OF DELIVERY

In addition to the structural form of delivery, the way in which PHC was provided stood out in almost all best practice experiences participants shared during the interviews. This theme is very broad and comprises four subthemes: Flexibility, Attitude & Behaviour of Health Care Professionals, Professionalism of CH workers and Continuity, Consistency & Collaboration.

### 2.1. FLEXIBILITY

Being able to prioritize needs of people with MCN, offering on the day appointments and adjusting the process of appointment making to the individuals' live realities was immensely important in examples of best practice. Namely, afternoon appointments, walk-ins and flexibility in the place of care delivery (at GP practice, in supported living facilities or at home) were the keys to good health care experiences for people with MCN. Additionally, the ability to keep cases open indefinitely and then being able to act fast when the client is engaging or when care is needed that some social services have was seen to be a very valuable quality.



"GPS BEING ABLE TO PRIORITIZE ON THE DAY APPOINTMENTS, THAT REALLY HELPED THE PATIENT FEEL MORE ASSURED"









# 5. Recommendations

Literature analysis as well as the results from the interviews indicate that there are two main roads toward better PHC for people with MCN:

1) Systematic changes to the structure of the UK Health care system and 2) changes to the way in which care is delivered. The later are for the most part directly linked to health care and social professionals working directly with MCN clients. Based on the findings and literature presented above this report presents the following six recommendations to provide the best possible PHC for people with MCN.

## Structural

### 1.1. Models of PHC

Specialized and localized models of care, intensive outreach programs carried out by multi-skilled teams.

Arch healthcare in Brighton is a potential template for best practice PHC in the field of GPs.

### 1.2. 'Wrap-around' care

Increased implementation of 'one-stop-shops', consolidate social and health care services to provide holistic care for people with MCN.

## Way of PHC provision

### 2.1. Flexibility

PHC providers should make a conscious effort to offer flexibility (especially regarding the process of making an appointment, appointment times and location of appointments).

### 2.2. Continuity

Strive for a linked social care and health care network. Ensure close communication and collaboration of services and individual service providers involved in the care of the same person.

### 2.3. Knowledge & Awareness

Sensitize professionals who work with people with MCN for their background, living situation, vulnerabilities and needs they have that may differ from other clients. Especially important in this regard seem:

- trauma informed care (training)
- familiarise PHC professionals with best practice on how to engage with MCN clients (attitude, language, communication style etc.)

3. There needs to be secure, long-term funding in order to achieve meeting the health care needs of people with MCN in an appropriate way.

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# APPENDIX

## Interview Guide

### 1. Introduction / Ethics

- Explain aim of the research, outline timeframe, risks / inconvenience of participating, ensure that the interview can be stopped at any time (without there being negative consequences for the participant)
- obtain informed, written consent from interviewee
- mention confidentiality, all information shared during the interview will be treated confidential, mention safeguarding issues, limits of confidentiality: even though identifiable information will be anonymised, there is a chance that participants might be recognized based on the little extracts of the interview that will be used as quotes in the final report
- client confidentiality: I don't need to know the clients' names etc., only give as much detail as necessary to illustrate the experiences you want to share during the interview

### 2. Interview

Thematic introduction:

This interview will focus on existing best practice examples of primary health care in the East Sussex region. You were invited to participate because you have experiences in this field in one way or another. When I talk about primary health care here, I mean any kind of health-related service that is a first point of contact and non-urgent.

- What are your experiences in primary health care with people with MCN?
  - If necessary: tell me more about your role

#### **Phase 1: Discovery: What are the strengths?**

- Can you think back to a time where you made (or witnessed) an especially positive experience with regards to multiple and complex needs and primary health care? Please tell me about this experience
  - Who was involved?
  - Where did the experience take place?
  - What are the aspects that made this experience especially positive?
  - What set it apart? What made this experience unique?
    - Interactions with health care professionals
    - Organisational aspects
    - Time
    - Context
  - What were the positive outcomes of this situation?
    - How did you know that this was a specifically positive experience?
    - What did this way of treatment mean to the person with MCN?
    - How did it make them feel?
- Do you have any other experiences that you consider to be particularly positive?
  - See above
- What do you / what do the people with multiple and complex needs you support appreciate / value most with regards to primary healthcare?
  - Please try to go into as much detail as possible

- Health care professionals
  - Communication
  - Organisation
  - Location
- What is the best that Brighton/Eastbourne/Hastings has to offer in terms of primary health care for people with MCN?
- In your experience, what are the things that make people with multiple and complex needs feel as comfortable as possible when getting primary healthcare treatment?
- In your experience, what ensures that people with multiple and complex needs receive the best quality of treatment?
- What do you believe to be the single most important variable in providing good primary health care for people with MCN?

### **Phase 2: Dream: What would work well in the future?**

- Imagine you wake up one morning, you open the eyes and by some miracle, the world of primary health care has changed and now meets the need of people with MCN perfectly. What does this new status/system look like?
  - Please try to go into as much detail as possible
  - What do you notice during that day, that makes you realize that these are the perfect conditions now?
  - How does this miracle affect people with MCN
    - In which ways do they feel differently?
    - How does it change their day to day life?
    - How does it affect their life overall?
- Tell me about the aspects you consider to be particularly relevant to provide the best care possible for people with multiple and complex needs/ Of all the things you've mentioned, what is the most important aspects
  - What would the ideal GP treatment look like?  
(only if not extensively mentioned in response to question above)
    - Way of treatment
    - Organisation around the appointment (e.g. how to book an appointment)
    - Communication with other health care professionals
    - Conditions for treatment (ID documents, payments etc.)

### **Phase 3: Design: What action do we need to take to make it happen?**

- What changes do you think could be made in primary health care treatment that would lead to an improvement for people with MCN?
  - What changes would you make with regards to enable better access for MCN clients?
  - What changes would you make with regards to better coordination for MCN clients?
- If you think about the Brighton/Eastbourne/Hastings area, what changes would you suggest?
- Tell me about the action you think that needs to be taken by
  - Health care professionals
  - Politicians
  - Social workers
  - Others

### 3. End

- Thank interviewee for their time and participation
- Check in with them whether they feel okay upon ending the interview / whether they are experiencing any kind of distress
- give an outlook on how the data will be used, offer to send interviewee the final research report