'Bright Spots'

What enables people with multiple and complex needs to access primary healthcare?

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INTRODUCTION

Fulfilling Lives South East (FLSE) understands that providing access to primary care services for people experiencing multiple and complex needs (MCN) can be difficult. FLSE's Manifesto for Change already highlights some of the health inequalities experienced by our clients and a change in approach is necessary because healthcare services can be inflexible, punitive for non-attendance of appointments, and stigmatising.

Lack of access to primary healthcare can lead people with MCN to present more frequently at crisis services. Our client data shows that out of the 118 clients supported since the start of FLSE, clients attended 657 A&E visits which cost a total of £125,662. If we also add hospital inpatient stays and mental health inpatient stays, the total increases to £1,070,306.

There are, however, some healthcare services that serve our communities well and make it easy for people with MCN to engage. This report has a focus on these 'bright spots' in healthcare and wider support systems in the South East. As a previous report indicates, the Bright spots project highlights good practices which could (with earlier intervention) help avoid premature deaths from treatable or preventable causes for people with MCN.

In this report, we unpack what these 'good' services are doing and how their practices help people with MCN to better access primary healthcare and unlock better outcomes. From these examples we offer recommendations and quick wins for funders and other healthcare providers which can be adopted to better enable people with MCN to access healthcare support.

Through in-depth client-facing work and connections with people who have lived experiences of support services, the FLSE team identified ARCH Healthcare, St John Ambulance Homeless Service, the Rough Sleeper Initiative East Sussex, and Seaview as 'good' providers, enabling better access to primary healthcare services for people with MCN. The FLSE team conducted interviews with each of these organisations to get a better understanding of what principles underpin their services and what mechanisms are going on behind the scenes to support people experiencing MCN.

SOME OF THE MAIN FINDINGS WERE:

- Drop-ins are the preferred access point to healthcare support for people experiencing MCN, followed by outreach, in reach and text messages.
- Lack of judgement is key to establish human, kind and trusting relationships.
- Multi-disciplinary approaches and meetings across services are necessary to provide the holistic support that patients need.
- Experts by experience (lived experience) need to be included when starting to set up new services.
- The top 3 tips to improve health services for people with MCN are: i) bring the services to them in a flexible way; ii) a collaborative approach between services (not just signposting); iii) invest in staff, training and resources.

FULFILLING LIVES SOUTH EAST

Fulfilling Lives South East started in 2014 and is funded by the National Lottery Community Fund. We are funded to:

(a) provide intensive support for people experiencing multiple disadvantage,

(b) involve people with lived experience of multiple disadvantage at all levels and,

(c) challenge and change systems that negatively affect people facing multiple disadvantage.

Fundamental to the project's ethos is the belief that the involvement of people with lived experience of complex needs is an essential part of the solution.

A snapshot of the project's caseload in 2017 revealed that all our clients had experienced complex (compound, multiple) trauma that continued throughout their lives.

We use the term Multiple and Complex Needs ('MCN') to describe persistent, problematic and interrelated health and social care needs which impact on an individual's life and their ability to function in society. We consider a person to have MCN if they experience three or more of the following four issues:

1. Homelessness
2. Mental, Psychological and physical health problems
3. Drug and / or alcohol dependency
4. Offending behaviour

People with MCN are more likely to experience violence and abuse, including domestic abuse, live in poverty and have experienced trauma in childhood and throughout their lives. Our data also suggests that 78% of our clients have a disability.

BACKGROUND

Between February and April 2021, FLSE created a subgroup across all teams, including the Service User Engagement team, Learning and Impact Team, client-facing staff and the Systems Change Team.

Together, we developed our criteria for services that could be described as 'good' in enabling people with MCN to access primary healthcare services and engage with healthcare support. These criteria helped us decide who to interview and who we could learn from.

WHAT CONSTITUTES 'GOOD' IN HEALTHCARE

The main criteria were:

- Flexibility
- A caring attitude
- Professionalism
- Continuity, consistency and collaboration
- Trauma-informed practice
- Psychologically informed environments

We identified the following four services as fitting our criteria:

- **ARCH Healthcare (Brighton)-** a specialised GP practice for people experiencing homelessness in Brighton & Hove
- **St John Ambulance Homeless service (Hastings)-** a volunteer-led, first-aid charity which now provides mobile primary healthcare as well as static drop-in clinics.
- **The Rough Sleeper Initiative East Sussex (Eastbourne, Lewes, Hastings, Rother & Wealden)-** a multi-disciplinary team providing intensive assessment and support work for verified rough sleepers (through local authority checks) to help with access to accommodation. Ongoing wrap-around support is provided by the multi-disciplinary team and dedicated Housing First support workers.
- **Seaview (St. Leonards-on-Sea)-** a day service providing support for marginalised people with addiction problems, mental health issues, ex- and at-risk offenders, and rough sleepers.

AWARDS AND OTHER RECOGNITIONS

We are not the only ones to recognise how amazing these services are for people experiencing multiple and complex needs.

- **ARCH Healthcare**

  Achieved a rating of OUTSTANDING on all areas (safe, effective, caring, responsive, well-led) by the Care Quality Commission at their last inspection. ARCH have also been recognised for putting people first and won an award at the annual BreatheHR as a Culture Leader of 2021.

- **Seaview (St. Leonards-on-Sea)**

  Seaview has received the GSK/Kings Fund Impact Award 2018 to recognise the outstanding work of community-based health care charities.

- **St. John Ambulance (Hastings)**

  The Every Day Heroes Awards is an internal award for St. John Ambulance. The St. John Hastings Homeless Service won the Community Hero Award 2019 for improving access to healthcare and support for homeless and vulnerably housed people in Hastings and St. Leonards-on-Sea for 15 years.

- **Rough Sleepers Initiative (Eastbourne, Lewes, Wealden, Rother, Hastings)**

  Commissioned by the 5 authorities, the RSI is the lead for all rough sleeping work across county. In partnership with National Probation, RSI is one of five UK areas awarded Trailblazer status for their work with homeless prison leavers. Considered a model of good practice by the Department for Levelling Up, Housing and Communities (DLUHC), they were recently awarded additional funding to pilot respite rooms for homeless individuals fleeing domestic violence. In partnership with Public Health, the RSI was instrumental in the roll out of Dentaid across the county which was recently featured on BBC Radio 4. The RSI services is working in continued partnership with the Clinical Commissioning Group ('CCG'), local health trusts, social services, probation and CGL STAR (East Sussex drug & alcohol services). The RSI service is being used as a template for MCN expansion through the local government 'Changing Futures programme' Sussex-wide.

  RSI also contributed to 'Fulfilling Lives Perspectives Project- interviews: Discussions on psychological support and complex trauma pre-substance misuse treatment'

1. OUR APPROACH

The FLSE sub-group was keen to follow robust research processes to better understand and learn from these four services.

THE POSITIVE DEVIANCE MODEL

We identified the Positive Deviance model as an approach that could help us. This model has a focus on identifying solutions that are already being practised in communities – it searches out who is achieving the best outcomes in a given situation or context. The model makes efforts to highlight these individuals, groups or organisations as a 'bright spot' in a system, understands the detail of what these 'bright spots' are doing differently and then champions for these practices to be replicated within local contexts to create sustainable change.

APPRECIATIVE ENQUIRY

As a group we wanted to find out more about which principles, values and structures are sitting behind these four 'good' organisations- ARCH Healthcare, Seaview, St. John Ambulance and Rough Sleepers Initiative. We felt that we had plenty of case studies and client data through our client-facing work and we wanted to use this opportunity to better understand how these organisations worked behind the scenes. What was it they were doing at a management level, with staff, with resources that helped them achieve different outcomes for people with MCN?

With this focus in mind, we chose an Appreciative Inquiry (David Cooperrider and Suresh Srivastva, 1987) research method to guide the interviews we conducted with the four organisations. We defined the topic of the appreciative inquiry as follows:

"Our local primary healthcare system needs more innovative person-centred practices which work for people with multiple and complex needs."

The FLSE Research and Evaluation Officer supported the team in formulating specific questions, focussing on the areas of:

1. The best of 'what is'

This section focuses on the most effective ways in engaging clients with MCN and what structures the organisations have in place 'behind- the- scenes'.

2. Imagine 'what could be'

This section looks at imagining a future for the service without limitations to time, budgets and resources.

3. Determining 'what should be'

This section focuses on bringing together the best of what is working now, with aspirations to create the 'ideal' service.

Once the questions had been agreed, experts by experience, together with an Engagement & Co-Production Worker conducted in-depth interviews which were recorded and summarised into the section below.

LEARNING FROM THE 'BRIGHT SPOTS'

1. THE BEST OF 'WHAT IS'

1.A. ARCH HEALTHCARE, BRIGHTON- GARY BISHOP (CEO)

For ARCH Health CIC, Covid-19 has had a big impact in how their services are being delivered. Even though walk-in appointments continued throughout, services have shifted to a mix of offers. One of them included giving out dozens of mobile phones to make sure patients can have the options of text messages, accessing the website or phone calls.

Outreach to supported accommodation and rough sleepers continues and hospital in-patients are linked in with the in-house ARCH team too. This has been a key way of working to support their patients and reach people with MCN.

Building relationships with patients is crucial. Gary stressed the point that,

'People need to be heard, known and trusted.'

He continued to explain that it is key to have,

'[c]lear communication and being really clear about what we can do and being transparent even when it's not convenient at the time. […] It's important that we remain open and clear- that we genuinely care.'

ARCH Healthcare understands the importance of recruiting the right people for the job. Their workforce receives coaching, mentoring and supervision. Workforce development is also acknowledged. ARCH is, 'committed to creating a person-centred workplace and creating a supportive culture of relationships.'

Listening to patients is seen as important and this feedback shapes the service. Gary emphasized that Covid-19 has brought a lot of changes for ARCH and that they, 'are exploring the responses from our service users about how they like the new forms of engagement. […]. Service users have quite liked this telephone contact and text service.'

1.B. ST JOHN AMBULANCE HOMELESS SERVICE, HASTINGS- ROGER NUTTALL (NURSE CO-ORDINATOR)

St. John Ambulance also had to change their working practice due to Covid-19, but patient choice has become an even greater factor shaping the way services are accessed. Roger said that, 'Up until a year ago our service was a drop-in. It was mostly ad- hoc consultations, then we got a vehicle for use as a mobile treatment van and this has enabled us to do outreach which has been really effective. Covid-19 has meant operating by appointments rather than drop ins. We have found that having a combination of both of these is the most effective approach. It's important to mix and match to the individual's needs'.

For Roger and his team, building relationships with people who have MCN is at the heart of their service and for them, the key to building relationships is empathy. Building rapport is about acknowledging an element of befriending. There's also been a focus on making small changes to the service to be as inclusive as possible for people who also experience learning disabilities:

'We have adapted the client assessment form, raised awareness within the team and hosted a learning event. We will be keeping up with this moving forward'.

For St. John's team it is important that staff members as well as volunteers have the opportunity for debriefing:

'Debriefing is very important to us. We don't use an official framework but we are a reflective team and we do this in more informal ways by talking to each other after the shifts'.

St. John Ambulance also offer a mix of internal and external training. Both, debriefing and training, is to make sure that the team has time and space for reflections in order to learn from each other, find solutions as well as gain new skills.

LEARNING FROM THE 'BRIGHT SPOTS'

1.C. ROUGH SLEEPER INITIATIVE (RSI), EASTBOURNE, LEWES, HASTINGS, ROTHER & WEALDEN COUNCILS - BECKY JACKSON (ROUGH SLEEPING INITIATIVE – COUNTY COORDINATOR)

One thing that seems to be clear to Becky Jackson is that the most effective ways to engage with people experiencing MCN are through drop-ins, targeted outreach, and intensive in-reach support for those staying in a range of housing placements. Multi-disciplinary wrap-around support and fast-track access to services is at the heart of the RSI model. The team includes clinical healthcare professionals who work in partnership with their colleagues in primary and secondary healthcare. This ensures there is a joined-up approach to managing individuals acute and chronic healthcare needs. Partnership delivery includes work with two primary care networks and both health trusts. Funded by Public Health, Trauma Informed Care pathways are being developed in partnership with the local mental health trust, an independent clinical psychologist, and an expanding team of mental health professionals (Community Psychiatric Nurses, Occupational Therapists, community support workers).

Becky reflected that:

'Multi-disciplinary drop-ins have allowed the team to work informally with individuals and to engage with historically hard-to-reach groups on their own terms. Having a GP and nurse present and accessible has proved invaluable. The Dentaid pilot has also been in high demand resulting in a funding increase for sessions across the county'.

Public Health have also funded an RSI mobile health unit to deliver health support across the county. The RSI will be developing a holistic mobile health service in partnership with PCNs, CGL STAR, Mental Health, Sexual Health, Opthalmology and Hep C services.

The RSI is a multi-disciplinary service led by Housing. The service covers the county with operational 'East & West' delivery (East – Rother & Hastings, West - Eastbourne, Lewes, Wealden). Staff are seconded from across a range of statutory services including health, mental health, substance dependence services, probation, and social care. The service has two large teams of dedicated Outreach & Housing First workers providing intensive engagement and support work throughout a client's housing journey. These services are provided by Southdown and Seaview who form an integral part of the team.

RSI has weekly multi-disciplinary team meetings where every case is reviewed to ensure a holistic care plan is in place. This multi-agency approach allows immediate interventions by trained specialists and fast-track referrals to services.

Trauma informed practice will underpin all RSI practice and future development. **Becky advised the success of the service has been:**

'due to the multi-disciplinary skill set of the team and their in-depth knowledge of how to engage those who are hard to reach. Alongside the step-up step-down housing model, the informal and flexible approach adopted by the team has allowed us to work with clients at their own pace. The service has one form and one system used by the full team. This minimises repeat assessments and individuals having to retell their often-traumatic experiences to multiple agencies'.

The RSI continue to work closely with partners in the third sector in all areas of delivery. This includes weekend provision, support during SWEP and the development of a county charter agreement and shared website led by Homelesslink.

RSI delivery partners include – Public Health, CCG, SPFT, ESHT, ESCC Social Services, CGL STAR, National Probation Service, Dentaid, Southdown and Seaview. The services are developing additional pathways with Kingdom Way Trust, Snowflake, Open Door, Salvation Army and Mathew 25.

LEARNING FROM THE 'BRIGHT SPOTS'

1.D. SEAVIEW, ST. LEONARD-ON-SEA - DAVE PERRY (CHIEF OFFICER)

Dave Perry is proud to offer an open access service, where homeless people can just walk in without an appointment; this enables easy access to healthcare and other support services. Seaview was established in 1985 and has been delivering this open access drop-in model for over 10 years, Dave stressed:

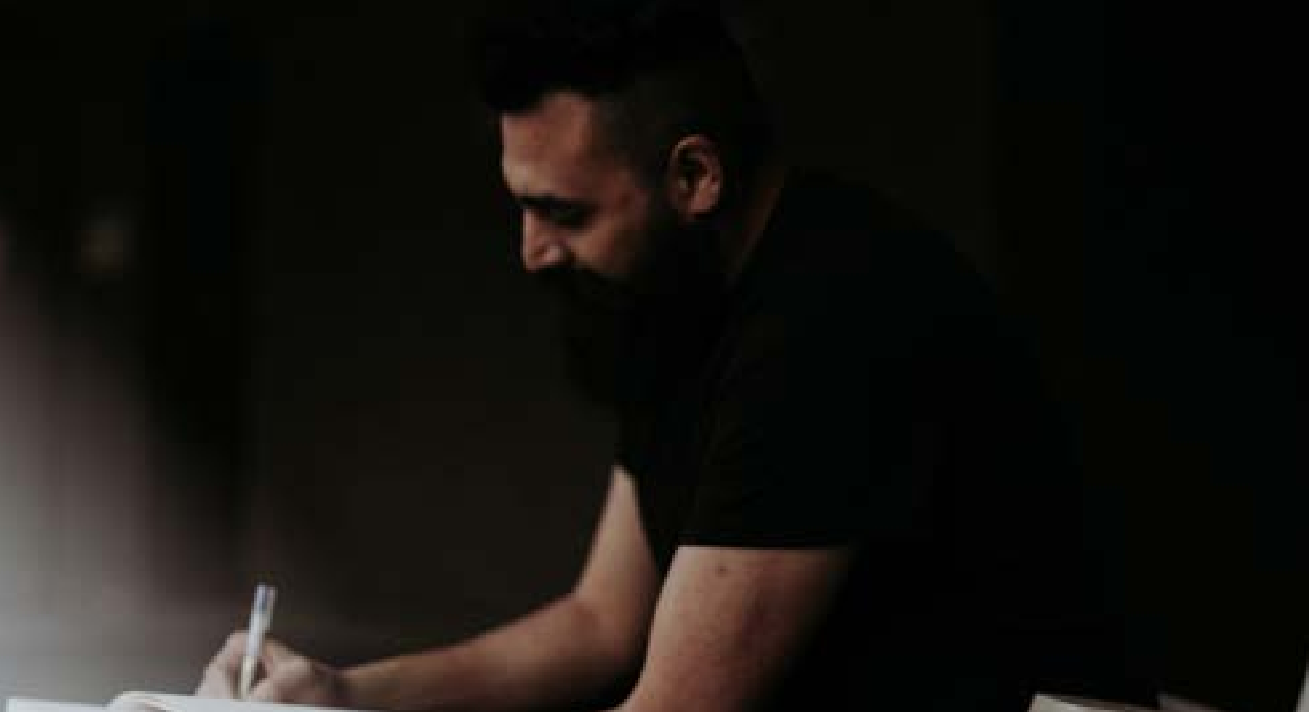
'We really recognise that it's not the easiest thing for clients to attend booked appointments. So, we are trying to make it as flexible as possible for them. Our day centre is also open on weekends when other services are closed.'

He emphasised that offering as many support services as possible under one roof and investing in staff wellbeing is key. This will ensure an empathic and non-judgemental approach.

A lot of value is also put on working in partnership with other services. Dave mentions that nurturing partners, such as Project Adder, RSI and St. John Ambulance, helps clients to build trust outside of Seaview and this in turn leads to better health outcomes. Creating mutual understanding and respect through open communication and a friendly approach over time has been invaluable for partnership development and connecting clients to wider healthcare services.

'Our priority is to nurture the relationships with our clients. We facilitate engagement at their pace and introduce other support when they are ready. It's about building trust so that they feel safe and secure.'

Dave Perry



LEARNING FROM THE 'BRIGHT SPOTS'

2. IMAGINE 'WHAT COULD BE'

2.A. ARCH HEALTHCARE, BRIGHTON- GARY BISHOP (CEO)

When it comes to big picture thinking Gary and his team have a clear goal:

'We have long had the vision to have a multi-disciplinary hub to address homeless health in the city. All the services are here but they're scattered over the city. [For patients] you're looking at miles of walking and hours of waiting. Would love to bring all those services under one roof in the city centre. Co-location would also drastically improve the communication between the services. […] Substance misuse services and mental health together would have such a massive impact'.

In an ideal world, ARCH Health CIC would like to offer many more of their staff specialist training on housing, debt and benefits advice, substance misuse and mental health. This would help further strengthen and broaden their support offer to patients – with a primary healthcare setting offering a door to many forms of advice and support.

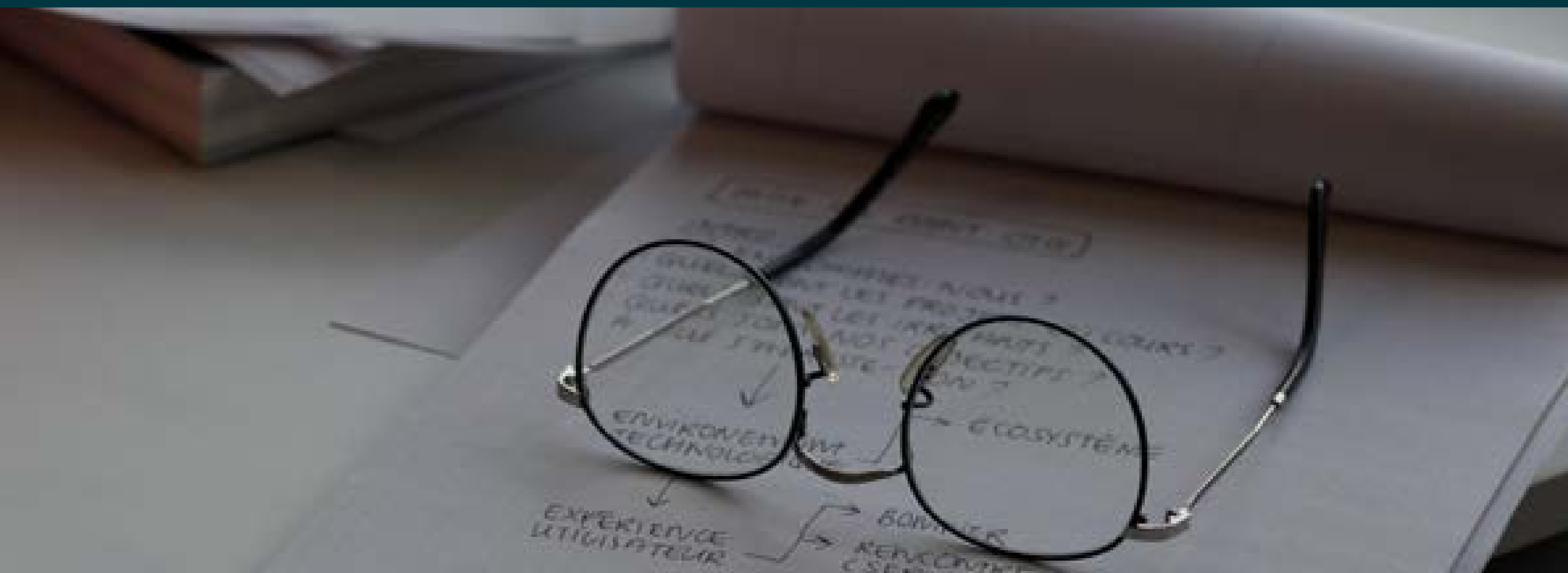
2.B. ST JOHN AMBULANCE HOMELESS SERVICE, HASTINGS- ROGER NUTTALL (NURSE CO-ORDINATOR)

For Roger and his team of nurses, including volunteer nurses, it's all about increasing reach. In an ideal world, having the budget to employ more nurses would lead to being able to reach more patients and locations and in turn, increase access to primary healthcare services for people with MCN. There's also a real desire for St. John's to become integrated into other services.

Roger says that:

'We have very good working partnerships but this is not the same as integration. We want to strive for this. [We] need a good electronic system that integrates with all homeless services and healthcare. This would lead to much better help for MCN'.

When it comes to resources, staff training has been identified as key, '(e)nsuring ALL of the team are trained up on mental health first aid and trauma-informed approaches'. For Roger and the team, they see these approaches as an important way to build relationships with people experiencing MCN and in turn, enable engagement with primary healthcare services.



LEARNING FROM THE 'BRIGHT SPOTS'

2.C. ROUGH SLEEPER INITIATIVE (RSI), EASTBOURNE, LEWES, HASTINGS, ROTHER & WEALDEN COUNCILS - BECKY JACKSON (ROUGH SLEEPING INITIATIVE – COUNTY COORDINATOR)

Due to the scale of the RSI, Becky has identified an informal office space/hub for the team to work from as an essential need. This would allow the team to discuss cases informally and provide a space for clients to visit the team.

Feedback from service user involvement has identified the need for lockers and showers as clients' top priorities. The RSI have submitted joint bids with local business leads, and Sussex Police for the provision of lockers. This would allow people to store their possessions safely during the day. Free access to showers has also been identified as a gap in both areas. Again, provision is being explored on both sides of the county. Public Health are supporting this work in order to ensure individuals basic needs, physical health and wellbeing are supported.

Strategically though, Becky is interested in exploring other models of support provision, such as jointly funded social enterprises. For Becky, models such as Community Interest Companies ('CIC' - a social enterprise model) can have fewer budgeting constraints and provide greater freedom for flexible service provision. In other areas of the country this has resulted in less silo working and a more holistic approach to supporting complex client needs:

'Bevan Healthcare is a great model of CIC delivery in Bradford, Leeds & the Humber. They work with homelessness, prison leavers, asylum seekers, domestic violence, and sex workers, come one and all. Everyone in the area knows the service and the governance and future strategy is steered by Heads of service from a broad range of disciplines. The model has proved it's efficacy with pathways far clearer for those using the service and less duplication of commissioning and provision within the community'.

Becky hopes that Changing Futures will encourage similar models of delivery to be explored.

A resource the RSI wish to explore further is a truly independent 'voices of people', 'experts by experience' group:

'It is important that those who have experienced difficulties accessing support are able to identify the barriers and problems within our service as well as what's working well. We would want this to be authentically led by them rather than adopting to our goals or being led by another service where the same problems may arise'.

Becky and the team see this as a pivotal way to improve access to, and experience of, services, including primary healthcare services.

RSI acknowledged that they have only been able to work with a defined cohort. Becky and the team have found this restrictive and would be interested in developing the service to support:

'homeless adults with complex needs who do not meet eligibility criteria for services support defined by national Care Acts. Many of these individuals rotate between services, without receiving any continuity or meaningful levels of care. Whilst many pilots have been trialled, funding is often short-term and results in clients being passed between additional tiers of services both internally and externally. This results in repeat assessments, duplicate care planning and multiple case conferences where case responsibility often remains blurred. The distinction between the support being offered by these services is often unclear and can appear generic to those needing to access support. The gap in provision for those who sit outside Care Act provision is well documented and we need to design a service for those who do not meet statutory support criteria. Many of these individuals will present to Housing services, as the inability to access or sustain a tenancy is an integral and fundamental part of the problem that those with complex needs face. Our hope is that Changing Futures will allow services to develop a holistic service specifically designed to meet this ever-increasing need'.

LEARNING FROM THE 'BRIGHT SPOTS'

2.D. SEAVIEW, ST. LEONARD-ON-SEA - DAVE PERRY (CHIEF OFFICER)

Dave is very keen to start a therapeutic community which is peer led. In an ideal world, Seaview has the resources to become a,

'specialist therapeutic accommodation […]. We have the skills, knowledge and track record with our client group to do that, but we don't have that kind of funding at the moment.'

He continued with the idea of,

'creat[ing] a social enterprise that people can engage with and get real paid employment experience through accessing Seaview. Maybe a Café with barista training and making lovely pastries. This would then also engage the local community.' Such an initiative would contribute to the health and wellbeing of their clients and be of itself a healthcare intervention.

Experiential learning for staff, volunteers and service users seem to work best for Seaview. This includes de-stigmatising work practices.

LEARNING FROM THE 'BRIGHT SPOTS'

3. DETERMINING 'WHAT SHOULD BE'

3.A. ARCH HEALTHCARE, BRIGHTON- GARY BISHOP (CEO)

Co-production and drawing on lived experiences to help shape how services are delivered is being developed at ARCH Health CIC. Resources have been invested to address this by receiving funding to establish the Common Ambition Project. Through this project:

'we are hoping to carry on some of Fulfilling Lives' work (in co-production) and will be carrying out a Peer Research health audit. This will be a massive piece of work. The Collaborative Pairs* project will also see this in practice. Seeing the mountain from different perspectives helps you scale it!'

Gary says that,

'(w)e have utilised service users for staff recruitment panels in the past and will be doing more of this in the future'.

To continue improving our service,

'we offer our staff training but not the patients. We would like to do this and really embody a shared environment.'

*The idea of Collaborative Pairs is that healthcare professionals, commissioners and other professional stakeholders are paired up with individuals who have lived experience of homelessness, to work together to better understand the challenges which each party faces when designing, delivering, and using the healthcare system.

3.B. ST JOHN AMBULANCE HOMELESS SERVICE, HASTINGS- ROGER NUTTALL (NURSE CO-ORDINATOR)

Roger sees the recruitment of the right staff for the right roles as key to make sure that there's continued improvement in healthcare service provision for people experiencing MCN. The idea of 'experts by experience' has also been talked about. Roger admits that,

'We haven't tried Service User Involvement in staff interviews in a while. We have done this before but not for a long time. This is something we will consider doing in the future. […] For years we had done a "working party". This is a quarterly meeting with partners […]. We would have service representatives at these. We are looking to revive this. […] We would also love to do more research involving our service users'.

For St. John's a foundation for accessible primary healthcare services is,

'having strong inspiring leaders with a passion for what they do is a must'.

LEARNING FROM THE 'BRIGHT SPOTS'

3.C. ROUGH SLEEPER INITIATIVE (RSI), EASTBOURNE, LEWES, HASTINGS, ROTHER & WEALDEN COUNCILS - BECKY JACKSON (ROUGH SLEEPING INITIATIVE – COUNTY COORDINATOR)

Becky identified that there should be long- term funding contracts. This would help attract highly skilled staff members. Setting up an independent lived experience group is also something to strive for.

Trauma- informed care training, combined with individuals seconded from other services should also lead to improved health outcomes from people experiencing MCN. Becky also highlighted the importance of, 'not closing a case because of non-engagement. People should not be penalised for not engaging'.

3.D. SEAVIEW, ST. LEONARD-ON-SEA - DAVE PERRY (CHIEF OFFICER)

Dave sees the importance of having service users on interview panels to make sure the right staff are being recruited. Ideally this could even be a group of services users.

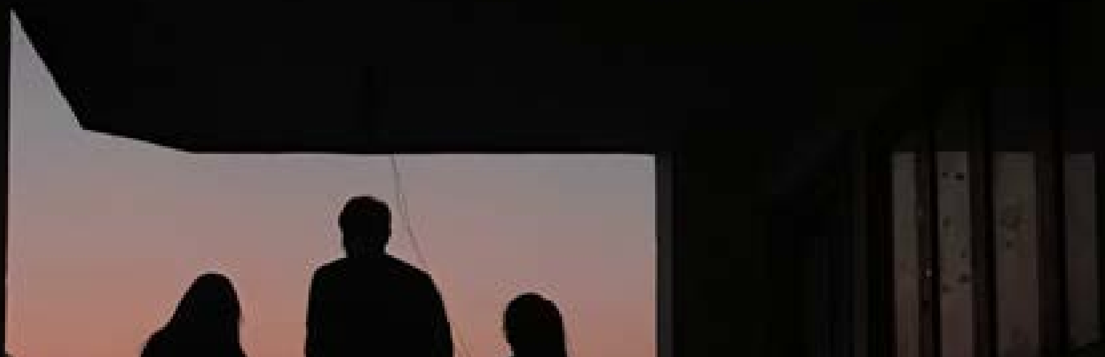
'We want to avoid the feeling of 'us' and 'them' and all work together.'

Dave also identified that,

'We currently don't have a robust management structure. (…) The management could be beefed up a bit but this depends on funding'.

However, he recognises that,

'we are fortunate to be such a small charity and have the agility to respond to changes. It's the passion in the team that enables change to happen. There's also never any pressure for clients to move on from Seaview. That's somethings we're very keen to protect'.



CONCLUSION

A main objective of Fulfilling Lives nationally and locally is to work in partnership with services and commissioners to nurture system change and help services develop more accessible, responsive, flexible and coordinated approaches for those with the most complex needs. We have already seen in the FLSE's Perspectives Project that a collaborative approach between mental health and substance use service is needed to provide holistic support. This is not only from a professional perspective, but also a client perspective.

The current healthcare system is siloed, under-resourced and difficult to access for our client group due to its lack of flexibility. FLSE and the four Bright Spots would like to see a collaborative and person-centred approach across the system where decision makers are investing in already existing, scalable and quality services.

The interviews we conducted with ARCH Healthcare, Seaview, St. John Ambulance and the RSI made it clear that there are recurrent issues across the healthcare services in Sussex. Our four Bright Spots services have also identified common practices that enable community and healthcare services to be efficient and effective for people experiencing MCN. Organisations, no matter how big or small they are, need to collaborate with each other, provide multi-disciplinary teams and put people they support at the centre of everything they do.

OUR RECOMMENDATIONS

We understand that due to Covid-19 and resource constraints, the health system is currently overburdened and treatment waiting times are increasing.

We do think though that there are quick wins which could be implemented in the short term by commissioners and healthcare providers to improve access to primary healthcare for people with MCN, and have created a set of recommendations:

1) Investing in existing services with long term funding

There are services in our community already enabling better access to primary healthcare for people with MCN and they can be scaled up and better supported. We believe that investment into already existing healthcare services, that provide outreach to people with MCN, is the way forward. We have seen through the Appreciative Enquiry interviews that we already have different, high-quality models working well. The first step is to expand and replicate services which are already working well for our clients.

2) Putting people first

What came across strongly through all interviews is the importance of putting people first, whether they are patients, volunteers, experts by experience or staff members.

A cultural shift towards trauma-informed systems is needed. Not only will this allow organisations to recruit, train and support their own staff members, but it also has an impact on the quality of support that the clients receive. Seeing patients holistically requires agile working and ideally a multi-disciplinary hub. This in turn could reduce waiting times for patients and lead to better patient outcomes.

OUR RECOMMENDATIONS

An initial investment in and ongoing incentives for the right staff members, will bring a long-term return on investment through higher productivity and improved wellbeing. It is not only a financial cost-benefit analysis we need to look at, but a qualitative one.

Commissioners need to recognise this shift to a holistic people-centred approach for staff and service users alike. Certain person-centred standards should be reflected in the way contracts are tendered, assessed, and monitored.

3) Building relationships

All interviewees agreed that it is important to invest in relationship building. This is about staff members being connected into other support agencies through multi-disciplinary team meetings, creating smooth referral pathways with the aim of providing the best care for the patient and not being siloed. It is also about patients being able to build relationships, which requires continuity, and patients being able to see the same staff members at appointments.

It is about creating a community of best practice, learning from each other and sharing information. The four Bright Spots identified that staff need incentives, to feel valued and have supervision or reflective practice spaces to keep a work-life balance. For clients it means that slowly they start to build trust.

With this in mind, we advocate for the concept and practice of co-production to be introduced in healthcare settings.This approach was confirmed when one of our client-facing staff members observed the following about a client accessing their GP: ‘From the receptionist to the nurse and GP, Jack (not his real name) was treated with compassion, which instilled him with the confidence to attend future appointments. Jack was visiting the surgery twice a week, once with the same nurse for blood pressure and blood tests and then the same doctor every time to explore options for treatment. He was engaging well with the GP surgery and even made a couple of appointments alone’.

4) Offering choices

In our experience, which is echoed by the Appreciative Enquiry interviews, patients and clients need a mix of contact points – not just being offered a scheduled appointment mid-week following a lengthy wait time for support. From our interviews we learnt that this looks like offers of in-person appointments, phone calls, texting, outreach, mobile healthcare support out in the community, and access at weekends.

As our Manifesto for Change states, we want to move away from a punitive system when patients miss their appointments and get closer to a system which meets people where they are at. Not only will a person-centred approach give them choices of engagement, but it also helps to build up a package of support that suits them. This in turn can lead to better health outcomes. One of FLSE’s clients said that, ‘I really want to get to appointments but will need reminding’.

We would like current and future services to include a variety of engagement options as a standard way of working with people experiencing MCN, led by staff teams that are enabled to offer support in flexible ways.

Therefore, we would like to call on commissioners and decision makers to include the above set of recommendations in any future funded service that aims to improve the health and wellbeing of people with MCN.

ANNEX

BRIGHT SPOTS QUESTIONS (APPRECIATIVE INQUIRY METHOD)

Define – What is the topic of inquiry? – It is important to define the overall focus of the inquiry (what the system wants more of). Definition is used to clarify the area of work to be considered. Definition defines the project's purpose, content, and what needs to be achieved. In this phase, the guiding question is, "What generative topic do we want to focus on together?

Our local primary healthcare system needs more innovative person-centred practices which work for people with multiple and complex needs.

Discover – Appreciating the best of 'what is' – Discovery is based on a dialogue, as a way of finding 'what works'. It rediscovers and remembers the organization or community's successes, strengths and periods of excellence.

1. In your experience working with [the service], which approaches to appointments/contact have been the most effective in engaging clients who are experiencing multiple and complex needs?

- For example: Drop-ins, appointments, flexibility, outreach, digital

2. Which approaches to building relationships appear to be the most effective in engaging this client group within your service?

- For example: patience, providing choice and transparency about processes

3. What kind of 'behind the scenes' planning and support helps client-facing workers to best support people experiencing multiple and complex needs in your service?

- For example: Recruitment, supervision, training, partnership working, handovers, formulation (formulation is similar to reflective practice but is used more in the health sector)

4. Can you remember a time when some changes were introduced to your service which you felt improved outcomes for people experiencing multiple and complex needs?

- You could additionally ask: what initiated that change, and did you get any client feedback?

ANNEX

BRIGHT SPOTS QUESTIONS (APPRECIATIVE INQUIRY METHOD)

Dream – Imagining 'what could be' – Imagining uses past achievements and successes identified in the discovery phase to imagine new possibilities and envisage a preferred future. It allows people to identify their dreams for a community or organization; having discovered 'what is best'. They have the chance to project it into their wishes, hopes and aspirations for the future.

So far we've been talking about the things which are currently happening in your service which you feel work well in supporting people experiencing multiple and complex needs. We would now like to hear about your idea of ideal support for this group, if all barriers were raised.

5. If there were no limits to time, resources, or budget, how would you change or improve your service to support people with multiple and complex needs?

- For example: Expanding the service, changing locations, opening times or policies

6. What training, support and resources would you draw into the service to support the work in an ideal world?

- For example: clinical supervision, peer support networks, partnership working with other agencies

Design – Determining 'what should be' – Design brings together the stories from discovery with the imagination and creativity from dream. We call it bringing the 'best of what is' together with 'what might be', to create 'what should be – the ideal'.

7. How could your service use their recruitment processes to continue to improve their support for people experiencing multiple and complex needs?

- For example: recruiting with particular values in mind, contract lengths, interviews involving service users

8. How could your service use their staff support mechanisms improve their support for people experiencing multiple and complex needs?

- For example: supervisions, training and codes of conduct

9. How could your service work with experts by experience to continue to improve their support for people experiencing multiple and complex needs?

- For example: changes to policy

10. Considering our conversation today, what would you say are the top 3 most effective ways to support people experiencing multiple and complex needs to engage in primary healthcare?

- In order of priority

ANNEX

BRIGHT SPOTS QUESTIONS (APPRECIATIVE INQUIRY METHOD)

11. Is there anything else you think is important to share about what works when supporting people experiencing multiple and complex needs?

Deliver/Destiny – Creating 'what will be' – The fifth stage in the 5Ds process identifies how the design is delivered, and how it's embedded into groups, communities and organizations. Based on more traditional organizational development practice. The term 'destiny' is more prevalent now.

A conclusion or 'road map' for improving MCN support and highlighting best practice. Written by FL on the basis of interview content, to be shared with identified stakeholders.

FURTHER READING

APPRECIATIVE ENQUIRY:

David Cooperrider and Suresh Srivastva

Microsoft Word - APPRECIATIVE_INQUIRY (oio.nl)

Jon Townsin: Appreciative Enquiry

https://www.youtube.com/watch?v=QzW22wwh1J4&ab_channel=JonTownsin

POSITIVE DEVIANTS AND 'BRIGHT SPOTS':

Switch:

Switch by Dan Heath, Chip Heath | Waterstones

Harvard Business Review:

The Power of Positive Deviancy (hbr.org)

Primary healthcare and people with MCN (Chapter 1, FLSE Manifesto for Change)

Lankelly Chase:

Hard Edges- mapping severe and multiple disadvantage

Kings Fund:

Addressing complex needs in the community: a GP trainee's perspective | The King's Fund (kingsfund.org.uk)

Institute of Health Equity: The Marmot Review- 10 years on

Marmot Review 10 Years On - IHE (instituteofhealthequity.org)

Care Quality Commissioning: Standardised guidance for standards below which your care must never fall.

The fundamental standards | Care Quality Commission (cqc.org.uk)

What to expect from a good care service | Care Quality Commission (cqc.org.uk)

FURTHER READING

CO-PRODUCTION:

Fulfilling Lives South East:

Fulfilling-Lives-Co-Production-TIP-V8.pdf (bht.org.uk)

What is Co-Production? - BHT Sussex

Publications - BHT Sussex

REVIEW OF DEATHS OF PEOPLE EXPERIENCING MCN

Fulfilling-Lives-T1-Mortalities-Report-2021.pdf (bht.org.uk)

We would like to acknowledge and thank everyone who contributed to this report by discussing ideas and giving feedback.

For further information about Fulfilling Lives South East Partnership, please visit https://www.bht.org.uk/fulfilling-lives