A PRIMARY CARE SERVICE FOR SOCIALLY EXCLUDED PATIENTS

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ABSTRACT Lydon, J., Harrison, S. (2007) A primary care service for socially excluded patients. Nursing Times; 103: 24, 30–31. This article describes the development of a community matron-led primary care service designed to meet the needs of people who are socially excluded, such as asylum applicants and homeless people. It suggests how primary care staff can improve services and access to them for these hard-to-reach groups.

Warrington PCT has devised an innovative public health service to extend mainstream services to marginalised communities. It works with local GPs and both statutory and voluntary agencies to achieve quality, patient-centred, culturally sensitive care.

A COMMUNITY-BASED FRAMEWORK We adopted the family-community health promotion model (FCHP) for delivering care (Mendoza and Fuentes-Afflick, 1999). This was developed on the premise that basic healthcare models tend to rely on three core predictive variables – genetic predisposition, environmental factors and health behaviours. This results in health professionals relying on medically derived morbidities and the frequency of healthcare contact to measure health. This approach does not often include functional health – individuals’ ability to manage effectively in their own environment.

The FCHP takes into account the core predictive variables of traditional models as well as the effects of sociocultural factors, signifying practices, family tradition and the interactions of government agencies and social services. For example, asylum applicants not only experience physical and psychological ill-health due to their history and exclusion but are also affected by negative publicity. A major supposition of the model is that if a community promotes beneficial health behaviours such as dietary preference and core health values, these become part of its signifying practices.

BACKGROUND TO THE PROJECT The project began in 2004. It aims to provide sustainable, user-focused services that:
- Reduce illness caused and exacerbated by homelessness, unstable accommodation, increased vulnerability and seeking asylum;
- Promote health and wellness in groups often lacking the motivation and support to achieve these aims.

The service focuses on increasing patients’ ability to access mainstream services. This is often a challenge as many mistrust statutory agencies and depend instead on emergency care.

In general, homeless and asylum-applicant communities have limited access to preventative services as they are often persistent temporary residents or not registered with a GP. In Warrington, A&E staff had no referral system to address this and refer back into primary care, creating a cycle of repeated contact with emergency services for primary care needs.

CULTURALLY APPROPRIATE CARE We began to address this with a drop-in service in a safe, non-threatening environment. Uptake was minimal so we looked for other ways to reach the group.

We have a flexible referral service that lets us offer appropriate care at the best time. Patients from other cultures often do not understand concepts such as appointment times and the notion of a ‘health history’, so the UK healthcare system is difficult to navigate. This is particularly so for those who do not speak English fluently or are reluctant to disclose their legal status. We have tried therefore to create a confidential and welcoming environment and to positively influence the attitudes of all colleagues.

Each referral is tracked to ensure patients are referred appropriately and to record and measure the outcome. This lets us measure health and social care needs and highlight areas for future service development.

Patients have a case manager rather than engaging with multiple agencies. This role has allowed us to develop strong links within secondary care and a care pathway for a coordinated discharge from hospital. This may take the form of accommodation being offered to prevent vulnerable adults being discharged onto the streets.

Holistic patient assessments include all aspects of health, with a strong focus on respecting individuals’ understanding and beliefs about health. Patients have reported a preference for this service as they find it...
BACKGROUND

Homelessness and asylum are prime focuses of UK social policy (Social Exclusion Unit, 1998). This is due to identifiable need, particularly as the number of homeless people and asylum applicants rises.

We use the term ‘asylum applicant’ rather than ‘asylum seeker’ to overcome negative images presented in the media (Quickfall, 2004).

Although homeless people and asylum applicants experience poorer levels of physical and mental health than the general population, they often have problems accessing healthcare (Wright and Tompkins, 2006). Their problems are often compounded by difficulty in gaining or maintaining legal status and being subject to hostility from the general population (Drennan and Joseph, 2005).

REFERENCES


Less judgemental than many mainstream services. A pathway for accessing the local out-of-hours service has been developed, giving voluntary and statutory sector workers a clearly defined route to ensure patients access the best service for them.

Active case management and inter-agency collaboration ensure patients’ total needs are identified, planned for and met.

Fragmented care packages are common in marginalised communities and patients often have to engage with several agencies.

By using person-centred and interpersonal communication models, professionals can examine their communication style and set sound therapeutic boundaries based on meeting patient-expressed needs, balanced with positive professional direction and leadership. This shared decision-making is essential to encourage independence and ensure patients feel in control of their care. It also ensures professional relationships are less about ‘us’ and more about patients – for example, those with chronic communicable diseases are seen as a whole person with information, accommodation, medication and dietary support needs.

The skills developed in our daily work with individuals, groups and communities are based on developing partnerships that build on the communities’ strengths. As a result, we are ideally positioned to deliver a variety of services in a system that gives more realistic resources to wellness initiatives. We have already achieved this by developing initiatives to raise health awareness for vulnerable adults and through extensive health education and promotion work. ‘Drip-feeding’ information is a slow and ineffective way of improving public health, so we have developed health champions from different backgrounds and services. These include homeless unit workers, and vulnerable adults themselves and their outreach workers.

The project also aims to influence the PCT and local health economy so patients’ needs are prioritised, planned for and included in policy and practice.

THE SERVICE PATHWAY

Referrals are accepted when patients present with a health crisis or minor ailment to A&E, the local homeless unit or voluntary or out-of-hours services. They and their families are offered a comprehensive health needs assessment by the community matron. Once their needs have been identified, planning takes place with the patient to secure priorities and establish shared decision-making. Referrals to other services are made as required to ensure a comprehensive and cohesive care package is offered that aims to reduce fragmentation and increase inter-agency working.

If children are involved, efforts focus on securing safety and fostering development opportunities, with transference to the local ‘child and family in need’ pathway if needed. Patients and/or families are reviewed to ensure continuity of care, increase concordance with care and medication, and facilitate access to mainstream services. We aim to improve patients’ functional health status and help them develop sustainable patterns of self-care so they benefit from the following:

- A reduction in fragmented care and unnecessary GP and hospital visits;
- Access to nurses with experience of working with vulnerable people;
- Health action plans;
- Better supported self-care opportunities;
- Clinical care with measurable outcomes.

A database has been set up to record, track and audit activity and outcomes. As many interventions are short, because of patients’ chaotic lifestyles and a high rate of non-return for follow-ups, effective audit is not always possible. Nonetheless, the database lets us track episodes of care and determine whether the service is effective.

By acknowledging that problem behaviour exists, we can work towards minimising the risks to patients’ health. While clinical case management is effective for marginalised groups, it does not fit all situations. It is helpful to have one person seeing those in greatest need but we also need a better way of stopping people from becoming homeless or vulnerable.