



Liverpool Community Health 
NHS Trust

 **options**
healthcare when and where you need it

Options outreach service: exploring and understanding the service user
experience and impacts on health and wellbeing

Dr Jan Hopkins¹
Miss Amy Luxton¹
Ester Ragonese²

¹Centre for Public Health
Research Directorate
Faculty of Health and Applied Social Sciences
Liverpool John Moores University

² School of Law
Liverpool John Moores University

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Executive Summary

As part of the national NHS Review led by the Health Minister Professor Lord Ara Darzi (DH, 2008), Knowsley Health and Wellbeing Primary Care Trust were required to establish three new General Practices and a GP led Health Centre.

Liverpool Community Health were commissioned to deliver this new “equitable access service” now called “Options”. The Options service includes a primary care outreach service for three “seldom heard” groups across several outreach sites in Knowsley. The three groups are

homeless/near homeless,

probationers

individuals who have been exposed to domestic violence.

The Centre for Public Health at Liverpool John Moores University was commissioned to undertake an independent evaluation of the outreach provision and specifically to explore and understand the service user experience and outcomes of service.

A mixed method design was adopted, which included both quantitative and qualitative methods. First, a survey instrument was distributed to service users before follow-up semi-structured interviews were convened with both service users and professional stakeholders.

A total of 40 questionnaires were completed and returned. Nineteen interviews were undertaken with 6 service users and 13 stakeholders. Three service users declined to be interviewed on the day and were unwilling to re-schedule.

This study was able to characterise and provide an understanding of the health & wellbeing needs and experiences of the three “seldom heard” populations.

Prior to Options;

Individuals had experienced a punctuated health journey characterised by limited access to health and social care and difficulties with onward signposting and referral.

Stakeholders argued that there was a general lack of understanding about the needs of the “seldom heard” cohorts and how to engage them in health care services. Moreover, stakeholders felt that inter-agency partnership was lacking.

Some service users felt that they were stigmatised or less worthy of care. Chaotic lifestyles, fear of disclosure and a lack of empowerment were among the factors which made engagement with care providers more problematic.

Conditions/needs could remain undiagnosed, untreated or neglected. In turn, problems escalated and inter-related needs e.g. alcoholism and offending persisted.

Stakeholders felt that opportunities for prevention, early intervention were lost and individuals often presented at crisis. Worse still individuals fell between the cracks, between agencies or if they moved to a new geographical location without being seen because of delays in referral.

“By the time that they would actually get the appointment the residents would have moved on. They’ve got their own home or moved to another refuge and waiting so they could have moved out of the borough again so it’s a brand new referral to another borough so quite a lot of the time, they slip through the net then and it’s left” [Stakeholder]

Options had an impact by;

Options made it easier to register with and access primary health and social care.

Options delivered added value by working in an integrated way internally as well as through its support of and partnership with the host sites, particularly residential ones.

“So I would struggle to see how well our service would operate without the Options team being involved. Because, since I have been in post within this service, the Options team has always been there and it’s so deeply integrated into a number of things that we do” [Stakeholder]

Options has **plugged deficiencies** in service and reversed some of the unmet need in these “seldom heard” populations. Stakeholders and service users were clear that experiences and outcomes in health wellbeing would be

“It has a real impact very quickly because a woman will go and have a general health check, the first day after they have arrived here...and it means that we can continue any health treatment that they have been having prior to coming here ...but it also means that from an very early point we can identify any potential health problems, that could escalate over time if they went unchecked or untreated [Stakeholder]

different if the service were to be withdrawn e.g. escalation of problems.

The service offered **flexibility and continuity** in an attempt to build up trust and understanding of the service users and to encourage their re-integration into mainstream provision.

“I’d say (name removed) had benefitted more because he’s confident with them now. Y’know usually if I have to take him to doctor’s I have to ask for a lady doctor, y’know what I mean? And cos he’s familiar with the faces, he’ll open up and tell them where he’s hurting and that. Now over [external practice] there I have to sit there and explain to the doctor. It’s better with kids because, how can I explain it? They’ve got a good relationship with all the kids and that cos a lot of kids in here have come from bad situations”
[Service User]

Although integrated offender management, which includes addressing **a range of health needs was a shared goal of the different agencies and needs to be optimised.**

Researcher Fieldwork Observation

During fieldwork at the Probation service it was apparent that not all Offender Managers were aware of the existence of the Options service and whilst many made scheduled and opportunistic use of the service this was not always the case.

1. BACKGROUND AND CONTENT

1.1. The Options service

As part of the national NHS Review led by the Health Minister Professor Lord Ara Darzi (DH, 2008), Knowsley Health and Wellbeing Primary Care Trust were required to establish three new General Practices and a GP led Health Centre. In common parlance these are often referred to as Darzi centres. The Practices and Health Centre were commissioned through a tender process.

Liverpool Community Health led the successful Partnership bid with Knowsley Integrated Provider Services and Urgent Care 24 to deliver the “equitable access service” now called “Options”

The aim of Options is to make sure that all Knowsley residents and those registered with a Knowsley GP have “equitable access” to GP services. In essence this means that primary medical care services are easily accessible at a time appropriate for service users’ lifestyle. This is regardless of their level of need, their ability to use NHS/related care and support services, or any other impacting factor. A reason could be of a simple logistical nature, such as an individual’s working shifts so they cannot get access to their GP practice in normal opening hours; or having family commitments that make it very difficult to get to existing services. Or matters could be more complex, with an individual feeling excluded because they have particular needs that make attending mainstream services difficult and require understanding and support when they do use a service.

The Options Service can be broken down into 3 component areas, although in essence it runs as a completely integrated service. These are briefly described here;

i) Booked Appointments

There is a 24 hour booking line which is used to book all GP and Practice Nurse appointments. The criteria for booking an appointment with the service are that the caller is a Knowsley resident and/or has a Knowsley GP. Patients do not have to fully register with the service in order to use it. Appointments are offered at 4 sites across the patch.

ii) Nursing /Residential Homes

Each Nursing and Residential Home in the Knowsley Borough (27 homes in total) receives a weekly visit from an Options GP. These homes cater to the elderly, people with dementia or those with a severe and enduring mental health difficulty. The service does not cover homes which cater for children, or people with learning disabilities. The residents can be seen by the Options GP regardless of whether or not they are fully registered with the service.

iii) Outreach Clinics

Options is currently working with the following specified 'seldom heard' groups at requested specific outreach sites

- 1) Probation Office
- 2) Domestic Violence services – both a refuge & onward care centre
- 3) Homelessness or at risk of becoming homeless – at 4 separate hostels across the Borough

'Seldom heard' has now replaced 'hard to reach' as the term of choice since the latter tends to apportion blame to the service users whereas 'seldom heard' puts the onus on agencies to reach out to excluded populations, to hear their voice and enable them to access services (SCIE, 2008).

The morbidity experienced and health needs of these cohorts are well evidenced.

In the case of domestic violence, statistics derived from the British Crime Survey and other sources are provided by the DH, and state that 1 in 4 women between the ages of 16-59 have been affected by domestic violence and between 40 and 50% of women who have experienced domestic violence are raped within their physically abusive relationship (DH, 2011) and have often been subjected to years of psychological abuse. Women who have suffered domestic violence are high users of healthcare services, with twice the level of general medical services and between 3 and 8 times the use of mental health services (DH, 2011). Commissioners are charged with responding to this need since the NHS Operating framework 2011/12 states '*that NHS organisations should ensure that they properly identify these patients and have suitable care pathways in place to ensure that they get the sensitive, ongoing care they need*' (DH, 2011 p9).

The operating framework provides further guidance to commissioners who should;

- Strengthen their partnership arrangements for services for women and children who are victims of violence or abuse
- Promote innovation in the services they commission, in order to better meet the needs of this group and become more cost-effective (DH, 2011, p10)

According to more local figures, during 2008/09 period Merseyside Police in Knowsley received over 3,400 calls for assistance which were assigned as a “Domestic Incident”. Reports of domestic related violent crime in Knowsley, accounted for on average 20 per cent of all reports of violent crime (Knowsley 1st April 2008 - 31st March 2009). NHS Knowsley referrals for the same period included 1366 children affected by domestic abuse. Fifty-five of these were subsequently referred to the Children’s Domestic Abuse Practitioner. The first women and children’s refuge opened in Knowsley in 2005. The most common reason for rejecting a referral was the refuge was full to capacity, but also women were rejected because of the lack of specialised mental health/substance misuse services to support them (Safer Knowsley Partnership, 2011).

In relation to the offender population, the Bradley report (2009) distils some of the significant data based on an Office for National Statistics survey of the mental health morbidity of the population in the criminal justice system;

Some key findings from this ONS survey illustrate the high level need in this population:

- over 90% of prisoners had one or more of the five psychiatric disorders studied (psychosis, neurosis, personality disorder, hazardous drinking and drug dependence);
- remand prisoners had higher rates of mental disorder than sentenced prisoners; and
- rates of neurotic disorder in remand and sentenced prisoners were much higher in women than in men (Bradley K, 2009 p8).

The case in the round for agencies to work together to address mental health needs for example, is set out in the Bradley report *‘it has become increasingly apparent that when people with mental health problems in the community are in crisis, neither the police nor the mental health services alone can serve them effectively and it is essential that the two systems*

work closely together' (Bradley K, 2009, p54). Bradley notes that PCTs and prisons have worked together to make great strides to address mental health, substance abuse and primary care needs whilst on remand, but that *'in reality, remand does not offer much time to engage with treatment, and where prisoners on remand are released directly from court there are significant difficulties in ensuring that any care started in custody continues in the community'* (Bradley K, 2009, p64). Ensuring continuity of care is also an issue for those who are released to the supervision of the Probation Service, but there is an increased chance of re-engagement if treatment is started in prison (Bradley, 2009).

The Options team operate their outreach services from sites on varying occasions during the week. Yates Court is a hostel for families at risk of homelessness or who are homeless and comprises of male and female residents and children. Ross House is a women's refuge and therefore is a female only establishment, with capacity for children. Field Lane is a homeless hostel with sole occupancy for men. Outreach is also provided at South Knowsley Probation Office and First Steps which is a drop in venue for domestic violence populations.

Appointments are only required at the practices as the homes/outreach sites are drop in/according to demand. However, appointments are made by the site management in advance at Ross House and on the day at Yates Court. The Nursing Team offer a Health Assessment (HA) followed by a Health & Wellbeing Action Plan (HWAP) to address any primary care needs, signposting and making onward referral where appropriate. A GP is commissioned for one or more sessions at each of the sites each week.

1.2. Rationale for our focus on outreach

Liverpool John Moores University was commissioned to undertake an evaluation of the Options Service. The study explored experiences and outcomes specifically relating to 'seldom heard' groups who accessed Options via its primary care outreach services. There are number of reasons for this focus. Firstly, that examination of data routinely collected as part of the management of the booked appointment service is likely to provide useful evidence around uptake/access and this aspect of evaluation could usefully be undertaken in-house. With respect to provision of services in Nursing/Residential Homes, it will be more difficult to attribute changes in patient experience and other outcomes directly to the Options

service due to direct intervention by residents own GP, particularly during periods of high pressure (for example in December 2010).

However, individuals within the ‘seldom heard’ groups supported by Options will often have complex health needs and feel excluded because their particular needs can make attending mainstream services difficult. Additionally, they may frequently require specific understanding and support when they do use a service and so capturing evidence of how these needs are addressed is of value to commissioners and providers.

1.3.Darzi Centres

The debate about the value of ‘Darzi’ centres is somewhat mixed and their fate equally so. Davies (2010) reports on some of the key arguments for and against. In the case of the latter, it is argued that it was ill-conceived to impose clinics on PCTs without an evidence base and piloting. Further, that the clinics were not always driven by local need as Darzi intended or taking into account existing provision. It is argued that existing practices perceived them to be a stick and a threat run by rival private led service, which added little value. Attendance at centres across the country has varied, some have not been well used whilst others have a high number of highly satisfied walk-in patients. Even this is not a metric of success argue opponents since many such patients could have attended their own practice and this represents a costly duplication of service. Further, there has been limited/no reduction in unplanned visits to hospitals.

Others contest the assumed percentage of hospital activity which is “primary care” and so the baseline figure, which it was hoped the centres would reduce, is debatable (Heyworth, 2010). Supporters of the centres argue that they are serving needs of disenfranchised individuals such as the homeless and asylum seekers who are unable to register with a doctor. Even where excellent nurse led services for marginalised groups exists, a tension may arise when an appointment with a GP is required (O’Malley, 2010). Proponents argue that general practices are not configured to fit around modern living and registered patients who struggle to get any care let alone continuity of care (see McKeown H, 2011). Advocates suggest working flexibly and in partnership with commissioners to look at the fit of the centres and how they complement existing services is a possible way forward.

However, closures have occurred and continue to take place and the fall-out from this withdrawal may impact on service users and the local NHS structure. NHS Stockport closed its clinic with limited public consultation. It was suggested, that service users, who had tasted continuity of care perhaps for the first time, had to register elsewhere and this was said to have irked local practices who were left to mop up the need at short notice (O'Malley, 2010). In Suffolk, a centre which a year before was hailed as joint-first in a national survey of patient satisfaction is facing closure on the grounds that it did not reduce A&E visits and its high annual running costs. The value of a flagship Darzi centre in Bradford was questioned by commissioners on the grounds that the service was too costly, was being used in some cases for a second opinion, without discernable impact on patients' health and no evidence that the most socially excluded were using the service (Iacobucci, 2011). NHS Peterborough faced criticism recently for a consultation exercise to review the future of its centre. The case was referred to the NHS Cooperation and Competition Panel who judged that the consultation about closure breached conflict of interest since it was led by GP commissioners working in practices which stood to gain from the closure of the centre (McNicoll, 2012).

2. AIMS AND OBJECTIVES

The purpose of this study was to explore and understand the impacts of the "Options" primary care outreach services on several 'seldom heard' service user groups namely; probationers in South Knowsley, populations exposed to domestic violence and the homeless or near homeless.

The overall objectives of the study were to explore both access and uptake of services and onward signposting and referral to support services. Embedded within this study was consultation with service users and service providers to explore their perceptions and experience of the outreach services and the impact on the health and wellbeing of the service user groups. Specifically, the objectives were;

1. To quantify and describe outreach services provided in terms of the types of services provided, numbers accessing and taking up services and onward referral/signposting to other support services.
2. To identify service users' perceptions of the strengths and limitations of this outreach service and their satisfaction with the service per se and in comparison to

access/use of their usual primary health services. Further, to determine what would happen in the absence of Options.

3. To explore service users' perceptions of the impact of Options service on their health and wellbeing.
4. To establish the views of professional stakeholders as to the strengths, limitations and impact of Options in relation to; service user engagement with primary care services, a reduction in demand for more costly and unplanned health services in the acute sector and improving the health and wellbeing of the probationer population.
5. To synthesise findings to identify how Options meets the needs of the service users, its impacts on their health and potential cost-efficiencies for the health economy.
6. To disseminate findings to commissioners, all stakeholders and service users.

3. METHODS

A mixed method approach was used here with a self-complete survey of service users followed by a qualitative design using semi-structured interviews with service users, Options stakeholders and other professional stakeholders working at the outreach sites.

A short questionnaire survey written in plain language was designed and peer reviewed. The questionnaire captured information about initial signposting to the Options service and service user perceptions of how accessible and flexible the service is in meeting their needs. The instrument captured data about access to health services in the absence of Options and intended future use of the outreach services. Questions concerning onward signposting and any impacts were also posed.

Two interview schedules (professional stakeholders and service users) were devised to tease out experiences and views of the Options service. The interpretation of the survey data was used to inform the interview schedules. The intention was to elicit a rich and deep understanding of the perceived strengths and limitations of the Options Service particularly in relation to access and flexibility of service and use/non-use of health services in the absence of Options. In the case of service users the topic guide sought to elicit the impact of the outreach service on the individual's health and wellbeing. The interview schedule was used as a guide and not a rigid instrument since participants were encouraged to discuss issues which they perceive to be of importance to them.

3.1. Participants and Eligibility

All residents who had accessed Options at five outreach sites served by Options were eligible. A sixth site, Roughdale Court, was rejected because the Options service was not being accessed by attendees. Three were residential sites and two was non-residential. Two served domestic violence populations, two served the homeless or near homeless and the fifth site was the Probation Office in South Knowsley. Anyone who had not accessed Options was necessarily excluded. Consent was assumed if the survey was completed. A participant information sheet outlining the project was provided. Written consent was taken before each interview.

3.2. Data Collection

In each case, a site visit took place before data collection began. The delegation typically included the university team, members of the Options management team and other Liverpool Community Health staff who were on the project steering committee. A traditional postal survey was rejected on the grounds that the response was likely to be poor. The purpose of the site visits was to prime the stakeholders at the site about the nature and the purpose of the study and where necessary deliver surveys and associated paperwork. As the study was an independent evaluation, it was decided that Options staff should not be involved in distributing the surveys and where possible key-workers at the sites would perform this task and help participants to complete the survey if literacy was an issue. It was agreed that key-workers would distribute the surveys at all five sites on behalf of the university research team. Surveys were completed and mailed back to the university using a freepost envelope. Email and telephone reminders were made to each of the sites as a prompt. In the case of the Probation site, the NHS REC committee stipulated that neither Options nor the probation site should be involved in distribution of the survey and so in this case researchers from the university team distributed and collected surveys on days when the Options service was present over a two week period.

Service users were asked whether they would like to take part in a follow-up interview and if so were asked to provide their contact details to the team. An interview matrix was devised to guide selection of survey participants to capture different characteristics of service users and patterns of use of Options. Those who agreed to take part in a follow-up interview were contacted after a two week cool-off period and a time and date for interview agreed. An

interview matrix was devised for the professional stakeholders and service users to ensure the representativeness of the sample. Stakeholders recruited included the following professional groups; GPs, nurses, social worker, offender managers and key-workers.

All interviewees were given a participant information sheet and consented at the time of the interview. As agreed, interviews were recorded and transcribed verbatim. Interviewees were sent the typed transcripts and asked to make any necessary revisions before their inclusion in the analysis. Each interviewee was asked to sign a consent form before participation. **Written and verbal assurances were given about protecting the anonymity of individuals and their employers.** Transcriptions were allocated a unique number and participants were coded P001 (patient) and S001 (stakeholder) respectively. These validation processes are true for both groups

3.3. Ethical Considerations

The study cohorts were divided into two for the purposes of Ethics. Ethical approval for the domestic violence and homeless and near homeless was considered under National Research Ethics Service (NRES) proportionate review and the committee decided that the study did not require full review. Subsequently, the study was presented to and approved by the Liverpool John Moores University Research Ethics Committee. That part of the study relating to the probation population was considered and approved by NRES committee, London South East in December 2011. This decision was confirmed by LJMU Ethics Committee. R&D approval was sought and approved in all cases.

3.4. Data Analysis

Questionnaire data were entered into SPSS. The data were cleaned and descriptive statistics calculated for each question. Open ended data was also captured and is used to illustrate quantitative findings.

Interviews were digitally-recorded and transcribed in full. Data were analysed using thematic framework analysis (Ritchie and Spencer 1994) to identify emergent patterns and themes. Initially we worked within cases to devise an index of key concepts and themes drawing on *a priori* issues linked to the study objectives. We then made comparisons across cases, refined themes and developed a framework. The themes were applied systematically to the data by

means of codes; and data were rearranged according to the thematic framework. We used mapping and interpretation to record the nature and scope of the themes and to develop associations. As Pope et al (2000) note, this process allowed us to explore consensus and discord within and across cases and illustrate this using quotations.

3.5. Rigour

Two university researchers analysed the transcripts independently and then met to discuss constructs and agree on the final thematic framework. Having completed data mapping, we audit trailed the process to check that all relevant data featured in the framework and that the final map represented the data derived from all transcripts.

4. RESULTS

In spite of the efforts of the providers and the university team, the First Steps site did not return any questionnaires. The results are based on the results from four outreach sites.

4.1. Questionnaire

A total of 40 questionnaires were completed (N=40). Nineteen (47.5%) were from the Probation site; 9 (22.5%) from Ross House; 9 (22.5%) from Field Lane and 3 (7.5%) from Yates Court. Out of all the respondents 42.5% were female (n=17) and 57.5% were male (n=23). The majority of respondents (75%) were from the 25–59 age group and this compares to 22.5% of respondents being aged between 16-24 (Table 1). There were no respondents aged over 60 years of age.

Table 1. Number of respondents by gender and age group

Age	Female	Male	Total	%
16-24	3	6	9	22.5
25-59	14	16	30	75
60 +	0	0	0	0
Blank	0	1	1	2.5
Total	17	23	40	100

Frequency of visits

Out of the 40 people who responded, 32.5% (n=13) of people had visited the Options team just the once; 40% (n=16) had used the Options service between two and five times; 7.5% (n=3) had reported to have visited between 6 and 10 occasions; and 20% (n=8) had been

more than 10 times. A higher percentage of female respondents said that they had visited Options on more than 10 occasions (Table 2). The modal frequency for males was between 2-5 visits.

Table 2. Frequency of visits to Options by gender and age

<i>Q1: How many times have you used the Options Service?</i>			
Frequency of Visit	Female	Male	%
Just Once	4	9	32.5
2-5 times	5	11	40
6-10 times	3	0	20
More than 10 times	5	3	7.5
Total	17	23	100

Promoting Awareness of Options

Most commonly, Options service was promoted by ‘word of mouth’. Recommendations were often made by staff members at host sites and/or the Options team opportunistically approaching potential clients. All respondents from Ross House and Yates Court said that their key-workers had informed them about the service. The majority of probationers were made aware of the service by the Options nurses approaching them in the waiting areas of the host site. Although all host sites widely displayed Options posters and leaflets, this was not the most memorable prompt for many service users (Table 3.1; Table 3.2).

Table 3.1: How service users were sign-posted to Options service.

<i>Question 2. How did you become aware of the Options Service?</i>	Count
Leaflet	0
Poster	3
Recommendation	2
Other Agency	1
Own GP	0
Walk in Centre	1
Other	33
Total	40

Table 3.2: How service users were sign-posted to Options service.
(‘Other’ category breakdown)

‘Other’ Category	Count
Women’s Refuge Staff/ Domestic Violence Team	9
Hostel (Yates Court) Staff	3
Hostel (Field Lane) Staff	2
Staff at hostel (undisclosed)	5
Probation officer	7
At reception desk- Probation	1
Health promotion day – Probation setting	1
Options Nurse approach in Probation setting	5
Total	33

Accessibility

In response to question 3, which asked about problems accessing Options, all respondents said that they had not experienced any difficulties.

When asked about alternative healthcare arrangements in the absence of the Options outreach service, 47% (n=19) stated that they would have gone to their own GP. Fourteen of these were male and five females. From these data, we suggest that males served at Probation and Field Lane were more likely to be not registered with Options.

Table 4: The number and percentage of respondents who would use alternative health services in the absence of Options Service

<i>Q4: If you hadn't been able to access the Options outreach service today what would you have done?</i>	Count	%
Gone to Own GP	19	47.5
Nothing	5	12.5
Gone to A&E	0	0
Gone to Walk in centre	12	30
Used out of Service	0	0
Only use Options	1	2.5
Blank	3	7.5
Total	40	100

In some cases, respondents had ready access to the ‘Options Walk-In Centre’ and so around 30% (n=12) stated that they would have used this service. Importantly, 12% (n=5) said that they would not have accessed any healthcare provision that day and an additional 2.5% (n=1) said that they would only access Options (Table 4). It is not possible to say what individuals

accessing the ‘Walk-In Centre’ would have done if it was not available but it is possible that some would not have accessed health care.

Consultation With Options Staff

The overwhelming majority of respondents stated that they felt they were able to discuss their concerns with Options staff during their last consultation (Table 5). This amounted to 90% (n=36).

Table 5: The number and percentage of respondents who felt able to discuss concerns with Options staff

<i>Q5: During your last consultation did you feel able to discuss your concerns with the Options staff?</i>	Count	%
Yes	36	90
No	1	2.5
Blank	3	7.5
Total	40	100

Only one respondent felt unable to discuss their concerns because ‘*the doctor in the hostel didn't have any background information*’ about them. Although another patient answered ‘yes’ to this question they added a comment to say ‘*but not the previous 2 times as I felt rushed and the GP kept looking at her watch*’.

A high percentage of respondents (90%) said that the advice and support provided by the Options staff was relevant to their needs. There were no explanation or elaboration in the case of the two respondents who replied ‘No’. Two respondents did not answer this question (Table 6.1).

Table 6.1: Number of respondents who said that advice/support was relevant to their needs

<i>Q6: Did the Options staff give you the advice or support relevant to your needs?</i>	Count	%
Yes	36	90
No	2	5
Blank	2	5
Total	40	100

All but one (n=38) (95%) of the respondents stated that information was explained to them in an understandable and appropriate manner. Although, one respondent reported a negative

experience and stated that she was ‘*disappointed, I was hoping to get the advice & support that I needed but she said come back next week*’. This response is expressing more dissatisfaction with the fact that no advice was given rather than a direct response to the question which asks about the communication process (Table 6.2)

Table 6.2: Number of respondents stating that Options staff explained things in a way that they understood

<i>Q7: Did the Options staff explain things to you in a way that you understood?</i>	Count	%
Yes	38	95
No	1	2.5
Blank	1	2.5
Total	40	100

When asked about satisfaction in relation to the length of the consultation, 90% (n= 36) of respondents said that they felt they were given enough time (Table 7). Five percent (n=2) felt that they did not have enough time. Both respondents cited a longer consultation and improved doctor/patient relationship would have enhanced their experience of the service on this occasion.

Table 7: Number of respondents stating that they received sufficient time during consultation

<i>Q8: Do you feel that you were given enough time during your consultation today?</i>	Count	%
Yes	36	90
No	2	5
Blank	2	5
Total	40	100

Ninety five per cent (n=38) of respondents felt that they were treated respectfully by the Options staff during their most recent visit. One service user stated that they did not feel that they were treated with respect and this was the same respondent who did not feel that they had enough consultation time (Table 8).

Table 8: Number of respondents who felt that they were treated respectfully during consultation

<i>Q9: Do you feel that the Options staff treated you respectfully during your visit today?</i>	Count	%
Yes	38	95
No	1	2.5
Blank	1	2.5
Total	40	100

Signposting and onward referral

Table 9.1 demonstrates that 57.5% (n=23) of service users had been referred to another service for further treatment and/or support.

Table 9.1: Number of respondents signposted to other services

<i>Question 10. Either today or in the past has the Options service put you in contact with another service?</i>	Count	%
Yes	23	57.5
No	15	37.5
Blank	2	5
Total	40	100

Table 9.2 disaggregates the ‘yes’ response to question 10.

Table 9.2: Details of the ‘YES’ answers from Question 10

Yes (category breakdown)	23
Alcohol Service Knowsley	1
Fazakerley Hospital	1
Activity for Life	5
CAF	1
Community Mental Health Team	1
Counselling	2
Dentist	3
Doctor appointment	2
Fag-Ends	5
Clinical Assessment Service	1
Gym	2
Dietician/healthy eating	2
Walk in clinic	1
GP	2
Referral to crisis team	1
Social worker (options)	1
Sexual health,	1
Healthcare navigator	1
Total	33

Service users were sign-posted or referred to a variety of services including behaviour change/management services such as ‘Activity for Life’, ‘Gym’, Dietician and ‘Fag-Ends’. Several individuals mentioned more acute referrals to Community Mental Health Team (CMHT) and crisis team. Some respondents mentioned referrals within the Options service.

When asked about the impact of signposting/referral on health and wellbeing only 12 respondents completed this question, despite 23 answering ‘yes’ to having been signposted/referred. It is possible that respondents had not taken up the service in spite of signposting. Some respondents were awaiting the outcome of the referral so couldn’t provide comment on their experience of how this has impacted on their health and wellbeing. The majority of answers were positive. Some of the free text answers to this question follow;

*I was given advice on benefits, BP and Cholesterol
Any service Options send you to are for the better
I was up for it but never heard anything more. No contact made by Activity For Life.
Don't want to go to that dentist again
Feel assured about process for referral in order to get health concern sorted
Helped because I got offered counselling. Counselling was good
Helped me out at the time. Immediate referral and immediate to access to crisis team to
prescribe meds
I am still waiting for counselling, 6-8 month waiting list, which makes my well being quite
low.
Pleased with my first appointment at musculoskeletal Clinic. Also with walk in centre
(Social worker) has arranged lots of support for me and everything is now in place. I
don't know what I would have done without this*

4.2. Interviews

A total of 19 interviews were conducted; 6 with service users and 13 with stakeholders (4 Options professionals and 9 other professional stakeholders across four sites). A further three service users declined on the day of interview and were unwilling to reschedule. This decision was respected and the service users were not contacted again.

Four central themes emerged from the data;

1. Core Features of Options,
2. Addressing Service User Health and Well-being
3. Limitations of Options *and*
4. Tensions In Referrals Process.

‘Cleaned up’ participant quotations, with ‘dross’ words such as um and err removed, are presented to illustrate the findings.

4.2.1. Theme 1: Core features of Options

The analysis revealed four core characteristics which helped to define the Options service. These were; speedier access/engagement, a patient centred approach, continuity of service and partnership working. These are not exclusively the domain of the Options service but interviewees persuasively argued that often the Options service was distinct from mainstream provision and made a difference to health and wellbeing of individuals.

Speedier Access/Engagement [registration, appointments and referrals]

Participants referred to barriers, difficulties and delays of registering patients prior to the setting up of Options service because service users were in temporary accommodation or considered to be a more costly/high maintenance patient.

If you had a woman come into refuge that was on a certain anti-depressant some surgeries were refusing to take them and you were always coming across barriers (S004-other stakeholder)

They're not able to register with our local GPs here, so having Options coming is invaluable to us really... Yes this is a temporary address but its short term accommodation. Yet, it's still not proper tenancy and for some reason they won't take our families from here (S005-other stakeholder)

By contrast the ethos of Options was perceived to be more inclusive, non-judgemental and more accessible, which may mobilise service users.

Accessibility and non-judgemental, which are very important and because we do get a lot of people who say I don't trust my doctor (S014-other stakeholder)

You can register on the day and be actually seen by the GP or the nurse (S010-Options stakeholder)

Everybody that comes in, we do say to them you know it's an option for you, Options is not, you don't have to see them but they are here every week if you want to. And

you'll find that the majority of the people that come in, I'd say 99.9% of them will use the Options service (S007-other stakeholder)

The fact that the service was available on site and on a regular basis accelerated and facilitated engagement with Options.

Just that they are pretty handy to have around. You don't have to go far for them. You just have to put your name in the book and then they will shout you [P019-service user]

I would say positive, because they like the ease of them visiting the building. We struggle to get families here to engage that's why they've ended up the way they are before they come in here, they're reluctant to get involved and they don't keep up dentists, doctors, you know immunisation for the children, that's normally things they don't do and if you have to ask them to go 20 minutes away they'll find a reason not to turn up to the appointment [S005-other stakeholder]

The outreach service had distinct advantages for both service users and the stakeholders who were supporting these individuals.

It has a real impact very quickly because a woman will go and have a general health check, the first day after they have arrived here...and it means that we can continue any health treatment that they have been having prior to coming here ...but it also means that from an very early point we can identify any potential health problems, that could escalate over time if they went unchecked or untreated (S001-other stakeholder)

We have had women that have had severe mental health issues that have literally left the property without any of their medication, and they are really dependant on the ability to have an initial appointment with a GP (S001-other stakeholder)

I think when you sort of move into this place, you're quite overwhelmed by everything, and I think it would be a good idea again if the doctors come here, then eventually that I could make an effort and go into the town. But for the first few weeks I think it's important to have a doctor here [P006-service user]

Stakeholders in particular referred to the fact that they had in the past struggled to achieve timely referrals and the consequences of this could be the exacerbation of a problem or individuals falling between the cracks.

I have made a referral in the past where it took weeks and weeks for the community mental team, when if the doctor or the nurses make that referral it does, it is a quicker

process. And the community mental health team will tell you that themselves. It's better for them to do it. (S004-other stakeholder)

If you've got a woman who's presenting with maybe an alcohol problem that could impact. If she's not referred and seen quickly by the alcohol team then she could very well go back and start drinking again...and if a woman has been drinking we do raise the question as to whether she can stay...which again has a knock on effect because you have already got a vulnerable women then you've got a drunk vulnerable women and then you're asking her to leave the premises. (S003-other stakeholder)

Quite a lot of the time [talking about the past], by the time that they would actually get the appointment the residents would have moved on. You know, they've got their own home or moved to another refuge and waiting so they could have moved out of the borough again so it's a brand new referral to another borough so quite a lot of the time, they slip through the net then and its left (S002-other stakeholder)

Options on the other hand was pivotal in providing swift onward signposting and referrals which helped to anticipate and avert problems and assist stakeholders in their own activities and planning to move clients on in terms of health and wellbeing.

I feel that since they (Options team) have come, the referrals to for the likes of speech therapy and CAMHS have been rushed through a lot quicker (S002-other stakeholder)

I mean I did work with one particular person who had quite significant alcohol issues. He had gone to his own GP and we just weren't getting anywhere. Options made the relevant referrals to mental health and we've managed to get the proper diagnosis and you know, I think I would have gone around in circles a lot longer if we had not had the facility really. (S013-other stakeholder)

Patient-Centred Approach

The participants characterised Options as flexible and responsive to the evolving needs of the client group.

I mean because we have at times quite a high turnover of residents as well, the Options service is very responsive to that (S002-other stakeholder)

Flexibility could include tailoring the service by offering more time to an individual as required to address a particular issue or crisis.

If we have women that come in that have got specific needs or that should be seen as an emergency, the GP is not kind of 'I can only spend 10 minutes with each person, he will bring a member of staff in if that's required, you know, which is something that we couldn't do if the service was outside of refuge (S002-other stakeholder)

Flexibility of service might include reaching out to individuals and cohorts who might lack confidence or feel unworthy or struggle to engage with health professionals and moving them on in their health journey.

A lot of the people that we work with, particularly the survivors of domestic abuse will feel very anxious about leaving the safety and security of the women's refuge and I think that is invaluable in terms of ensuring primary health care needs are fulfilled (S010-Options stakeholder)

The role of the healthcare navigator is in supporting clients who may not have the confidence to go to an appointment. And it may just be just sitting with them in a waiting room and they go into that appointment themselves or going in with them and just sitting alongside them for somebody on their side because it's quite a common thing for people who are vulnerable, who have had risky behaviour to think oh well maybe they don't deserve to be treated. (S008-Options stakeholder)

Although it was stated that in some circumstances service users might require a more proactive management stance, it was recognised that there was a balance to strike and a need to empower service users to make decisions about their own health needs and encourage them to self-manage in their own time.

They don't rush me, they don't force me into anything. They always ask me before they go and tell the doctor anything, cos sometimes I don't always want to see the doctor every week, y'know, he likes to see me, so I go to them [the nurses] and they say 'well you should be seeing the doctor' and I always say 'well I really can't be bothered this week', so they always give me an option. They give me a choice [P006-Service User]

And they get me somewhere where there's a local meeting and get me involved there. But there's no pressure. Although I asked for it she's not like, 'well have you quit yet?', she's taking it at my pace which is better for me... There's no pressure. It's all the ball in my court. She offers me the things and it's my decision whether I take them or not [P001-Service User]

Moreover, stakeholders perceived that the Options service was underpinned by a more equitable model where clinicians and patients may be viewed as joint partners, which challenges the hegemony of a medical model with clinicians the sole arbiters of what constitutes health and wellbeing.

GP, nurse and healthcare navigator, we're all human, we're all equal and that even though the GP has gone to university and you know is a doctor does not mean that you know the person who is a service user is less, less worthy and seeing that GP and

that nurse as we're all equal and we're all there to work together and to help and we all participate in you know in a positive future [S008-Options stakeholder]

Continuity of Service

Options staff offered continuity by acting as a first and regular point of contact for service users. This was seen as vital to build up trust over time amongst cohorts who as pointed out above might lack confidence, mistrust agencies or not have the skills to engage with health services.

I always see (nurse name). And I don't like to see a different one. She knows me and that. She just knows [P001-service user]

The sphere of influence might also include the children of women who had left a violent relationship.

I'd say (name removed) had benefitted more because he's confident with them now. Y'know usually if I have to take him to doctor's I have to ask for a lady doctor, y'know what I mean? And cos he's familiar with the faces, he'll open up and tell them where he's hurting and that. Now over [external practice] there I have to sit there and explain to the doctor. It's better with kids because, how can I explain it? They've got a good relationship with all the kids and that cos a lot of kids in here have come from bad situations. [P009-service user]

Continuity of provider had the added benefit of building up understanding of the cohorts and the individuals being cared for.

On occasion, Options ensured continuity by facilitating seamless provision at the primary/secondary interface when uptake of service might be problematic.

We had a health care navigator and we were sort of working with the nurses to see if they could transport these women to the hospital and go with them to get this care they needed. Otherwise women' wouldn't go, they put their own health on the back shelf and it's really important isn't it. Some of them have never even had, after care, after having a baby [S004-other stakeholder]

A single point of contact was seen as useful for host agencies who might struggle with a lack of integrated provision or geographical variations in service and outcomes.

The process of getting health information or making referrals can be a little bit disjointed and depending on where that person lives whether it be Kirby or Huyton you can get a different result. I suppose having the Options team now, there is a more of a central point of contact more of a continuity with what you do, even if you just

have concerns about someone you may not necessarily need to refer them but you can chat with the nurses or the GP and it's a lot better. [S0014-other stakeholder]

Partnership Working

Options staff saw their role as supporting and not replacing the key-workers and other stakeholders who were working with the different client groups.

So we're not interfering with their services, we're there to support their services and building I suppose successful relationships and showing that. [S008-Options stakeholder]

Only one interviewee recounted an occasion when the host organisation felt that Options had undermined their position and taken a service user's perspective without consulting them for a more rounded view of a situation.

Options has kind of immediately reacted to that woman's perspective at the time and kind of said 'oh well that's not right' or 'I'd go and speak to someone about that'. Rather than going 'ok, I'll do a little bit of investigating around that for you and come back to you [S001-other stakeholder]

Initially, there was some scepticism about the role and aims of the Options service but now they were viewed as synergistic with many of the host agencies.

At the start we did have problems with maybe going into one or two site. Maybe they were very reluctant at the time because you're thinking you know are these clients going to suffer for what we may do or are we going to cause additional problems to them. But very quickly they realised that we're just there to you know look at the health and the social needs of the clients and support the people who work their. [S008-Options stakeholder]

So I would struggle to see how well our service would operate without the Options team being involved. Because, since I have been in post within this service, the Options team has always been there and it's so deeply integrated into a number of things that we do [S001-other stakeholder]

Stakeholders suggested that they felt more secure in their decision making because of the presence of Options. In the residential outreach sites in particular there was evidence of regular dialogue, without breaching confidentiality, between Options and the key-workers and this integrated approach enhanced the care and advice individuals received.

We work with social services in making referrals and a social worker might ask myself to go to core groups, case conferences and write up regular progress reports. Having Options staff here is really good for that extra support or any questions that you don't quite understand or quite a lot of the terms that social services use can confuse the women, Options are really good at explaining what they mean. Again,

when we have got issues there are dealt with quicker because Options are on site.
[S002-other stakeholders]

The key workers will also know then that you know maybe we do need to keep an eye on somebody because you know the doctors are concerned or the nurses are concerned, so it is just a slight alert you know, that they might not know about if they were outside [with outside agencies] [S012-Options stakeholder]

It also ensured that the advice and care of Options mirrored their own goals around health and wellbeing for the service users.

Immunisations do get brought up to date [by Options], that's something we have to, as the support provider we have to ensure that if they are behind that they meet that target you know, as part of the support plan we do, so if they have got health issues its up to us to ensure that they do meet them before we can move them on [S004-other stakeholder]

Focussing specifically on the Probation setting there was a clear strategic rationale and vision for integrated offender management linked to health services.

I think there is a recognition that we have offenders basically who come on the books, off the books, go into prison, come out of prison and their whole lives are disrupted around that in relation to all the areas as you know, accommodation, employment, training, education and health as well [S0015-other stakeholder]

There were exemplars of an inter-agency approach between Options and the Probation service as typified by the following vignette which describes the case of an offender who was not only denying the link between a health issue and his offending but was contesting his underlying health issues.

With that individual case the diagnosis was alcohol hallucinosis he believed it was something completely different but we managed to get that assessed very quickly and it was also the fundamental reason that he was on a suspended sentence order and you know all the issues that he had in terms of his offending was to do with alcohol. He was unwell as well because he had his bloods done and his results were abnormal and he was having hallucinations. So we were able to kind of bring all that together and say to him you know, kind of present to him, look you know this is an issue, and if we didn't have that contact with the GP he could have carried on saying "no its nothing to do with the drinking, its something else". So we were able to kind of focus a lot more on what we needed to and get him support that he needed to get as well.
[S0013-other stakeholder]

However, it was felt that whilst the probation service was likely to pick up and address acute problems, less obvious health issues might be overlooked. Additionally, there was a possible

lag or organisational factors which might impede the operationalization of the strategic plan at the grassroots level.

I mean it's taken me time to recognise how critical sort of health, the health Options scheme is in relation to the day to day management of offenders. If you've got an offender who's got very acute alcohol problems and that is linked to domestic violence that is acute, but it is perhaps less obvious when we're looking at some of the underlying physical health needs...so I think its taking time and it does take time for the penny to drop in relation to that but increasingly, and as we become integrated as an offender management unit into this locality then, that is a process we increasingly certainly at strategic level, understand how important sort of broader integration of offenders is and part of that is, them taking responsibility and looking after their health. It is perhaps taking a bit more time for offender managers but that's inevitable really given the environment they're operating in [S0015-other stakeholder]

Health targets and attendance at Options were not enforceable nor would offender managers wish them to be so. However, it was clear that at the grassroots level uptake of the service by the probation population could be optimised with some minor changes or refreshers to improve awareness and understanding of the role and reach of Options.

I've not really had a lot to do with the current doctors... the initial couple of doctors that came in had a lot more to do with... I'm not very familiar with the current one's. Maybe a meeting would help. [S0014-other stakeholder]

4.2.2. Theme 2: Addressing service user health and wellbeing needs

In addition to the core features, several factors emerged from the data which centres around addressing service user health and wellbeing needs. These factors could be assigned to; meeting unmet need, opportunistic engagement and service user defined goals. The themes discussed in the following sub-section resonate with the discussion above.

Meeting Unmet Need

Options was seen to provide an outreach service to patients with a story of neglected health needs or co-morbidities which were not always diagnosed or managed.

We're accessing people who never really or very rarely access primary care so we're finding people who have an undiagnosed chronic illness or who have got a worrying problem that's not being addressed [S008-Options stakeholder]

A lot of them will put their own health on the back burner and most women that come in, at point of telephone referral we ask if they're on any medication or if they've got

any physical needs. Many are on anti-depressants but others have some kind of mental health i.e. anxiety, not sleeping and they're not on medication. [S004-other stakeholder]

You're reaching people who don't normally come and call in the surgery... What we tend to do is pick up a lot of people who probably neglect themselves a little bit because of their social circumstance or whatever, acute problems that they're having [S011-Options stakeholder]

I think if they weren't here, I don't think I would bother even going. I'd just let things slip away, and my health would deteriorate [P006-service user]

A lack of confidence and a feeling of unworthiness have been previously cited but specifically, in relation to the domestic violence population fear of disclosure is a key reason for women not to seek health care for themselves. This in turn impacted on children's access to health care so whole families were missing out on essential care which would avert or nip problems in the bud.

A number of them don't access health care. That is frequently part of the domestic abuse. They are not allowed to access services for fear of what they may say, what they may disclose about what's going on at home. So a large number of women come here and you know, the last time that they saw a GP was kind of 5 or 6 years ago. We do see children relatively frequently that have real problems with the milk teeth, if not their older teeth. [S001-other stakeholder]

Options' modus operandi was to attend to the specific as well as holistic health and wellbeing needs of the clients served so not just seeking to address medical needs but social determinants or consequences of ill-health. This was strengthened by both social and health partners working together as part of an integrated service.

The fact that we are going out; the fact that we are looking at things holistically, we're looking at not only medical side but the social care side. I think a lot of the nursing and GP practice nurses, well I hope they do, feel that as being invaluable, having that contribution social care within the practice [S008-Options stakeholder]

Options tailored solutions to fit the individual and service users said they liked the fact that the service did not seek to medicalise all problems or offer a pharmacological solution.

And then she got me a pass for the Active for Life in the new gym that's just opened in Huyton, and I can do three sessions, well a minimum of three sessions a week to try and get....cos she said it could just be your energy levels, y'know with having children and stuff. My bloods have come back ok and she helps you with your diet and if I want the quitting smoking and she's been brilliant, she's really good. She never

prescribes anything but sometimes you don't necessarily need a medicine, you just need advice don't you? [P006-service user]

However, few service users said that they did not want or have time for an enhanced service instead they preferred a 'no-frills', 'no questions asked' service.

It's just they kind of... try and persuade you to...for example the doctor said to me you don't need to be having sick notes and everything and its none of his business really, so just write one out for me and just get on with your job basically... If that was my usual practice, they would have just gone like that, as I says, they just would have gone boom. There you go. Come back next time. Come back in a month's time and I will write another one out for you [P019-service user]

Service User Defined Goals

Stakeholders felt that they had to be accepting and work around the priorities of service users. User priorities might be health related or impacting on health, but not necessarily so. This viewpoint went beyond recognising the inter-relationship between health and its social determinants.

Individualise health and social care plans really, looking at somebody as an individual but my needs and what your needs are may be very different or my priorities may be different to what yours are and it's looking at, so a nurse's, priority maybe that you go to see the doctor because of your asthma but their priority might be that they need to earn some more money or their benefit or get a house. That's what their priority is and it's looking at helping them succeed in their priorities and also gearing them towards something to do with their health. So it's just basically holistic individual assessments really [S008-Options stakeholder]

Breaking Down Barriers [optimising engagement]

Options was characterised as a service which flexed and integrated with the host services. Moreover, it was able to respond opportunistically to the needs of individuals.

I mean well yes, yes there is a lot of people that I've worked with here and who maybe haven't got good relationships with their GP's or they don't feel that their listened to by their GP's so there are barriers. It's different when I say "well you know there is somebody here now would you like to just have a quick chat"? It's a lot more inclusive and you know, people feel like they've got that support... they've [nurses] been out in the waiting room saying you know "would you like to have a chat with us, are you are smoker would you like help with giving up" you know, anything it is definitely a positive step [S013-other stakeholder]

I really enjoy having that facility in-house because I think if we say to somebody "right you're not registered with the dentist or you're not registered with the doctor. That's you're task for today, go and sign yourself up with a GP" you know, they walk

out of here and unfortunately you know, probation is relatively peripheral to their lives. So once they've spent their 40 minutes with you and they leave they're probably not going to think about you until the next week. So it's a matter of trying to get as much done whilst they're here [S014-other stakeholder]

As one exemplar, the health promotion days hosted by the Probation Service and staffed by a range of health partners and other agencies involved in health and wellbeing were a successful way of opportunistically targeting and engaging the probationer population.

I went away and took away the information and it was like a refresher and it does impact and you do take it on board [P020-service user]

The aim of Options is to encourage re-engagement with primary care services where it has been absent and the objective is to move individuals on as typified by the following quote.

Women are getting enrolled on Activity for Life, you know general health and well being, their eating habits. And myself and the Assistant Manager had a meeting with women in here last year and we were saying about the Option service and how their life's changed since coming into refuge and a lot of them said they wouldn't of never ever gone to see a doctor or a nurse. [S004-other stakeholder]

One of our residents was diabetic and he relied on them (Options) regularly, each week they'd come in and they'd sort of, I mean he'd see the nurses and the GP....it is a good service you know because he might not have gone somewhere else and kept putting it off and putting it off but because it was on the door the step if you know what I mean, the service is coming to you [S007-other stakeholder]

There was only limited evidence that service users felt that Options did not provide as good a service as their GP.

Nothing that makes me think that I will use these guys more [P019-service user]

4.2.3. Theme 3: Limitations of Options

Five sub-themes which emerged were barriers to access, equivocal guidance to users, unmet need, re-integration to mainstream services and host site management.

Barriers to Access

In the main there was agreement that appointment provision within outreach settings was very good.

No, there's always a slot, there's never a wait, there's always an appointment [P006-service user]

However, there were some issues with the frequency and number of appointment slots which could become a problem at times of high demand times.

I think the limits are when they actually limit the numbers they can see on one visit, because if we've got a woman in, because if you had a woman in with 6 children and say all her children had some sort of virus that would be counted as 6 appointments... In those instances we've made appointments to go to the walk in centre, which again is not sort of outlandish but by the same token, because the service is coming in it would be nice if they could access the service in here for all the reasons I've spoken about [S003-other stakeholder]

With regard to non-outreach Options clinics, which some users might use, it was suggested that the number of clinic slots might need to be increased in some locations.

More day time opening hours in Huyton and in the South of the borough because I know that they are limited to evening clinics only so I think that that would be a better selling point [S010-Options stakeholder]

There was a suggestion from one service user that hosting the clinic on the same day each week was not always helpful.

The only thing I would say is I think the day should be changed. I don't think it should be every single Thursday. Because, I know it might sound daft but not everybody's sick at the end of the week. You know if they could alternate it, maybe Tuesday, Thursday, alternate it each week [P013-service user]

Equivocal Guidance

Some service users were unclear about the differences in registered and non-registered options, which was further confused by the advice given by some non-Options practices.

And then they did give you a registration form but there's been a bit of confusion because a few people have registered with the Options team and then been told that they can't register with a GP. But I've still got my GP and the Options team is still seeing me but the medical centre opposite, I know people have been over to register with them and they won't take them because they're registered with Options... But now there's a bit of dispute over whether..that the Options team can provide the on-going treatment and the referrals to the hospital [P006-service user]

Stakeholders felt that some of the confusion arose because of the politics around the service and the perceived threat that Options presented to mainstream provision.

There is a bit of confusion I think sometimes with patients in that... they don't understand the sort of politics behind the Options service... And how we're not

allowed to perhaps as actively register patients previously [S011-Options stakeholder]

Unmet Need

Typically only one GP is available at each Options outreach clinic. The gender of the health care professional was seen as important by some service users.

Yeah [when asked about gender of health care professional]. Only cos of me past. But I feel more relaxed here, with the nurses. My little boy does as well [P009-service user]

In some settings access to a female doctor/nurse is limited. However, the following illustrates that over time the qualities of the doctor may supersede gender.

He's a male doctor which at first I thought 'oh no' because I don't like, I'm not really into male doctors to be honest. And when I first met him I felt very very uncomfortable with him, very. And I thought 'what am I going to do? I'm stuck with this man now every week probably, who knows', and as time's gone on, I've realised he's a very good doctor and he listens to me and he has time for me and he's not rushing me [P006-service user]

Stakeholders talked of using chaperones as a way of overcoming any issue relating to gender.

As it's generally a male doctor, sometimes if a particular type of examination is required, he will ask a member of staff to sit in and support in that so I have done that before [S001-other stakeholder]

Access to a single doctor could sometimes be problematic if a previous experience was less favourable.

There's another doctor that comes in, I think she's (personal information removed), absolutely brilliant, and she really does sit and listen to you, but the doctor we've just had the past few times, she doesn't listen to anything you've got to say. So to me, to be honest, the past couple of times I've not bothered coming to see her, just made an appointment with my own doctor instead [P013-service user]

Some issues were raised by both stakeholders and service users relating to the use of rooms which are not exclusively for consultations or difficulties resulting from use of a non-clinical setting.

The only problem I had one day, but it's only a small problem this, it was the second time, was I was taken into the staff kitchen and she was discussing confidential things with me, my health, and staff were coming in and out and I felt so stressed and I felt quite ill in there, and I thought 'this doesn't seem right'. So eventually, after, say, 10

minutes, I had to tell her that we need somewhere more private than this [P006-service user]

There is a little sort of blind, so what we do is we stand behind the blind, right behind the door so I can examine somebody and if anyone tries to come in, they can't, but it's about making do [S011-Options stakeholder]

On a limited number of occasions a service user might be required to attend a regular NHS clinic instead.

If it's something that's quite intimate we would request that they attend in a clinic because obviously in most of the outreach sites it would not be you know, there's no lighting and things like that maybe to do an intimate examination but we would support them in going to that clinic [S008-Options stakeholder]

Stakeholders recalled problems with IT access and felt that this might sometimes hamper them during a consultation.

We don't always have enough computer access... a lot of the time you would end up fire fighting, and if you, when you talk about the pro-active care that you want to do, it's really time consuming to try and organise, to know exactly, which patient needs what, you know, pro-actively when you haven't got a computer in front of you [S011-Options stakeholder]

At some sites room allocation hampered professional interactions and lack of space meant that clinics were sometimes poorly accommodated.

One of the limitations is the room availability especially in xxx, ideally we would like to be working alongside the GP to bat to and fro any problems but because of the rooms availability in xxx, we're not able to do clinics alongside the GP because the room that we would use the GP is using so that can cause a problem. [S008-Options stakeholder]

They're an organisation and they can't always accommodate having a GP clinic there [S010-Options stakeholder]

Stakeholders reasoned that an increase in staff numbers would enable them to address other health promotion priorities or mop-up unmet need.

Additional social work staff. With social work anyway, you can dig as deep as you physically able to do and I think there would be opportunity to work with another social worker to do more creative and thorough work anyway [S010-Options stakeholder]

At the moment limitations would be we haven't got that many nursing staff, but, what we could is we could do a lot more health promotion and a lot more education within the outreach setting but with the low numbers that we have which is not really a fault of options it's just a recruitment problem we're quite restricted as to what we can do. If we had more nursing staff I would probably say we would go in do more health promotion clinics and maybe attend more outreach sites really and see how maybe we can move the service forward more [S008-Options stakeholder]

Re-integration To Mainstream

It was perceived that Options was bridging a gap and kick-starting re-engagement with outside and 'mainstream' services but that it was a slow paced transition.

I think that's what options do because that's what I'm saying they get used to coming to see the nurses and the doctor and realise then that there is no fear here you know, these actually are alright with me and this that and the other so they'll then you'll find they'll go and register for a GP, they'll go and look for a dentist which they probably haven't had for years but it does give them that kick start [S007-other stakeholder]

I think I would eventually but I'd actually take my time" [when asked about registering outside or using Walk-In Centre] [P006-service user]

Other service users expressed concern about re-integrating to mainstream provision following the individualised care they received via Options.

Yeah, I am feeling quite apprehensive regarding going to another doctor now because the doctor here in the refuge is excellent and I sort of feel it's took me a long time, but I feel comfortable with him now because I am quite nervous about going to see a doctor. The nurses as well, I'm sort of used to them now and to start looking for someone else now again, it can be a problem [P009-service user]

There was a slight concern that Options might encourage dependency or demand for demand sake.

I know there's people in here that come down every week without fail. I think that they're finding an ailment to tell the doctor to be honest [P013-service user]

However, this was thought to be a minority issue and in the main individuals were being encouraged to self-care and manage and further down the line seek some reassurance.

I don't know its about reliance isn't it?....And sort of being able to sort things out yourself. And then after a while they sort of tend to say "oh I'll run this by you, do you think it's ok"? So in a way it's more... the majority of it is good but there is a small element where I suppose it makes people a little bit more dependent [S011-Options stakeholder]

Host Site Management

The Options service was managed in slightly different ways by the different outreach sites and this could impact positively and negatively on uptake and the experience of service for professionals and service users.

Because I know sometimes I've waited outside for 45 minutes while she's been speaking to one of the girls upstairs and that's not a problem. If you need to speak to the doctor that long, that's fine. But then I'll come in and she's rushing round for five minutes cos she knows she's gotta go. So that's where you feel like she's not listening properly...Like I think of a morning, say it's a Thursday morning, there should be a box on the desk and everybody who wants, rather than the buzzing system, everyone should put their name on the back of a card and stick to that order maybe. So you know you've put your card in first, you're first... Because there's no time slots. It's just literally a piece of paper and your name and your flat number. But it never ever sticks to that order, no matter, and then there's always someone else that wants to come or someone doesn't turn up but you're still waiting outside [P013-service user]

Equally whether the host site was residential/drop-in could impact on uptake but generally it was argued that demand was unpredictable and variable.

I know when we were running the Options service at another site and I know that it wasn't getting a very good response at all because it was like was like a walk in for the public around there. That's the only negative really... You know but really as a drop in or as residential it can be hit and miss either way you know [S008-Options stakeholder]

Options evolved to find creative solutions to the challenges faced in certain settings so in non-residential settings, a more proactive stance to engage the client group might be adopted.

Some of the nurses will come out and go are you waiting to see the nurse now, come on in and see me and then you'll go down for your offender and you kind of go where are they? And they've gone in with the nurse well ok they're only going to be 5 or 10 minutes you can wait. Others aren't that pro-active and I think it's the pro-activity that is nice to see [S014-other stakeholder]

4.2.4. Theme 4: Tensions in referral process

The final theme explored the impact on the service and service users of delays/complications arising from referrals.

There was a general viewpoint that the Options service has improved and speeded up the referral process. However, referrals to mental health services were cited as a case in point where significant delays might still occur.

I do think there's a huge waiting list, there's not enough counsellors, the real problem with the mental health team, there's not enough people and patients are having to wait five, six months and that's not good [P006-service user]

The wait might cause further anxiety for the service user.

I feel a bit left out in the dark with it, to be honest with you, which is frightening because some days I do get very low and I think 'well when's this appointment going to happen? And I do think that women, men, they could even take their lives through waiting. There's too much of a wait [P006-service user]

It might result in other 'holding' strategies which are acceptable but not the most relevant support.

It's really helped me a great deal. The only thing is the counselling which I am having at Platform 51. It's a different sort of counselling than what I'm needing [P006-service user]

It might also create additional demands on Options professionals to 'hold' the client and ultimately dissatisfaction with Options if the service user expectation is not met, which all arises from an upstream problem.

I get very apprehensive because I like to know what day he's arriving and he's never sure, and so I don't really know until the day, sometimes the day before, and I panic [P006-service user]

The roles and responsibilities of Options versus other primary care providers was a source of frustration for service users and stakeholders alike. For instance, referrals/scripts for registered Options patients were often more straightforward and faster to process.

It can cause tension because if somebody's registered with the options service for example in Field Lane you can then make other referral on to maybe secondary care or you know to another community setting but if somebody's in equitable access you may have to go back to their own GP and say can you do this referral or if it's to do with medication they do ask a lot can I have repeat of my medication so that causes a lot of problems because they do not understand that the risk of giving somebody repeat medication when it's not your regular GP who doesn't have enough information it outweighs, and it would be easy for us to give it to them, but their risk is too much, so we have to refer them back and that can cause a lot of problems [S011-Options stakeholder]

5. LIMITATIONS OF THE STUDY

Despite providing valuable information about the role and functioning of Options, the limitations of the study should be acknowledged.

Roughdale Court was excluded from this study because it had no registered patients and First Steps were unable to facilitate service user involvement at the site. There was not scope as part of this study to tease out why involvement at the latter site was not possible but it would be useful for the provider to consult with the host sites to find out a little more about any needs of the populations at these sites and whether these could be addressed.

We did not interview any individuals who had left the outreach Options service and so it was not possible to determine the experience of individuals who had moved on. Several interviewees did outline the process at transition and hand over and how this is optimised but it would be useful to capture the experience at transition to ensure patients are well managed as they transfer to services outside Knowsley. An additional reason for interviewing this cohort would be to determine sustained benefits of Options outreach service.

We have taken note of the literature which outlines strategies to improve response/uptake rates to questionnaires (Edwards et al, 2002). We did not recruit as many service users to interview as specified in the protocol, but there were problems recruiting to target even with incentives in place and offering to reschedule. For some service users, hospitalisation or having too much else to cope with were legitimate reasons for 'refusing' to be interviewed even after scheduling a time and date. However, we did interview at least one participant from each of the four sites and as we do not intend to generalise the findings beyond the scope of this service the findings are adequately representative.

6. DISCUSSION

Barriers of engagement in marginalised cohorts including no proof of address are documented in the literature and are consistent with our own findings prior to the inception of Options. Some studies have indicated that the homeless are forty times less likely to be registered with a doctor (DH, 2010). A Social Exclusion Unit (SEU) report (2002) noted that around half of all prisoners were not registered with a GP at the time they came into prison. Although Bradley notes that this situation has improved, he is optimistic that the GP led

clinics proposed by Darzi would improve access without the necessity for registration. With such facts in mind, one of the key aims of Options is to provide fairer access to services. Fittingly, our respondents felt that Options satisfied many of the deficiencies of mainstream provision in enabling more inclusive and equitable access to an integrated primary health and social care service pathway with signposting and seamless onward referral to other services as appropriate. The only exception to this were the delays experienced in being seen by some specialised mental health services even though Options had made a referral.

The evidence base points to a greater burden of ill-health in the populations served by the Options outreach service. The Bradley report (2009), as previously quoted sets out the prevalence of psychiatric problems in the prison population. The SEU reported that 70% of female prisoners were affected by 2 or more mental disorders, which is 35 times greater than of the general population (SEU, 2002). Typically, populations that sleep rough or have ever slept rough or have stayed in hostels are more likely to suffer from premature mortality and suffer a disproportionate burden of morbidity when compared to the general population (DH, 2010). Furthermore, the homeless have a tendency to present at crisis and to access/need more costly emergency rather than primary services. Hospital Episodes Statistics (HES) indicates that the length of stay (LOS) is typically longer 6.2 as opposed to 2.1 days in an equivalent non-homeless population (DH, 2010). Our study revealed examples of poor physical and mental health, which had sometimes remained undiagnosed or ‘neglected’ in both adults and children. It identified possible explanations for barriers of engagement with health care e.g. fear of disclosure in the domestic violence population which fit with the previous evidence (Women’s Aid, 2009). It is therefore encouraging, that in a generic sense Options was characterised as a service which mobilised and built up trust with the populations served. It also offered continuity and flexibility of service [e.g. responsive to crisis points/nipping problems in the bud] and sought a more holistic understanding of the individual not just addressing their co-morbidities. The latter is important since that we know that the homeless for example will not seek healthcare until a critical point because their health needs are eclipsed by other burdens (DH, 2010). A more direct response employed by Options to encourage better outcomes was the utilisation of health care navigators. Policy documentation outlines that the navigator role is designed to support and equip individuals through the implementation of the (already agreed) care planning process, to advocate on their behalf and ensure compliance with medications, interventions and referrals (DH, 2008).

Examples of such practice were identified here and the navigator role was viewed by professional stakeholders as a pivotal part of the skill-mix.

The interdependence between health on the one hand and the social dimensions of our lives on the other is clearly established. The literature outlines the complexity of these antecedents since mental health (Craig et al 1996) and/or alcohol and drug dependency (Wincup et al 2003) may be present before homelessness. It is now commonly accepted that in many cases ill-health pre-exists and maybe part of the transition to homelessness (DH, 2010). Acknowledging and understanding these complexities is one part of the solution. Equally fundamental is the joint working with other stakeholders to enable the co-management of health and social issues. Poor inter-agency working is a common theme in the literature (Bradley, 2009) and was a feature pre-Options. However, 'Care is care is care' for the person in need as patients are not interested in divisions between 'primary and 'secondary', 'upstream' and 'downstream' (NHS Future Forum, 2011). It was of note here that professional stakeholders cited the benefits of integrated, co-ordinated and harmonised working arrangements across the social/health care interface. At slight odds with this finding was the situation in the probation setting, where a working partnership with Options at the grassroots level was sometimes less obvious. This reflects the position nationally where partnership between health and criminal justice is relatively new and needs to be developed further (Bradley, 2009 and NHS Hertfordshire, 2011).

The outreach service offered real benefits for service users and was closely linked to NHS agendas around offering personalised care. Including;

- giving patients greater convenience and flexibility
- valuing and working with their choices around health decision-making and
- mobilising, enabling and empowering them to take more control over their care

Options stakeholders provided tailored health care at a number of levels including recognising that the priorities of clinicians and priorities of the individual were not always compatible so getting a job might be the individual's priority above dealing with their health. Nonetheless, in the case of offenders, where physical and mental health issues are not adequately addressed then it becomes more difficult for individuals to make the best use of education and training which can then influence their re-offending (SEU, 2002). Equally,

addressing mental health problems may make gaining and keeping meaningful employment more likely (Bradley, 2009).

Although many service users were described by some stakeholders interviewed here as having high and complex need, they were also represented as co-producers not just passive recipients of health care and individual choices were taken into account and respected. This was particularly important since one of the objectives of the service was to integrate back into mainstream services. On the other hand, Options did advocate and negotiate on behalf of certain individuals to facilitate uptake of services.

7. RECOMMENDATIONS AND WAYS FORWARD

- There is an opportunity to optimise integrated offender management in the probation setting and as part of that to generate greater awareness of the reach and the potential of Options. It is important that the staff in the probation setting work very closely with the Options staff to allow this to occur. Suggestions that may assist this process are 1. Including information on Options within the probation induction process; 2. Regular inputs at staff/team meetings.
- Providing more choice in terms of gender of GP and clinic sessions is a suggested improvement. It is vital to explain to service users the differences between the registered and non-registered service and what individuals may expect at key points on the pathway e.g. when waiting for a referral or when exiting the pathway to move to a geographical location not covered by Options. The service needs to explicitly publicise the mechanisms whereby service users may record any dissatisfaction with the Options service.
- Options has plugged gaps in service and met some of the needs of several disadvantaged groups. The impact on unmet need should be taken into account if the service were not available.
- It is important to consider how to disseminate the key messages from the study to participants, stakeholders within Options and at the outreach organisations and the

wider footprint. Equally, it is important to consider how to translate them into service development.

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Centre for Public Health
Research Directorate
Faculty of Health and Applied Social Sciences
Liverpool John Moores University
2nd Floor, Henry Cotton Campus
15-21 Webster Street
Liverpool
L3 2ET
Web: www.cph.org.uk
Tel: 0151 231 4539/4449
Fax: 0151 231 4552
Email: j.hopkins@ljmu.ac.uk