Tool 2: Place based Primary Care; Inclusion Health Services

This is a tool to support the primary care system in delivering the Service Specification for Inclusion Health Services in Wales through Primary Care.

Service Lead	
What partners, services and / or individuals can you engage at the beginning? See Appendix 1	

Understand your population-

Who are they & what are their needs?

Who in your cluster population may be eligible for Inclusion Health Services?	Eligible populations include people who have severe and multiple disadvantages, experience social exclusion and health inequalities e.g. 1. People experiencing or at risk of homelessness, including: Those in temporary and unstable accommodation, Young people or care leavers at risk of homelessness. 2. People in regular contact with the criminal justice system. 3. People seeking asylum, refugees, vulnerable migrant workers and undocumented or trafficked migrants. 4. People engaged in sex work. 5. Roma, Gypsy and Travelling people.
Do you know how to identify your population?	Data can help you understand your population and identify different population groups and can be used to support planning inclusion health services. Data for each area can be accessed at the inclusion health planning support and resource page - data is limited and incomplete, we present what is nationally available. ***Important this data should be supplemented by conversations with the community, third sector and people with lived experience.***
Do you know their health needs?	Poor health among inclusion health groups is a combination of factors, including the wider determinants of health, health care access and

	quality, discrimination, and low uptake in preventative and primary services. Extremely vulnerable groups have; • Significantly poorer morbidity and mortality outcomes when compared to the general population and deprivation. • Significantly more likely to be exposed to trauma and/ or violence. • Chronic disease, infectious diseases, cancer are more prevalent in these groups. • Low uptake in immunisation and screening. • Significant risk of mental health distress and disorders. • Poorer antenatal and postnatal outcomes. Data and intelligence - Primary Care One (nhs.wales)
Do you know what other needs should be considered?	Individuals who experience multiple disadvantages face challenges engaging with primary health care. Any inclusion health service should consider: • Access to services • Barriers to services • Language and cultural needs • Previous patient experiences • Other social determinants of health which may be affecting individual overall health and wellbeing (Housing, employment etc.)

☐Checkpoint

Considering the above, can you describe the inclusion health service that is needed to meet the needs of your population?

Addressing the need & who else can help you?

What do you need to know to develop an inclusion health services?	The type of service required is dependent on: • **The numbers** How many individuals living in your area experience multiple disadvantage and social exclusion How many eligible population groups are within your local area

	• **Complexity** Are your patients needs complex, requiring more time, resource and specialist care? See Appendix 1 Inclusion Service Tiers for further information
Are you collecting the necessary data?	There is very little data on extremely vulnerable groups. Data collection is essential to understand local need. Locally, you can improve data by agreeing to systematically record the same data across cluster areas, consider: • Extremely vulnerable groups • Demographic • Protected characteristics • Health need
Are you aware of what services are available locally and/ or nationally?	Important that at the beginning of this process should ideally be done in collaboration with partners across the locality, including third sector, local authority, and people with lived experience. • Have you included key partners? • Have you listened to individuals with lived experience • Have you got sufficient resources? Workforce Need: Numbers and Training Links below can help you understand and identify what this need looks like locally • Workforce Planning • Inclusion health Directory of Training resource Understand what is already available • Description of services providing Primary Health Care to vulnerable groups across Wales • See Appendix 2 Service Mapping
Do you know which service and/ or individuals are key?	Across the cluster system there are opportunities to engage, collaborate and adopt a muti-disciplinary approach to deliver inclusion health services **Professional Collaboratives / Clusters** Collaboratives and clusters can provide local information and soft data and knowledge which can support the case for and development of inclusion health services that meet the needs of the local population.

	Statutory Services Engage relevant services that are already working with your identified population group(s) e.g. Housing / probation / sexual health clinics / Health Visiting and Midwifery. **Third Sector** Many Third Sector organisations will be working with and for vulnerable population groups and are key partners in service delivery as well as service development. See Appendix 1 for more information.
Have you listened to individuals with lived experience?	Individuals with lived experiences are **essential** in developing accessible and appropriate services. Include the people you are developing services for. Consider the different approaches: **Co-produced services** are services developed in partnership with patients and population group(s). Patient groups are involved at the beginning of service development and are fully engaged and influence the entire process. **Patient engagement** in service development considers and responds to patient voice and experiences but the input can be limited, and this approach is likely to miss patient voice at initiation and development stage. **Patient feedback** provides service users the opportunity to feedback on experience once a service in development. This approach should be key in evaluation of services and done alongside other engagement with patient groups(s) **Place Based approaches** to service development can support service developing with a focus on the assets of the community, further information can be found on Planning Portal for Primary Care.

☐Checkpoint

Checkpoint: see the caution card to identify any action that could potentially increase health inequalities.

Have you made a difference? **How can you monitor or evaluate your service?** **How can you define success?**	The Planning Portal, Monitoring and Evaluation webpages, provides information and resources to support monitoring and evaluation of service initiatives. Consider ☐How will you know if you have made the change you wanted to? ☐What does your collected data tell you? ☐Has your patient's experience changed? ☐Has your intervention decreased or increased health inequalities? ☐For further advice on defining success and measures, see tool 3; Health Equity Assessment Tool - Review

☐Check List

Over the next year we commit to these actions (Please use this space to list SMART actions which can be used to communicate action in cluster planning)

1.

2.

3.

4.

5.

Appendix 1 – Supporting a Partnership Approach

Development of good working relationships with partners across health, social care and third sector will support services to be co-developed, and support referral pathways and easy lines of communication:

Consider inviting colleagues from a range of services to engage, including:

- Counselling/Psychology services
- Community Mental Health Teams
- Primary Mental Health Services including care for those with complex Post Traumatic Stress
- Substance misuse services
- Infectious Disease services including Tuberculosis (TB)
- Sexual health and family planning
- Sexual assault and referral centres
- Unscheduled care service such as Emergency Units/Out of Hours
- Chronic pain services
- Musculo Skeletal Services
- Podiatry
- Optometry
- Dietetics
- Oral Health Care and Dentistry
- Occupational Health
- Trauma informed physiotherapy services
- Midwifery services
- Health Visiting services.
- Collaboration with case tracking, contact tracing, community treatment and public health measures including TB, HIV, Hepatitis C
- Wound Care Team
- Speech and Language Therapy
- Health Promotion Services (smoking cessation, Healthy weight etc)

Appendix 2 Inclusion Health Service Tiers

Tier 1

- Universal Care provided to all patients via mainstream GMS (General Medical Services)
- Services are accessible to all patient groups in the area
- Current and developing services should consider equitable access and care for all

Tier 2

- Pan Cluster Planning Groups or Health Boards commission inclusion health services.
- Already established services are adapted to meet the needs of eligible groups and individuals.
- Consider use of care navigators and services to facilitate joined up care
- Out-reach services established which target, identify, and provide care for population groups outside of regular clinics.

Tier 3

- Specialist services commissioned for localities based on high numbers and complexity of need of traditionally excluded groups
- Alternative clinics established.
- Targeted outreach and mobile health care considered
- Complex case management and MDT approach

Appendix 3 Service Mapping

	Homeless Service	Asylum Seeker / Refugee service	Prison Leave services	Sex worker services	Roma, Gypsy, and Traveller services
Aneurin Bevan UHB	X	X			X
Betsi Cadwaladr UHB	X				
Cardiff and Vale UHB	X	X		X	
Cwm Taf Morgannwg HB	X	X	X	X	
Hywel Dda UHB	X	X			X

Powys HB	**X**	**X**			**X**
Swansea Bay UHB	**X**	**X**	**X**	**X**	