Standards for commissioners and service providers

Self assessment tool for primary care providers

The Faculty for Homeless and Inclusion Health

February 2015

Contents

1   About this document

1.1   About the Standards

In January 2014 the Faculty for Homeless and Inclusion Health launched version 2 of *the Standards for commissioners and service providers* (referred to here as the Standards). These Standards can be accessed here: http://www.pathway.org.uk/wp-content/uploads/2014/01/Standards-for-commissioners-providers-v2.0-INTERACTIVE.pdf.

Our first set of Standards were published in 2011 and focused on health care for homeless people. In 2013 we became the Faculty for Homeless and Inclusion Health, extending our remit to include explicitly Gypsies and Travellers, vulnerable migrants and sex workers, as well as homeless people.

The Standards were written by a collaborative of professionals from a variety of disciplines in consultation with people with lived experience. Their purpose is to set clear minimum standards for planning, commissioning and providing health care for homeless people and other multiply excluded groups. They call on organisations to combine generosity, kindness and compassion with a passionate commitment to professional quality in providing health services for homeless and multiply disadvantaged groups.

The Standards have three sections:
- Part A outlines our strategy for improving health care for homeless people, Gypsies and Travellers, vulnerable migrants and sex workers.
- Part B provides commissioning guidance to ensure high quality health services for homeless people, Gypsies and Travellers, vulnerable migrants and sex workers.
- Part C presents generic standards for all services, followed by specific standard sets addressing a wide range of clinical settings and considering specific excluded groups.
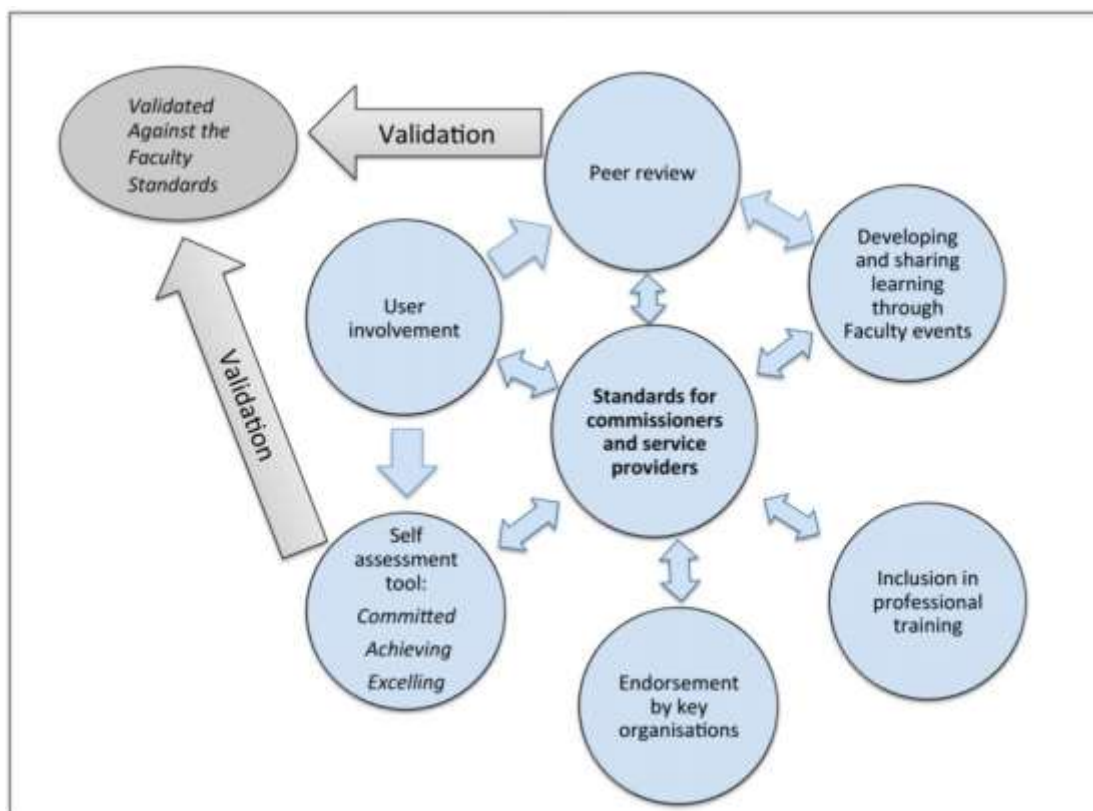
1.2   Implementing the Standards

Implementing these Standards is not a statutory requirement. However, doing so will allow organisations to design and deliver services in a way that applies the fundamental rights of all people to be treated with dignity, compassion and respect. It will also enable them to share experience of what works with other similar organisations and demonstrate their commitment to quality, patient centred services with others, including commissioners.

The Faculty has developed an implementation framework to support organisations to progress towards alignment with the Standards, which is described in figure 1 below. This self assessment tool forms part of the implementation framework. The purpose of this process is to celebrate good practice and support teams to identify areas for improvement and develop plans for further improving their quality of care

The implementation framework for the Standards recognises that organisations providing health services are subject to extensive regulatory requirements. It does not intend to add to or duplicate these requirements. Instead it aims to support and enable organisations to meet the Standards and to demonstrate that they are doing so. It has been developed based on the principles that implementation of the Standards should:

- Be value driven.
- Be centred on the user's experience of the service.
- Capture the importance of the culture of a service and the crucial role of leadership in this.
- Be applicable to the range of health care providers.
- Promote the genuine sharing of learning.
- Be feasible and make best use of existing monitoring information.
- Build credibility with commissioners and other external bodies.

Figure 1: The implementation framework for the Faculty Standards

1.3   About this self assessment tool

Purpose of the self assessment tool

This self assessment tool enables organisations to assess whether they are meeting the Standards, to identify and share good practice and to highlight areas where improvements are needed. The self assessment tool also provides practical information on how to meet the Standards. It is intended to be straightforward to apply. The tool is aimed at providers of primary care service to homeless people and other multiply excluded groups. [1]

The self assessment tool can be used in two ways:

1. Organisations can use it as an internal audit tool to support service improvement.
2. Organisations can use it as the first stage in gaining validation against the Faculty Standards. This process is described in more detail below.

Validation against the Faculty Standards

The process of validation against the Faculty Standards involves the organisation completing the self assessment tool, submitting this to the Faculty and receiving a peer review visit from a team made up of three peer reviewers (a Faculty moderator, a clinician and a service user champion). During the peer review visit, these reviewers observe practice, talk to patients and discuss with staff members the challenges, areas of good practice, points of learning and future support needs the organisation has in meeting the Standards. The peer review team uses the completed self assessment form as a starting point. The peer review team works with the organisation to develop a programme for the peer review visit. They then produce a report summarising their findings which the organisation can comment on.

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[1] The Faculty will make available other tools for use by specialist and secondary care services.

Peer review team members are all practicing professionals who have real life experience of working with homeless people and other multiply excluded groups. Their role is to support and help generate learning, for the Faculty as well as the organisation, rather than to inspect.

If the peer review visit validates the organisation as in line with the Standards, it will receive a certificate confirming this and will be able to use the following logo and wording on its information materials:

Validated Against the Standards of Faculty for Homeless and inclusion health

The Faculty is working with key commissioning and professional organisations to ensure the Standards are well recognised and highly credible. Therefore, we anticipate using this logo will be helpful in discussions with commissioners and regulatory bodies. In addition, the reflection on practice and planning for improvement involved means that completing this self assessment process can form a valuable part of personal development plans and continuing professional development (CPD) for staff. The Faculty is currently working to have the self assessment process for the Standards accredited as a CPD activity.

The self assessment process should be completed every two years in order to ensure it provides an up to date picture of the organisation and is based on the most recent version on the Standards, which we anticipate will be updated every two years.

Structure of the self assessment tool

The self assessment tool is divided into nine key values. These are:
1. Continuity of care
2. Ease of access
3. Multi-disciplinary collaborative care
4. Person centred care
5. Recording and reviewing information
6. High quality care
7. Ensuring services are safe
8. Commitment to reflection and learning
9. Service user involvement

For each of these values the tool:
- Describes why this value is important
- Signposts the Standards that make up the value
- Provides guidance on good practice and good practice examples
- Gives examples of indicators that demonstrate alignment with the Standards for each of the levels articulated as:
  - Organisations *committed* to this Standard can demonstrate that…
  - Organisations *achieving* this Standard can demonstrate that…
  - Organisations *excelling* at this Standard can demonstrate that

Additional resources are provided in the following appendices:

- Appendix 1 quotes the Standards that make up each value in full;
- Appendix 2 provides information about national requirements and guidance that are relevant to the Standards and may help organisations make useful links;
- Appendix 3 provides sources of further information and support.

The self assessment process requires organisations to describe how they are meeting the Standards and to identify learning points, good practice, areas of difficulty and action they are taking to improve. Because this information can be used to generate learning for the Faculty to share with other members and to identify areas for further work, we ask organisations to share it with the Faculty, even when they are using the self assessment tool internally and are not intending to request validation. This information can be provided by completing a concise self assessment form. This form is available as a Word document that can be downloaded at www.Pathway.org.uk When you have completed the form, please return it to the Faculty of Homeless and Inclusion Health at info@Pathway.org.uk

2   The self assessment tool

2.1   How to use this self assessment tool

The self assessment tool is intended to be straightforward to carry out as we recognise that individuals and organisations have many competing demands on their time. It is also intended to help organisations reflect on practice and articulate learning points that can be shared with other Faculty members. It is not intended to be an exercise in form filling. We would welcome comments on its design and how it can be improved in future.

The key tasks involved in completing the self assessment process are:

1. Decide who in the organisation is coordinating the process and who else needs to be involved. This needs to include input from the organisation's leadership.

2. Read through the information included in the nine values of the self assessment tool.

3. Reflect on your organisation's practice for each of these values, discuss with other staff and gather relevant information, including input from users.

4. In discussion with others decide what you think is a fair and realistic rating for your organisation for each value. The possible ratings are:

   - *Committed:* not able to meet all the relevant Standards but recognising their importance and taking action to improve.

   - *Achieving*: able to describe and demonstrate how the relevant Standards are being met most of the time.

   - *Excelling:* able to describe and demonstrate how all the relevant Standards are being met consistently and showing good or innovative practice.

5. Complete the form (available at: www.Pathway.org.uk)

6. Discuss this with other people involved and amend the draft as necessary.

7. Discuss and decide if your organisation intends to seek validation and so requests a peer review team visit.

8. Submit the completed form to the Faculty of Homeless and Inclusion Health at: info@pathway.org.uk

There is no 'one size fits all' approach for completing the self-assessment tool.   Different organisations may go about it in different ways. However, there are some important considerations in ensuring the self assessment process and its outcomes are valid. These include:

- Ensuring service users are engaged in meaningful ways and that their views are acted on is a separate value. However, service user views are also important in exploring whether the organisation meets the all the other values. Make sure you think about how users' input will be captured in the self assessment process.

- Leadership is central to the culture of an organisation. Think about who leads your organisation and make sure they are actively involved in the self assessment process.

- Try to be as honest and objective as possible. The process is about learning and sharing learning, rather than proving compliance.

- Get different people's views when you are deciding how to rate the organisation. It is not a scientific process but rather one that requires you to make an overall judgment based on different information and perspectives.

- Please provide information openly about the challenges and obstacles you experience, as well as good and innovative practice. This helps the Faculty develop a programme to support organisations that is relevant. All self assessment forms are confidential and the names of organisations and individuals will not be used in learning materials.

- The Faculty is available to offer advice and support on this process. Please contact info@pathway.org.uk if you would like to discuss any part of the process.

As you will see the form also includes some questions about your experience of using this tool and other ways the Faculty can support the implementation of the Standards. Please help us by completing these.

Finally, the Faculty for Homeless and Inclusion Health thanks you for taking the time to complete this process.

2.2   The values

Value 1: Continuity of care

This is important because

Homeless people and people from other multiply excluded groups often experience difficulties in registering with a GP so frequently end up accessing health care in accident and emergencies departments. They also may need care from a number of different specialist services. Their care is often uncoordinated and they are unable to develop trusting relationships with clinicians. Often as a result of childhood abuse and neglect, many homeless people find it hard to develop trust. This, combined with their vulnerability and complex multiple health needs, makes it particularly important that they experience continuity of care, facilitating the development of trusting therapeutic relationships.

The related Standards are
- Principles for clinical standards in inclusion health care 2.0 and 2.13 on developing respectful relationships and coordination of the health care of excluded people.

Guidance on good practice and good practice examples includes

- The RCGP's policy paper Promoting Continuity of Care in General Practice available at: http://www.rcgp.org.uk/policy/rcgp-policy-areas/~/media/Files/Policy/A-Z-policy/RCGP-Continuity-of-Care.ashx
- Mechanisms in place to ensure consistency of care if the key clinician is unavailable for any reason. This requires good communication, clearly documented and agreed care plans which others can implement and proper recording of all patient encounters.

Examples of action that indicate alignment with the Standards include the following (provide evidence of these or other comparable actions)

Organisations *committed* to this Standard can demonstrate that:	• Plans are in place to ensure consistency of care within a team. • Plans are in place to carry out staff training on the complex needs of users.
Organisations *achieving* this Standard can demonstrate that:	• The above are in place. • Adequate time is available for consultations with patients who have complex needs. • Information about who works at the practice and their roles is clearly available, for example by displaying photos of staff in the reception area. • Service users have a named clinician and are told who this is. • Service users can make an appointment with their own clinician. • There are mechanisms to ensure consistency of care if the named clinician is unavailable for any reason. • There is an accessible system for service users to give feedback. • All staff, including reception staff, receive regular training on the complex needs of users. • Guidelines and procedures are in place to minimize the risks of patients being excluded from the practice. • There are procedures in place to communicate the reasons for exclusion and arrangements for continued health care to any patient who is excluded. • There is a register of any patients excluded from the practice with reasons why.
Organisations *excelling* at this Standard can demonstrate that:	• 80% of the above are in place. • The practice provides service users with a named liaison worker who helps them access the services they need. • The practice works with other services to develop an integrated care plan for service users identified as having complex needs that brings together all their care needs in a single document. • Service users are asked what they want from the service, either when they are registered or during a later appointment, and their priorities are recorded. • Service users' feedback has been used to make improvements to continuity of care and examples are provided.

Value 2: Ease of access

This is important because

There are many barriers that prevent homeless people and people from other multiply excluded groups from accessing health care, which need to be actively addressed through enhanced access. They are often prevented from registering with GP services because of administrative barriers such as the requirement for proof of address. In addition, due to chaotic lifestyles, they may find it hard to access services due to restricted opening hours and lack of drop-in or same-day appointments. They frequently feel stigmatized and threatened by health care and other professionals. Outreach and mobile service provision is often not available or inadequate. Homeless people may be concerned about what will happen to their pets and belongings if they visit a health care facility. Some vulnerable migrants may be concerned about coming to the attention of the authorities if they attempt to access care.

The related Standards are
- Principles for clinical standards in inclusion health care 2.1, 2.9 and 2.16 on outreach treatment for vulnerable migrants.
- Standards for primary care services 3.5 and 3.8 on regular outreach, liaison with street outreach teams, improving vaccination coverage and approaches to ensuring easy access.

Guidance on good practice and good practice examples includes
- Approaches promoted by the Street Medicine Institute (http://streetmedicine.org/wordpress/)
- Ensure consultation with service users about when they are able to attend appointments or drop in sessions.
- Provision for people to bring belongings to health care facilities when needed.
- Access to volunteer helpers that can take care of pets for homeless patients while they are seeing a clinician.
- Flexible timing of sessions to meet needs of particular groups, for example late evening clinics for street sex workers.

Examples of action that indicate alignment with the Standards include the following (provide evidence of these or other comparable actions)

Organisations *committed* to this Standard can demonstrate that:	• Services actively seek to offer treatment to homeless people and multiply excluded groups including, vulnerable migrants and those with no recourse to public funds. • Plans are in place to review and improve accessibility of the service.
Organisations *achieving* this Standard can demonstrate that:	• The above are in place. • There is a health outreach team that provides drop in services at hostels and other centres. • Patients can see a clinician at drop in sessions that take place regularly as well as make an appointment. • Interpreting services are easily available and used. • Active steps are taken to reach excluded groups in routine vaccination programmes. • There is routine liaison with and provision of medical support to street outreach teams. • Sessions take place at flexible out of hours times to meet needs of particular groups. • Engagement with service users takes place regularly to seek

	their views on how to make services easier to access.
Organisations *excelling* at this Standard can demonstrate that:	• 80% of the above are in place. • Pro-active management of high risk clients takes place. This involves weekly interagency meetings. • Assertive and systematic outreach takes place on a regular basis to target unengaged clients with health assessment and treatment. • The practice can help service users to access advocates who can attend appointments with them to support them in explaining their needs. • Changes have been made to how and when services are available based on the feedback of service users.

Value 3: Multi-disciplinary collaborative care

This is important because

Many homeless people and people from other multiply excluded groups have multiple healthcare needs. They may need to be referred to other services for specialist care. It is important that there is pro-active coordination between agencies to ensure that care is provided in an integrated way and service users do not get lost between services.

The related Standards are
* Principles for clinical standards in inclusion health care 2.2, 2.6, 2.7, 2.8, 2.10, 2.11, and 2.21 which cover hospital in-reach services, working with public health departments, respite care, multi-agency planning, coordinated care in hospitals and specialist services.
* Standards for primary care services 3.2 and 3.6 on pro-active management of selected patients, multi-agency review and care plans, collaborative case tracking and health screening and access to treatment.

Guidance on good practice and good practice examples includes
* Pathway Report # 03.01 - Medical Respite for Homeless People (May 2013) available at: http://www.pathway.org.uk/wp-content/uploads/2013/05/Pathway-medical-respite-for-homeless-people-03.01.pdf
* Combined Homeless Information Network (CHAIN) available at: http://www.broadwaylondon.org/CHAIN/WhatisCHAIN.html
* Practices participating in local rough sleepers action groups that meet monthly. The membership of these includes housing, hostel providers, fire service, health (general/mental), drug and alcohol services, police, probation, church, street outreach staff and others. They discuss individual cases to develop an action plan for support.
* Practices working with other agencies to follow up and regularly review integrated care plans for vulnerable patients, including having a named lead professional and the input of hospital in reach services.

Examples of action that indicate alignment with the Standards include the following (provide evidence of these or other comparable actions)

Organisations *committed* to this Standard can demonstrate that:	• The practice has regular on-going collaboration between other statutory and non-statutory agencies.
Organisations *achieving* this Standard can demonstrate that:	• The above are in place. • All new patients are offered health assessment including to blood pressure, pulse, body mass index, screening for dental/oral problems, BBV (Blood Borne Viruses), smoking, drug and alcohol problems, TB (Tuberculosis) screening, screening for mental health problems, diet and exercise. • There is on-going liaison with public health departments. • There is accessible provision of mental health, drug and alcohol treatment services, dental and podiatry care. • When services users do not attend referral appointments, there is a process in place to follow these up. • Patients are supported to attend appointments when referred.
Organisations *excelling* at this Standard can demonstrate that:	• 80% of the above are in place. • There is proactive, planned multi-agency collaboration to identify and follow up high risk service users involving statutory and non-statutory services. • There is provision of 'respite care' – community based residential medical facilities for homeless people with significant and complex health care problems.

Value 4: Person centred care

This is important because

Many socially excluded people have low health aspirations and poor expectations of services. These feelings are exacerbated when they are not involved in decisions about their own healthcare and if they are not treated with respect. Service providers need to recognise and take pro-active measures to address the disempowerment experienced by service users. This requires engaging with service users to define their own needs and articulate how these should be met.

The related Standards are
- Principles for clinical standards in inclusion health care 2.3, 2.4, 2.5 and 2.12 on service user involvement, cultural competence and sensitivity and the recovery approach.
- Standards for primary care services 3.4 on individual service level measures.

Guidance on good practice and good practice examples includes
- Psychologically informed services for homeless people: Good Practice Guide available at: http://homelesshealthcare.org.uk/pies/
- More information about the recovery model is available at: http://www.mentalhealth.org.uk/help-information/mental-health-a-z/R/recovery/
- More information on an outcomes approach to working with homeless people is available at: http://www.homelessoutcomes.org.uk/
- More information on the Outcomes Star, a tool for supporting and measuring change when working with homeless people, is available at: http://www.outcomesstar.org.uk/homelessness

- Include service users representatives on practice management forums.
- Undertake snapshot interviews are one-off interviews with only a few key questions, to discuss people's views and needs. They are short and do not demand long-term commitment from the service user, so people are more likely to engage.

Examples of action that indicate alignment with the Standards include the following (provide evidence of these or other comparable actions)

Organisations *committed* to this Standard can demonstrate that:	• There are private areas for all consultations. • There is an accessible complaints procedure and all service users who complain receive feedback
Organisations *achieving* this Standard can demonstrate that:	• The above are in place. • Service users are involved in defining their own needs and care planning. • Staff are trained to understand and recognise the links between behaviour, emotion and past experience. • The service's design and planning mechanisms use the question "What do we expect to change for our clients as a result of what we do?" • For booked appointments, there is a policy to try to see service users on time, and this is displayed in the reception area. • The practice has systems in place to ensure that patients are treated with cultural competence, for example staff training.
Organisations *excelling* at this Standard can demonstrate that:	• 80% of the above are in place. • Individual service users' plans are used to follow up progress using an outcomes approach so that service users can see how far they have come, for example Outcomes Star, WRAP or comparable tools for individual outcomes.

Value 5: Recording and reviewing information

This is important because

Homeless people and people from other multiply excluded groups often find it difficult to register with a GP. Consequently they are prevented from accessing primary care when they need it so they go to A and E departments for healthcare. This means they often seek healthcare much later than people with good access to primary care and their care is likely to be fragmented and lack continuity. In addition, because they are not registered with a GP their needs are less likely to be reflected in regional and national datasets and information on which local commissioning requirements are based.

The related Standards are
- Principles for clinical standards in inclusion health care 2.14 and 2.18 on recording children as individuals and recording housing status.
- Standards for primary care services 3.1 on registration.

Guidance on good practice and good practice examples includes
- Useful guidance for non-specialists on safeguarding vulnerable families is available at: http://www.qni.org.uk/docs/Safeguarding Homeless Families.pdf

Examples of action that indicate alignment with the Standards include the following (provide evidence of these or other comparable actions)

Organisations *committed* to this Standard can demonstrate that:	• All patients are registered at first consultation with a full registration (unless already registered with another homeless service). • Those only entitled to emergency treatment from the NHS have an immediate and necessary registration completed. • Patient information is treated with confidentiality. • Proper records are kept of all consultations.
Organisations *achieving* this Standard can demonstrate that:	• The above are in place. • Housing status is recorded and reviewed regularly. • Language needs are recorded. • Medical care plans are documented. • Records maintained by the practice are shared with other health professionals involved.
Organisations *excelling* at this Standard can demonstrate that:	• 80% of the above are in place. • Information is used in discussion with commissioners and others to advocate for service users' needs.

Value 6: High quality care

This is important because

Homeless people and people from multiply disadvantaged groups often have complex healthcare needs. They are also frequently marginalised and excluded by services. Where they do access health services, treatment may focus on treating the acute health problem that led to them attending and not address underlying health issues or chronic conditions.   This experience further contributes to low health aspirations and poor expectations of services.   Services for multiply disadvantaged groups need to be of the same high quality and take account of the same conditions that lead to preventable mortality as those for the population as a whole, in addition to addressing particular health needs.

The related Standards are
- Standards for primary care services 3.2 and 3.3 on using Key Performance Indicators (KPIs) and the Quality Assurance Framework (QOF) in a way that reflects the needs of the population served and reporting on these in an annual report.

Guidance on good practice and good practice examples includes
- Practices actively seek to understand and then direct resources at the chronic illness pattern affecting the population they serve. QOF standards provide a useful starting point, but will not adequately reflect the needs of the populations served by specialist practices.
- Some practices have negotiated and agreed with their commissioners quality outcome measures and/or KPIs that take account of the specific needs of homeless people and other excluded groups served by the practice and use these as part of performance monitoring.
- Some practices have internal audits of the quality of care.
- Some practices have set up mechanism for staff and service users to proactively identify ways of improving the quality of care.

Examples of action that indicate alignment with the Standards include the following (provide evidence of these or other comparable actions)

Organisations *committed* to this Standard can demonstrate that:	• Work to apply QOF standards that are relevant to the population served is underway.
Organisations *achieving* this Standard can demonstrate that:	• The above are in place. • QOF standards that are relevant to the population served are used in monitoring performance and achieved for some conditions. • Negotiations with commissioners are underway to identify quality outcome measures and KPIs that take account of the specific needs of the population served. • Systems are in place within the practice to collect information on the quality of care, review this and take action to improve it. • Staff and patients are actively encouraged to develop ideas about how quality of care could be improved, including learning from significant events.
Organisations *excelling* at this Standard can demonstrate that:	• 80% of the above are in place. • Quality outcome measures and KPIs have been agreed with commissioners that take account of the specific needs of the population served. • QOF standards that are relevant to the population served are achieved for many conditions and action identified to improve performance where they are not achieved. • An annual report including data on quality outcome measures and KPIs that take account of the specific needs of the population served is produced.

Value 7: Ensuring services are safe

This is important because

All service users have the right to receive services that are safe in a supportive environment. Many homeless and other multiply disadvantaged people are particularly vulnerable to abuse or harm. These vulnerabilities need to be addressed in the design and delivery of services.

The related Standards are
- Principles for clinical standards in inclusion health care 2.17 on using relevant guidance.
- Standards for primary care services 3.7 on prescription review.

Guidance on good practice and good practice examples includes
- The Social Care Institute for Excellence has produced an Adult Safeguarding Resource which is available at:
  http://www.scie.org.uk/publications/elearning/adultsafeguarding/resource/index.html
- The GMC Good practice in prescribing and managing medicines and devices is available at:
  http://www.gmc-uk.org/guidance/ethical_guidance/14316.asp
- The Mental Capacity Act Code of Practice is available at:
  https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/224660/Mental_Capacity_Act_code_of_practice.pdf

- The BMA has produced Safeguarding vulnerable adults – a tool kit for general practitioners available at: http://bma.org.uk/-/media/files/pdfs/practical%20advice%20at%20work/ethics/safeguardingvulnerableadults.pdf
- The psychologically informed environments (PIEs) approach has been used in health services for homeless people and other vulnerable groups. It is intended to help staff and services to be able to work more creatively and constructively with people with so-called challenging behaviours. It uses the latest insights and evidence from the psychological disciplines to give rough sleepers and homeless people the best chance of sustainably escaping the cycle of poor wellbeing and chronic homelessness. For more information see: http://homelesshealthcare.org.uk/pies

Examples of action that indicate alignment with the Standards include the following (provide evidence of these or other comparable actions)

Organisations *committed* to this Standard can demonstrate that:	- Relevant guidance is used to identify and manage risk for vulnerable service services. - There are clear procedures in place to manage incidents and significant events, including to identify and undertake immediate action, and to undertake notifications. - There are procedures in place to identify and manage risk around prescribing.
Organisations *achieving* this Standard can demonstrate that:	- The above are in place. - There are clear limits defined for unacceptable behavior and consequences for such behaviour are explained. This is accompanied by procedures to minimize the risks of patients being excluded from the practice. - There is training for staff in safeguarding, managing violence and aggression. - The practice has a named lead on safeguarding. - Staff are trained in identifying and supporting patients at particular risk from abuse, including domestic abuse and trafficking awareness. - Incidents and significant events are discussed at regular staff meetings and there is "no blame" policy. - There is provision to support service users who have literacy problems on correct use of medication.
Organisations *excelling* at this Standard can demonstrate that:	80% of the above are in place. - Building layout and operation takes account of safety considerations. - Service users' views on how to make services safer is sought and acted on. - The service incorporates a psychologically informed environments (PIEs) approach.

Value 8: Commitment to reflection and learning

This is important because

A culture of openness is crucial if we are to improve how we provide healthcare for multiply disadvantaged groups. This involves being able to discuss and learn from mistakes in a supportive and reflective environment, as well as sharing successes. It also requires engaging service users to get their views on what needs to be done differently and how.

The related Standards are
- Principles for clinical standards in inclusion health care 2.19, 2.20 and 2.22 on building an evidence base, profession education and promoting inclusion health as a career choice.
- Standards for primary care services 3.9 on ensuring staff are trained in the specificity of socially excluded clients' needs and are appropriately supported.

Guidance on good practice and good practice examples includes
- A 'community of practice' uses specially trained facilitators to promote more collegiate styles of working, for example, taking time to develop the social relations of the group and to promote things like 'active' listening skills. It is centered on 'case-based' learning and reflection and opportunities for more evidence-informed practices. This approach has been used by some practices to enable reflection and support staff.

Examples of action that indicate alignment with the Standards include the following (provide evidence of these or other comparable actions)

Organisations _committed_ to this Standard can demonstrate that:	• There are regular team meetings with opportunities for all staff to input. • There are regular staff trainings. • Service users views are actively sought.
Organisations _achieving_ this Standard can demonstrate that:	• The above are in place. • Team meetings can lead to review and changes in the day-to-day operation of the service. • Service user views are used to review and make changes in the day-to-day operation of the service. • There is joint training of different professional groups • Service user perspectives are incorporated into staff meetings. • There are arrangements for staff to ask for and receive emotional support. • There are systems in place ensure that significant events are reviewed, learning identified and changes made where necessary.
Organisations _excelling_ at this Standard can demonstrate that:	• 80% of the above are in place. • All staff have regular reflective supervision with a consistent supervisor. • Peer-support is valued and encouraged. • Staff are involved in planning their own development.

Value 9: Service user involvement

This is important because

Homeless people and people from other multiply excluded groups are often not involved in designing, delivering and managing health services. This can contribute to their disempowerment and means services may not adequately address their needs. All service users need to have meaningful opportunities to get involved in service delivery and have their views sought and listened to. Homeless people and people from other multiply excluded groups may be so focused on day to day survival that engagement is not a priority for them and them may not be used to being asked for and giving their views. This means service user involvement needs to be prioritised at all levels and properly supported.

The related Standards are
- Principles for clinical standards in inclusion health care 2.3 on service user involvement and 2.5 on the recovery approach ("no decision about me without me").
- Standards for services in any setting 2.12 on visible service user involvement in planning and evaluation of services 3.9 on ensuring staff are trained in the specificity of socially excluded clients' needs and are appropriately supported.

Guidance on good practice and good practice examples includes
- Clear information about how the organization works and how users can give their views and get involved, for example a notice in the reception area.
- Making it easy for service users to give immediate feedback, for example through a feedback box. Summarising this feedback and how it has been acted on, for example in practice newsletters or on notice boards.
- An on-going mechanism for service user involvement such as a user group, which meets regularly and can present its views to the organisation's management board.
- Having service user representatives on an organisation's management board or team meetings.
- Seeking the views of users proactively through user engagement surveys.
- Providing different mechanisms and levels for involvement as different people will want to be engaged in different ways (and some people will not want to get involved).

Examples of action that indicate alignment with the Standards include the following (provide evidence of these or other comparable actions)

Organisations *committed* to this Standard can demonstrate that:	• Service users' feedback is actively sought. • There is an on-going mechanism for service user involvement such as a user involvement group.
Organisations *achieving* this Standard can demonstrate that:	• The above are in place. • Service users' views are actively reviewed, acted on when appropriate and feedback is given. • The views of service users are regularly considered at the organisation's management and team meetings. • There are different options for the involvement of service users.
Organisations *excelling* at this Standard can demonstrate that:	• 80% of the above are in place. • Peer-support is user to enable user involvement. • Service user engagement surveys are regularly undertaken.

	- Service users views are include in staff recruitment. - Proactive efforts are made to engage particularly excluded groups of users, for example using one to one support.

Appendix 1: The Standards

The Standards for commissioners and service providers which are included in this self assessment tool for primary care providers are quoted in full below. The full Standards document is available at: *http://www.pathway.org.uk/publications/faculty-for-homeless-and-inclusion-health-publications/*

Value 1: Continuity of care
- A trusting and respectful relationship formed with a familiar clinician and team. (2.0)
- Coordination of the health care of excluded people as they move between different organisations and settings (hostels/drop-ins, shelters for homeless families, Gypsy and Traveller sites etc.). This may be best achieved via a named liaison worker and supported by a shared integrated care plan/formulation emphasising individual goals and strengths. (2.13)

Value 2: Ease of access
- Requires walk in provision, in reach to hostels and street outreach to rough sleepers – commonly described as "Street Medicine". (2.1)
- Services should actively seek to offer treatment to vulnerable migrants and those with no recourse to public funds. (2.9)
- Plans for assertive outreach for non-engaged clients in each area; e.g. specialist clinicians with flexible hours, able to provide street outreach; specialist Health Worker/ Health Visitor for Travellers. (2.16)
- Pro-active management of selected patients with high needs by – weekly multi-agency meetings including local street outreach, statutory and non-statutory services hospital in reach ward rounds/visits for homeless patients where necessary in the local Acute and Mental Health Trusts (3.2)
- Regular outreach clinics in local hostels and drop-in centres (3.2)
- There should be routine liaison with and provision of medical support to street outreach teams and provision of continuing care for recently housed and socially excluded patients, with a focus on enabling access to mainstream services. (3.5)
- Concerted efforts need to be made to reach excluded groups - with specific approaches to improve coverage - in routine vaccination programmes. (3.8)
- Regular review of locally negotiated approach to ensure easy access, including drop-in clinics and outreach clinics at hostels and drop-in centres to include primary care based mental health treatment (3.2)

Value 3: Multi-disciplinary collaborative care
- This is central to effective care because many homeless people present with multiple healthcare needs. (2.2)
- Inclusion Health services should provide a bridge linking hospitals and community care through hospital in-reach services. (2.7)
- Inclusion Health services should work closely with public health departments particularly with important communicable diseases (e.g. TB or blood borne virus transmission). (2.8)
- Homeless services should include the provision of "respite care" – community based residential medical facilities for homeless people with significant and complex health care problems. This could be achieved cost-effectively through joint working with local hostel providers and the voluntary sector. These services improve outcomes and reduce subsequent unscheduled hospital admissions. Pathway has recently published standards for Medical Respite in England. (2.10)
- Regular involvement in, and where necessary leadership of, multi‑agency planning for rough sleepers. (2.11)

- Coordinated health care in hospital settings – for homeless population – by collaboration with homeless ward rounds and attending multi-agency care planning meetings. For all excluded groups, informative and timely discharge summaries to primary care should be standard even when the patient self discharges. (2.15)
- Where specialist services are provided they should act as a catalyst to improve care throughout the local health service. (2.6)
- Promotion and encouragement of accessible provision of mental health, dental and podiatry care. (2.21)
- Pro-active management of selected patients with high needs by – weekly multi-agency meetings including local street outreach, statutory and non-statutory services hospital in reach ward rounds/visits for homeless patients where necessary in the local Acute and Mental Health Trusts (3.2)
- Collaboration with multi-agency review and care plans for all registered patients admitted to hospital twice or more in any 6 months period and when necessary those with Combined Homeless Information Network (CHAIN) or other rough sleeping record in the same period (3.2)
- Services should collaborate with case tracking, contact tracing, community treatment and public health measures e.g. TB, HIV, Hepatitis C. (3.6)
- All patients offered drop-in clinics with presenting problem addressed first, but offered health screening and access to treatment to include, physical health assessment, screening for dental/oral problems, BBV (Blood Borne Viruses), smoking, drug and alcohol problems, TB (Tuberculosis) screening, screening for mental health problems, diet and exercise (3.2)

Value 4: Person centred care
- Services should be provided with cultural competence and sensitivity. (2.4)
- The recovery approach developed by users of psychiatric services should be incorporated into the design of all services. Summarised by the phrase – Hope, Agency and Opportunity for all. This seeks to make shared decision making the norm. "No decision about me without me" (2.5)
- Individual service level measures should be defined by the service and defined by the question "What do we expect to change for our clients as a result of what we do?" (3.4)

Value 5: Recording and reviewing information
- Children treated and recorded as individuals, not nameless adjuncts to the parent. (2.14)
- Recording of housing status with regular review. (2.18)
- A unified electronic record accessible wherever the patient is seen (e.g. EMIS web or System One). All patients must be registered at first consultation. Ideally and usually this should be full registration, unless already registered with another homeless service, when temporary registration is acceptable. For those only entitled to emergency treatment from the NHS, an immediate and necessary registration is to be completed. In this way every patient is logged and costed and becomes visible to the NHS. Services which cannot register patients – such as nurse led community services - should have achieving GP registration for all their patients as a primary goal. (3.1)

Value 6: High quality care
- Managing long term conditions to QOF standards (3.3)
- QOF or KPI funding thresholds should reflect the challenges of working with excluded groups. (3.2)
- An annual report should be produced including QOF data. (3.3)

Value 7: Ensuring services are safe

- Using relevant guidance: Using guidance on the Mental Capacity Act, Mental Health Act and Safeguarding Alerts for adults at risk of abuse, in assessing rough sleepers who refuse care. (2.17)
- Prescription review: case studies in the Gypsy and Traveller communities reveal examples of repeat prescriptions being renewed without review for long periods, particularly when families are highly mobile, and also inappropriate usage (wrong dosage, frequency or sharing prescriptions) due to literacy problems1 (3.7).

Value 8: Commitment to reflection and learning

- Recognition and support of the need to build an evidence base for what works for socially excluded groups. Participation in documenting, researching and publishing on the health hazards of exclusion, evaluations of service delivery models (including models of preventative healthcare), continuous monitoring of longer term outcomes, action research approach to service development. (2.19)
- Education and involvement in undergraduate and postgraduate training of medical, nursing, dental, psychological therapy and social work students. Develop links with relevant professional bodies. (2.20)
- Promotion of Inclusion Health care as a viable and attractive career choice for staff. (2.22)
- Ensure professionals within the primary care team are switched onto the specificity of socially excluded clients' needs and appropriately supported, e.g. turn receptionists into 'gate openers' for excluded groups rather than 'gatekeepers' (Bromley by- Bow Centre project1). (3.9)

Value 9: Service user involvement

- Service user involvement in planning and delivery. (2.3)
- The recovery approach developed by users of psychiatric services should be incorporated into the design of all services. Summarised by the phrase – Hope, Agency and Opportunity for all. This seeks to make shared decision making the norm. "No decision about me without me" (2.5)
- Visible service user involvement in planning and evaluation of services. (2.12)

Appendix 2: Relevant national requirements and guidance

This appendix provides information about national requirements and guidance that are relevant to the Standards. This information is intended to enable organisations to identify how implementing the Standards can help reinforce and demonstrate good practice and compliance in other areas. Organisations may also find that it helps identify indicators that be can be used when completing the self assessment tool.

Value 1: Continuity of care
- Care Quality Commission (CQC) domains: responsive, caring
- Care Quality Commission (CQC) fundamental standards:
  - Care and treatment must be appropriate and reflect service users' needs and preferences.
  - Service users must be treated with dignity and respect.
- National Health Service Outcomes Framework (NHSOF) indicator 4a: patient experience of primary care.
- National Institute for Health and Clinical Excellence (NICE) Quality Standard 15 Quality standard for patient experience in adult NHS service. Statement 15: Patients experience continuity of care delivered, whenever possible, by the same healthcare professional or team throughout a single episode of care.

Value 2: Ease of access
- Care Quality Commission (CQC) domains: responsive
- Care Quality Commission (CQC) fundamental standards:
  - Care and treatment must be appropriate and reflect service users' needs and preferences.
- NHSOF Domain 4 - Ensuring that people have a positive experience of care: 4.4i) Access to GP services

Value 3: Multi-disciplinary collaborative care
- Care Quality Commission (CQC) domains: effective, responsive
- Care Quality Commission (CQC) fundamental standards:
  - Care and treatment must be appropriate and reflect service users' needs and preferences.
  - Service users must be treated with dignity and respect.
- NHSOF Domain 4 - Ensuring that people have a positive experience of care: 4.9 People's experience of integrated care

Value 4: Person centred care
- Care Quality Commission (CQC) domains: caring, responsive
- Care Quality Commission (CQC) fundamental standards:
  - Care and treatment must be appropriate and reflect service users' needs and preferences.
  - Service users must be treated with dignity and respect.
  - Care and treatment must only be provided with consent.
- NHSOF Domain 4 - Ensuring that people have a positive experience of care: 4a Patient experience of primary care: i) GP services; ii) GP Out-of-hours services; 4.7 Patient experience of community mental health services

Value 5: Recording and reviewing information
- Care Quality Commission (CQC) domains: effective, safe
- Care Quality Commission (CQC) fundamental standards:

- o Care and treatment must only be provided with consent.
- o Care and treatment must be provided in a safe way.
- o Service users must be protected from abuse and improper treatment.
- o Systems and processes must be established to ensure compliance with the fundamental standards.
- o Registered persons must be open and transparent with service users about their care and treatment (the duty of candour).

Value 6: High quality care
- Care Quality Commission (CQC) domains: effective, responsive and caring
- Care Quality Commission (CQC) fundamental standards:
  - o Care and treatment must be appropriate and reflect service users' needs and preferences.
  - o Service users must be treated with dignity and respect.
  - o Care and treatment must only be provided with consent.
  - o Care and treatment must be provided in a safe way.
  - o Service users must be protected from abuse and improper treatment.
  - o All premises and equipment used must be clean, secure, suitable and used properly.
  - o Systems and processes must be established to ensure compliance with the fundamental standards.
  - o Sufficient numbers of suitably qualified, competent, skilled and experienced staff must be deployed.
  - o Registered persons must be open and transparent with service users about their care and treatment (the duty of candour).
- Adult Social Care Outcomes Framework (ASCOF) Domain 2 - Delaying and reducing the need for care and support: 2F: Dementia - a measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life (NHSOF 2.6ii)
- Public Health Outcomes Framework (PHOF) Domain 2 - Health improvement indicators including: 2.10 Self-harm; 2.11 Diet; 2.12 Excess weight in adults; 2.13 Proportion of physically active and inactive adults; 2.14 Smoking prevalence – adult (over 18s); 2.15 Successful completion of drug treatment; 2.16 People entering prison with substance dependence issues who are previously not known to community treatment; 2.17 Recorded diabetes; 2.18 Alcohol-related admissions to hospital; 2.19 Cancer diagnosed at stage 1 and 2; 2.20 Cancer screening coverage; 2.21 Access to non-cancer screening programmes; 2.22 Take up of the NHS Health Check Programme – by those eligible; 2.23 Self-reported wellbeing
- PHOF Domain 3 - Health protection indicators including: 3.3 Population vaccination coverage; 3.4 People presenting with HIV at a late stage of infection; 3.5 Treatment completion for Tuberculosis
- PHOF Domain 4 – Healthcare, public health and preventing premature mortality indicators including: 4.3 Mortality from causes considered preventable; 4.4 Mortality from all cardiovascular diseases (including heart disease and stroke); 4.5 Mortality from cancer; 4.6 Mortality from liver disease; 4.7 Mortality from respiratory diseases; 4.8 Mortality from communicable diseases; 4.9 Excess under 75 mortality in adults with serious mental illness; 4.10 Suicide rate; 4.11 Emergency readmissions within 30 days of discharge from hospital
- NHSOF Domain 1 – Preventing people from dying prematurely: 1a.Potential Years of Life Lost from causes considered amenable to health care; 1.1 to 1.4: Reducing premature mortality from the major causes of death (PHOF 4.4 to 4.7); 1.5 Excess under 75 mortality in adults with serious mental illness; (PHOF 4.9); 1.7 Excess under 60 mortality rate in adults with a learning disability

- NHSOF Domain 2 – Enhancing quality of life for people with long-term conditions: 2.1 Proportion of people feeling supported to manage their condition; 2.3i Unplanned hospitalisation for chronic ambulatory care sensitive conditions

Value 7: Ensuring services are safe
- Care Quality Commission (CQC) domains: safe.
- Care Quality Commission (CQC) fundamental standards:
    - Care and treatment must be provided in a safe way.
    - Service users must be protected from abuse and improper treatment.
    - Service users' nutritional and hydration needs must be met.
    - All premises and equipment used must be clean, secure, suitable and used properly.
    - Complaints must be appropriately investigated and appropriate action taken in response.
    - Systems and processes must be established to ensure compliance with the fundamental standards.
    - Sufficient numbers of suitably qualified, competent, skilled and experienced staff must be deployed.
    - Persons employed must be of good character, have the necessary qualifications, skills and experience, and be able to perform the work for which they are employed (fit and proper persons requirement).
    - Registered persons must be open and transparent with service users about their care and treatment (the duty of candour).
- NHSOF Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm: 5a Patient safety incidents reported; 5b Safety incidents involving severe harm or death; 5.4 Incidence of medication errors causing serious harm

Value 8: Commitment to reflection and learning
- Care Quality Commission (CQC) domains: well led and responsive
- Care Quality Commission (CQC) fundamental standards:

    - Complaints must be appropriately investigated and appropriate action taken in response.
    - Systems and processes must be established to ensure compliance with the fundamental standards.
    - Sufficient numbers of suitably qualified, competent, skilled and experienced staff must be deployed.
    - Persons employed must be of good character, have the necessary qualifications, skills and experience, and be able to perform the work for which they are employed (fit and proper persons requirement).
    - Registered persons must be open and transparent with service users about their care and treatment (the duty of candour).

Value 9: Service user involvement
- Care Quality Commission (CQC) domains: responsive and caring
- Care Quality Commission (CQC) fundamental standards:

    - Care and treatment must be appropriate and reflect service users' needs and preferences.
    - Complaints must be appropriately investigated and appropriate action taken in response.
    - Registered persons must be open and transparent with service users about their care and treatment (the duty of candour).

Appendix 3: Sources of guidance and information

- The Queens Nursing Institute Homeless Health Initiative has produced an on-line learning resource: *Improving healthcare for homeless people.* This is designed for use by a wide audience, including specialist primary care practices. It is available at: http://www.qni.org.uk/for_nurses/opening_doors/resource_pack

- Homeless Link has produced a *Health Needs Audit Toolkit* to help organisations gather information about the health of people who are homeless. It is available at: http://homeless.org.uk/toolkits-and-handbooks/health-needs-audit#.Uz1TrCiS8k8

- St Mungo's Broadway has produced a report exploring the evidence on the costs and cost benefit of use of health services by homeless people and looking at gaps in the evidence. It is available at: http://www.mungosbroadway.org.uk/documents/4153/4153.pdf

- The NHS Confederation has produced a briefing on *Mental health and homelessness Planning and delivering mental health services for homeless people.* It is available at: http://www.nhsconfed.org/Publications/Documents/mental_health_homelessness.pdf

- Homeless Link has produced a *Mental Health And Wellbeing Guide* to support frontline staff and managers to work successfully with clients who present with various mental health and wellbeing needs. It is available at: http://homeless.org.uk/sites/default/files/SECTION_1-5_Mental_Health_Guidance.pdf

- A short review of evidence on homelessness, smoking and health has been produced by the Health Development Agency to support local health and community professionals who work with homeless smokers. It is available at: http://www.nice.org.uk/nicemedia/documents/homelessness_smoking.pdf

- More information on mortality and homelessness can be found in *Homelessness: A silent killer: A research briefing on mortality amongst homeless people* produced by Crisis and available at: http://www.crisis.org.uk/data/files/publications/Homelessness - a silent killer.pdf