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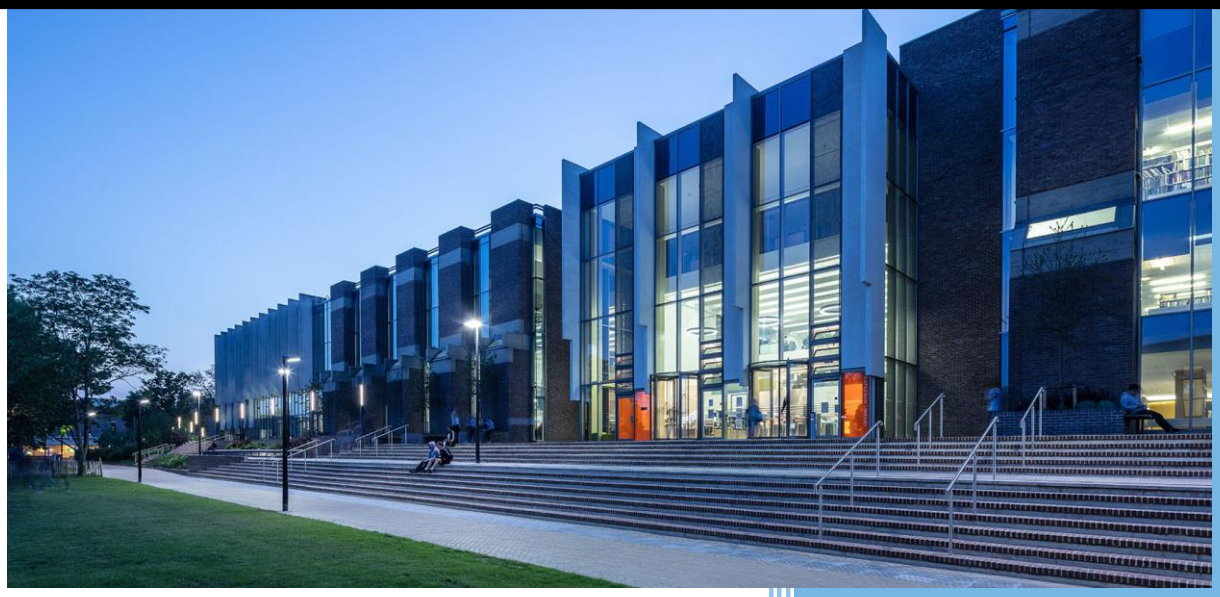
Inequality of access to primary and community health services: A scoping review



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March 2024

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EXECUTIVE SUMMARY

Introduction

The West Kent Home Treatment Service (WKHTS) is delivered by Kent Community Health NHS Foundation Trust (KCHFT) and provides hospital-level treatment at home for older people with frailty. Within the WKHTS it has been observed that fewer referrals are received for those in socioeconomically deprived areas compared to more affluent areas. This suggests there is a high level of unmet need amongst people with frailty in socioeconomically deprived areas in West Kent. KCHFT commissioned the Centre for Health Services Studies (CHSS) at the University of Kent to carry out a scoping review to explore inequalities of access to community frailty services, particularly in relation to socioeconomic status.

Methodology and Methods

The aim of the review was to determine socioeconomic (and other factors) influencing inequality of access to primary and community health services, including factors influencing GPs and other health and care professionals referral processes. There were too few studies identified which directly addressed access to frailty services, hence the review was widened to access to community services more generally. The review was carried out between November 2023 – March 2024 and included peer reviewed articles published in academic journals, websites and grey literature. 27 articles were included in the final review. Of these, 3 were reports, 9 were reviews, 6 were qualitative studies, 6 were secondary analysis of quantitative data, 1 was a mixed methods study and 2 were prospective cohort studies. Publication dates ranged from 2003-2023.

Results and Discussion

A conceptual model of 'candidacy' is a useful framework within which access to community health services can be viewed. It involves relationships, decision-making processes and beliefs (Dixon-Woods, 2006). The authors identify seven inter-related dimensions of candidacy: Identification; Navigation; Permeability of services; Appearances at health services; Adjudications; Offers and resistance; and Operating conditions.

The literature is predominantly focused on GP referral processes. However, the WKHTS receives referrals from other health and care professionals and organisations such as SECAmb and the community 'hubs'. Frailty may be normalised by patients and carers and seen as a natural process of ageing for which medical intervention is not useful. Also, the perceptions that the GP (or other health professional) is 'too busy' or 'not wanting to be a bother' may influence help seeking. There is some evidence to suggest that such beliefs may be more prevalent in those from low socioeconomic groups. Other factors impacting on identification of candidacy are low self-esteem which may be more prevalent in those with low socioeconomic status and those with complex co-morbidities which may include frailty.

There is good evidence that those with low socioeconomic status, particularly migrant populations do not have enough knowledge about the health and care 'system' to access it. Even once navigated, lack of available transport and associated costs disproportionately affects those with low socioeconomic status.

GP services and the WKHTS have low permeability of access due to the need for referral and eligibility criteria. The permeability of the WKHTS may be increased by flexible points of access including self-referral and referral from a wide range of health and care professionals. In practice, there recent set-up of community 'hubs' in which a multidisciplinary team make joint decisions, is likely to enhance permeability of the service.

Low health literacy, language barriers, cultural differences may all impact on the quality of the interaction with the GP and other professionals and therefore referrals to the WKHTS. Availability of interpreters and translated materials written in 'plain English' both within primary care and the WKHTS may help.

Professionals (GPs and other referrers) knowledge and attitudes to ageing and frailty may be important mediators for accessing the WKHTS. This includes the belief that patients are likely to benefit from the service. The perception that frailty is a natural part of ageing for which medical intervention is ineffective should be challenged. A multidisciplinary approach to decision-making and referral through the 'hubs' is likely to reduce the influence of individual beliefs and values as barriers to referral.

It may be that GPs with a special interest in gerontology and frailty and other professionals with specialist interest may be more likely to refer to specialist frailty teams including the WKHTS. Understanding the unique barriers and facilitating factors for referral is likely to increase referral rates, including for those with low socioeconomic status.

The capacity of the WKHTS to accept referrals, past experience of referring to the service by professionals, an understanding by referrers of what the service provides and the role of individuals within it (e.g specialist doctors, ACPs) are all likely to encourage referral. In addition, clear referral criteria and processes and personal relationships between the WKHTS and referrers may be important.

Conclusion

There is limited specific literature on socioeconomic factors influencing access to community frailty services. However, there is some evidence around the factors influencing access to primary and community services predominantly around access to GP services by vulnerable groups and onward referrals to specialist services. Although there is some explicit reference to socioeconomic status, most studies identify populations such as migrants, people experiencing homelessness, BAME populations, older people, those with multiple complex morbidities, people who are disabled and those with mental health conditions, as indicators of low socioeconomic status. The conceptual model of candidacy offers a useful lens through which equality of access to health services can be viewed. We can apply our understanding of the application of this model to people with frailty and frailty services, although conclusions are necessarily tentative based on lack of robust evidence. In addition to a presentation of the findings of this review, suggestions to promote equality of access to the WKHTS are offered.

BACKGROUND AND AIMS

The West Kent Home Treatment Service (WKHTS) is delivered by Kent Community Health NHS Foundation Trust (KCHFT) and provides urgent care at home. The service aims to keep patients from being admitted to an acute hospital by delivering hospital-level treatments in people's homes. The focus of the service is on people aged over 65 years with frailty, however, the service also accepts those in younger age groups. The team is made up of a variety of staff including Speciality, Associate and Staff (SAS) grade doctors, Advanced Clinical Practitioners (ACPs) and Healthcare Assistants. The service aims to see patients within two hours of a referral dependent on clinical need. Referrals into the service are via GPs or other healthcare professionals.

It has been well established that frailty is more prevalent among people with low socioeconomic status (Hoogendijk et al, 2018; Wang and Hulme, 2021). However, within the WKHTS it has been observed that fewer referrals are received from GPs in socioeconomically deprived areas compared to more affluent areas. This suggests there is a high level of unmet need amongst people with frailty in socioeconomically deprived areas in West Kent.

KCHFT have commissioned the Centre for Health Services Studies (CHSS) at the University of Kent to carry out a scoping review to explore inequalities of access to community frailty services, particularly in relation to socioeconomic status. It is the intention that this review will inform the development of interventions to help ensure the service is equitable and inclusive.

METHODOLOGY AND METHODS

AIM:

The original aim of the review was to explore the socioeconomic factors influencing access to community frailty services. However, an initial search yielded too few relevant papers. The search was then broadened to focus on older adults, rather than frailty, and all factors influencing access to primary and community services, including factors influencing GP referral processes.

Therefore, the final aim of the review was:

To determine socioeconomic (and other factors) influencing inequality of access to primary and community health services, including factors influencing GP referral processes

SEARCH STRATEGY:

The search was conducted with the support of a specialist healthcare librarian.

(i) Databases, Journals and Search Engines:

The databases: Abstracts in Social Gerontology; CINAHL; MEDLINE; SocINDEX; and Scopus were searched. The specific journals, Journal of Health Inequalities and International Journal of Health Inequality, were searched individually. Google Scholar was also searched.

(ii) Search terms for databases and journals:

1) "Access to healthcare" OR "Access to services" OR "Access to care" AND "factors" OR "causes" OR "influences" OR "reasons for"
2) "General practitioner" OR "GP" OR "Primary Care" OR "Healthcare Professional" AND "referral" OR "referral process" OR "Care pathway" AND "factors" OR "causes" OR "influences" OR "reasons for"

The search was limited to publication dates 2003-present, in English, in the UK and older people or adults.

For Google Scholar the search terms "frailty" or "older people" and "inequality" and "healthcare" were used. The first 50 'hits' were reviewed.

Additional articles were identified by handsearching the reference list of the included studies.

(iii) Identification of studies:

(See Appendix 1: PRISMA flowchart)

(iv) Summary of included studies:

Of the final 27 included articles, 3 were reports, 9 were reviews, 6 were qualitative studies, 6 were secondary analysis of quantitative data, 1 was a mixed methods study and 2 were prospective cohort studies. Publication dates ranged from 2003-2023.

FINDINGS

Equity of access to healthcare in the UK has traditionally adopted a health economic model focused on the measurement of 'utility' i.e units of healthcare, such as consultations and procedures, that people have 'consumed'. This approach is somewhat unhelpful in understanding the factors influencing access as it makes assumptions about the 'correct' level of utilisation (Dixon-Woods et al, 2006). Dixon-Woods et al (2005; 2006) carried out an analysis of vulnerable groups access to healthcare. The focus was on equity and the need to understand how access was achieved in a UK (and Canadian) healthcare system. They argued that studies of utilisation and receipt of healthcare showed evidence of distinctive patterning according to age, gender, socioeconomic status and ethnicity.

They proposed a conceptual model of 'candidacy' which includes sociological constructs involving relationships, decision-making processes and beliefs. Candidacy is defined as:

> *"The ways in which people's eligibility for medical attention and intervention is jointly negotiated between individuals and health services. Candidacy is a dynamic and contingent process, constantly being defined and redefined through interactions between individuals and professionals, and managed in the context of operating conditions, including the biography of the relationship between patients and staff, the typifications staff use in categorising people and diseases, availability of resources, local pressures and policy imperatives"* (Dixon-Woods, 2006).

The authors identify seven inter-related dimensions of candidacy (Table 1).

Table 1:

Dimensions and Characteristics of Candidacy (adapted from Dixon-Woods et al, 2006; Koehn, 2013)

Dimension	**Characteristics**
Identification	Recognition of symptoms as needing medical attention; personal perceptions of health and illness
Navigation	Knowledge and awareness of services; mobilisation of practical resources e.g transport, costs
Permeability of services	The ease with which people can use services – services those that are 'porous' require few personal resources (e.g A@E), services that are less porous require considerable personal resources e.g the need for registration (primary care), appointment systems, referrals.
Appearances at health services	Asserting a claim for medical intervention. Requires a set of 'competencies' i.e the ability to formulate and articulate the health problem. Relies on health literacy and language. Influenced by power dynamics and social distance between professionals and people and the formation of trusted relationships.
Adjudications	Professional judgement and decision-making to determine eligibility for treatment. Includes 'deservingness'.

Offers and resistance	Resistance of users to accepting referrals or treatment. Relates to Cultural beliefs about services and trust in professionals.
Operating conditions	Locally-specific influences on candidacy including policies and availability of resources and the professional knowledge of how to access them

Identification

The first step in gaining access to healthcare is in determining that you need and deserve it. Koehn (2013) applied the candidacy model in exploring the barriers to access to care for 'ethnic minority seniors' (EMS). Within this population, viewing families as 'systems' was important. The dynamics within migrant families contributed to a failure to identify candidacy for medical attention. Arora et al (2018) found that older migrants conceptions of family care was rooted in traditions that emphasis reciprocity of care between children and parents. They also found that preference for family care was present for some even when such care could not be provided or maintained. However, this idealised notion that ethnic minority communities 'take care of their own' has been challenged in a number of studies and can lead service providers to shift the burden of care to family members with deleterious consequences for both care-givers and elderly recipients. Stereotypical assumptions about older migrants preference for family care was given as an explanation for lack of initiative on the part of the GP (Koehn, 2013).

Kovandzic et al (2011) explored access to community mental health services for 'hard-to-reach' groups (defined as those from Black and Minority Ethnic (BAME) groups, those with prolonged sickness absence from work and older people). They found a perception that GPs were not worth contacting either because GPs were too busy or had more important work to do. Shipman et al (2009) identified the factors that influenced contact with the GPs in those with advanced COPD in SE London. Perceived disease severity and the perception that there was little a GP could do acted as barriers to contacting GPs. Some also did not want to 'bother the doctor inappropriately'. Interestingly, loss of self-esteem resulting from a worsening condition contributed to belief that their need for help was 'invalid'. Lack of self-esteem as a barrier to accessing healthcare by people experiencing homelessness is also cited by Perkin et al (2023).

MacDonald et al (2016) described illness identity as an important component of candidacy. They compared help-seeking and access to healthcare in patients with cancer and heart disease. They found significant differences in the dimensions of candidacy between the patient groups. Where the illness identify was not clear (in terms of symptoms, diagnosis and prognosis) and where the illness trajectory was one of deterioration (rather than cure), referrals were reduced and care was fragmented. Perceptions of self, health and illness are also influenced by gender (Annandale et al, 2007). Those with low socioeconomic status, were more likely to manage health as a series of minor and major crises, rather than through maintenance and prevention which is likely to be linked to the normalisation of ill health in more deprived communities (Dixon-Woods et al, 2005).

Navigation

Once a decision to seek medical attention has been made, people must invest effort and resources to find their way through health services. This includes having Information about the 'system' and practical resources such as transport and associated costs. Koehn (2013) found that the recency of migrants arrival influenced their ability to navigate the system. The range of overlapping and

fragmented services also limited the ability to access the system effectively. Many ethnic minority seniors in this study were unaware of the range of health services available. Health professionals in this study referred to this lack of knowledge in cultural terms i.e 'shy, humble and not in the habit of asking for things…and so don't know where to go'. Linney et al (2020) also found navigating and understanding the system was challenging within Somali communities. Arora et al (2018) found that older migrants were unfamiliar with the healthcare system of their host country including the role of the GP. These authors also found that older migrants relied on people with similar migration backgrounds for knowledge of health services.

Kovandzic et al (2011) found users resources and skills were factors influencing navigation for mental health services in 'hard-to-reach' groups. Facilitating factors were the feeling of having 'ownership' over the NHS, having adequate and timely information about available services, availability of social networks to assist in navigating care pathways and time available for engagement with services.

A number of studies have cited lack of available transport and associated costs as a significant barrier to accessing services (Koehn, 2013; Dixon-Woods 2006; Shipman et al, 2009). Sakellariou and Rotarou (2017) in a secondary data analysis of the European Health Interview Survey, explored access to healthcare for those with disabilities in England. They reported unmet need due to distance and lack of transportation and financial barriers including the cost of treatment/medication. Croker and Campbell (2009) examined satisfaction with access to healthcare of people in rural (specifically island) communities. The main barrier was lack of local specialist advice and services and long journey times, particularly for older people.

Permeability of services

Services that are described as having low permeability require referrals, have strict eligibility criteria for referral and have restricted access hours. Appointment systems, for example, threaten permeability by socioeconomically disadvantaged people because they require resources and competencies including stable addresses and the ability to present at specific places as specific times (Dixon-Woods et al, 2006).

Linney et al (2020) found that the Somali community in the UK faced numerous barriers in accessing primary care such as registering with a GP, making appointments and subsequent challenges with onward referral to services. The GP was frequently the only connection with health services, and determined whether or not the person was referred to specialist services (i.e a 'gatekeeper') (Annandale et al, 2007). They propose an ethnically sensitive model includes outreach to community agencies, and flexible with multiple 'access ports'.

Kovandzic et al (2011) identified two aspects of permeability of primary care and mental health services in 'hard-to-reach' groups which they termed configuration and receptivity of services. Configuration relates to geographical and physical accessibility, including distance of services from home and inappropriate or unpleasant architecture and design of facilities which act as barriers to access. Receptivity relates to experiencing a sense of openness and welcome from professionals.

A number of studies have specifically looked at the challenges faced by people experiencing homelessness in accessing services. Elwell-Sutton et al (2016) found that that this population were significantly less likely to be registered with a GP due to having no fixed address, difficulties keeping appointments and lack of transport. Similarly, McWilliams et al (2022) in a review of access to nurse-led services by people experiencing homelessness found that rigid appointment times, lack of a fixed address and competing priorities i.e the relative importance of seeking food and shelter set against health needs, were barriers to accessing healthcare.

Perkin et al (2023) explored access to healthcare for the homeless population in Gateshead. They identified a number of facilitating factors including strategies to support registration with primary care such as the ability to register through a third sector organisation 'care of' address; staff training to develop greater awareness of homelessness; better integration of services; the use of the voluntary sector to facilitate access to services; access to specialist roles such as mental health practitioners and drug and alcohol services, and bespoke services aligned to need.

A review by Boyle et al (2010) on behalf of the Kings Fund examined access to primary care in England. Dimensions of access to GPs included physical access such as the availability of GPs (e.g number of GPs per head of population and registrations), proximity, design of premises and availability of telephone, electronic access and home visits. In terms of design of premises the authors found that for at least 10% of patients even basic access to premises was denied. 11% said they were unable to contact their GP practice by email and only 9% said they could access their medical records by computer. Fu et al (2022) examined migrants access to healthcare in the early stages of the COVID-19 pandemic. They found a reduction in the use of services by older people, migrants and those with poorer health which was believed to be due to a digital divide exacerbating existing health inequalities. They concluded that those in the greatest need of healthcare were also those least able to access remote services at this time.

Other dimensions of permeability according to Boyle et al (2010), were timeliness of access such as availability and ease of booking appointments, out-of-hours care, waiting times, ease of getting prescriptions and choice of which practice to register with and which professionals could be accessed.

Appearance at health services

Once contact is made with health services a set of 'competencies' are then required i.e the ability to formulate and articulate the health problem. Such competencies are reliant on health literacy, language and cultural alignment. The consultation is also influenced by power dynamics and social distance between professionals and those seeking healthcare and reliant on the formation of trusted relationships.

Presenting to health service providers requires the ability to formulate and articulate the issue for which help is being sought and the ability to present credibly. Those with low socioeconomic status were less able to provide coherent, abstracted explanations of need and felt intimidated by the social distance to health professionals and alienated by the power relationships that characterised conversations with professionals. Those with higher socioeconomic status are likely to be more able to voice their demand for services, be more articulate and confident (Dixon-Woods et al, 2006). Kovandzic et al (2011) found that some patients from 'hard-to-reach' groups struggled to articulate their health problem so that it matched the professionals clinical criteria. Patients social status and their ability to articulate verbally influences the likelihood of referral (Dixon-Woods et al, 2006).

Linney et al (2020) found language barriers and difficulties articulating distress to a GP, barriers to using primary care services in a Somali population in the UK. The availability of an interpreter at the GP practice was helpful. Similarly, Arora et al (2018) found that older migrants either did not speak the language of the host country or were not fluent enough. The availability of interpreters was helpful although family members were preferred due to fears of breaches of confidentiality if the interpreter was from their own neighbourhood. Jayaweera (2018) reported that general practice reception staff did not make an effort to understand different accents of Eastern European migrant women. Language barriers and low levels of health literacy in some communities also contributed to

limited access to services in ethnic minority seniors (Koehn, 2013). Translation of written information may not be panacea imagined as many ethnic minority seniors, particularly women, were not literate in their own language.

McWilliams et al (2022) found that stigmatising and prejudiced attitudes amongst professionals to those experiencing homelessness was a barrier to accessing health services. Distrust of professionals discouraged help seeking behaviour. Shipman et al (2009) found that the decision to seek healthcare was influenced by the quality of the relationship with the professional and continuity of care. Fear of detention by immigration services was also a factor related to lack of access to services in migrant populations (Fu et al, 2022). Linney et al (2020) found mistrust of authority figures and fear and anxiety over potential economic repercussions including immigration status and access to housing were barriers to accessing health services within Somali communities.

Adjudication

This relates to professional judgements and decisions made about candidacy that influences onward referrals and access to services and interventions. This firstly involves service users 'presenting well' in order to demonstrate authenticity and legitimacy of a claim to services (see appearance at health services). The 'adjudications' that health professionals make about their patients and the way in which they were categorised influenced the decision to refer to specialist services (Dixon-Woods, 2006). Dixon-Woods et al (2005) argue that healthcare organisations rely on the 'ideal user' who matches the precise set of competencies and resources to the way in which services are intended to be used according to the providers.

A number of studies explored the factors influencing GP referral rates to specialist services. Lueckmann et al (2021) carried out a systematic review of socioeconomic inequalities in access to primary care and specialist health services. Specialist services were more likely to be accessed by those in the highest socioeconomic groups compared to those in the lowest socioeconomic groups. The authors acknowledge that they were not able to infer whether these inequalities were based on need, specific barriers to access, or patient choice. One possible reason for access barriers to specialist care may be related to rurality of low socioeconomic groups. Other hypotheses are that the relationship with primary care physicians is more trusted and familiar than with specialists, or those with low socioeconomic status experience greater communication problems and lower health literacy and so may be reluctant to be referred. Gurol-Urganci et al (2020) examined the determinants of referral of women to specialist (continence) services. They found that older women and those from BAME groups were less likely to be referred from primary care to specialist. Again, it is unclear to what extent this variation reflects differences in clinical need, patient choice or inequities in referral patterns.

Walton et al (2018) examined the influence of socioeconomic deprivation on decisions of GPs to refer patients to specialists (cardiology) by comparing the perceptions of GPs working in affluent and deprived areas. GPs in deprived areas perceived that the identification of problems needing referral was more difficult in patients with lower health literacy (deprived areas) which was compounded with patients whose first language was not English. GPs in affluent areas described the identification of the presenting complaint as more straightforward. GPs also normalised symptoms where patients did not push for action (those in deprived areas). They describe decision-making in areas of high deprivation as Doctor-led compared to those in affluent areas where decision-making was patient-led. This study also uniquely comments on the referral of frail, older people where lack of referral was most evident in deprived areas. 'Patient pressure' was identified as a factor in the decision to refer by GPs by Foot et al (2010).

O'Donnell (2000) aimed to describe the factors influencing variation in referral rates and GPs decision-making processes. They found that patient characteristics (age, gender and socioeconomic status) explained 40% of the variance in referral rates. Practices with high levels of economic deprivation had high total referral rates. Practice and GP-related characteristics explained 10% of the variance. Single-handed GPs had higher referral rates. There was no difference in referral rates in relation to the age or years of experience of GPs. Interestingly, GPs with specific training or interest in a particular specialism had higher referral rates to that specialism as they were 'more confident'. In terms of decision-making, it was proposed that individual GPs may have a 'referral threshold' which combines all the factors influencing referral decisions including confidence in their clinical judgment, knowledge and the desire to sustain the esteem of Consultant colleagues. These authors conclude that there is no clear evidence that local guidelines and policies are effective in modifying referral behaviour.

Ageist attitudes held by providers manifest as judgements about the ability of the older person to benefit from services, thereby justifying the 'investment' of services. Professionals perceptions about which patients are likely to 'do well' as a result of an intervention may disadvantage those from low socioeconomic backgrounds (Koehn, 2013). Older migrants reported prejudice and discrimination when seeking help and reported professional indifference as concerns were dismissed as a normal part of ageing (Arora et al, 2018).

People in disadvantaged groups are more likely to smoke, be overweight and have co-morbidities and assumptions of health gain may act as a barrier to referral and intervention (Dixon-Woods et al, 2006). Annandale et al (2007) described social or moral adjudication based on an assessment of the likely social benefits of an intervention or service or the moral worth of individual candidates.

Offers and resistance

This relates to the uptake of offers for referral, intervention and treatment. Referral implies that a GP has identified the features of candidacy and is seeking to match those to an appropriate service but patients can resist being referred (Dixon-Woods et al, 2006). Walton et al (2018) described GPs in areas where there was a high level of deprivation needing to 'persuade' reluctant and fearful patient of the benefits of referral. This was due, in part, to patients in deprived areas having different priorities i.e to provide basic necessities of housing and food.

Operating conditions

Local conditions influence the production of candidacy and include the availability and suitability of services (actual and perceived) and local policies. Particularly pertinent is the knowledge and understanding of referral criteria and past experience of the service. Lack of capacity, variations in quality, differences in resource allocations and features of service configuration all create 'access-disadvantaged' groups (Dixon-Woods, 2005).

Jayaweera (2018) reported on a survey of commissioners of health services who felt that there was a lack of knowledge of the needs of migrant women and lack of capacity of staff and availability of funding to address specific needs. This author asserts that ever-increasing hostile policies towards migrant entitlement to healthcare leads to discrimination and inequality of access to services.

Siersbaek et al (2021) carried out a realist review of the contexts and mechanisms that promote access to healthcare for those experiencing homelessness. They found that services that were organised around the individual, had a high degree of flexibility and a culture that rejected stigma, improved access to healthcare.

The following 3 studies, identify policies and strategies to improve referral and access to services. Khanassov et al (2016) carried out a review of organisational interventions in improving access to primary healthcare for vulnerable populations (defined as low socioeconomic and/or immigrant status and those with chronic conditions). Integration of specialists into primary care (e.g mental health teams) and a single point of access facilitated access to care as did the presence of 'brokers' or community workers proactively identifying eligible patients, often through engagement with community groups. Foot et al (2010) on behalf of the King's fund examined the quality of GP diagnosis and referrals and cite a number of approaches that can be effective in improving the quality of referrals including educational and organisational interventions, guidelines, financial incentives and the use of measures and metrics. Peer review by other GPs and feedback from Consultants was particularly effective. Good clinical relationships, information exchange and learning opportunities underpinned high quality referrals. A strong clinical governance framework involving clinical audit and peer review was highlighted as an effective enabler. Shared expectations between the GP and specialist was also important. This study also uniquely examines referrals to community services. They found a lack of clarity among some GPs around the role of other professionals and services such as community nurses and physiotherapists. This was particularly problematic when job titles and roles frequently changed. Foot et al (2010) found that a lack of a clear referral criteria contributed to high levels of inappropriate referrals.

Garrett et al (2020) is one of the few studies that focused on reducing inequalities for people living with (premature) frailty. Following a review they identified key themes and recommendations for commissioners, service providers and health, care and support staff. In order to identify people with premature frailty they advocate a broader, shared understanding of frailty recognising that frailty may occur in younger people. They further recommend reaching out to under-represented groups which goes beyond an 'open door' policy of access to services. They have produced a specific set of recommendations aimed at improving access to health and care services, namely: involving patients from diverse communities in the development of services; treating all patients with respect and ensuring their right to access services e.g never wrongfully refusing registration in primary care; ensuring that disadvantaged patients are offered accessible information e.g by identifying communication preferences, providing access to interpreters; offering advice to patients who may have practical difficulties getting to appointments e.g signposting to advice on travel and meeting healthcare costs.

DISCUSSION AND IMPLICATIONS FOR THE WEST KENT HOME TREATMENT SERVICE

There is a greater prevalence of frailty in people with low socioeconomic status. However, within the WKHTS it has been observed that fewer referrals are received from GPs and other health and care professionals in socioeconomically deprived areas compared to more affluent areas. This suggests there is a high level of unmet need amongst people with frailty in socioeconomically deprived areas in West Kent. The reasons for this are likely to be complex involving patient-related, professional-related and organisation/system-related factors.

There is limited literature on the influence of socioeconomic factors on access to home treatment services, virtual wards or community services more generally. Commonly, groups with typically low socioeconomic status include (but are not limited to) migrants, people experiencing homelessness, BAME groups, older people, those with complex co-morbidities, people with disabilities and those with mental health conditions. Therefore, in this review these groups were used as a 'proxy' for low socioeconomic status in the absence of other literature.

The concept of candidacy is a useful theoretical framework to explore inequalities of access to the WKHTS, particularly in relation to socioeconomic status. In accessing the WKHTS, the pathway for patients with frailty (and/or their families) begins with them first recognising frailty as a condition that requires medical attention (or they have been pro-actively identified by the GP or other healthcare professional as being frail) *(identification);* they then need to navigate the healthcare system by knowing that they can seek help from their GP or other health professionals and mobilise personal resources such as transport *(navigation);* once this is achieved they need to access primary care or other services *(permeability);* they then need to articulate their need for help from the GP or other health professional *(appearance at services);* the professional then needs to recognise that the patient could benefit from the WKHTS and make a referral *(adjudication);* the patient (and/or carer) need to accept the referral *(offers and resistance);* and finally, the referral to the service requires the availability of the service and the professionals knowledge of how to access it *(operating conditions).*

For each dimension of candidacy, the following factors may help explain inequality of access to the WKHTS:

Identification - Frailty may be normalised by patients and carers and seen as a natural process of ageing for which medical intervention is not useful. Also the perceptions that the GP or other professional is 'too busy' or 'not wanting to be a bother' may influence help seeking. There is some evidence to suggest that such beliefs may be more prevalent in those from low socioeconomic groups. Other factors impacting on identification are low self-esteem which may be more prevalent in those with low socioeconomic status and those with complex co-morbidities which may include frailty. Patients from migrant populations may be more reliant on family and community support and so do not identify the need to seek medical attention. However, this is an assumption which may not always be accurate and so should be challenged.

Navigation – there is good evidence that those with low socioeconomic status, particularly migrant populations do not have enough knowledge about the health and care 'system' to access it. Even once navigated, lack of available transport and associated costs disproportionately affects those with low socioeconomic status. Knowledge about available services are often shared through communities and social networks. Targeted engagement with such groups may offer opportunities to make services more visible and aid navigation.

Permeability – GP services have low permeability requiring registration which can be difficult for migrant and homeless people with no fixed address. They have limited opening hours and appointment systems and waiting times are barriers to access. Physical access may be problematic for those with frailty, older people and those with disabilities. Lack of digital skills and equipment including the availability of internet access in rural areas, also disproportionately affects those who are older, frail and those with low socioeconomic status. The WKHTS also has low permeability due to the need for a referral and eligibility criteria. The permeability of the WKHTS may be increased by flexible points of access including self-referral and referral from a wide range of health and potentially social care professionals such as paramedics and community nurses, social workers and allied health professionals including therapists. In practice, there recent set-up of community 'hubs' in which a multidisciplinary team make joint decisions, is likely to enhance permeability of the service.

The WKHTS could review its eligibility criteria so that it is clear to all referrers and does not indirectly discriminate against those with low socioeconomic status through for example, strict clinical criteria requiring a high degree of health literacy. Although more appropriate for the pro-active 'cold' frailty services, using community groups and voluntary organisations as a source of referral may widen participation. Those accessing this service may have need to access the acute WKHTS service in the future and so may positively influence referrals in the medium to long-term.

Appearance at services – low health literacy, language barriers, cultural differences all impact on the quality of the interaction with the GP or other professional and therefore referrals to the WKHTS. Positive relationships are a facilitator and social distance between professionals and those with low socioeconomic status are a barrier. Availability of interpreters and translated materials written in 'plain English' both within primary care and the WKHTS may help.

Adjudication – Professionals (GPs and other referrers) knowledge and attitudes to ageing and frailty are important mediators for accessing the WKHTS. This includes the belief that patients are likely to benefit from the service in terms of hospital admission avoidance, improved satisfaction with care and improved clinical outcomes, for example. The perception that frailty is a natural part of ageing for which medical intervention is ineffective should be challenged. There is some evidence to suggest that 'premature' frailty (<65 years) is linked to lifestyle factors which in turn is linked to low socioeconomic status. Perceptions that such individuals are 'less deserving' should equally be challenged.

It may be that GPs with a special interest in gerontology and frailty and other professionals with specialist interest may be more likely to refer to specialist frailty teams including the WKHTS. There is some evidence that referrals made for those with low socioeconomic status is professional led, while for those with high socioeconomic status, referral is patient-led. A multidisciplinary approach to decision-making and referral through the 'hubs' is likely to reduce the influence of individual beliefs and values as barriers to referral. Identifying professionals with high referral rates and engaging them as 'champions' of the service may be a useful strategy for engaging with professionals with low referral patterns. Taking time to develop relationships with referrers and understanding the unique barriers and facilitating factors for referral is likely to increase referral rates, including those with low socioeconomic status. Peer review of referrals and positive feedback from the WKHTS may encourage further referrals.

Offers and resistance – There is limited evidence in the literature that can be applied to the WKHTS. In fact, once offered, patients (and family carers) are likely to be motivated to receive care from the WKHTS as an alternative to hospital admission (MacInnes et al, 2022).

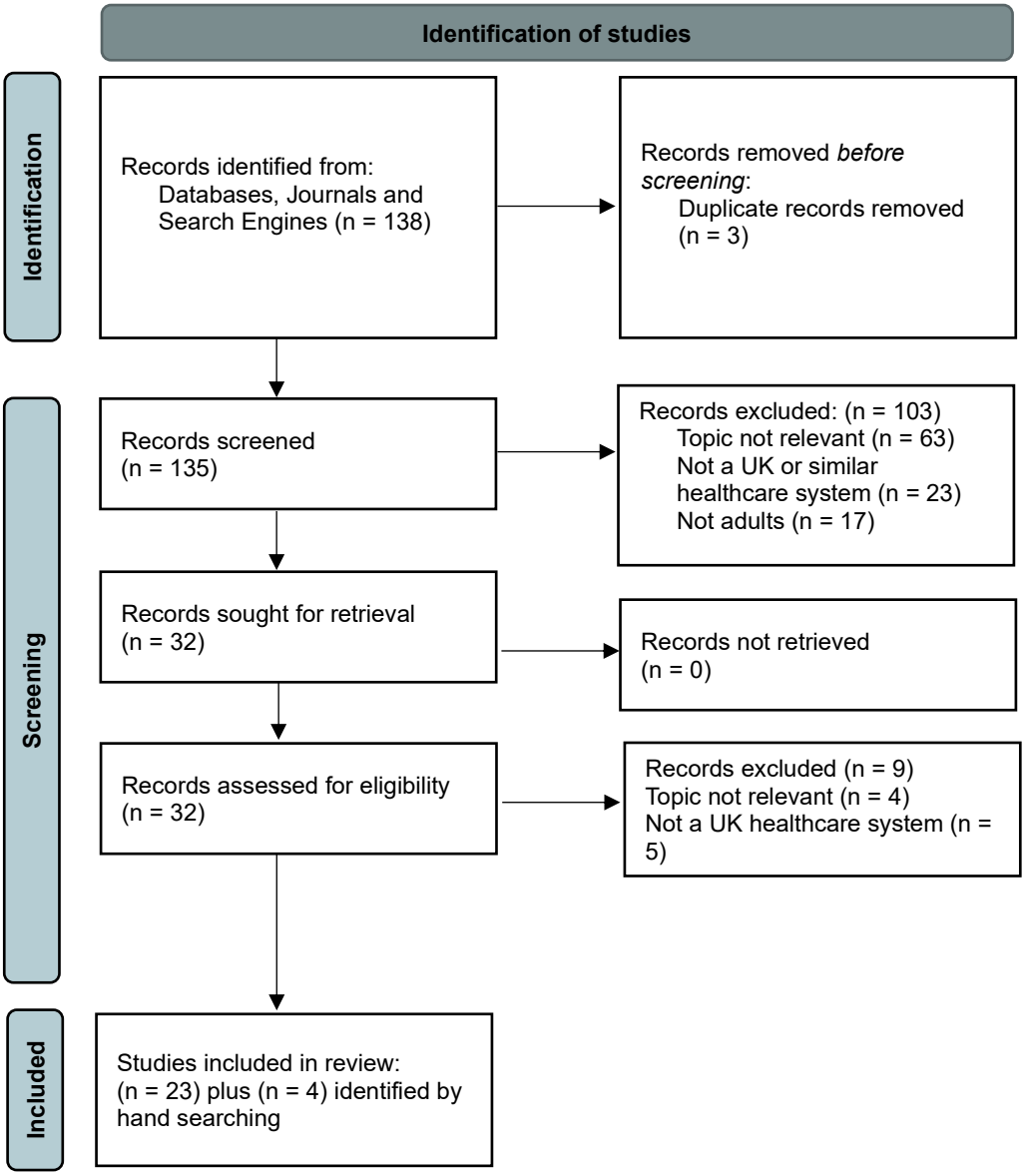
Operating conditions – The capacity of the WKHTS to accept referrals, past experience of referring to the service by professionals, an understanding by referrers of what the service provides and the role of individuals within it (e.g SAS Doctors, ACPs) and mechanisms for feedback are all likely to encourage referral. In addition, clear referral criteria and processes and personal relationships between the WKHTS and referrers are important.

CONCLUSIONS

There is limited specific literature on socioeconomic factors influencing access to community frailty services. However, there is some evidence around the factors influencing access to primary and community services, predominantly around access to GP services by vulnerable groups and onward referral to specialist services. Although there is some explicit reference to socioeconomic status, most studies identify populations such as migrants, people experiencing homelessness, BAME populations, older people, those with multiple complex morbidities, people who are disabled and those with mental health conditions, as indicators of low socioeconomic status. The conceptual model of candidacy offers a useful lens through which equality of access to health services can be viewed. We can apply our understanding of the application of this model to people with frailty and frailty services, although conclusions are necessarily tentative based on lack of robust evidence. In addition to a presentation of the findings of this review, suggestions to promote equality of access to the WKHTS are offered.

APPENDICES

Appendix 1: Adapted PRISMA flowchart



Appendix 2:

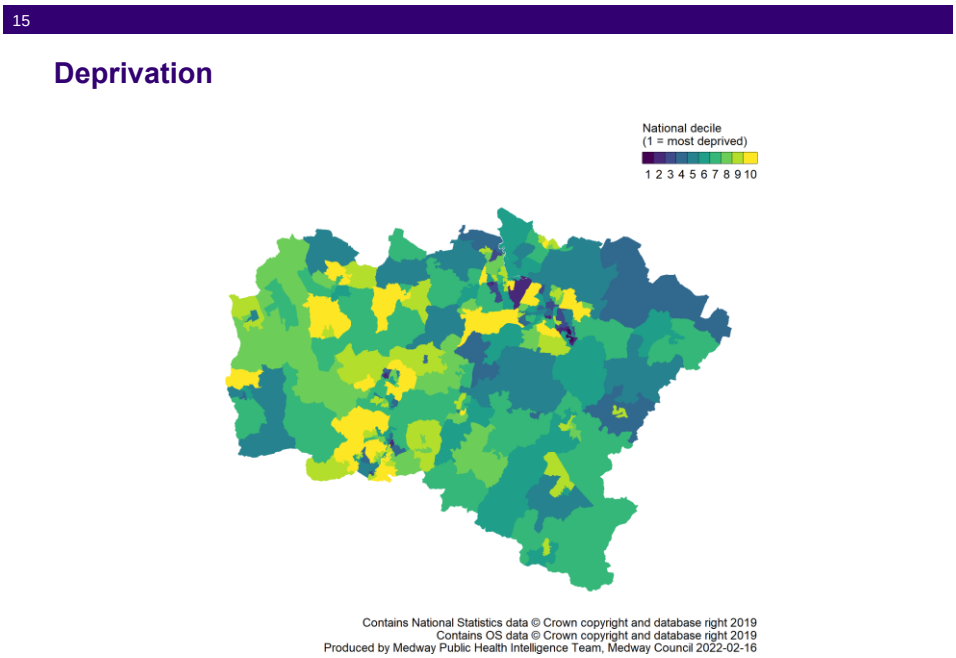
Public Health Data Summary

There are 9 PCNs in West Kent: ABC, Athena, Maidstone Central, Malling, Sevenoaks, The Ridge, Tonbridge, Tunbridge Wells, Weald.

Levels of deprivation

The Index of Multiple Deprivation (IMD2019) is the official measure of relative deprivation in England. Across Kent and Medway, there are 901 Lower Super Output Areas (LSOAs). Sevenoaks, Tonbridge & Malling and Tunbridge Wells have no LSOAs within the 10% most deprived deciles of the IMD2019. Tunbridge Wells ranks as the least deprived local authority in Kent. Tonbridge & Malling has experienced the largest increase in deprivation relative to other areas since IMD2015[1]

Figure 1: Deprivation in West Kent[2]



However, within this overall picture there are differences in deprivation between PCNs (figures 3-9) show levels of deprivation within each PCN[3] and the location of each primary care practice.

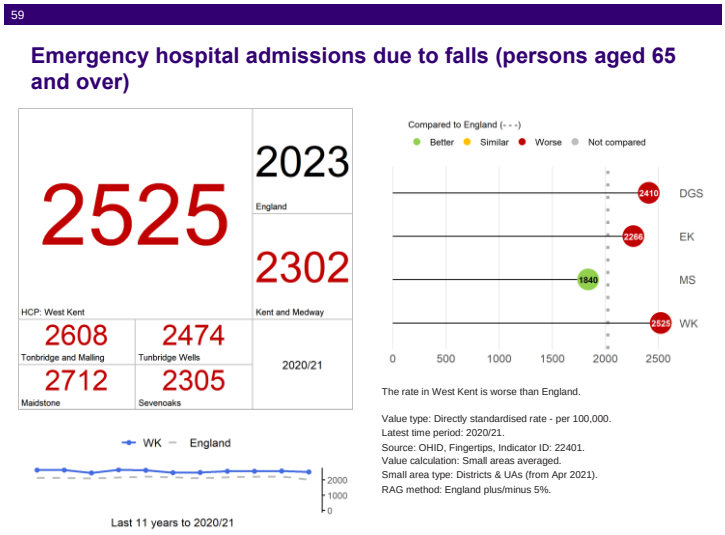
[1] Strategic Commissioning Statistical Bulletin, KCC, 2020
[2] West Kent Health and Care Partnership Profile. Medway Council Public Health Intelligence Team and Kent Public Health Observatory, 2024
[3] Public Health PCN profiles, life course indicators, 2023

Ageing, frailty and health and care needs

Across the previous CCG footprint in West Kent, 26 primary care practices had a significantly higher proportion of their registered population aged 65 and over than the CCG average[4]. Furthermore, the number of patients progressing to high or very high frailty in West Kent is predicted to rise from approximately 2,000 to 2,500 between 2024-2030[5]

In terms of health and social care needs, although the overall number of emergency hospital admissions in West Kent is lower than the Kent average[6] the number of emergency hospital admissions due to falls is significantly worse in West Kent than either Kent as a whole or England averages.

Figure 2: Emergency hospital admissions due to falls (persons aged 65 and over)[7]

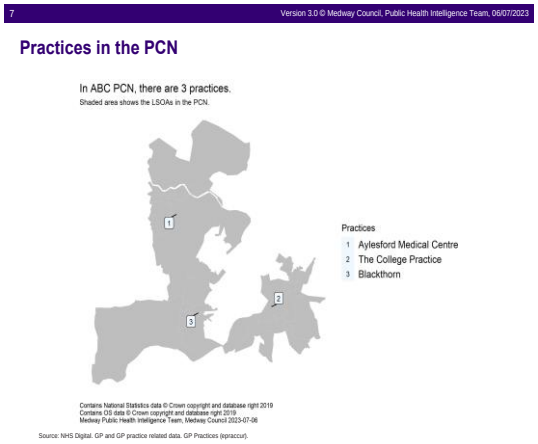


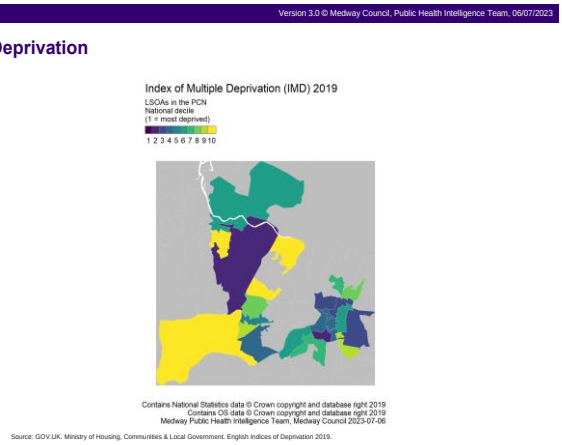
[4] Living Well: Overview. Living well in Kent (CCGs), Kent Public Health Observatory (undated)
[5] Population Health Needs, Inequalities and Commissioning Opportunities in West Kent CCG. Kent Public Health Observatory, 2018
[6] Living Well: Overview. Living well in Kent (CCGs), Kent Public Health Observatory (undated)
[7] West Kent Health and Care Partnership Profile. Medway Council Public Health Intelligence Team and Kent Public Health Observatory, 2024

West Kent PCNs: Primary Care Practices and IMD2019

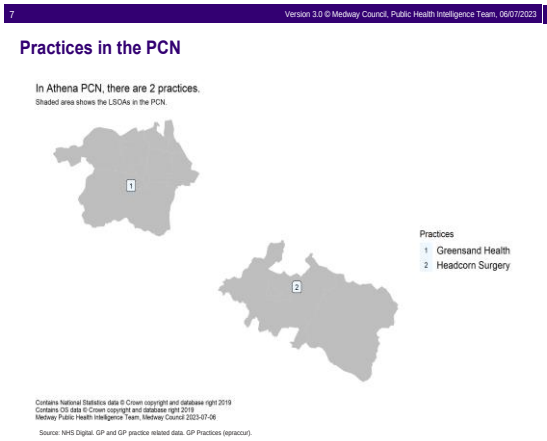
Figures 3-12

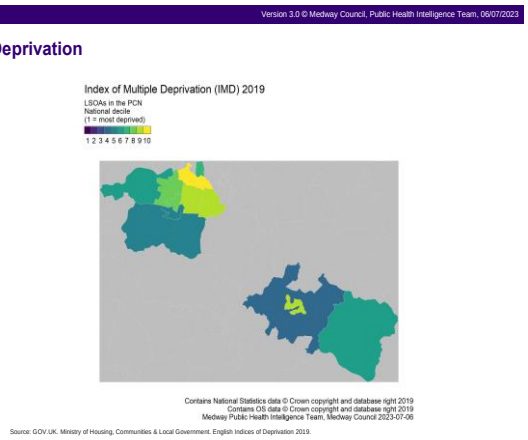
PCN: ABC



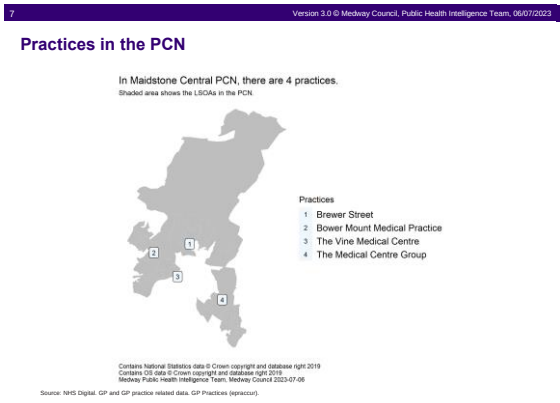


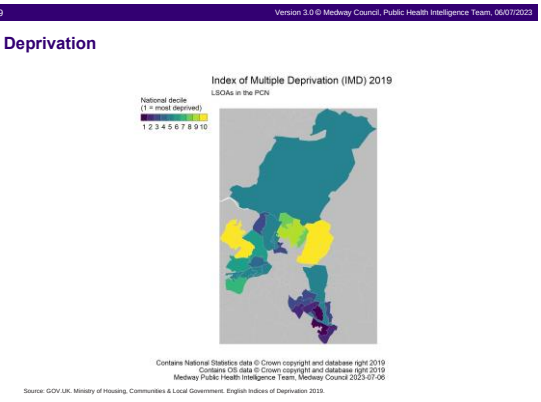
PCN: Athena





PCN: Maidstone Central





PCN: Malling

Practices in the PCN

In Malling PCN, there are 5 practices.

Shaded area shows the LSOAs in the PCN.

Practices

1. Phoenix Medical Practice
2. Snodland Medical Practice
3. Thornhills Medical Practice
4. West Malling Group Practice
5. Wateringbury

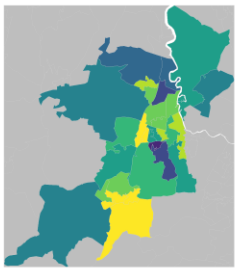
Source: NHS Digital. GP and GP practice related data. GP Practices (epraccur).

Deprivation

Index of Multiple Deprivation (IMD) 2019

LSOAs in the PCN

National decile
(1 = most deprived)
1 2 3 4 5 6 7 8 9 10



Source: GOV.UK. Ministry of Housing, Communities & Local Government. English Indices of Deprivation 2019.

PCN: Sevenoaks

Practices in the PCN

In Sevenoaks PCN, there are 8 practices.

Shaded area shows the LSOAs in the PCN.

Practices

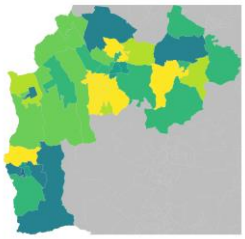
1. Otford Medical Practice
2. Borough Green Medical Practice
3. St John's Medical Practice
4. Amherst Medical Practice
5. Town Medical Centre
6. South Park Medical Practice
7. Westerham Practice
8. Edenbridge Med Practice

Source: NHS Digital. GP and GP practice related data. GP Practices (epraccur).

Deprivation

Index of Multiple Deprivation (IMD) 2019

LSOAs in the PCN
National decile
(1 = most deprived)
1 2 3 4 5 6 7 8 9 10



Source: GOV.UK. Ministry of Housing, Communities & Local Government. English Indices of Deprivation 2019.

PCN: The Ridge

Practices in the PCN

In The Ridge PCN, there are 4 practices.

Shaded area shows the LSOAs in the PCN.

Practices

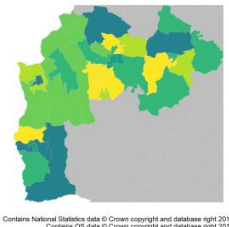
1. Bearsted
2. Len Valley Practice
3. Langley
4. Sutton Valence Group Practice

Source: NHS Digital. GP and GP practice related data. GP Practices (epraccur).

Deprivation

Index of Multiple Deprivation (IMD) 2019

LSOAs in the PCN
National decile
(1 = most deprived)
1 2 3 4 5 6 7 8 9 10



Source: GOV.UK. Ministry of Housing, Communities & Local Government. English Indices of Deprivation 2019.

PCN: Tonbridge

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Practices in the PCN

In Tonbridge PCN, there are 5 practices.

Shaded area shows the LSOAs in the PCN.

Practices

1. Hadlow Medical Centre
2. Hildenborough Medical Group
3. Warders Medical Centre
4. Tonbridge Medical Group
5. Woodlands Health Centre

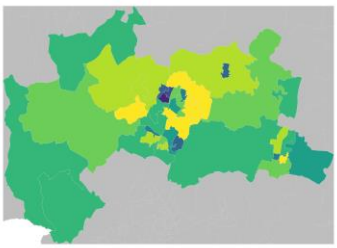
Source: NHS Digital. GP and GP practice related data. GP Practices (epraccur).

Deprivation

Index of Multiple Deprivation (IMD) 2019

LSOAs in the PCN
National decile
(1 = most deprived)

1 2 3 4 5 6 7 8 9 10



Source: GOV.UK. Ministry of Housing, Communities & Local Government. English Indices of Deprivation 2019.

PCN: Tunbridge Wells

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Practices in the PCN

In Tunbridge Wells PCN, there are 8 practices.

Shaded area shows the LSOAs in the PCN.

Practices

1. St Andrews Medical Centre
2. Waterfield House Surgery
3. Speldhurst & Greggswood Medical Group
4. The Wells Medical Practice
5. Grosvenor & St James Medical Centre
6. Rusthall Medical Practice
7. Kingswood Surgery
8. Lonsdale Medical Centre

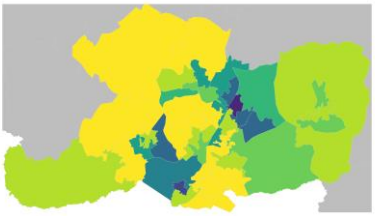
Source: NHS Digital. GP and GP practice related data. GP Practices (epraccur).

Deprivation

Index of Multiple Deprivation (IMD) 2019

LSOAs in the PCN
National decile
(1 = most deprived)

1 2 3 4 5 6 7 8 9 10



Source: GOV.UK. Ministry of Housing, Communities & Local Government. English Indices of Deprivation 2019.

PCN: Weald

Version 3.0 © Medway Council, Public Health Intelligence Team, 06/07/2023

Practices in the PCN

In Weald PCN, there are 10 practices.

Shaded area shows the LSOAs in the PCN.

Practices

1. Yalding
2. Marden Medical Centre
3. Malling Health Four
4. Howell Surgery
5. Old Parsonage Surgery
6. Old School Surgery
7. The Crane
8. Orchard End
9. Lamberhurst
10. Weald View Medical Practice

Source: NHS Digital. GP and GP practice related data. GP Practices (epraccur).

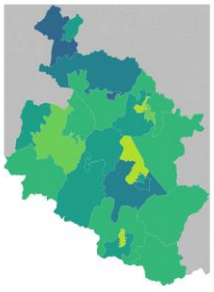
Deprivation

Index of Multiple Deprivation (IMD) 2019

LSOAs in the PCN

National decile
(1 = most deprived)

1 2 3 4 5 6 7 8 9 10



Source: GOV.UK. Ministry of Housing, Communities & Local Government. English Indices of Deprivation 2019.

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