KING'S College LONDON

Mapping of specialist primary health care services in England for people who are homeless

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February 2018

SOCIAL CARE WORKFORCE RESEARCH UNIT

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- To contribute to theory development, by exploring the causes of homelessness, and transitions into, through and out of homelessness.
- To understand better the problems and needs of people who are or have been homeless, and the effectiveness of services for disadvantaged and socially excluded groups.
- To influence policy and practice development regarding the prevention and alleviation of homelessness, and the improvement of services for people who are or have been homeless.

Crane, M., Cetrano, G., Joly, L., Coward, S., Daly, B., Ford, C., Gage, H., Manthorpe, J., and Williams, P. 2018. *Mapping of Specialist Primary Health Care Services in England for People who are Homeless.* London: Social Care Workforce Research Unit, King's College London.

Front-cover images from Shutterstock.

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Foreword

My first experience of health care for people experiencing homelessness was in 1990 when I began a GP outreach clinic at a local hostel and drop in centre in Leicester. Like many such services it came about as a result of local lobbying and was sustained by a passion for social justice. I worked in clinical isolation, although supported by my patients and colleagues in the voluntary sector. My patients told me about similar services in other towns and I visited as many as I could contact, to learn from them. As the waves of change rolled through the NHS we weathered austerity and seized each initiative as an opportunity, setting up a Personal Medical Services pilot in 1999, becoming a specialist primary care drug misuse prescriber in 2002 and establishing a Social Enterprise Community Interest Company in 2010.

We learned from our patients, surviving on the margins of the system and learning to embrace change and chaos in order to survive. We gathered evidence and shared it with the Social Inclusion Unit, Inclusion Health Board and other government bodies as they came and went. More recently we have come together through the network of the Faculty for Homeless and Inclusion Health supported by Pathway Charity. Our research collaboratives have recently confirmed that homeless people experience the extremes of morbidity and mortality with standardised mortality ratios of around 10 times that of the general population.[1] There is a growing understanding that health care for homeless people requires targeted investment in order to address the challenging combination of physical and mental ill health, complicated by addictions and rooted in childhood psychological trauma, that characterise people experiencing long term homelessness. This targeting of resources is championed by Professor Sir Michael Marmot with the concept of proportionate universalism,[2] required by the health inequality duties enshrined in the Health and Social Care Act 2012 and justified by high numbers of ambulance call outs, emergency department attendances and emergency admissions in this patient group.[3]

But as yet there is no clear consensus about which models of primary and community health care provision are best in which circumstances. This NIHR funded research has a real prospect of contributing to our evidence base, starting with this mapping exercise, which clearly describes the varying approaches to tackling (or in some cases apparently ignoring) the health care needs of homeless people around the country. It provides a base point to describe and map approaches to service delivery, measure change over time, and establishes an extremely important first step towards the next stage of identifying the key approaches to delivery of effective services in England.

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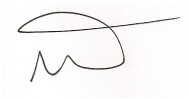
1 Aldridge RW, et al. Morbidity and mortality in homeless individuals, prisoners, sex workers, and individuals with substance use disorders in high-income countries: a systematic review and meta-analysis. *The Lancet.* Published Online November 11, 2017. http://dx.doi.org/10.1016/S0140-6736(17)31869-X.

2 Marmot M, Allen M, Allen J, Hogarth S. Working for Health Equity: The Role of Health Professionals. UCL Institute of Health Equity. London, March 2013. http://www.instituteofhealthequity.org/resources-reports/working-for-health-equity-the-role-of-health-professionals.

3 Hewett N. What works to improve the health of the multiply excluded?' in Bonner A (ed) *Social determinants of health. An interdisciplinary approach to Social Inequality and Wellbeing*. Chapter 20 Policy Press, Bristol, 2017.

This research will build on previous work. High quality health care for people experiencing homelessness is described in the Faculty Standards document[4] and the latest evidence of what works in Inclusion Health is summarised by an international evidence synthesis, written by Faculty members and published in the Lancet.[5] The evidence supports multi-disciplinary, multi-agency and multi-component care coordination and delivery. Involvement of experts by experience, and outreach (for example into hostels) provide the most effective health care for people experiencing homelessness. This research can help us understand how best to deliver such care, through the primary and community health care systems in England.



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Secretary to the Faculty for Homeless and Inclusion Health

4 The Faculty for Homeless and Inclusion Health, Standards for commissioners and service providers, 2013. http://www.pathway.org.uk/wp-content/uploads/2014/01/Standards-for-commissioners-providers-v2.0-INTERACTIVE.pdf

5 Luchenski et al. What works in inclusion health: overview of effective interventions for marginalised and excluded populations. *The Lancet*. Published Online November 11, 2017. http://dx.doi.org/10.1016/S0140-6736(17)31959-1.

Acknowledgements and disclaimer

We send many thanks to the primary health care services across England that provided information about their service, and to those who completed a template and agreed for this to be included in the inventory.

We are also extremely grateful to the many homelessness organisations that participated in the survey about their services and experiences of accessing primary health care for their clients. This included senior managers who encouraged their staff to participate and coordinated responses within their organisation, and hostel and day centre staff that completed the questionnaires.

Special thanks are sent to Homeless Link which provided databases of accommodation and day centres services in England for single people who are homeless. These were very useful as a starting point for the survey of homelessness services. Thanks are also sent to Gordon Chaston, Xanthe Noble and Victoria O'Dwyer who have advised and assisted with the study. We also appreciate the help given by Ruby Fernandez-Fu with the mapping exercise.

The research team appreciate the guidance and advice provided by members of the Study Steering Committee: Jennifer Beecham, PSSRU, University of Kent; Caroline Bernard, Homeless Link; Andrew Casey, St Mungo's; Liddy Goyder, ScHARR, University of Sheffield; Mohammed Ismail, Analytical Research Ltd; Gill Leng, Homelessness and Health Consultant, and formerly National Advisor to Public Health England; Jeremy Porteus, Housing, Learning and Improvement Network; Rebecca Rosen, Nuffield Trust; Sara Shaw, Nuffield Department of Primary Health Care Services, University of Oxford.

Special thanks are sent to Nigel Hewett, Medical Director, Pathway, and Secretary to the Faculty for Homeless and Inclusion Health, for reviewing the report and providing a response to the study findings at the launch of the report in February 2018. We also greatly appreciate the input of the following at the launch event: Jane Cook, Clinical Nurse Lead, London Homeless Health Programme; Rick Henderson, Chief Executive, Homeless Link; and Gill Leng (see above).

We also appreciate the help and support given by Sarah Rawlings, George Murkin and Archie Drake of the Policy Institute at King's College London, with the production of this report and the dissemination of findings.

The study is funded by the NIHR Health Services and Delivery Research Programme (Reference 13/156/03 – Delivering primary health care to homeless people: an evaluation of the integration, effectiveness and costs of different models). The study has received support from NIHR Clinical Research Network Teams.

Disclaimer

The views expressed in this report are those of the authors and not necessarily those of the NHS, the NIHR or the Department of Health and Social Care.

Abbreviations and definitions

Abbreviations

APMS	Alternative Provider Medical Services
CCG	Clinical Commissioning Group
CQC	Care Quality Commission
DCLG	Department for Communities and Local Government (now Ministry of Housing, Communities and Local Government)
DH	Department of Health (now Department of Health and Social Care)
DWP	Department for Work and Pensions
GMS	General Medical Services
JSNA	Joint Strategic Needs Assessment
LAD	Local Authority District
NHS	National Health Service
PHE	Public Health England
PMS	Personal Medical Services
QNI	The Queen's Nursing Institute
STPs	Sustainability and Transformation Plans / Partnerships

Definitions

For the purpose of this report, the following definitions have been applied:

Day centres
The term 'day centres' refers collectively to day centres, drop-in centres and soup kitchens that meet the inclusion criteria (Table 2.1).

Hostels
The term 'hostels' refers collectively to temporary accommodation projects, including hostels, night shelters, and supported housing projects with congregate living arrangements, that meet the inclusion criteria (Table 2.1).

Specialist primary health care services
Specialist primary health care services refers to those that: (i) work primarily with single people who are homeless; or (ii) serve the general population but provide enhanced or targeted services to single people who are homeless.

1 | Introduction and background

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This report presents the findings of a systematic mapping exercise across England of specialist primary health care services for single people who are homeless (hereafter specialist primary health care services). The mapping exercise was part of a larger study that is in progress which is examining the integration, effectiveness and cost-effectiveness of different models of delivering primary health care to people who are homeless (HEARTH study).[1] The study is funded by the Health Services and Delivery Research Programme of the National Institute for Health Research, and is being conducted at the Social Care Workforce Research Unit, within the Policy Institute at King's College London, and at the University of Surrey. The overall aim of the mapping exercise was to identify the availability and types of specialist primary health care services across England, and thus inform the selection of case study sites for the HEARTH study. The objectives are described in Chapter 2.

This report describes the distribution and characteristics of different specialist primary health care services in England. It draws on information provided by the managers of these services, and from the services' websites and CQC reports. The mapping exercise was not intended to assess the effectiveness of different models of specialist primary health care services, and therefore this report does not comment on the quality of these services. Recommendations are therefore not made in this report about the types of primary health care services that are needed for single people who are homeless. It was also beyond the scope of the mapping exercise to determine the scale of the problem of homelessness in specific locations, and assess whether the health needs of local people who are homeless are being met. A separate inventory consists of 77 templates of specialist primary health care services which were identified in the mapping exercise and agreed to be included. Each template provides brief details of the service and its work with people who are homeless. A summary of this report is also available. All these documents can be found online.

This chapter summarises the health needs of single people who are homeless, and how policies and services have developed over the last 25 years to address their health needs and access to primary health care. It describes models of specialist primary health care services that have been developed in England for single people who are homeless, and our current understanding of the effectiveness of these arrangements.

1 journalslibrary.nihr.ac.uk/programmes/hsdr/1315603 (accessed 11 November 2017)

1.1 The health needs of people who are homeless

Homelessness has been a growing problem in many areas across England since 2010. The number of households assessed as homeless by local authorities in England has increased by almost 42 per cent, from 62,420 in 2009-10 to 88,410 in 2016-17 (Department for Communities and Local Government (DCLG), 2017a). A much higher number of people who are homeless stay in hostels, with relatives or friends on a temporary basis, or sleep on the streets, and are not included in these statistics. According to official figures, the number of people sleeping rough in England on a single night increased by 134 per cent, from 1,768 people in 2009-10 to 4,134 in 2015-16 (Fitzpatrick et al, 2017). An even greater number of people who are homeless sleep rough during the course of a year. In London, for example, 3,673 people slept rough at some point during 2009-10, increasing by 121 per cent to 8,108 during 2016-17 (Fitzpatrick et al, 2017; Mayor of London, 2017).

Several reports in the 1980s and 1990s described links between poor housing and health inequalities (Acheson, 1988; Black et al, 1982). More recently, the 2010 Marmot Review highlighted the social gradient of health inequalities in England – the lower one's social and economic status, the poorer one's health is likely to be (Marmot et al, 2010). Homelessness can have a devastating impact on health and well-being. People who are homeless and sleeping rough or staying in hostels and shelters have significantly higher levels of physical and mental ill health and premature mortality than the general population. They are more likely to have higher rates of serious and multiple health problems, and have higher rates of problematic drug and alcohol use (Wright and Tompkins, 2006).

There are difficulties in meeting the health needs of people who are homeless. Many neglect their health, have low self-esteem, and their unsettled lifestyle and sometimes chaotic behaviour reduce their likelihood of completing treatment programmes. At the same time, many people who are homeless face barriers in accessing health services, including the inflexibility of services and appointment systems, negative staff attitudes, and the difficulties that services have in treating people with complex and multiple needs (Lester and Bradley, 2001). They are less likely than the general population to be registered with a GP, and they make unusually high demands on emergency services such as hospital accident and emergency departments (Crane and Warnes, 2011; Riley et al, 2003). A 2010 report by the Department of Health (DH) estimated that people who are homeless consume around four times more acute hospital services than the general population, costing at least £85m per year. Moreover, when admitted to hospital, people who are homeless tend to stay on average three times longer than the general population due to the severity of their health conditions (DH Office of the Chief Analyst, 2010).

The difficulties of providing health care to people who are homeless have long been recognised. The 1981 Acheson Report, on primary care in London, noted that people who were homeless had difficulty registering with a GP (London Health Planning Consortium, 1981). Almost 20 years later, a study undertaken in 1998 on behalf of the DH found that access to mainstream GP services for people sleeping rough was poor, with variation between and within areas across England (Pleace et al, 2000). The following sections examine how policies and services have developed over the last 25 years to address the health needs of people who are homeless and their access to primary health care.

1.2 Health policy developments since the 1990s

Several policy developments since the 1990s concern the delivery of primary health care to people who are homeless or otherwise marginalised. A Working Party on 'Homelessness and Ill Health' established by the Royal College of Physicians in the early 1990s recommended that the DH should introduce systematic monitoring of the health of people who are homeless and their access to health services, and that the government should promote the funding of special practices for people who are homeless, and restructure deprivation payments to GPs (Connelly and Crown, 1994). The *NHS (Primary Care) Act 1997* provided the statutory framework for the development of Personal Medical Services (PMSs) in primary care. Through flexible contractual arrangements, PMSs encouraged health care professionals to deliver accessible primary health care services to people living in deprived communities, and to under-served and disadvantaged groups, including people who are homeless. According to Wright (2002, p. 13), this was 'the most significant favourable piece of legislation for homeless people since the start of the NHS'. Local Development Schemes (LDSs) were also introduced by the DH in April 1998, through which additional payments were available for GPs and allied staff to provide services in deprived areas with high morbidity populations and practice workloads (later known as 'enhanced services'). The extra funding enabled GPs, for example, to register and provide medical care to people who were homeless and staying in hostels.

In August 2002, the DH published a document, *Addressing Inequalities: Reaching the Hard-to-Reach Groups*, as a practical aid to implementing primary care. The document stated that, 'improved access, improved prevention and early intervention in primary care are central to reducing inequalities in health' (DH, 2002, p.1). Among its recommendations were that Primary Care Trusts (PCTs; replaced by Clinical Commissioning Groups (CCGs) on 1 April 2013) should encourage GPs and nurses to focus on hard-to-reach groups via PMS and/or investing in LDSs, and where appropriate General Medical Services (GMS) (DH, 2002, pp 4-5). The Royal College of General Practitioners also produced a statement on homelessness and primary care in 2002, which included recommendations for practices, PCTs, and for those at a national level (Royal College of General Practitioners, 2002). In April 2004, Alternative Provider Medical Services (APMSs) were established, which allowed Primary Care Organisations (PCOs) to improve capacity in primary care, particularly in areas of under-provision. PCOs were able to commission APMSs to provide essential services, additional services where GMS / PMS practices opted out, enhanced services and out-of-hours services. They could contract for these services from various providers, including commercial and voluntary sector agencies, social enterprises and NHS Foundation Trusts (British Medical Association General Practitioners Committee, 2006).

Influential publications such as the report by Wanless (2004) on *Securing Good Health for the Whole Population* and reducing health inequalities in England, and the 2010 Marmot Review (described earlier) ensured that equalising health outcomes across society gained prominence within national agendas. In March 2010, the Social Exclusion Task Force of the Cabinet Office and DH launched Inclusion Health, a framework for driving improvements in health outcomes for socially excluded groups. A DH paper published alongside Inclusion Health acknowledged that health care for people who were homeless was likely to have been historically under-funded due to inaccurate population data (DH Office of the Chief Analyst, 2010). A National Inclusion Health Board was established to lead the Inclusion Health agenda. Just three months

after the launch of Inclusion Health, however, the Labour Government was replaced by a Coalition Government of Conservatives and Liberal Democrats, and in late 2010 the Social Exclusion Taskforce which laid the foundation for Inclusion Health as a policy was disbanded. A critical review in 2015 of the impact of the Inclusion Health policy claimed that the health care that had been offered to people who were homeless had had 'meagre benefit from promising beginnings' (Clossick and Ohlsen, 2015, p. 82).

The *Health and Social Care Act 2012* came into force and transferred commissioning responsibilities to CCGs and allowed for greater GP control of service provision. It also imposed several health inequalities duties that are pertinent to service provision for people from disadvantaged groups. Under the Act, NHS England must have regard to the need to reduce inequalities in access to health services and outcomes achieved by health services. In addition, CCGs must have regard to the need to reduce health inequalities and provide services in an integrated way where this will reduce health inequalities in access and outcomes (Hewett, 2013). Health and Wellbeing Boards were established under this Act to act as a forum in which key leaders from the health and social care system could work together to improve the health and wellbeing of their local population and to promote integrated services (The King's Fund, 2016). They were established by local authorities and have a statutory duty, with CCGs, to produce a Joint Strategic Needs Assessment (JSNA) and a Joint Health and Wellbeing Strategy for their local population. They became fully operational on 1 October 2013.

Public health responsibilities were transferred from PCTs to local authorities in April 2013, and Public Health England (PHE) was established to bring together public health specialists into a single public health service. It is responsible for protecting and improving the public's health and for reducing health inequalities. In 2015, it launched *All Our Health: Personalised Care and Population Health*, which was a call for action for all health care professionals to use their skills and relationships to maximise their impact on avoidable illness, health protection and promotion of well-being and resilience. In 2016, PHE produced a framework to support the call to action, and later that year issued specific guidance on homelessness (PHE, 2016a; 2016b). It recommended that homelessness is recognised by Health and Wellbeing Boards in their JSNAs and where appropriate in their Health and Wellbeing Strategies, and that the relationship between health and homelessness is acknowledged in local housing authorities' homelessness reviews.

In 2016/17, Sustainability and Transformation Plans (STPs) were introduced in 44 areas across England as a key part of the planning process for health and social care. Now known as Sustainability and Transformation Partnerships, STPs require NHS organisations in different parts of England to come together to develop plans for the future of health services in their area, including working with local authorities and other partners. They represent an important shift in NHS policy on improvement and reform. While the *Health and Social Care Act 2012* sought to strengthen the role of competition within the health care system, NHS organisations are now being asked to collaborate rather than compete to plan and provide local services (Alderwick et al, 2016).

The agenda to improve the health of people who are homeless has also been driven by organisations such as Pathway Charity. Pathway was set up in 2010 to improve the quality of care in the NHS for people who are homeless or excluded, and has pioneered the 'Pathway' model of integrated care to bridge the gap between primary and secondary care. This involves staff of specialist primary health care services collaborating with secondary care services to

support people who are homeless and admitted to local hospitals or attending A&E departments to improve their care and help plan discharge.

Pathway Charity also supports The Faculty for Homeless and Inclusion Health (formerly The Faculty for Homeless Health), which is a multi-disciplinary network of health care workers and experts by experience, involved in health care for people who are homeless or excluded. The Faculty produced a set of standards for commissioners and service providers in 2011 regarding the planning, commissioning and provision of health care for people who are homeless and other multiply excluded groups (The Faculty for Homeless Health, 2011). These were revised in 2013 to take into account duties imposed by the *Health and Social Care Act 2012* on NHS England and CCGs to reduce health inequalities (The Faculty for Homeless and Inclusion Health, 2013). More recently, The Faculty developed a set of standards specifically for GP receptionists on service provision for people who are homeless (The Faculty for Homeless and Inclusion Health, undated).

The London Homeless Health Programme was formed in 2015, as part of the Healthy London Partnership.[2] It produced guidance (as a set of commitments) for London's CCGs on improving health outcomes for people who are homeless. It proposed that a Homeless Health Lead should be identified in every CCG area to champion the local homeless health agenda and engage on a pan-London level with other Homeless Health Leads and with wider London homeless health clinical networks, such as The Faculty for Homeless and Inclusion Health (Healthy London Partnership, 2016a). In collaboration with Groundswell (a registered charity that supports people who are homeless), it also produced a 'My Right to Access Healthcare Card' and guidance notes to help people who are homeless register with a GP practice (Healthy London Partnership, 2016b). The Queen's Nursing Institute (QNI) has established a Homeless Health Programme, which has produced an online Health Assessment Tool for nurses (QNI, 2015a), and guides relating to specific aspects of health care for people who are homeless, such as oral health and epilepsy (Parker-Radford et al, 2016; QNI, 2015b).

The agenda to improve health care for people who are homeless has further been driven by homelessness organisations within the voluntary (or third) sector. Over the years, several organisations, including Centrepoint, Crisis, Homeless Link and St Mungo's, have campaigned for improved health services for people who are homeless (Centrepoint, 2014; St Mungo's, 2015; Thomas, 2011). In 2009-10, Homeless Link was funded by the DH Third Sector Investment Programme to pilot a Homeless Health Needs Audit Tool in nine PCT areas, with the aim of helping health service commissioners and providers, and local authorities to gather data about the health needs of local people who are homeless and their use of health services (Crane and Warnes, 2011). An online survey tool was designed and has since been administered in many areas across England, including Brighton and Hove, Greater Norwich, and Surrey (Brighton and Hove City Council, 2014; Norwich City Council, 2016; Surrey Homeless Alliance, 2016). The Audit was updated in 2015, with funding from PHE, to take into account changes to local commissioning environments and other reforms that impacted on homelessness and health (Homeless Link, 2015).

Despite the many policies and initiatives over the last few years to improve health care for people who are homeless and other groups of people who are socially excluded, the DH concluded in its 2016/17 annual report that health inequalities between people living in the most deprived areas and the least

2 myhealth.london.nhs.uk/healthy-london/programmes/homeless (accessed 11 November 2017)

deprived areas remain large, and that more needs to be done to see changes in health inequalities in terms of access, outcomes and experience (DH, 2017).

1.3 Specialist primary health care services for single people who are homeless

The development of specialist primary health care services in England dates back to the 1970s. Great Chapel Street Medical Centre, in central London, was the first 'walk-in' medical centre developed in 1976 exclusively for people who were homeless. Luther Street Medical Centre, Oxford, opened in 1985 to provide health care to people who were homeless, and initially operated from a portacabin. In 1987, doctors from Great Chapel Street Medical Centre received a grant from the London-Edinburgh Trust to purchase a van. This was converted into a mobile surgery, and the team provided weekly outreach health clinics on the streets at two London sites where people who were homeless congregated (Ramsden et al, 1992). In 1986, the Department of Health and Social Security (DHSS, now DH) funded the establishment of two primary health care pilot schemes, one in east London (East London Homeless Health Project), and the other in Camden, north-west London. At both schemes, team members were employed to do outreach work and deliver services at day centres, hostels and night shelters where people who were homeless congregated (Williams and Allen, 1989).

During the late 1980s and subsequently, various specialist primary health care services have been developed in several English towns and cities. They include health centres primarily for people who are homeless, mainstream GP practices that provide enhanced or targeted services for people who are homeless, and mobile homeless health teams that provide health care in several hostels and day centres used by people who are homeless. Many, but not all, of the schemes were established through PMS or APMS contracts. The White House Surgery in Sheffield, for example, is a mainstream GP practice that has provided medical care in a hostel for men who are homeless since 1990. It has received a 'local enhanced service' payment for this work only since 2012 (Watton and Gallivan, 2013). Further details of the origins of specialist primary health care services are described in Chapter 4.

1.4 Models of specialist primary health care services for single people who are homeless

There have been several attempts to categorise specialist primary health care services for people who are homeless. Wright (2002) identified three types of GP practices that provided care to people who were homeless:

1. Practice 1: general practice that dealt exclusively with people who were homeless – attempted to meet all the health needs of people who were homeless, including mental health problems and problematic drug and alcohol use, through an extended multi-disciplinary team.
2. Practice 2: mainstream general practice with an interest in working with people who were homeless – attempted to meet the health needs of people who were both housed and homeless, and had a dedicated team of GPs who saw people who were homeless both at the surgery and at 'satellite clinics' in hostels.
3. Practice 3: mainstream inner-city general practice with high workload and little or no interest in working with people who were homeless.

In 2010, the Office of the Chief Analyst, DH, identified four specialist homeless health care models:

1. Mainstream GP practice that holds regular sessions for people who are homeless in a drop-in centre or sees them at the GP practice. May not register patients and no 24/7 provision.
2. Outreach team of specialist homelessness nurses that provide advocacy and support, dress wounds etc., and refer to other health services, including dedicated GP clinics. Unlikely to register patients and no 24/7 provision.
3. Full primary care specialist homelessness team that provides dedicated and specialist care. Co-located with a hostel or drop-in centre, usually registers patients, and provides 24/7 cover.
4. Fully coordinated primary and secondary care that provides an integrated service, including specialist primary care, outreach services, intermediate care beds, and in-reach service to acute beds (DH Office of the Chief Analyst, 2010).

The DH report noted that model 4 was based on services provided in Boston, Massachusetts, but was believed to be unavailable in England. It also reported that one-third of PCTs did not provide any specialist primary health care service for people who were homeless, while another one-third had a specialist health service but did not provide permanent GP registration.

Despite the expansion of specialist primary health care services in England for single people who are homeless, little is known about the spread of different health care models, and their effectiveness and cost-effectiveness. The 2010 DH report documented that it was 'unable to demonstrate how far [specialist primary care] provision is fully meeting the needs of [the homeless] population' (DH Office of the Chief Analyst, 2010, pp. 20-21). It identified a lack of systematic data on use of health services and the costs by people who were homeless, and a lack of research evidence on the potential for improved primary care to reduce secondary care costs and improve health outcomes.

1.5 This report

This report has six further chapters. These describe the design and implementation of the mapping exercise, and report the findings of two complementary surveys of specialist primary health care services in England for single people who are homeless, and of hostels and day centres that serve this group. The chapters cover the distribution and characteristics of specialist primary health care services, whether hostels and day centres for people who are homeless are linked to these services, and the experiences of accessing primary health care for those hostels and day centres that are not linked to a specialist primary health care service. The final chapter summarises key findings about the current provision of primary health care services for people who are homeless, and raises questions for consideration by service commissioners and providers about the future provision of such services for this client group.

Throughout the report, details about specific specialist primary health care services have been anonymised unless these are already in the public domain or the service has given permission for their details to be released. When reporting the survey of hostels and day centres, details of individual projects have not been identified. In areas where there are only a few such projects, broad terms have been used to describe their geographical location, such as south England, instead of identifying the town or city and county.

2 | Design and implementation of the mapping exercise

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The mapping exercise involved two complementary surveys of (i) specialist primary health care services in England, and (ii) accommodation and day centre services used by single people who are homeless. This chapter describes the design and implementation of the two surveys, and the outcomes of contacting the service providers. The mapping exercise builds on earlier surveys undertaken by the lead author of access to health care in South Yorkshire for single people who were homeless, and of the profiles and needs of single people in London who were homeless (Crane and Warnes, 2001; 2011).

2.1 Aims and objectives

The overall aim of the mapping exercise was to identify and map the availability and types of specialist primary health care services across England for single people who are homeless. This has informed the selection of case study sites for the HEARTH study (described in Chapter 1). The objectives of the mapping exercise were:

1. To examine the prevalence of specialist primary health care services for single people who are homeless, and their geographical distribution.
2. To identify the models or types of specialist primary health care services, and the main characteristics of these services.
3. To determine the extent to which accommodation and day centre services for single people who are homeless have access to specialist primary health care services.
4. To collect information from accommodation and day centre services that are not linked to a specialist primary health care service about accessing primary health care for their clients and whether there are unmet needs.
5. To produce a report and inventory about specialist primary health care services in England.

2.2 Overall design

The mapping exercise involved two complementary surveys that collected information from:

1. Specialist primary health care services about the key characteristics of their service.
2. Managers of homelessness services (temporary accommodation and day centres) for single people about the arrangements for accessing primary health care for their clients, and the effectiveness of these arrangements.

Each of these surveys is described below in more detail. Ethical approval for the study, including the mapping exercise, was obtained from London Bloomsbury Research Ethics Committee (Reference 15/LO/1382).

The mapping exercise started in October 2015 and continued until March 2017. It took longer than intended as there were difficulties in collecting

information from some specialist primary health care services and from some hostels and day centres (discussed later). At the same time, there have been considerable changes to specialist primary health care services and to hostels and day centres for single people who are homeless since the mapping exercise started.

2.3 Survey of specialist primary health care services

The mapping exercise started with the collection of information from specialist primary health care services. Such services were defined as those that:

1. Worked primarily with single people who were homeless, and possibly other groups of people who were marginalised; or
2. Served the general population but provided 'enhanced' or targeted services to single people who were homeless, such as GP practices that ran clinics in a hostel or day centre, or provided drop-in clinics or other services at the GP practice exclusively for single people who were homeless.

The survey did not include GP practices that registered and provided general medical services to people who were homeless, but did not have targeted or additional services or clinics for them. It also did not include specialist health services for people who were homeless that did not offer general medical care, but focused on mental health, problematic drug or alcohol use, TB or sexual health.

2.3.1 Identifying specialist primary health care services

Specialist primary health care services were identified in various ways:

1. Knowledge acquired by the research team from previous experience and research.
2. Internet searches of health services, including inspections of Care Quality Commission (CQC) reports.
3. Information obtained during the survey of hostels and day centres for single people who are homeless (Section 2.4).
4. Publicising the study in (i) the Queen's Nursing Institute newsletter of October 2015; and (ii) The Faculty for Homeless & Inclusion Health newsletter.
5. Having exhibition stands to publicise the study at (i) the Homeless & Inclusion Health Conference, London, March 2016; and (ii) Homeless Link's annual conference in Hinckley, Leicestershire, July 2016.
6. Meetings with senior managers of local specialist primary health care services, and with the former Associate Director of the London Homeless Health Programme.
7. Discussions with identified specialist primary health care services.

It was decided not to collect information through Clinical Commissioning Groups (CCGs) for the following reasons: (i) it would not have identified GP practices that were delivering specific services without additional funding for people who were homeless, or primary health care services funded by charitable organisations or provided on a voluntary basis by doctors or nurses; and (ii) it might have identified GP practices that were funded to provide health care to people who were homeless but did not offer specific services that met the study inclusion criteria.

2.3.2 Collecting information from specialist primary health care services

A semi-structured questionnaire was designed to collect information from the managers of specialist primary health care services about key characteristics of their service, including origins, changes over time, opening hours, types of patient registration, staff composition, client groups served, numbers of patients who are homeless, types of services provided, outreach work in hostels, day centres and on the streets, integration with other services, funding sources, and the perceived strengths and limitations of their service.

Once a specialist primary health care service had been identified, the manager was contacted by phone or email and sent an Information Sheet about the study and a questionnaire for completion. The questionnaire could be returned by email or post. Some managers did not return the questionnaire despite reminders over several months. Various strategies were adopted to encourage their participation. Besides emphasising the importance of their contribution in newsletters and at conferences (described above), the research team offered to visit local specialist primary health care services and assist with the completion of the questionnaire. This was taken up by two managers.

As the second survey of homelessness services progressed, it became apparent that many more GP practices than expected were providing specialist primary health care services to people who were homeless in addition to providing care to the general population. Due to the time taken for some specialist primary health care managers to complete the questionnaire, a shorter version of the questionnaire was designed and used specifically for GP practices that provided targeted services to people who were homeless. The aim was to reduce workload for the practices and consequently improve the return rate.

The mapping exercise identified 123 specialist primary health care services in England. Difficulties remained, however, in getting some specialist primary health care services to provide information, and therefore to encourage participation, a template for each service was created. The templates were firstly completed as far as possible by the research team using information that was already in the public domain, and then each specialist primary health care service was asked to check the template and provide additional information. Practice managers were informed that, with their permission, information provided in the template would be used in the Inventory. Templates were created for 110 specialist primary health care services, and 77 were returned for inclusion in the Inventory. Of the remainder, three mainstream GP practices were no longer providing enhanced services to people who were homeless, five schemes requested their details were not included in the Inventory, one scheme had ended, and 24 specialist primary health care services did not respond. It was not possible to create templates for 13 specialist primary health care services that could not be contacted as there was limited information about their service.

2.4 Survey of homelessness services

The second survey in the mapping exercise involved collecting information from the managers of temporary accommodation and day centre services in England for single people who are homeless about access to primary health care services. The criteria for including a service are summarised in Table 2.1. The definition of homelessness is not clear-cut and it was therefore important to ensure that the services surveyed were primarily for people who were homeless rather than for people who were formerly homeless, or had housing needs but were not homeless.

In relation to 'accommodation services', for example, it is sometimes difficult to clarify whether a housing scheme that offers temporary accommodation and support, such as a foyer or a YMCA, is for people who are homeless or in housing need. Foyers were originally established in Britain in the early 1990s to provide housing, training and employment opportunities with little other support for young people aged 16-25 years who were in housing need but not necessarily homeless (Warnes et al, 2003). Some foyers now provide temporary accommodation and support to young people who are homeless. When contacted during the survey, some foyers and YMCAs confirmed that they were working with people who were homeless, but some did not believe that their service fitted the study inclusion criteria as their clients were not homeless prior to residency at the project. Services were consequently excluded if the staff reported that their clients were not regarded as homeless.

In relation to 'day centre services' for people who are homeless, some services are referred to as day centres, some as drop-in centres, and others as soup kitchens. Nineteenth century soup kitchens for people who were destitute were forerunners to the evolution in the 1960s of day centres for people who were homeless, often in response by church-based groups to the public visibility of people on the streets in a particular locality (Waters, 1992). There is no clear distinction between day centres or drop-in centres for people who are homeless. Both are non-residential services that offer a 'front line service' to meet people's basic needs, such as food, showers and clothing. Day centres tend to be open more often and for longer than drop-in centres, and to offer additional services such as housing and welfare advice, education and training programmes, and health care. They are also more likely to have salaried staff. Moreover, there is no clear distinction between drop-in centres and soup kitchens for people who are homeless. The latter tend to be staffed by volunteers, open for a few hours each week, and provide only food and beverages.

For the purpose of reporting:

1. All accommodation projects that were included in the survey will collectively be referred to as **hostels** hereafter.
2. All day centre services that were included in the survey will collectively be referred to as **day centres** hereafter.

Table 2.1: Criteria for inclusion and exclusion of homelessness services

Service characteristics	Inclusion	Exclusion
All services		
Location	England	Not in England
Age	Primarily people aged 18+ years	Maximum age 19 years or less.
Client group	Primarily for single people who are homeless, or couples who are homeless but do not have co-resident children.	Primarily for vulnerable people who are not homeless, e.g. people leaving care or prison, people in housing need or with special needs, such as people with mental health problems. Women or families who are homeless and have co-resident children. Exclusively for people who are refugees or seeking asylum.
Accommodation services		
Type of housing	Hostels and night shelters. Supported housing projects with congregate living arrangements.	Dispersed accommodation in the community, consisting of individual tenancies. Lodgings in volunteers' homes. Treatment centres, e.g. detoxification or rehabilitation units. Probation hostels (approved premises). Intermittent emergency accommodation, e.g. winter shelters.
Length of stay	Temporary housing, usually with maximum length of stay.	Long-term, permanent or move-on housing with no restricted length of stay.
Day centre services		
Type of service	Provides basic services, such as food, showers and clothing.	Primarily a training or advice centre.
Accessibility	Open-access during operating hours.	Only for people accessing specific training or advice. May need appointments.

2.4.1 Identifying hostels and day centres

The starting point for identifying hostels and day centres was two databases provided by Homeless Link in June 2015 of accommodation and day centre services in England for single people who are homeless. These projects were also listed on Homeless UK's website (a national database of homelessness services). The accommodation database contained details of 1,375 hostels and temporary housing projects, and the day centre database listed 214 day centres and drop-in centres. Projects listed on the two databases that did not meet the study criteria were excluded. These included projects for families who were

homeless or women with children, long-term or permanent housing schemes, dispersed housing in the community, lodging schemes for young people in volunteers' homes, and projects that worked with people who were vulnerable but were not homeless. Their relevance was either apparent from the written information in the database, or when a service was contacted.
Besides the databases provided by Homeless Link, various other methods were used to identify hostels and day centres:

1. Internet searches of services in different geographical areas.
2. Information obtained during the survey of specialist primary health care services.
3. Publicising the study in the newsletter circulated by Sitra / Homeless Link in late 2015.
4. Having an exhibition stand and presenting details of the study in July 2016 at Homeless Link's annual conference in Hinckley, Leicestershire. This proved helpful in making direct contact with several Chief Executives and Senior Managers of organisations.
5. Discussions with the managers of hostels and day centres about other projects in their locality.
6. Contacting senior managers in large organisations that deliver multiple services for people who are homeless.

2.4.2 Collecting information from hostels and day centres

A semi-structured questionnaire was designed to collect information from hostel managers about: type of accommodation project and when started; age and sex of clients; number of beds and duration of stay; access to primary health care for clients, including names of GP practice(s) used, type of registration offered and particular arrangements provided by the GP practice; clinics run by doctors or nurses at the accommodation and frequency; any difficulties accessing primary health care for clients; and whether the primary health care needs of clients were being met. A second semi-structured questionnaire was designed to collect similar information about access to primary health care from day centre managers.

The survey of homelessness services started in late 2015, and various strategies were used to collect information. Initially, it had been anticipated that information would be gathered through telephone interviews with hostel and day centre managers. Although information about a few services was collected this way, most managers preferred the questionnaire to be sent to them by email. Some wished to have time to consider the questions or wanted to discuss them with other staff members, and some needed to seek approval from senior staff in their organisation before they could respond. In some organisations with multiple projects, the Chief Executive or a senior manager was contacted, and they arranged for their staff to complete questionnaires. If it was already ascertained that clients of a hostel or day centre could access a specialist primary health care service, it was not necessary for the manager to complete a questionnaire.

Although some hostels and day centres returned questionnaires promptly, there were considerable delays in getting information from others, despite them being contacted several times. Several project managers and senior staff explained that they were keen to participate, but pressures at work and staff changes contributed to delays in questionnaires being returned. For some large organisations with national coverage, it often took a long time to work through their 'internal system'. Initially contact was made with Head Office, and then service managers in different regions were identified. It was then necessary

to liaise with the service managers to reach individual hostels. Another major factor that contributed to delays in questionnaires being returned was that there had been considerable changes to services for people who are homeless within the preceding 18 months, and further changes were taking place as the mapping exercise progressed. Several organisations had been taken over by another service provider, and in some instances the name of the organisation or the service had changed. Several other projects had closed or had changed the type of service that they provided. For example, 50 hostels and 11 day centres listed in Homeless Link's 2015 databases had closed at the time of our contact. At the same time, several new hostels had been established.

2.4.3 Outcomes of contacting hostels and day centres

A total of 900 services for single people who were homeless were identified as meeting the inclusion criteria – 702 were hostels and 198 were day centres. A further 50 hostels met the criteria but were eventually omitted from the study as they were small projects (10 beds or less) specifically for young people who were homeless. These 50 projects were contacted once, did not return their questionnaire, and no further follow-up work was undertaken with them. This decision was agreed at the Study Steering Committee meeting in July 2016, after consideration was given to the large number of questionnaires still to be returned and the workload involved.

Of the 900 hostels and day centres, 804 were listed in Homeless Link's databases, and 96 were identified by the research team (Table 2.2). They comprised 204 services specifically for young people aged 25 years or under, and 696 schemes that worked with people above this age. Many of the latter also worked with young people.

Table 2.2: Source of identification of hostels and day centres

Project	Homeless Link[1]	Survey[2]	Total
		Numbers	
Hostels	652	50	702
Day centres	152	46	198
Total	**804**	**96**	**900**

Notes: 1. Homeless UK national database. 2. Research team.

Information from hostels and day centres about clients' access to health care was collected in various ways. Some managers returned questionnaires (282 questionnaires were returned, and 279 of these related to services that met the study inclusion criteria). In addition, information was obtained through telephone interviews, and through details provided by the managers of specialist primary health care services. As shown in Table 2.3, complete information about the hostel or day centre and clients' access to primary health care was obtained for 661 projects (73.4%), including staff's experiences of accessing mainstream GP services for clients if the project was not served by a specialist primary health care service. Partial information was obtained for a further 92 projects (10.2%), in that details were available about the service and whether it had access to a specialist primary health care service, but no data were gathered about experiences of accessing mainstream GP practices

for clients. For the remaining 147 hostels and day centres (16.3%), no data were collected about the provision of primary health care for their clients. Of these, most managers had initially agreed to complete the questionnaire, while nine managers declined to participate in the survey.

As shown in Table 2.3, complete data were obtained about 91.9% of day centres and 68.2% of hostels. One reason why it was easier to obtain information about day centres was that they were more likely to be linked to a specialist primary health care service and information about the day centre was obtained from the health service. A slightly lower response rate was obtained from hostels and day centres exclusively for young people (Table 2.4).

Table 2.3: Completeness of data collected from hostels and day centres about access to primary health care services

Data collected	Hostels		Day centres		All projects	
	Number	%	Number	%	Number	%
Complete data	479	68.2	182	91.9	661	73.4
Partial data[1]	81	11.5	11	5.6	92	10.2
No health data[2]	142	20.2	5	2.5	147	16.3
Total projects	**702**	**100.0**	**198**	**100.0**	**900**	**100.0**

Notes: 1. Description of project and whether it is served by a specialist primary health care service, but no information about staff's experiences of accessing mainstream primary health care services for clients. 2. Description of project but no data about the provision of primary health care for clients.

Table 2.4: Completeness of data collected about access to primary health care services by age groups served by hostels and day centres

Data collected	Projects for young homeless people[1]		Projects for homeless adults[2]		All projects	
	Number	%	Number	%	Number	%
Complete data	127	62.3	534	76.7	661	73.4
Partial data[3]	31	15.2	61	8.8	92	10.2
No health data[4]	46	22.6	101	14.5	147	16.3
Total projects	**204**	**100.0**	**696**	**100.0**	**900**	**100.0**

Notes: 1. Maximum age limit up to 25 years. 2. Maximum age limit over 25 years. 3. Description of project and whether it is served by a specialist primary health care service, but no information about staff's experiences of accessing mainstream primary health care services for clients. 4. Description of project but no data about the provision of primary health care services for clients.

2.5 Data analyses

Quantitative data from the surveys of specialist primary health care services and of hostels and day centres were entered into two SPSS databases. Brief characteristics about each service were recorded together with town or city and county, and arrangements for accessing primary health care were entered for each hostel and day centre.

All specialist primary health care services and hostels and day centres were classified into the following groups:

1. NHS Region (North, Midlands and East, London, South West or South East);
2. Local Authority District; and
3. 2011 Rural-Urban Classification of Local Authority Districts in England (Bibby and Brindley, 2014).

In England, a Local Authority District (LAD) is a generic term used to cover the (i) 32 London boroughs; (ii) 36 metropolitan boroughs; (iii) 201 non-metropolitan districts; (iv) 55 unitary authorities; and (v) the City of London and the Isles of Scilly. A LAD is an area smaller than a local authority, and there are 326 LADs in England.

The 2011 Rural-Urban Classification of Local Authority Districts in England categorises each LAD as rural or urban based on the percentage of their resident population living in rural areas or rural-related hub towns, and its conurbation context. Hub towns are built up areas with a population of 10,000-30,000 and have the potential to be centres of business and service provision for a surrounding rural area. The classification has six categories:

1. Mainly rural – ≥80% of the resident population lives in rural areas or hub towns;
2. Largely rural – 50-79% of the resident population lives in rural areas or hub towns;
3. Urban with significant rural – 26-49% of the resident population lives in rural areas or hub towns;
4. Urban with city and town;
5. Urban with minor conurbation;
6. Urban with major conurbation.

The latter three categories are characterised by the presence or absence of a conurbation and, for each, ≥74% of the resident population lives in urban areas.

2.6 Overview

This is the first comprehensive mapping exercise that has been undertaken in England of the prevalence and distribution of specialist primary health care services, and of the extent to which hostels and day centres for single people who are homeless are served by these health services. Although the two complementary surveys proved very time-consuming as responses from some services were slow, a high response rate was eventually achieved both from health schemes and from services for people who are homeless.

The mapping exercise started in October 2015 and ended in March 2017. During this period, and subsequently, there have been many changes both to services for people who are homeless and to the provision of primary health care to single homeless people. Several hostels and day centres have closed or changed their service, while several new hostels have been established. At the same time, four of the specialist primary health care services identified in the mapping have closed or they have changed their service and no longer run clinics specifically for people who are homeless. Hence, this report refers to health services and hostels and day centres that were in operation between October 2015 and March 2017.

3 | Types and distribution of specialist primary health care services

3 | Types and distribution of specialist primary health care services

This chapter summarises the types of specialist primary health care services identified during the mapping exercise and their distribution. It refers to those services that were in operation in March 2017 – the features of these services are described in more detail in Chapter 4. As mentioned in the previous chapter, some specialist primary health care services, and some hostels and day centres, did not provide information. This chapter, therefore, refers to the minimum number of specialist primary health care services that were in operation during the mapping period.

3.1 Models or types of specialist primary health care services

The mapping exercise identified 123 specialist primary health care services in England for single people who were homeless. The types of services varied greatly and it was not straightforward to categorise them into specific models. A taxonomy was therefore created to group the specialist primary health care services using categories that distinguished their different characteristics (Table 3.1). For example, some services operated primarily from a 'fixed' site, i.e. a health centre or surgery, while some were undertaken by a mobile health team that did not have a fixed base but ran clinics in various hostels and day centres or church halls used by people who were homeless.

Table 3.1: Taxonomy of specialist primary health care services

Types of services	Service delivered from fixed health site	Outreach clinic(s) at hostels or day centres	Service primarily for people who are homeless	Service has two or more health workers	Provides GP registration
Specialist health centre	Yes	Most services	Yes	Yes	Yes
GP practice with homeless services	Yes	Some services	No	Yes	Yes
Mobile homeless health team	No	Yes, multiple sites	Yes	Yes	Not usually
Single-handed mobile homeless nurse	No	Yes, multiple sites	Yes	No	No
Nursing service based at hostel or day centre	No	Yes, one site	Yes	Not usually	No
Volunteer health care service	No	Yes, one or multiple sites	Yes	Some services	No
Other medical / nursing arrangements	No	Yes, one site	No	Yes	Not usually

Some specialist primary health care services were exclusively or primarily for people who were homeless, while some were delivered by GP practices that provided health care to the general population and also ran clinics at hostels or day centres or provided enhanced or targeted services at the surgery to people who were homeless. Some specialist primary health care services comprised a team of workers, while a few consisted of a single nurse based at or visiting a hostel or day centre. Finally, there were differences regarding GP registration. Some specialist primary health care services included at least one GP on the team and offered GP registration. Others, such as many of the mobile health teams, did not provide GP registration. They were mainly staffed by nurses who instead encouraged or assisted people who were homeless to register with local GP practices.

Using the taxonomy, the 123 specialist primary health care services were classified into six main groups plus a seventh group which encompassed 'other medical / nursing arrangements' (Table 3.2). The 123 services included 28 health centres or surgeries primarily for people who were homeless. Some of these were described as health centres, some as surgeries, and some as a homeless health care team. A common feature was that they operated from a fixed site. For the purpose of reporting, they will be referred to as a 'specialist health centre' hereafter. Among the other specialist primary health care services were 61 GP practices that provided some enhanced or targeted services for this patient group, i.e. outreach clinics in hostels or day centres or on the streets and /or services at the surgery. Of the 61 GP practices, 59 were mainstream practices serving the general population and two were specialist practices for people with problematic drug and alcohol use. They will be referred to as a 'GP practice with homeless services' hereafter. Other specialist primary health care services were: (i) 12 mobile homeless health teams; (ii) four mobile homeless nurses who operated single-handedly and ran clinics at several hostels or day centres; (iii) seven services whereby a nurse was based at a single day centre or hostel; and (iv) five volunteer health care services that operated mainly in hostels or day centres. In addition, six specialist primary health care services did not fit into any of the above categories. A few of these were run by social enterprises and commissioned by local CCGs, and they provided specific health services for the general population, such as 'out-of-hours' services, and also health care in hostels or day centres.

All 28 specialist health centres and 61 GP practices with homeless services offered GP registration to homeless people. Most of the 12 mobile homeless health teams were nurse-led, and only one team directly offered GP registration with GPs who were employed as part of the team. Some of the mobile homeless health teams, however, worked closely with GPs to encourage registration at local GP practices (described in Chapter 4). Most other types of specialist primary health care services did not provide GP registration to people who were homeless (information was unavailable for three services). In total, of the 120 specialist primary health care services where details were available, 90 services (75%) provided GP registration (Table 3.2).

Table 3.2: Availability of specialist primary health care services

Types of services	Total	Provided GP registration
	Number	
Specialist health centre	28	28
GP practice with homeless services	61	61
Mobile homeless health team	12	1
Single-handed mobile homeless nurse	4	0
Nursing service based at hostel or day centre	7	0
Volunteer health care service	5	0
Other medical / nursing arrangements	6	Note 1
Total	**123**	**90**

Notes: 1. No GP registration for three services; unknown for three services.

3.2 Distribution of specialist primary health care services by NHS Regions

The 123 specialist primary health care services were spread across the five NHS England Regions – 32 were in the North; 26 in Midlands and East; 29 in London; 20 in South East; and 16 in South West. There were some regional differences in the types or models of services available. All regions had a few specialist health centres and mobile homeless health teams (Table 3.3). London and the South Regions, however, had fewest GP practices with homeless services, while the Midlands and East Region had the highest number. Midlands and East and South West Regions tended not to have services other than specialist health centres, mobile homeless health teams and GP practices with homeless services. The South East Region had the highest numbers of volunteer health care services.

There were also variations across the NHS Regions in the number of specialist primary health care services that provided GP registration (Figure 3.1). Midlands and East had the highest number of such services (22), while South West had 15 such services, and South East had 14. This is associated with the availability of specialist health centres and GP practices with homeless services in each region, as these two types of models were most likely to provide GP registration. As a result, 15 of the 16 specialist health services (93.8%) in South West Region and 22 of the 26 services (84.6%) in Midlands and East, provided GP registration. This compares to just 18 of the 29 services (62.1%) in London, and 21 of the 32 services (65.6%) in the North.

Table 3.3: Types of specialist primary health care services by NHS Regions

Types of health services	NHS Region					Total
	North	Midlands and East	South West	South East	London	
	Number					
Specialist health centre	7	6	4	4	7	28
GP practice with homeless services	14	16	10	10	11	61
Mobile homeless health team	4	3	2	1	2	12
Single-handed mobile homeless nurse	2	0	0	0	2	4
Nursing service based at hostel or day centre	1	1	0	1	4	7
Volunteer health care service	1	0	0	3	1	5
Other medical / nursing arrangements	3	0	0	1	2	6
Total health services	**32**	**26**	**16**	**20**	**29**	**123**

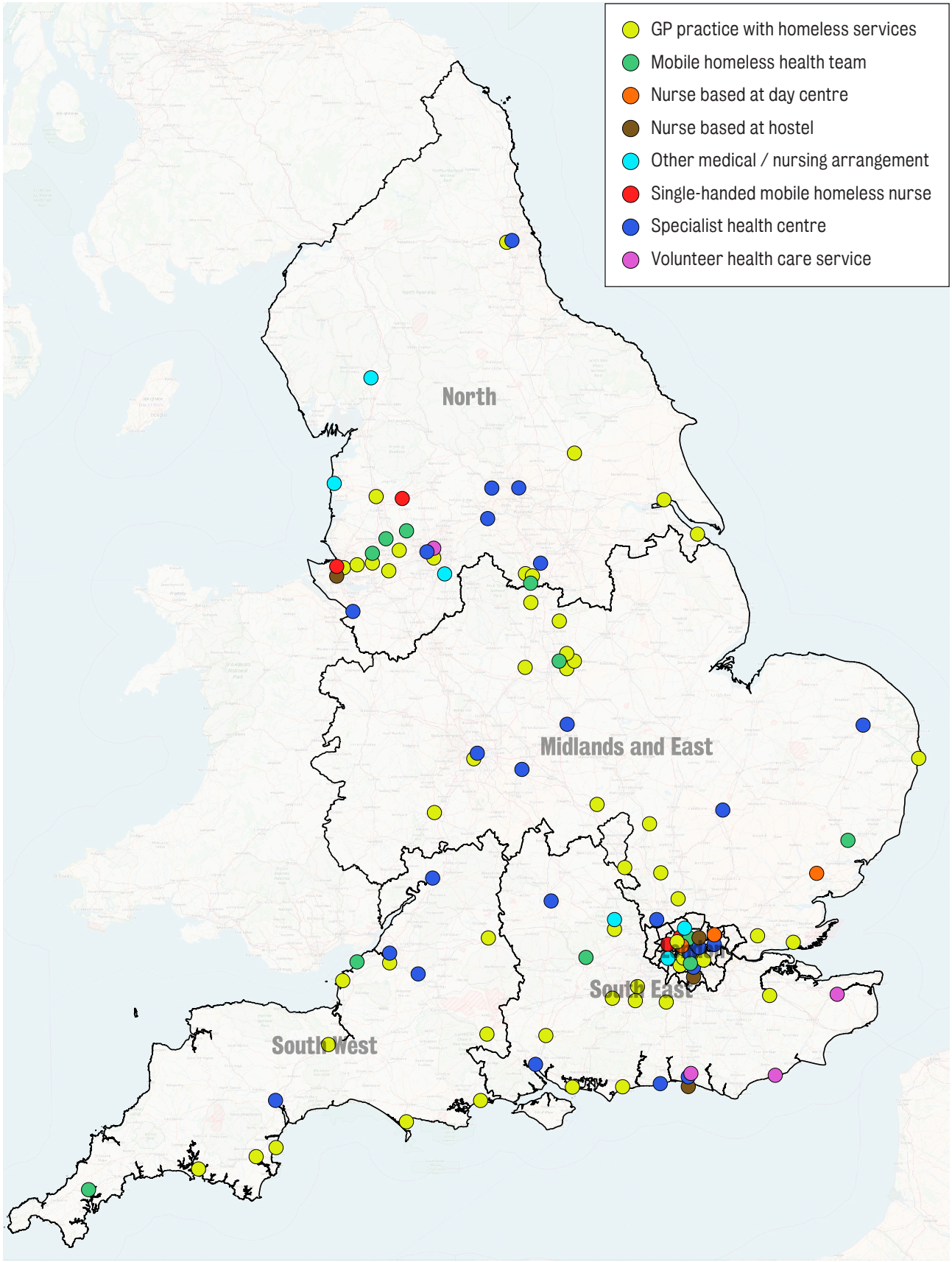
Figure 3.1: Specialist primary health care services that provided GP registration by NHS Regions

Figures 3.2 and 3.3 show in more detail the distribution of specialist primary health care services by NHS Regions and within London by boroughs. The maps indicate where the service is based. A few of the mobile homeless health teams cover several small towns. The four specialist primary health care services that have ended are not included in the maps. As shown in Figure 3.2, there is a cluster of such services in NHS North Region around Greater Manchester and Merseyside, and a single such service is found at several towns along the coast in NHS South West and South East Regions. In contrast, relatively few specialist primary health care services were identified in the northern part of NHS North Region, and in parts of NHS Midlands and East Region.

Although there were a relatively high number of specialist primary health care services in Greater London, these were not evenly distributed among the 32 London boroughs and the City of London. Such a service was identified in just 14 London boroughs, namely Barnet, Brent, Camden, Croydon, Hackney, Hammersmith & Fulham, Kensington & Chelsea, Lambeth, Lewisham, Newham, Redbridge, Southwark, Tower Hamlets and Westminster (Figure 3.3). Most of these boroughs had one or two services, while Kensington & Chelsea, Lewisham and Westminster each had three, Lambeth had four, and Hammersmith & Fulham five services.

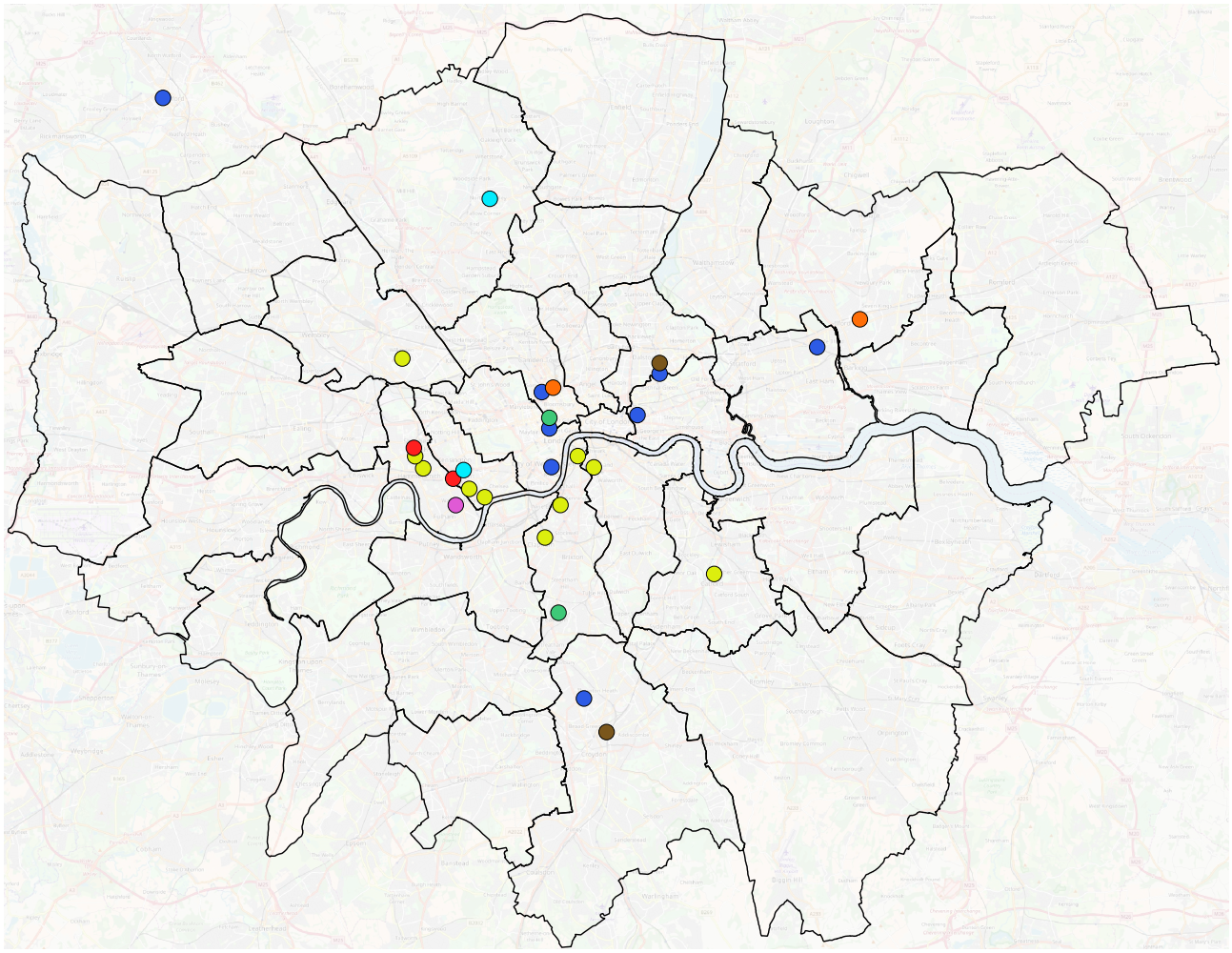
No specialist primary health care service was identified in the City of London nor in the following 18 London boroughs: Barking & Dagenham; Bexley; Bromley; Ealing; Enfield; Greenwich; Haringey; Harrow; Havering; Hillingdon; Hounslow; Islington; Kingston upon Thames; Merton; Richmond upon Thames; Sutton; Waltham Forest; and Wandsworth. Most of these are outer London boroughs, although three (Greenwich, Islington and Wandsworth) are in inner London. In Wandsworth, there was a mobile homeless health team but this provided health care primarily to families who were homeless.

Figure 3.2: Distribution of specialist primary health care services in England by NHS regions



Note: The map shows where the service is based. Some services work at several locations.

Figure 3.3: Distribution of specialist primary health care services in England by Greater London Boroughs



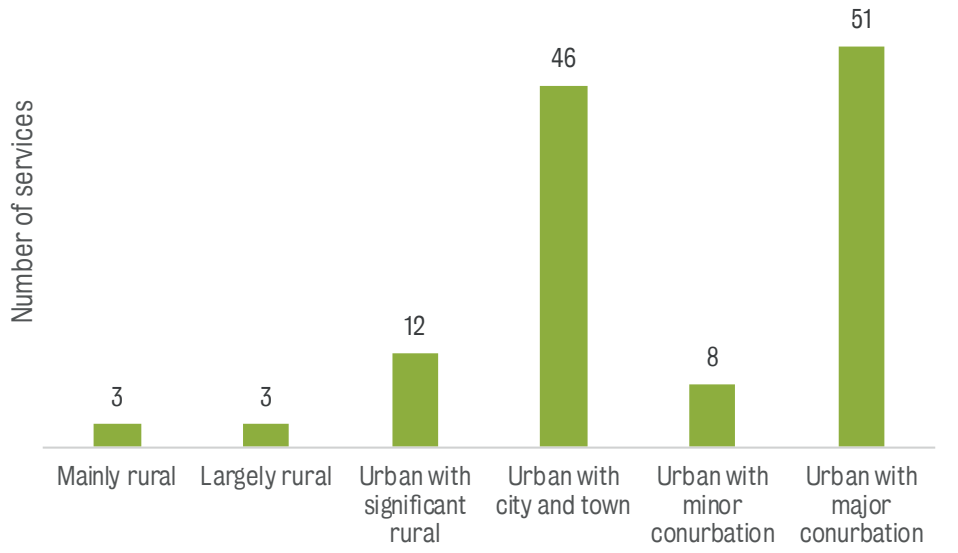
Note: The map shows where the service is based. Some services work at several locations.

- GP practice with homeless services
- Mobile homeless health team
- Nurse based at day centre
- Nurse based at hostel
- Other medical / nursing arrangement
- Single-handed mobile homeless nurse
- Specialist health centre
- Volunteer health care service

3.3 Distribution of specialist primary health care services by Local Authority Districts

When the availability of specialist primary health care services is considered by Local Authority Districts (LADs), they tended to be in urban rather than rural areas (Figure 3.4). Drawing on the 2011 rural-urban classification for LADs in England (described in Section 2.5), the survey identified just three such health services in 'mainly rural' areas and three in 'largely rural' areas. In contrast, there were 51 specialist primary health care schemes in urban areas with major conurbations, and 46 in 'urban with city and town' areas. There were relatively few such services in urban areas with minor conurbations – this is because there are only nine LADs in this classification. This compares to 75 LADs in urban with major conurbation areas, and 97 in urban with city and town areas.

Figure 3.4: Location of specialist primary health care services by urban and rural areas[1]



Notes: 1. See Chapter 2, Section 2.5.

When the ratio of specialist primary health care services to the number of LADs in each urban-rural classification group is considered, it shows that rural areas were least well served (Table 3.4). The ratio for 'mainly rural' areas was 0.06 and for 'largely rural' areas was 0.07. In comparison, urban areas with minor or major conurbations had much higher ratios (0.89 and 0.68 respectively). Hence, urban areas were much more likely than rural areas to have a specialist primary health care scheme.

Table 3.4: Proportion of specialist primary health care services to number of local authority districts by rural-urban areas[1]

Rural-urban areas	Specialist health services	Local authority districts (LADs)	Specialist health services to LADs
	Number	*Number*	*Ratio*
Mainly rural	3	50	0.06
Largely rural	3	41	0.07
Urban with significant rural	12	54	0.22
Urban with city and town	46	97	0.47
Urban with minor conurbation	8	9	0.89
Urban with major conurbation	51	75	0.68
Total	**123**	**326**	**0.38**

Notes: 1. See Chapter 2, Section 2.5.

There were some differences in the types of specialist primary health care services available in rural and urban areas. As shown in Table 3.5, most of the specialist health centres were in urban locations, although two were in LADs classified as 'urban with significant rural', i.e. Bath and Chester. Most of the specialist primary health care services in rural areas were GP practices with homeless services, although a mobile homeless health team operated in Cornwall and served three locations (Camborne, Penzance and Truro).

At least one specialist primary health care service was identified in most counties in England – the majority had one to three such services, while six counties each had four (Devon, East Sussex, Hampshire, Lancashire, Somerset and South Yorkshire), Nottinghamshire had five, and Merseyside and Greater Manchester each had six services. Not surprisingly, Greater London had by far the largest number of specialist primary health care services – 29 in total. There were seven counties where no service was identified. These were County Durham, Herefordshire, Isle of Wight, Northumberland, Rutland, Shropshire and Warwickshire. All except Rutland had at least one hostel or day centre for people who were homeless.

Table 3.5: Types of specialist primary health care services by rural-urban areas[1]

Types of services	Mainly rural	Largely rural	Urban with significant rural	Urban with city and town	Urban with minor conurbation	Urban with major conurbation
				Number		
Specialist health centre	0	0	2	11	1	14
GP practice with homeless services	1	3	7	26	5	19
Mobile homeless health team	1	0	1	3	2	5
Single-handed mobile homeless nurse	0	0	0	1	0	3
Nursing service based at hostel or day centre	0	0	1	1	0	5
Volunteer health care service	0	0	0	3	0	2
Other medical / nursing arrangements	1	0	1	1	0	3
Total health services	**3**	**3**	**12**	**46**	**8**	**51**

Notes: 1. See Chapter 2, Section 2.5.

When the availability of specialist primary health care services in the 35 largest cities in England (excluding Greater London) is examined, most cities had at least one such service. Nottingham appeared to be very well served, with a mobile homeless health team and three GP practices with homeless services. In contrast, there were six cities where no specialist primary health care service was identified – Wakefield, Sunderland, Wolverhampton, Peterborough, Lancaster and St Albans (Table 3.6). According to statistics in Autumn 2016 from the Department for Communities and Local Government (DCLG), all of these cities have people who are homeless and sleeping on the streets (DCLG, 2017b). They also have hostels or day centres for people who are homeless but, as survey responses were not received from some of the homelessness services in these areas, it cannot be concluded that these cities had no specialist primary health care service.

Table 3.6: Number of specialist primary health care services in the 35 largest English cities (excluding Greater London)[1]

City	Population size	Specialist health centre	GP with homeless services	Mobile homeless health team	Other specialist services	Total services
Birmingham	992,200	1	1	0	0	2
Leeds	720,000	1	0	0	0	1
Sheffield	512,000	0	2	1	0	3
Bradford	467,000	1	0	0	0	1
Liverpool	440,000	0	1	0	0	1
Manchester	420,000	0	1	0	1	2
Bristol	380,000	1	1	0	0	2
Wakefield	316,000	*None identified*				
Coventry	305,000	1	0	0	0	1
Nottingham	285,000	0	3	1	0	4
Leicester	280,000	1	0	0	0	1
Sunderland	280,000	*None identified*				
Newcastle upon Tyne	259,000	1	1	0	0	2
Brighton	248,000	1	0	0	2	3
Hull	240,000	0	1	0	0	1
Plymouth	240,000	0	1	0	0	1
Stoke-on-Trent	239,000	0	0	1[2]	0	1[2]
Wolverhampton	239,000	*None identified*				
Derby	230,000	0	1	0	0	1
Southampton	220,000	1	0	0	0	1
Salford	215,000	1	0	0	0	1
Portsmouth	186,000	0	1	0	0	1
York	182,000	0	1	0	0	1
Peterborough	157,000	*None identified*				
Lancaster	135,000	*None identified*				
Oxford	135,000	1	0	0	0	1
Preston	130,000	0	1	0	0	1
St Albans	130,000	*None identified*				
Norwich	125,000	1	0	0	0	1
Chester	118,000	1	0	0	0	1
Cambridge	115,000	1	0	0	0	1
Salisbury	115,000	0	1	0	0	1
Exeter	111,000	1	0	0	0	1
Gloucester	110,000	1	0	0	0	1
Winchester	108,000	0	1	0	0	1

Notes: 1. 2017 UK cities: www.ukcities.co.uk/populations 2. This service closed in early 2017.

3.4 Overview

The survey has revealed 123 specialist primary health care services across England for single people who are homeless. Although these were spread across the five NHS England Regions, it can be argued that there were relatively few such services considering the number of LADs in England. The types of specialist primary health care services and their distribution varied greatly. The services were mainly located in urban areas where there are several hostels and day centres for people who are homeless. In some London boroughs and a few large English cities, however, no specialist primary health care service was identified, yet they had hostels and day centres for homeless people. Very few specialist primary health care services were found in rural areas. The next chapter describes the characteristics of these services in more detail.

4 | Characteristics of specialist primary health care services

4 | Characteristics of specialist primary health care services

This chapter summarises the characteristics of specialist primary health care services for single people who are homeless. The sections cover specialist health centres, GP practices with homeless services, mobile homeless health teams, and other specialist primary health care services. Further details of individual services are described in the templates contained in the appendix. The final sections compare the models identified during the mapping exercise, and these models with those described by the DH Office of the Chief Analyst (2010). It was not possible to collect detailed information from managers of some specialist primary health care services, particularly from managers of GP practices with homeless services. This chapter therefore relies on the following sources of information:

- Questionnaires and templates completed by the managers of specialist primary health care services;
- Care Quality Commission (CQC) reports of specialist primary health care services;
- Websites of the above services and other documentation available on the internet;
- Information obtained during the survey of hostels and day centres.

A few services have been anonymised or their details (other than that which is in the public domain) withheld as they requested that the information they provided is not shared. As mentioned in Chapter 1, this report does not comment on the quality of services.

4.1 Specialist health centres

4.1.1 Origins and development

The survey identified 28 specialist health centres exclusively or primarily for people who are homeless (Table 4.1). Three had been in operation since the 1970s or 1980s, seven were established during the 1990s, and 16 between 2000 and 2007 (details were unavailable for two). Hence, where information was obtained, all health centres had been operating for at least 10 years, and 10 for more than 20 years. Some were in large cities, such as London, Coventry, Leeds and Newcastle-upon-Tyne. Some were in coastal areas, such as Brighton, Southampton and Worthing, or in towns and cities such as Cambridge, Gloucester and Norwich. Just two were in urban areas with a significant rural element, i.e. Bath and Chester.

Various pathways had led to their establishment. York Street Health Practice, Leeds, for example, originated from a mobile service (No Fixed Abode Team) that worked with people who were homeless and in hostels or on the streets. It became a service at a fixed site in 1995. The Joseph Cowen Healthcare Centre, Newcastle upon Tyne, was also established in 1995 through a partnership between statutory health and social care services, and Byker Bridge Housing Association. Many specialist health centres had been developed through Primary Care Trusts (PCTs).

Table 4.1: Specialist health centres in England primarily for people who are homeless

Name of service	Location	Year started	Premises	Managed by	Clinical Commissioning Group
NHS North Region					
Bevan House Primary Care Centre	Bradford, West Yorkshire	2003	Stand-alone premises	Bevan Healthcare CIC	NHS Bradford City
Joseph Cowen Healthcare Centre	Newcastle upon Tyne, Tyne and Wear	1995	Stand-alone premises	Tyne Housing Association	NHS Newcastle Gateshead
Salford Homeless GP Project	Salford, Greater Manchester	2007	Located at Windsor Drop-in Centre for people who are homeless	Salford Health Matters	NHS Salford
St Werburgh's Practice for the Homeless	Chester, Cheshire	2005	Stand-alone premises	Northgate Medical Centre, Chester	NHS West Cheshire
The Gate Surgery	Rotherham, South Yorkshire	2002	Stand-alone premises	Gateway Primary Care CIC	NHS Rotherham
The Whitehouse Centre	Huddersfield, West Yorkshire	2003	Shares building with other health services	Locala Community Partnerships CIC	NHS Greater Huddersfield
York Street Health Practice	Leeds, West Yorkshire	1995	Shares building with St Anne's Resource Centre for people who are homeless, and with Big Issue North.	Bevan Healthcare CIC (from April 2017). Formerly Leeds Community Healthcare NHS Trust.	NHS Leeds South and East
NHS Midlands and East Region					
Anchor Centre	Coventry, West Midlands	n.a.	Stand-alone premises	Virgin Care Coventry LLP	NHS Coventry and Rugby
Cambridge Access Surgery	Cambridge, Cambridgeshire	2003	Stand-alone premises	Malling Health (UK) Limited	NHS Cambridgeshire and Peterborough
City Reach Health Services	Norwich, Norfolk	2003	Shares building with a Training and Development Centre managed by St Martins Housing Trust	Norfolk Community Health and Care NHS Trust	NHS Norwich

Table 4.1: Specialist health centres in England primarily for people who are homeless (continued)

Name of service	Location	Year started	Premises	Managed by	Clinical Commissioning Group
NHS Midlands and East Region (continued)					
Health Inclusion Matters	Watford, Hertfordshire	2003	Stand-alone premises	Health Inclusion Matters CIC	NHS Herts Valley
Inclusion Healthcare	Leicester, Leicestershire	1999	One site is stand-alone premises. Second site is located at Dawn Centre (temporary accommodation for people who are homeless)	Inclusion Healthcare Social Enterprise CIC	NHS Leicester City
The Health Xchange (Primary Care Services for the Homeless)	Birmingham, West Midlands	Around 2002	Stand-alone premises, adjacent to William Booth Centre for people who are homeless	Birmingham and Solihull Mental Health NHS Foundation Trust	NHS Sandwell and West Birmingham
NHS South West Region					
Clock Tower Surgery	Exeter, Devon	2001	Shares building with hub of services, including mental health, housing, probation and street outreach	Access Health Care	NHS Northern, Eastern and Western Devon
Homeless Healthcare Team	Gloucester, Gloucestershire	1997	Shares building with Gloucester City Mission and Gloucester Foodbank	Gloucestershire Care Services NHS Trust	NHS Gloucestershire
Julian House Medical Practice for the Homeless	Bath, Somerset	2003	Located at Julian House hostel and day centre for people who are homeless	Bath and North Somerset Doctors Urgent Care Limited	NHS Bath and North East Somerset
The Homeless Health Service	Bristol	n.a.	Located at The Compass Centre (hub of services for people who are homeless)	Brisdoc Healthcare Services	NHS Bristol
NHS South East Region					
Arch Healthcare	Brighton, East Sussex	1998	Shares building with hub of services, including homeless outreach multidisciplinary team	Arch Health CIC	NHS Brighton and Hove
Health Central Surgery	Worthing, West Sussex	2000	Stand-alone premises	Worthing Medical Group	NHS Coastal West Sussex
Homeless Healthcare Team	Southampton, Hampshire	1992	Located at Two Saints Day Centre for people who are homeless	Solent NHS Trust	NHS Southampton
Luther Street Medical Centre	Oxford, Oxfordshire	1985	Stand-alone premises, adjacent to O'Hanlon House (hostel for people who are homeless)	Oxford Health NHS Foundation Trust	NHS Oxfordshire

Table 4.1: Specialist health centres in England primarily for people who are homeless (continued)

Name of service	Location	Year started	Premises	Managed by	Clinical Commissioning Group
NHS London Region					
Camden Health Improvement Practice	LB Camden	1990	Shares building with South Camden Drug Service	Turning Point	NHS Camden
Great Chapel Street Medical Centre	LB Westminster	1976	Stand-alone premises	Great Chapel Street Medical Centre	NHS Central London (Westminster)
Health E1	LB Tower Hamlets	2000	Stand-alone premises	East London NHS Foundation Trust	NHS Tower Hamlets
Newham Transitional Practice	LB Newham	2000	Two stand-alone premises	East London NHS Foundation Trust	NHS Newham
The Doctor Hickey Surgery	LB Westminster	1987	Located at Cardinal Hume Centre for people who are homeless	The Doctor Hickey Surgery	NHS Central London (Westminster)
The Greenhouse	LB Hackney	2007	Shares building with hub of housing and welfare services for people who are homeless.	AT Medics	NHS City and Hackney
The Homeless Health Team	LB Croydon	2001	Stand-alone premises	Croydon Health Services NHS Trust	NHS Croydon

Notes: n.a. information not available.

For example, St Werburgh's Practice for the Homeless, Chester, was originally set up by the PCT in 2005. Health E1, London Borough of Tower Hamlets, was established in 2000 as a first wave Personal Medical Services (PMS) pilot for three years, and remains in operation 17 years later. The Greenhouse, London Borough of Hackney, opened in 2007 to provide health care, and housing and welfare advice services to people who were homeless. It was formed through a partnership between Hackney Council, the NHS and Thames Reach (a provider of services for people who are homeless).

Many of the specialist health centres are now managed by not-for-profit community interest companies, which are contracted by the NHS to provide health services to people who are homeless. For example, Meadowell Centre, Watford, was established in 2003 by the local PCT. It became a social enterprise in 2011, and is now known as Health Inclusion Matters. Likewise, Homeless Healthcare in Leicester, originally developed through the city's PCT, became Inclusion Healthcare Social Enterprise CIC in September 2010. A few specialist health centres have experienced more recent management changes. Brighton Homeless Healthcare was managed by an independent provider, The Practice Group, through a PMS contract until January 2017. A newly established community interest company, Arch Health CIC, made up of clinicians and professionals in Brighton & Hove was then awarded the contract for three years from February 2017 to run the service and to address the health needs of people who are homeless or vulnerable in Brighton. York Street Health Practice, Leeds, had been managed by Leeds Community Healthcare NHS Trust for more than 20 years, until a new contract was awarded to Bevan Healthcare CIC in April 2017. The characteristics of the 28 specialist health centres differ in many ways. These are discussed in the following sections, and summarised in Table 4.2.

4.1.2 Premises

Most of the specialist health centres operate from single premises in a town or city centre. Newham Transitional Practice, Greater London, has two sites, and Inclusion Healthcare in Leicester has two sites. Fourteen of the specialist health centres occupy 'stand-alone' premises, although two of these are adjacent to a hostel for people who are homeless, and several others are close to hostels or day centres for this client group. Luther Street Medical Centre, Oxford, for example, is adjacent to a hostel for people who are homeless which is also the base of the street outreach team. The remaining 14 specialist health centres operate from buildings shared with other services, or are located in hostels or day centres for people who are homeless (Table 4.1). For example, Salford Homeless GP Project operates from Windsor Drop-in Centre, and the Homeless Healthcare Team, Southampton, from Two Saints Day Centre. City Reach Health Services, Norwich, occupies the ground floor of a building it shares with St Martins Housing Trust (SMHT). Julian House Medical Practice for the Homeless, Bath, is based in the same building as a hostel and day centre for people who are homeless.

A few specialist health centres are located within a hub of health and welfare services. For example, Clock Tower Surgery, Exeter, operated from converted offices since its inception in 2001. In 2017, it moved to purpose-built premises at a new service hub (CoLab), which also includes mental health, housing and probation services, and street outreach services for people who are homeless. Likewise, The Whitehouse Centre, Huddersfield, occupied a converted house until it moved to Princess Royal Health Centre in mid-2017. Other services at the latter centre include dentistry, sexual health, diabetes, TB nursing and podiatry. Arch Healthcare, Brighton, shares

a building with the homeless outreach multi-disciplinary team, and with dental services. Camden Health Improvement Practice, London Borough of Camden, is in the basement of a building which is shared with South Camden Drug Services.

A few managers of specialist health centres commented that the size of their building and lack of space made it difficult for their service to expand, and that the premises were outdated and not fit for purpose. In contrast, a few of the health centres were in purpose-built buildings. Inclusion Healthcare, Leicester, for example, occupies a purpose-built building with eight consultation rooms (CQC, 2015a). Health Central Surgery, Worthing, was initially located in a Salvation Army hall and had basic facilities. It has now moved to a purpose-built surgery.

Table 4.2: Characteristics of the specialist health centres

Service characteristics	Service provision	Base[1]
A Staff team and sessional workers		
Medical staff	100% had services provided by GPs and nurses. Number of GPs and nurses, and their hours varied. Nursing grades also varied.	28
Mental health workers	75% had services provided by mental health specialists (part of core team or sessional workers). This included mental health nurses, psychiatrists, counsellors and psychologists.	24
Drug and alcohol workers	79.2% had services provided by drug and alcohol workers (part of core team or sessional workers).	24
Podiatry	25% hosted clinics provided by podiatrists.	24
Dentistry	25% hosted clinics provided by dental staff. Varied from weekly surgery by dentist and dental nurse at one centre, to dental nurse visiting monthly at another.	24
Housing, financial or advice workers	45.8% had services provided by housing, financial or advice workers (mostly by sessional workers).	24
B Opening hours and GP registration		
Opening hours	96.4% open Monday-Friday; 3.6% open 3 days per week. 7.1% held clinics after 6.30 pm. None held clinics before 8 am or at weekends.	28
Type of registration	100% offered permanent GP registration. 54.2% also offered temporary registration.	24
Number of registered patients (January 2017)	29.6% had <500 patients. 22.2% had 500-1,000 patients. 33.3% had >1,000-2,000 patients. 14.8% had >2,000 patients.	27
C Outreach services		
Clinics held in hostels / day centres for homeless people	85.7% held clinics at least weekly in hostels or day centres, or was adjacent to a homelessness service. 14.3% did not hold clinics in hostels or day centres, and was not adjacent to a homelessness service.	28
Street outreach services	28.6% undertook regular street outreach work. 14.3% undertook occasional street outreach work in response to specific situations or requests from street outreach teams. 57.1% did not undertake street outreach work.	28
Hospital and intermediate care services	29.6% involved in hospital and / or intermediate care services.	27

Notes: 1. This column shows the number where information is available for each service characteristic. Total number 28.

4.1.3 Staff team and sessional workers

The numbers and skill-mix of staff who were either employed at the specialist health centres or conducted regular sessions at the services varied (Table 4.2). Besides GPs and practice nurses, most practices employed staff from many different disciplines. Three-quarters (75%) had one or more mental health specialists, and 79.2% had drug and alcohol workers, as part of the core team or as sessional workers. Health centres that also worked with families who were homeless had midwives and health visitors employed by the service or running clinics on a sessional basis. Nearly one-half (45.8%) of health centres had housing, financial or advice workers either as part of the core team or, in most instances, as sessional workers.

Six specialist health centres (25% of 24 centres where information was available) hosted regular clinics by podiatrists, and a similar percentage by dental staff. The extent of dental care that was available, however, varied. At Luther Street Medical Centre, Oxford, a dentist held a surgery once a week and had access to an equipped dental room. At Anchor Centre, Coventry, a dental nurse visited monthly and offered advice on dental hygiene and registration at a local dental practice (CQC, 2017a). Bevan House Primary Care Centre (Bradford) was piloting a dental programme with Dentaid, whereby newly-qualified dentists volunteered their time. Physiotherapists undertook sessional work at two health centres (Clock Tower Surgery, Exeter, and York Street Health Practice, Leeds).

Other health specialists running clinics on a sessional basis at one or more of the health centres included sexual health nurses, Blood Borne Viruses specialists, an acupuncturist (at Luther Street Medical Centre, Oxford), a dietician (at Bevan House Primary Care Centre, Bradford), and a hepatology specialist nurse (at Clock Tower Surgery, Exeter). At Camden Health Improvement Practice, London, a health navigator was employed by the practice, and funded by the local CCG, to support patients and ensure that they attended hospital and other appointments (CQC, 2017b).

Sixteen of 24 specialist health centres (66.7%) reported concerns about staffing levels and insufficient resources to cope with increased service demands (discussed below). Six health centres had experienced a reduction in staff hours or the ending of a post due to financial constraints. A few of the smaller specialist health centres mentioned difficulties in running the service when staff were on annual leave or absent due to illness. As the following managers described:

> *"GP retired and was not replaced … loss of funding for a nurse and reception support".*

> *"Reduced number of GP hours, and the counsellor position has gone … we do not have the capacity for medical outreach".*

> *"We are a stand-alone service with a small team … juggling sickness and annual leave can be difficult."*

4.1.4 Client groups, number of patients and GP registration

All specialist health centres accepted people who were homeless and staying in various living arrangements, including on the streets, in hostels, squats and bed-and-breakfast hotels, and people staying temporarily with relatives or friends (sometimes referred to as 'sofa-surfers'). Most also provided a service to other people who were marginalised or socially excluded, such as people who were refugees or seeking asylum, people with no recourse to public funds,

people who are sex workers, gypsies or travellers, people with problematic drug or alcohol use, women fleeing violence, ex-offenders, and people who were housed but had complex needs and had difficulty accessing mainstream GP services. In addition, two centres (St Werburgh's Practice for the Homeless, Chester, and Homeless Healthcare Team, Gloucester) provided health care to people allocated by NHS England through its Potentially Violent Patients Scheme. The aim of many specialist health centres was to transfer patients to mainstream GP practices once their health needs, housing and social situation had stabilised.

The number of patients registered at the specialist health centres in January 2017 varied. Of the 27 practices where information was available, 29.6% had less than 500 registered patients, while 48.1% had more than 1,000 (Table 4.2). The latter were mainly practices in London or large cities such as Birmingham, Bradford, Huddersfield, Leeds and Rotherham. Information was collected from 24 practices about the type of GP registration provided to patients. All provided permanent GP registration, including 13 that also offered temporary GP registration.

Six health centre managers reported a substantial increase in demand in recent years for their service and for specialist help – both patient numbers had increased greatly, and the health needs of patients were now more complex. At the same time, however, they reported that there had been no increase in resources, and some centres had experienced loss of staff posts or a reduction in staff working hours (discussed above).

4.1.5 Accessibility of the service to people who are homeless

All except one of the 28 specialist health centres were open Monday to Friday, and the majority were open each morning and afternoon. Most closed by 5.30 pm but four remained open until 6.30 pm. Only two centres held evening clinics – Anchor Centre was open to women once a week from 5 pm to 7 pm; and Bevan House Primary Care Centre (Bradford) stayed open until 8 pm once a week, and ran a clinic on three Thursday evenings per month from 7.30 pm until 10.30 pm for female sex workers. No health centres provided clinics before 8 am or at weekends.

Information about 'out-of-hours' cover was available for 27 health centres. Of these, 19 (70.4%) had arrangements for out-of-hours cover through another provider. The remaining eight centres advised patients to call NHS 111 for non-urgent medical help during the evenings and at weekends. Three health centre managers perceived restrictive opening hours and lack of out-of-hours cover to be limitations of their service.

Most centres reported that they offered longer appointment times than the customary 10 minutes, and provided both drop-in clinics and booked appointments. A common practice was to hold drop-in sessions each morning and booked appointments during the afternoon. This applied to many health centres, including Cambridge Access Surgery, Camden Health Improvement Practice, Clock Tower Surgery, and Luther Street Medical Centre. Bevan House Primary Care Centre operated a drop-in triage daily at 9 am for patients who were homeless, and a 'homeless drop-in' two mornings a week which people could attend with their support workers.

4.1.6 Clinics at homelessness services and on the streets

Of the 28 specialist health centres, 24 held at least weekly clinics in one or more hostels or day centres for people who were homeless, or they were adjacent to such services and therefore had regular contact with their clients. For example, a nurse from Newham Transitional Practice ran clinics at many

local services, including a large hostel, a bail hostel, drop-in centres and soup kitchens linked to local churches, and a project for sex workers. Likewise, in Gloucester, the Homeless Healthcare Team ran clinics at several soup kitchens and drop-in centres used by people who were homeless. It also provided health care to people who were homeless and staying in bed-and-breakfast hotels, and checked on their progress each week by phone. Just four specialist health centres did not conduct clinics in hostels or day centres and were not adjacent to such a service.

Staff from eight health centres were regularly engaged in street outreach work, and staff from a further four centres provided street outreach occasionally in response to specific situations or if requested by street outreach teams. For example, a GP, nurse and other staff from City Reach Health Services, Norwich, carried out an average of 10 hours' street outreach work per week. Likewise, a primary care nurse and a community alcohol worker from The Health Xchange, Birmingham, undertook weekly street outreach work. A nurse from Newham Transitional Practice undertook a street 'night round' together with staff from the local council and a drugs and alcohol worker. Bevan House Primary Care Centre had a 'Street Medicine Team' consisting of GPs, nurses, and a mental health nurse, who ran mobile outreach clinics five days per week on the streets and at several drop-in centres and soup kitchens. The team operated from a 'Street Medicine Bus'. An audit of the scheme had found that people's engagement with primary health care had increased since the service commenced (CQC, 2016a).

The managers of four specialist health centres that were not regularly engaged in street outreach work perceived this to be a limitation of their service. The main reasons given why their centre was unable to provide this service were financial pressures and lack of staff resources. One manager reported that nurse outreach sessions from the centre were stopped partly because of financial pressures and partly because senior managers did not regard them to be effective.

4.1.7 Hospital and intermediate care services

Three-tenths (29.6%) of specialist health centres were involved in hospital and / or intermediate care services. York Street Health Practice, Leeds, hosted the Homeless Accommodation Leeds Pathway (HALP), which was developed in 2013 by Leeds Community Healthcare NHS Trust in collaboration with St George's Crypt (a charity working with people who are homeless). HALP worked with people who were homeless and either admitted to local hospitals or attended A&E departments to improve their care and help plan discharge, and intermediate care was available to those leaving hospital in one of three beds at St George's Crypt. Support to people who were homeless and admitted to hospital was also provided by the following health centres: Arch Healthcare (Brighton), Bevan House Primary Care Centre (Bradford), and Health E1 (London). The services described in this section all work to the Pathway model (described in Chapter 1).

Bevan Healthcare CIC, Bradford, had further developed BRICSS (Bradford Respite and Intermediate Care Support Service), in collaboration with Horton Housing. BRICSS had 14 beds and offered short-term accommodation to people who were homeless or vulnerably housed and were ready to be discharged from hospital but still had significant health and support needs. Horton Housing managed the accommodation, and Bevan Healthcare provided clinical care to the residents. Likewise, the Homeless Healthcare Team, Gloucester, was a partner in the 'Time to Heal' project developed by Elim Housing in 2013. The latter found accommodation and provided support

to people who were homeless on discharge from Gloucester Royal Hospital, and the Homeless Healthcare Team managed their health needs.

Great Chapel Street Medical Centre, London, operated the Intermediate Care Network as an alternative to hospital care for people who were homeless and on the streets and had health conditions that were difficult to treat while they remained on the streets. The service was commissioned by NHS Central London CCG, and was run by Hestia in partnership with Westminster City Council. Intermediate care was provided for up to six weeks in designated beds in hostels and bed-and-breakfast hotels across Central London (Great Chapel Street Medical Centre, 2016). In Chester, St Werburgh's Practice for the Homeless had a medical respite bed in a local hostel.

4.1.8 Social and welfare support

Besides addressing the health needs of people who were homeless, many specialist health centres provided other types of support. As mentioned earlier, nearly one-half offered housing, financial and welfare advice. For example, Great Chapel Street Medical Centre, London, employed a social advocacy worker to offer advice around housing, immigration, welfare rights, debts and employment. The worker assisted patients with job applications, represented them at Benefits Appeal Tribunals, liaised with housing services on behalf of patients, and undertook outreach work on the streets and in hostels with a practice nurse (CQC, 2015b). At three health centres, Citizens Advice workers ran advice sessions for patients.

Many health centres allowed people who were homeless to use the practice address in order to receive post. Several also provided financial assistance or day bus passes to enable people in need to attend appointments at the surgery or at hospital. Bevan House Primary Care Centre distributed clothing, food, personal hygiene packs, and 'cold weather packs' (consisting of gloves, socks, hat, scarf, water and chocolate) to those in urgent need (CQC, 2016a). Likewise, The Gate Surgery, Rotherham, had a food and clothes bank for people who were homeless, and distributed 'winter rescue packs' (see template). It also opened on Saturdays in the winter months to offer soup, warmth and a meeting place for vulnerable patients. St Werburgh's Practice for the Homeless had showers that people who were homeless could use, and provided clothing and toiletries where needed. Each year, the practice also launched a Christmas 'sock appeal' so that new socks could be given to patients (CQC, 2015c).

4.2 GP practices with homeless services

The survey identified 61 GP practices that provided enhanced or specific services for people who are homeless (see Section 2.3 for definition). Most (n=59) were mainstream practices that provided health care to the general population – the remaining two were specialist GP practices that provided health care primarily to people with problematic drug and alcohol use. Eight practices also registered people who had been removed from other GP surgeries due to aggressive or violent behaviour and were allocated under the Potentially Violent Patients Scheme.

Table 4.3 provides brief details for 53 of the 61 GP practices. Of the remainder, three requested that their details are not included as they no longer provide specific services for people who are homeless, four still provided such services but did not wish their details to be shared, and it was not possible to ascertain whether one GP practice continued to provide such services. Most of the information regarding staff composition, opening hours, and number of registered patients has been gathered from the GP practices' websites and from their CQC reports. Wherever possible, details relating to service provision

for people who are homeless has been collected from the practice managers. This has also been supplemented by information obtained during the survey of hostels and day centres.

Table 4.3: GP practices in England with homeless services

Name of practice[1]	Location	Start of homeless service	Clinical Commissioning Group
NHS North Region			
Brownlow Health	Liverpool, Merseyside	Approx. 10 years ago	NHS Liverpool
Cornerstone Surgery	St Helen's, Merseyside	n.a.	NHS St Helens
Cornerways Medical Centre	Huyton, Merseyside	2016	NHS Knowsley
Cruddas Park Surgery	Newcastle upon Tyne, Tyne and Wear	n.a.	NHS Newcastle Gateshead
Devonshire Green and Hanover Medical Centres	Sheffield, South Yorkhire	24+ years ago	NHS Sheffield
Eric Moore Partnership Medical Practice	Warrington, Cheshire	2012	NHS Warrington
Open Door Surgery	Grimsby, Lincolnshire	2007	NHS North East Lincolnshire
Park View Surgery	Preston, Lancashire	n.a.	NHS Greater Preston
Premier Health Team	Leigh, Lancashire	n.a.	NHS Wigan Borough
The Quays Medical Practice	Kingston upon Hull, East Riding of Yorkshire	n.a.	NHS Hull
The White House Surgery	Sheffield, South Yorkshire	1990	NHS Sheffield
Urban Village Medical Practice	Manchester, Greater Manchester	1999	NHS North Manchester
York Medical Group	York, North Yorkshire	2015	NHS Vale of York
NHS Midlands and East Region			
Avenue House Surgery	Chesterfield, Derbyshire	2010	NHS North Derbyshire
Bassett Road Surgery	Leighton Buzzard, Bedfordshire	Approx. 2010	NHS Bedfordshire
Bellevue Medical Centre	Birmingham, West Midlands	n.a.	NHS Birmingham South Central
Estuary Healthcare Services	Southend-on-Sea, Essex	n.a.	NHS Southend
Family Medical Centre – Sood	Nottingham, Nottinghamshire	1983	NHS Nottingham City
Farrier House Surgery	Worcester, Worcestershire	2015	NHS South Worcestershire
Kirkley Mill Health Centre	Lowestoft, Suffolk	2016	NHS Great Yarmouth and Waveney
Larkside Practice	Luton, Bedfordshire	n.a.	NHS Luton
Maple Access Partnership	Northampton, Northamptonshire	2001	NHS Nene
NEMS Platform One Practice	Nottingham, Nottinghamshire	2010	NHS Nottingham City

Table 4.3: GP practices in England with homeless services (continued)

Name of practice	Location	Start of homeless service	Clinical Commissioning Group
NHS Midlands and East Region (continued)			
Roundwood Surgery	Mansfield, Nottinghamshire	2009	NHS Mansfield and Ashfield
The Windmill Practice	Nottingham, Nottinghamshire	1988	NHS Nottingham City
Wilson Street Surgery	Derby, Derbyshire	2011	NHS Southern Derbyshire
NHS South West Region			
Broadmead Medical Centre	Bristol	2009	NHS Bristol
Carfax NHS Medical Centre	Swindon, Wiltshire	2009	NHS Swindon
Cumberland Surgery[2]	Plymouth, Devon	n.a.	NHS Northern, Eastern and Western Devon
Graham Road Surgery	Weston-super-Mare, Avon	n.a.	NHS North Somerset
Leatside Surgery	Totnes, Devon	2014	NHS South Devon and Torbay
Providence Surgery	Bournemouth, Dorset	Approx. 2006	NHS Dorset
Royal Crescent Surgery	Weymouth, Dorset	2016	NHS Dorset Group
Three Swans Surgery	Salisbury, Wiltshire	n.a.	NHS Wiltshire
Victoria Gate Surgery	Taunton, Somerset	n.a.	NHS Somerset
NHS South East Region			
Bersted Green Surgery	Bognor Regis, West Sussex	2014	NHS Coastal West Sussex
Dapdune House Surgery	Guildford, Surrey	2000	NHS Guildford and Waverley
Guildhall Walk Healthcare Centre	Portsmouth, Hampshire	n.a.	NHS Portsmouth
Medwyn Surgery	Dorking, Surrey	2013	NHS Surrey Downs
Priory Surgery	High Wycombe, Buckinghamshire	n.a.	NHS Chiltern
Southview Medical Practice	Woking, Surrey	2015	NHS North West Surrey
St Clements Surgery	Winchester, Hampshire	2011	NHS West Hampshire
The College Practice	Maidstone, Kent	2014[3]	NHS West Kent
Victoria Practice	Aldershot, Hampshire	2009 (or earlier)	NHS North East Hampshire and Farnham
NHS London Region			
Brook Green Medical Centre	LB Hammersmith & Fulham	n.a.	NHS Hammersmith & Fulham
Dr Curran and Partners	LB Lambeth	n.a.	NHS Lambeth
Mawbey Group Practice	LB Lambeth	Before 2003	NHS Lambeth
Nexus at Princess Street Practice	LB Southwark	n.a.	NHS Southwark

Table 4.3: GP practices in England with homeless services (continued)

Name of practice	Location	Start of homeless service	Clinical Commissioning Group
NHS London Region (continued)			
Richford Gate Medical Practice	LB Hammersmith & Fulham	2016	NHS Hammersmith & Fulham
Rushey Green Group Practice	LB Lewisham	1996	NHS Lewisham
The Good Practice	LB Kensington & Chelsea	2015	NHS West London
The Redcliffe Surgery	LB Kensington & Chelsea	n.a.	NHS West London
Waterloo Health	LB Lambeth	n.a.	NHS Lambeth

Notes: 1. Details not included for three GP practices that no longer provide specific services to homeless people, four who still provide such services but did not wish their details to be shared, and one practice where it is unknown whether they still provide homeless services. 2. Cumberland Surgery closed in 2017 and the homeless service provided by the GP transferred to Adelaide Street Surgery. 3. Service previously provided by another GP practice since around 2009. n.a. not available.

Of the 61 GP practices with homeless services, information was available from 36 about when their targeted services to people who were homeless began – six had been providing such services since the 1990s or earlier, while 12 had started to provide targeted services in 2014 or more recently. As shown in Table 4.4, the services offered to people who were homeless by the 61 GP practices varied between practices. This is now discussed.

4.2.1 Staff team and sessional workers

The number of staff involved in the delivery of health care to people who were homeless varied between GP practices. At most, people who were homeless received health care from various GPs and nurses if they attended the practice, but a dedicated GP and / or nurse ran clinics at a hostel or day centre. A few practices had a team of health professionals dedicated to providing care to people who were homeless. For example, in Manchester, the Urban Village Medical Practice's Homeless Healthcare Service consisted of two GP partners who led on the delivery of the homeless service, a Homeless Team Manager, a specialist practice nurse, three specialist case managers, and an administrator. It established the Manchester Pathway, a hospital in-reach service offering assessment of medical and social needs and discharge planning for homeless people admitted to hospital. It also undertook case management of homeless patients that were frequent attenders at the A&E department, and those with complex needs who were discharged from hospital. Likewise, Brownlow Health, in Liverpool, operated a homelessness service run by two dedicated homelessness nurses, a specialist alcohol nurse, a GP, and a shared care drugs worker.

Nearly three-quarters (72.4%) of GP practices had one or more mental health specialists, including mental health nurses or counsellors, as part of the core team or as sessional workers. Just over one-half (56.9%) of practices had input from drug or alcohol workers who were either part of the team or sessional workers who ran clinics at the practice. At Leatside Surgery, Totnes, for example, three GPs offered a recovery programme to patients suffering from problematic drug or alcohol use. In West London, a GP from The Good

Practice ran a weekly clinic for homeless people at a church, in conjunction with mental health and substance misuse workers. Together with a specialist substance misuse worker, weekly substance misuse clinics were held at the Family Medical Centre (Sood), in Nottingham. Devonshire Green and Hanover Medical Centres, Sheffield, had close links with the Homeless Mental Health Team, which was based within the practice. It also worked closely with Hepatitis C treatment services to encourage patients into treatment. A few GP practices (17.2%) received services from a housing, financial or advice worker, mainly through sessions held by a Citizens Advice worker.

Table 4.4: Key characteristics of GP practices with homeless services

Service characteristics	Service provision	Base[1]
A Staff team and sessional workers		
Medical staff	100% had services provided by GPs and nurses. Number of GPs and nurses, and their hours varied. Nursing grades also varied.	61
Mental health workers	72.4% had services provided by mental health specialists (part of core team or sessional workers). This included mental health nurses, counsellors and psychologists.	58
Drug and alcohol workers	56.9% had services provided by drug and alcohol workers (part of core team or sessional workers). Some GPs were specialists in this field.	58
Housing, financial or advice workers	17.2% had services provided by housing, financial or advice workers (mostly by sessional Citizens Advice workers).	58
B Opening hours and number of registered patients		
Opening hours	100% open Monday-Friday. 24.6% held a clinic at least once a week before 8 am. 63.9% held a clinic at least once a week after 6.30 pm. 45.9% were open at some time during the weekend.	61
Number of registered patients	15.5% had up to 5,000 patients. 44.9% had >5,000-10,000 patients. 39.6% had >10,000 patients.	58
C Drop-in sessions and outreach services		
Drop-in sessions	29.8% provided drop-in clinics / walk-in sessions for people who were homeless.	57
Clinics held in hostels and day centres for homeless people	66.7% held clinics at least weekly in hostels or day centres. 7.0% held clinics less than weekly in hostels or day centres. 26.3% no outreach clinics in hostels or day centres.	57
Street outreach services	13.3% undertook street outreach work 86.7% did not undertake street outreach work.	60

Notes: 1. This column shows the number of GP practices where information is available for each service characteristic. Total number 61.

4.2.2 Accessibility of the service to people who are homeless

All GP practices were open Monday to Friday and nearly one-half (45.9%) were open at some time during the weekend (usually Saturday mornings for booked appointments). One quarter held early morning clinics, and almost two-thirds evening clinics, at least once a week (Table 4.4). The size of the practices varied greatly: 15.5% had 5,000 registered patients or less, while 39.6% had more than 10,000 patients. Several GP practices allowed people who were homeless to register and receive health appointments using the practice address. Three-tenths held regular drop-in clinics at the surgery exclusively for this patient group, or had daily walk-in appointments for them. For example, the Urban Village Medical Practice ran a weekly drop-in clinic every Wednesday afternoon for people who were homeless, which was staffed by GPs, practice nurses, a wound care nurse, a community psychiatric nurse, drugs workers, and a social worker from the drug service. It also held specialist clinics during the week for people who were homeless, including three wound care clinics, and an infectious disease clinic to facilitate access to treatment for Hepatitis C and other blood borne viruses.

Similarly, Brownlow Health, in Liverpool, ran a Homeless Access Clinic every Thursday afternoon specifically for people who were homeless. During these sessions, secondary care consultants often visited to advise on specific health problems, such as chronic obstructive pulmonary disease or diabetes, and organisations such as Crisis and Citizens Advice provided advisory services. Guildhall Walk Healthcare Centre, Portsmouth, ran a weekly 'additional support clinic' for people who were homeless or had mental health problems or problematic drug or alcohol use, and found it difficult to register with a GP practice or access other mainstream health services.[3] Premier Health Team, in Leigh, Lancashire, held two drop-in clinics at the surgery each week for homeless people in the locality (CQC, 2017c).

Some GP practices either allocated several appointments each day for people who were homeless and might arrive at the surgery, or ensured that they would be attended to if they came to the practice. NEMS Platform One Practice, Nottingham, had a high number of patients registered from hard-to-reach groups, including people who were transient, homeless, or had multiple illnesses and social needs. The practice held several appointments each day to accommodate urgent requests from patients who could not cope with an appointment system, and arranged transport for those who struggled to attend appointments. It also extended its boundary so that people who were homeless could remain registered if they moved to a neighbouring area (CQC, 2015d). In Worcester, Farrier House Surgery offered morning and afternoon GP emergency appointments to people who were homeless, and to new arrivals to the city who presented at the local homeless day centre, were not registered with a GP, and required medication or other emergency care.

Other ways to encourage people who were homeless to access health care had been implemented at some GP practices. At The Quays Medical Practice, Kingston upon Hull, the staff organised support evenings on the practice premises, where a stall was set up to distribute clothing, warm food, drinks and toiletries to homeless people. The service was communicated to homeless people through hostels, soup kitchens and word of mouth. Practice staff also searched the local area to hand out provisions to people who were homeless and on the streets (CQC, 2016b). The practice manager at Leatside Surgery, Totnes, sought advice from the practice's patient participation group about reaching out to people who were homeless or hard-to-engage, raising their awareness of the services available, and encouraging them to access services.

3 www.guildhallwalkgp.nhs.uk/what-we-do/clinics/additional-support-clinic (accessed 25 October 2017)

4.2.3 Using medical records to alert practice staff of people who are homeless

Several GP practices had established systems to identify patients who are homeless, at risk, and required extra help to ensure that they received medical care. The Good Practice in West London, for example, maintained a register of people living in vulnerable circumstances, including those who were homeless. These patients had 'pop ups' on their electronic medical record to alert staff of their vulnerability and additional needs, such as the need for double appointments and risk assessments. Likewise, the Bassett Road Surgery in Leighton Buzzard, Bedfordshire, had a system whereby people who were homeless were given an 'orange card' status on their medical record. This alerted practice staff of their needs, such as longer appointment times, and the staff endeavoured to ensure that they were seen by just one of two doctors to help with continuity of their care.

A third GP practice, in South London, had developed a 'green list' for people who were vulnerable and did not attend appointments. If such patients telephoned or presented at the practice, they would be prioritised and seen within an hour. This provided more flexibility in terms of accessing appointments and health care, and reduced the number of non-attendees. Three Swans Surgery, in Salisbury, Wiltshire, had identified that ex-military personnel were at high risk and had flagged their medical records accordingly to ensure that consideration was given to liaising with the charity SSAFA (Soldiers, Sailors, Airmen and Families Association) at times of difficulty (CQC, 2016c).

4.2.4 Clinics at homelessness services and on the streets

Three-quarters of GP practices with homeless services held clinics in one or more hostels or day centres for homeless people (Table 4.4). Most provided this service at least once a week, including 15 practices (26.3%) that held such clinics three or more times a week. Some of these clinics were run by GPs, some by practice nurses, and some by a combination of GPs and nurses. For example, a nurse from Avenue House Surgery, in Chesterfield, ran a clinic five days a week at the local homeless day centre. Likewise, in Winchester, clinics were held twice a week at the homeless day centre by a GP from St Clements Surgery, and twice a week by a nurse from the surgery. A GP from the Family Medical Centre (Sood), in Nottingham, ran twice weekly clinics at local hostels in collaboration with nurses from the mobile Homeless Health Team in Nottingham (described in next section).

The staff at Eric Moore Partnership Medical Practice, Warrington, had found that outreach clinics resulted in people who were homeless engaging with health care and eventually attending the GP practice, and not using accident and emergency departments unnecessarily (CQC, 2016d). At Southview Medical Practice in Woking, Surrey, where a GP regularly visited a homeless shelter, it was also found that this helped increase the residents' attendance at the GP surgery and had a positive impact on their health outcomes (CQC, 2016e). Several used health care services for the first time in years, and some with long-term conditions received specialist help which they had not previously accessed. Similarly, a nurse from Roundwood Surgery, in Mansfield, Nottinghamshire, ran a weekly clinic at a local church providing drop-in services for people who were homeless. The clinic was held at mealtimes to maximise attendance. The GP practice found that it took a while to gain the trust of people who were homeless, but over time the staff built up a good rapport with them and they became more willing to attend the GP surgery for medical care and to have dressings changed.

Health staff from eight GP practices (13.3%) undertook work on the streets to engage with rough sleepers who were not accessing health care. Providence Surgery, in Bournemouth, for example, operated a mobile 'health bus' once a week, which parked in the town centre and offered GP services to people who were homeless and hard-to-engage. The surgery intended to increase the number of days that the mobile bus operated if funding could be obtained. Bellevue Medical Practice, Birmingham, worked closely with a faith-based charity to distribute food three times a week to people who were homeless and on the streets (CQC, 2016f). This provided an opportunity for GPs to identify health problems and offer extra help to people at high risk. The close working relationship between the GP practice and the homeless charity also aided referrals between the services when needs were identified. GPs from Leatside Surgery, Totnes, offered an outreach service to two traveller communities in the area to ensure that they were aware of the services available.

4.2.5 Social and welfare support

Besides addressing the health needs of people who were homeless, some GP practices with homeless services provided other types of support. Some practices referred or signposted people who were homeless to social and welfare services where appropriate, such as to local food banks. For example, Medwyn Surgery in Dorking, Surrey, was the hub for the Dorking Food Bank. The staff at The Quays Medical Practice, Kingston upon Hull, organised support evenings on the practice premises, where a stall was set up to distribute clothing, warm food, drinks and toiletries to people who were homeless (CQC, 2016b). The service was communicated to people who were homeless through hostels, soup kitchens and word of mouth. Practice staff also searched the local area to hand out provisions to people who were homeless and on the streets. For the past three years in October, the Urban Village Medical Practice, Manchester, has run a 'Socktober' campaign. The Homeless Team collected socks to distribute to people who were homeless in order to promote foot care, and prevent trench foot and the spread of infections. In 2016, more than 2,000 pairs of socks were donated by patients at the surgery, and through collection points in the community.

One GP practice, in South England, established an arrangement with the Department for Work and Pensions (DWP) whereby sickness certificates were emailed directly to the DWP to avoid delays in their submission which could result in benefit sanctions. Cornerstone Surgery in St Helens, Merseyside, arranged for hospital appointment letters for homeless patients to be sent to the practice. The practice staff then liaised with local homelessness services to identify a person to accompany the patient to the appointment. At Leatside Surgery, Totnes, the practice staff worked with the Caring Town Totnes group to raise awareness of the issue of homelessness in the area. Through collaboration with the voluntary sector and NHS England, Royal Crescent Surgery, Weymouth, raised funds to develop a local outdoor exercise programme for homeless people and other patient groups (see template). A few GP practices were involved in fund-raising or support activities in collaboration with homelessness services (see template: Cornerways Medical Centre, Liverpool).

4.3 Mobile homeless health teams

The survey identified 12 mobile health teams that worked primarily with single people who were homeless. These are listed in Table 4.5, although the Health Inclusion Team in Stoke-on-Trent is no longer in operation, having ended in early 2017. Three of the teams (in Nottingham, Sheffield and South London) have been operating since the early 1990s, while the team in Weston-super-Mare commenced in 2014 and the one in Wigan in 2016. Although most of the teams were based in urban areas, some nonetheless covered a wide geographical area. For example, Health Outreach NHS is based in Ipswich, but the team ran clinics in several market towns and other locations across Suffolk, including Felixstowe, Sudbury, Stowmarket and Leiston. The distance between Ipswich and Leiston is approximately 25 miles. Likewise, Cornwall Health for Homeless served three locations (Camborne, Penzance and Truro). The distance between Penzance and Truro is approximately 26 miles.

4.3.1 Staff team and sessional workers

The mobile teams mainly consisted of nurses and nurse practitioners. Some had several staff who were employed by the service or were sessional workers, while other teams involved just two nurses and an administrator. A few had GPs on the team or worked closely with GP practices. Cornwall Health for Homeless had three GPs on the team, while nurses from the Homeless Health Service in Nottingham ran joint clinics in some hostels with a GP. The Health Inclusion Team (South London), and Health Outreach NHS (Suffolk), also had input from GPs. Nurses from the Central London Community Healthcare Homeless Health Team worked closely with two health centres primarily for people who were homeless – The Doctor Hickey Surgery and Great Chapel Street Medical Centre (described earlier). Three of the teams had input from a mental health nurse, and a fourth from a counsellor. The managers of three teams without mental health workers identified this as a limitation of their service. None of the teams included drug or alcohol workers. Instead some teams ran health clinics at specialist services for people with problematic drug and alcohol use. Health Outreach NHS (Suffolk) had social workers and support workers on the team. Two teams (Central London Community Healthcare Homeless Health Team, and Community Outreach Team, Weston-super-Mare) offered regular sessions from a podiatrist, and the latter also had input from a Citizens Advice worker and a housing advice worker.

Table 4.5: Mobile health teams in England working primarily with single people who are homeless

Name of service	Location / base	Year started	Managed by	NHS region	Clinical Commissioning Group
Central London Community Healthcare Homeless Health Team	LB Westminster, Greater London	2002	Central London Community Healthcare NHS Trust	London	NHS Central London (Westminster)
Community Outreach Team	Weston-super-Mare, North Somerset	2014	North Somerset Community Partnership	South West	NHS North Somerset
Cornwall Health for Homeless	Truro, Cornwall	2003	Cornwall Partnership NHS Foundation Trust	South West	NHS Kernow
Health for the Homeless – St Helen's	St Helens, Merseyside	2006	Bridgewater Community Healthcare NHS Foundation Trust	North	NHS St Helens
Health Inclusion Team	Sheffield, South Yorkshire	1992	Sheffield Health and Social Care NHS Foundation Trust	North	NHS Sheffield
Health Inclusion Team[1]	Stoke-on-Trent	2010	Staffordshire and Stoke on Trent Partnership NHS Trust	Midlands and East	NHS Stoke-on-Trent
Health Inclusion Team, South London	LB Lambeth, Lewisham and Southwark, Greater London	1992	Guy's and St Thomas' NHS Foundation Trust	London	Hosted by Lambeth
Health Outreach and Inclusion Service	Wigan, Greater Manchester	2016	Bridgewater Community Healthcare NHS Foundation Trust	North	NHS Wigan Borough
Health Outreach Liaison Team (HOLT)	Reading, Berkshire	n.a.	Berkshire Healthcare NHS Foundation Trust	South East	n.a.
Health Outreach NHS	Ipswich, Suffolk	n.a.	Essex Partnership University NHS Foundation Trust	Midlands and East	NHS West Suffolk and Ipswich and East
Homeless and Vulnerable Adults Specialist Nursing Service	Bolton, Lancashire	2006	Bolton NHS Foundation Trust	North	NHS Bolton
Homeless Health Service	Nottingham, Nottinghamshire	Around 1990	Nottingham CityCare	Midlands and East	NHS Nottingham City

Notes: 1. Service closed in early 2017. n.a. not available

4.3.2 Patient groups and numbers

The mobile teams worked with people who were homeless and other vulnerable groups who found it difficult to access mainstream services, such as people seeking asylum and those with no recourse to public funds, gypsies and travellers, migrant workers, people with mental health or problematic drug and alcohol use, ex-offenders, sex workers, women fleeing domestic violence, and vulnerably housed people. They ran clinics or saw patients in hostels, bed-and-breakfast hotels, day centres, soup kitchens, accommodation for ex-offenders or bail hostels, refuges, and other temporary accommodation and drop-in facilities used by homeless people. Some of the larger teams ran clinics at many sites. The Health Inclusion Team (South London), for example, ran clinics at 36 sites across three London boroughs (Lambeth, Lewisham and Southwark).

It is difficult to report the number of patients that the teams work with. Most did not provide GP registration but had a list of patients which changed constantly as new people were seen and others no longer used the service. For example, the Health Outreach and Inclusion Service, Wigan, saw approximately 150 new referrals every three months. Central London Community Healthcare Homeless Health Team, in LB Westminster, saw approximately 1,400 patients each year, which involved 5,500 consultations during this period. Likewise, around 60-70 patients were seen each week by the Homeless and Vulnerable Adults Specialist Nursing Service in Bolton.

4.3.3 Clinics and services

The teams operated Monday to Friday, usually from 8.30 am or 9 am to 5 pm. The Health Inclusion Team (South London) also held some evening clinics. Five of the teams undertook regular street outreach work, often in the evenings or early mornings, and a sixth team undertook street outreach work when needed. For example, the Health Outreach and Inclusion Service, Wigan, engaged in targeted outreach work in the evenings and at weekends, and Nottingham's Homeless Health Service did outreach work early morning (from 5 am) twice a week with the street outreach team. Likewise, Bolton's Homeless and Vulnerable Adults Specialist Nursing Service undertook weekly 'walk-about-town' sessions with the Homeless Welfare Team to advise homeless people about accessing health care.

The main types of help provided by the mobile teams included: comprehensive health assessments; health screening; treatment for minor illnesses, wounds, injuries and infestations; advice on the management of long-term conditions; health promotion such as advice on diet, and safer sex and drug use; and referrals and support to register with GPs and access other health and social care services. Some teams carried out routine blood tests, immunisations and vaccinations, and provided help to stop smoking, and some had nurses trained to prescribe certain medicines and dressings. The teams worked closely with other local services and agencies.

4.4 Other specialist primary health care services

Twenty-two additional primary health care services that targeted people who were homeless were identified during the mapping exercise. Seven involved a nursing service based at one hostel or day centre four or five days a week. Such services were, for example, found at the following day centres: Beacon House (Colchester), The Welcome Centre (Ilford), and New Horizon Youth Centre (LB Camden). The nurses provided services such as health assessments and screening, management of chronic and long-term health conditions, and wound care. The nurse from Beacon House also provided an outreach service at a soup

run in Colchester for people who were homeless. At two of the services which operated at day centres, other health professionals worked in collaboration with the nurse. For example, Homeless Healthcare Redbridge, based at The Welcome Centre (Ilford), consisted of a lead nurse practitioner, a healthcare assistant, and sessions that were led by a massage therapist, a counsellor, a podiatrist, and an exercise coach. Likewise, the Health Team at New Horizon Youth Centre consisted of a nurse, a nutrition and cookery tutor, and a sports and men's worker.[4] Some of the seven services received funding from the NHS, while others relied on charitable funding and money raised by homelessness service providers. For example, Homeless Healthcare Redbridge was mainly funded by the Big Lottery.

There were four examples of a single-handed mobile nurse who ran clinics in a few homelessness services. For example, a Homeless Health Pilot in the London Borough of Hammersmith & Fulham involved one specialist nurse who ran clinics at three local hostels and a day centre for people who were homeless. The nurse's work included health assessments and screening, management of long-term health conditions, routine blood tests, vaccinations, and engaging homeless people with GP services and other NHS care. By being present in the homelessness services regularly, the nurse could engage with people who were homeless and encourage them to address their health needs.

Five volunteer health care services were identified. Some were provided entirely by volunteers and some by paid health professionals with volunteers. For example, St John Ambulance Brighton Homeless Service, Brighton, has been in operation since 2000. A volunteer nurse and voluntary worker ran a weekly drop-in clinic at a local day centre for people who were homeless, and a mobile 'treatment centre' on Brighton seafront one evening each week. Its services included health assessments, treatment of wounds or changing of dressings, and support to register with GPs and referrals to other services. Likewise, St John Ambulance Hastings Homeless Service has been in operation since 2003, and consisted of a nurse co-ordinator who managed a team of 12-18 volunteers, including some who had a nursing background. It ran health clinics at a soup kitchen and a day centre for people who were homeless, and provided similar services to those of St John Ambulance Brighton Homeless Service. Both these services relied on charitable funding. Greenlight is a Social Justice Initiative that involved a team of skilled volunteers in a medical van doing street outreach work in London in the evenings, and running sessions at soup kitchens and drop-in centres used by people who were homeless. It offered minimal invasive medical care to people who were homeless and on the streets, provided advice, and signposted them to health and other services. It operated in several London boroughs, including Croydon, Hackney, and Hammersmith & Fulham.

A further six health schemes provided health care to homeless people through other nursing or medical arrangements that did not fit into any of the categories already described in this chapter. For example, Mastercall Healthcare, Stockport, was established in 1996 as a social enterprise organisation to provide a range of 'out of hospital' health care services across north-west England. Since 2009, it has provided GP clinics twice a week, and a clinic run by an advanced nurse practitioner three times a week, at The Wellspring day centre for people who are homeless. The nurse also provided support to residents of local hostels. Similarly, Fylde Coast Medical Services (FCMS) was established in 1994 as a non-profit making GP co-operative to

4 nhyouthcentre.org.uk/what-we-do/health-and-fitness (accessed 13 September 2017)

provide out-of-hours medical services in the Blackpool, Fylde and Wyre areas.[5] A GP from FCMS ran a weekly clinic at a day centre in Blackpool for people who were homeless, and a nurse ran a clinic twice a week at the day centre. In London, NHS Barnet CCG funded doctors from local GP practices to provide regular sessions at Homeless Action in Barnet, a day centre for people who were homeless (NHS Barnet CCG, 2016).

4.5 Comparison of models including those identified in the 2010 DH report

Nearly three-quarters of specialist primary health care services identified in the mapping exercise were either specialist health centres, or GP practices with homeless services. There were, however, key differences in the services provided by these two models. The specialist health centres worked primarily with people who were homeless and tended to have many fewer patients than the GP practices with homeless services. They were also more likely to provide specialist services such as drug and alcohol clinics, and housing or financial advice sessions, although around three-quarters of services in both models had services provided by mental health specialists. Specialist health centres were less likely, however, to offer extended opening hours. Unlike GP practices with homeless services, none of the specialist health centres opened early morning (before 8 am) or at weekends, and only a minority offered evening clinics. The specialist health centres and GP practices with homeless services offered GP registration, but this was not generally the case for other models.

Most of the specialist primary health care services identified during the mapping exercise fitted into one of the first three models described in 2010 by the DH Office of the Chief Analyst (see Chapter 1). Their characteristics, however, differed in several ways (Table 4.6). The first model identified in the DH report was 'mainstream practices providing services for homeless people', whereby a GP held regular sessions in a drop-in centre for people who were homeless or saw them at the GP surgery. The DH report suggested that this model was the 'least specialised and dedicated service', the GP practice may not register patients, there was no 24/7 provision, and that it was likely to be appropriate in areas with a small population of people who were homeless. This model is comparable to that of 'GP practices with homeless services' described in the mapping exercise. Most of these GP practices registered homeless people, had arrangements for out-of-hours cover, and there were examples of this model operating in large cities such as Liverpool and Manchester, which have large numbers of people who are homeless, and dedicated staff teams to deliver the service.

The second model in the DH report was an 'outreach team of specialist homelessness nurses' who 'provide advocacy and support, dress wounds etc., and refer to other health services including dedicated GP clinics'. The outreach team was unlikely to provide GP registration and did not provide 24/7 cover. This model is comparable to the 'mobile homeless health teams' identified in the mapping exercise that ran clinics at different hostels and centres used by people who are homeless. Although the teams mainly consisted of nurses, some also involved other health professionals, including one team that included GPs. The DH report suggested that this model was likely to be appropriate in areas with small numbers of people who are homeless. The mapping exercise found, however, that this model operated both in large cities such as Nottingham and in South London, as well as in rural areas and small market towns, such as parts of Cornwall and Suffolk.

5 fcms-nw.co.uk/about (accessed 13 September 2017)

Table 4.6: Comparison of models of specialist primary health care services

DH Office of the Chief Analyst, 2010	Mapping exercise 2017 (HEARTH study)
Mainstream practices provide services for homeless (Model 1) GP from mainstream practice holds regular sessions for people who are homeless in drop-in centre or sees them at the surgery. May not register patients. No 24/7 provision.	**GP practice with homeless services** GPs and / or practice nurses from GP practice run clinics in hostels or drop-in centres used by people who are homeless. Many also provide targeted services for people who are homeless at the GP practice. People who are homeless are encouraged to register with the practice. Most who attend the practice are registered. Out-of-hours cover available for those who are registered.
Outreach team of specialist homelessness nurses (Model 2) An outreach team of specialist nurses provide advocacy and support, dress wounds etc, and refer to other health services including dedicated GP clinics. Unlikely to register patients and no 24/7 provision.	**Mobile homeless health team** Mobile team consisting mainly of nurses, although a few have input from other services including GPs, mental health specialist, podiatrist, social worker or housing advice worker. Unlikely to provide GP registration and no 24/7 provision.
Full primary care specialist homelessness team (Model 3) Team of specialist GPs, nurses and other services (CPN, podiatry, substance misuse) provide dedicated and specialist care. Co-located with a hostel / drop-in centre. Usually registers patients and provides 24/7 cover.	**Specialist health centre primarily for people who are homeless** Team of specialist GPs, nurses and other services (e.g. mental health, substance misuse, dentistry, podiatry, housing / financial advice) provide dedicated and specialist care. Most are 'stand-alone' buildings in the community. A few are located at a hostel or day centre; most others run clinics in hostels and day centres. Usually registers patients and out-of-hours cover is available for those who are registered with the practice.
Fully coordinated primary and secondary care (Model 4) Team of specialists spanning primary and secondary care provide an integrated service, including specialist primary care, outreach services, intermediate care beds and in-reach services to acute beds. Model based on services in Boston, Massachusetts, but was believed to be unavailable in England.	**Integrated model** This is an emerging model. Eight specialist health centres and one GP practice with homeless services provide integrated services that span primary and secondary care.

The third model in the DH report was 'full primary care specialist homelessness team', described as a team of specialist GPs, nurses and other services (CPN, podiatry, substance misuse specialists) who provide dedicated and specialist care. According to the DH report, the team is co-located with a hostel / drop-in centre, usually registers patients, and provides 24/7 cover. This model is comparable to the 'specialist health centres' identified in the mapping exercise, but with some differences. Although some of the latter were located at a hostel or drop-in centre, others operated from 'stand-alone' premises. Some of these were adjacent to homelessness services. The authors of the DH report suggested that the third model is likely to be justifiable in major urban areas with larger homelessness populations. Although most specialist health centres identified during the mapping exercise were in major urban areas, a few were located in smaller towns and cities, i.e. Chester and Watford.

Model 4 in the DH report was 'fully coordinated primary and secondary care', described as a team of specialists spanning primary and secondary care to provide an integrated service, including specialist primary care, out-reach services, intermediate care beds, and in-reach services to acute beds. The report noted that this model is loosely based on services provided to people who were homeless in Boston, Massachusetts, although it is not representative of health care provided to this client group across the United States. It also documented that no such service was known to exist in England, although pilots were underway to increase the integration of care for people who were homeless, such as ward rounds of homeless patients in central London hospitals and care navigators, and intermediate care beds located in a hostel for people who were homeless. This work has continued to progress in England. The mapping exercise identified eight specialist health centres (Section 4.1.6) and one GP practice with homeless services that were also involved in providing hospital and / or intermediate care services for people who were homeless.[6]

4.6 Overview

This chapter has described the specialist primary health care services that were identified during the mapping exercise. Most fitted into one of three broad models (specialist health centres, GP practices with homeless services, or mobile homeless health teams), although there was great variation between services within each model. The models identified are comparable to those described in the 2010 DH report, although several other smaller types of specialist primary health care services were also revealed during the mapping exercise that were not discussed in the DH report. Some of these were reliant on volunteers and / or charitable funding. There were also some differences between the models identified in the DH report and the mapping exercise.

Regardless of the model, the specialist primary health care services identified during the mapping shared some common characteristics. They tended to provide easily accessible and flexible services that reached out to people who were homeless. Most offered either drop-in sessions at their service and / or ran clinics at hostels and day centres. Most specialist health centres and many other specialist primary health care services provided integrated care together with other health and social care providers. One of the reported challenges faced by some of the specialist primary health care services was cuts to funding which, in a few cases, had resulted in a reduction in staff hours or the ending of a post or the closure of a service. According to some managers of specialist health centres, there had also been an increase in recent years for their service and for specialist help – both patient numbers

6 http://www.pathway.org.uk (accessed 1 December 2017)

had increased greatly, and the health needs of patients were now more complex. The next chapter examines the extent to which hostels and day centres for people who are homeless were covered by one or more specialist primary health care services.

5 | Coverage of homelessness projects by specialist primary health care services

5 | Coverage of homelessness projects by specialist primary health care services

This chapter reports on findings from the survey of hostels and day centres in England for people who are homeless. It firstly discusses the difficulties associated with gathering data about the number and distribution of single people who are homeless across England. The second section describes homelessness projects in the survey and their geographical location, the extent to which these projects were served by a specialist primary health care service, and how this differed by type of homelessness project and its location. The chapter then summarises the models of specialist primary health care services that served hostels and day centres, and the availability and frequency of clinics run by health staff at the homelessness projects.

5.1 The number and distribution of single people who are homeless

As described in Chapter 1, homelessness has been a growing problem in many areas across England since 2010. It is extremely difficult, however, to determine how many single people are homeless at any one time or over any given period. Homelessness is a fluctuating state with frequent entries into and exits from homelessness, and frequent moves between the streets, hostels, and other temporary or makeshift accommodation. There are no reliable figures of the number of people who are homeless and on the streets, in temporary accommodation, or staying with relatives or friends. According to the DCLG (2017c) an estimated 4,134 people across England slept rough on a single night in autumn 2016. Only 47 (14%) of the 326 local authorities had, however, conducted a street count. The remaining 279 local authorities (86%) had provided an 'estimated' figure. The 10 local authorities reported to have the highest number of people sleeping rough were: LB Westminster; Brighton & Hove; Cornwall; Manchester; Luton; Bristol; LB Croydon; LB Redbridge; Bedford; and Birmingham. Single night counts only provide partial data, however, about rough sleeping in an area. For example, in LB Westminster, the single night street count revealed that 260 people were sleeping on the streets (DCLG, 2017c, p.4, Table 2). Yet in the 12 months to March 2017, a total of 2,767 people had slept on the streets in the borough for at least one night (Mayor of London, 2017).

The hostels surveyed in the mapping exercise had a total of 20,273 beds. There is limited information, however, about the duration of stay in such accommodation and hence the number of people who use homelessness accommodation over the course of a year. Among 262 accommodation providers surveyed by Homeless Link in 2016, 26% said that residents stayed for less than one month, and 40% for one to six months (Homeless Link, 2016). This suggests a fairly rapid turnover of people staying in hostels. Some people will have been rehoused on departure from a hostel, but others will have moved from one temporary accommodation project to another or to the streets. Moreover, the distribution of services for people who are homeless does not necessarily reflect the size of the problem of homelessness in an area. Some people who become homeless access services in another area either because

they are avoiding circumstances in their original location, or because there are no available services for people who are homeless in that location.

5.2 Homelessness projects and their location

Of the 900 homelessness projects surveyed, 702 were hostels or temporary housing projects (hereafter hostels), and 198 were day centres or drop-in centres (hereafter day centres) primarily for homeless people. Just over one-fifth (22.7%) of homelessness projects were exclusively for young people (aged up to 25 years); the rest were for adults of all ages. The majority of hostels were for both men and women – just 12% were for men only, and 7% for women only. The size of hostels varied greatly – 50% had 20 beds or less, 28.9% had 21-40 beds, and 21.1% had more than 40 beds. The latter included 17 projects that had more than 100 beds. Among the day centres, two-thirds were open at least five days per week. The homelessness projects were more commonly found in urban rather than rural areas, although just over one-fifth were in rural areas or in an urban area with a significant rural element (Table 5.1).

Table 5.1: Location of homelessness projects by rural-urban areas

Rural-urban areas[1]	Hostels		Day centres		All projects	
	Number	%	Number	%	Number	%
Mainly rural	37	5.3	6	3.0	43	4.8
Largely rural	60	8.5	11	5.6	71	7.9
Urban with significant rural	56	8.0	21	10.6	77	8.6
Urban with city and town	230	32.8	69	34.8	299	33.2
Urban with minor conurbation	28	4.0	8	4.0	36	4.0
Urban with major conurbation	291	41.5	83	41.9	374	41.6
Total projects	**702**	**100.0**	**198**	**100.0**	**900**	**100.0**

Notes: 1. See Chapter 2, Section 2.5.

5.3 Homelessness projects covered by specialist primary health care services

Just over two-fifths (43.4%) of homelessness projects were served by a specialist primary health care service (Table 5.2). This included 36.5% of hostels and 68.2% of day centres. Two-fifths of homelessness projects were not linked to a specialist primary health care service. The managers of most of these said that their staff assisted clients to access local GP practices that served the general population. It was not possible to obtain information about primary health care arrangements for 147 projects (16.3%). Considering that data were gathered from most specialist primary health care services, however, it can be assumed that the majority of these 147 projects were not served by a specialist primary health care service. Hence, it is likely that up to 56.5% of homelessness projects were *not* linked to a specialist primary health care service.

Table 5.2: Homelessness projects covered by specialist primary health care services

Has coverage	Hostels		Day centres		All projects	
	Number	%	Number	%	Number	%
Yes	256	36.5	135	68.2	391	43.4
No	304	43.3	58	29.3	362	40.2
Not known	142	20.2	5	2.5	147	16.3
Total projects	**702**	**100.0**	**198**	**100.0**	**900**	**100.0**

There were differences in the availability of specialist primary health care services according to the age of service users that homelessness projects targeted. Hostels and day centres that worked exclusively with young people (up to age 25 years) were less likely to be linked to a specialist primary health care service than homelessness projects for adults of all ages. This applied to 16.7% of projects exclusively for young people compared to 51.3% of projects for adults. The reasons for this are unknown. It may be that young people are perceived to have fewer or less complex health needs than adults. A few hostels for young people received monthly, two monthly or twice yearly visits from a nurse from a local GP practice who ran sessions specifically on sexual health. As described in Chapter 2, however, the mapping exercise did not include specialist health services, such as mental health, TB or sexual health services that did not provide general medical care.

Large hostels were more likely to be covered by a specialist primary health care service than smaller ones. This applied to 58.4% of hostels with 41-60 beds, 51.7% with 61 or more beds, but only 23% that had 20 beds or less (Table 5.3). The slightly lower percentage for very large hostels (61+ beds) as compared to those with 41-60 beds is partly explained by the age differences of residents. Some of the very large hostels included foyers and YMCAs for young people and, as described above, projects for young people were less likely than those for adults to be served by specialist primary health care services.

Table 5.3: Hostels covered by specialist primary health care services by number of hostel beds

Has coverage	Number of beds				
	Up to 20	**21-40**	**41-60**	**61+**	**Total**
			Percentages		
Yes	23.0	43.8	58.4	51.7	35.9
No	54.3	37.3	24.7	31.0	43.7
Not known	22.7	18.9	16.9	17.2	20.4
Total number of projects[1]	**348**	**201**	**89**	**58**	**696**

Notes: 1. Information unavailable for six hostels.

5.4 Homelessness projects covered by NHS Regions

There were differences in the availability of specialist primary health care services according to the NHS Region in which homelessness projects were located. Hostels and day centres in the London region were most likely to be linked to a specialist primary health care service (Table 5.4). NHS Midlands and East Region had the highest number of homelessness projects, particularly hostels, and the highest number of hostel beds. A slightly lower percentage of homelessness projects in this region, however, were linked to a specialist primary health care service (Table 5.4).

Table 5.4: Homelessness projects covered by specialist primary health care services by NHS Regions

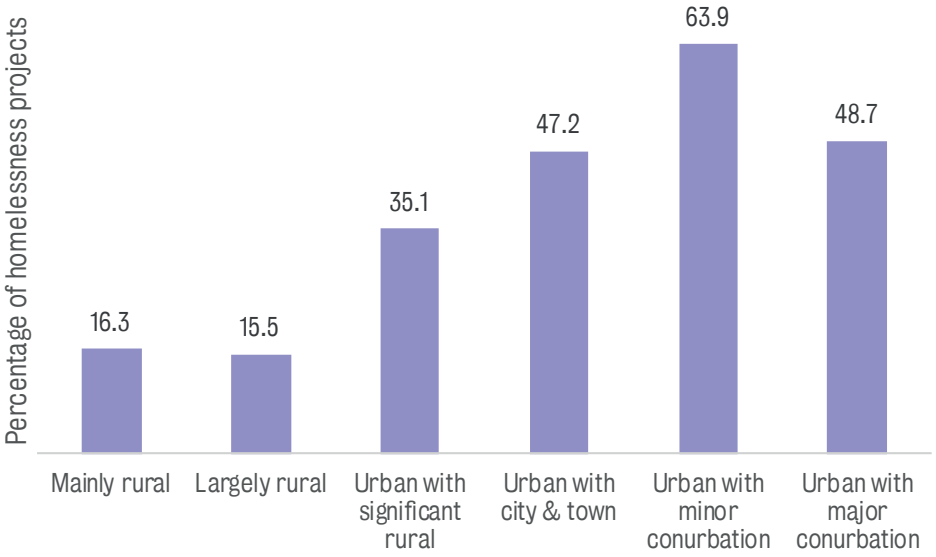
NHS Region	Hostels		Day centres	Homelessness projects[1]		
	Total number	Number of beds	Number	Total number	Number with health service[2]	% with health service[2]
North	178	4,514	47	225	102	45.3
Midlands and East	210	5,512	45	255	97	38.0
South West	110	2,400	27	137	60	43.8
South East	81	2,443	30	111	45	40.5
London	123	5,404	49	172	87	50.6
Total	**702**	**20,273[3]**	**198**	**900**	**391**	**43.4**

Notes: 1. Hostels and day centres. 2. Served by specialist primary health care service. 3. Information unavailable for six hostels.

5.5 Homelessness projects covered by Local Authority Districts

There were noticeable differences in whether homelessness projects were linked to a specialist primary health care service according to whether they were located in rural or urban areas (Figure 5.1). Hostels and day centres in rural areas were much less likely to be served by such a service than those in urban areas. Around 16% of homelessness projects in 'mainly rural' or 'largely rural' areas had such links. This compares to 63.9% of projects in urban areas with minor conurbations and 48.7% in urban areas with major conurbations.

Figure 5.1: Homelessness projects covered by specialist primary health care services by rural-urban areas[1]



Notes: 1. See Chapter 2, Section 2.5.

5.6 Types of specialist primary health care services that covered homelessness projects

When the types of specialist primary health care services that served homelessness projects are considered, almost one-fifth of hostels and day centres were linked to a specialist health centre, 14.6% to a GP practice with homeless services, and 8.1% to a mobile homeless health team (Table 5.5). A few homelessness projects were served by more than one type of specialist primary health care service. For example, a few hostels hosted clinics by a nurse from a mobile homeless health team and by a doctor from a GP practice with homeless services (sometimes these were joint clinics by the two health professionals).

Table 5.5: Types of specialist primary health care services that covered homelessness projects

Types of health service	Hostels[1]	Day centres[1]	Total[1]
		Percentages[2]	
Specialist health centre	16.7	27.8	19.1
GP practice with homeless services	12.7	21.3	14.6
Mobile homeless health team	6.4	14.1	8.1
Other special health services	2.9	11.1	4.7
Total number of homelessness projects	**702**	**198**	**900**

Notes: 1. Some hostels and day centres were served by more than one specialist primary health care service. 2. The percentages refer to each type of health service; the columns do not therefore add up to 100%.

5.7 Primary health care clinics provided at homelessness projects

Clinics were held by a doctor or nurse from a specialist primary health care service at almost one-quarter of hostels and day centres. As shown in Table 5.6, day centres were more likely than hostels to have this facility – one-half of day centres hosted weekly health clinics provided by a doctor or nurse, including one-quarter that had clinics at least twice a week. In comparison, just 14.3% of hostels had health clinics each week. A further 2% of hostels and day centres shared a building with or were adjacent to a specialist primary health care service, and therefore their clients could easily access health care.

Clinics run by specialist primary health care services were more likely to be held in large hostels. For example, 30.3% of hostels with 41-60 beds, and 24.1 % with 61 or more beds, either had health clinics at least weekly on the premises or were adjacent to a specialist primary health care service. This compares to 16.5% of hostels with 21-40 beds, and just 6.9% with fewer beds. It also applies to very few (2%) homelessness projects exclusively for young people aged 25 or under, as compared to 27.9% of projects for adults.

Table 5.6: Frequency of clinics provided by specialist primary health care services at homelessness projects

Frequency of clinics	Hostels	Day centres	Total
		Percentages	
Has health clinic	16.2	52.0	24.0
... 2+ times per week	5.6	25.8	10.0
... once a week	8.7	23.7	12.0
... fortnightly or monthly	1.9	2.5	2.0
Attached / adjacent to specialist health service[1]	1.4	4.0	2.0
No health clinic at homelessness project	61.4	40.4	56.8
Not known	21.1	3.5	17.2
Total number of homelessness projects	**702**	**198**	**900**

Notes: 1. Specialist primary health care service

5.8 Overview

The mapping of hostels and day centres has revealed that just over two-fifths were served by a specialist primary health care service. Day centres were nearly twice as likely as hostels to be linked to such a service, and to have regular clinics provided by doctors and / or nurses on the premises. There could be several explanations for this. Generally, day centres try to encourage external agencies to provide support on the premises to people who may be disengaged from mainstream health and welfare services. The majority attract a relatively large number of people who are homeless each day, including those who are sleeping on the streets and reluctant to access other services, and those who are not eligible for public funding and therefore cannot claim housing benefit and stay in hostels. At day centres, also, clients are visible as they spend time in communal areas. This affords health staff an opportunity to 'reach out' to those who may not seek health care. In hostels, residents may leave the premises during the day or remain in their room, and there is less likelihood of health staff observing and contacting them opportunistically. Health

commissioners and practice staff may perceive that limited resources should focus on delivering health care in homelessness projects where there are likely to be high levels of unmet needs, and non-engagement with mainstream health services. Health and hostel staff may also believe that people in hostels are more settled and should thus be encouraged to access mainstream GP practices outside of the hostel rather than have a specialist service taken to them.

6 | Homelessness projects without specialist primary health care services

6 | Homelessness projects without specialist primary health care services

The mapping exercise has also highlighted that the majority of homelessness projects are not served by a specialist primary health care service. Most are reliant on their clients accessing health care at mainstream GP practices alongside the general population. Not surprisingly, homelessness projects in rural areas were less likely to be linked to a specialist primary health care service than those in urban areas. The next chapter describes the experiences of accessing primary health care among the homelessness projects that were not linked to a specialist health scheme, and the difficulties that sometimes occurred.

Among the 900 homelessness projects that were included in the mapping exercise, 391 were linked to a specialist primary health care service, 362 were not linked to such health care, and the situation of the remaining 147 projects was unknown. This chapter summarises reports from the managers or senior staff from the homelessness projects that were not served by specialist primary health care services about their views and experiences of primary health care provision for their service users. Of the 362 relevant projects, information was collected for 243 projects (67.1%). The staff of a further 30 projects (8.3%) said they were not involved in arranging or accessing health care for their service users and, therefore, could not answer the questions. The latter were mainly soup kitchens and drop-in centres in church halls that were open just a few hours each week, and were staffed mostly by volunteers.

6.1 Project managers' ratings of primary health care arrangements

6.1.1 Extent to which primary health needs of homeless people are met

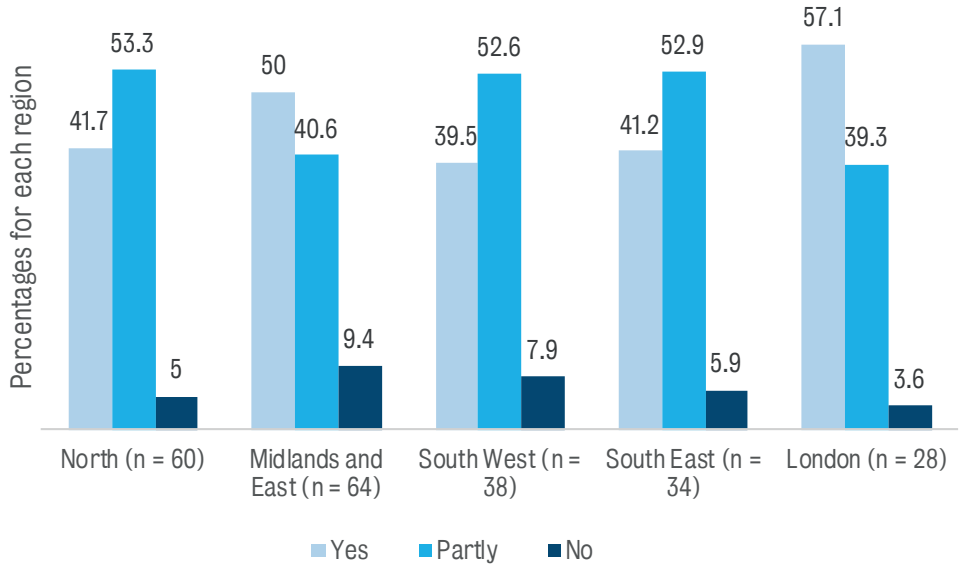
The managers of homelessness projects that were not linked to a specialist primary health care service were asked to rate whether they believed that the primary health needs of their clients were being met. They could answer: 'yes'; 'partly'; or 'no'. Among 224 managers that responded, 45.5% believed that their clients' health needs were being met, 47.8% said that the needs were 'partly' met, and 6.7% said 'no'. Although the numbers are small, the managers of large hostels (61+ beds) were more likely to say that their clients' health needs were not being met. There were no differences in responses between homelessness projects for young people and those for adults.

There were, however, differences by NHS Regions (Figure 6.1). Nearly three-fifths (57.1%) of managers of homelessness projects in London reported that the health needs of their clients were being met. This compares to just 39.5% of managers of projects in the South West Region, 41.2% in the South East Region, and 41.7% in the North Region. These groups were more likely to report that their clients' primary health care needs were 'partly' being met.

There were also some differences between rural and urban areas as to whether project managers believed that the primary health care needs of their clients were being met (Table 6.1). Those in 'mainly rural areas' were most likely to believe that this was the case even though, as described in Chapter 5, projects in rural areas were least likely to have a specialist primary health

care service. This may be because there were fewer day centres and very large hostels with concentrations of homeless people in rural areas, which might make it easier for GPs to manage the health needs of people who are homeless. In contrast, project managers in areas classified as 'urban with city and town' were most likely to say that their clients' health needs were only 'partly' met.

Figure 6.1: Homelessness project managers' views as to whether the primary health care needs of their clients are met by NHS Regions[1]



Note: 1. Excludes managers of homelessness projects linked to a specialist primary health care service

Table 6.1: Homelessness project managers' views[1] as to whether the primary health care needs of their clients are met by rural-urban areas[2]

Health needs are met	Mainly rural	Largely rural	Urban with significant rural	Urban with city and town	Urban with minor conurbation	Urban with major conurbation
			Percentages			
Yes	57.9	50.0	50.0	32.3	44.4	50.6
Partly	36.8	38.5	45.5	58.5	44.4	45.8
No	5.3	11.5	4.5	9.2	11.1	3.6
Total homelessness projects	**19**	**26**	**22**	**65**	**9**	**83**

Notes: 1. Excludes managers of homelessness projects linked to a specialist primary health care service. 2. See Chapter 2, Section 2.5.

6.1.2 Difficulties accessing primary health care services

The managers of homelessness projects not linked to a specialist primary health care service were also asked whether their clients experienced difficulties accessing primary health care services. They could answer: 'yes, a lot'; 'yes, sometimes'; or 'no'. Among 225 managers that responded, 10.7% said that their clients experienced 'a lot' of difficulties, 46.7% said their clients 'sometimes'

had difficulties, and 42.7% said that there were no problems. Hence, just over one-half (57.4%) reported difficulties some or a lot of the time. There were slight differences in responses between projects exclusively for young people (aged 25 or under) and those that worked with adults. The latter were more likely to report 'a lot' of difficulties (14%, compared to 5.6% of projects for young people). This may be partly explained by the higher likelihood of projects for homeless adults having clients with multiple health problems.

There were differences in project managers' reports according to the size of hostels, although caution must be taken when interpreting these findings due to the small numbers of relevant large hostels. As shown in Table 6.2, hostels with more than 60 beds were highly likely to report difficulties in accessing primary health care services. This may partly reflect the increased workload on a local GP practice if it is located close to a hostel that accommodates many people who may have chronic and multiple health problems.

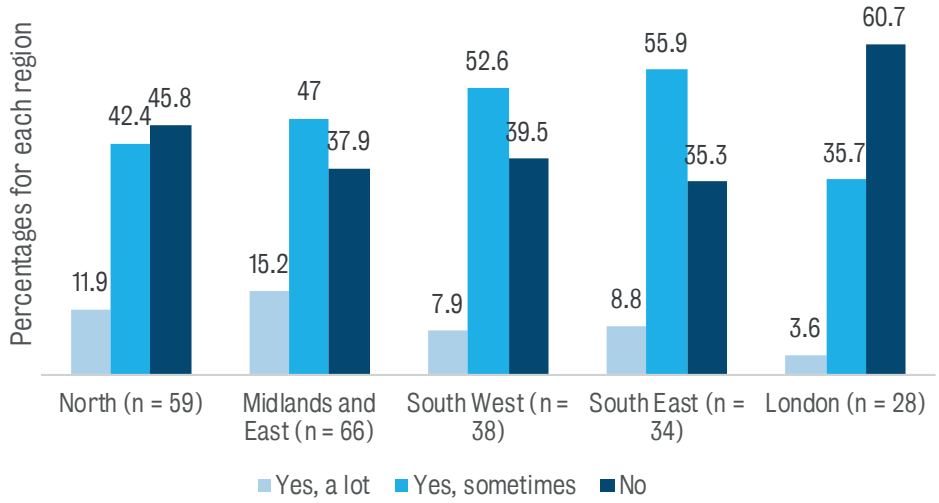
Table 6.2: Difficulties accessing primary health care services by hostel size: reports from homelessness project managers[1]

Has difficulties	Number of beds			
	Up to 20	**21–40**	**41–60**	**61+**
	Percentages			
Yes, a lot	5.8	14.3	6.3	30.0
Yes, sometimes	47.8	44.9	37.5	60.0
No	46.4	40.8	56.3	10.0
Total number of projects	**138**	**49**	**16**	**10**

Notes: 1. Excludes managers of homelessness projects linked to a specialist primary health care service.

There were differences by NHS regions according to whether homelessness project managers without specialist primary health care services described difficulties in their clients accessing health care (Figure 6.2). A high percentage (60.7%) of homelessness projects in London reported no problems, compared to just 35.3% in South East Region.

Figure 6.2: Difficulties accessing primary health care services by NHS Regions: reports from homelessness project managers[1]



Notes: 1. Excludes managers of homelessness projects linked to a specialist primary health care service.

There was little overall difference between rural and urban areas in reports of difficulties accessing primary health care services, although project managers in areas classified as 'urban with city and town' were most likely to say that their clients had difficulties accessing health care 'some' or 'a lot' of the time (68.7% of managers). This compares to 57.4% of projects overall. This also reflects earlier findings in which homelessness project managers in areas classified as 'urban with city and town' were least likely to say that the primary health needs of their clients were being met.

The following five counties had several hostels and day centres that were not linked to specialist primary health care services, although project managers in these areas were unlikely to report difficulties accessing health care: Greater London, Greater Manchester, Hertfordshire, Tyne and Wear, and Wiltshire. In contrast, counties where there were at least six homelessness projects not linked to specialist primary health care services and where homelessness project managers reported difficulties accessing primary health care 'a lot' or 'some of the time' were: Berkshire, Buckinghamshire, Cornwall, Gloucestershire, Nottinghamshire, West Midlands, and West Yorkshire.

6.2 Factors contributing to difficulties of accessing primary health care

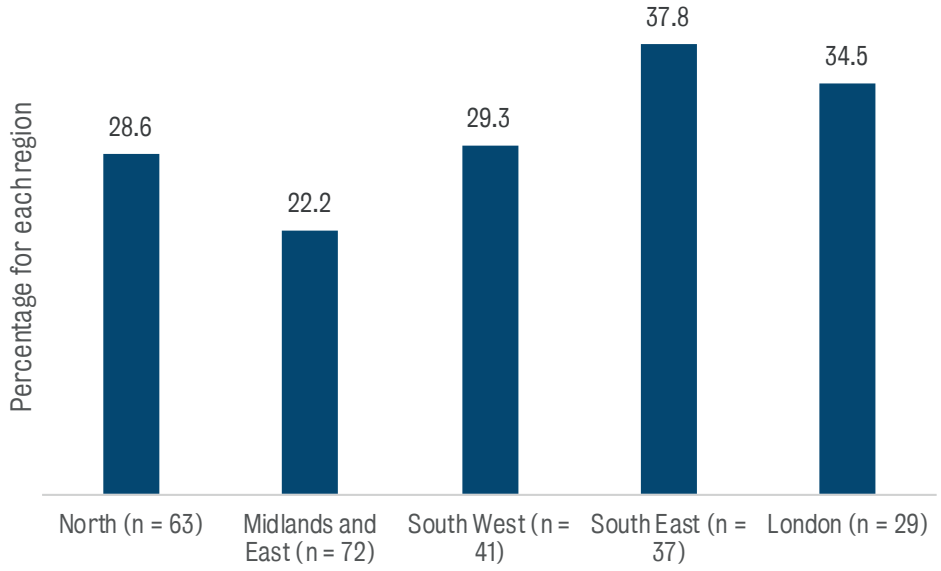
Managers of hostels and day centres not linked to a specialist primary health care service were asked to describe the types of difficulties, if any, their staff and clients experienced in accessing primary health care. Overall, 243 managers responded and their answers were grouped into the following themes.

6.2.1 Difficulties registering with a GP

Most homelessness project managers (71.1%) reported no difficulties in their clients registering with local GPs. According to several hostel managers, their clients were registered with one of two or three local GP practices. Some remained registered with their original GP if they were still living or staying in

the same locality as the GP practice. Almost three-tenths (28.9%) of hostel and day centre managers, however, described problems registering clients with a GP practice. The difficulties tended to be reported by managers of projects for adults rather than those for young people (aged 25 or under). There were also differences by NHS Regions. Managers of projects in South East England and London were most likely, and those in Midlands and East least likely, to report that their clients experienced difficulties registering with a GP (Figure 6.3).

Figure 6.3: Has difficulties registering with a GP by NHS Regions: reports from homelessness project managers[1]



Notes: 1. Excludes managers of homelessness projects linked to a specialist primary health care service.

From the managers' reports, their clients faced several barriers to GP registration. The first concerned clients' lack of photo identification (ID) and proof of address. Some people who are homeless do not have photo ID, having lost or had crucial documents stolen. There are often delays in getting these documents replaced, particularly if people have little or no income and cannot afford to have these replaced. As two project managers described:

> *"GP services have in the past requested photo identification. Some clients do not have this type of identification and this can cause a delay in registration." (Hostel manager, north England)*

> *"We have had problems with GP surgeries [not] accepting our service users as patients due to them not having an address even though we act as a 'care of' address whenever this is needed." (Day centre manager, West Midlands)*

The project managers said that difficulties with GP registration were exacerbated when people who are homeless were new to an area or had recently slept rough. As a result, this affected their ability to obtain prescribed medications and a medical certificate to enable a benefit claim to be processed. According to one project manager, clients new to an area experienced a three-week delay in seeing a GP. Other comments included:

"We are unable to register [clients with a GP] or get urgent assistance with medications that have run out or get urgent sick notes to enable a benefit claim for those new to the area." (Day centre manager, West Midlands)

"Residents have had to go back to a previous GP (not necessarily locally) to be able to get a doctor's certificate and medication, as the local GP surgery has not been able to access their past [medical] records." (Hostel manager, Essex)

"GP practices should be willing to see clients who may not be registered with them or have a postal address, at least on a triage basis. Because this is not available, homeless clients are FORCED to seek access to health care via hospital A&E. This is costly to the NHS and absorbs vital resources." (Hostel manager, Nottinghamshire)

A few project managers reported that local GP practices displayed mixed responses to registering people who are homeless – some practices would register them but others refused. In some instances, hostel staff signposted residents to GP practices that were known to accept people who were homeless. They described various strategies to overcome the problems of GP registration:

"Not all local GP surgeries will accept rough sleepers and people with no fixed address. We've never had an issue with referring people to [name of GP practice]."(Day centre manager, south-west England)

"If a resident doesn't have ID, it [GP registration] can sometimes be difficult. We therefore speak to the local GP surgery and they now accept a letter from us to confirm the person is a resident at this address." (Manager of a hostel for young people, north England)

According to the project managers, some GP practices offer people who are homeless temporary rather than permanent registration, but the former could lead to additional problems. Temporary registration is for a limited time only, and full medical records were generally not obtained from the previous GP. This could result in interruptions to medical care. As two hostel managers explained:

"If homeless people do not have ID, we work with the surgeries around this. The problem is that they [homeless people] are only registered as temporary patients, and their case can be closed if they do not go to the practice regularly. Also, the doctors cannot access their medical history." (Hostel manager, south England)

"Referrals pending from [the] previous GP are lost when having to use [register with] a GP practice temporarily. One resident recently came to us as they were waiting for a specialist eye appointment. This was not known at the temporary GP practice." (Hostel manager, Essex)

Another barrier to GP registration identified by some project managers concerned the behaviour of some people who are homeless. Firstly, some were transient and moved frequently, did not remain in a specific catchment area, and therefore needed to often change GPs. Secondly, aggressive behaviour by some people who are homeless has resulted in them being barred by a GP. Two

hostel managers described the difficulties of getting health care for residents who have been barred from local GP practices:

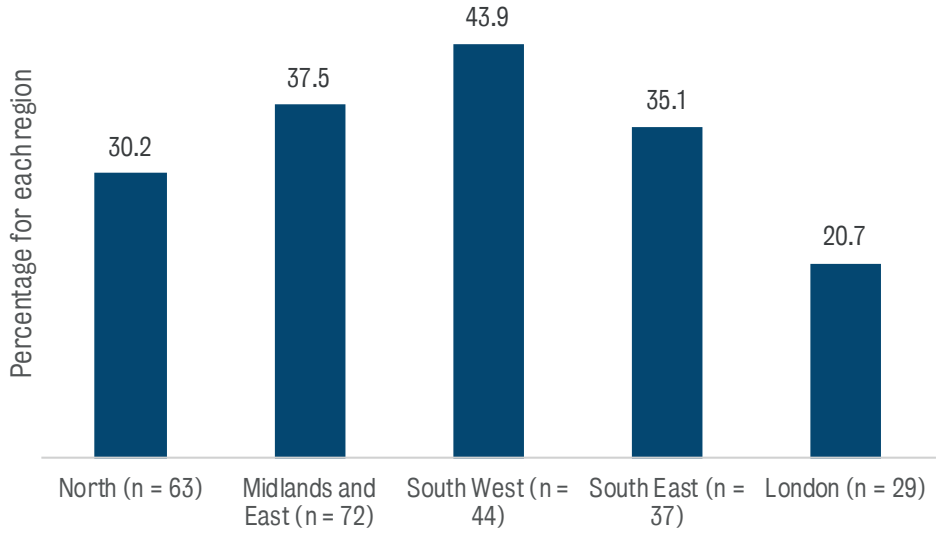
"Historical behaviour has been a problem for some residents where GP practices have barred them; and in some instances this has resulted in a bar across the whole locality. There have been cases where these bans have been two or three years old and have not been reviewed, and appear to have no time limit on them. This has made GP registration and access to medication difficult, where for example a resident has left prison with an existing prescription." (Hostel manager, north-east England)

"The customers we have are deemed high risk, and sometimes that could have caused ASB [anti-social behaviour] within the GP surgery, warranting them to be barred from the service. It makes it difficult for us to access primary health care for them once this has happened." (Hostel manager, Derbyshire)

6.2.2 Difficulties arranging GP appointments

Just over one-third (34.3%) of homelessness project managers without specialist health services described difficulties arranging GP appointments. Managers of projects for young people were more likely to report difficulties than those of projects for adults (45.6% and 27.6% respectively). There were also differences between NHS regions (Figure 6.4). Homelessness projects in London were least likely to report that their clients had difficulties getting GP appointments, while hostels and day centres in the South West Region followed closely by the Midlands and East Region were most likely to report such problems.

Figure 6.4: Has difficulties arranging GP appointments by NHS Regions: reports from homelessness project managers[1]



Notes: 1. Excludes managers of homelessness projects linked to a specialist primary health care service.

Several managers reported lengthy waiting times, sometimes of two to three weeks, before clients could get a GP appointment. This presented problems as some clients required urgent access to health care if, for example, they were without medication, but not necessarily emergency treatment that would

warrant a visit to a hospital accident and emergency department (A&E). In such instances, the managers believed that GP practices should offer more readily available same day appointments or a drop-in clinic for people with urgent health needs. They also believed that this would encourage people with chaotic lifestyles to access health services, as some may be deterred from seeing a GP if they had to wait a few weeks for an appointment. In some instances, it was preferable for a hostel worker to accompany a client to the GP practice if there were concerns about their health and the person was unreliable at attending appointments or found it hard to explain their problems. However, it could be difficult to arrange an appointment at a time that was convenient for the hostel worker. Their comments indicate the difficulties:

"Readily available appointments [are needed]. Some clients have to wait three weeks for a GP appointment." (Manager of a hostel for young people, East Midlands)

"They are often requiring immediate health care, but not emergency treatment. Yet they struggle to be given a GP appointment ... they also struggle if getting an appointment is a drawn out process. This can result in them choosing to not access health care. It is hard to get an appointment that fits in with their lifestyle, for example in the morning before they become too intoxicated or, for some, later in the day when they are no longer affected by sleeping tablets or mental health medication." (Hostel manager, South England)

"Scheduling of appointments at a time when a support worker can attend with the client is not always possible, and can lead to difficulties and delays." (Hostel staff team, London)

Several project managers also commented on the process of making an appointment and believed it to be unsuitable for people who are homeless and have chaotic lifestyles and no access to phones or the internet. If a person requires an urgent appointment, many GP practices require them to phone the practice early in the morning to book an appointment. There can, however, be difficulties getting through to the practice before the allotted numbers of appointments for the day have been taken. As two hostel managers explained:

"Residents have to make appointment over the phone at 08:00 in the morning ... The surgery's website has an option for people to book appointments on-line but this option is not actually working." (Manager of hostel for young people, North England)

"Waiting time for appointments – have to call at 8 am to get an appointment but struggle to get through and when you do there are no appointments left so people have to wait another day before seeing a GP." (Hostel manager, East Midlands)

6.2.3 Difficulties using primary health care services once registered

Project managers also highlighted the poor use by many clients of primary health care services once they have registered with a GP. As one hostel manager explained, "residents will often leave their illnesses and minor injuries and not bother going to see the doctor until they become worse." Low self-esteem, lack of confidence in dealing with health professionals, poor motivation, embarrassment, self-harming behaviours and chaotic lifestyles

were all mentioned by project managers as reasons why some clients were reluctant to engage with health services:

"They may struggle with needing to go to a GP practice, especially if they are still sleeping rough and are struggling with keeping appointments, as well as feeling they may have poor hygiene (due to sleeping rough) and so don't want to sit in a waiting room." (Hostel manager, Hampshire)

"Many of our residents experience depression and anxiety issues which can make sitting in busy waiting rooms with strangers quite difficult for them." (Hostel manager, east England)

Another barrier mentioned by a few hostel managers was the mistrust of health care professionals by some people who are homeless, often due to past experiences. Issues of mistrust can be exacerbated if people are unable to be seen by the same GP at the practice. This can compromise the possibility of building trust with a healthcare professional. As the managers explained:

"Many homeless people struggle with a chaotic lifestyle which can make booking a health appointment relatively low on their list of priorities. Some of the service users have reported that they have had previous bad experiences with a health professional whereby they haven't felt listened to or have felt judged." (Hostel manager, Tyne and Wear)

"Part of the problem is that our residents cannot always see their own doctor, so trying to build a positive trusting relationship can be difficult if they are seeing different professionals each time. Some residents are reluctant to access [health] services until absolutely necessary because of this." (Hostel manager, East Midlands)

Difficulties associated with travelling to health services, including poor transport links and costs, were mentioned by a few managers (6.2%). The problems were more commonly reported by managers of projects in north England and in rural settings. As explained by two managers:

"[Our hostel] is approximately three to five miles from the nearest town and city centres, where most services are located. Transport costs can be prohibitive when accessing services." (Hostel manager, north-east England)

"The district we work in is made up of five market towns spread across a very large geographic area with key services spread over these towns. We only have drug and alcohol services in two towns, and the job centre is in a third town ... There is no train network and limited (and expensive) public transport. Accessing any service including health is very difficult." (Day centre manager, south England)

6.2.4 Negative attitudes of some primary health care staff

One-third (32.6%) of homelessness project managers raised concerns about the negative attitudes of some GP practice staff, particularly doctors and receptionists, towards people who are homeless. Concerns were reported across the five NHS Regions. According to the project managers, negative attitudes of some GP staff have resulted in some people who are homeless feeling stigmatised, judged and discriminated, and reluctant to access health care. The

project managers believed that negative staff attitudes were more evident if their clients had drug or alcohol problems:

"Service users have felt discriminated against due to having other support needs i.e. if they use illegal substances they have often felt like they have been blamed for causing the health complaint." (Hostel manager, East Midlands)

"Some examples of a culture within healthcare professionals whereby the clients are thought to bring on their own problems through choices; in relation to their drug/alcohol use and are seen as 'time wasters' and therefore undeserving of healthcare services. Better training for healthcare staff to address the culture which leads to discrimination at times against people with drug / alcohol issues." (Manager of a small hostel in north England)

"Discretion by receptionists – some residents have been asked to speak at the desk to the receptionist about their health needs. This has made them reluctant to return to the surgery." (Manager of supported housing, Greater Manchester)

Some managers associated the negative attitudes of health staff with their lack of understanding about the backgrounds of people who are homeless, and their problems and needs. As a result, the health needs of people who are homeless are sometimes overlooked or dismissed when they seek medical help, or they may be judged to be time-wasters and removed from patient lists if they miss appointments. According to some project managers:

"[Health staff need to look] beyond the alcohol or substance misuse, dependency and excessive use as well as challenging behaviour, and listen to what the resident [homeless person] is reporting as there may be something else that needs addressing. Enabling primary care staff to deal with challenging behaviour, increase their awareness about addiction and mental health, and look beyond the stigma that sometimes comes with the above support needs and homelessness." (Hostel manager, London)

"Many of our clients have been classed as frequent attendees for GP services or hospital admissions, so they are often viewed as more of a hindrance and affecting their [health services] statistics rather than as vulnerable clients." (Hostel manager, south coast)

"Access to some services can be difficult due to a combination of issues. These include ... lack of understanding and empathy from professionals regarding residents' circumstances and previous life experiences that have contributed to homelessness." (Hostel manager, north-east England)

6.2.5 Relationships between primary health care and homeless sector staff

Another area of concern related to the relationships between primary health care and homeless sector staff, particularly with regard to communication and working practices. Several homelessness project managers believed that there should be improved links and partnership working between themselves and health care workers. According to some managers, primary health care staff do not understand the help and support provided by hostel staff to residents, including the help that is given around their health needs. At the same time, there is poor information sharing and hostel staff are not always kept informed about treatment plans for residents, health appointments that have been

made, and medications that they are receiving. Hence, hostel staff are unable to effectively support residents with, for example, reminding them about or escorting them to health appointments. The views of a staff team working in a hostel in London clearly summarise the difficulties and what they believe is needed:

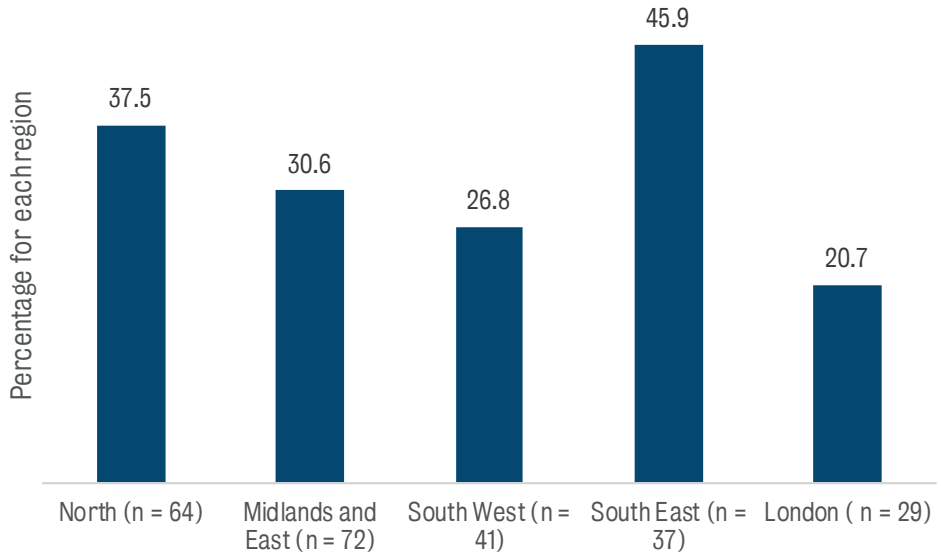
"Communication between the medical practitioners and support staff here. Whilst our staff are not medical professionals, we oversee and manage health needs for our women. Sometimes a client may make an appointment but we do not know about this and so cannot support our women. To be kept informed about which of our women have appointments and when would allow us to better support them to attend appointments, by reminding, prompting and attending with them where possible. Also information sharing is difficult so a GP or nurse may advise a client, but we are not 'kept in the loop' so are unable to assist in managing health. At times medical professionals have discharged our women, expecting that our staff (who are not medically trained) will manage health needs, but we are unable to do this. At times medical professionals will not allow us to share, or even they will not consider information from our staff about the medical needs / symptoms / effects / self-management that we witness as their support workers who see them 24/7."

6.3 Need for specialist primary health care services

The previous sections have summarised the difficulties perceived by homelessness project managers that people who are homeless face in accessing primary health care services. One-third (32.9%) of managers believed that there should be a specialist primary health care service for their clients. This included 26.4% of managers of projects for young people, and 36.8% of managers of projects for adults. There were differences by NHS Regions – only 20.7% of managers of homelessness projects in London and 26.8% in the South West Region believed that there was a need for such a service. This compares to 45.9% of managers in the South East Region (Figure 6.5).

As described in Chapter 5, a high proportion of day centres (68.9%) were already served by a specialist primary health care service. Among the remaining day centres, most (69.2%) believed that there should be clinics run by GPs or nurses on the premises. In contrast, a much smaller proportion of hostels without specialist primary health care services (28.6%) believed that there was a need for such a service. Indeed, one hostel declined the opportunity to have GP clinics on the premises. Another hostel manager said that plans were in process for an annex to be built attached to a local GP practice that would be specifically for patients who were homeless.

Figure 6.5: Need for specialist primary health care services for people who are homeless by NHS Regions: views of homelessness project managers[1]



Notes: 1. Excludes managers of homelessness projects linked to a specialist primary health care service.

The manager of a large hostel in north England felt that the provision of a weekly or monthly drop-in surgery at the hostel "would significantly improve access to appropriate levels of primary health care". Several other managers concurred with this and stressed the importance of having regular on-site clinics run by a GP or nurse, particularly for clients who were hard-to-engage, would not keep appointments or had chaotic behaviour, as shown by the following examples:

"A nurse visiting once a month for those who are unable to register at the surgery or are not prioritising their health care." (Hostel manager, Birmingham)

"We could benefit from a district nurse providing a regular visit especially for those with wounds that need dressing regularly." (Hostel manager, south Yorkshire)

"One GP who was specifically trained to deal with the client group and who could also visit our project on a regular basis as our clients can be chaotic." (Hostel manager, Greater Manchester)

Other suggestions included drop-in clinics at the GP practice specifically for people who are homeless, and a named worker at the practice that homelessness project staff could link with. Among the latter, some managers perceived this to best be a nurse or GP, some an administrator or receptionist, and some were unclear:

"A designated worker to link in with our service offering support, guidance and direct referrals to external services." (Hostel manager, Kent)

"Would be useful for a named nurse to attend the hostel and [that we could] access for telephone advice and make appointments with the relevant practitioner." (Hostel manager, central Midlands)

"Would be great to have a named contact at the medical practice who could come out to the project and distribute registration forms." (Hostel manager, Birmingham)

Eleven project managers said that a nurse or GP used to run clinics at their hostel or day centre but this was stopped, mainly because of a change in health service contracts and funding restrictions. Some managers also mentioned a need for health promotion workshops run by health professionals. Several managers of hostels for young people were concerned that their clients' sexual health needs were not being met, and felt that practitioners needed to be more sensitive about the issues concerning young people. As the managers explained:

"Nurse or dietician could provide a drop-in ... what residents are eating and drinking day-to-day has very low nutritional content and I do not think they realise how it affects their health. We run healthy-eating sessions but I think a discussion with a professional would increase awareness." (Manager of supported housing for young people, north-west England)

"I think that visits from health care professionals could be good if relevant workshops could be developed on healthy living ... [this] could help residents learn ways to prevent illness which would be a benefit to all." (Hostel manager, Gloucestershire)

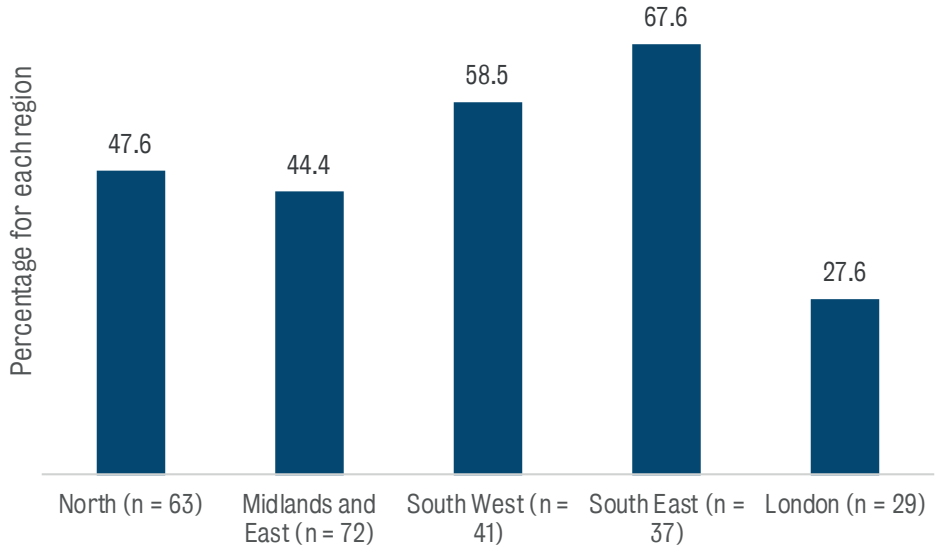
"It is difficult to motivate young people to see their GP regarding sexual health ... [previously] sexual health outreach nurses ran clinics and visited our project ... [this was] much more useful." (Hostel manager, south-east England)

6.4 Difficulties accessing mental health services

Almost one-half (49.2%) of homelessness project managers reported difficulties accessing mental health services for their clients. This included 54.4% of project managers working with young people (aged up to 25 years), and 46.1% with adults. There were marked differences according to NHS regions. Problems of accessing mental health services were most commonly reported in the South East Region, particularly in Kent, and least commonly reported in

London (Figure 6.6).

Figure 6.6: Difficulties accessing mental health services by NHS Regions: reports from homelessness project managers[1]



Notes: 1. Excludes managers of homelessness projects linked to a specialist primary health care service.

Several project managers reported that mental health issues were significant problems among their clients and were concerned about the difficulties in getting mental health care for them. Waiting times for an initial appointment for a mental health assessment were lengthy, and there was lack of help when clients were in crisis because of mental health issues. The manager of a hostel in north England reported a six to eight week waiting time for a client to be seen by a mental health worker. As other managers described:

"Increase in mental health, self-harm, substance misuse, suicide, bipolar depression and disabilities, yet limited resources to specialist services." (Manager of hostel for young people, West Yorkshire)

"Poor mental health is by far the biggest problem. Gaining psychiatric assessments can be a long wait." (Day centre manager, south England)

"Not enough adequate support when people are in crisis with mental health issues." (Hostel manager, Kent)

Several managers also expressed concern about the care offered to clients once a mental health assessment had been made. One reported problem was that some clients are not given a specific diagnosis and are therefore not offered specialist help. However, the managers believed that they required mental health support:

"If they are referred into mental health services and, on the initial interview, state that they do not have mental health issues, they are discharged and we have to start the process again." (Hostel manager, East Midlands)

"Some clients not meeting a particular threshold for mental health services but need ongoing support with mental health. Some of our clients may not have a diagnosis or are diagnosed with a personality disorder and get no further support. However, their behaviour suggests vulnerability to living independently in the community." (Hostel manager, north England)

"There seems to be a lack of support for young women who have mental health issues but not a diagnosis. The waiting lists to see mental health professionals seem to be too long also. The GP often does not give the young people time, and only if a worker goes with them does it seem that they are listened to properly." (Manager of temporary supported housing for young people, south-west England)

Another problem appears to be that once an initial assessment of a client's mental health has been made there is inadequate help available if more specialist interventions are required. In some cases there are long waits for counselling services or a lack of such services, and some people are simply referred back to their GP. The problem was reported by both project managers working with young people, and those working with adults. Several managers believed that there was a need for mental health services that target young people. The limitations of mental health services for people who are homeless are evident by their reports:

"If a client is referred to Stage 1 mental health services, and they deem the client's needs to be too great for their service then they should refer a client on to appropriate level, not simply tell a client they have to go back to their GP and start the referral process again." (Hostel manager, East Midlands)

"There is limited access to counselling and other mental health services within the area. I currently have young people on the waiting list for [name of service] and have been informed there are seventy something people on the waiting list." (Hostel manager, West Midlands)

"Securing specialist mental health support after initial assessment and past the IAPT/CMHT [Improving Access to Psychological Therapies / community mental health team] service is a problem for those with very complex issues. We do not appear to have somewhere for these referrals to go – [they] can fall between stools." (Hostel manager, north England)

Access to mental health services was reported to be even more problematic if people who are homeless also had drug or alcohol problems. According to homelessness project managers, there is a lack of joint working among these services to enable mental health needs to be addressed alongside substance misuse issues. As a result, it is extremely hard to get a mental health assessment for a person while they are drinking heavily or misusing drugs, and instead a person tends to be "passed around" from service to service. The managers stressed the need for a more holistic approach and the provision of integrated treatment and support. As they explained:

"We struggle to access primary mental health care services because mental health services often reach a conclusion that the client's drug/alcohol abuse has led to their mental health issues and therefore they are not offered treatment. In many of these cases we believe the clients are 'self-medicating',

i.e. using substances and / or alcohol to address their mental health issues (issues they would suffer regardless of any substance abuse). This situation (where it is unclear which came first, the mental health issues or the drug/ alcohol use) results in clients not receiving correct/any mental health care." (Hostel manager, north England)

"Access to secondary health care: mental health, alcohol and drug services is slow and in the case of mental health, seems limited to simple cases. Complex needs, involving a crossover of mental health, substance misuse and other issues seems poorly met." (Hostel manager, south England)

"Community mental health teams are reluctant to support people with substance misuse issues. Recovery teams deal with substance abuse issues, but there is a need for both mental ill health and substance abuse to be treated together, which is not happening." (Hostel manager, north England)

Project managers outlined the negative consequences of inadequate mental health provision. It sometimes resulted in a deterioration of a person's mental state and behaviour, which could then jeopardise their stay in temporary accommodation. It also resulted in additional work and stress for hostel staff as they had to find ways to cope with a person's poor mental health state, even though they were not qualified to offer such help. This in turn had an impact on their other work. The difficulties faced by clients and homelessness sector staff through inadequate mental health care provision are described by the managers:

"A significant number of homeless service users often have ongoing mental health issues; the main referral route currently is to Talking Therapies, which has been unsuccessful for the majority of service users who have been pointed down this route. The current mental health support through the GP is not conducive to a chaotic, complex lifestyle for those with multiple support needs. There are often long waiting lists for counselling support (if that is offered at any point), and often the behaviour/symptoms deteriorate during that time which may result in warnings/eviction." (Manager of a hostel for young people, north England)

"Mental health provision is very poor in this area and we find ourselves managing people's behaviours rather than treating people's support needs." (Hostel manager, Nottinghamshire)

"Mental health support is particularly difficult in [name of town] as they often will not work with drug users or drinkers unless clean and sober. This leaves unqualified practitioners dealing with crisis situations or having to support people through A&E." (Hostel manager, Berkshire)

6.5 Overview

This chapter has presented the many difficulties identified by some homelessness project managers in accessing primary health care for their clients. The problems were reported across the five NHS Regions. There were some areas where problems were more prevalent, although caution must be taken when interpreting the findings as information about accessing primary health care services was not collected from some homelessness projects. Nonetheless, among the homelessness projects that were not linked to a

specialist primary health care service and that responded to the survey, NHS South East Region experienced the greatest difficulties in registering clients with a GP and in accessing mental health services. The homelessness project managers in this region were most likely to believe that there was a need for specialist health care provision for their clients. Fewest problems were reported in the London Region.

The difficulties experienced by people who are homeless in accessing primary health care are partly related to their circumstances and behaviour. Some have been homeless for years, have mental health problems or problematic drug or alcohol use, and find difficulty in engaging with health and other services. At the same time, service factors contribute to these difficulties. The ways in which primary health care services are delivered mean that some people who are homeless cannot easily register with a GP because of lack of photo ID, or cannot manage the bureaucracy of appointment systems, or face long waits before they can see a GP or get specialist help for mental health issues. This is despite guidance being issued in November 2015 by NHS England, which states that people who are homeless are eligible to register with a GP practice, and that if a person cannot produce any supportive documentation but says that they reside within the GP practice boundary, then practices should accept the registration (NHS England, 2015).

Economic factors and poor transport links can be a barrier to accessing health care if people who are homeless are living in rural areas and need to travel some distance to health appointments. Healthwatch Northamptonshire (2017) also found that people who were homeless in Rushden had to register with a GP in a nearby town as local practices were not accepting new patients, and that this had implications for their service use in terms of travel and costs. As discussed in Chapter 4, in rural areas where there are mobile homeless health teams, primary health care is delivered in local hostels and day centres.

People who are homeless may also have to contend with the negative attitudes of some primary health care staff, and poor communication and working practices between health and homelessness sector staff. Similar concerns about health staff's lack of understanding of the needs of people who are homeless, and poor communications between primary health care staff and homelessness sector workers, were raised in a report by Healthwatch Norfolk (2013). Although several guides have been produced to assist health staff working with people who are homeless (see Chapter 1), a DH funded study of education and training for health care professionals working with people who are homeless or socially excluded found 'a sizeable gap between what the workforce needs to know, the skills they need to be able to demonstrate, and the readily accessible high quality specialist education and training that will guarantee these achievements.' According to the 2016 report, practitioners reported difficulty in accessing specialist training programmes to help them develop their clinical and non-clinical knowledge and skills to care for such patients (Davis and Lovegrove, 2016).

7 | Conclusions

7 | Conclusions

This report has described findings from a comprehensive mapping exercise of specialist primary health care services in England for single people who are homeless, and the extent to which homelessness projects are served by these health services. It presents descriptive data about the characteristics and distribution of specialist primary health care services, and the accompanying inventory contains templates which provide further details of the majority of these services and their contact details. As mentioned in Chapter 1, the mapping exercise was not intended to assess the effectiveness of different models of primary health care provision, and therefore this report does not comment on the quality of services or make recommendations about the types of primary health care services that are needed for single people who are homeless. This report and the inventory are intended as resources for health service commissioners, primary health care providers and homelessness service providers who wish to seek further information about the provision of primary health care to people who are homeless in a particular CCG or NHS Region, or nationally.

This final chapter firstly outlines the strengths and limitations of the mapping exercise. It then summarises key findings about the provision of primary health care services in England for people who are homeless. The last section draws on the mapping exercise to raise questions for consideration by health service commissioners and providers about the provision of primary health care services for people who are homeless.

7.1 Strengths and limitations of the mapping exercise

The aims and objectives of the mapping exercise (described in Chapter 2) have been met. It has involved the two most extensive surveys to date of the availability and distribution of specialist primary health care services in England for single people who are homeless, and of the extent to which hostels and day centres for this client group are served by these health services. We are confident that the mapping exercise has identified most specialist health centres and mobile homeless health teams. However, as it was not possible to collect information about the arrangements for accessing primary health care from some hostels and day centres, some specialist primary health care services may have been missed. Even though a few such health services failed to provide details about their service, it was possible to obtain some information from their CQC report or website.

The mapping exercise was carried out between October 2015 and March 2017. This was longer than originally planned as some services took a long time to respond. A high response rate was eventually achieved both from health services and from hostels and day centres. Findings from the mapping exercise are time-specific and relate to primary health care arrangements for the survey period only. During the survey period, some hostels closed or changed their service, and several new ones were identified. In addition, a few specialist primary health care services closed or changed their service provision, while some GP practices began to provide enhanced services to people who were homeless.

7.2 Primary health care services for people who are homeless: current provision

7.2.1 Specialist primary health care services

The mapping exercise identified 123 specialist primary health care services in England for single people who are homeless. These were defined as primary health care services that: (i) worked primarily with single people who were homeless; or (ii) served the general population but provided enhanced or targeted services to single people who were homeless. The specialist primary health care services were classified into six models or groups, plus some additional services. Most fitted into one of three categories – specialist health centres; GP practices with homeless services; or mobile homeless health teams. There were key differences between these services. The specialist health centres worked primarily with people who were homeless and tended to have many fewer patients than the GP practices with homeless services. The former were also more likely to have specialist staff, such as drug or welfare advice workers, as part of the team or as sessional workers. They were less likely than the GP practices with homeless services, however, to offer extended opening hours. The specialist health centres and GP practices with homeless services offered GP registration, but this was not generally the case for other models. The mobile homeless health teams worked primarily in hostels and day centres.

The specialist primary health care services were spread across the five NHS Regions, although their distribution varied greatly between and within areas. They were mainly located in urban areas where there are concentrations of people who are homeless and homelessness services. Relatively few such health services were found in rural areas. Most of the 35 largest cities in England and several London boroughs had at least one specialist primary health care service. However, in more than one-half of London boroughs and a few large cities no specialist primary health care service was identified, despite these locations having homelessness services. For example, in the London Borough of Waltham Forest, four hostels and a day centre for people who are homeless were identified but no specialist primary health care service. Moreover, in 2015, the local Healthwatch group reported that people who were homeless in the borough experienced difficulties in accessing GP services (Healthwatch Waltham Forest, 2015). Likewise, despite Healthwatch Stoke-on-Trent highlighting in 2016 that people who were homeless experienced difficulties in registering with local GPs (Wilson and Astley, 2016), the mobile homeless health team in Stoke-on-Trent closed in early 2017.

7.2.2 Coverage of homelessness projects by specialist primary health care services

Just over two-fifths (43.5%) of homelessness projects were served by a specialist primary health care service. Although information was not obtained from all hostels and day centres, it nonetheless suggests that up to 56.5% of most homelessness projects are not covered by a specialist primary health care service. Day centres were more likely than hostels to be linked to such a service, and to host health clinics staffed by a doctor or nurse. Homelessness services exclusively for young people were least likely to be linked to a specialist primary health care service. Hostels and day centres in rural areas were also much less likely than those in urban areas to be served by such a service.

One-third of managers of homelessness projects without access to specialist primary health care services believed that there was a need for such a service. Some believed that a regular health clinic at their project would greatly

improve their clients' access to health care. Others suggested drop-in clinics at the GP practice specifically for people who are homeless, or a named worker at the GP practice that homelessness project staff could liaise with. Managers of projects in NHS South East Region were most likely to report a need for specialist primary health care services.

7.2.3 Experiences of accessing mainstream primary health care services

Nearly three-fifths of managers of homelessness projects without specialist primary health care services said that their clients experienced difficulties some or a lot of the time with accessing mainstream primary health care services. Problems were reported across the five NHS Regions in England, and throughout various LADs. The main difficulties were related to registering with a GP, arranging a GP appointment, the poor use of GP services by people who are homeless, the negative attitudes of some health staff and their lack of understanding of the needs of people who are homeless, and poor communication and partnership working between primary health care and homelessness sector staff. The difficulties of accessing GP practices in some rural areas were compounded by poor transport links and travel costs.

7.3 Considerations for primary health care service commissioners and providers

A great deal of guidance has been issued since the 1990s about the commissioning and provision of primary health care services for people who are homeless (see Chapter 1). The findings of the mapping exercise, however, raise several questions for consideration by health service commissioners and providers about the provision of such services. These are now discussed.

7.3.1 Are the primary health care needs of local people who are homeless being met?

The first question for consideration by health service commissioners and providers concerns the extent to which the primary health care needs of people who are homeless are being met in different locations. Through the Health and Social Care Act 2012, Health and Wellbeing Boards have been established by local authorities and have a statutory duty, with local CCGs, to produce a Joint Strategic Needs Assessment (JSNA) which identifies health needs in an area (see Chapter 1). Several factors must be taken into consideration with regard to the provision of primary health care services for people who are homeless. These include the scale and nature of homelessness in an area over a period, current primary health care services in the locality and their potential to change or develop to meet the health care needs of people who are homeless, and the practicalities and costs of providing specialist or mainstream primary health care services.

This report aims to open up the debate about how decisions are reached about the commissioning of primary health care services to meet the needs of people who are homeless. As described in Chapter 1, several documents have recently been published relating to the planning and commissioning of such services (Healthy London Partnership, 2016a; Public Health England, 2016b; The Faculty for Homeless and Inclusion Health, 2013). In November 2015, NHS England also issued guidance relating to patient registration for primary medical (GP) services, including the registration of people who are homeless (NHS England, 2015). In addition, in collaboration with the DH, Homeless Link has developed a Homeless Health Needs Audit Tool to help health service commissioners and providers, local authorities and third sector

organisations gather data about the health needs of local homeless people and their use of health services (see Chapter 1).[7]

7.3.2 What models of primary health care services are needed?

The second question for consideration by health service commissioners and providers is what models of primary health care services are needed for people who are homeless in particular locations. Although various models have been developed in England since the 1970s, there have been very few evaluations of these services and little is known about their effectiveness and cost-effectiveness in engaging and treating people who are homeless. Debates have taken place over many years as to whether primary health care for people who are homeless should be provided by mainstream or specialist services. Several researchers and clinicians believe that some form of targeted provision is necessary to enable people on the streets to access primary health care, but that the aim should be integration into mainstream primary health care services (Connelly and Crown, 1994; Williams and Allen, 1989; Wright, 2002).

There are, however, mixed views among people who are homeless and homelessness service providers. A survey in the late 1990s, for example, of 86 service users at a drop-in centre for people who were homeless found that 84% preferred to use specialist rather than mainstream primary health care services (Hewett, 1999). A 1999 survey in England of homelessness project managers found that the majority favoured integration into mainstream primary health care services for their clients and believed that separate services were divisive. Some form of targeted provision was thought necessary to enable people on the streets to access primary health care, but they believed that the long-term aim should involve integration into mainstream primary health care services (Pleace et al, 2000, p. 44). As described earlier, in the mapping exercise some managers of homelessness projects without specialist primary health care services believed that a GP or nurse clinic at their project would greatly improve clients' access to health care, but other managers preferred drop-in clinics at the GP practice. Indeed, as noted earlier, one hostel had declined the opportunity to have GP clinics on the premises.

At present, there is a paucity of information to guide health service commissioners and providers about the most appropriate types of primary health care services for people who are homeless according to different settings and different population sizes. As discussed in Chapter 4, there are some discrepancies between the models proposed in the 2010 DH report and the findings of the mapping exercise in terms of their suitability in different locations. The authors of the DH report acknowledged that there is little information about whether specialist primary health care services for people who are homeless are located where they are needed most, and whether the provision is sufficient to meet the needs of the local homeless population in a given area (DH Office of the Chief Analyst, 2010, p. 17). They also reported lack of research evidence regarding the potential for improved primary care to reduce secondary care costs and improve health outcomes. St Mungo's was commissioned by DH to investigate the extent to which evidence is available on the costs and outcomes of specialist primary health care services for people who are homeless. It found that, although such services have established successful models for working with people who are homeless and have long histories of multiple and chronic problems, data on costs and outcomes of treatment to inform commissioning and demonstrate the impact and financial

7 homeless.org.uk/our-work/resources/homeless-health-needs-audit/health-needs-audit-toolkit (accessed 2 December 2017).

benefit of this work are not routinely collected (St Mungo's, 2013).

Although there are many gaps in understanding about the effectiveness of different models, two trends in recent years in the development of primary health care services for people who are homeless are apparent from the mapping exercise. Firstly, most specialist services that have been established since 2010 involve mainstream GP practices that provide enhanced or targeted services to people who are homeless, rather than the development of specialist health centres exclusively for people who are homeless. Secondly, several of the specialist primary health care services for people who are homeless have adopted an integrated or 'Pathway' model of service provision to bridge the gap between primary and secondary care (see Chapter 1). This involves staff of specialist primary health care services collaborating with secondary care services to support people who are homeless and admitted to local hospitals or attending A&E departments, or with local authority and voluntary sector staff to deliver intermediate care services to people who are homeless.

There remains a scarcity of evidence, however, for both health service providers and commissioners about the effectiveness and cost-effectiveness of the different primary health services arrangements for people who are homeless, and the extent to which they meet the health needs of the local homeless population. Better understanding of the effectiveness of different models in different settings is crucial if the primary health care needs of people who are homeless are to be successfully addressed.

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