KING'S College LONDON

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

Summary of findings and considerations for health service commissioners and providers

Maureen Crane, Gaia Cetrano, Louise Joly, Sarah Coward, Blánaid Daly, Chris Ford, Heather Gage, Jill Manthorpe and Peter Williams

February 2018

SOCIAL CARE WORKFORCE RESEARCH UNIT

The Policy Institute at King's

The Policy Institute at King's

The Policy Institute addresses complex policy and practice challenges with rigorous research, academic expertise and analysis focused on improving outcomes. Our vision is to contribute to building an ecosystem that enables the translation of research to inform policy and practice, and the translation of policy and practice needs into a demand-focussed research culture. We do this by bringing diverse groups together, facilitating engagement between academic, business, philanthropic, clinical and policy communities around current and future societal issues.

The Social Care Workforce Research Unit

The Social Care Workforce Research Unit (SCWRU) at King's College London is funded by the NIHR Policy Research Programme and a range of other funders. It undertakes research on adult social care and its interfaces with housing and health sectors and complex challenges facing contemporary societies.

The **Homelessness Research Programme** is based within SCWRU. Its aims are:

- 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: Summary of findings and considerations for health service commissioners and providers.* London: Social Care Workforce Research Unit, King's College London.

Front-cover images from Shutterstock.

Introduction

Homelessness has been a growing problem in many towns and cities across England since 2010. It can have a serious adverse impact on a person's 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 health problems than the general population. They also have higher rates of problematic drug and alcohol use (Wright and Tompkins, 2006).

There are challenges in meeting the health needs of people who are homeless. Many neglect their health, 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 attitudes from some health staff, and the difficulties that services have in treating people with complex and multiple needs.

This summary report presents key findings from a systematic mapping exercise across England of specialist primary health care services for single people who are homeless. It raises questions for consideration by health service commissioners and providers about the provision of primary health care services for this patient group.

The mapping exercise was part of a larger study 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). The HEARTH 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. Ethical approval for the study was obtained from London Bloomsbury Research Ethics Committee (Reference 15/LO/1382).

Other publications from the mapping exercise

Mapping of specialist primary health care services in England for people who are homeless goo.gl/NhRGnP

Inventory of specialist primary health care services in England for people who are homeless goo.gl/NhRGnP

The mapping exercise

The main objectives of the mapping exercise were: (i) to examine the prevalence of specialist primary health care services for single people who are homeless, and their geographical distribution; (ii) to identify the models or types of specialist primary health care services, and the main characteristics of these services; (iii) 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; and (iv) 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.

Specialist primary health care services were defined as 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, such as GP practices that run clinics in a hostel. It did not include GP practices that provide general medical services to people who are homeless, but do not have targeted or additional services or clinics for them. It also did not include specialist health services that did not offer general medical care, but focused on mental health, problematic drug or alcohol use, TB or sexual health.

The mapping exercise started in October 2015 and continued until March 2017. It involved two complementary surveys. The first collected information about the distribution of specialist primary health care services across England and the key characteristics of these services. The second survey collected information from homelessness projects about their arrangements for accessing primary health care for their clients, and the effectiveness of these arrangements. This involved hostels (including night shelters and temporary supported housing projects) and day centres (including drop-in centres) primarily for single people aged 18 years and over who are homeless.

Models of specialist primary health care services and key characteristics

The mapping exercise identified 123 specialist primary health care services in England for single people who are homeless. The types of services varied greatly. Some operated from a 'fixed' site, while some were a mobile team that ran clinics in various homelessness projects. Some were primarily for people who were homeless, while some provided health care to the general population but also delivered targeted services to people who were homeless. Some comprised a team of workers, while a few consisted of a single nurse who worked at a hostel or day centre.

A taxonomy was created to group the services, using categories that distinguished their different characteristics (Table 1). The 123 specialist primary health care services were classified into six models plus a seventh group which encompassed 'other medical / nursing arrangements':

- Model 1 consisted of 28 '**specialist health centres**' primarily for people who were homeless. They operated from a fixed site, and many offered

services provided by a multidisciplinary staff team, including mental health, drug and alcohol, and housing or welfare advice workers. Most also ran clinics in hostels or day centres for people who are homeless.

- Model 2 was **61 'GP practices with homeless services'**. These were mainstream GP practices that served the general population, but also provided enhanced or targeted services for people who were homeless at the GP practice or they ran clinics in hostels and day centres.

- Model 3 was **12 'mobile homeless health teams'** that worked with people who were homeless and other vulnerable groups who found it difficult to access mainstream services. The teams mainly consisted of nurses and nurse practitioners. They ran clinics or saw patients in various hostels, day centres, and other temporary accommodation and drop-in facilities.

- Other smaller specialist primary health care service models were:

  Four 'mobile homeless nurses' who operated single-handedly and ran clinics at several hostels or day centres (model 4); **seven 'nursing services based at a single day centre or hostel'** (model 5); **five 'volunteer health care services'** that operated mainly in hostels or day centres (model 6); and **six 'other medical or nursing arrangements'** (model 7). Some of the latter were run by social enterprises, commissioned by local Clinical Commissioning Groups, and provided specific health services for the general population, such as 'out-of-hours' services, and also health care in hostels or day centres.

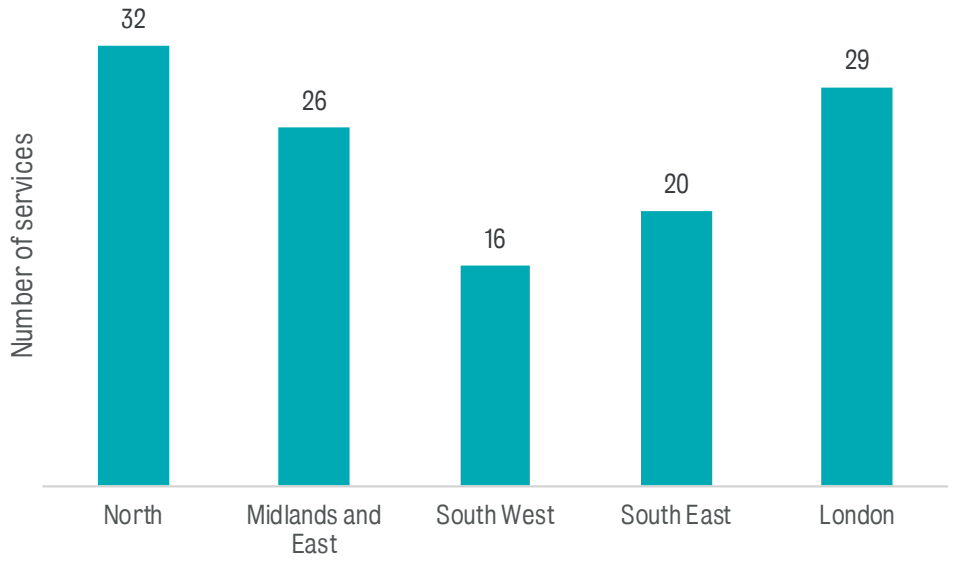
Table 1: Taxonomy of specialist primary health care services

Model	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
1.	Specialist health centre	Yes	Most services	Yes	Yes	Yes
2.	GP practice with homeless services	Yes	Some services	No	Yes	Yes
3.	Mobile homeless health team	No	Yes, multiple sites	Yes	Yes	Not usually
4.	Single-handed mobile homeless nurse	No	Yes, multiple sites	Yes	No	No
5.	Nursing service based at hostel or day centre	No	Yes, one site	Yes	Not usually	No
6.	Volunteer health care service	No	Yes, one or multiple sites	Yes	Some services	No
7.	Other medical / nursing arrangements	No	Yes, one site	No	Yes	Not usually

Distribution of specialist primary health care services

The 123 specialist primary health care services were spread across the five NHS England Regions (Figure 1). There was a cluster of such services in the North Region around Greater Manchester and Merseyside, and a single such service was found at several towns along the coast in the South West and South East Regions (Figure 2). 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.

Figure 1: Availability of specialist primary health care services by NHS regions

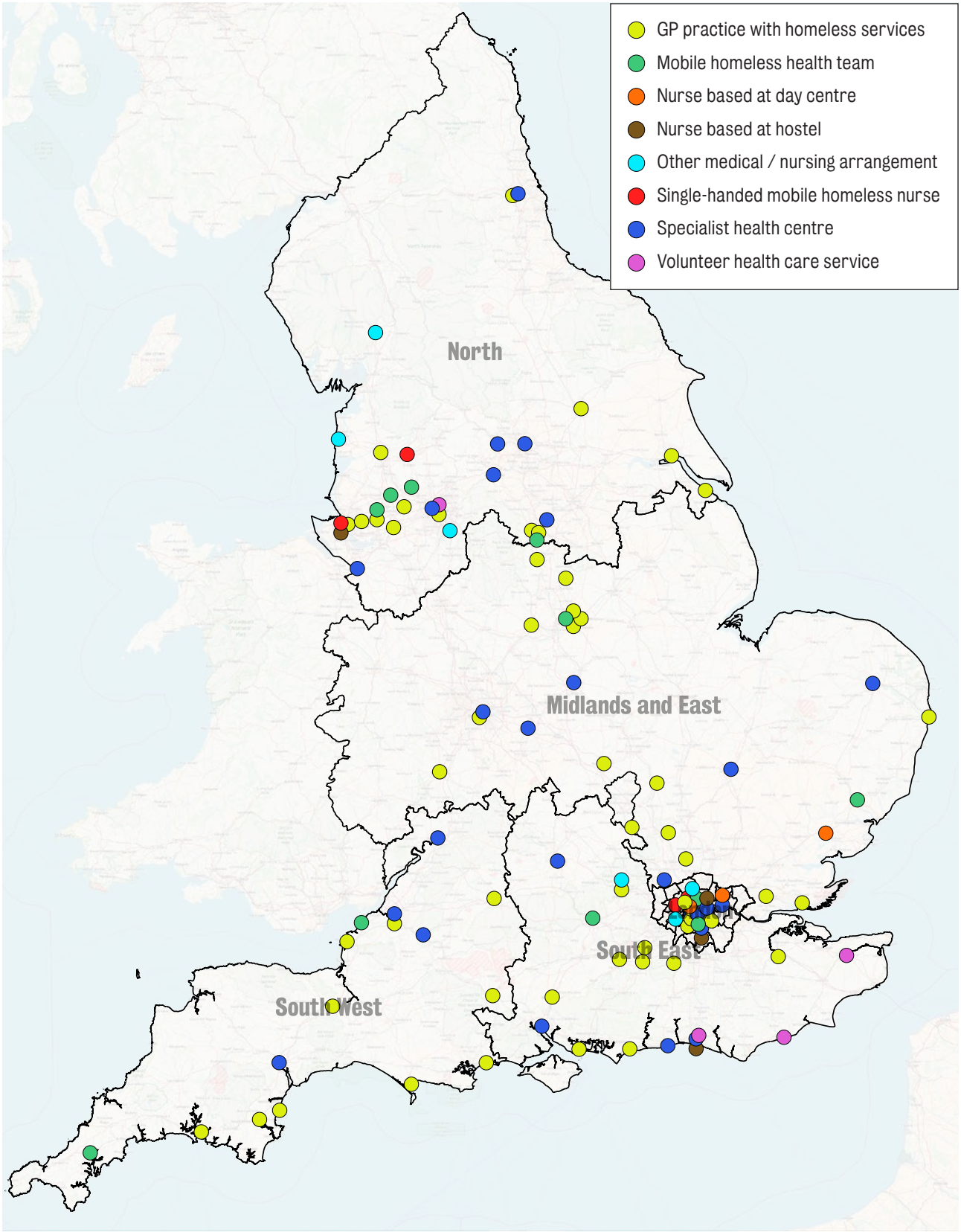


The specialist primary health care services were mainly located in urban areas where there are concentrations of people who are homeless, and hostels and day centres for this client group. Few such services were identified in rural areas, although a few of the mobile homeless health teams were based in urban areas and covered several small market towns.

Among the 35 largest cities in England (excluding Greater London), at least one specialist primary health care service was identified in 29 cities. There were six cities where no such service was identified – Lancaster, Peterborough, St Albans, Sunderland, Wakefield and Wolverhampton – despite these cities having people sleeping on the streets, and hostels and day centres for people who are homeless (Department for Communities and Local Government, 2017). As survey responses were not received from some of the homelessness services in these areas, however, it cannot be concluded that these cities had no specialist primary health care service.

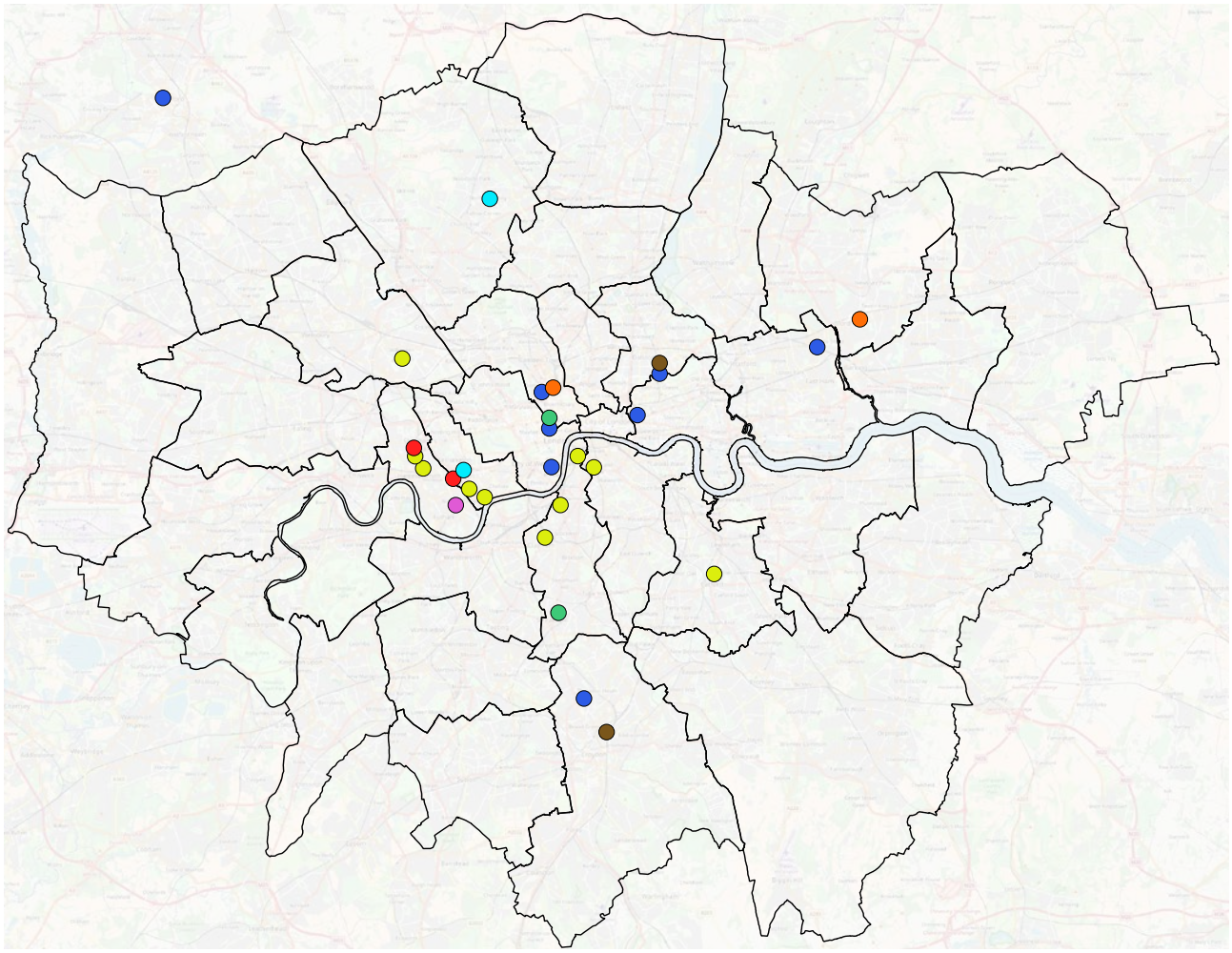
In Greater London, 29 specialist primary health care services were identified, but these were not evenly distributed among the boroughs. Such a service was identified in just 14 London boroughs. No specialist primary health care service was found in 18 boroughs nor in the City of London. Most of the boroughs without such a service were in outer London (Figure 3).

Figure 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: Distribution of specialist primary health care services 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

Homelessness projects and their links to specialist primary health care services

A survey was conducted of 900 homelessness projects (702 hostels and 198 day centres). Of these, 43.4% were linked to a specialist primary health care service, 40.2% were not linked to such a service, and information about health care was unavailable for 16.3% of homelessness projects. Given that data was gathered from most specialist primary health care services, it can be assumed that the majority of homelessness projects where no information was available were not served by such a service. This suggests, therefore, that up to 56.5% of homelessness projects were not linked to a specialist primary health care service.

Day centres were nearly twice as likely as hostels to be linked to a specialist primary health care service. This applied to 68.2% of day centres compared to just 36.5% of hostels. Health clinics run by a doctor or nurse were held at least weekly at 49.5% of day centres and 14.3% of hostels.

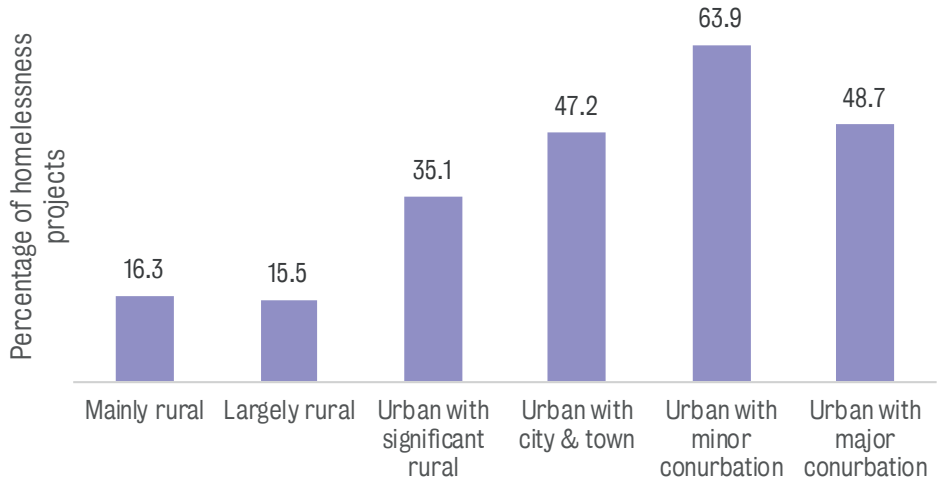
Large hostels were more likely to be covered by a specialist primary health care service than smaller ones. This applied to 58.4% of hostels with 41-60 beds, 51.7% with 61 or more beds, but only 23% that had 20 beds or less.

Hostels and day centres that worked exclusively with young people aged 25 years or under 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 for young people compared to 51.3% for adults.

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, and those in Midlands and East region least likely, to be linked to a specialist health scheme (50.6% and 38.0% respectively).

Hostels and day centres in rural areas were much less likely to be served by a specialist health service than those in urban areas. This applied to around 16% of homelessness projects in 'mainly rural' or 'largely rural' areas, compared to nearly two-thirds of projects in urban areas with minor conurbations and nearly one-half in urban areas with major conurbations (Figure 4).

Figure 4: Homelessness projects covered by specialist primary health care services by rural-urban areas



Note: Rural-urban classification for Local Authority Districts in England (Bibby and Brindley, 2014).

Homelessness projects without specialist primary health care services

Many homelessness projects are reliant on their clients accessing primary health care from mainstream GP practices that do not provide special or enhanced services for people who are homeless. Information was collected from the managers or senior staff of 243 such projects about their views and experiences of primary health care arrangements for their clients.

Among the managers of homelessness projects not linked to a specialist primary health care service, 10.7% said that their clients experienced 'a lot' of difficulties accessing primary health care services, 46.7% said that their clients experienced 'some' difficulties, and 42.7% said that there were no problems.

There were differences in reports of difficulties accessing primary health care by NHS regions. In the Midlands and East Region, and the South West and South East Regions, nearly two-thirds of homelessness project managers reported difficulties some or a lot of the time. In comparison, just 39.3% of managers in London reported problems.

Difficulties accessing primary health care for clients was most commonly reported by homelessness project managers in the following counties: Berkshire, Buckinghamshire, Cornwall, Gloucestershire, Nottinghamshire, West Midlands and West Yorkshire.

The main difficulties of accessing primary health care 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 healthcare 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. In some rural areas, the difficulties were compounded by poor transport links and travel costs.

Considerations for health 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. The findings of this mapping exercise, however, raise two important questions for consideration by health service commissioners and providers about what local services should offer.

1. Are the primary healthcare 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 their locality. Several local 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, the availability and accessibility of current primary health care services in the locality to people who are homeless, and the extent to which these services are effectively engaging with and meeting the health care needs of local people who are homeless.

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 most effective in meeting the health care needs of 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.

Although there are many gaps in evidence 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 this mapping exercise: (i) 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; and (ii) 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. 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 or reablement services to people who are homeless.

More information is needed, however, 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 (rural / urban areas) and different population sizes. 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.

References

Bibby, P. and Brindley, P. (2014). *Rural-Urban Classification of Local Authority Districts in England: User Guide*. London: Department for Environment, Food and Rural Affairs, and Office for National Statistics. https://www.ons.gov.uk/methodology/geography/geographicalproducts/ruralurbanclassifications/2011ruralurbanclassification (accessed 12 November 2017).

Department for Communities and Local Government (2017). *Rough Sleeping Statistics England Autumn 2016: Table 1 Street Counts and Estimates of Rough Sleeping in England, Autumn 2010-2016*. London: DCLG. https://www.gov.uk/government/statistics/rough-sleeping-in-england-autumn-2016 (accessed 22 October 2017).

Wright, N.M.J. and Tompkins, C.N.E. (2006). How can health services effectively meet the health needs of homeless people? *British Journal of General Practice*, 56, 286-93.

Acknowledgements

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.

About the authors

Gaia Cetrano, Research Associate at King's College London, has a background in social work and was awarded a PhD in Psychiatric Sciences from the University of Verona, Italy, in 2015. With her thesis 'Quality assessment of mental health and social care services. Findings from the European REFINEMENT project and an Italian multicentre study', she has contributed to the mapping of mental health services in nine European countries and the development of a set of tools for the assessment of mental health care provision in Europe. Research interests include health systems analysis, homelessness, mental health care, and health and social care outcomes evaluation.

Sarah Coward is a Freelance Research Consultant and has been working with SCWRU for the last seven years. She has 18 years' academic research experience in the fields of housing and homelessness, and has a particular interest in the housing, health and social care needs of homeless people. Sarah specialises in qualitative research and has worked on a number of large scale longitudinal studies. She is currently studying for a PhD at The University of Sheffield entitled: 'The meaning of home for people with experience of homelessness'.

Maureen Crane, Principal Research Fellow at King's College London and former Reader in Applied Social Research at the University of Sheffield, has been conducting studies on homelessness since 1989. She pioneered research in the UK into older homelessness, and completed a PhD in 1997 on 'Pathways into Later Life Homelessness'. She has since developed a substantial research programme on homelessness among people of all ages. Groundbreaking studies include a three-nation study of the causes of homelessness among older people in England, Boston (Massachusetts), and Melbourne (Australia), and a longitudinal study of the outcomes over five years for homeless people who were resettled.

Blanaid Daly is Professor and Consultant in Special Care Dentistry at the Dublin Dental University Hospital at Trinity College Dublin. She is lead for provision of dental care for individuals and groups with special care dental needs, and is involved in workforce training and research in Special Care Dentistry. Prior to her return to Ireland in August 2016, Blanaid was involved in developing dental services for homeless people in the UK, including 12 years providing a targeted dental service for homeless people in south London.

Dr Chris Ford recently retired from General Practice after 30 years. She developed special interests in working with people who use drug and/or alcohol, HIV and hepatitis and sexual health, enjoyed the work and learnt from the people she cared for. As there was no support for this work back then, with a small group of friends she founded Substance Misuse Management Good Practice (SMMGP) and remained its Clinical Director until 2011. Increasingly concerned about the gap between practice and policy, in 2009 Chris set up International Doctors for Healthier Drug Policies (IDHDP) to be the bridge between practice and policy and increase the international participation of medical doctors in drug policy.

Professor Heather Gage is an experienced health economist and health services researcher, and Director of the Surrey Health Economics Centre. Within the Centre, Heather manages five research analysts and an ongoing portfolio of over 20 collaborative studies that focus on evaluative studies and outcome measurement. Heather's research is typically interdisciplinary, with interests encompassing many aspects of health service delivery. She has published over 100 articles in international peer reviewed health, clinical and medical journals. She has held visiting positions at the Boston University School of Public Health and the Center for Health Quality, Outcomes and Economic Research of the US Veterans Healthcare Administration.

Louise Joly, Research Fellow at King's College London, has worked in health and social care research since 2003, following a career in district nursing and in providing primary health care to single people who are homeless. She was awarded a PhD (University College London, 2009) in primary care and population sciences with her thesis 'A mixed methods study to explore interagency working to support the health of people who are homeless'. Her research interests include homelessness and social exclusion; delivery of health care to people who are homeless; and interprofessional and interagency working.

Jill Manthorpe is Professor of Social Work and Director of the Social Care Workforce Research Unit at King's College London where she undertakes studies at the interface of health, care and housing services. She is Emeritus Senior Investigator with the National Institute of Health Research (NIHR), a former Non-executive director of NHS Trusts. Prior to her research career Jill ran an urban advice centre and provided training on housing benefits, welfare rights and tribunal representation.

Peter Williams has worked as a medical statistician for over 30 years, undertaking planning (primarily in relation to required sample sizes, notably in his current part-time role as an adviser for the South East branch of the NIHR funded Research Design Service) and analysis in over 500 projects. These range from randomised controlled clinical trials (both human and veterinary) to large scale observational surveys and epidemiological studies. He also provides advanced level statistical computing support (SAS/SPSS).

kcl.ac.uk/sspp/policy-institute
@policyatkings

---

kcl.ac.uk/sspp/policy-institute/scwru
@SCWRU